



Euthanasia Services: The Next Health Tourism Wave

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Abstract: This paper explores euthanasia as a medical tourism product. Euthanasia and physician assisted suicide are generating much controversy and have been legalized in some countries and banned in others. The study examines the trends, characteristics and legality of euthanasia as tourism product. A comparative analysis between selected western (Netherlands, Mexico) and eastern countries (Japan, India) is provided. Euthanasia services are gaining popularity and becoming tourism pull factors in few western countries. Whereas, eastern countries provide euthanasia services only to the local population. The research showed that countries with strong religious convictions tend to oppose euthanasia more than those with less religious convictions. Due to “Die with Dignity” campaign, the number of euthanasia supporters in developed countries is increasing tremendously. An increasing number of affluent residents of the world will continue to travel to euthanasia service providing western countries in the pursuit of a new tourism product (euthanasia).

Keywords: Euthanasia Medical Tourism, Health Tourism, Tourism Product

Introduction

This paper explores euthanasia services as a potential medical tourism product. The acceptance and validity of this new tourism product (death tourism) will be assessed. In selected countries (Switzerland, Belgium, Netherlands, and five American states) the idea of ending one's life through assisted death "Euthanasia" is becoming indefatigable and socially acceptable. However, assisted death has strong opposition and is considered illegal in several developed countries including (Spain, United Kingdom, Australia, France, Ireland...) (Miller & Gonzalez, 2013). This divide led terminally-ill individuals who are determined to end their lives to travel to favorable countries (Switzerland, Netherland, Mexico...) to receive lethal medical assistance. Death tourism is an emerging business which has generated international debate about the legality of both euthanasia and physician-assisted suicide (Safyan, 2011).

The origin of the word euthanasia comes from Greek where it means happy and easy death (Reich, 1978). Euthanasia is defined as the act of painlessly ending the lives of individuals who are suffering from an incurable disease (Mahmood, 2008). Huxtable (2009) defined assisted suicide tourism as helping individuals to travel from one jurisdiction to another to be assisted in ending one's life. Euthanasia has been a topic of much controversy throughout the years. William (1985) argued that the act of euthanasia violates medical ethical codes. Williams believes that the first priority of medical professionals is to save life. If a life were to be lost, medical professionals consider this loss as a personal failure and as a deficiency in one's professionalism and know-how. If euthanasia were to be legalized and widely practiced, the professional norms of medical experts may be compromised.

This controversial issue has generated lots of debates, especially when millions of dollars are being spent for the sole purpose of dying. In fact, a business that is built on the principles of death galvanizes this undertaking. It is in the best interest of terminally ill individuals as well as euthanasia service providers to support this practice. The mission of euthanasia service providing centers is being challenged as to whether the centers are there to ease the pain and suffering or generate profit and improve the bottom line.

Literature Review

Until the eighteenth century, there was not much discussion about euthanasia in Europe (Manning, 1998). In 1973, a court in Netherlands has initiated a bold ruling toward legalizing euthanasia. The magistrate decided not to penalize the doctor who has assisted her severely-ill mother to her death after multiple requests to be euthanized (Sheldon, 2007).

Despite the fact that many countries completely ban euthanasia, there has been a rising demand to legalize euthanasia in several countries such as United Kingdom, Scotland, Germany and New Zealand... For example, in 2011, New Zealand reduced the sentence for assisting in suicide to five months of detention rather than lifelong incarceration as for an ordinary criminal. Due to public outcry and to the huge support for euthanasia, a euthanasia service provider is perceived as a counselor and not as a terminator (Norman, 2012). Sean Davison, who is a microbiologist, has assisted his 85 years old mother to her death after realizing that she no longer desires to live. Davison published a book *Before we Say Goodbye* on how hard but right it was to fulfill his mother's desire (Davison, 2012).

Legally, euthanasia is classified into three categories. As a murder requiring lifelong sentence, as assisted death for economically privilege individuals, and as a legal method to fulfill all the needed requirements while decriminalizing service providers. The crackdown on euthanasia service providers in countries where euthanasia is illegal, ranges from several months of detention to death penalty (Božidar & Veljko, 2014).

Since 2000, few countries have come forward and legalized euthanasia. In 2002, the Netherlands passed laws legalizing euthanasia. Later on, Belgium and Luxembourg embraced similar laws (Tinne, et al., 2011). All the three countries limited euthanasia services only to their local residents (Karlsson, 2011). On the other hand, Switzerland allowed doctors to prescribe drugs and lethal doses to foreign nationals. This action led to an increase in the number of incoming death tourists. Nowadays, Swiss assisted suicide businesses are becoming more popular and are promoting their country as a destination for people willing to terminate their lives. "Dignitas" and "Exit" clinics supply the patients with the needed drugs and premises to end one's life at an affordable price (\$6000). "To live with Dignity, to die with Dignity" is Dignitas motto.

According to Dignitas, which was established in 1998, 200 deaths resulted from their work and the number is increasing (Fischer, et al., 2008). In the United States five states (Oregon, New Mexico, Vermont, Washington and Montana) have legalized assisted suicide.

Netherlands took an unprecedented move toward child euthanasia. When the law was first passed in 2002, it was restricted to only fully conscious adults who made up their minds to terminate their lives (Tinne, et al., 2011). Hence, the parliament had decided that even a 12-year old child who is severely suffering from an incurable painful disease has the right to bury his agony (Bosch, 2014). Assisted suicide has become a widely acceptable practice in the Netherlands. According to a recent study, one out of 33 people end their lives through euthanasia in Holland (Reid, 2015). It has been much as a life style choice rather than a final desperate alternative.

Euthanasia opposing countries (Germany, United Kingdom) consider it a felony if a person were to facilitate euthanasia (as helping the patient travel to Switzerland). This type of felony requires fourteen years of imprisonment. Some legal analysts consider that Germany and Great Britain are outsourcing their assisted suicide matters to Switzerland, removing the burden off their shoulders on confronting the legality issues of euthanasia (Roxby, 2012).

German death tourists are ranked number one and are almost a quarter of the euthanized patients in Switzerland. According to a study published in the Journal of Medical Ethics, the number of German suicide tourists that visit one of the four clinics in Switzerland, which offer “death services” for locals and foreigners, is estimated to be 268. Next comes United Kingdom with 126 patients (Guathiar, et al. 2014). In Switzerland, six right-to-die organizations have provided up to six hundred suicide deaths annually (Keating, 2012).

In an attempt for a fair play, even countries legalizing assisted suicide have established best systems of palliative care. Palliative care tackles the emotional, physical, and psychosocial anguish of severely-ill patients. Moreover, palliative care extends its support to family members through the delivery of medical care and attention to loved ones. Belgium, Iceland, Switzerland, the United States and sixteen other countries worldwide initiated palliative care services. Physicians working at palliative care centers who provide euthanasia services are at one hand extending one’s life and on the other ending the lives of those who are terminally-ill and desire to do so. Palliative care centers want their patients to be confident and satisfied with their health

care systems, along with providing the best medical amenities to terminally-ill people, keeping assisted-suicide as a remote option (Bernheim, et al. 2014).

It is important to differentiate between the four different types of euthanasia. 1) The voluntary active euthanasia is when the doctor intentionally gives medication to end the patient's life. Life ending medication could only be provided at the patients request and full consent. 2) The voluntary passive euthanasia is about discontinuing life support (Manning, 1998). 3) Physician assisted suicide (PAS), which has been commonly used in some countries, is when the doctor gives a prescription of a lethal drug to terminate patient life upon request, and the patient self-administers the drug (Materstvedt & Kaasa, 2002). 4) Terminal Sedation is used in 96% of the times when a terminally ill person is in the last days of existence. This process requires dispensing substantial amount of heavy drugs to the patient to relieve pain; however, the side effects of this method may induce coma-like state. Morphine is the most commonly used treatment, though this medicine doesn't assist in death but only masks the pain. The patient rarely survives more than few days after the drug is administered (Rietjens, Maas, Philipsen, Delden, & Heide, 2009).

Methodology

The study compares euthanasia practices in two western countries verses two eastern countries. Euthanasia practices in a Western European country (Netherlands) and a North American country (Mexico) will be compared to those practices of two eastern countries (India and Japan). The impact of such medical services on the tourism industry will be discussed.

Case of Netherlands

In 2002, Netherlands enacted the law of "Termination of Life on Request and Assisted Suicide Act". This law aims at regulating euthanasia and assisted suicide for locals and tourists. Physicians who provide euthanasia or suicide services must act in accordance with due care. If not, their services may be questioned and their actions are subjected to strict laws. Due care requires: the consent of the patient, assessment of the level of suffering, providing detailed information to the patient, the pursuit of a second expert medical opinion and the inclusion of an in-depth detailed description of euthanasia procedure. All the above criteria must be filed in a report and reviewed by a special committee to approve or dismiss the case.

The procedures related to euthanasia and assisted suicide, were proposed by the 66th minister of Health, Mr. Els Borst, and have been embraced by the medical community for over twenty years. The “Termination of Life on Request and Assisted Suicide Act” permits euthanasia and assisted suicide under the following circumstances:

- 1) The patient is suffering badly, and no expected improvement can be forecasted.
- 2) The request of the patient for euthanasia or assisted suicide must not be taking place under the effect of drugs, psychological illness, or by the influence of others. In other words, the request must persist over time, and should be voluntary.
- 3) Doctors must make sure that the patient is fully aware of his/her situation and the available treatment options.
- 4) After the completion of the diagnosis process with the first doctor, the file of the patient will be presented to another independent doctor for approval or denial.
- 5) The death procedures are to take place with medical appropriateness. Committing suicide might be done by the patient himself or with the aid of a doctor; however, in all cases, the presence of a doctor is mandatory.
- 6) Assisted dying is not allowed for those less than 12 years old. Moreover, patients belonging to the age group [12-16] years are supposed to have parental approval.

When death takes place, the physician is required to report the patient’s cause of death along with the entire file to the municipal coroner. The whole file must be in accordance with the appropriate requirements of the “Burial and Cremation Act”. The Review committee takes the file, and assesses whether it is in compliance with the due care criteria. If it is in compliance, the case is closed. Otherwise, the case will be brought forward to the Public Prosecutor to be assessed again. Moreover, explicit recognition is offered in the presence of a written declaration of will regarding assisted suicide or euthanasia. This might take place in cases when the patient is unable to declare consent or desire to be assisted for suicide or euthanized, as in the case of a coma. In short, if either the criteria of due care or the standards mentioned above are not met, euthanasia is considered a criminal offense. Some exceptions which are not subjected to the limitations of the law include the following:

- If the medical treatment is stopped
- If the patient requested stopping or starting the treatment
- If serious suffering is increased as a side-effect by speeding up the death

This strict qualification criteria, is becoming easier and easier with the years. First, when regulations were implemented, only terminally-ill individuals that were in unbearable painful situations were considered eligible to be euthanized. The definition of “unbearable suffering” is being broadened each year. However, nowadays, doctors are offering assistance for people willing to die if they feel lonely, depressed, have no interest in life anymore, or even depending on others for care. Boer as cited in Ross (2015) stated that one in ten of the past 500 files he has read contained some reference to “loneliness”.

Right-to-Die organizations are gaining large popularity in Netherlands. According to “Right-to-Die Netherlands” statistics, its members increased from 120,000 in 2010 reaching 160,000 in 2015. The average daily signups is 30 to 50 (Ross, 2015).

In Netherlands, the situation is not controllable or limited anymore. Even the minors can now choose euthanasia. If parental consent is provided, children from the age 12-15 can ask to be euthanized. At 16, teenagers are allowed to make their own decision with only “parental involvement”. Pediatrician Eduard Verhaegen helped establish the Dutch euthanasia guidelines for infants argues “If we say the cutoff line is age 12, there might be children of 11 years and nine months who are very well capable of determining their own fate and making their own decisions, but they’re not allowed to ask for euthanasia (Ross, 2015).”

The critics of legalizing euthanasia in Netherlands claim that much of it has to do with financials. The CEO and president of Not Dead Yet, a group that acts against the legalization of euthanasia and assisted suicide, Diane Coleman says, “We see people denied the care they need for economic reasons. Assisted suicide is the cheapest kind of treatment that could be offered by the system. These pressures are a reason for concern.”

According to Netherlands’ data, from 2002 till 2013 the number of people who chose assisted-suicide tripled to reach 4829 deaths. This contributes to one in every 28 deaths in Netherlands (Cessou, 2014).

Case of Mexico

Passive euthanasia has been legalized in Mexico since 2008. Passive euthanasia enables severely-ill patients to sign a document which prevents the administration of drug or medication which expedite death. However, active euthanasia is still banned and considered illegal. In countries, where the law is compromised due to the absence of tight governmental control, active euthanasia is widely practiced. The Mexican government's laws concerning assisted dying are not as rigid as those mandated on clinics in Switzerland or Netherlands. In the latter countries, doctors are required to council and advise the patient to choose life over death.

Pentobarbital is a drug used to euthanize animals if used in concentrated form. When diluted, Pentobarbital can also be used to anesthetize humans during surgeries. Veterinary shops sell this liquid form of drug to individuals willing to end their lives. Pentobarbital could be purchased by both local citizens and tourists. The drug is sold for a very affordable price of \$35 to \$50, and when adding the expenses of the trip for "death-tourists" it sums up to \$3000 which is reasonably priced compared to the one set by assisted suicide clinics (Robin, 2008). However, there is a price for being a low cost drug. There are numerous instances where the designed for animals Pentobarbital drug, had been administered to humans. Studies indicate that this low cost drug is not as efficient when administered to humans; in fact it has caused numerous complications (Patten, Naqvi, Raszynski, & Totapally, 2015).

Pentobarbital is viewed as the most peaceful, cost effective and easy way to die. It makes the person fall asleep and within one hour the individual will lose breath and die without suffering. Mexico is rated as the number one country for the accessibility and Pentobarbital ease of use. In fact, Mexico is viewed as one of the most competing tourism suicidal destination (Lacey, 2008). On the other hand, the Catholic Church has a strong position and favors the banning of euthanasia. The Church considers the legislation of passive euthanasia a very irresponsible act named "disguised euthanasia". Father Jorge Raúl Villegas when criticizing the legislation of passive euthanasia states "we would be almost talking about suicide, that is to say, whenever I am sick, I sign a statement so that according to my desire they won't give me any treatment and I can die without pain" (Hoffman, 2010).

Another interesting fact about assisted Suicide in Mexico is the origins of this practice. It started in 1996 with Dr. Philip Nitschke. Dr. Nitschke introduced Pentobarbital, which was known in Australia as Nembutal. Few months of its debut, the Australian government prohibited the selling of Nembutal. This prohibition led Dr. Nitschke to relocate to Mexico. In his book; *The Peaceful Pill Handbook* Dr. Nitschke describes ways in which a person can peacefully kill himself especially in Mexico. He explains his choice of Mexico for being an affordable destination because the government has turned its blind eye on suicide issues. In his book, he pinpoints the specific stores where a person can find the drug and how to be administered (Nitschke & Stewart, 2007). This book is updated annually. Pentobarbital gave Mexico its fame for being the perfect destination for suicidal tourists; thus, it would not be surprising to find that this destination receives far more “death-tourists”.

Case of India

India is perceived as the land of religions. Hinduism is the dominant religion in India where 82% of Indians are Hindus. Then comes Islam where 12% of Indians are Muslims.

There are two opposing perspectives on euthanasia in Hinduism:

- Some Hindus believe that euthanasia cannot be allowed because it breaches the teaching of ahimsa (doing no harm). In addition, they believe that by serving to terminate a person’s life, even one loaded with agony, individual is interfering in the timing of the phase of death then resurrection, causing the disturbance of the cycle. In this case, the euthanasia service providers will have to take and bear proportionally the remaining Karma of the dead patient, and each participant (drug seller, nurse assistant, supervising physician) will face a similar karmic situation in this life or a future life according to his/her degree of contribution.
- On the other hand, some Hindus view euthanasia as a good action. They believe that by serving to terminate an agonizing painful life, the physician or service provider is performing a good act, thus satisfying his/her ethical commitments (Roy, 2011).

Islam explicitly bans euthanasia and suicide. Muslims believe that the lord (Allah) gives life and chooses the date of death. They believe that human life is sacred, and that humans have nothing

to do with choosing the way, the date and the place of their departure from this life. "Do not take life, which Allah made sacred, other than in the course of justice." (Qur'an, Surah, Al-Isra', 17:33). It is clearly stated in Qur'an that euthanasia and suicide are prohibited: "Destroy not yourselves. Surely Allah is ever merciful to you" (Qur'an, Surah, Al-Nisa', 4:29). Moreover, it is believed in Islam that when a person is suffering, the best thing to do is patience. "And bear in patience whatever (ill) maybe fall you: this, behold, is something to set one's heart upon" (Qur'an, Surah, Luqman, 31:17). Islam encourages taking care of patients, and to relieve their suffering. Quran says, "Anyone who has saved a life, it is as if he has saved the life of whole mankind" (Qur'an, Surah, Maeda, 5:32). Prophet Muhammad stressed this issue when he said "O Muslims seek cure, since God has not created any illness without creating a cure."

In Indian law neither euthanasia nor Physician Assisted Suicide is considered legal. This was till December 2014 where the Supreme Court took the decision of legalizing Passive Euthanasia (withdrawing medical treatments or life support machines) for patients who are brain dead or suffering from permanent vegetative state.

The case that created the euthanasia debate in India was the "Aruna Shanbaug" case. In 1973, Aruna – a medical nurse- was raped and choked by the janitor at the hospital where she was working. The incident caused her severe brain stem injury and left her blind and deaf. She has been in this state for four decades (Supreme Court's judgment on Aruna Shanbaug euthanasia petition, 2011). Pinki Virani wrote a book about Aruna in 1998 and then went to the court to plea for Aruna's passive euthanasia. Due to her relationship with the patient, the court didn't approve her euthanasia request on Aruna's behalf. Virani didn't stop there; she pleaded the Supreme Court to legalize euthanasia in cases like Aruna. The hospital and nurses fought for Aruna's life in the court, where Parker the dean of the KEM Hospital and Medical College stated "Euthanasia does not even enter our minds as a thought. It does not exist in our vocabulary. Everybody in the hospital loves Aruna so much. We come from a culture which believes in destiny, duty and compassion. We are not an individualistic society" (Lakshmi, 2015).

Case of Japan

In Japan there are no official laws related to euthanasia. But from the cases that happened in Japan, both passive euthanasia and physician assisted suicide can be considered legal if satisfying certain conditions. In both cases the doctors were considered guilty, since not all

conditions were met. They received two to three years imprisonment with hard labor term which was suspended later on.

In order for Passive euthanasia to be legal, three conditions should be met:

1. The patient must be suffering from an incurable disease, and in the final stages of the disease from which he/she is unlikely to make a recovery.
2. The patient must give express consent to stopping treatment, and this consent must be obtained and preserved prior to death. If the patient is not able to give clear consent, their consent may be determined from a pre-written document such as a living will or the testimony of the family.
3. The patient may be passively euthanized by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, IV drip, etc.

The court then listed four conditions under which mercy killing would be permitted in Japan:

1. The patient is suffering from unbearable physical pain.
2. Death is inevitable and imminent.
3. All possible measures have been taken to eliminate the pain with no other treatment left open.
4. The patient has clearly expressed his or her will to approve the shortening of his or her life.

Kawasaki-Kyodo-Hospital-Case 2005:

A 58 years old man was suffering from hypoxemia that resulted in damaging his brain, causing him the permanent loss of consciousness. His doctor believed that he was in the last days of his life, and wanted him to breathe naturally in his last moments. The doctor removed the respiration tube from his trachea. To her surprise, when she removed the tube, the patient stayed alive breathing with difficulty. The doctor thought of administering a muscle relaxant drug into the patient's vein, but she didn't want his relatives to observe the procedure. She asked a nurse to inject the drug, and shortly after that the patient was dead. She then told his family that he was 99% brain dead. When reviewing the case, the court found the doctor guilty of homicide, and sentenced her to three years of imprisonment with hard labor.

Research Findings

The research showed that countries with strong religious convictions tend to oppose euthanasia more than those with less religious convictions. From a religious view, “God has forbidden the act of willingly taking someone’s life”. The concept of assisted or organized suicide revolves around the criticized idea of “playing God”. However, various documentaries that taped clients throughout the phases of their assisted suicides were broadcasted to the Media. Those people that were taped emphasized the fact that when suffering comes to the game, even doctors and nurses play God.

Due to “Die with Dignity” campaign, the number of euthanasia supporters in developed countries is increasing tremendously. An increasing number of affluent residents of the world will continue to travel to euthanasia service providing western countries in the pursuit of a new tourism product (euthanasia). Consider the impact of such a trend when it becomes an organized touristic plan for those who suffer from a terminal or progressive illness, or a "weariness of life". In Switzerland, the number of terminally ill tourists using Swiss medical facilities for voluntary euthanasia doubled between 2009 and 2012. In total, 611 foreign tourists were euthanized in Dignitas clinic between 2008 and 2012 (Kooren, 2014) . When promoting its euthanasia business “Exit International”, campaign included the following statements: “You do this trip because you want an insurance policy; you make it in good health so that if you become terminally ill this can guarantee you a quicker exit" Irwin as cited in (Emmott, 2008). Special trips are planned for UK residents to go to Mexico and buy the “killing drug” (Emmott, 2008).Suicide tourism as explained earlier is a controversial trend in which various factors interfere. In fact, major critics on this type of organized tourism mainly revolve around psychological, social, legal, and religious dimensions.

Assisted suicide or euthanasia creates a bundle of mixed reactions and people would have different personal opinions on this subject, especially with morality issues related to such deaths. But beyond that, there are also issues of legality. In fact, what is legally acceptable in one country is a punishable crime in another and that’s why only few countries host this type of dark tourism. People now would travel to another country that legally allows them to end their lives. For those countries in which suicide tourism is being legalized, the legalization of the practice

would be by itself considered as a strategic marketing campaign. More and more people around the world would be informed about the existence of such a trend; and therefore tourists would be intrigued to go visit and discover the truth of what is being reflected by the Media. Supporters of suicide clinics and legislators that promote assisted suicides would argue that banning such a practice would imply an increase in the number of violent and aggressive deaths.

Conclusion and Implications

The purpose of this study was to explore whether euthanasia services promises to be a potential tourism product. The study compared euthanasia practices in two western countries versus two eastern countries. The discussion of euthanasia in the four countries showed that the level of acceptance and adoption of euthanasia practices vary between countries based on religion, culture and legality. Eastern countries possess a stronger tie with religion and an explicit bold view toward banning euthanasia. While western developed countries had witnessed many citizens' movements to support euthanasia practices in their countries. Euthanasia in Western countries is considered as a human right or as final resort in extreme cases.

Suicide tourism has been used interchangeably with concepts like "euthanasia tourism", "assisted dying", and "assisted suicide". Suicide tourism is a form of tourism associated with the pro-euthanasia movement. This form of tourism revolves around suicide candidates organizing trips to the few destinations that allow such practice. Suicide tourism remains an ill-grasped concept around the globe. Zurich (Switzerland), Belgium, Holland (Netherlands), Cambodia, Luxembourg, and few states in the United States including Oregon, Washington, and Montana have already legalized assisted dying. While tolerated in many countries, the practice is highly criminalized and penalized in other areas. Tourism researchers question if suicide tourism solve a problem or does it create a new sets of problems? Is the industry ready to embrace this new kind of business? In the 20th century, the hospitality and tourism industry embraced the concept of assisted living, and retirement communities. Remain to be seen if in the 21 century the industry would embrace euthanasia services as a medical tourism product.

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