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UNDER WHICH CONDITIONS COULD ACTIVE EUTHANASIA BE LEGALISED IN LATVIA?

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8.04.2024.

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Abstract

Over the past few years, more and more countries in the EU have begun discussions on legalising euthanasia. An increasing number of people are publicly showcasing their support for it as they consider it to promote a patient's autonomy and rights. Latvians are no different, as in 2021, a petition called "Par labu nāvi – eitanāzija legalizācija" gathered the needed 10,000 signatures to be put forward to the parliament of Latvia – Saeima. Nevertheless, the petition was quickly rejected without the involvement of specialists from the field that the law would impact. Thus, we decided to understand what the opinions of medical personnel are, the rationale behind the Members' of Saeima resistance to legalisation, and whether their concerns could be eased by a preliminary list of criteria for the performance of active euthanasia. First, we performed document analysis to determine the overall stance of the interviewed medical personnel on legalising active euthanasia. We concluded that the overwhelming majority are in favour. Second, we employed content analysis to develop a list of criteria for the performance of active euthanasia that would be acceptable to the majority of medical personnel. This was a pivotal step in our thesis, as it would be used to address the concerns of politicians who oppose it. Thirdly, we performed document analysis once again to identify arguments of opposing politicians from the semi-structured interviews. All in all, we identified 10 groups of objections. Fourthly, we implemented qualitative comparative analysis to understand which of the criteria from the developed list were more likely to respond to the concerns raised by Members of Parliament. We discovered that one concern and another partially can be addressed by the criteria. The rest of the arguments *against* underwent a separate evaluation from which we concluded that they are not strong either, when confronted with fact-based evidence against them. Regarding the limitations of our thesis, it could be conducted on a larger scale of medical personnel, all representatives of Saeima, and involve the Latvian society, as it would eliminate any potential biases occurring through sampling techniques and provide the true and full picture of the matter in Latvia.

Keywords: Euthanasia, medical ethics, public ethics, Latvian healthcare, Latvian politics.
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1. Introduction

Euthanasia, classically, is defined as "the hastening of death of a patient to prevent further sufferings," (Chao et al., 2002, para. 4). This entails that another party – medical personnel – is engaged in the process of ending the life of an individual – usually understood as a terminally ill patient. Due to the reason that euthanasia entails allowing an individual or a group of individuals - the medical personnel -, to hasten or cause the death of an individual ("an innocent"), euthanasia has become a challenge for the 21st-century science of criminal justice, as this topic is gaining more and more attention nowadays. On the one hand, the main responsibility of criminal justice is to protect the interest of an individual, set in the criminal law, from any possible threats imposed by the other party (Poļaks, 2015). However, the law mustn't illegitimately interfere with one's fundamental human rights – "human will is an important part of human dignity," (Council of Europe, 2022, para. 8).

Not only is euthanasia a challenge for criminal justice but also ethics, especially medical ethics. As Nunes and Rego (2016) describe it "from a strict medical ethics perspective, international guidelines following the Hippocratic Oath and the World Medical Association Declaration of Geneva still consider euthanasia and physician-assisted suicide as a morally forbidden practice," (p. 1). Doctors give Hippocratic oath to not harm patients but also to respect a patient's autonomy (Rīgas stradiņa universitāte, n.d.). This all leads to the conclusion that due to the various dimensions of euthanasia, such as ethical, legal, and religious, it can be deemed as one of the most controversial and complex issues facing human rights nowadays as it runs against many intuitions, religions, and moral prohibitions of murder (Shala & Gusha, 2016).

In 2002, the Netherlands became the first country to fully legalize euthanasia in Europe (The Guardian, 2014). The modern movement from traditional authority structures – based on long-standing traditions, such as hierarchical arrangements among medical professionals on decision-making - to an expansion of patient autonomy – patient's right to make decisions on their medical treatment based on their beliefs - in the Netherlands gave motivation to campaigns for decriminalisation[1], even the legalisation[2] of euthanasia elsewhere in Europe, as Belgium approved a law legalising euthanasia shortly after and Luxembourg a few years later (Atwill, 2008; Carter, 2016; Osborn, 2001). Whilst the number of European countries that have

[1] *Decriminalisation* – changing the law to make something, in our case, the act of euthanasia, no longer a crime, the removal of criminal penalties (Cambridge Dictionary, n.d.,a).
[2] *Legalisation* – the process when something – in our case, the act of euthanasia, becomes allowed by law, removing penalties if one complies with regulations (Cambridge Dictionary, n.d.,b).

officially, and fully legalised euthanasia continues to be very small, over the last two decades one can notice an increasing number of countries whose parliaments have begun debates regarding this matter. The most recent countries to launch debates over this topic are Portugal and France (Hurst & Bello, 2022). Whilst many bigger countries in Europe have started the road to a more harmonized Europe in terms of converging laws on end-of-life care, Latvia is not one of them.

In March 2021, the public initiative called "Par labu nāvi – eitanāzijas legalizācija" gathered the necessary 10,000 signatures to be put forward to the parliament of Latvia – Saeima - for further discussion. However, the majority of the members of Saeima voted in favour of rejecting the initiative, and no further discussions were held (Gaidule, 2021). From the transcript from March 2021 of the only discussion held regarding the legalisation of active euthanasia, the most common reasons brought by the members of Saeima for rejecting holding any further discussion on this matter are that active euthanasia violates medical ethics and that there is no need for active euthanasia if palliative care experiences improvements (Latvijas Republikas Saeima, 2021). However, only deputies participated in discussing this very complex matter, the medical professionals were not directly involved.

The opinions of professionals - individuals who care for and would perform such an act (if it were to be legalised) on terminally ill patients – were neglected for an unknown reason. This fact led us to the belief that the decision to reject the initiative was unreasonable, possibly even biased. Thus, we decided to dig deeper and understand the stance of the medical specialists of Latvia working in the palliative care unit. If the medical personnel are in favour of legalising active euthanasia in Latvia, then proceed with the research in a direction where we investigate if the objections of the politicians could be undermined by a set of criteria for performing active euthanasia. Therefore, we define the research questions of this paper as follows:

1. What are the stances of the medical personnel on the legalisation of active euthanasia in Latvia?

2. What could be the criteria for performing active euthanasia that would be acceptable to the medical personnel of Latvia?

3. Could the criteria for the performance of active euthanasia proposed by the medical personnel respond to concerns raised by the Members of the Parliament who oppose the legalization of active euthanasia in Latvia?

The aim of this research is to develop a preliminary list of criteria for the eligibility for the procedure of active euthanasia which would be approved by both the majority of medical

personnel and the members of Saeima. In 2023, two studies were done on a similar topic. The first being *Medicīnas nozares darbinieku viedoklis par eitanāziju (Opinion of medical professionals on euthanasia)* by Lapenkova, and the second - *Vispārējās aprūpes māsu viedoklis par eitanāzijas legalizēšanu Latvijā* (*Opinion of nurses of General care on legalization of euthanasia in Latvia*) by Veisa (Lapenkova, 2023; Veisa, 2023). However, none of these studies captured the politicians' arguments against euthanasia. Furthermore, they didn't develop a list of eligibility criteria for the procedure of active euthanasia.

The contents of the paper are Abstract, Introduction, Literature Review, Methodology, Discussion and Results, and Conclusions. The Literature Review familiarizes the reader with the history, the definition, and types of euthanasia and the ethical dilemmas it raises. The Methodology includes the main methods – document analysis, content analysis and qualitative comparative analysis. The Discussion and Results section describes arguments provided by medical personnel and deputies, the proposed list of criteria for application for active euthanasia by the medical personnel, and evaluating the objections raised by the deputies' – whether the objections are strong and whether the criteria respond to the concerns raised by the Members of the Parliament who oppose the legalisation of active euthanasia in Latvia.

2. Literature Review

The literature review is presented in the following form. First, we touch upon the history of euthanasia. Second, we introduce the reader of the paper to the various definitions and types of euthanasia. And lastly, we take a closer look at the various ethical dilemmas associated with euthanasia.

2.1. History

Euthanasia, without a doubt, has been and still is a complex topic. This is the case especially nowadays when it is getting more and more attention from citizens and governments from all over the world. However, before we delve into the various specifics of euthanasia and its relevance, it is important to understand the origins and evolution of the procedure.

According to the Online Etymology Dictionary (n.d.), the word euthanasia comes from the 17th century. In the 1640s, Greeks had a word that described a gentle death - euthanasia. The word is a combination of *eu-*, which means good and *-thanos*, which means death. At the same time, there are other sources that, when focusing purely on the philosophical side of the discussion, have found origins for the word as far back as ancient times. Whilst the act may not have been labelled as euthanasia, however, similarities can be drawn, Haddadi and Ravaz (2021) report that the topic of a beautiful and gentle death or even suicide has been discussed by philosophers and poets, such as Posidippus, as early as 300 BC.

In a medical context the term 'euthanasia' was used in practice only after quite a while. According to Cooney (2022), in a medical context, it was first used in the 17th century by Sir Francis Bacon. Cooney (2022) reports that Bacon, being a philosopher, called out to the community, to raise awareness of unnecessary suffering. While this might seem like very progressive thinking for the 17th century, Malczewski (2004) contradicts this thought, by arguing that what Sir Francis Bacon meant was that there need to be improvements in palliative care, so people would suffer less. Some might still argue over what Sir Francis Bacon meant, but one cannot deny that this started discussions at a higher level. This idea is supported by Avasthi, Kumar, and Mehra (2021) who report that after Sir Francis Bacon, numerous philosophers expressed their views and thoughts on euthanasia. While it may not seem of utmost importance, among those philosophers were Karl Marx[3] and Hippocrates[4]. The latter's

[3] *Stance of Marx* – not against euthanasia, in his opinion, it is a doctor's moral duty to ease the suffering of death by using medication (Avasthi, Kumar and Mehra, 2021).
[4] *Stance of Hippocrates* – strongly against by pledging to never give a deadly substance to anybody if asked for it (Emanuel, 2003, Ch. 79, para 1).

views were at the very base of the well-known Hippocratic Oath[5] (more on this in the Ethical Dilemmas section of our paper).

Euthanasia should not be viewed only from the physician's perspective. The procedure involves a medical practitioner and a patient who wishes to end their life peacefully. Such a procedure exists as the aforementioned wish creates demand for it. Hiatt (2016) reports that in the 19th century, some soldiers after they were denied euthanasia and recovery seemed impossible, slit their throats to alleviate themselves from suffering. This begs the question - should the demand truly be denied or ignored if the incurable patient wishes to end their suffering? Bolano-Romero et al. (2022) add that already in the 19th century, a journal, which published texts by Darwin, Edison, Pasteur, and Beecher, had arguments for active euthanasia, stating that seriously ill patients without a cure should be administered anaesthetics. One of the anaesthetics advised to use was chloroform - meant to reduce the consciousness of the patient, therefore quickening their death, and making it painless.

Whilst there were always arguments against euthanasia, over the years the procedure gained a more positive popularity. Sadly, in the 20th century, the reputation of euthanasia changed for the worse. An example of a reason for this is the largest, however, not the first and only mass euthanasia program in history - Adolf Hitler's Euthanasia program. Bolano-Romero et al. (2022) report that approximately 275,000 people, who had some type of mental disability, were killed in this program due to their disability. The authors also report that at the beginning of the 20th century, London euthanised the disabled and the rejected - blind, deaf, mentally disabled, criminals and rapists. Mass events like these altered the perception of the already delicate topic of euthanasia.

The discussions of whether it should be legal or not are still ongoing today. As of now, the view is still very split, with some arguing that a patient should have the option of dying with dignity, while others argue that euthanasia is murder. Nevertheless, the topic of euthanasia entails more than just its history, it is crucial to understand how it is perceived in a legal and ethical sense, especially in the present times.

2.2. Definitions

In the previous section, it was established that euthanasia has deep historical roots. Further, we move on to introduce the reader to the various definitions associated with the topic

[5] Relevant passage in the original Hippocratic Oath regarding euthanasia – 4th. An explanation for this passage is explained in the notes of the text (Boston University, n.d.).

of euthanasia. There is a consensus on what is euthanasia, however, the smaller subcategories are still up for debate.

We turn to the World Medical Association's (hereafter WMA) official position on the general terms of euthanasia. The reason for such a decision is the fact that the WMA currently has 114 member states, which participate in the Association's debates. We assume that this wide participation guarantees more refined definitions that may be acknowledged by the majority of medical practitioners (World Medical Association, n.d.). Hence, as of October 2019, the WMA defines euthanasia as "a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's voluntary request," (para. 2). The definition of euthanasia is not set in stone, it changes over time, but the general idea remains – a patient makes the decision for themselves, and the physician is directly involved in ending the patient's life. Although the Latvian Doctors Association (hereafter LDA) has not published a definition of euthanasia as of now, due to it being a member of the WMA, it is safe to assume that LDA completely or mostly agrees with the definition provided by WMA.

As the WMA does not segment the different types of euthanasia, further, we delve into the Latvian medical ethics books. According to Sīle (1999), euthanasia has two main descriptive forms: active and passive. Active euthanasia is described as a situation when a medical specialist prescribes a lethal dose of drugs to a patient after the request for such an action has been made by the patient or an authorised person. However, Passive euthanasia is defined as withholding treatment either at the patient's or the authorised person's request (more on this in sections 2.3. and 2.4.).

Whilst Poļaks (2015) agrees with Sīle by reporting that both active and passive should be considered subcategories of euthanasia, the author takes it a step further and explains how there are even more subcategories, depending on which point of view is perceived. According to Poļaks (2015), active and passive euthanasia should be viewed from the point of the medical practitioner, as "active" would mean active involvement of the doctor in the procedure and "passive" - no involvement. However, the author explains that if we look at euthanasia from the patient's side, then there are two additional categories – voluntary and involuntary. To put it briefly, euthanasia can be classified as "voluntary" when a patient gives their consent to the procedure, and "involuntary" when the decision is made for the patient by someone else.

As for our further research, we use the classification provided by Poļaks (2015). Whilst his book is not necessarily used by medical professionals, we believe that the classification provided by him is the most up-to-date currently available, at least in the Latvian literature.

Additionally, due to our thesis containing not only the medical practitioner's point of view but also the legal aspect, it seems more appropriate to use definitions that have been provided in the context of both medical ethics and law. For the reader's ease, we summarise in our own words the definitions of each type of euthanasia classified by Poļaks (2015) in the following table:

Type of euthanasia	Description
Passive voluntary euthanasia	Cases where a patient opts out of continuing the necessary treatment that sustain their life. It is in the patient's rights to refuse treatment and they make this choice consciously. The doctors inform the patient of the consequences.
Passive involuntary euthanasia	Cases where a patient's family members or closest relatives make the choice to withhold or withdrawal treatment that is necessary to sustain the patient's life. The medical professional abstains from providing this treatment based on the wishes of the patient's family.
Active voluntary euthanasia	Cases where a patient dies by receiving a deathly dose of a certain drug through an intravenous injection. The patient is fully informed and makes the choice to go through with this procedure to release themselves from unbearable pain caused by an illness.
Active involuntary euthanasia	Cases where a patient dies by receiving a deathly dose of a certain drug through an intravenous injection. The patient is not capable of making a decision by themselves, thus it is made for them by a family member or closest relatives.

Table 1. Summary of euthanasia definitions discussed in this research. Made by authors.

2.3. Passive Euthanasia

As explained by Poļaks (2015), passive euthanasia occurs when a medical professional refrains from providing a patient with the necessary means to survive (e.g., medication or life support) or withdraws such treatment. In such cases, a patient's death is not inflicted directly, but rather it comes naturally as the patient succumbs to their illness. Garrard and Wilkinson (2005) elaborate on this by providing clear conditions that, when fulfilled, deem that a procedure can be labelled as passive euthanasia. These conditions are the following:

1) There is a withdrawal or withholding of life-prolonging treatment.
2) The main purpose of withdrawing or withholding treatment is to bring about a patient's death.
3) The reason for "hastening" death is that dying is in the patient's own best interests (p. 65).

Following these conditions is important because not every case, where treatment is withheld, can be labelled as passive euthanasia, especially due to the third condition. To answer the question of "Why is this the case?", further we divide passive euthanasia into the two

classifications proposed by Poļaks (2015) - voluntary and passive – as the reasonings differ between the two.

2.3.1. Passive Voluntary Euthanasia

Passive voluntary euthanasia - a patient opts out of treatment on their own accord -, while not labelled as such, under Latvian law is technically a legal procedure (Poļaks, 2015). Based on the Latvian Patient's Right Law (Likumi.lv, 2009) article 6 point 4, "a patient is allowed to refuse medical treatment before it begins,". The medical practitioner is responsible for informing the patient of the consequences of withholding their medical treatment, however, due to the rights of the patient, the patient is not obliged to disclose the reasons for their choice of withholding treatment. However, due to this very reason – of not knowing for sure that the patient is acting in their best interest – Poļaks (2015) argues that such a situation is indeed passive and voluntary but should not be thought of as euthanasia. This proves to be true if we consider the aforementioned conditions proposed by Garrard and Wilkinson (2005). Such cases cannot always be labelled as passive euthanasia, as it only and completely fulfils the first two conditions, however, the fulfilment of the third condition remains blurry. As reported by Garrard and Wilkinson (2005), there are some cases, when treatment is withheld, for example, due to it being too costly. In such a case, if a patient wishes to continue living, then it would be in the patient's best interests to continue with the treatment, however, it is not possible for them due to their financial struggles, hence, this case does not fulfil all of the conditions for it to be labelled as passive euthanasia.

2.3.2. Passive Involuntary Euthanasia

Although Poļaks (2015) advocates for the fact that the aforementioned situations should not be labelled as euthanasia, on the other hand, he provides a long and very well-detailed description of passive involuntary euthanasia:

> Cases where the medical practitioner or any other person consciously and out of compassion, based on their own or any other person's individually subjective assessment of the permissibility of using such a method and/or necessity, interrupts or abstains from a certain or terminally ill person performance of actions aimed at preserving life and artificially maintaining it, without preventing it the occurrence of death caused by disease, and as a result of which the said consequences also occur, with the aim of releasing them from the excruciating pain and suffering caused by disease (p. 45).

The first half of the description highlights the involuntary aspect of the act. This entails that at the time of the decision to withdraw from further life-prolonging treatment, the patient is not able to decide for themself, thus it is done by a medical specialist or an authorised person.

According to the Latvian Patient's Rights Law (Likumi.lv, 2009) article 7 points 1 through 9, in cases when a patient is not of age or sound of mind, a decision to withhold treatment can be made by a patient's authorized person or spouse. If there are none, then the closest adult relative. Signalling that, while it may not be labelled as passive involuntary euthanasia, withholding, or withdrawing treatment on behalf of another individual is legal in Latvia, adhering to the law. Furthermore, if we consider the conditions proposed by Garrard and Wilkinson (2005) once again, one can see that the first two conditions coincide with the definition provided by Poļaks (2015). However, the third point of Garrard and Wilkinson (2005) requires a bit more attention and discussion. Similar concerns raised to the voluntary type of passive euthanasia can be raised to the involuntary type as well. For example, authorised persons, loved ones do not have sufficient funding to sustain the life-prolonging treatment of the terminally ill, hence, a decision of withholding treatment is taken. However, there are a few possible scenarios of such a case, each of them entailing different conclusions – one can be considered passive involuntary euthanasia, whilst the other not.

If the patient has expressed earlier their will to be withheld from life-prolonging treatment when a specific stage of the illness occurs (either in writing or to the authorised persons directly), then withholding the treatment would satisfy the third condition of Garrard and Wilkinson (2005) - "hastening" death in the patient's own best interests -, hence, passive involuntary euthanasia takes place. Gorman (1999) reports real-life examples of this - two different cases of cancer patients. In both cases, the patients had reached a state where they were being kept alive in artificial ways, through different life-sustaining measures. And, in both cases, the patient’s family requested for the life-supporting devices to be withdrawn or withheld, as they knew that the patient did not wish to be held alive this way. These cases are clear examples of involuntary passive euthanasia: a withdrawal of treatment, done to hasten their death, and in the patient’s best interests.

On the other hand, if the patient has never expressed such a wish, then the fulfilment of the third condition once again becomes blurry. If authorised people do not have the funds to further sustain the life-prolonging treatment and withdraw, and the patient would have wanted to stay until the disease kills, then this could not be considered as passive involuntary euthanasia, as it doesn’t fulfil the third condition. However, if the patient had the opposite wish, then such a case is indeed passive involuntary euthanasia. But as one can gather, the authorised people bear the burden of deciding on behalf of the terminally ill without a way of knowing their true wishes. Cohen and Winter (1999) report that with modern medicine, a patient's life can be maintained for prolonged periods meaning that a patient's organ system is

supported in artificial ways until their natural death. However, this can be a long and mentally exhausting process for the patient and their loved ones. If the patient is terminally ill and in pain, then in such cases opting to withdraw or withhold treatment could be considered in the patient's and even in the loved ones' best interests.

2.3.3. Ethical Considerations of Passive Euthanasia

Though we have established that both types of passive euthanasia can technically be considered legal, we should not neglect the existing ethical considerations of it. Due to the reason that a medical professional doesn't take an active role in the patient's death, passive euthanasia is perceived to be the morally preferable option compared to active euthanasia. In other words, there is a perceived great difference between 'killing a patient' and 'letting them die'. While it may seem as if a patient suffers unbearable pain until their death, that is not entirely true. A practice called pain relief therapy exists, which is meant to ensure that a patient's pain is somewhat alleviated, even if they choose to opt out of treatment. As reported by Better Health Channel (n.d.) pain therapy includes providing the patient with hot or cold packs, massages, physical therapy, as well as antibiotics, opioids, or antibiotics.

Even with such a therapy in place, many still argue that letting a patient die naturally is as bad as killing them. Rachels (1975) writes that letting a patient die can be a long and excruciating process for the patient and thus it should not be considered better than 'killing a patient'. The reality is, that even with the pain relief therapy in place, it may not be accessible to everyone. Apine (2005) reports that approximately 40% of Latvian patients who require pain relief therapy do not have access to it. What is more, Aleksejeva and Nicmane-Aišpure (2022) report that a lot of doctors interpret a patient's pain to be lesser than what the patients say they are feeling, thus, the patient is prescribed medication that is not effective for their case. For example, Apine (2005) reports a case where a patient was prescribed only half of the necessary pain reliever dose, and, sadly, committed suicide from the unbearable pain.

Although passive euthanasia does not require the physician to violate medical ethics, can this type of death truly be labelled as ethical, especially if we keep in mind the fact that pain relief therapy may not be accessible to the patient when he needs it the most? Is it truly death-with-dignity when the disease kills the terminally ill patient over an unknown period of time with continuous pain? Would it not be the case that death-with-dignity would happen when a patient is put to rest quickly and peacefully with, for example, an active type of euthanasia?

2.4. Active Euthanasia

In the previous section, we established that both passive voluntary and passive involuntary euthanasia, while not labelled as such, are technically already legal in Latvia. As all types of euthanasia result in the patient's death, it seems odd that one is "legal", and the other is not. Due to this very reason, we turn our focus to the active type of euthanasia.

Before we delve deeper into what an active type of euthanasia is, it is important to explain what it is not. Often the terms - active euthanasia and assisted suicide - are used as synonyms, thought of as the same procedures, however, this is a false assumption. According to the World Federation of Right-to-Die Societies (n.d.), assisted suicide is a procedure when a medical practitioner prescribes a lethal dose of drugs (usually as pills) to a patient which they can choose to take whenever without the medical specialist's involvement. This is different from active euthanasia, as according to Poļaks (2015), active euthanasia is performed by having the active involvement of a medical practitioner, usually through an intravenous delivery[6] of a lethal substance. This is further supported by McKinnon and Orellana-Barrios (2019), who define active euthanasia as *"*causing the death of someone through a direct action at an individual's request,*"* (p. 37). Due to the very reason the medical practitioner takes on an active role in the patient's death, opposition arises, as it goes against morally right actions. However, Poļaks (2015) tries to ease this worry by explaining that in active euthanasia a medical practitioner is guided by compassion - to help ease the patient's suffering.

The Government of the Netherlands (n.d.,b) explain that active euthanasia usually consists of a physician administering a fatal dose of a suitable drug to a patient who meets the strict list of eligibility criteria. Active euthanasia is quite similar amongst most countries which have legalised the act, however, the types of drugs used in the procedure may differ. For example, Chambaere et al. (2018) report that in Belgium the recommended drugs to use for this procedure are barbiturates and neuromuscular relaxants. Furthermore, according to the study done by Halko et al. (2022) about the medication provided in Canada, the most administered drug is midazolam, which is a common sedative. Other prescribed drugs were lidocaine and opioids, like morphine and fentanyl. Even though the drugs may differ between countries, in most cases, a sedative is used to end a patient's life painlessly.

Similarly, as in the chapter on passive euthanasia, we move on to introducing the reader to the subgroups of the active type of euthanasia – voluntary and involuntary.

[6] *Intravenous delivery* – "an injection or infusion method of drug administration, which means drugs are sent directly into your vein using a needle or tube," (CD Bioparticles, n.d., para. 2).

2.4.1. Active Voluntary Euthanasia

According to Nwadiugwu (2015), cases in which a competent patient requests euthanasia should be considered voluntary. By combining the aforementioned aspect of voluntary with active - physician takes active action directly to the patient -, Poļaks (2015) defines active voluntary euthanasia as:

> Cases where, based on a clearly formulated request of a terminally ill person, expressed in any way and by any means a reasonable time before the initiation of the act of euthanasia, treatment or any other natural person, guided by motives of compassion, in a way that does not cause additional pain and suffering, active actions directly cause the death of a terminally ill person with the aim of thereby relieving him of the excruciating pain and suffering caused by the disease (p. 53).

Firstly, the voluntary part of the definition represents the patient's point of view. As already explained before, the case can be labelled as active voluntary euthanasia if the request is made by a conscious and sound-of-mind patient. In some countries, patients are not only allowed to request euthanasia at a time when their state meets the criteria but also offered the option of an advanced care plan – usually called the living will. According to Andreasen et al. (2022), it is a legal document in which a patient can express their preferred treatment (e.g., what medicine is preferred, whether to withhold treatment or not), as well as authorize another person to make medical decisions for them once they are incapable of doing so themselves. Such a document is prepared in cases when a patient is aware that their cognitive capabilities will deteriorate as their illness progresses. Sadly, according to Grifo, Rodado and Sanchez (2021), up until 2015 only 14 countries in the EU recognized the living will to be a legal document. At the time of the research, the UK was still a part of the EU so in the research, the number is 15[7]. Although the number of countries remains small, it signals a rise in awareness – people should have the option of expressing their will in advance to losing their competency due to sickness.

Secondly, the active part of the definition explains the medical practitioner's point of view. A seemingly small detail mentioned in the definition provided by Poļaks is that a medical practitioner is guided by compassion. Spina (1998) argues that while doctors must not harm their patients, keeping them artificially alive on feeding tubes and breathing machines is not always what is best for the patient. The author also argues that doctors should act on what

[7] Countries in Europe that have recognized the advanced care plan to be a legal document – Germany, Austria, Belgium, Denmark, Slovenia, Spain, Estonia, Finland, France, Hungary, Latvia, Luxembourg, The Netherlands, Portugal, The United Kingdom (Grifo, Rodado & Sanchez, 2021).

would improve the patient's quality of life, even if that means providing them with an easy death. As the procedure of active euthanasia requires them to directly inject a patient with a lethal dose of drugs, this type of euthanasia entails an active involvement from a medical practitioner. Kavehrad (2018) explains that due to the very reason that the physician hastens the patient's death, they have to comply with strict statutory due care criteria. The author also emphasizes that most countries in the EU, where euthanasia is legalised, have a long and strict procedure in place to ensure that the physician is performing euthanasia, not committing a criminal offence. According to Buiting et al. (2009), documentation of the patient's request is also mandatory and necessary because medical practitioners must hand it in for further review by an ethics committee to ensure that a patient has died of their own free will (more on eligibility criteria in the section 2.4.3.).

2.4.2. Active Involuntary Euthanasia

According to Vizcarrondo (2013), involuntary euthanasia occurs when the procedure is performed without a patient's consent. In most cases, the decision is made by the patient's family, spouse, or any other authorised person but if there are none then the physician can make the decision. By combining the aspect of involuntary with active, Poļaks (2015) defines active involuntary euthanasia as:

> Cases when treatment or any other person out of compassion, with the aim of getting rid of excruciating pain and suffering caused by the disease, by performing an active action that does not cause additional pain and suffering, causes the death of a terminally ill person, without clarifying his will about the permissibility of using such a method against on the grounds that the person has not previously expressed this will, but is no longer able to do so at the moment (p. 54).

This definition can be divided into two parts, in a similar way to active voluntary euthanasia: the patient's point of view and the doctor's point of view. The patient's point of view explains the involuntary part – it implies that a patient is not able to decide for themself, and instead, the decision is made by someone else. However, the doctor's point of view stays the same as for active voluntary euthanasia, as the procedure itself does not change - the term active explains that a medical practitioner injects a patient with a lethal dose of drugs to relieve them from insufferable pain.

Comparing the involuntary to the voluntary type of euthanasia, it gains more criticism. Ebrahimi (2012) argues that due to the procedure happening without a patient's consent and approval, it ultimately is murder. However, what the author fails to acknowledge is the existence of the living will discussed in section 2.4.1. For example, if a patient has stated in

advance to reaching a state of unconsciousness their wish for euthanasia when they come to meet the eligibility criteria, then carrying out such a request should not be considered murder. The medical practitioner performing the act is carrying out the patient's wish.

2.4.3. Eligibility Criteria

When discussing euthanasia, it is important to not only understand the difference between the various subcategories but also to understand in what circumstances a patient would be eligible for such a procedure. As this procedure ends with the patient's death, it calls for a strong list of criteria to ensure the honourability of the medical personnel performing the act and that the patients do not abuse their right to such a procedure. In this section, we delve into the eligibility criteria of the patient for the procedure of euthanasia in EU countries that have already legalised active euthanasia. Whilst minor details differ among these countries, however, most of the criteria overlap. For example, for the three countries which have legalised active euthanasia the longest in the EU - Netherlands, Belgium, and Luxembourg -, we observed the following overlapping criteria (see Appendix A for a summary table):

- The patient must make the request voluntarily, thoughtfully, and repeatedly.
- The patient must be emancipated, capable, and conscious at the time of application.
- The patient must be of legal age.
- The patient reports physical suffering which cannot be alleviated as a result of an incurable condition.
- The patient reports psychological suffering which cannot be alleviated as a result of an incurable condition.
- Either the patient or an appointed person (if the patient is not capable of completing this task themselves) records the request in writing.

Regarding the aforementioned differences in the list of criteria, for example, in Belgium and the Netherlands, people not of legal age are also eligible for euthanasia if they fulfil the rest of the criteria listed above. Furthermore, the Netherlands and Luxembourg do not limit the procedure only to their citizens (Government of the Netherlands, n.d.,a; Guichet.lu, 2023; Health, Food Chain Safety and Environment, 2016).

The Netherlands, Belgium and Luxembourg legalised the act over 10 years ago now, so we can conclude that these criteria for eligibility are strong, as they continue to allow for such a procedure to be performed legally (Presse, 2021). They serve as a great example to countries only beginning the process of legalisation.

2.5. Ethical Dilemmas of Active Euthanasia

The topic is seen as controversial due to the procedure entailing a physician to end a patient's life. Multiple values must be considered in this discussion, both the medical practitioner's and the patient's. To better understand the full scope of the topic it is important to understand and acknowledge how the act is seen in the context of medical ethics and what type of ethical dilemmas the medical personnel are faced with.

Newly graduated medical professionals, In Latvia, must take the *Hippocratic Oath*[8]. The name comes from the Greek physician Hippocrates and, according to McPherson (2015), it was written around 400 BCE. However, from the time of its creation, up until the 1500s, there are almost no references to this oath. Comparing the lack of reference in history to the current importance of the oath indicates that it was too "modern" for its time. According to Gabre (2022), the Hippocratic Oath did not change much throughout the years but rather was changed in the modern years according to the medical ethics of a given country. Nowadays, new medical professionals in Latvia give the revised version of the oath and the main prompt of it is clear – do not harm. Furthermore, they swear to respect the patient's autonomy[9] (Rīgas stradiņa universitāte, n.d.). Sedig (2016) explains that doctors must respect a patient's autonomy, even in moments when the patient's decisions or wishes would contradict the medical specialist's given recommendations and beliefs. Thus, in theory, if all physicians would always abide by the concepts of autonomy and do not harm, then euthanasia would not be considered an ethical dilemma[10], as euthanasia does not harm the patient, but rather relieves them. However, due to the following statement - human life must be held in the highest regard -, the Hippocratic Oath becomes contradictory.

The contradiction can be clearly seen if we assume a situation when the medical practitioner, completely following the Hippocratic Oath, is confronted with the request for euthanasia. Following the statement of respecting the patient's autonomy, the medical practitioners would need to abide by the request of any patient, who fulfils the criteria for active euthanasia. Meanwhile, if the same medical practitioner tries to abide by the following statement of the oath, an ethical dilemma arises – should patient autonomy or the preservation

[8] The full oath can be read in Appendix H.

[9] *Patient's autonomy* – "the right of competent adults to make informed decisions about their own medical care," (British Medical Association, 2020, para. 3).

[10] *Ethical dilemma* – "a situation where a choice has to be made between competing values, and no matter what the choice is made, it will have consequences. Hence, a dilemma may be if the nurse is forced to choose between options that are considered equally desirable or undesirable but may also occur when forced to compromise or act against own professional values" (Haahr, A, 2020, p. 259, para 5.).

of human life be held in the highest regard? If euthanasia were to be legalised in Latvia, a revised version of the Hippocratic Oath must be made, to dismiss this dilemma.

Medical practitioners perform an immensely important function in our societies, taking care of people's most important value - health. However, due to the nature of their work, by negligence, mistake, or bad luck, they may end up harming their patients or even contributing/hastening their death without the intent to do so. Therefore, laws on how much medical specialists are ethically allowed to interfere with a patient's treatment and autonomy exist in each country. In Latvia, these laws are called the Treatment law and the Patient's Rights law. Furthermore, as the WMA provides a base for medical ethics for all of the countries that are a part of the association, in 1998, LDA, being a part of the WMA, adopted a similar version of the ethics code, which is binding for all Latvian medical practitioners (Latvijas Ārstu Biedrība, 1998). In this ethics code point 2.9., translates to "when death is inevitable, a doctor must let a patient die with dignity, relieving the dying person from potential pain,". The former statement begs the question – shouldn't then active euthanasia be available to the patient to give them the option of dying with dignity if they meet the eligibility criteria and they wish to? Well, the WMA declaration on euthanasia (2019), states that they strongly oppose active euthanasia, and the LDA, due to it adopting the ethical beliefs of the WMA, must also share the same stance. According to both aforementioned associations, doctors are meant to do everything in their capabilities to alleviate pain, and they firmly believe that for a doctor to take an active part in a patient's death means violating medical ethics. However, can it truly be thought of like that? A patient being denied the procedure causes direct limitations to their autonomy.

Interestingly enough, in the WMA declaration on end-of-life medical care (2022), it is stated that "if a patient is experiencing unbearable pain in their last days, the doctors shall sedate the patient to unconsciousness, to relieve this pain," (para. 8). This statement raises a concern – why is sedating a patient to unconsciousness assumed to better than letting them die in a similar matter with dignity if they express their will for it? It appears that the only difference is that the former is perceived as relieving and the latter - as killing. However, this is the physician's point of view. If we look at both situations from the patient's point of view, he or she is indifferent, as he or she can be considered as not living – dead – in the case of euthanasia and completely unconscious in the case of sedation (Banović, Turanjanin & Miloradović, 2017). So, a dilemma arises – which is truly the most respectful way of going about the patient who has no prospects of improvement, for whom death is inevitable? Should

the patient's autonomy be completely respected or rather abide by the ethics code declared by the WMA?

When discussing ethical dilemmas, it is also important to not neglect the medical practitioner's personal values. If we value the patient's autonomy in high regard, we must also value the doctor's autonomy, within the legal limits of course. The study done by Evenblij et al. (2019), raises awareness of the burden that physicians endure from performing euthanasia. They stress the fact that physicians must not be made to overstep their values to perform the procedure, and the possibility of opting out should always be available. What is more, in a study done by Evans et al. (2022), where they interviewed physicians who perform active euthanasia in the Netherlands, the participants highlighted the fact that the physician needs to believe that such a decision is best for the patient. On the other hand, Ely et al. (2016) report that some physicians strongly believe that modern medicine is advanced enough to manage pain and, hence, minimising the case of euthanasia. From this alone, we can see that physicians have different experiences, beliefs, and values. Respecting each party's – the patient's and the medical practitioner's - autonomy in any medical discussion is a crucial aspect, neither should be pressured into any procedure they don't wish to be performed. In the case of euthanasia, this statement stands. However, a patient's autonomy should not be limited by the autonomy of the medical practitioner and even the legislators who oppose euthanasia. The act may be performed by another specialist, who supports euthanasia and agrees to performing it. Approaching the act of euthanasia in this way ensures that the personal values of each physician are acknowledged and not gone against.

3. Methodology

The following section provides an in-depth description as well as justifications for the chosen research design, data collection method and data analysis method for answering our three research questions. Lastly, we identify the possible limitations of our research.

3.1. Research design

The decision to focus only on the *active* type of euthanasia is the fact, as previously discussed, that passive voluntary euthanasia, while not labelled as such, under Latvian Patient's Right Law (2009) article 6 point 4 is technically allowed. Thus, this leads us to investigate the illegal case of active voluntary euthanasia – "a physician (or third person) intentionally ending a person's life normally through the administration of drugs, at that person's voluntary and competent request," (Fontalis, Prousali, Kulkarni, 2019, para. 3). Furthermore, we consider that there are strong, compelling reasons in favour of legalizing active euthanasia due to the fact that this type of euthanasia makes the death of the patient who is suffering quicker and, in some cases, even less painful, than in the case of performing passive euthanasia (BBC, n.d.).

As our research is aimed at a controversial topic, we thought it would be only suitable to align our research with an existing theory in the field of ethics. We believe that the concept of autonomy is the most fitting for discussing the complex topic of active euthanasia. According to Dworkin (2015), "autonomy is conceived of as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values," (p.14). Dworkin (2015) defines *first-order preferences* as the immediate, initial tendencies individuals incur, and *second-order capacity* as the process when an individual is able to apply a higher level of reflective thinking to their first-order preferences, desires and wishes and be able to respond to these reflections – either to accept the immediate, initial preferences or attempt to change them depending on the deeper understanding of the individual's values. When individuals exercise the capacity of autonomy, they grant coherence to their lives and take responsibility for being the type of person they are (Dworkin, 2015). The concept of autonomy plays a role in any patient's life. As Dworkin (2015) describes it, "patient autonomy is the ability of patients to decide on courses of treatment, choose particular physicians and so forth," (p. 11). This theory provides clear reasoning for the legalisation of euthanasia - a person should be able to decide when they want to stop treatment and end their suffering from an incurable medical condition, or disease, and it should be one of their basic

rights. Medical personnel have not only the duty to treat an ill patient but also respect the patient's choices, autonomy.

To answer the proposed research questions, we have employed a qualitative research design, namely the case study research design. According to Shuttleworth (2008), this type of design is aimed at understanding a situation fully from all points of view. What is more, the case study research design does not depend only on statistical data but rather provides real insights and opinions from people regarding a given situation or problem. In our case, it is the opinions of the medical personnel and members of the parliament in Latvia on the legalisation of active euthanasia.

Furthermore, our research consists of various methods which are employed for each of our research questions The process of methodology is summarised in the following table:

Research Question	**Data Analysis Method**
RQ1 - What are the stances of the medical personnel on the legalisation of active euthanasia in Latvia?	*Document Analysis* - collecting and categorizing arguments from transcripts of the semi-structured interviews with the medical personnel of Latvia to understand the overall stance on the matter.
RQ2 - What could be the criteria for the performance of active euthanasia that would be acceptable to the medical personnel of Latvia?	*Content analysis* - identifying patterns and trends, the frequency counts of specific criteria to develop a preliminary list of criteria for active euthanasia.
RQ3 - Could the criteria for the performance of active euthanasia proposed by the medical personnel respond to concerns raised by the Members of the Parliament who oppose the legalization of active euthanasia in Latvia?	*Document Analysis* - collecting and categorizing arguments from transcripts of the semi-structured interviews with the Members of the Parliament of Latvia. *Qualitative Comparative Analysis* - understanding which combinations of proposed criteria by the medical personnel were more likely to respond to the concerns raised by Members of Parliament.

Table 2. Methodology process scheme. Made by authors.

3.2. Data analysis methods

3.2.1. Document Analysis

Document analysis is employed as the basis for both of the further data analysis methods - content analysis and qualitative comparative analysis. According to Bowen (2009), "document analysis is a systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and internet-transmitted) material," (p.1). This analysis entails that a researcher examines and interprets the documented data from different methods – publicly available sources and semi-structured interviews in our case - to develop empirical knowledge with reduced potential biases existing in a single study (Bowen, 2009). The nature and characteristics described by Bowen (2009) of document analysis are the reasoning for employing such an analysis, as it aligns with our planned analysis.

We use extensive document analysis in the first part of our analysis to find the various, possibly opposing viewpoints of deputies and medical personnel towards the legalisation of active euthanasia. It is crucial to understand the stance of deputies and medical personnel because it determines the direction of our research.

The steps to be taken to employ document analysis in our research:

1. Reviewing the transcripts of the semi-structured interviews and gathering the arguments expressed on the legalisation of active euthanasia in Latvia.
2. Recognising patterns, recurring themes, and variations of opinion within the gathered data to assess the general stance of both the medical personnel and deputies.

3.2.2. Content Analysis

After completing the document analysis on the transcripts of interviews with the medical personnel, we move on to the content analysis method to answer the second research question of this paper. Columbia University (2019) describe content analysis as "a research tool used to determine the presence of certain words, themes, or concepts within some given qualitative data" (para. 1). Content Analysis was selected as a tool for this paper because this method will allow us to create the preliminary list of criteria for active euthanasia, which is crucial for answering the last research question of our paper.

The steps to be taken to employ content analysis in our research:

1. Design a table of the existing conditions in the Netherlands, Belgium, and Luxembourg (countries in Europe where active euthanasia is legal) to be met by a person applying for active euthanasia. This part is completed before the interviews (see Appendix A).
2. Gather opinions of medical personnel on the existing conditions to be met by a person applying for active euthanasia from the interview transcripts.
3. Develop and implement a coding scheme for the interview transcripts to collect the frequency of approval and the actual criteria approved by the personnel to develop a preliminary list of criteria for active euthanasia to be brought to the interviewed deputies.

3.2.3. Qualitative Comparative Analysis

Lastly, we employ the qualitative comparative analysis to fully answer the third research question after the completion of document analysis on the transcripts of interviews with the members of Saeima. According to Simister and Scholz (2017), Qualitative Comparative Analysis (QCA) is a case-based approach developed by Charles Ragin in the

1970s, and it is "regularly used within monitoring and evaluation process to investigate situations in particular contexts and settings," (para. 3). As established earlier, our research is based on a case of legalising active euthanasia in Latvia, and we wish to investigate whether the presence of strict criteria may respond to concerns raised by the Members of the Parliament, the lawmakers. As the characteristics of this method align with our goal of the third research question, we employ the qualitative comparative analysis.

The steps to be taken to employ qualitative comparative analysis in our research:

1. Develop a Theory of Change – we assume that some deputies may become more open (from being against the legalisation of active euthanasia in Latvia to not being completely opposed) if a set of factors - specific criteria - may be employed. The criteria may undermine the arguments *against* provided by the politicians.
2. Develop a set of factors – in our research we define factors as the criteria for the performance of active euthanasia which were developed with the medical personnel of Latvia.
3. Score the factors – we develop a scale with which we rate each of the criteria in the list presented to the deputies. We rate a criterion with "1" if the criterion completely addresses the objection provided by the politician, "0.5" if partially, and "0" if not.
4. Analyse, interpret the findings and revise the Theory of Change – looking for combinations and frequency of proposed criteria by the medical personnel that responded to the concerns of Members of Parliament and eased their opposition.

3.3. Data collection

Background research – publicly available information

Firstly, we conducted a review of publicly available information on the expressed opinions of active euthanasia by the members of the parliament. This includes news portals, such as Delfi, LSM, etc., books, journals, Saeima sitting video transcript, and other relevant sources from 2018 to 2023. This time period was chosen because we want to reflect the arguments provided by the previous (13th) Saeima, which rejected the public initiative "Par labu nāvi – eitanāzijas legalizācija", and also focus on the arguments provided by the current (14th) Saeima, which can make the final decisions on laws regulating legality of active euthanasia currently.

Secondly, we gathered data on which are the representatives who are in charge of overseeing any matter related to healthcare in the name of their political party represented in

Saeima (summarised in Table 2). The reason for focusing only on these individuals is the fact that it is their sole duty to speak on behalf of their party when any health care matter arises. This was accomplished by reviewing the information provided on the official websites of the political parties represented in the 14th Saeima and by contacting the parties, which do not disclose such information on their website, individually through the party's e-mail or phone number.

Political Party of the 14th Saeima	**Name of the representative**
Jaunā Vienotība (JV)	Ingrīda Circene
Apvienotais Saraksts (AS)	Lauris Lizbovskis
Nacionālā Apvienība (NA)	Jānis Grasbergs
Zaļo Zemnieku Savienība (ZZS)	Līga Kozlovska
Progresīvie (P)	Edgars Labsvīrs
Stabilitātei (S!)	Svetlana Čulkova
Latvija Pirmajā Vietā (LPV)	Vladimirs Keidāns

Table 3. A list of deputies in charge of overseeing healthcare-related matters for all political parties represented in the 14th Saeima. Made by authors.

Thirdly, we gathered data on which public healthcare institutions, hospitals offer free palliative care (summarised in Table 3). The reason for limiting our research to only these kinds of hospitals is the belief that they have a more diverse patient population regarding different socioeconomic backgrounds, and, additionally, Saeima's regulations more directly influence public healthcare institutions than private ones. This step was accomplished by reviewing NVD's (Nacionālais veselības dienests) official website's section on palliative care (Nacionālais veselības dienests, 2020). Furthermore, we gather the number of specialists working in these palliative care units in each of the hospitals (summarised in Table 3). We believe that these numbers are an adequate indicator of how big one hospital is compared to the other. Hence, to get a representative sample we apply existing ratios when deciding on the number of medical personnel to interview. For example, in our sample, there shall be 3x more workers from Daugavpils reģionālā slimnīca than from Vidzemes slimnīca. This step was accomplished by reviewing the information provided on the official websites of the hospitals offering palliative care and by contacting the hospitals, which do not disclose such information on their website, individually through the hospital's e-mail or phone number.

Whilst we do use the numbers of specialists working in the palliative care units to establish the number of interviews we shall conduct, our sample doesn't consist only of this type of medical specialists. Our sample also includes anaesthetists-resuscitators, transplantologists, gynaecologists, a hospital chaplain, an emergency medicine doctor, a neurologist, an internist, and specialists working in the intensive care unit. One of the reasons (more on this in the Limitations section) for not focusing only on palliative care specialists is

the fact that patients with incurable diseases – the patients who could be eligible for the procedure of euthanasia if it were to be legalised - are present in many of the hospital units. The reason for this is the widely known and also acknowledged fact that the number of specialists and beds in palliative care units is very limited (Runce, 2021). Hence, many different medical specialists care for these types of patients on a daily basis.

Name of the hospital	**Number of specialists**
Paula Stradiņa klīniskā universitātes slimnīca	12
Rīgas Austrumu klīniskā universitātes slimnīca	8
Daugavpils reģionālā slimnīca	3
Rēzeknes slimnīca	5
Vidzemes slimnīca	1
Ziemeļkurzemes reģionālā slimnīca	2

Table 4. On the left side of the table are the names of the hospitals offering free palliative care. On the right side are the number of medical personnel working in the given palliative care unit. Made by authors.

Lastly, to better assess the topic and prepare for the semi-structured interviews we researched the prerequisites to apply for the procedure in European countries which have already legalised active euthanasia from publicly available documents provided by the parliaments of the Netherlands, Belgium, and Luxembourg (see Appendix A). The reason for focusing only on countries in Europe that have legalised active euthanasia is that we believe it would provide us with more relevant and meaningful comparisons. As the European Union can be described by the process of integration and its linkage to the emergence of a shared European identity, it seems only natural to compare the case of Latvia to its "partner countries", which together pursue the collective goal of Europe – and integrated entity (Tekiner, 2020). The created thorough table, which summarizes the existing conditions and procedure steps in the Netherlands, Belgium, and Luxembourg, allowed us to create a possible preliminary list of prerequisites for Latvia. As these countries have already gone through the complex process of grappling with the various dimensions of euthanasia over a longer period of time than other European countries which have recently legalised this procedure, their put-forward ethical and legal framework can be deemed as a great foundation for the government of Latvia to shape and form to fit the needs and values of the society of Latvia.

Data for analysis – semi-structured interviews

The analysis part of our thesis can be divided into two parts. The first part focuses on the for and against arguments provided by both the palliative care unit workers, as well as the members of the Parliament on legalising active euthanasia in Latvia. However, the second part of our research focuses on the opinions of both groups on the existing prerequisites for active

euthanasia in European countries where it is legal. The data needed for both of the parts of the paper are mostly obtained from semi-structured interviews.

According to Mashuri, Sarib, Rasak, and Alhabsyi (2022), semi-structured interviews are a more powerful tool for researchers, as they allow the acquisition of more in-depth information from interviewees by being flexible and adaptable. In semi-structured interviews, the direction is taken into account very carefully, however, a researcher has room for adjustments, such as changing the order of questions and adding or removing questions, to make the interview feel more like a freer and natural conversation (Mashuri et al., 2022). We implement such a data collection method in order to fill in the existing information gap. For example, we gather the opinions of the current deputies (part of the 14th Saeima) in charge of overseeing healthcare-related matters, as there currently is no publicly available source which would provide us with such information. Furthermore, even though some research has been done on the opinions of medical staff on the legalisation of active euthanasia in Latvia, there is no publicly available research in Latvia that would focus on the opinions of palliative care unit workers – the specialists who on a daily basis care for the patients experiencing constant and unbearable suffering which cannot be alleviated.

The first batch of interviews was conducted with medical personnel from hospitals summarised in Table 3. Altogether 31 interviews were conducted, however, the number of invitations exceeds it. Questions that were asked during the semi-structured interviews are summarised in Appendix B. However, the second batch of interviews was conducted with the representatives who oversee and address anything related to healthcare matters in the name of their political party represented in Saeima. Altogether 7 deputies were invited to the interview, all of whom also accepted the invitation. Questions asked during the semi-structured interviews are summarised in Appendix C.

3.4. Limitations

There are several limitations to our proposed research methodology. Firstly, we acknowledge that we may encounter difficulties regarding the retrievability of documentation, as some important documents and discussions already held in Latvia regarding this matter are or may be blocked and not publicly available, which would suggest a "biased selectivity". As Hegedus and Moody (2010) describe it, selection bias occurs when research has been done on a less representative sample, which could result in inaccurate findings and restricted validity

of a study. However, to address this limitation we hold interviews with the current deputies and medical personnel to fill in some existing information gaps.

Secondly, the previously mentioned "biased selectivity" may not only be appointed to the documentation but also to the interviewed sample. The rejections to participate in our interview from the medical personnel side and the selected group of doctors may lead us to a somewhat biased analysis and conclusions. One might argue that what matters is only the opinions of medical specialists working in the palliative care units because they are at the end of the day individuals who have specialised specifically in the care for patients in their end-of-life phase. However, we encountered difficulties in trying to reach out to palliative care specialists, which led us to regroup our original plan of interviewing only the workers of palliative care units to include also various medical specialists working in the hospitals offering free palliative care (summarised in Table 3). Once again, we want to highlight that due to the limited capacity of palliative care units incurably ill patients are present in various other hospital units, which to some extent addresses this limitation. Many other medical specialists have experience in caring for these patients. Additionally, our research may be seen as something to build upon, for example, further, even larger research in which one would be able to gather the opinions of all palliative care unit workers and a greater number of other types of medical personnel.

Thirdly, we acknowledge that interviewing only one representative – one in charge of addressing anything health care related in the name of their political party – may lead to somewhat biased results on the stance of each political party represented in the current, 14th Saeima. Reasoning for this is that, even though the interviewed deputies oversee and address these matters, however, the opinions regarding any matter may vary greatly amongst all of the participants of each political party. As most of the interviewed deputies clarified, they do not feel comfortable claiming that their opinions can be viewed as a collective one of the whole party. However, once again our research may be seen as something to build upon, for example, even larger research in which one would be able to gather the opinions of all deputies of Saeima.

Fourthly, we acknowledge that the answers provided by our interviewees may be biased, as they may hide some information or not reveal their true opinions. However, to overcome this limitation we make our interviewees feel comfortable by avoiding leading or suggestive language which may prompt certain responses and assure them that their responses will be handled with strict confidentiality and anonymity if preferred.

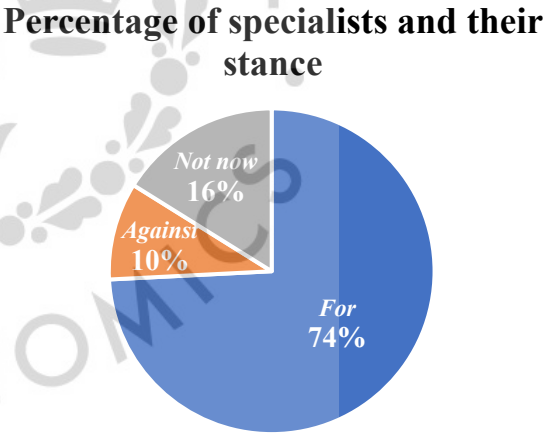
4. Results and Discussion

We begin this section by gathering the stances of the interviewed medical personnel on the legalisation of active euthanasia in Latvia. Additionally, focusing on arguments provided by specialists who are opposed. Afterwards, we move on to developing the list of conditions under which medical personnel would be in favour of legalising active euthanasia in Latvia. Further, we move on to gathering and categorising the arguments for and against the legalisation of active euthanasia in Latvia provided by the deputies. This allows us to understand their stance and move on to the last part – addressing their concerns by applying a criterion to the performance of active euthanasia brought forward by the medical personnel.

4.1. Overall stance of interviewed medical personnel

Collecting and categorizing the various arguments provided by the medical personnel was a crucial step in determining the direction of our research. We summarise the stances of the 31 medical workers interviewed in Graph 1.

From the illustrative graph, we can see that 74% or 23 of the interviewed medical personnel sample are for and 16% or 5 are not against, but expressing concerns that should be addressed before such a procedure could be legalised in Latvia. Furthermore, only 10% or 3 of the interviewed are strongly against the legalisation of active euthanasia in Latvia.



Graph 1. The number of medical specialists who supported each stance on the legalisation of active euthanasia in Latvia. The data used to create this graph is from Appendix D. Made by authors.

The results of the graph signal that the overwhelming majority of the interviewed medical personnel are not against the legalisation of such a procedure in Latvia.

4.1.1. Medical personnel's "against" argument categorisation

Although the overall stance on the legalisation of active euthanasia in Latvia is positive amongst the medical personnel, it is important to not neglect the concerns raised by the specialists who are opposed or unsure. After reviewing the conducted semi-structured interviews, we identified arguments *against* and categorised them accordingly:

Argument	Description brought by the medical personnel
Medicine, especially palliative care, is underdeveloped in Latvia	There are not enough beds, specialists to provide each and every individual who is in need of palliative care. Before this problem is addressed patients will not have the access to an appropriate treatment level and support to not choose euthanasia.
There is no such pain that cannot be alleviated with the help of medicine	Medicine in Latvia has evolved and continues to do so as years go by. Hence, there is almost no pain that the doctor cannot alleviate the patient from with the help of modern medicine.
The education level in Latvia is very low	Both the public and the medical staff need to firstly be educated on the subject as a whole and mature enough to understand the reasoning behind it, but we are not there yet. Some Latvians may feel that the doctors want to "cheat" and "not do their jobs" when they would be proposed such a procedure
The act of euthanasia goes against the doctors' Hippocratic Oath, violates medical ethics	Doctors are taught to do everything in their means to save and maintain a patient's life and well-being, they swear this with the Hippocratic Oath. Killing a patient is forbidden by medical ethics. New amendments have to be signed or the Hippocratic Oath must be changed because with the existing one the doctor may get their diploma revoked if they kill a patient through this procedure despite the patient's expressed wishes.
The act of euthanasia goes against the law	Killing another person is punishable by law. Why would euthanasia be considered as something different?
The act of euthanasia goes against religion	Killing oneself and/or someone else is a sin. Hence, the procedure of euthanasia is a sin.
Risk of people requesting euthanasia for the wrong reasons	Euthanasia is an easy way to solve the funding problem. There may be a situation when the patient doesn't have the funds for treatment and opt for euthanasia because they see it as their easy or "only" option.
Problems with the current legislation in Latvia	Latvian legislation is not ready at the moment. For example, the documents on the patient's free choice of resuscitation measures need to be arranged for anyone to even begin to discuss the legalisation of such a procedure.
What about eternal kids and minors?	Eternal kids and minors in general are not emancipated and capable to make rational decisions even on small everyday things, they need guidance. The same would apply on the procedure of euthanasia. But how can one make such a difficult decision for another person? In a way this can be seen as genocide or ethnic cleaning. The law makers would have to put a lot of effort in addressing this ethical problem.

Table 5. Summarizing data from Appendix E and Appendix F and using the same data sources that were used to make Appendix E and Appendix F. Made by authors.

Reviewing the various arguments provided by the medical personnel, we can notice very complex problems that should be addressed and taken into consideration when developing the list of criteria for active euthanasia. All but one could be addressed over time through very strict and well-thought-through laws and developments in the medical and education sectors. However, linking religion to the act of euthanasia raises a plethora of moral and ethical dilemmas that require careful deliberation. Nonetheless, the legalisation of active euthanasia wouldn't affect any of the parties – the medical personnel and patients – directly, only if they wish to. No medical practitioner would be pressured to perform such an act if they do not want to and the same applies to patients.

4.2. Conditions for active euthanasia

As the overwhelming majority of the interviewed medical personnel are not against the legalisation of such a procedure in Latvia, we move on to the next step of gathering the opinions of these specialists under which list of conditions could active euthanasia be legalised in Latvia. This discussion was held only with the medical personnel with the stance "for" and "not now", as specialists with the stance of "against" strongly highlighted that their opinion on the matter wouldn't change regardless of what list conditions to be fulfilled by the patients were to be developed. They strongly believed that there are no conditions under which this procedure is acceptable.

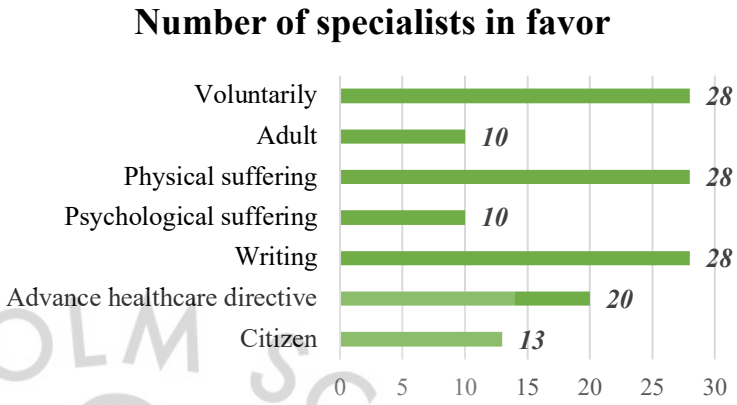
In the process of criteria list discussion and development, 28 medical personnel participated. They were presented with the existing prerequisites to apply for the procedure of active euthanasia in the Netherlands, Belgium, and Luxembourg (summarised in Appendix A) and asked to add, remove, or modify this list to be the best fit for Latvia. To show the stance of the medical personnel in a more illustrative way, we begin the analysis by labelling each of the prerequisites accordingly:

Label	**The criteria the label represents**
Voluntarily	The request is made voluntarily, thoughtfully, and repeatedly and is not the result of external pressure.
Adults	The patient must be an emancipated, capable, and conscious adult at the time of application, doesn't apply to minors.
Physical suffering	The patient is in an unresolved medical situation and reports constant and unbearable physical suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition.
Psychological suffering	The patient is in an unresolved medical situation and reports constant and unbearable psychological suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition.
Writing	The patient's request for euthanasia or assisted suicide is recorded in writing. If not possible then an appointed person by the patient completes this part.
Advance healthcare directive	If the patient is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request. The requirements of due care, referred to in the first paragraph, apply mutatis mutandis.
Citizen	The patient has to be a citizen/resident.

Table 6. Summarizing data from Appendix A and using the same data sources that were used to make Appendix A. Made by the authors.

We summarise the number of medical personnel strongly supporting each of the labelled criteria in Graph 2.

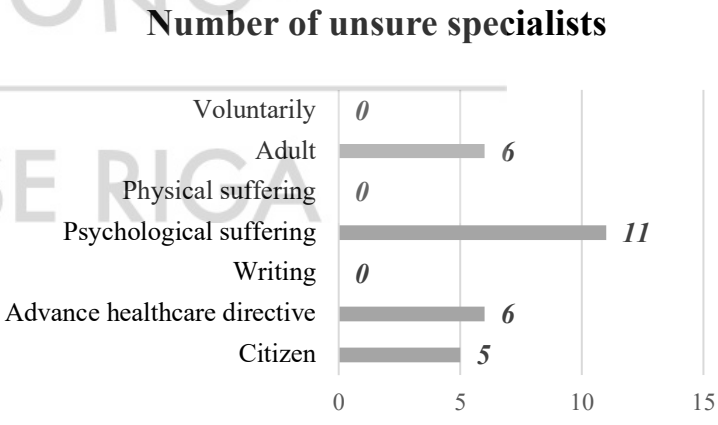
From the graph, it can be seen that the 3 criteria all specialists agreed to be important are "voluntarily", "physical suffering" and "writing". Indicating that it is crucial that the request for active euthanasia is made voluntarily, thoughtfully, and repeatedly and is not the result of external pressure and recorded in writing. Additionally, all of the medical specialists agreed that patients with constant and unbearable physical suffering that cannot be alleviated, resulting from a serious and incurable condition without a doubt would be eligible for active euthanasia.



Graph 2. The number of medical specialists who supported each criteria label. On Y axis: respective criterion label. On X axis: the number of medical personnel. The data used to create this graph is from Appendix G. Made by authors.

However, medical personnel were not unanimous on the criteria limiting active euthanasia only to adults, allowing patients with incurable psychological sufferings to request such a procedure, carrying out the individual's wish for euthanasia made in advance to reaching the state in which they would meet the criteria for granting euthanasia, and, lastly, limiting active euthanasia only to citizens/residents of Latvia.

Not only do we believe that what should be taken into consideration is the opinions of medical personnel with strong votes "for" or "against", but also with – "unsure". Reasoning for this is the fact that these specialists see the criteria they are unsure of as ones with potential, they do not disregard the importance of them.



Graph 3. The number of medical specialists who were unsure about each criteria label. On Y axis: respective criterion label. On X axis: the number of medical personnel. The data used to create this graph is from Appendix G. Made by authors.

The reasons for hesitating include the belief that a large amount of Latvia's population would strongly disapprove of it due to various reasons, such as a low

level of education or other personal beliefs, and also the fact that it would be very difficult to "draw the line" on which psychological sufferings could be eligible, as mental health is not taken to be a very serious illness amongst the population of Latvia, according to the interviewed medical personnel. Furthermore, the 6 medical workers voting "unsure" and 12 voting "against" on limiting active euthanasia only to adults, explained that they strongly believe that it is unfair to draw the line at 18+, as some minors may also incur lethal, painful diseases which cannot be treated and limit their lives in a way. However, the specialists voting "unsure" highlighted their uncertainty on how they feel about the fact that another person makes such an important and difficult decision on behalf of another – talking about the parents or an authorised person. But once again, they do not oppose this idea, they are cautious.

By counting all of the votes of medical personnel voting "for" or "unsure", we create the following list of criteria that a patient shall meet to be eligible for the procedure of active euthanasia according to the medical personnel:

1. *The request is made voluntarily, thoughtfully, and repeatedly and is not the result of external pressure. [28 supported, 0 opposed, 0 were unsure]*
2. *The patient must be an emancipated, capable, and conscious person at the time of application, no matter the age. [12 supported, 10 opposed, 6 were unsure]*
3. *The patient is in an unresolved medical situation and reports constant and unbearable physical suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition. [28 supported, 0 opposed, 0 were unsure]*
4. *The patient is in an unresolved medical situation and reports constant and unbearable psychological suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition. [10 supported, 7 opposed, 11 were unsure]*
5. *The patient's request for euthanasia or assisted suicide is recorded in writing. If not possible then an appointed person by the patient completes this part. [28 supported, 0 opposed, 0 were unsure]*
6. *If the patient is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request. The requirements of due care are referred to in the first paragraph. [20 supported, 2 opposed, 6 were unsure]*
7. *The patient has to be a citizen/resident. [13 supported, 10 opposed, 4 were unsure]*

4.2.1. Additional conditions for active euthanasia

Until now we have only focused on criteria in place in the Netherlands, Luxembourg, and Belgium. Although not many, some of the medical specialists who are very passionate about this subject had other, in their opinion, important criteria propositions to be added to the previously established list.

One might question why we choose to draw attention to propositions that only some of the medical personnel added, not the majority. We argue this by the fact that possibly some of the interviewed medical personnel were caught off guard and couldn't think of them on the spot, but possibly would be in favour of the additions offered by other specialists if they were to be presented with them in another meeting. Furthermore, we strongly felt that it is important not only to present the deputies with criteria that the majority supported but also the additions because a possibility exists that the additions would address the concerns raised by these deputies. We summarise the additional conditions for active euthanasia provided by the medical personnel:

1. *From the age of 14, a person may apply for the procedure themselves, however, that person must undergo a psychological examination to conclude his or her decision-making ability, and psychological maturity.*
2. *An authorised person may apply for the procedure a person under the age of 14. Still, that person must undergo a psychological examination to conclude his or her decision-making capacity, and psychological maturity.*
3. *If the patient is unable to sign the request due to his or her illness, a video recording with the request shall be created.*
4. *The patient can also sign the request with an e-signature if preferred.*
5. *The patient shall be allowed to make such a request in time before reaching the condition of a serious or incurable disease, by making a note on the website of the State eHealth system – E-veselība.*
6. *Over time, people with other nationalities in whose countries this procedure is permitted should also be allowed to request active euthanasia in Latvia: (a case in which the patient's condition becomes severe when visiting Latvia).*
7. *Over time, people of other nationalities whose countries do not allow this procedure should also be allowed to request active euthanasia in Latvia. A person who visits Latvia is subject to its legislation.*
8. *Active euthanasia legislation applies only to a person who has obtained medical documentation confirming a patient's diagnosis/pathology, confirming the unbearable pain.*
9. *Active euthanasia legislation applies only to a person who has obtained medical documentation confirming that the patient has received optimal treatment, all of which has been tried to the maximum capacity possible in Latvia.*

4.3. Overall stance of the interviewed politicians

After developing the preliminary list of criteria with the medical personnel, we move on to analysing the interviews conducted with the lawmakers of Latvia – members of the political parties of the 14th Saeima. Although the interviews were conducted with individuals who are in charge of addressing anything healthcare-related in the name of their political party,

the interviews began with a clarifying question. With it, we understood whether each of the politicians would represent the opinion of the whole party they represent or theirs as an individual. Furthermore, we asked them to provide the reasoning for it. We summarise the results accordingly:

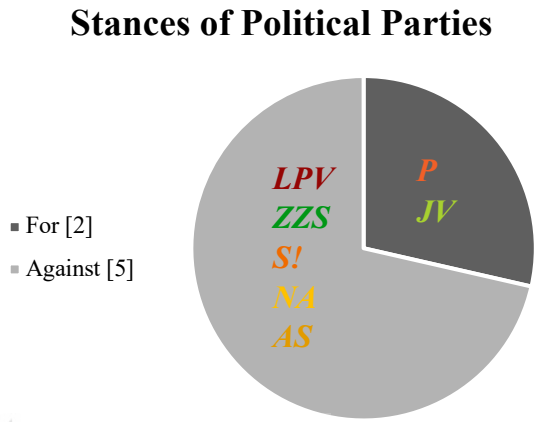
The politician (*their political party*)	**Whose opinion they represent**	**Reasoning**
Edgars Labsvīrs (*P*)	Individual	Feels more comfortable this way, however, assumes that the whole party would have a similar stance. Additionally, highlights that currently there is no one else in the party better than him to speak on topics related to medicine in the name of the party.
Ingrīda Circene (*JV*)	Individual	Highlighted that their party doesn't have a collective stance and that they do not have a draft plan for the law, so she can speak only for herself.
Vladimirs Keidāns (*LPV*)	Political party's	No specific reason was brought up.
Līga Kozlovska (*ZZS*)	Individual	Highlights the fact that ZZS has not addressed this issue in their faction, hence, she speaks for herself.
Svetlana Čulkova (*S!*)	Individual	No specific reason was brought up, however, states that her opinion doesn't differ from her party's.
Lauris Lizbovskis *(AS)*	Political party's	Highlights the fact that for the most part he will speak for himself for the criteria part of the interview, however, he gathered the overall stance of the political party on the stance of legalising active euthanasia in Latvia.
Jānis Grasbergs (*NA*)	Individual	Highlights the fact that their party doesn't have a collective stance. If there were to be a vote, then every member would provide their own opinion rather than say the whole party's position.

Table 7. Summarizing data from Appendix I and using the same data sources that were used to make Appendix I. Made by the authors.

Although most of the interviewed politicians feel more comfortable representing their individual opinions, they are individuals who were brought forward by their political party as most competent to speak on the matter. Furthermore, the most common reason for not opting to represent the opinion of their whole political party is the fact that this topic has not yet been discussed, hence, no collective stance as of now.

Keeping in mind the clarification, we move on to reviewing and summarising the stances on the legalisation of active euthanasia in Latvia of the politicians of the political parties of current Saeima in Graph 4.

From the illustrative graph, we can see that 2 individual politicians, one *Progresīvie member* and one *Jaunā Vienotība* member, expressed their stance as "for" and 2 political parties, *Latvija Pirmajā Vietā* and *Apvienotais Saraksts,* and 3 individual politicians, one *Zaļo un Zemnieku Savienība* member, one *Stabilitātei!* member and one *Nacionālā Apvienība member,* expressed a stance of "against" the legalisation of active euthanasia in Latvia. Results signalling that the overall stance is negative.



Graph 4. The stances on the legalisation of active euthanasia in Latvia provided by the politicians of the political parties of 14th Saeima. The data used to create this graph is from Appendix J. Made by authors.

4.3.1. Politicians' "against" argument categorisation

As the overwhelming majority is strongly against the legalisation of such a procedure in Latvia, we move on to identifying all of their introduced arguments *against.* We categorise them accordingly:

Argument	**Who supports the given argument**	**Description brought by the interviewed politician**
Euthanasia goes against Christian values	*Latvija Pirmajā Vietā*	Political party's values are based on Christian values, and one of the 10 commandments also state that "thou shall not kill".
	Svetlana Čulkova *(Stabilitātei!)*	Political party's values are based on Christian values, in Christianity life is the greatest treasure.
Euthanasia goes against the philosophy of life	Jānis Grasbergs *(Nacionālā Apvienība)*	No individual determines the 2 ends of their life – nor the beginning, nor the ending.
Modern medicine weakens the case of euthanasia	*Latvija Pirmajā Vietā*	Modern and effective pain relief medicine is available. There is a chance that new medicine or treatment methods will be developed which could help treat the patient.
Palliative care has seen improvements over the years, which minimises the case for the legalisation of euthanasia	Līga Kozlovska *(Zaļo un Zemnieku Savienība)*	A new legislation on national hospice care for patients with probable 6 months of survival has been adopted.
	Apvienotais Saraksts	Many important steps towards improving palliative care, especially hospice care, have been taken since the rejection of the Latvian society's brought-forward initiative.
Currently, palliative care and other death-with-dignity measures are underdeveloped in Latvia	*Apvienotais Saraksts*	As of now citizens of Latvia are not guaranteed a high-level free palliative care. Currently the demand is higher than the supply for palliative care.

Lack of knowledge among citizens of Latvia on what euthanasia entails.	*Apvienotais Saraksts*	A lack of knowledge exists between, for example, euthanasia and the help of a doctor to commit suicide among individuals.
There is no demand for such a procedure in Latvia	Svetlana Čulkova *(Stabilitātei!)*	As of now the Latvian society is not prepared for such discussions and there is no such demand. The party is actively fighting for a decent and respectful life for all Latvians.
What about people who are unable to decide for themselves?	*Apvienotais Saraksts*	Are there any morally ethical, spiritual, social, and financial criteria by which another individual can determine the free will of children and psychiatrically ill people?
Euthanasia may be used for the wrong reasons	*Latvija Pirmajā Vietā*	There is a risk, that doctors would use euthanasia with malicious intent to make their palliative care department statistically more appealing.
	Jānis Grasbergs *(Nacionālā Apvienība)*	How can you draw a line between suicide and active euthanasia?
The possibility of error	*Apvienotais Saraksts*	There is a chance that a patient may change their mind.
	Latvija Pirmajā Vietā	There is a chance for a wrong diagnosis.
	Svetlana Čulkova *(Stabilitātei!)*	Euthanasia has similarities with the death penalty. Both carry a heavy weight as there's always a chance of getting it wrong. One can never be absolutely certain that the decision to end someone's life is the right one, and that's a terrifying possibility.

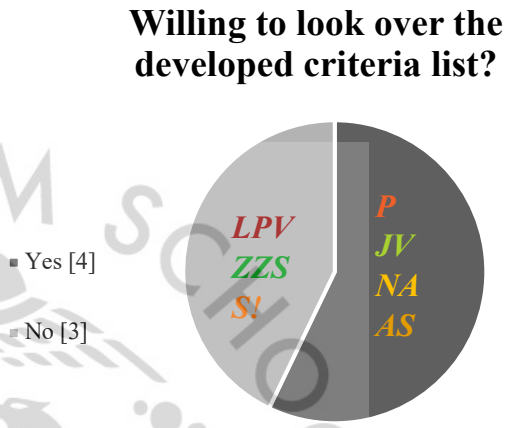
Table 8. Summarizing data from Appendix J and using the same data sources used to make Appendix J. Made by the authors.

Politicians provided, all in all, 10 arguments for why they are against the legalisation of active euthanasia in Latvia. The arguments cover such matters as the current level of healthcare in Latvia, lack of knowledge in terminology relevant to active euthanasia, and religious and ethical concerns. Some arguments were raised by various politicians. This signals that the interviewed politicians are most concerned about the fact that euthanasia may be used for the wrong reasons (supported by 2 out of 7) and the possibility of error (supported by 3 out of 7). Furthermore, 2 politicians highlight the fact that the case of legalising active euthanasia in Latvia is undermined by the fact that palliative care has already seen valuable improvements over the years, and palliative care is a viable alternative to euthanasia when a patient is experiencing unbearable suffering with no prospect of improvement. Lastly, 2 politicians state that euthanasia goes against Christian values which are the basis of the political party they represent.

4.3.2. Politicians' willingness to view the criteria list

As the overwhelming majority of the interviewed politicians are against the legalisation of such a procedure in Latvia, we move on to the next step of our research – seeing whether the arguments and concerns raised by deputies can be undermined with the criteria list developed with the interviewed medical personnel.

During the interviews, all of the politicians were asked to go through the criteria list. As politicians with the stance *for* highlighted that they believed the developed list of criteria is a great starting point for a further, detailed discussion on the matter, we further focus on politicians with the stance *against*. From their willingness to look over, we could, firstly, notice which politicians are open to the topic as they possibly recognize the need for public discussion on the issue although they are personally opposed. As Indiana University (2020) greatly puts it - "good politicians are able to put aside partisan differences when necessary and work for the common good," (para. 8). Secondly, we could see which of the criteria gained the least and the most criticism by the politicians, and which criteria may ease the worries and make politicians more open to the possibility of legalising active euthanasia in Latvia.



Graph 5. The willingness of politicians towards going over the developed criteria list of medical personnel. The data used to create this graph is from our conducted semi-structured interviews with politicians. Made by authors.

However, some politicians were not willing to even look over the developed criteria list. Vladimirs Keidāns (*LPV*) explained "We oppose active euthanasia, so there are no conditions for fulfilling it", Svetlana Čulkova (*S!*) stated that "The issue of euthanasia is not acceptable in Latvian society", and Līga Kozlovska (*ZZS*) was not willing to fully participate in the interview. The opposition does not harm the quality and aim of our analysis, the politicians still presented us with their arguments *against* the legalisation of active euthanasia which we further analyse and try to address with the criteria list.

4.4. Politicians' objections and the criteria list

In this part of our thesis, we employ the Qualitative Comparative Analysis to see which arguments *against* provided by the politicians can be addressed and undermined by the criteria

proposed by the medical personnel. However, by looking at the summary of arguments *against* in Table 8 we conclude that only two arguments can be addressed by the criteria.

Argument: **The possibility of error - there is a chance that a patient may change their mind.**

Criterion: The request is made voluntarily, thoughtfully, and repeatedly and is not the result of external pressure. [factor score = 1]

This argument was raised by *Apvienotais Saraksts*. Whilst the concern is undoubtedly a serious one, it can be addressed by the criterion indicated above. It is the due diligence of the medical personnel to assess whether the patient is an emancipated, capable, and conscious individual at the time of making such a request and make sure that the patient truly wants this procedure to be performed on them. If at any point a patient becomes uncertain or changes their mind, the procedure shall not be performed, as with any other medical procedure. The process of applying and performing such a procedure takes time, which gives the patient the possibility to truly and completely understand whether it is something they wish to be granted.

Additionally, *Apvienotais Saraksts*, being against legalising active euthanasia, themselves seem to support the given criterion which addresses their argument:

> Yes. In the case of the legalisation of euthanasia or assisted suicide, I would support the Dutch approach to such procedures, where the patient must make a request for euthanasia himself and, at the time of the decision, the patient must be capable of making judgements and informed about possible palliative care with medication to alleviate pain, as well as help with social and psychological problems. The patient's pain should be intolerable and permanent, decision-making should be lengthy to rule out impulsive action. At the same time, it is imperative that the treating doctor consults colleagues and submits a report to the government.

Argument: What about people who are unable to decide for themselves?

Criterion: The patient must be an emancipated, capable, and conscious person at the time of application, no matter the age. [factor score = 0.5]

This argument was also raised by *Apvienotais Saraksts*, highlighting the fact that they believe there are no criteria by which another individual can override the free will of another - children and the mentally ill. This argument poses many ethical problems, however, by counting the votes of the interviewed medical personnel we concluded that they wouldn't want the procedure to be limited to only people of legal age. The reason for this is the fact that they believe it's unfair to grant different options to minors and adults with the same diagnosis and

prognosis. Although we cannot comment on medical personnel's opinions on mentally ill patients, the argument of unfairness could also be applied in this instance. Furthermore, we cannot forget that there are a lot of matters that the parents or guardians do decide on behalf of the minor/mentally ill, as they know better. Nevertheless, *Apvienotais Saraksts* do not approve of the given criterion: "No. A very debatable issue, directly related to the patient's age and psychological condition."

Although we were able to completely address one and partially another, no other arguments *against* can be successfully undermined, addressed by the criteria (set of factors). The reason for this is the fact that the developed list is a list of criteria that a patient shall meet to be eligible for the procedure of active euthanasia, however, most of the arguments *against* do not address concerns about patient eligibility but broader matters.

4.5. Addressing other politicians' objections

Although undermining most of the arguments *against* provided by the politicians with the developed list of criteria is deemed unsuccessful, further we take a slightly different route. Due to these arguments being so broad, we delve into understanding whether these arguments *against* can be considered valid in such a delicate discussion, especially if they cannot be resolved by implementing changes at the hospital, governmental and societal level.

Arguments: Euthanasia goes against Christian values & Euthanasia goes against the philosophy of life.

Latvija Pirmajā Vietā and Svetlana Čulkova (*S!*) raised the argument on Christian values and Jānis Grasbergs (*NA*) – philosophy of life. We chose to group them, as they both highlight the fact that euthanasia goes against their ideological beliefs. While it is true that euthanasia goes against Christian values – the Fifth Amendment states that thou shall not kill - it should not be used in a political discussion (Latvijas Evaņģēliski Luterāniskā Draudze, n.d.). This is because Article 99 in the Constitution of the Republic of Latvia states that "everyone has the right to freedom of thought, conscience, and religious beliefs. The church is separated from the state," (Čakste & Ivanovs, 1922). Although the article allows politicians to have their personal and religious beliefs, as any other citizen, basing arguments on religion, when discussing new legislation, seems to be violating the Latvian Constitution. Similarities can be drawn with the various philosophies of life. Politicians imposing their ideological beliefs on citizens who may not share the same beliefs could be considered wrong and even immoral. Furthermore, some may question – what about situations when a patient may impose

on medical personnel whose ideological beliefs deem the act of euthanasia as immoral? The answer to this is straightforward, none of the parties – nor the medical specialist, nor the patient – are obliged to carry out anything that contradicts their beliefs. Hence, if a medical specialist views euthanasia as morally wrong, they are not pressured to perform the act, a specialist with an opposite view would step in to carry it out at the patient's (who meets the eligibility criteria) will.

Argument: Modern medicine weakens the case of euthanasia.

This argument was raised by *Latvija Pirmajā Vietā*. This party highlights the fact that modern and effective pain relief medicine is already available and that new medicine or treatment methods which could help treat the terminally ill could be developed in the future. Although modern and effective pain medication does relieve the patient from pain but what about the bad side effects of such medicine? For example, one of the most popular acute pain medications is opioids. The several side effects include depression, physical dependence, and quick building of tolerance which in turn entails the need to increase the dosage for the same pain relief (Centers for Disease Control and Prevention, n.d.). Furthermore, claims that there might be advances in medicine in the future which could treat the terminally ill are solely unpredictable. Even if such developments do happen then these patients would not be eligible for the procedure, as they would no longer be labelled as "incurably ill". Hence, modern medicine doesn't truly weaken the case of euthanasia, as modern medicine is packaged with potential bad side effects and uncertainty. Furthermore, according to Immad's (2024) list of the 15 countries with the best healthcare in Europe, Belgium ranks 11th, Luxembourg ranks 6th and the Netherlands - 5th. These countries have legalised active euthanasia and they secure top positions in healthcare quality rankings.

Arguments: Palliative care has seen improvements over the years, which minimises the case for the legalisation of euthanasia & Currently, palliative care and other death-with-dignity measures are underdeveloped in Latvia.

Apvienotais Saraksts and Līga Kozlovska (*ZZS*) raised the argument that palliative care has already encountered improvements and *Apvienotais Saraksts* also raised the argument that palliative care needs more developments in this field. These arguments are directly affected and can be resolved by the representatives providing the arguments. Based on point 117 of the Latvian National Development Plan for 2021 to 2027, improving palliative care – access to the provision of social innovation and personalized social services - is set as a goal (Pārresoru

koordinācijas centrs, 2020). Since the beginning of this year, palliative care mobile team service at the patient's residence has been provided, however, there are no such services in Zemgale yet and these mobile teams provide services only up to 8 hours a day (Eniņa, 2024). Furthermore, according to Ministru kabinets (2020), the number of palliative-care specialists has been and still is insufficient, a lack of information exists for people on options for receiving palliative care, and the tariffs for paying for healthcare do not accord with the actual costs. All of this leads to the conclusion that the parliament of Latvia has been aware of the underdevelopment of palliative care in Latvia for years, however, drastic actions have not yet been taken to tackle this as of now. Whilst of course the focus should not be taken away from improving palliative care in Latvia, what about respecting patient autonomy? According to Likumi.lv (2009) the Law on the Rights of Patients section 5, point 1 "in accordance with the procedures specified in the Medical Treatment Law, each person has the right to receive medical treatment corresponding to the state of health,", however, the patient also has the right to autonomy – the right to making decisions on their medical care. Improved palliative care will benefit those who express the want and need for it, but it should not limit the autonomy of patients who wish to end their life due to incurable diseases with the procedure of active euthanasia.

Argument: Lack of knowledge among citizens of Latvia on what euthanasia entails.

This argument was raised by *Apvienotais Saraksts*, highlighting the fact that they believe a lack of knowledge exists between, for example, euthanasia and the help of a doctor to commit suicide among individuals. We assume that the political party signals the fact that the society of Latvia is not educated enough on the matter and, hence, may not be able to understand the reasoning behind it. Why this may be seen as a concerning fact is that if the society – people who are affected by the laws made by the government – is not familiar with the justification for legalising such an act there is a possibility that distrust in and tension towards the government would rise. Some who lack knowledge of the rationale of the act may view this as the government being in favour of medical personnel killing off patients, as an immoral and a slippery slope law. However, we conclude that this is a weak argument, as there is no concrete data to back it up. According to Eng.LSM.lv (2022), in 2021 46% of the Latvian population had completed education for people above school age (either college, university, or vocational courses), surpassing the EU target level of 45% to be met by 2030. Indicating that Latvia has a quite high level of educated people with critical thinking skills. This skill allows individuals to navigate complex matters by making informed judgments and avoiding

cognitive biases (Young, 2023). If individuals were to be introduced to and educated more on this matter in educational institutions, as currently, that's not the case, this argument could be dismissed.

Argument: There is no demand for such a procedure in Latvia.

This argument was raised by Svetlana Čulkova *(S!)*. This is a weak argument because there are no direct statistics that could prove it. From interviews with the medical personnel, we know that there have been patients who have expressed the want for euthanasia or stated that they want to die. Additionally, the 2021 public initiative called "Par labu nāvi – eitanāzijas legalizācija" which gathered the necessary 10,000 signatures to be put forward to the parliament of Latvia directly signals a demand for such a procedure in Latvia. Furthermore, according to Fridrihsone and Lazdiņš (2021), the survey conducted by "Kantar" (research company) shows that 63% of respondents support the aforementioned initiative and also that Rīgas Stradiņu University has another sufficiently representative survey which once again confirms that the majority of Latvian citizens support voluntary euthanasia in particular cases.

Argument: Euthanasia may be used for the wrong reasons.

Latvija Pirmajā Vietā highlights the fact that doctors may use euthanasia to make the statistics of the palliative care department more appealing, and Jānis Grasbergs (*NA*) – how can medical personnel distinguish between a patient wanting euthanasia or to commit suicide? By applying the study conducted by Benatar (2011), we conclude that both raise "abuse" arguments[11]. Claiming that euthanasia may be used to make statistics more appealing does not justify withholding the individual's right and freedom to die, as he/she sees fit. Individuals should not be withheld the right to a reasonable activity on the grounds that some may abuse that right. Detailed regulations and close monitoring would serve as safeguards against such abuse (Benatar, 2011). Medical personnel do not have the right to pressure a patient into doing something they do not wish to. Furthermore, we assume that Jānis Grasbergs (*NA*) has worries that some patients who do not meet the eligibility criteria would abuse this right by demanding euthanasia to commit suicide. However, what the politician fails to acknowledge is that with clear regulations, criteria for eligibility such incidents would be eliminated.

[11] *Abuse argument* – "the argument that such a right will be abused and that no legal safeguards can prevent that abuse," (Benatar, 2011, para. 6).

Argument: The possibility of error – a chance for a wrong diagnosis & one can never be certain that the decision to end someone's life is the right one.

Latvija Pirmajā Vietā highlighted the possibility of a wrong diagnosis and Svetlana Čulkova (*S!*) draws similarities between euthanasia and the death penalty, as they both carry a weight of uncertainty about whether the decision to carry it out is the right one. Whilst there always exists a chance for a wrong diagnosis, to limit such a probability and understand the further treatment tactics Multidisciplinary Teams (Ārstu kosilijs) exist. Such teams already operate in hospitals in Latvia. In the case of euthanasia, they would operate similarly, the only difference being the fact that another option would be granted to the patient – the possibility to request active euthanasia. The decision to carry out the procedure of active euthanasia should not lay on the shoulders of only one doctor to limit some possible biases. The patient expresses their will for euthanasia and the physician is reliable in making sure that the patient meets all the due care criteria. Furthermore, drawing similarities between euthanasia and the death penalty is a fallacy of weak analogy[12]. Both actions have completely different natures, as those sentenced to death do not request to end their life at their own will.

[12] *Fallacy of weak analogy* – "a fallacy committed when an analogical argument is presented, but the analogy is too weak to support the conclusion," (Oxford University Press, n.d., para. 24).

5. Conclusions

The purpose of this paper was to understand under which conditions active euthanasia could be legalised in Latvia. We interviewed deputies and medical personnel to, firstly, understand their views on active euthanasia – should it be legalised or not and why – and, secondly, to develop a strong preliminary list of criteria. The criteria list aimed to reduce the worries of opponents of euthanasia. We found that the majority of the medical personnel are for legalising active euthanasia and thus we were able to develop the list of criteria to be presented to the deputies. However, we found that the majority of the deputies were against euthanasia and refused to discuss the list of criteria, as they deemed it unnecessary due to their stance. Although we were not able to undermine all of their arguments *against* with the list of criteria, we were able to deem the rest as not strong as well, similar to oppositions raised by the medical personnel. Interestingly enough, medical personnel and deputies raised similar arguments *against*. However, our research concludes that most of these arguments cannot be backed up with any data and many can be addressed over time through very strict and well-thought-through laws, criteria, and developments in the medical and education sectors.

This thesis could help raise public awareness of euthanasia and the standards for arguments against legalising it. Demand for euthanasia comes from real people who have endured long-term unbearable suffering with no prospects of improvement. Limiting patients' autonomy must require stronger arguments *against*. We hope that we have shed the reader with a different, more positive, light on euthanasia and what could be the eligibility criteria under which it could be legalised in Latvia, and that future discussions on this topic should involve more high-quality arguments if one is opposed to it. The results of this thesis could potentially help increase the knowledge of euthanasia and why it should be considered a viable option for people who are suffering.

There are also several areas this thesis did not cover due to its limited scope. The most notable one is that we interviewed only 31 medical personnel and one representative of each political party and not all of them represented the opinions of the whole party. For future research, it could be beneficial to interview a larger number of medical personnel from both public and private hospitals in Latvia and all deputies of Saeima, as the views on euthanasia could differ even more tremendously. Additionally, developing a full due diligence list, which would include an explanation of the whole procedure and what the doctor must do could also help reduce the opposition's worries. Besides, more attention could be given to the Latvian society's stance on euthanasia, as the legalisation of euthanasia would affect their autonomy.

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7. Appendices

Appendix A – Summary of conditions a patient must meet to be eligible for euthanasia in EU countries which have legalised the act

Country	The Netherlands	Luxembourg	Belgium
Law	*Termination of Life on Request and Assisted Suicide (Review Procedures) Act*	*Law of 16 March 2009 on euthanasia and assisted suicide.*	*Euthanasia Act*
Date	**1.04.2002.**	**16.03.2009**	**28.05.2002**
Conditions			
1. the request is made voluntarily, thoughtfully and repeatedly and is not the result of external pressure;	**X**	**X**	**X**
2. the patient is an emancipated, capable and conscious adult at the time of application;	**X**	**X**	**X**
3. the patient is an emancipated, capable and conscious minor at the time of application;	**X**		**X**
4. the patient is in an unresolved medical situation and reports constant and unbearable physical suffering which cannot be alleviated and which results from a serious and incurable accidental or pathological condition;	**X**	**X**	**X**
5. the patient is in an unresolved medical situation and reports constant and unbearable psychological suffering which cannot be alleviated and which results from a serious and incurable accidental or pathological condition;	**X**	**X**	**X**
6. The patient's request for euthanasia or assisted suicide is recorded in writing. If not possible then an appointed person by the patient completes this part.	**X**	**X**	**X**
7. If the patient is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request. The requirements of due care, referred to in the first paragraph, apply mutatis mutandis.	**X**	**X**	**X**
8. the patient has to be a citizen/resident			**X**

Table A.1. Made by authors. (Government of the Netherlands, n.d.,a; Guichet.lu., 2023; Health, Food Chain Safety and Environment, 2016).

Appendix B – Questions for interviews with medical personnel

Interviews were conducted in Latvian and were translated to English. The interview questions in English are the following:

Characteristics of the respondents.

1. What is your specialisation?
2. For how many years have you been working in the health care sector?
3. Have you ever cared for a patient at his/her end-of-life?
4. Have you had training in palliative care? If yes, could you specify the palliative care training that you have had?
5. What experiences have you had with medical end-of-life decisions in your practice?
6. What is your religious affiliation/philosophy of life?
7. How would you rate the importance of religion/philosophy of life in your professional attitudes towards medical end-of-life decisions?

Attitudes of respondents regarding euthanasia.

1. In the book "The right to die. Criminal, medical and ethical aspects of euthanasia" the author Rihards Poļaks defines active euthanasia as “cases where, based on a clearly formulated request of a terminally ill person, expressed in any way and by any means at a reasonable time before the initiation of the act of euthanasia, medical personnel or any other person, guided by compassionate motives, in a way that does not cause additional pain and suffering by his active actions directly causes the death of a terminally ill person with the aim of thereby relieving him of the excruciating pain and suffering caused by the disease”. Do you resonate with the definition of active euthanasia provided by Rihards Poļaks - Doctor of legal Sciences, Sworn advocate?
2. How would you define ‘excruciating pain and suffering caused by the disease’ for a terminally ill person? Could you give some examples?
3. Have you ever encountered patients who have expressed a desire to die in your medical practice?

3.1. How often have you encountered patients who have expressed a desire to die?

4. Have you ever encountered patients who have expressed a desire for euthanasia or assisted suicide in your medical practice?

4.1. How often have you encounter patients who have expressed a desire for euthanasia or assisted suicide in your medical practice?

5. Have you noticed some improvements in the palliative care units since you started working in the palliative care unit?
6. Do you think that those improvements in palliative care since you started working in the palliative care unit undermine in a way the case of legalising euthanasia?
7. Are there situations where palliative care might be a viable alternative to euthanasia when a patient is experiencing unbearable suffering with no prospect of improvement?

7.1. "if yes" - Under which circumstances or conditions palliative care could be preferable to euthanasia?

8. Are you in favour of legalising active euthanasia in Latvia?

9. For which reasons are you in favour/not in favour?

further : (if the doctor is NOT opposed)	further : (if the doctor IS opposed)
Now that you have specified that you are not against the legalisation of active euthanasia, could we go through some of the main conditions that are imposed in countries that have legalised active euthanasia and tell us what you think about it?	You are against the fact that active euthanasia in Latvia should be legalised, however, if this procedure was limited with strict criteria inspired by the list of criteria from countries where active euthanasia is legal that an incurably ill patient must meet, is there any possibility for you to rethink your position. For example, if euthanasia is limited to...

Discussing conditions for active euthanasia.

What do you say - do you agree that there should be the condition that...

1. the request for active euthanasia is made voluntarily, thoughtfully, and repeatedly and is not the result of external pressure;

2. active euthanasia legislation should be limited to only adults (18+);

2.1. If you responded with "Does not just apply to adults," what age criterion would you put forward?

3. active euthanasia legislation should be limited to constant and unbearable physical suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition;

4. active euthanasia should be also possible to patients with constant and unbearable psychological sufferings which cannot be alleviated;

further : (if the doctor is NOT opposed)	further : (if the doctor IS opposed)
4.1. active euthanasia should be also possible to patients with constant and unbearable psychological sufferings such as in the situation when...	4.1. Do you resonate with the argument that…
4.1.1. A patient suffers from a personality disorder	4.1.1. If a psychiatric patient requests euthanasia then that is a part of their disease, and it cannot be a reason to perform euthanasia
4.1.2. A patient suffers from a treatment-resistant depression	4.1.2. a psychiatric patient can never be considered incurable, terminal.
4.1.3. A patient suffers from dissociative identity disorder	4.1.3. the course of a mental illness is unpredictable and uncertain, so euthanasia cannot be granted to patients with psychological distress.
4.1.4. A patient suffers from schizophrenia	
4.1.5. A patient suffers from bipolar disorder	
4.1.6. A patient suffers from dementia	

4.2. Are there any other situations where you think active euthanasia should also be possible for patients with constant and unbearable psychological sufferings that cannot be mitigated, that we didn't look at before?	

5. the patient's request for euthanasia or assisted suicide is recorded in writing;

6. If the patient is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request;

7. active euthanasia legislation should be limited to only citizens;

8. Are there any other conditions that come to your mind that should be added to the previously discussed list of conditions the patient, applying for active euthanasia, should meet?

Discussing the possible scenarios if active euthanasia would be legalised.

1. Would you be willing to perform such an act if a patient fulfils all of the conditions?

2. What resources or training do you believe medical professionals should have to navigate complex discussions and decisions related to euthanasia?

3. Do you agree that the doctor should always agree to a request for euthanasia if the patient meets the criteria set?

Appendix C – Questions for interviews with the deputies of Saeima

Interviews were conducted in Latvian and were translated to English. The interview questions in English are the following:

1. Will you answer the following questions as an individual or on behalf of the entire party in a follow-up interview?
2. What is your position in your political party?
3. Have you participated in any discussion in your professional experience on euthanasia and its legalization in Latvia?
4. Is your party for or against the legalization of active euthanasia in Latvia?
4.1. For what reasons are you for/against the legalization of active euthanasia in Latvia?
5. Is your opinion as an individual different from that of your party?

"The next part of the interview relates to the list of criteria a patient must meet to apply for the procedure of active euthanasia. Criteria labelled as "1", "2" and so on are ones that all medical specialists support. However, criteria labelled as "2.1.","5.3." and so on are ones that some specialists introduced as additions to be added in the list of criteria for active euthanasia. Please read each rule and provide us with comments - do you agree or not or adjust them to your liking."

the list of criteria of criteria a patient must meet to apply for the procedure of active euthanasia execution must contain the condition that...

1. The request for active euthanasia is made voluntarily, thoughtfully and repeatedly and is not the result of external pressure.

2. The patient must be an emancipated, capable, and conscious person at the time of application
2.1. From the age of 14, a person may apply for the procedure themselves, but that person must undergo a psychological examination to conclude his or her decision-making ability, and psychological maturity.
2.2. An authorised person may apply for the procedure a person under the age of 14, but that person must undergo a psychological examination to conclude his or her decision-making capacity, and psychological maturity.
3. The patient is in an unresolved medical situation and reports constant and unbearable physical suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition.
4. The patient is in an unresolved medical situation and reports constant and unbearable psychological suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition.
5. A patient's request for euthanasia is recorded in writing.
5.1. If the patient is unable to sign the request due to his or her illness, a video recording with the request shall be created.
5.2. The patient is also allowed to sign the request with an e-signature if preferred.
5.3. The patient shall be allowed to make such a request in time before reaching the condition of a serious or incurable disease, by making a note on the website of the State eHealth system – E-veselība.
6. If the patient is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request.
7. Active euthanasia legislation should be limited to Latvia's citizens and residents.
7.1. Over time, people with other nationalities in whose countries this procedure is permitted should also be allowed to request active euthanasia in Latvia: (a case in which the patient's condition becomes severe when visiting Latvia).
7.2. Over time, people with other nationalities whose countries do not allow this procedure should also be allowed to request active euthanasia in Latvia. A person who has visits Latvia is subject to its legislation.
8. Active euthanasia legislation applies only to a person who has obtained medical documentation confirming a patient's diagnosis/pathology, confirming the agonising pain.
9. Active euthanasia legislation applies only to a person who has obtained medical documentation confirming that the patient has received optimal treatment, all of which has been tried to the maximum capacity possible in Latvia.

Do you think another criterion is necessary? If so, what would you add?

Appendix D - Medical personnel and their stances/votes regarding active euthanasia

		Number of specialists with the stance		
	Stance on the legalisation of active euthanasia in Latvia	*For*	*Against*	*Not now*
Hospitals offering free palliative care	Rīgas Austrumu klīniskā universitātes slimnīca	4	2	2
	Paula Stradiņa klīniskā universitātes slimnīca	11		1
	Rēzeknes slimnīca	5		
	Daugavpils reģionālā slimnīca	2		1
	Vidzemes slimnīca			1
	Ziemeļkurzemes reģionālā slimnīca	1	1	

Table D.1. Made by authors. On the left side of the table are the hospitals offering free palliative care. To the right of each of the hospitals are the number of medical workers with each of the stances on the legalisation of active euthanasia in Latvia: “For”, “Against” and “Not now”. Data gathered from the semi-structured interviews.

Appendix E - Quotes of the interviewed medical personnel against the legalisation of active euthanasia in Latvia

Rīgas Austrumu klīniskā universitātes slimnīca		Ziemeļkurzemes reģionālā slimnīca
Dr. no. 1 - Resuscitator	Dr. no. 2 - Palliative care specialist	Dr. no. 3 - Palliative care specialist
"Our country doesn't have enough of palliative care, we don't have enough palliative care beds in hospitals. We have very bad, very bad, generally under every criticism home care"	"This could only be discussed if the documents on the patient's free choice of resuscitation measures are arranged, and if the patient is provided with quality palliative care, if the patient expresses such a will, it could be debated, but under no circumstances, without the above!"	"I can't imagine how this might be realized at all. Because medical … No doctor, medical ethics would allow anything like that. So, a doctor who is not a palliative care doctor has to do everything to save and maintain life. The basic principle of palliative care is that we are not trying to extend or shorten life. So, we're not trying to detain death, but we're not trying to promote him either in any case. This is a basic principle. And euthanasia has no place here at all. And whoever would do something like that is hardly a medic now. It would be an executioner. Well, after all, we live in Europe, and our civilisation and culture are based on abrasive ones, first on Christianity, eventually other abrasive religions, and then … both killing ourselves and killing the other person, that's the biggest sin anyone can have at all. The sin of death. Everyone's religiousness levels are different, but we are Europeans and I think we shouldn't be allowing things like this."
	"I will repeat, but the doctor is taught how to treat the patient, reduce suffering, but not kill! The definition of palliative care says that a person's length of life cannot be shortened or extended, this is a tough issue in medicine because it is not talked about in intern medicine at least in Latvia because we are taught to be saved, but other times we have to think about or with rescue we will improve the quality of life for a person and not do this suffering you mention!!!"	
"In our country, it's all in the baby's diapers … that's why it's very, very premature to talk about euthanasia in Latvia. When it's gonna be like Norway, the Netherlands, where home care, where a person comes several times a day to tie, flip, feed, and there's enough functional beds brought home. Well, we're not on the same level … So it's very early to talk about euthanasia here."	"1) If euthanasia is performed, then the person himself does, and the doctor is not responsible! 2) A person should have access to full care, support not to choose euthanasia! 3) There is no level of education in Latvia at all levels in order to legalise this one! 4) Why can big money be paid to kill a person but can't pay for quality care, so the patient doesn't have " excruciating distress and pain" ?!"	
"I would rather agree that chronic pain is not the reason for euthanasia."		
"Through these years I've seen all sorts of miracle recoveries. When, for example, after a week a person with a severe head injury sits and eats porridge and is well."	"First, the public and medical staff should know: 1) Human life cycle as it goes! Death is a natural process – believe me, not everyone knows it and accepts it, but most fear it! 2) What to do and what to do when there really are complaints about pain or other suffering also existential problems to turn to for help! 3) Provision of care (both medical and social) on a daily basis until death! 4) What medications and in what situations should the patient mean and why! 5) Communication with patients, relatives of patients about the course of the disease! 6) And then will there be questions about euthanasia?"	
"If the death penalty is forbidden in our country, well... Euthanasia is actually the death penalty. Well, it's not the death penalty, but it's killing."		

Table E.1. Made by authors. Data gathered from the semi-structured interviews.

Appendix F - Quotes of the interviewed medical personnel who are unsure about the legalisation of active euthanasia in Latvia now

Paula Stradiņa klīniskā universitātes slimnīca	Daugavpils reģionālā slimnīca	Vidzemes slimnīca
Dr. no. 3 - Neurologist	Dr. no. 4 - Resuscitator, anaesthetist	Dr. no. 5 - Chaplain
"So I say - we can't sort out the base stuff... Right now, I'm too, considering what it's like now, I'd be certain against too. I am definitely global about euthanasia, but not in Latvia right now. No way right now."	"The problem is that euthanasia is a very good, very easy way to solve the funding problem. All the very sick are very expensive customers for our system, our budget. If euthanasia were to be legalised with us now, with the existing medicine and with the existing problems, then I fear that too many sufferers who could be helped would choose euthanasia because they don't have the funds and we lack "free" time. From the start, we need to improve our medicine, our system, get more money and develop. Once we are at a level where our patients will not have to be sent to Estonia or Sweden on a conditional basis, for example, for a liver transplant, when our medical level is appropriate, for example, like the Polish medical level, then we may be able to talk about euthanasia and how to get it in Latvia."	"I cannot answer this question unequivocally at this time, because this question is a complex one and requires not only knowledge and development of criteria, as well as changes in Latvian legislation."
"There is an extremely low level of education in the country as a whole. We don't have basic health training in schools, so people understand what's happening to their body at all. Because if you're less educated, you think somebody here always wants to cheat, and that encourages aggression. So with the euthanasia issue right now, it would be exactly the same thing when doctors don't want to do their jobs, want to kill everybody, and euthanize them. Hundred point this would be the main argument as opposed."	"I think then we should change how we teach students because I had been taught so that my knowledge and experience did not harm the patient directly. I don't know how legally it is … because when I graduated, we did not have the Hippocratic Oath, but the oath of a doctor, and it said that we do not kill the sick. Here we would get to kill them, and then new doctors who graduate from the faculty should come together, some amendments have to be signed or another doctor's oath has to be defined, where euthanasia will be mentioned. If, for example, I agreed to administer medication with my hand now, I fear that I would be called straight away from the medical department and said, " You know, your doctor's diploma is revoked because you killed a sufferer … despite the fact that the sufferer expressed his or her will until the last moment and everything happened humanely. You signed the oath, so we revoke the diploma through certain laws."	
"As a society as a whole, I think we're now maybe like as a teenager, not exactly as a child anymore, but as a teenager rather. Teenagers don't have to make decisions like euthanasia."		
"Now, it's clear, with adults diagnosed with some kind of chronic illness, they can express their desire. But what about these kids who are the eternal kids? Who makes the decision for him? Can anyone make a decision for him? Now this in a way could also be considered as genocide or ethnic cleansing, wouldn't it? Because that person has never expressed his wishes."		

Rīgas Austrumu klīniskā universitātes slimnīca	
Dr. no. 1 - Internist	Dr. no. 2 - Resuscitator, anaesthetist
"I'm more against right now because it's very, very important here to sort out all the legal aspects as well, so that it's really a thoughtful decision and that it really is the decision of the patient, not his or her affiliates, or someone else. Well, I would say that at this point Latvia as a whole is not prepared for this, as well as with legislation."	"I was thinking before I came to this interview whether to tell if I agree or disagree. On the one hand, I agree because it's very normal and very civilised, but there are very many, many points out there that have to happen to realise all of this. If we put ahead of the many dots that we have in Latvia for the moment from the legislation, from the availability of doctors, from medicine, from everything possible … If we take this as the primary, I can say at once to the current circumstances and I think of the closest future in Latvia, euthanasia is absolutely contraindicated and should not be allowed, because we will not have provided the patient with all the rights and needs that he has before we make this kind of decision. And then it becomes murder."
"I think Latvia is very far from this procedure, but now, taken as a whole, this is already being discussed. For both euthanasia and other treatments. Because from Latvia, as far as I know, only one patient has gone to Switzerland or the Netherlands, I don't remember which country that patient went to."	"We have very undeveloped palliative care, we don't get to many of the medical specialists, let alone palliative care specialists. So until this is sorted out, I'll say absolutely no. If it's sorted and we solve a lot of things, then why not."

Table F.1. Made by authors. Data gathered from the semi-structured interviews.

Appendix G - Medical personnel and their stances/votes regarding conditions a patient must meet to be eligible for euthanasia in EU countries which have legalised the act.

Daugavpils reģionālā slimnīca		**Vidzemes slimnīca**	**Ziemeļkurzemes reģionāla slimnīca**							
Head of Palliative care	Resuscitator, anaesthetist	Chaplain	Resuscitator, anaesthetist							

Paula Stradiņa klīniskā universitātes slimnīca					Rēzeknes slimnīca					
First-year internist	Pneumonologist	Vascular surgeon	Neurologist	Certified cardiologist	Midwife	Midwife, general nurse	Gynaecologist, obstetrician	Nurse	Doctor	Senior nurse in Palliative Care

	Transplantologist	Resuscitator, anaesthetist	Resuscitator, anaesthetist	Resuscitator, anaesthetist	Neurologist	First-year resident of endocrinology
Resuscitator, anaesthetist						
Internist						

	Rīgas Austrumu klīniskā universitātes slimnīca			
	Resuscitator, anaesthetist	Resuscitator, anaesthetist	Resuscitator, anaesthetist	Emergency medicine doctor
Conditions				
The request is made voluntarily, thoughtfully, and repeatedly and is not the result of external pressure.				
The patient must be an emancipated, capable, and conscious adult at the time of application.				
The patient is in an unresolved medical situation and reports constant and unbearable physical suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition.				
The patient is in an unresolved medical situation and reports constant and unbearable psychological suffering which cannot be alleviated, and which results from a serious and incurable accidental or pathological condition.				
The patient's request for euthanasia or assisted suicide is recorded in writing. If not possible then an appointed person by the patient completes this part				
If the patient is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request. The requirements of due care, referred to in the first paragraph, apply mutatis mutandis.				
The patient has to be a citizen/resident				
Would you be willing to perform such an act if a patient fulfils all of the conditions?				

Table G.1. Made by authors. The table summarises each of the interviewed medical personnel (who voted "for" or "not now" on legalising active euthanasia in Latvia) profession and their opinions on each criterion, and whether or not they would be willing to perform the act. Green = "For/Yes", Red = "Against/No", Yellow = "Unsure". Data gathered from the semi-structured interviews.

Appendix H – Hippocratic Oath that must be given by new medical professionals after receiving their degree

As a representative of the medical profession:

I SOLEMNLY PROMISE to devote my entire life to the service of humanity;
MY PATIENT'S HEALTH AND WELLBEING will always be my top priority;
I WILL RESPECT my patient's autonomy and self-respect;
I will regard human life with the HIGHEST RESPECT;
I WILL NOT allow the performance of my professional duties to be influenced by the patient's age, illness or disability, religious beliefs, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social status or any other consideration;
I WILL KEEP SECRETS entrusted to me – even after the patient's death;
I WILL PERFORM my professional duties to the best of my conscience and in good faith in accordance with good medical practice;
I WILL PROMOTE the honour and noble traditions of the medical profession;
I WILL BEHAVE with due respect and gratitude towards my teachers, colleagues and students;
I WILL SHARE my medical knowledge for the benefit of the patient and the improvement of healthcare;
I WILL CARE about my health, and well-being and develop my abilities to provide the highest standards of treatment;
I WILL NOT use my medical knowledge to violate human rights and civil liberties, even if threatened.
THIS PROMISE I GIVE solemnly, of my free will, and confirm with my word of honour (Latvijas Ārstu Biedrība, n.d.).

Appendix I – The interviewed political parties' politicians on whose opinion they represent – personal or political party's

Interviews were conducted in Latvian and were translated to English:

The politician (*their political party*)	**Quotes by the interviewed politicians**
Edgars Labsvīrs (*Progresīvie*)	"Well probably about myself, but now Progresīvie don't have a health task force official anymore, eh? There is a united task force in which the health and social protection issues are tackled. So I don't have an official position in the party anymore, and so yes, I will speak for myself. However, I have been the head of the health task force since 2017 and until last year, having written all the programmes for both the parliamentary and local elections so far… Well, that is why the euthanasia issue has also been a matter of discussion, although it has never been at the centre of focus, but of course it is such a politically sensitive issue that we always have had to position ourselves on it and I was responsible for it. Yes, I've been a bit away from jobs in the party, but no one else hasn't replaced me, eh? Let's just say that there is no one else in the party better than me to speak in the party's name about health-related matters for now. So I don't know if I've answered your question. Rather, I'm talking about myself. It's safe to say."
Ingrīda Circene (*Jaunā Vienotība*)	"We don't have a collective party opinion because we don't have bills like this, I can only speak in my own name. Yes, because we haven't had a bill like that, not that setup. But I have a part of politics for a long time, we've talked about it in earlier commissions. And, of course, thoughts differ diametrically, depending on the basic education, the nature of the work, and the religious beliefs, all of these factors have an effect, of course."
Vladimirs Keidāns (*Latvija Pirmajā Vietā*)	No specific reason was brought up, only the fact that he will represent the whole political party's opinion.
Līga Kozlovska	"I'm not for euthanasia right now, so other questions are not topical."

(*Zaļo Zemnieku Savienība*)	"ZZS has not addressed this issue in the faction. That's my personal opinion. Legislation on national hospice care for patients with probable 6 months of survival has been adopted."
Svetlana Čulkova (*Stabilitātei!*)	No specific reason was brought up, only the fact that she will represent her own opinion.
Lauris Lizbovskis *(Apvienotais Saraksts)*	"I will respond in my own name, but I have also listened to the opinions of my fellow party members."
Jānis Grasbergs (*Nacionālā Apvienība*)	"I will express myself as an individual because we have no unified opinion in the party on this. If there was a vote on the subject, then we would each vote in our conscience rather than say the party's position."

Table I.1. Made by authors. The column on the left side: the name of the interviewed politician and their political party in the current, 14th Saeima. The column on the right side: quotes by the politician in charge of addressing anything related to the topic of medicine on the question – "Will you answer questions in your name or on behalf of the entire party in the following interview?".

Appendix J – Summary of the interviewed political parties' arguments for whether euthanasia should be legalised

Political Party	**For/ Against**	**Arguments**
Progresīvie	**FOR**	1. The discussion about euthanasia is sensitive, but an important one. To some extent sees it is the role of his party – to discuss the sensitive topics. 2. If we measure life quality from 0 to 10 – 0 being death and 10 being alive and well – there are some states, where it can go below zero. 3. How large is our freedom, if when we want to leave this world with dignity, it is not allowed?
Jaunā Vienotība	**FOR**	1. To be able to argument legalisation with opposing parties, strong criteria must be in place. 2. Has been a doctor long enough to have seen many people suffering. Pain relief is only a part of the process, but there is not much that can be done.
Latvija Pirmajā Vietā	**AGAINST**	1. Political party's values are based on Christian values, and one of the 10 commandments also state that "thou shall not kill". 2. There is a chance for a wrong diagnosis. 3. Modern and effective pain relief medicine is available. 4. There is a chance that new medicine or treatment methods will be developed. 5. There is a risk, that doctors would use euthanasia with malicious intent to make their palliative care department statistically more appealing.
Zaļo un Zemnieku Savienība	**AGAINST**	As the stance is "against", further questions were labelled as "irrelevant". Highlighting that a legislation on national hospice care for patients with probable 6 months of survival has been adopted, which minimises the case for the legalisation of euthanasia even further.
Stabilitātei!	**AGAINST**	1. Political party's values are based on Christian values, in Christianity life is the greatest treasure. 2. Latvian society is not prepared for such a discussion. 3. There is no demand for such a procedure in Latvia. 4. Euthanasia is similar to the death penalty. 5. There's always a chance of error – one can never be 100% sure that the right decision has been made.
Apvienotais Saraksts	**AGAINST**	1. Currently the citizens of Latvia are not offered a high-level free palliative care. 2. Not all citizens of Latvia currently have the access to free palliative care. 3. Since 2017 (when the Latvian society's brought-forward initiative for legalising active euthanasia in Latvia was dismissed by Saeima) many important steps towards improving palliative care, especially hospice care have been taken, which minimise the case of euthanasia as these improvements give the terminally ill patients an alternative to ending their life. 4. How to express your will correctly, legitimately, and surely, so, there wouldn't be an error - what I say today, I can deny it tomorrow.

		5. How and by what morally ethical, spiritual, social, and financial criteria, can free will be determined on behalf of children and psychiatrically ill people who are unable to decide for themselves? 6. Lack of knowledge between euthanasia and the help of a doctor to commit suicide. 7. Developments in palliative care should currently be the priority for healthcare, however, discussions regarding assisted suicide should not be eliminated completely. (An argument "for" euthanasia).
Nacionālā Apvienība	**AGAINST**	1. No individual determines the 2 ends of their life – the beginning and the ending. 2. How can you draw a line between suicide and active euthanasia? 3. There are more questions than answers regarding this matter.

Table J.1. Made by authors. The column on the left side: the political party in the current, 14th Saeima each of the politicians represents. The column in the middle: the party's or individual's stance (for/against) on the legalisation of active euthanasia in Latvia. The column on the right side: arguments provided on the stances by the politician in charge of addressing anything related to the topic of medicine.

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