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Revisiting Euthanasia:

A Comparative Analysis of a Right to Die in Dignity

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Abstract

Euthanasia is a practice that has taken place since immemorial times. And since immemorial times it has been controversial and a source of harsh debates. Throughout the last decades, many changes have been introduced in this field and many practices, until then only taking place without public knowledge, were progressively revealed and regulated.

This paper aims, firstly, at clarifying the terminology and concepts usually used in the euthanasia debate and presenting, in a lucid way, the arguments that civic movements and authors resort to when defending or criticising the liberalisation of euthanasia. Secondly, it describes the legal and social situation regarding euthanasia in several countries, where cases and legislation have demanded greater awareness from society. Thirdly, it attempts to compare the different national situations previously analysed. Finally, it discusses ways of improving the present situation and finding better solutions for the regulation of euthanasia.

In such a debate, where moral, ethic and religious arguments and beliefs are called upon, it is crucial not to lose sight of the foundations of our culture(s) and society(ies). Therefore, this paper, although concentrating on the legal aspects of this debate, tries to take into account of some non-legal aspects which are also relevant and without which it is not possible to thoroughly discuss this issue. Ultimately, this paper does not attempt to portray a neutral position, since legal scholars should not necessarily limit themselves to technical and cold analysis of legal provisions.

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I. And now, Ladies and Gentlemen...

... Euthanasia. The last few months have brought this issue to the public arena in an acute way more than ever before. Several events have triggered a very strong and emotional discussion on euthanasia. The French Senate approved a law regarding the rights of patients and the end of life, which according to many was a big step towards legalising euthanasia. Two powerful and touching movies depicting the life and death of the Spaniard Ramon Sampedro ("Mar adentro"¹) and American Maggie Fitzgerald ("One million dollar baby"²) were released and hit the screens in 2004. Finally, and most importantly, the death of the American Terri Schiavo became the daily soap opera in the houses of many families all over the world. All these events, of course, only gained the repercussion that they have because the necessary social and cultural conditions exist. Among these, one can point out some: the individualism that characterises our society; the role of mass media; our tendency, on one hand, to deny death, and on the other hand, to try to control it; the trending legalism of all issues that somehow affect our lives; and the rising competition between different world views.³

- * All Internet websites indicated in this work were last checked on 4 November 2005.
- 1 "Mar adentro" ("The sea inside"), 2004, directed by Alejandro Amenábar and starring Javier Bardem and Belén Rueda: "the real-life story of Spaniard Ramon Sampedro, who fought a 30 year campaign in favour of euthanasia and his own right to die", <<http://www.imdb.com/title/tt0369702/>>.
- 2 "One million dollar baby", 2004, directed by Clint Eastwood and starring Clint Eastwood, Hilary Swank and Morgan Freeman: "a hardened trainer-cum-manager works with a determined woman in her attempt to establish herself as a boxer", <<http://www.imdb.com/title/tt0405159/>>.
- 3 These, and some other causes (such as fear, materialism and consumerism, mystery and impact of scientific advances) are mentioned by M. Sommerville, *in* "Death talk: the case against euthanasia and physician-assisted suicide", McGill-Queen's University Press, Montreal *et. al.*, 2001, pp. 105-118. Although the selection of societal and cultural causes indicated by this author seem, in fact, to have contributed to the creation of the necessary ground for the debate on euthanasia to become so lively, we do not agree with the negative evaluation that she does from them. In fact, individualism does have the merits of providing the necessary space to individuals to pursue their happiness and not be oppressed by communitarian wishes or intentions; mass media have an indisputably valuable importance in providing a great audience access to many relevant issues and information; although legalism, taken to its extremes, contributes to an even more complex and litigious society, it is understandable and respectable that individuals feel the need to call for legal rules and court decisions to protect their rights that are not recognised in practice; etc. Therefore, although we do

We therefore find it a opportune moment now to revisit basic notions related thereto and to make a comparative analysis of the present legal regime of euthanasia in several countries in Europe and elsewhere, as well as to try to see how the public awareness and perception of the problem developed in the last years. We have adopted an interdisciplinary approach, embracing legal, socio-logical and criminological policy aspects. We have refrained from describing in much detail each argument or legal regime, in order to maintain a workable overview of the complete problematic. Additionally, we believe that, in regards to such a complex and sensitive issue such as euthanasia, it is more important to collect different perspectives that allow us to enrich the analysis, rather than describing in detail legal technicalities that only render the debate more difficult. Finally, we thought it more valuable to concentrate our efforts in pointing out the latest legal, as well as social, developments, and make several proposals *de iure condendo*, rather than exhaustively listing *de iure condito* solutions.

The image that first comes to mind when talking about euthanasia is definitely the one of the person who, due to his/her degenerating body, is no longer able to conduct a satisfactory life. All the new dimensions that death and the process of dying have gained in the last few decades force people into very complicated medical decisions, which also increase the number of persons who are sensitive and sympathetic to the idea of voluntary euthanasia. In fact, the most modern life sustaining and reanimation methods have come to prolong life beyond any forecast, leading to unexpected and negative consequences: prolonging of suffering in case of terminal illnesses, maintenance of life under very diminished or nonexistent conscience, and a whole range of conditions considered by many not worth to be lived.⁴ These may derive from traumatic head (brain and skull) injuries causing, e.g., irreversible coma or persistent vegetative state. These medical conditions lead, in the words of Defanti,⁵ to the dissociation of the biological life (which persists) from the psychological life (which disappears), making people ask themselves if using reanimation therapies is always opportune. This scenario has also lead an increasing number of people to think of “mercy killing” as an act of compassion, an excusable murder.

“Euthanasia” derives from the Greek, meaning “good or easy death” (“eu”, which is good, and “thanasia”, which is death). It has come to mean acting or withholding action so that someone else will die under circumstances in which

find very pertinent the causes pointed out by this author for the growing desire to legalise euthanasia, we do not share her pessimistic interpretation of the same.

⁴ See C.A. Defanti, “Eutanasia, cambiamenti e norme”, in “Una norma giuridica per la bioetica”, a cura di Cosimo Marco Mazzoni, il Mulino, Bologna, 1998, pp. 237-250.

⁵ *Ibidem*, p. 239.

death would be a benefit to that person him/herself. The word “euthanasia” was actually invented in the XVII century, by the philosopher Francis Bacon, in his “Novum Organum”. In this book, he defended the position that the doctor’s function was not only to cure, but also to allow for an easy and sweet death. In 1794, the Prussian Code was the first one to approach the question, condemning anyone who committed euthanasia as a murderer. The Norwegian Penal Code of 1902 also considered euthanasia specifically, deciding on the sentence reduction. The Russian Penal Code of 1922, which only lasted for 4 years, went further than any other, allowing euthanasia. Organized movements to legalise voluntary euthanasia started in England, with the Voluntary Euthanasia Legislation Society, in 1935. Later, the legislation of Uruguay and Colombia⁶ also predicted impunity in certain cases of euthanasia. Codes like the Greek (1950) or Filipino ones only allowed for sentence reduction instead. In 1962, a Japanese court even clearly set down the criteria for legal euthanasia.⁷ The ever-growing possibility of prolonging life to an extent in which the patients themselves believe that life is not a benefit demanded the reconsideration of legalising euthanasia. Still, it is a repugnant idea to many people, either because they relate it to unjust killing, condemned by western civilization, or to nazi-kind of programs. Of course that even just considering the question rises a never ending number of problems: Who can make the decision (doctors, relatives, the patient)? When does consent have to be given. How to administer euthanasia? Does it not imply too many risks in what regards family and society’s pressure? Etc.

- 6 In May 1997, the Colombian Constitutional Court declared euthanasia lawful, concluding that the fundamental rights to a life of dignity and to protection of the independence of the individual did not allow for punishment of the assisted suicide. Article 326 of the Colombian Criminal Code regarding compassionate homicide was, therefore, inapplicable to physicians assisting terminally ill patients wishing to die. Some authors have, however, asked for a careful analysis of the fact that Colombia has one of the world’s highest rates of homicide (along with South Africa and Russia). See Judgement of 20 May 1997, Action for constitutional review brought by José Eurípides Parra Parra, *cit. in* Communication no. 1024/2001, Sanles Sanles v. Spain, (Decision adopted on 30 March 2004, eightieth session), *in* Report of the Human Rights Committee (Volume II), Seventy-ninth session (20 October-7 November 2003), Eightieth session (15 March-2 April 2004), Eighty-first session (5-30 July 2004), [http://www.unhchr.ch/tbs/doc.nsf/0/f0c6766939e65645c1256ffd0024998f/\\$FILE/G0443700.pdf](http://www.unhchr.ch/tbs/doc.nsf/0/f0c6766939e65645c1256ffd0024998f/$FILE/G0443700.pdf), p. 510, and *in* Público, 11 April 2001.
- 7 Decision of the Nagoya Court of Appeals, High Court Criminal Reports, Vol. 15, No. 9, p. 674 (Dec. 22, 1962), *cit. in* M. Fukuda, “A survey Research of Doctors Attitudes Toward Euthanasia in Boston and in Tokyo”, *in* Osaka University Law Review, No. 22, 1975, pp. 19-77.

II. Clarifying Concepts and Precising Terminology

We should right away distinguish euthanasia as we defined it above from other completely different behaviours: the so-called eugenic and economical euthanasia. The first one aims at selection in order to eliminate the weak and handicapped from the society, thus improving the human species. The second one believes in eliminating all people, sick or old, incapable of taking care of themselves, getting rid of this financial burden of families and society. In any case, the correct understanding of euthanasia as it is discussed today has nothing to do with any of these. Political programs of race improvement or savage economical directives are in no way connected to allowing terminally ill patients in extreme pain to die in a dignified way.

Defining “death” is also relevant, even if only indirectly, to this discussion. External observation (breathing, self-consciousness, pulse, etc.) and heart-arrest for an irreversible time were the two criteria used to define death until a few years ago. Nowadays the brain-death criterion is the one followed in general medical practice. It means that death is declared when machines cannot register the slightest brain activity. Only knowing when we can talk about death makes it possible to consider certain reanimating techniques ethically obsolete or not, establishing the duty of care and life-saving treatment, etc.

Several concepts and terminology rise frequently in this debate, therefore, we shall proceed with making clear the meaning given to those, before we further use them in the comparative analysis of the rules applying to euthanasia in different jurisdictions. When talking about euthanasia, it is usual to distinguish between **passive** and **active** euthanasia.⁸ It amounts to the question of whether killing is actually worse than letting die. Criminal Law tends to accept and act according to a different judgement of the same result depending on the fact that originated it: the agent is often more severely punished for an action than an omission. Therefore, passive euthanasia, which consists of ceasing or not starting life-saving treatment, usually deserves a milder punishment than active euthanasia, which can be defined as the specific intervention of a third person with the aim of ending someone’s life. The first one includes not treating severely deformed neo-born babies and retrieving heart, kidney or lung support. The second one consists normally of a lethal injection. It remains, however, to

⁸ See Council of Europe (COE), “Replies to the questionnaire for member states relating to euthanasia”, <http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%202015Jan03.asp#TopOfPage>. This document provides the definition of these concepts in each member state of the COE, being these always very close to the ones provided by us.

be proved that there is actually a real difference between these two ‘forms’ of euthanasia: Where does one end and the other one start? What reason is there to think that it is less ethically unacceptable to let a baby in extreme pain for several days in a row until he/she dies than terminate his/her life with a lethal injection? Not doing anything is already doing something; it is deciding what to do, just as taking an action. As Defanti, a physician himself, defends, the decision to not resort to a life sustaining mean or to suspend it after its use has started cannot be considered a mere case of omission, for it is already a decision.⁹ Therefore, we believe that omissions and actions should, as far as the euthanasia debate is concerned, deserve the same punishment. For the sake of coherence, the law should determine the same solution for both passive and active euthanasia. Besides, the active intervention, such as administering a lethal drug that interrupts both (unbearable) pain and life immediately, is more beneficial for the patient than the passive waiting for a death which in many cases is a long, useless agony.¹⁰

Another common distinction is the one between **ordinary** and **extraordinary** medical means. The first ones would be of current use and proportionate efforts and the second ones would demand for extreme situations and disproportionate actions. Some authors accept more easily the suspension of extraordinary means of treatment rather than of ordinary means. However, it is obvious, especially to medical care professionals, that this is an excessively ambiguous distinction, mostly because all means to save life are considered, at least ideally, ordinary for hospitals. This distinction is also extremely hard if we realise that what were unusual means little time ago are today common practice in any hospital and that what is extraordinary in certain cases is ordinary for others and vice-versa.¹¹

Finally, the concept of **indirect** euthanasia is also used in medical and legal texts. Indirect euthanasia means causing death through the prescription of drugs that, even if only aimed at making pain bearable, have the effect of knowingly accelerating the moment of decease. It is what one can call ‘accepted secondary effect’ of the fight against pain. Providing large doses of painkillers, even when

9 C.A. Defanti, *op. cit.*, p. 245; M. Casado Gonzalez, “La eutanasia: Aspectos éticos y jurídicos”, REUS, S.A., Madrid 1994, pp. 19-22 and 25. Of the same opinion, calling the distinction between active and passive euthanasia a mere appearance and not fundamental, see Y. Kenis, “L’euthanasie et l’opinion publique – Un divorce entre les médecins et la société?”, in: Pinsart M.-G. et Susanne C. (éds.), *L’euthanasie ou la mort assistée*, De Boeck, 1991, pp. 35-43.

10 C.A. Defanti, *op. cit.*, pp. 246; L. Schwarzenberg, “Penser l’euthanasie”, in Pinsart M.-G. et Susanne C. (éds.), *op. cit.*, pp. 89-97, especially p. 96.

11 For more details, see M. Casado Gonzalez, *op. cit.*, pp. 24-25.

it leads to shortening the life of the patient, is expressly allowed in countries such as Albania, Denmark, Finland, Germany and Switzerland.¹²

All these distinctions end up having no value in assessing a certain treatment as compulsory or voluntary. At the end, they lack clarity and become irrelevant. Moreover, this remains true no matter what final solution we defend for euthanasia. Nevertheless, a fundamental distinction can be drawn: **voluntary** and **non-voluntary** euthanasia. This is the definitely crucial distinction we have to draw, when making legislative decisions. It is according to this classification that we can make a clear moral and ethical evaluation of the admissibility of euthanasia. We should, therefore, consider these kinds of euthanasia:

Voluntary: one person helps another one in putting an end to his/her life according to his/her request and/or will (in which we could include the physician-assisted suicide and most cases of active and passive euthanasia);

Non-voluntary: the patient cannot at the present and did not previously express consent nor will as to whether he/she would like to live or die (where we can also include some cases of active and passive euthanasia).

This is the most relevant classification as to decide on whether we should allow euthanasia, and which kind, or not. Once again, there is no room for eugenics, murder, genocide or arbitrary destruction of the sick, deformed, senile or mentally deficient. Only the possibility of permitting each person to die in a painless and dignified way is at stake, not the hideous intention of human disposal.

III. The Different Sides of the Barricade

The issue of euthanasia can be reduced to three main moral and judicial values:

- the necessity for reducing physical pain of terminally ill patients;
- the necessity for rendering possible the freedom of choice of the terminally ill patients in defining their remaining days;
- the necessity of assuring the right to life of the terminally ill patients.

It is, therefore, an extremely complex task to satisfy all of these interests: how to protect both people's lives and let them choose their own end? If we decide that it is better to die than to go on living, we are also saying that life quality is more important than life quantity. It is, therefore, the right to life and the con-

12 See COE, *op. cit.*

ception we have of it that is going to determine in great part the final solution we give to the problem. If we can destroy life to guarantee the security of other juridical values, than we make life a relative value, not absolute as so many authors consider it. However, if we already oppose to life other values as self-defence, why not oppose it also to life quality, the will of living or the self-determination right? If we consider the right to life as entitling people to:

- their bare minimum needs for continued life, whatever that may require, as long as it does not violate anyone else's similar right and there are available resources; and,
- protection against unjust assault or interference with these vital interests; then, there is no conflict between the right to life and beneficent euthanasia, whatever form it may take. Let us then review the main arguments usually evoked in favour and against voluntary and non-voluntary euthanasia.

A. Voluntary Euthanasia¹³

Voluntary euthanasia refers specifically to the right of the adult person who is in command of his/her faculties to have his/her life ended by a third person, pursuant to his/her own intelligent request, under specific conditions prescribed by law, and by painless means. We can, therefore, infer that voluntary euthanasia involves at least two willing persons: the patient and the person who assists him/her, which means that it is also a voluntary action to the person assisting. Voluntary euthanasia is then basically equivalent to physician-assisted suicide, where are implicated adult persons who have a serious physical illness that is both incurable and terminal, and which causes severe distress to the patient or renders him/her incapable of leading a meaningful existence. Still, some authors insist in separating voluntary euthanasia from physician-assisted suicide, saying that in the second one, as opposed to the first one, the element of killing is absent, the main idea is helpfulness and only doctors can do it. It is obvious, however, that there is no solid reasoning for this affirmation. Besides that, this brings us back to the distinction between passive and active euthanasia, which we have already considered unjustified and irrelevant. Both distinctions (voluntary euthanasia vs. physician assisted suicide and active vs. passive euthanasia) are aimed at prohibiting one and allowing the other, which opens unbearable breaches on any possible coherent regulation of

13 For a more exhaustive review of all arguments involved in the voluntary euthanasia debate, see main bibliography listed at the end of the text. See also, M. Otlowski, "Voluntary Euthanasia and the Common Law", Clarendon Press, Oxford 1997, pp. 187-256.

euthanasia, as stated previously.

In any case, the mere will of the patient should not be enough for euthanasia to take place; it should be carefully controlled by a statute and allowed only under rigorously defined circumstances. These can differ from proposal to proposal and from law to law, therefore, we will not discuss them all in detail, but, still, we will discuss the general arguments usually raised. It should be clear that all religious grounds and arguments have to be set apart and ignored, whether they are against or for legalising voluntary euthanasia. Voluntary euthanasia legislation must stand or fall on its own secular merits, never on its religious acceptability or repugnance.

Voluntary euthanasia can find justification in reference to three basic values:

1) Prevention of Cruelty: Laws forbidding euthanasia are cruel, as they require a person to be kept alive against his/her will, while denying his/her pleas for merciful death and letting him/her decay for a long period. The legal system lacks compassion and mercy should dictate intervention under request to provide relief, even if it brings death. Far from being immoral or unethical to accede to such a request, it is cruel to stand by without coming to the aid of the person pleading for the end.

2) Allowance of Liberty (principle of autonomy and respect for self-determination): We should start with the assumption that all voluntary acts are permissible and, in absence of some legitimate reason to deny it, we would presume that a doctor and a patient are free to act as they wish.¹⁴ In a free society, it is the restraint on liberty that must be justified, not the possession of liberty. Therefore, law has to demonstrate the necessity of repressing the doctor and patient's conducts on social grounds. What secular social interest is so compelling that justifies preventing the incurably ill sufferer from exercising his/her liberty of choice to accelerate death? In addition, if one accepts the patient's right to freely choose to die in suicide, what ethical or moral drawback can there be in the exercise of such a right if the choice is merely executed by another? After the decision of death, what can be wrong in asking another person to assist in carrying out this legitimate choice or in accepting such request? Individual autonomy is essential in bio-ethics and law. Therefore, it is fundamental to respect it whenever truly voluntary consent is given and no abuse or

14 For more developments on the historical and philosophical grounds of the rational perspective of a 'right over life', based on the thought of Locke and Hobbes, see F. Cavalla, "Diritto alla vita e diritto sulla vita", *Rivista internazionale di filosofia del diritto*, IV Serie, LXV, 1998, Giuffrè Editore, pp. 16-31. The author, however, reaches rather unpredictable and unreasonable conclusions, understandingly and admittedly influenced by Roman Catholic roots.

harm to third persons is caused.¹⁵

3) Enhancement of Human Dignity: Allowing for freedom and preventing cruelty would let patients control their own death, enhancing their dignity, since it would allow the sufferer to receive a merciful death and not endure pointless pain.¹⁶

Of course, there are also very strong arguments to ground objection to the legalisation of voluntary euthanasia:

1) No Ethical Value of Consent: This argument accepts the right of the patient to refuse treatment, but never the possibility of the doctor assisting at suicide. No ethical or lawful legitimacy would derive from the patient's consent

15 For a thorough and interesting account of the most important considerations arising from the principle of autonomy and respect for self-determination, namely problems related to informed consent, medical care personnel own autonomy and self-determination and the role and importance of living wills, see H. Biggs, "Euthanasia, death with dignity and the law", Hart Publishing, Oxford *et. al.* 2001, pp. 95-144.

16 Concerning this argument, Montero claims that it transforms the concept of dignity more diffuse, mostly subjective and relative, and places it closer to the concept of 'quality of life'. He defends, instead, a universal concept of dignity, applicable to all humans (E. Montero, "Vers une légalisation de l'euthanasie volontaire? Réflexions à propos de la these de l'autonomie", *Cahiers de la faculté de droit de Namur*, 3, 1998). In fact, the concept of dignity in present western societies has become more 'demanding', does not seem to be so universal as it was probably thought to be. The concept of 'dignity' has most likely always been very much dependent on specific cultural contexts, and the fact that the modern western societies place so much value on individuals and self-determination might explain why life's dignity might signify and require different things for different individuals. There is, then, a subjective concept of dignity. In fact, as Otlowski underlines, "it is through the recognition of the principle of self-determination that respect is shown for individuals and human dignity is promoted", i.e., the concept of dignity deals with "power to control important aspects of one's life including matters of life and death", which does "in no way purports to deny the intrinsic worth and dignity of all human beings regardless of their health or condition" (M. Otlowski, *op. cit.*, pp. 205-206). See also, H. Biggs, *op. cit.*, pp. 145-174. The author examines how euthanasia may enhance a dignified death and stresses out that, due to the legal prohibition of euthanasia, its practice creates undignified implications both for patients as well as for physicians who engage in it (such as court judgments, violation of professional ethics and feelings of guilt). The author defends, therefore, that a "gradual relaxation of the present legal restrictions could facilitate a highly regulated system of medically assisted dying for those who require it, while providing a high level of protection for everybody" (p. 173). For an interesting analysis of the concept of dignity in the field of biomedicine, see A. Krajewska, "Fundamental Rights Concerning Biomedicine in the Constitutional Treaty and Their Effect on the Diverse Legal Systems of Member States", <<http://www.germanlawjournal.com/article.php?id=666>>.

or request since suicide remains an individual and non-delegable act. Nevertheless, the right to self-determination so fiercely protected by nowadays society makes one wonder if there is not enough ethical ground to the legal value of consent to euthanasia.

2) Difficulty of determining voluntary consent: In many cases it will be impossible to make sure that consent is truly voluntary since the patient will be in great distress due to the pain or stupefied by drugs. However, all consent given by the patient while still in a rational and sane state, before any extreme distress caused by pain or stupefaction due to drugs, escapes this argument. It is sufficient, therefore, to require that a patient execute a formal document declaring his/her desire for euthanasia. If the statute legalising voluntary euthanasia demands this kind of document, truly voluntary consent would be satisfactorily obtained and guaranteed. This kind of previously written consent is usually called living will, where patients can: refuse caring medicine and/or palliative care (as opposed to curative medicine and efficient treatment) or life-saving treatment, ask for the use of all possible means to diminish the pain and even ask for active euthanasia as a last resort.¹⁷

3) Risk of Incorrect Medical Diagnosis: This argument only makes sense if euthanasia is administered well before the final stages of the incurable and terminal disease, before the nature of the disease becomes patently clear and death inevitable. However, euthanasia is by principle to be administered by physicians only as a last resort, after the final progression of the disease has become evident. Of course, there is the possibility that doctors, as any other professional in other field, might produce a mistaken diagnosis. Still, this happens also in any other medical diagnosis concerning any other case (including with possible lethal effects). In any case, the demand for a second physician's opinion (a consultant) certifying that the patient really suffers from an incurable terminal condition would greatly diminish this risk and, therefore, weaken this argument.

4) Possibility of new medical discoveries: If accepted, this argument would implicate leaving all presently dying patients to the mere chance of a future medical innovation that would eventually make possible that patient's cure. However, first of all, we cannot forget that the relevant moment would not even be the discovery of a new cure, but its availability to general use. Secondly, when a patient requires euthanasia and it can be considered acceptable, he/she is definitely suffering from an incurable terminal disease that has

17 For more explanations on the impact of such legal instruments, see N.L. Cantor, "The Permanently Unconscious Patient, Non-Feeding and Euthanasia", *American Journal of Law & Medicine*, Volume XV, Number 4, 1989, pp. 381-437 (especially 398-410).

also reached its last stages and is suffering from great pain and distress. Therefore, when euthanasia is administered, the progression of the fatal disease will have weakened or impaired the patient's body processes to such an extent that any new medical discovery, even if immediately available for use, would be of little aid to him/her.

5) The Use of Modern Drugs to Control Pain Obviates the Need for Resort to Voluntary Euthanasia: This argument relies on the pain-controlling capacities of modern drugs. However, no painkillers prevent people from realising their artificial and hopeless condition, nor does it put an end to all the suffering felt by terminally ill patients, especially being aware of their impending deaths.

6) The Slippery Slope Objection: This argument consists of not innovating because we do not know what its consequences will be. Therefore, voluntary euthanasia should not be legalised because other worse practices (murder, genocide, etc.) could then follow. However, firstly, no legal proposal, especially the most important ones, escapes this kind of pessimistic prediction. Secondly, this argument is not addressed at the merits of voluntary euthanasia itself, but at a catastrophic parade of supposedly following horrors. In our opinion, this objection only aims at installing confusion in the discussion by introducing irrational and irrelevant concerns about unethical practices. It especially mixes voluntary and involuntary euthanasia. Even if caution is undoubtedly justified when introducing serious legal changes (as in the case of legalising addictive drugs, relaxing child labour laws or allowing for less protection against censorship), the risks here discussed are definitely rhetorical and the warnings are needless since carefully tested safeguards can be created. The line between voluntary and involuntary euthanasia and between euthanasia and practices such as murder or genocide is certainly clear enough in order not to let any space for posterior abusive interpretations.¹⁸

18 For a reasonable and moderate analysis of the slippery slope argument, although not entirely accurate in our opinion, see K. Amarasekara and M. Bagaric, "Euthanasia, morality and the law", Peter Lang, New York *et al.* 2002, pp. 63-72. The authors discuss the results of surveys conducted in the Netherlands and Australia, which concluded that the rate of non-voluntary euthanasia is higher in Australia than in the Netherlands, although euthanasia is prohibited in the former and legal in the later. Some authors have, therefore, concluded that "there are greater risks inherent in the current laws which hold active euthanasia to be illegal, but which are in practice flouted, than exist when genuine attempts are made to control and regulate the practice as has occurred in the Netherlands" (M. Orlowski, "Voluntary Euthanasia and the Common Law", Oxford University Press, 2000, p. xiv). K. Amarasekara and M. Bagaric, however, have found this conclusion to fail on grounds of the non-prosecution policy followed in Australia in these cases, which, in fact, makes the Australian legal

Considering all these arguments, we can reach the conclusion that most objections to voluntary euthanasia fail on analysis and a properly drafted law can meet those that have some force. It is, therefore, not enough to just oppose euthanasia. Considering the suffering of the people who reach the radical point of asking for his/her own death, should one not do much more to respect their choice to refuse treatment or speed their own death?

B. Non-Voluntary Euthanasia

This constitutes the most complex issue in the euthanasia discussion. This kind of euthanasia concerns several categories of people, including:

- a) persons who could have previously decided if they wanted or not euthanasia to be administered to them, but, because of loss of mental or physical capacities, ended up not expressing their will (vegetative chronic states, life-supported patients);
- b) persons who never had the ability or the capacity to make such option since they were never in possession of the necessary faculties (babies, deeply incapacitated persons).

As for the **cases included under a)**, if the patients had used living wills, their will would have been stated and should be respected, at least as far as the informed consent requirements could be proven to have been satisfied. We would be dealing with a voluntary euthanasia case, even if the patient had fallen into a vegetative state. As for the people who actually fall under a), for not having expressed their will, we should start by referring that most of these cases have to do with caring medicine: most doctors take as their motto doing everything within their reach to preserve life, even if a vegetative one, while families and other medical personnel many times question this blind perseverance. Caring medicine and palliative care in general have no therapeutic value, since it only consists of artificially prolonging life when there is no more possibility of cure or even improvement.

The chronic vegetative cases have to be very carefully diagnosed, since in a few cases the neurological symptoms may be confused with vegetative states: locked-in syndrome, neo-cortical death, brain death, etc. In order to assure an accurate diagnosis, some medical teams propose a reasonable waiting period (1 year) after which it would be permissible to talk about chronic and irreversible vegetative states. What is at stake here is very often the possibility to renounce caring medicine and/or palliative care: should it be legal for a patient's family

practice similar to the Dutch one.

or/and doctor to renounce caring treatment/artificially-supported life? Most medical teams and families already agree in not pursuing any further medical care and administering euthanasia to patients in a chronic vegetative state or depending on life-supporting machines. Of course, that common practice does not justify by itself its legalisation, but the truth is that maintaining vegetative 'lives' in hospital beds for months and years is purely hopeless and distressing for everyone dealing with the situation.

As for the **cases included under b)**, decisions about the use of surgery and/or life-support systems for prolonging or improving the lives of defective newborns or deeply incapacitated adults with medical serious complications are normally made by parents or closest family together with their doctors and eventually the consultation of the hospital ethics committee. Many consider this a violation of the right to life of every infant and adult. However, is there really a right to life-sustaining treatment in *all* cases? Firstly, 'negative effects' of an impaired child or adult in other people's lives (family, society) should not deserve any consideration. Secondly, prospective handicaps should not receive these treatments only if the disability at stake or its treatment is so severe that their lengthening has no net benefit for the patient. Within these two restrictions, a decision about life-sustaining supports is to be made by the parents and physicians if they agree, and by a hospital board or court if they do not.

Let us now look at the actual situation of the legal regulation of euthanasia at the international and national levels, in several countries and regions of the world. We will begin with looking into the contribution of the Council of Europe and the European Union to this debate. Then we will illustrate the traditional legal position regarding euthanasia, through the examples of Germany and Portugal. Finally, we will see how other countries have innovated the legal solutions regarding euthanasia in several regions of the world, such as in continental Europe and in some countries with a common law system. This analysis will allow us to realise how the concepts and terminology so far explicated are used in actual regulation. Besides this, it will help us pointing out several unreasonable and incoherent aspects of this regulation and how these can be improved and overcome.

IV. The Input from International Organisations

Several international bodies have been alert to the intense and important debate over euthanasia. The debate is so relevant for the civil society that a large number of non-governmental organisations have intervened in the protection of their views. We can mention, e.g., the group of European non-governmental

organisations that has drafted the European Charter of Patients' Rights.¹⁹ This document states that in no case patients can be left with no care at all (Article 2). However, on the other hand, it also stipulates patients' rights to consent and to free choice, as well as the right to avoid unnecessary suffering and pain (Articles 4, 5 and 11). In any case, the most crucial decisions in this field at the international level come from the Council of Europe and the European Union.

A. The Council of Europe

There is no international instrument stipulating any definitive solution for euthanasia. Still, there are some recommendations issued by international entities that should be taken into account. Amongst the most important, we should refer the ones drafted by the Council of Europe, valuing the role of the medical profession, opening space for 'passive' euthanasia and excluding the possibility of 'active' euthanasia. The Council of Europe has been clear on its mind about this issue²⁰, when it recommended that

"the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects (...):

c. by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

i. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";

ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."

Although this move consisted of a desperate call for the States not to legalise active euthanasia, the same document recognised that the respect and protection of the dignity of terminally ill or dying persons demanded protection of

19 <http://www.activecitizenship.net/projects/project_europe_chart.htm>.

20 See Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying, adopted by the Assembly of the COE on 25 June 1999 (24th Sitting), <<http://assembly.coe.int/Mainf.asp?link=http://assembly.coe.int/Documents/AdoptedText/ta99/EREC1418.htm>>

their right to self-determination, through measures:

“9. (...) b. (...)

iii. to ensure that no terminally ill or dying person is treated against his or her will while ensuring that he/she is neither influenced nor pressured by another person. Furthermore, safeguards are to be envisaged to ensure that their wishes are not formed under economic pressure;

iv. to ensure that a currently incapacitated terminally ill or dying person’s advance directive or living will refusing specific medical treatments is observed. (...)

v. to ensure that – notwithstanding the physician’s ultimate therapeutic responsibility – the expressed wishes of a terminally ill or dying person with regard to particular forms of treatment are taken into account, provided they do not violate human dignity;

vi. to ensure that in situations where an advance directive or living will does not exist, the patient’s right to life is not infringed upon. A catalogue of treatments which under no condition may be withheld or withdrawn is to be defined”.

This seems to indicate that some room should be given to the eventual practice of passive euthanasia. However, the exact sense of paragraph vi. creates some doubts by referring to a “catalogue of treatments which under no condition may be withheld or withdrawn”. It is not clear if this refers only to “situations where an advance directive or living will does not exist” or if this catalogue should include, e.g., life-sustaining mechanisms for unconscious patients with no perspectives of recovery.

More recently, the Council of Europe has promoted, through its Steering Committee on Bioethics, a questionnaire to the Council’s member states concerning “aspects of their law and practice relating to euthanasia and other end of life decisions”.²¹ The answers to this questionnaire constitute a very rich source of information. The two main conclusions we can take thereof are the following:

- Euthanasia-related terminology is of common use in all member states of the Council of Europe (euthanasia, active euthanasia, passive euthanasia, assisted suicide), to the exception of assisted dying, at least as far as medical literature and other non-legal documents go (question 1).
- In the great majority of state members it is legal to withdraw life sustaining treatment from a patient who is considered as being brain dead (ques-

21 COE, *op. cit.*

tions 17-18).

Besides this, the case law from the European Court of Human Rights (ECtHR) has also provided many jurisdictions with milestone decisions. *Pretty vs. United Kingdom*, decided in 29 April 2002, was definitely one of the most important.²² This was the first time that the ECtHR pronounced itself on the question of knowing if the prohibition of assisted suicide violates the rights granted by the European Convention of Human Rights (ECHR). Mrs. Pretty, who was paralysed and suffered from a degenerative and incurable illness, wished her husband to help her commit suicide, since her neuro-degenerative illness could lead her to have an undignified end of life and she was not able to commit suicide by herself. According to the interpretation defended by her in Court, Article 2 ECHR, guaranteeing the right to life, also guaranteed the “right to choose to continue or stop living” and the “right to self-determination in relation to issues of life and death” (§ 4). Besides that, the British Authorities would violate Article 3, which prohibits the infliction of inhuman or degrading treatment, if prosecuting her husband for having helped her to commit suicide. Furthermore, the refusal of the Director of Public Prosecutions to grant an immunity from prosecution to her husband and the prohibition in domestic law on assisting suicide infringed her right to respect for private and family life, her freedom of thought, conscience and religion, and the prohibition of discrimination (Articles 8, 9 and 14 ECHR). The Court dismissed the application by unanimity, refusing the interpretation Mrs. Pretty argued from both Articles 2 and 3. Moreover, the Court stated that even though Article 8 grants the right to respect for the private life, state interferences thereto are licit in the name of protection of the right of others, given “the risk of abuses and the possible consequences of abuses that may be committed which a relaxation of the general prohibition of assisted suicide or the creation of exceptions to the principle would entail” (§ 74). This argument of the Court corresponds to the slippery slope objection and, as already explained above, is hardly convincing: pessimistic predictions can oppose any legal innovation and the merits of euthanasia itself are simply ignored. Still, even if the court refuses to identify a right to die, that does not mean that a state party to the convention may not, under certain conditions, allow death to be inflicted on a person upon his/her request, without violating its duty to protect the right to life.^{23 24}

22 *Pretty v. the United Kingdom* (application no. 2346/02), European Court of Human Rights, 29 April 2002.

23 European Union Network of Independent Experts in Fundamental Rights (CFR-CDF) – Report on the Situation of Fundamental Rights in the European Union and its Members States in 2002, p. 33, <<http://www.cprdr.ucl.ac.be/cridho/CFR-CDF.Report2002.en.pdf>>.

Anyhow, the approach taken by the ECtHR in several decisions leads us to believe that this Court will not, anytime in the near future, introduce any developments in the legal status of euthanasia in Europe. In fact, the ECtHR considers, in regards to this as to other issues, that “the steps appropriate or necessary to discharge a positive obligation will be more judgemental, more prone to variation from State to State, more dependent on the opinions and beliefs of the people and less susceptible to any universal injunction”.²⁵

B. The European Union

The European Parliament (EP) has also decided to participate in the public debate. Some members of the EP have expressed that the European Union member countries should walk towards legalising euthanasia:

“The European Parliament, (...) 28. Considers that the prohibition of torture and inhuman and degrading treatment, as well as the protection of human dignity, include the prohibition of over treatment, the promotion of palliative care, respect for the patient's wishes, as expressed through his or her will, for example; calls on the Member States to consider the possibility of amending laws on the end of life to this end by regulating euthanasia”.²⁶

However, in its formal declarations, the EP is considerably more cautious, stating the exact opposite ideas.²⁷

24 See under comments regarding the Netherlands.

25 § 15 *Pretty v. the United Kingdom* (application no. 2346/02), European Court of Human Rights, 29 April 2002, p. 10, in regards to Article 3. See also § 37 *Rees v. United Kingdom* (1986) 9 EHRR 56, pp. 63-64, regarding Article 8.

26 Draft European Parliament Resolution, in Committee on Citizens' Freedoms and Rights, Justice and Home Affairs (Rapporteur: Alima Boumediene-Thiery), Report on the situation as regards fundamental rights in the European Union (2003) (2003/2006(INI)). In the same document, we can find another reference to euthanasia: “many legal judgements support the death of disabled people, either through euthanasia laws or through regulations and judgements of quality of life leading to suspension of treatment”. See <<http://www2.europarl.eu.int/omk/sipade2?PUBREF=-//EP//TEXT+REPORT+A5-2004-0207+0+DOC+XML+V0//EN&L=EN&LEVEL=2&NAV=S&LSTDOC=Y>>>.

27 See, e.g., “Respect for human rights in the European Union in 1995”, <<http://www2.europarl.eu.int/oeil/file.jsp?id=108582>> and “Report on Fundamental rights situation in the European Union for 2001”, <<http://www2.europarl.eu.int/oeil/file.jsp?id=204772>>.

“‘Why don’t you want to let a dying man himself decide when he cannot take it anymore?’ I answered. ‘It is the least we can do!’”²⁸

in “Die Nacht von Lissabon”

V. National Positions

A. *The Traditional Position*

Law in Germany or Portugal is as traditional and conservative in relation to this issue as most other countries’ regulation on euthanasia. The regulation in these countries can, therefore, be taken as good examples of how legislation traditionally deals with this problem, as for example in other countries with so different cultural and legal backgrounds and traditions such as Austria, Croatia, Czech Republic, Finland, Greece, Italy²⁹, Ireland³⁰ or Turkey.³¹ It is, however,

28 E. M. Remarque, “Die Nacht von Lissabon”, Droemer Knaur, München/Zürich 1962, p. 194.

29 For more details on the Italian situation, and promoting a more reasonable and progressive legal development, see F. Giunta, “Diritto di morire e diritto penale”, in “Una norma giuridica per la bioetica”, a cura di Cosimo Marco Mazzoni, il Mulino, Bologna 1998, pp. 251-279. Already in the beginning of the 1970’s, some voices were heard for a more progressive position, e.g., F. Mantovani, “Problemi giuridici della eutanasia”, Archivio Giuridico “Filippo Serafini”, Vol. CLXXVIII, Fasc. 1-2, S.T.E.M.-Mucchi, Modena 1970, pp. 37-51 (however, the same author seems to have evolved much himself, since 18 years later he states a nearly more conservative opinion on the same issue: F. Mantovani, “Aspecti giuridici della eutanasia”, Archivio Giuridico “Filippo Serafini”, Vol. CCVIII, Fasc. 1-2, Mucchi Editore, Modena 1988, pp. 67-95; Rivista Italiana di Diritto e Procedura Penale, XXXI, Fasc. 2, Aprile-Giugno, 1988, Dott. A. Giuffrè Editore, Milano, pp.448-469).

30 Although the Irish legal rules regarding euthanasia can be inserted in the large group of countries that prohibit it, the Irish Supreme Court has offered a decision which shows signs of evolution: a forty-five years old woman, who had been in coma for 23 years, was kept alive by a naso-gastric feeding tube. The court upheld the decision to cease treatment, following her parents petition, defending a large concept of the right to life (as including the right to die) (*In re Ward of Court* [1995] 2 I.L.R.M. 401, *cit. in* E. Woods, “The right to die with dignity with the assistance of a physician: an Anglo, American and Australian international perspective”, 4 ILSA J. Int’l & Comp. L. 817, Spring 1998).

31 See W. Sohn and M. Zenz (eds.), “Euthanasia in Europe: national laws, medical guidelines, ethical aspects”, Schattauer, Stuttgart/New York 2002; Answer to question I.2, COE, *op. cit.*

interesting to note that, even countries where this kind of traditional legal frame exists, case-law developments are expected to ensure some evolution. This is the case, e.g., in Italy: *Eluana Englaro* has been in a vegetative state for 13 years now, as a consequence of a car accident. Her father (and guardian) has requested the withdrawal of the feeding tube and forced hydration. Although the Appeal Court of Milan has denied the request, arguing that feeding and hydration are not therapeutic treatments, it also recognised that he had the right to express consent or refuse therapeutic treatment to his daughter.³²

1. Germany³³

The word “euthanasia” remains until these days a complete taboo, since it is connected with the Nationalist-Socialist period atrocities. Instead, people rather use the word ‘Sterbehilfe’ (help to die).³⁴ ³⁵ There is no specific legislation on euthanasia: the provisions contained in the Constitution and in the Penal Code regulate this issue. In fact, Article 1 (1) of the German Constitution (Grundgesetz, GG) states that “Human dignity shall be inviolable”³⁶, and, based on this provision, terminally ill patients are awarded the same protection than any other patient. Article 2 (1) GG protects the “right to free development of his personality insofar as he does not violate the rights of others or offend against constitutional order or the moral law” and (2) of the same provision awards every person “the right to life and physical integrity”. Still, this does not mean that one has the right to dispose from his/her own life, because these provisions enforce protection of the right to life from third parties’ aggressions.

As for the Penal law, Article 216 (1) of the Penal Code (Strafgesetzbuch, StGB) establishes that “If someone is induced to homicide by the express and

32 Reported in “La Repubblica”, 22 March 2005, p. 16. The Appeal to the Supreme Court (Cassazione) was also refused: “Cassazione, respinto il ricorso del padre Eluana Englaro continuerà a vivere”, <<http://www.repubblica.it/2005/c/sezioni/cronaca/eutanasia/deciscassaz/deciscassaz.html>>.

33 In general, see Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée No 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>, and German answer to question II.2 of COE, “Replies to the questionnaire for member states relating to euthanasia”, *op. cit.*

34 See, as a clear example of how some German authors have severe difficulties to separate eugenic nazi euthanasia practices from nowadays debate, W. Creutzfeldt, “Euthanasie: geistige Wurzeln im 19., Verbrechen im 20., Legalisierung im 21. Jahrhundert?”, Medizinische Klinik 2000; 95:714-719 (Nr. 12).

35 All translations of legal rules and scholarly writings, originally in a language other than English, quoted in this work have been translated by us, unless otherwise stated.

36 Translation taken from <<http://www.iuscomp.org/gla/index.html>>.

earnest request of the person killed, then imprisonment from six months to five years shall be imposed”.³⁷ This corresponds to a lighter sanction than the one applicable in case of murder (life imprisonment), manslaughter (minimum five years imprisonment) or less serious case of manslaughter (one to ten years imprisonment), foreseen in Articles 211-213 StGB. Besides that, assisted suicide is punishable as far as it may constitute a case of failure to render assistance, as foreseen in Article 323 (c) StGB. According to this rule, “Whoever does not render assistance during accidents or common danger or need, although it is required and can be expected of him under the circumstances and, especially, is possible without substantial danger to himself and without violation of other important duties, shall be punished with imprisonment for not more than one year or a fine.” The reasoning of the Federal Supreme Court (Bundesgerichtshof, BGH) is the following: suicide is not punishable, and the person who merely assists to suicide does not take an active role in the suicide itself, therefore, he/she cannot be considered the author of such conduct. The court also considers suicide as an accident (one wonders how exactly can that be), so the person who assists to it will be punished (and only in that case) if the one who commits suicide loses conscience. In this case, Article 323 (c) StGB imposes a duty to render assistance. This means that assisting to suicide is not punishable, but not rendering assistance when it has been already attempted is. The incoherent and outrageous consequences of this reasoning are quite clear: if the assistance to suicide has as effect of producing an immediate death, without a period of unconsciousness (e.g., providing a gun, which is used for a shot in the head), there is no opportunity for rendering assistance to save the person who wants to die, so there is no punishable conduct. However, if the assistance leads to a slow death, with a period of unconsciousness (e.g., providing lethal pills with a slow effect), then there is the duty to assist in saving the person who wants to die. This remains true even knowing that committing suicide with a gun can be more painful and traumatising for everyone involved than doing it with lethal pills.

Case law has been in general more lenient with cases of assisted suicide when the patient is physically capable of committing the final act. On the other side, courts are very demanding in regards to cases where the patient has such grave disabilities that he/she would have difficulties carrying out the suicide him/herself. This distinction obviously sanctions patients who are already in a worst condition due to their disabilities. It means that if you can carry out the suicide yourself, you can even receive assistance in your act (and no one will be punished as long as the death is fast and there is no opportunity for assis-

37 *Ibidem.*

tance to save from it). However, if you are so severely handicapped that you cannot carry the act yourself, than you cannot receive any assistance, otherwise the person providing such assistance will be very likely punished for homicide by request (Article 216 (1) StGB). The results produced by the existing provisions and case law are, in conclusion, unsatisfactory and unfair.³⁸

As for the case of indirect euthanasia, German courts have stated that prescribing pain killing medication according to the expressed or presumed will of the patient is acceptable even if it unintentionally leads to the acceleration of death as an unavoidable side-effect.³⁹ Both scholars and courts are generally in favour of a painless, albeit faster, death, in respect of the patient's will, than prolonging the patient's life to the cost of great pain.

With regard to passive euthanasia, the interruption of life-prolonging medical treatment is considered licit when the patient so requests, the pain is much and inevitable and death is predicted to happen soon. The self-determination right, protected by Article 2 (1) GG, allows, therefore, for refusing intensive care and treatment of further medical difficulties. This is also valid for patients who are incompetent to give their consent, in which case physicians base their decision on the patient's living will or presumed will, taking into account previous oral or written statements or religious or philosophical convictions. §§ 1896-1908 of the German Civil Code (Bürgerliches Gesetzbuch, BGB) also foresee the possibility for incompetent patients to designate a guardian, who is entitled to take decisions regarding medical care. § 1904 specifies the case of medical decisions that may cause the death or severe physical injury of the incompetent patient: in this case, the guardianship court has to confirm the decision of the guardian. The BGH defined its stand on these issues in 1993.⁴⁰ On one hand, the BGH stated the necessity of hearing the guardianship court when ceasing life-sustaining treatments, on the other hand, it determined the legal binding effect of living wills. More precisely, the court has found that, when a patient is not competent, life-sustaining measures must cease when the patient's will, in the form of something like a living will, so determines. This is a consequence of the concept of human dignity and right to self-determination.

38 For a better understanding and deeper analysis of German case law and distinction performed by the courts between active, passive and indirect euthanasia, and assisted suicide, see K. Becker-Schwarze, "Möglichkeiten der rechtlichen Regulierung einer selbstbestimmten Entscheidung am Lebensende", in Gert Brüggemeier (Hrsg), "Liber Amicorum, Eike Schmidt zum 65. Geburtstag am 26.11.2004", C.F.Müller Verlag, Heidelberg 2005, pp. 1-31.

39 BGHSt 42, 301, from 15 November 1996 - Indirekte Sterbehilfe, <<http://www.oefre.unibe.ch/law/dfr/bs042301.html>>.

40 BGH, Beschluss v. 17.3.2003 – XII ZB 2/03 (OLG Schleswig).

The court only has to determine the presumed will of the patient (based on his/her life decisions, values and convictions), when the patient has not previously expressed his/her will. The patient's guardian should express and concretise the will of the patient. However, when such will pertains life sustaining and prolonging treatments, it has to be confirmed by the guardianship court. Voices against this decision arouse immediately, though, pointing out the negative effect that such conclusions might have on legal certainty.⁴¹

Some authors go even further and argue that decisions regarding the interruption of medical treatment should be excluded from the powers awarded to guardians. Nonetheless, the possibility for passive euthanasia, be it for competent or incompetent patients, does not generally allow for refusing general care such as artificial feeding and hydration. The Federal Supreme Court opened one exception in 1994⁴², when it accepted the request of the son of a woman in coma for several years to cease her mother's artificial feeding. The court based this exception in the presumed will of the patient, and a similar decision was taken by the Oberlandesgericht Frankfurt in 1998.⁴³ Both these decisions raised some controversy, since the death was not predicted to take place in a short period of time. On the contrary, ceasing artificial breathing is generally accepted, because it is considered interrupting a treatment. Should the ceasing of artificial breathing and feeding not have the same legal standing? Why is one controversial and the other is not? There does not seem to be any substantial difference between one and the other: both are life-sustaining treatments and removing any of them has the effect of causing death.

Finally, although without any binding value, the directives emanated by the Federal Chamber of Physicians have provided some guidelines regarding the treatment of terminally ill patients and euthanasia.⁴⁴ These guide-lines were released in 1979 for the first time and were later on revised, in 1993, 1998 and in 2004, after debates over these issues and other developments have taken place. Although the last version of this document still proclaims the duty to maintain life as the main medical duty of physicians, it also recognises that therapy can be replaced with palliative care under certain circumstances. In any case, even if the right to self-determination is said to be relevant in all cases, the possibility of practicing active euthanasia is completely set aside.

41 Spickhoff, Comment on decision of BGH from 17.3.2003, *in JZ* 2003, 739-741.

42 BGH, 1. Strafsenat v. 13.09.94; BGHSt 40, 257-272.

43 OLG Frankfurt a. M., Beschlüsse v. 15.07.1998 – 20 W 224/98; NJW 1998, 2747 ff.
See also, more recently, OLG Karlsruhe, Beschlüsse v. 26.3.2004 – 11 Wx 13/04; NJW 2004, 1882-1883.

44 “Grundsätze der Bundesärztekammer zur ärztlichen Sterbebegleitung”, <<http://www.bundesaerztekammer.de/30/Richtlinien/Empfidx/Sterbebegl2004.pdf>>.

The latest guidelines of the Federal Chamber of Physicians place the patients' self-determination right at the top of the medical care priorities.⁴⁵ Still, the opinions amongst politicians are much divided, even within the same political groups, as the opposite declarations from the health and justice ministers concerning the already mentioned decision from the Oberlandesgericht Frankfurt demonstrate. More recently, a working group has been in charge of discussing if it would be advisable to introduce amendments to the law to better protect dying patients' autonomy (BMJ-Arbeitsgruppe "Patientenautonomie am Lebensende"). It was expressly out of the scope of this group's work considering the legalisation of active euthanasia. Still, the opinions expressed in the final report⁴⁶ of the working group created enough controversy to provoke reactions, such as that from the Enquete-Kommission of the German Parliament "Ethik und Recht der modernen Medizin".⁴⁷ The discussion focuses now on how to protect patients' right to self-determination in practice. This reveals some progression in the German debate, which will, hopefully, eventually lead to more coherent and suitable rules and decisions.

2. Portugal⁴⁸

We can distinguish the contributions of different legal levels to the debate on euthanasia. As far as the constitutional rules go, Article 24 of the Constitution⁴⁹, which protects the right to life, states: "1) Human life is inviolable" and "2) In no case shall the death penalty be applied". As already previously discussed, the definition of the right to life raises several fundamental questions, namely, if there is a right for each person to organise his/her own death. In what specifically concerns euthanasia, the majority of the Portuguese authors considers that there is no juridical-constitutional right to 'active' euthanasia. Therefore, there is no right to ask a third person to provoke his/her death in or-

45 *Ibidem*, and "Charta der Patientenrechte" (Draft), from 27 October 1999, <<http://www.bundesaerztekammer.de/30/Richtlinien/Empfidx/Patientenrechte.html>>.

46 "Bericht der Arbeitsgruppe 'Patientenautonomie am Lebensende' vom 10. Juni 2004", <<http://www.bmj.bund.de>>.

47 For more details on the present debates, see K. Becker-Schwarze, *op. cit.*, p. 2.

48 J. J. Canotilho, V. Moreira; "Constituição da República Portuguesa, Anotada", Coimbra, Coimbra Editora, 1993; Conselho Nacional de Ética para as Ciências da Vida, "Aspectos éticos dos cuidados de saúde relacionados com o final da vida", Lisboa, Presidência do Conselho de Ministros; J. F. Dias et. al., "Comentário Conimbricense do Código Penal", Coimbra, Coimbra Editora, 1999.

49 Constitution of the Portuguese Republic, from 2 April 1976, Text according to the Fourth revision introduced by the Constitutional Law no. 1/97 of 20 September, <http://www.parlamento.pt/ingles/cons_leg/crp_ing/index.html>.

der to finish the pain and allow for a ‘sweet death’, since respect for others’ lives cannot exempt mercy-killers. As far as ‘passive’ euthanasia is concerned (defined as the right to oppose artificially sustained life in case of incurable disease), it is agreed that the Constitution allows for special rules to be applied to terminally ill patients, in order to ensure their right to death with dignity. However, this possibility would not even allow for clearly stopping ‘treatment’ (palliative care or caring medicine).

The essential rules of the Penal Code attaining the problem in question are Articles 134⁵⁰ and 135⁵¹. Article 134 (homicide at request of the victim) corresponds to a suicide for the victim and a killing for the agent; therefore, the Portuguese Penal Code opted for considering this conduct a privileged form of the fundamental form of the crime of homicide (as it also happens in Austria, Switzerland or Germany). It is the “serious, insistent and expressed request” from the victim that legitimises the reduction of both the wrongfulness and the guilt: the request expresses the victim’s autonomy and self-determination as well as his/her renouncement to the penal protection of the juridical value, this way reducing the wrongfulness of the agent’s conduct. In any case, this makes the so-called ‘active’ euthanasia forbidden. However, for many authors, firstly, a juridical value should be conceived as merely subjective and relational and, secondly, lesions caused to someone else by request and self-lesions should be valued as normatively equivalent. Still, the majority agrees with the political-criminal legitimacy of this legal provision. Consent does not make any difference, since penal protection is given to the patient’s life, no matter if he/she wants it or not.

A crucial moment in defining this crime is deciding if it can only occur by action or also by omission. Much case law and some authors have argued that it is also possible to commit this crime by omission. However, the majority of the authors clearly deny this possibility. The victim’s request does not give the right to kill, but it does not create the duty to save either – it would be the patient’s opposition to the help that would eliminate the doctor’s or anyone else’s duty to save him/her. According to Portuguese lawyers’ opinion, this makes the so-

50 Article 134: “(Homicide at request of the victim) 1. Who kills another person determined by expressed, insistent and serious request that has been addressed to him is punished with prison for a maximum of 3 years. 2. Attempt is punishable.”

51 Article 135: “(Instigation or help at suicide) 1. Who instigates another person to commit suicide, or gives that person help for that aim, is punished with prison for a maximum of 3 years, if suicide is effectively attempted or consummated. 2. If the instigated person or the one to whom help is being given is a minor of under 16 years old or has, for any reason, his capacity of valuation or determination sensibly diminished, the agent is punished with prison from 1 to 5 years.”

called ‘passive’ euthanasia legal according to the Portuguese legal system (such as turning off the life-supporting system), at least if administered by a doctor. Nevertheless, this opinion is hardly reconcilable with three other facts:

- a) The Portuguese Penal Code also states that any crime can, in principle, be committed by omission (Article 10), and there is no definite reason to deny this possibility in the case of homicide at request of the victim.
- b) The crime of help at suicide or even the crime of omission of the duty of help (Article 200), as determined by the Portuguese Penal Code, would most likely include many of the conducts not punished by this article.
- c) This position fails any test of coherence, as it also happens to the distinction between ‘passive’ and ‘active’ euthanasia.

As for Article 135 (instigation or help at suicide), it is conceived as an independent type of crime, not a special kind of homicide. Only a few countries have this crime in an independent rule (Austria, Switzerland, Greece, Spain, France), but, in reality, countries which do not even have an identical article punish the same conduct (sometimes even more than countries that expressly foresee that crime) through other provisions (homicide by omission at request of the victim or omission of the duty of help). We should start by distinguishing this provision from Article 134: homicide at request of the victim starts and instigation or help at suicide ends when the agent’s cooperation in someone’s death is not just mere help and becomes a typified conduct of the agent. This distinction is essential for basically two reasons: Some legal systems (like, as we have seen above, the German one) only punish homicide at request of the victim and not help at suicide and the systems that punish both have different rules for each one (in the Portuguese case, although both conducts are punished with the same number of years of prison, attempt is only punishable in the case of homicide by request of the victim). Of course that applying this distinction in concrete cases is extremely complex and many theories fail in giving a satisfactory answer. Still, one of the probably most capable one uses the criteria of the dominion over the act that directly and irreversibly produces death. Also in what concerns this provision, authors try to make it possible for ‘passive’ euthanasia to be legal, saying that it is not suicide (at least for what this article is concerned), for example, refusing treatment, even if it is a life-saving treatment. However, would it not be more reasonable to base this solution in the patient’s autonomy or self-determination right? Is it not a twisted game playing with reality this way? It would definitely be more conceivable accepting euthanasia rather than forbidding it and then allowing a limited number of cases through distorting the law.

Still at the penal law level, we should refer Article 156, which prohibits compulsory treatments or surgical intervention: doctors who maintain life-

saving treatment for patients who have expressly denied it are criminally responsible. The self-determination right, stated in Article 70 of the Civil Code, also supports this solution. Once again, we can see a breach for ‘passive’ euthanasia, but patients in a vegetative state could benefit from this rule, since they cannot refuse treatment. Euthanasia remains without a proper and adequate solution; Portuguese law still denies too many people a dignified death and refuses to offer a coherent and valid set of useful and reasonable rules. As a Portuguese scholar puts it, “it is important to reflect upon the ethical fairness of that [the Portuguese] solution in cases where the patient, by him/herself, cannot put an end to his/her life and, consequently, is in disadvantage in comparison to all other human beings – beings who can freely choose their own death. This is the perspective that should be adopted as a starting point of a discussion that has been repeatedly obstructed by an obsessed affirmation of principles, which subjugates to its ideological weight the most respect worthy human needs”⁵².

On a report from the National Ethics Council for the Sciences of Life, all prejudices and mistakes of the law were reproduced.⁵³ The main point was reinforcing caring medicine as the only solution for people in a morbid state (although it definitely is not, as already previously discussed). Caring medicine, besides all its scientific limitations, does not solve any of the problems related to patients in vegetative states nor does it save terminally ill incurable patients from extreme psychological and physical pain. This report also re-affirmed the ethical validity of the Penal Code rules and, when accepting the validity of living wills that ask for the suspension of therapeutic measures whose only effect is a prolongation of the process of death, it refuses to call it euthanasia.

Finally, the Deontological Code of the Medical Doctors Association⁵⁴, in its Article 50, allows for retrieving “extraordinary means of life-support” in cases of irreversible coma, as well as for the possibility of not enforcing treatment on terminally ill patients. Here we see again the preference for letting patients die slowly and left to their pain rather than helping them die in a faster but comforting way. And once again pointless and euphemistic distinctions are used (such as ordinary/extraordinary means) in order to differentiate allowed and not allowed conduct, even if at the end they all lead to the same thing: let-

52 R. Pereira, “Eutanásia e tratamentos médicos”, *Expresso*, 6 April 2002, p. 24.

53 “Parecer sobre aspectos éticos dos cuidados de saúde relacionados com o final da vida (11/CNECV/95)”, <http://www.cnecv.gov.pt/NR/rdonlyres/73BC59DC-729C-48A2-8149-9126D7CDF3EE/0/P011FinalDaVida.pdf>.

54 Although this document does not have the legal status of law, it is legally relevant at the level of disciplinary responsibility and as an indirect source of rights, in particular in what regards civil responsibility: F. Dias, S. Monteiro, “Portugal”, in E. Deutsch/ H.L. Schreiber (eds.), *Medical Responsibility in Western Europe*, Springer-Verlag, p. 522.

ting someone die when his/her life is not willingly lived anymore.

B. Other Continental European Solutions

1. Belgium

Both withholding and withdrawing life-saving treatment have long been generally accepted in Belgium. Moreover, popular support for euthanasia reached 72% of the population in 2001.⁵⁵ In that same year, a proposal of law on euthanasia was adopted by the Senate and, afterwards, by the House of Representatives. This legal act can be put into a very specific political context: the ‘rainbow’ coalition, which included the liberal, socialist and green parties and arrived to power in 1999, opened the way to a series of themes that were considered taboo until then, such as legalising cannabis consumption, homosexual marriage and euthanasia.⁵⁶ The process of legalisation of euthanasia took three years in total and was considered to produce a stricter regime than the Dutch one.⁵⁷

The act legalising euthanasia, Act of 28 May 2002 on euthanasia, effective on 20 September 2002, established the following requirements (Article 3):⁵⁸

- of age or emancipated minor patient, but never younger than fifteen years old;
- constant and unbearable physical or mental suffering that cannot be alleviated;
- result from an accidental or pathological disorder;
- serious and incurable condition;
- physician’s verification of capacity to express request, age and consciousness of patient;
- request has to be voluntary, repeated and carefully considered, as well as not result from outside pressure;
- request has to be written, dated and signed, can be made at the moment itself or beforehand (validity limited to 5 years) and may be revoked or

55 Público, 15 May 2002, p. 22.

56 Daniel do Rosário, “Eutanásia vai ser legalizada”, Expresso, 12 May 2001.

57 *Ibidem*; “Bélgica discute lei da eutanásia”, Expresso, 16 May 2002.

58 Belgisch Staatsblad/Moniteur Belge, 22 June 2002, pp. 28515-28520, <http://www.juridat.be/cgi_tit/titf.pl>.

changed at any time;

- interview where the physician, namely, informs the patient of therapeutic options which may still be available, as well as several periodical interviews to ensure that the patient is in fact persistently physically or psychologically suffering and reiterates his/her request.

Besides these, the law also requires consultation of:⁵⁹

- another physician, independent and expert of the relevant pathology, who has to submit a report confirming the health condition of the patient;
- the team of medical care professionals who take care of the patient;
- the people close to the patient that he/she designated, in case he/she so wishes.

In case the patient is not terminally ill, the physician has to consult a second independent expert physician. This physician has to submit a similar report to the one from the first independent physician and a period of at least one month between the request for euthanasia and the act has to be respected. In case the patient is unconscious and has not produced a living will, the patient's proxy may also request the ceasing of medical treatment if he/she can prove that his/her request derives from the patient's expressed will.⁶⁰

There is a federal Commission in charge of controlling and evaluating the application of the law⁶¹: all files of patients who have received euthanasia, specifying the conditions of the act and the procedure that was followed, are sent to this Commission. It then verifies if the rules were respected. If it was not the case, the Commission passes the file on to prosecuting authorities and the case will be handled according to the general terms of criminal law. According to this, the responsible medical care professional can be charged with voluntary homicide, premeditated homicide and/or poisoning (Articles 393, 394 and 397 Penal Code), or, if it is a case of assisted suicide, with non assistance to person in danger (Articles 422 *bis* and 422 *ter* Penal Code).⁶² This Commission is also in charge of submitting to the legislative Chambers reports describing and evaluating the application of this law, as well as providing rec-

59 Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 109”, July 2002, <<http://www.senat.fr/lc/lc109/lc109.pdf>>, p. 8.

60 Service des études juridiques du Sénat, “Étude de législation comparée n° 139, novembre 2004 – Les droits du malade en fin de vie”, <<http://www.senat.fr/lc/lc139/lc139.pdf>>, pp. 21-22.

61 See answer to question I.2 and II.12 of COE, *op. cit.*

62 Service des Affaires Européennes du Sénat, “L’euthanasie- Étude de législation comparée n° 109”, July 2002, <<http://www.senat.fr/lc/lc109/lc109.pdf>>, p. 7.

ommendations for changes or additions to the law when necessary.

It is important to mention that, according to the Act of 14 June 2002 on palliative care⁶³, public authorities have the obligation to guarantee equal access to palliative care for incurable patients, both in what regards its provision and reimbursement. This way, it is clearly avoided that disadvantaged, isolated or vulnerable patients request suicide for financial reasons, i.e., for not being able to afford good palliative care.

2. Denmark⁶⁴

Active euthanasia remains forbidden in Denmark. It can be punished through Articles 239 (homicide upon request of the victim) and 240 (help to commit suicide) of the Danish Penal Code. The penalties for these crimes are lighter than those applied to homicide, and can even be further attenuated or suppressed if those acts were committed under specific circumstances (Articles 84 and 85 Penal Code).

On the other hand, the practice of passive and indirect euthanasia has been officially recognised and regulated in Denmark. In fact, the Medical Profession Exercise Act 1992 recognises the right to any person of age who has the capacity thereto to express in advance his/her refusal to treatment, if he/she would find him/herself in a situation in which he/she would not be able to express his/her will (Article 6 (a)). Even when there is no such living will, physicians may withhold or withdraw medical treatment if the patient is dying or will inevitably die and the treatment would merely delay death (Article 6 (5)). Indirect euthanasia is allowed by Article 6 (5) of the same Act, which says that, if the patient is dying or will inevitably die, physicians may prescribe analgesics, sedatives or similar drugs when necessary to calm the patient, even if that action may lead to hasten the moment of death.

In addition, the Patient Status Act 1998 reinforced the protection to the right to self-determination of patients, in the same terms as the already mentioned Medical Profession Exercise Act 1992, i.e., recognising the binding value of living wills and allowing for passive and indirect euthanasia (Articles 16 and 17). Besides that, it stated the exact contents the living wills could have and the rules

63 Belgisch Staatsblad/Moniteur Belge, 14 June 2002, pp. 49160-49161, <http://www.juridat.be/cgi_tit/titf.pl>.

64 See, in general, Danish answer to question II.5 of COE, *op. cit.*, and Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

regarding their use.⁶⁵ Finally, it made clear that, although living wills have a binding value in case of terminally ill patients, they only possess a mere indicative value in case of serious or disabling disease (Article 17, (2) and (5)).

Denmark offers us a particularly interesting example of how the borders between (supposedly) different concepts can, at the end, be extremely feeble. Indirect euthanasia is legally and medically accepted, as in many other countries, like the ones possessing the typical legal framework presented above for Germany and Portugal. However, a report of the Ethics Committee from 1996⁶⁶ showed that one in ten physicians exaggeratedly resorted to the prescription of morphine to shorten the life of dying patients. A practice consensually considered to be in accordance to medical ethics is only a step away from active euthanasia, which, again, leads us to doubt the correctness of the traditional categories of active, passive and indirect euthanasia.

3. *France*

The debate over euthanasia has come about regularly in the French society during the last two decades. The common practice in certain hospitals of administering lethal cocktails was very much publicized during the 1980's. These lethal cocktails consisted of a mixture of drugs given in such quantities that lead the patient to a state of unconsciousness and accelerated the process of dying. Such mixtures are, according to the belief of a large group of professionals and public opinion, used constantly, even systematically, in certain hospital services, having become the regular "medication" in the last days before death. This even happens when the patient does not request it, or when he/she is not suffering from severe pain. This is the case, even though the Medical Deontological Code of 1995 states that the "physician must accompany the dying person until his/her last moments, ensure through appropriate health care and appropriate measures the quality of a life which is ending, protect the dignity of the patient and comfort his/her close contact. The physician does not have the right to provoke deliberately a death" (Article 38).⁶⁷

The National Advisory Ethics Committee for Life Sciences and Health⁶⁸ delivered an opinion in January 2000 entitled "End of life, ending of life, euthana-

65 These were further detailed by the Regulation of the Ministry of Health of 14 September 1998.

66 Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 49", January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

67 Code de déontologie de l'Ordre National de Médecins, <<http://www.conseil-national-medecin.fr/?url=deonto/rubrique.php>>.

68 Comité consultatif national d'éthique pour les sciences de la vie et de la santé (CCNE).

sia”.⁶⁹ It explicitly proposed more flexibility towards the possibility of practicing euthanasia, evoking the possibility of a “euthanasia exception” enabling a response, without incurring a criminal sanction, to a specific request from a suffering patient who is dying.⁷⁰ The “principle of refusal of therapeutic relentlessness” was by then a central piece of the debate and became the cornerstone of the law guaranteeing access to palliative care. The level of people who some way or the other supported the practice of euthanasia reached 84% in 2001.⁷¹

The Law of 4 March 2002⁷², regulating the rights of patients and the quality of the health care system, empowered the protection of the right to dignity of the sick person. The debate taking place since 1995 was, in fact, able to produce a movement towards greater respect for the patient’s freedom and right to refuse treatment.⁷³

During the year of 2004, the French Senate analysed two law proposals regarding the issue of euthanasia, perhaps impelled by the previous Dutch and Belgian legal evolution. One of these proposals regarded the right to benefit from euthanasia, and the other one the autonomy of person, living wills, medical assistance to suicide and voluntary euthanasia. A third law proposal, referred rather euphemistically to “the rights of patients and to the end-of-life”, ended up conquering more supporters.⁷⁴ The report prepared by a special commission of the French Assemblée Nationale⁷⁵ on this law proposal found

69 “Avis N° 063 – Fin de vie, arrêt de vie, euthanasie”, <http://www.ccne-ethique.fr/francais/start.htm>.

70 See answer to question II.13 of COE, *op. cit.*

71 Público, 12 April 2001.

72 “Loi relative aux droits des malades et à la qualité du système de santé”, Loi n° 2002-303, 4 March 2002, published in the French Republic Official Journal n. 54, on 5 March 2002, pp. 4118 ff., <http://www.legifrance.gouv.fr/>.

73 See answer to question I.2 of COE, *op. cit.*

74 This law also found support in the practices of other European countries. In fact, in November 2004, the Service des études juridiques du Sénat (Legal Studies Service of the Senate) prepared a comparative study on the rights of patients at the end-of-life. It concluded that in all countries that were analysed (Germany, England, Wales, Belgium, Denmark, Spain and Switzerland):

- the refusal of treatment was admitted, even if it risked leading to death (although in Germany, Denmark and Switzerland this right applies essentially to patients at the end-of-life);

- living wills are recognised (although, again in Germany, Denmark and Switzerland, its application is dependable on the health condition of the patient); and,

- the request for ceasing medical treatment from the proxy of an unconscious patient is generally submitted to several conditions. See <http://www.senat.fr/lc/lc139/lc139.pdf>.

75 “Rapport fait au nom de la Commission Spéciale chargée d’examiner la proposition de loi (n° 1882) de M. Jean Leonetti et plusieurs de ses collègues relative aux droits des

that, when trying to give an answer to the philosophical, religious, ethical, juridical, social and medical issues at stake, the legislator did not have to either maintain the *status quo* nor legalise euthanasia. The legislator had, as a middle way, the possibility of improving and modernising the *status quo*, without completely legalising euthanasia. This option would take into account the common practice in hospitals, which included, e.g., the actual turning off of between 75.000 and 100.000 reanimation machines, and the patients' desire for more legal certainty. This legal proposal was approved in November 2004⁷⁶ and recognises the right to refuse treatment that is necessary to survival, i.e., to passive euthanasia, even in the case of patients who are not at the end of life (Articles 1 and 6). Besides this, it established that the decision regarding ceasing treatment of an unconscious patient had to be taken through a collegial procedure; in other words, passive euthanasia is also foreseen for unconscious patients (Articles 5 and 9). Furthermore, indirect euthanasia is also accepted, as long as the patient is aware of it (Article 2). Finally, the legal value of living wills is recognised (Article 7). As the *rapporteur* of the report on this law, Mr. Jean Leonetti, precised, this law places again the most fundamental human values in the centre of the debate, namely the right to freedom and human life autonomy, as well as respect for the person.

However positive this evolution may be, the “Loi Léonetti” is still considered by many as a repressive legal solution, as far as assisted suicide remains completely excluded. A movement for liberalisation of euthanasia in France calls for a “Loi Vincent Humbert”.⁷⁷ *Vincent Humbert*, at the time with conscience and paraplegic as a consequence of a car accident, died in September 2003 after he repeatedly requested his mother and a physician to help him die.⁷⁸ The exact circumstances – administration of a lethal drug or mere refusal of treatment or withholding of reanimation – are still to be determined by the court, and the mother and the physician face a 5 and 20 years imprisonment sentence respectively. This case, which resonated profoundly in the media, would not find a satisfactory solution in the Loi Léonetti. Therefore, the movement pro-liberalisation of euthanasia found a good source of motivation and inspiration in it to show its disproval towards the Loi Léonetti and continue calling for a more progressive law.

76 malades et à la fin de vie”, <<http://www.assemblee-nationale.fr/12/rapports/r1929.asp>>.

77 Loi n° 2005-370 du 22 Avril 2005 parue au JO n° 95 du 23 avril 2005, <<http://www.senat.fr/dossierleg/ppl04-090.html>>.

78 <<http://www.fautquonsactive.com>>.

79 “Sans toi ni loi”, <<http://www.liberation.fr/page.php?Article=257255&AG>>.

4. Spain⁷⁹

Spain offered us a striking and poignant case that inspired the already mentioned film “Mar adentro”. Ramón *Sampedro*, a quadriplegic Galician who spent the last 29 years of his life lying in bed, committed suicide with the assistance of eleven friends in 2002. His five year long legal battle for a ‘dignified death’ did not lead to any satisfactory conclusion. Albeit the arguments invoked (the rights to dignity, free development of one’s personality, to life, to physical and psychological integrity and to a fair trial), no judge was convinced of his ultimate motto: “living is a right, not an obligation”. He finally succeeded in his aim, through the assistance of a group of friends, one of which was taken to court in 2005: the prosecution right fell due to statute of limitations and the claim was archived.⁸⁰ The well-succeeded assisted suicide drew much attention from the media and gave a new impetus to the campaign for decriminalisation of euthanasia, both in Spain and in many other countries.⁸¹

The *Sampedro case* gave grounds for international case law as well. His heir, Manuela *Sanlés Sanlés*, proceeded with *Sampedro*’s legal claims and eventually appealed to the ECtHR. She argued the violation by the Spanish state of the right to a life of dignity and a dignified death in respect of Ramón *Sampedro*, the right to non-interference by the state in the exercise of his freedom and his right to equal treatment. The claim was considered inadmissible *ratione personae*, since an heir was not entitled to pursue such proceedings. The case then reached the Human Rights Committee of the United Nations.⁸² The heir claimed the violation of *Sampedro*’s rights not to be subjected to inhuman or degrading treatment, to life, to freedom of thought and conscience and to manifest his personal beliefs through practices or deeds, to liberty and to equal protection of the law (Articles 7, 6, 18, 9, 2, 26 International Covenant on Civil and Political Rights⁸³). The Spanish State defended, among other things, that this claim was in practice the exercise of a *actio popularis*, since it was legally and scientifically impossible to recognise a dead person’s right to

79 For an overview of legislative and social aspects of the euthanasia debate in Spain, see M. Casado Gonzalez, *op. cit.*, pp. 29-56.

80 “Ramona Maneiro no tendrá que sentarse en el banquillo”, <<http://www.20minutos.es/noticia/11693/0/ramona/maneiro/absuelta/>>.

81 “O inferno de Sampedro”, José Alves, *Vidas/Expresso*, 4 January 2003, p. 34.

82 Communication no. 1024/2001, *Sanles Sanles v. Spain*, (Decision adopted on 30 March 2004, eightieth session), in Report of the Human Rights Committee (Volume II), Seventy-ninth session (20 October-7 November 2003), Eightieth session (15 March - 2 April 2004), Eighty-first session (5-30 July 2004): <[http://www.unhchr.ch/tbs/doc.nsf/0/f0c6766939e65645c1256ffd0024998f/\\$FILE/G0443700.pdf](http://www.unhchr.ch/tbs/doc.nsf/0/f0c6766939e65645c1256ffd0024998f/$FILE/G0443700.pdf)>, pp. 505-511.

83 Adopted by General Assembly Resolution 2200 A (XXI) of 16 December 1966.

die. The communication was, at the end, considered inadmissible in reason of Sampedro having committed suicide and the authorities not having pursued proceedings against those involved.

The Spanish Penal Code 1995 reform had already softened the sanctions applied in cases of euthanasia (from 6 months to 6 years imprisonment).⁸⁴ After the *Sampedro case*, reactions from politicians, intellectuals and even members of religious groups became more open to this issue and supported a further development of the legislation. Besides this, the law regarding the rights of the patient foresees the legal value of living wills and the application of the right to refuse treatment to any patient or treatment, even when leading to death, i.e., passive euthanasia is in practice legal.⁸⁵ In case the patient is unconscious or incompetent and has not produced a living will, the patient's proxy may, according to the patient's own presumed will and scale of values, accept or refuse medical treatment. In these cases, the deontological rules assume a particular value: therapeutic relentlessness should be avoided and indirect euthanasia is acceptable.⁸⁶

More recently, a medical scandal raised awareness about the problem of excessive sedation, i.e., indirect euthanasia, in Spain. A series of anonymous denunciations alerted the sanitary inspection authorities to about 400 cases of excessive sedation in a particular hospital in the region of Madrid.⁸⁷ All physicians who integrated the internal commissions of the hospitals resigned as a sign of protest against the suspicions raised.⁸⁸ However, the experts called

84 For more details on the legislative process that lead to this result and a comparative analysis between suicide, consented homicide and active direct euthanasia, see E. Diaz Aranda, "Dogmatica del suicidio y homicidio consentido", Madrid, 1995, pp. 55-81 and 217-255. The author argues that the punishment of consented homicide does not merely aim at preventing that someone loses his/her life, it aims at prohibiting that someone who is able to commit suicide uses the help of a third person to die. Therefore, those who are not able to commit suicide by themselves (e.g., quadriplegics, as in the case of Ramón Sampedro) may, in respect of the principle of equality, ask to be killed by someone without that person being criminally punished (p. 237).

85 Law 41/2002, 14 November 2002 on patient's autonomy and rights and obligations regarding medical information, *cit. in*, Service des études juridiques du Sénat, "Étude de législation comparée n° 139, novembre 2004 – Les droits du malade en fin de vie", pp. 27-28, <<http://www.senat.fr/lc/lc139/lc139.pdf>>.

86 Étude de législation comparée n° 139, novembre 2004 – Les droits du malade en fin de vie, Service des études juridiques du Sénat, pp. 28-29, <<http://www.senat.fr/lc/lc139/lc139.pdf>>.

87 "11 preguntas sobre el caso 'Severo Ochoa'", <<http://www.20minutos.es/noticia/15299/0/lamela/leganes/hospital/>>.

88 "Dimiten todos los médicos de las comisiones internas del Hospital Severo Ochoa en Leganés", <<http://www.20minutos.es/noticia/19055/0/severo/ochoa/leganes/>>.

upon to investigate the allegations did conclude that there were 73 cases of “inadequate or not recommended” sedations⁸⁹ and 4 physicians related therewith were, as a consequence, moved a disciplinary process.⁹⁰ Although this situation indicated that passive euthanasia is commonly accepted by health care providers, Prime-Minister Zapatero declared that the executive had no intention of amending the Spanish legislation to legalise euthanasia.⁹¹

5. Switzerland

Assisted suicide is legal, as long as the author is not driven by a selfish motive (in accordance with Article 115 Penal Code, *e contrario*).⁹² Furthermore, the ASSM Directives, i.e., the medical-ethic directives of the Swiss Medical Sciences Academy on medical assistance to patients at the end of life or suffering from extreme brain problems, play a very important role. Although these do not have legal value, the political authorities recognise their suppletive legal validity and courts refer to their dispositions. Therefore, the fact that these directives allow both passive euthanasia and indirect active euthanasia leads authorities to consider these practices lawful.⁹³ Interestingly enough, according to these rules, and as far as passive euthanasia goes, the notion of life-sustaining treatment that can be withheld includes, among others, artificial hydration and feeding, administration of oxygen, assisted breathing, medication, blood transfusion and dialysis.

Finally, both directives from the Swiss Medical Sciences Academy and several of the Swiss cantons have approved legislation recognising the validity of living wills, which had been, in any case, already previously recognised by the courts.⁹⁴ Active euthanasia remains prohibited, even upon request from the patient.

In recent years, Switzerland has become famous for facilitating what is called by harsh critics as the ‘death tourism’: terminally-ill patients travel

89 “Hubo 73 casos de sedaciones irregulares en el Severo Ochoa, según el informe de los expertos”, <<http://www.20minutos.es/noticia/26838/0/sedaciones/severo/ochoa/>>.

90 “Expediente ‘en suspenso’ para cuatro médicos de Leganés”, <<http://www.20minutos.es/noticia/28089/0/Expediente/suspensomedicos/>>.

91 “Zapatero asegura que el Gobierno no legalizará la eutanasia”, <<http://www.20minutos.es/noticia/17268/0/eutanasia/zapatero/legalizacion/>>.

92 See answer to question II.9 of COE, *op. cit.*

93 See the Swiss answer to question II.5 of COE, *op. cit.*

94 Among which those of Valais, Geneva, Lucerne, Neuchatel and Zurich. See Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

to that country in order to be allowed to die through medical assistance which is denied in their own countries.⁹⁵ Regardless of this, according to surveys conducted for the last decade, between 75% and 80% of the population is favourable to active euthanasia.⁹⁶ In addition, a parliamentary motion has been presented on June 2005, in order to legislate the practice of passive and indirect euthanasia.⁹⁷

6. *The Netherlands*⁹⁸

The Netherlands is the ultimate paradigm of euthanasia in practice in today's world. The Medical Association of Netherlands is the only one in the world to accept that medical practices consist of healing and promoting health, but also helping patients achieve a peaceful and dignified death. Generally, no great moral distinction between ending one's life and taking that of others is drawn, as long as the criteria set in the law have been satisfied.

The Termination of Life on Request and Assisted Suicide (Review Procedures) Act was adopted in 12 April 2001 and came into force on 1 April 2002.⁹⁹ ¹⁰⁰ The Netherlands became, then, the first country in the world to legalise active euthanasia, a practice that had been tolerated in this country for more than twenty years already.¹⁰¹ 85% of the Dutch population supported the approval of this Act.¹⁰²

Euthanasia or assisted suicide is not regarded as an offence if certain conditions are met. Both euthanasia and assisted suicide are still considered criminal offences (Articles 293 and 294 Criminal Code), but, as a consequence of the

95 <http://news.bbc.co.uk/1/hi/uk_politics/2782887.stm> and <<http://news.bbc.co.uk/1/hi/health/3623874.stm>>. The same is said to happen in relation to the Netherlands, although in smaller proportions: Abigail Levene/Reuters, *Público*, 1 April 2002, p. 19.

96 See Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 49", January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

97 <http://www.parlement.ch/afs/data/f/gesch/2005/f_gesch_20053352.htm>.

98 For a deeper analysis of some aspects of the Dutch legal regime and its evolution, such as the necessity defence and the concepts of 'hopeless and unbearable suffering' and 'existential suffering', see U. de Vries, "A Dutch perspective: the limits of lawful euthanasia", 13 *Annals Health L.* 365, 2004.

99 "Wet van 12 April 2001 houdende toetsing van levensbeëindiging op verzoek van hulp bij zelfdoding en wijziging van het wetboek van strafrecht en van de wet op lijkbezorging", Implementation Decree published in the Bulletin of Acts, Orders and Decrees (Staatsblad) 2002, 165.

100 See answer to question II.5 of COE, *op. cit.*

101 *Público*, 12 April 2001.

102 Inês Nadais, "O dia um da eutanásia na Holanda", *Público*, 2 April 2002, p. 22.

amendment introduced by this Act to these articles, the responsible physician is not prosecuted if he/she has observed the due care criteria listed in section 2 of the Act and reported his/her intervention to the municipal pathologist. The criteria are the following:¹⁰³

- a) there are voluntary, well-considered, persistent, and explicit requests for euthanasia (including under the form of anticipated written requests from patients who are at least sixteen years old);¹⁰⁴
- a) the physician informs the patient about his/her situation and his/her prospects;
- b) according to prevailing medical opinion, patient's suffering is unbearable and without prospect of improvement;
- c) the physician and the patient discussed alternatives to euthanasia and have agreed that there is no other foreseeable solution;
- d) the doctor consulted at least one other physician with an independent point of view, who must have seen the patient and given a written opinion on the due care criteria;
- e) euthanasia was performed in accordance with good medical practice.

As already mentioned, the physician reports to the municipal pathologist the euthanasia or assisted suicide act that he/she has practiced. This report is extremely detailed and has to give exhaustive answers to all essential aspects regarding the disease, the request for euthanasia, the consultation of another/other physician/s and the carrying out of the euthanasia itself.¹⁰⁵ Then, the municipal pathologist reports the case to the regional review committee, which assesses whether the attending physician acted in accordance with the due care criteria. If he/she is found to have respected such criteria, the report is put into archive, otherwise the committee presents its findings to the Public Prosecution Service, which decides whether or not to prosecute. When a physician has not respected the criteria set in the law, he/she can be sentenced to 12 years imprisonment, subject to verification.¹⁰⁶

This Act does not address:

- withholding or withdrawing life-prolonging treatment;

¹⁰³ See answer to question II.19 of COE, *op. cit.*

¹⁰⁴ Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 109", July 2002, p. 12, <<http://www.senat.fr/lc/lc109/lc109.pdf>>.

¹⁰⁵ *Ibidem*, pp. 14-17.

¹⁰⁶ European Union Network of Independent Experts in Fundamental Rights (CFR-CDF), *op. cit.*, p. 32, <<http://www.cpdr.ucl.ac.be/cridho/CFR-CDF.Report2002.en.pdf>>.

- alleviation of pain and symptoms with an unintended life-shortening effect;
- medical interventions to terminate life without an explicit request by the patient;
- neonates – they are excluded from the scope of this law and only persons aged 12 or older may request euthanasia or assisted suicide, although cases involving minors have to respect stricter criteria: parents or guardian's consent, until the age of 15, or at least consultation of these, between the age of 16 and 18. These rules are in harmony with the law regarding the patient's consent to medical treatment, in force since 1995 and incorporated in the civil code.¹⁰⁷

The Dutch government has made clear that this law does not, in any way, need to be amended as a consequence of the above-mentioned *Pretty case* at the ECtHR.¹⁰⁸ In fact, this law was considered to be compatible with Article 2 ECHR, since, according to the Dutch rules, there is no 'right to euthanasia' and doctors cannot be obliged to accede to requests of euthanasia. Besides that, the Dutch legal regime strikes a balance between the protection to the right to life and personal autonomy, whose importance the ECtHR underlined. At any rate, the *Pretty case* decision stated itself that, although the English legal solution was justifiable, "that is not to say that no other law or application would be consistent with the Convention, it is simply that the present legislative and practical regime do not offend the Convention".¹⁰⁹

In fact, the Supreme Court (Hoge Raad) has decided in the so-called *Brongersma case*, in December 2002, that the mere repeated request for termination of life does not suffice.¹¹⁰ The patient in this case was not terminally ill, but simply "tired of living". These circumstances do not allow removal of physician's culpability, since the objective criteria established by Dutch law was not respected. Therefore, the right to personal autonomy sometimes has to cede to the protection of the right to life and euthanasia is still criminally punishable under certain circumstances.

In 2004, the Dutch Authorities promoted a new independent study to assess how the Termination of Life on Request and Assisted Suicide (Review Proce-

¹⁰⁷ Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 109", July 2002, pp. 11-12, <<http://www.senat.fr/lc/lc109/lc109.pdf>>.

¹⁰⁸ See *supra* footnote no. 22.

¹⁰⁹ § 30 *Pretty v. the United Kingdom* (application no. 2346/02), European Court of Human Rights, 29 April 2002.

¹¹⁰ Hoge Raad, no. 00797/02, 24 December 2002, NJ (Dutch Law Reports) 2003, 167.

dures) Act was working in practice.¹¹¹ It focused, in particular, on terminal sedation, experience with the review procedure, notification behaviour and the relationship between euthanasia and palliative care.¹¹² Some problems specifically addressed by this study were the due care criteria, review procedures, notification of euthanasia and assisted suicide, requests from patients without any serious physical or psychiatric disorder, patients suffering from senile dementia who have previously drawn up advance directives, minors, action to end life where no express request has been made, and sedation of dying patients.¹¹³ This study has found that:¹¹⁴

- Some 500 general practitioners have been trained to provide independent assessments to the physician attending the patient and they have been found to give better assessments – such training should, in the future, be extended to hospital specialists and doctors working in nursing homes.
- Assessing how unbearable is the suffering of the patient is the most difficult element of the due care criteria.
- Even in the cases where doctors do not fulfil all due criteria, the Public Prosecution Service finds that disciplinary action may be more appropriate than criminal proceedings when the due criteria not followed is merely formal or procedural.
- There is an increased readiness from doctors to notify cases of euthanasia and assisted suicide, which is seen to help increase both public acceptance of medical action to terminate life on request and the quality of medical decision-making in this respect – still, it is known that some doctors do not notify all cases, be it due to the doctor-patient relationship or to the circumstances of the individual case.
- Since dementia is not in itself a sufficient ground for termination of life on request and physicians are under no obligation to comply with a request for euthanasia recorded in an advance directive, physicians are extremely cautious in relation to advance directives of patients with dementia and very often do not honour the expressed wishes of patients.
- Euthanasia in the case of minors is rare and the decision is taken with ut-

¹¹¹ See Comments by the Government of the Netherlands on the concluding observations of the Human Rights Committee (CCPR/CO/72/NET), International Covenant on the Civil and Political Rights, Human Rights Committee of the United Nations, CCPR/CO/72/NET/Add.3, 16 December 2004.

¹¹² *Ibidem*, p. 3.

¹¹³ *Ibidem*.

¹¹⁴ *Ibidem*, pp. 3-12.

most care and always with the parents' involvement: it only occurred in 0,7% of all child deaths and it usually only takes place in cases of cancer¹¹⁵ – still, concern regarding non-reporting of cases and failure of control in what regards minors subsists.^{116 117}

- Although physicians very often do not realise it, patients sedation many times resembles termination of life on request, then becoming what can be called 'terminal sedation'; therefore, these cases should be notified and reviewed and it is advisable to produce guidelines which will clarify the practice of sedation.
- Finally, the report advices further developments in palliative care and expertise in terminal care, since they may render many cases of euthanasia unnecessary (although the palliative care policy has already stepped up in the last years and 61% of the physicians believe that euthanasia will have a place no matter how good the care and support for the terminally ill and of adequate pain relief may be).

This report concludes that the main focus should centre on increasing compliance with the due care criteria, which has anyway been found to have increased since 1995.¹¹⁸ The growing transparency clearly shows how positive it can be to adopt legislation regulating medical practices already occurring (such as euthanasia, be it passive, indirect or active), rather than forbidding them and turning the back to their illegal practice.

As we have seen, concerns about abuses and slippages in the Dutch practice

115 The report adds that in 2% of these cases the patient had not requested euthanasia, since sometimes a neonate was at stake. This is in contradiction to the fact that neonates are excluded from the application of this law, as above mentioned (see also Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 109", July 2002, pp. 11-12, <<http://www.senat.fr/lc/lc109/lc109.pdf>>).

116 Report on the thirty-fifth session of the Commission on the Rights of the Child (12-30 January 2004), p. 68, <<http://documents-dds-ny.un.org/doc/UNDOC/GEN/G04/415/37/pdf/G0441537.pdf?OpenElement>>.

117 R. L. Marker, "Assisted Suicide: Not for Adults Only?", <<http://www.internationaltaskforce.org/noa.htm>>.

118 Already before 1995, public awareness regarding the non-reporting of euthanasia cases was raised due to a case of a physician who practiced forgery and fraud in order to avoid notifying the municipal authorities that he had practiced euthanasia. The physician at stake was considered guilty of taking another person's life at the person's request, falsifying, in his capacity as physician, a death certificate as regards the cause of a person's death, and falsifying prescriptions, and was condemned to a suspended term of imprisonment of six months and a fine of 50,000 Netherlands guilders (Regional Court of Rotterdam, 11 May 1995, *cit. in Zoon v. The Netherlands*, Application no. 29202/95, 7 December 2000, ECtHR).

of euthanasia regard non-reporting of cases and the consequential impossibility to verify whether the criteria has been satisfied, as well as high level of non-compliance of all legal criteria in the cases reported. But even if the Dutch experience shows the difficulty of holding the line against slippage across the most crucial established criteria, it is also clear that the nightmare slippery slope scenarios of ending up with anything like nazi-style mass involuntary euthanasia have not materialised. Moreover, the harsh analysis of the Dutch legal solution that some authors provide¹¹⁹ can hardly be upheld, since there is no thorough data on the same parameters in other countries as the Dutch surveys offer, which impairs any comprehensive or ultimate conclusion on, let alone condemnation of, the Dutch policy regarding euthanasia.

Finally, it is legitimate to wonder why the Netherlands have taken the lead in establishing progressive rules regarding the practice of euthanasia. The most relevant reasons that have been pointed out pertain the religious and social features of the Dutch: a tradition of religious and moral tolerance has contributed to a democratic and permissive society, where people are fiercely independent, value moral integrity and eagerly defend civil liberties. Furthermore, the key-role of the family doctor (who is very often not only a professional, but also a family friend) and the characteristics of the legal system (absence of a minimum level of punishment) have also added strength to the legalisation of euthanasia.¹²⁰

C. Voices from the Common Law World

1. Australia

The awareness regarding the problems relating to the need to respect patients' self-determination was raised already in the 80's in Australia. In fact, in 1988 two Australian states legalised living wills and in 1994 and 1995 two other states adopted laws foreseeing the designation of a proxy with the power to refuse medical treatment in case the patient loses capacity thereto.¹²¹ Subsequently, the Rights of the Terminally Ill Act 1995 came into force in the Northern Territories in July 1996.¹²² However, the Euthanasia Laws Bill over-

119 See, e.g., J. Keown, "Euthanasia, ethics and public policy: an argument against legalisation", Cambridge University Press, Cambridge *et. al.* 2002, pp. 136-149.

120 See M. Otlowski, *op. cit.*, pp. 448-450.

121 Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 49", January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

122 <<http://www.nt.gov.au/lant/parliament/committees/rotti/parldebate.shtml>>.

turned it in March 1997.¹²³ The Northern Territory law allowed passive and active euthanasia, as well as assisted suicide, and, during the two years that it was in force, four people died as a result of the administration of a lethal dose of intravenous drugs by one medical practitioner.¹²⁴

In reality, both passive and indirect euthanasia were known to be practiced until this moment without giving raise to any punishment. The number of patients who died as a consequence of these practices was around 30% of the total number of deaths, according to surveys conducted in 1994 and 1997.¹²⁵ Passive euthanasia, in particular, had even been codified in several Australian states, such as Victoria, Northern Territory, Australian Capital Territory, and South Australia, through regulation admitting the validity of living wills stating the refusal of future medical interventions under certain circumstances.¹²⁶ However, the Euthanasia Laws Bill 1997 raised quite some uncertainty in regards to the lawfulness of these practices, above all, in what concerns indirect euthanasia.

In 2002, this uncertainty exploded into a much-publicised case. On 22 May 2002, *Nancy Crick*, a 70-year-old woman, committed suicide in the presence of 21 friends and relatives. She allegedly suffered from cancer (which turned out to be an “inoperable twisted bowel” at the end) and could not bear the pain anymore.¹²⁷ This case raised a debate on the legalisation of assisted suicide, allowing for passionate interventions.¹²⁸ At the end, none of the presents at the suicide of Nancy Crick was prosecuted.¹²⁹ At any rate, this case could shape a homicide through omission, but never euthanasia or assisted suicide, since Nancy Crick took the poison by herself, without assistance from the presents.

Finally, it is worthwhile to mention that in all surveys that have taken place in the last years, approximately 75% of Australians are favourable to the legalisation of active euthanasia. Moreover, courts hardly ever condemn physicians or relatives who have committed homicide for compassion and the prosecution authorities rarely consider opportune to prosecute in cases of assisted suicide.¹³⁰

123 Euthanasia Laws Act 1997, of 23 March 1997, <<http://www.comlaw.gov.au/ComLaw/Legislation/Act1.nsf/0/484CEDAD0DB7D221CA256F720018A878?OpenDocument>>.

124 *Ibidem*.

125 *Ibidem*.

126 *Ibidem*.

127 <<http://www.vesv.org.au/docs/crick050602.htm>>.

128 See, e.g., D. van Gend, “Euthanasia: Nancy Crick - what is the real story?”, <http://www.newsweekly.com.au/articles/2002jun15_crick.html>.

129 <<http://www.abc.net.au/brisbane/stories/s1135200.htm>>.

130 Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

2. England¹³¹

As already mentioned, in 1935 there were already organized movements to legalise voluntary euthanasia in England. Although there is not a specific legislation in England regarding euthanasia, courts assimilate these cases to homicide, resorting to the Homicide Act 1957. In this line, there have been a number of convictions of family members who have performed euthanasia. However, these persons have generally been found to have diminished responsibility and, if convicted at all, have been convicted of manslaughter (which requires only recklessness, traditionally seen as deliberately taking an unjustified risk)¹³² and some of them have not even been sentenced to prison. In addition, the Suicide Act 1961 prohibits assisted suicide. Its Article 2 states that every person who helps, encourages, recommends or allows the suicide of a third person is punishable with maximum 14 years imprisonment.

As for indirect and passive euthanasia, the English courts have been more lenient and have long accepted its practice. In 1957, the decision of the case involving *Dr. John Bodkin Adams*¹³³ argued already the legitimacy of indirect euthanasia, which was also supported by the House of Lords Select Committee on Medical Ethics in 1994.¹³⁴ On the other hand, passive euthanasia finds support in the right of the patient to self-determination regarding life and therapeutic relentlessness.

Already by 1975 it was admitted that the courts had to pay more attention to what the medical practice in fact was: “A doctor may be charged with manslaughter but hope for a conditional discharge. It might be asked whether reliance upon a court to grant a conditional discharge does not place both the court and the doctor in the moral dilemma which should be resolved by the community: is voluntary euthanasia permissible or not? It is perhaps to be seen as a pragmatic approach, based on recognition of the fact that voluntary euthanasia does now take place, and settling the limiting conditions for it”.¹³⁵

In 1993, the *Airedale N.H.S. Trust v. Bland* case¹³⁶ set the criterion which were to be used in the future in all cases regarding euthanasia. The court had to decide on the interruption of artificial feeding and hydration of a patient in per-

131 In general, see *ibidem*, p. 9.

132 P. W. D. Redmond and P. Shears, “General Principles of English Law”, seventh edition, The M & E Handbook Series, pp. 373 and 374.

133 H. Palmer, “Dr Adams’ trial for murder”, Crim Law Rev 1957:365-377.

134 Report of the Select Committee on Medical Ethics (1993-94) HL 21-I.

135 “On dying well”, Church Information office, 1975.

136 Chamber of Lords, 9 February 1993, AC 789.

sistent vegetative state since 1989. The main guiding principles to be considered in this field were considered to be the following:

- the prescription of a lethal substance is forbidden;
- the right to refuse treatment is a fundamental freedom;
- the right to refuse treatment also refers to life-saving treatments.

The best interests criteria was also used to decide whether or not to disconnect the life-sustaining machine. As in so many cases in several jurisdictions, the court tried to overcome contradictory arguments and incoherence in the traditional legal reasoning. Although at the end artificial feeding to the patient was removed, Lord Browne-Wilkinson insisted in pointing out his dismay: "How can it be lawful to allow a patient to die slowly, although painlessly over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection?"¹³⁷

From the guiding principles that came out from *Airedale N.H.S. Trust v. Bland* derives that physicians cannot be prosecuted when passive euthanasia takes place, as long as they inform the patient properly about all therapeutic alternatives and consequences of ceasing medical treatment. Furthermore, these principles should also apply to the people who foresee that they will be in a persistent vegetative condition or similar and who express their will not be subjected to any medical treatment, not even artificial feeding.¹³⁸ This expression of will, i.e., a living will, was considered to be valid by the courts if the patient:¹³⁹

- had the necessary discernment when he/she expressed refusal of treatment;
- finds him/herself in the exact situation that he/she foresaw in his/her expression of will;
- fully assessed the consequences of such refusal of treatment;
- was not morally influenced by any other person at the moment of taking the decision.

137 *Cit. in* <<http://www.bma.org.uk/ap.nsf/Content/Endoflife>>.

138 Opinion of Lord Keith of Kinkel in *Airedale N.H.S. Trust v. Bland*, *cit. in* Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 49", January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

139 *Re.T. (Adult refusal of medical treatment)*, 1992, Civil Chamber of the Appeal Court, *cit. in* Service des Affaires Européennes du Sénat, "L'euthanasie - Étude de législation comparée n° 49", January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

The British Medical Association reinforced the binding value of living wills in its deontological code published in 1995.¹⁴⁰ ¹⁴¹ However, since there is no thorough legal regulation of previous consent of incapable patients, the legal value of such consent may still give rise to uncertainties under some circumstances. In any case, even when the patient has not produced any living will, the medical team and the relatives of the patient may decide to cease the prescription of medication, as well as, although more controversially, the artificial feeding and hydration.¹⁴² Regarding this issue specifically, the British Medical Association has made clear that “the important factor making withdrawal of artificial nutrition and hydration ethically acceptable is not the label attached to the condition or state, but the loss of specific and definable neurological pathways, the result of which is the permanent loss of sensitivity to external stimuli and loss of sentience”.¹⁴³

Following raising debate and controversy about the inflexibility of the case law, the House of Lords Select Committee on Medical Ethics considered euthanasia in depth and reported in 1994.¹⁴⁴ This report concluded that it was not advisable amending the law, neither in order to allow the practice of euthanasia, nor to create a specific infraction of homicide for compassion.¹⁴⁵ Soon after, the government itself supported this report. Despite this, a consultation from the British Medical Association (BMA) on “Euthanasia and physician assisted suicide: Do the moral arguments differ?”, from April 1998, has revealed how divided medical professionals feel in regards to these issues: “Within the profession there is a very wide range of views on physician assisted suicide

140 See also “End of life decisions - views of the BMA”, June 2000, <<http://www.bma.org.uk/ap.nsf/Content/Endoflife>>, and <<http://www.bma.org.uk/ap.nsf/Content/Endoflife~statements>>: “BMA has strongly supported the general concept of patient choice and therefore has also supported the concept of anticipatory decision making”.

141 The BMA “has classified all types of anticipatory decision-making as ‘advance statements’, including within this term oral and written decisions, advance refusals and advance authorisations of treatment and statements of future desires and intentions as well as firm decisions”. See <<http://www.bma.org.uk/ap.nsf/Content/Endoflife~statements>>.

142 *Airedale N.H.S. Trust v. Bland*, cit. in Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

143 “End of life decisions - views of the BMA”, June 2000, <<http://www.bma.org.uk/ap.nsf/Content/Endoflife>>.

144 See answer to question II.11 of COE, *op. cit.*

145 Opinion followed by the British Medical Association in a resolution passed in June 1997, <<http://www.bma.org.uk/ap.nsf/Content/Endoflife~euthanasia>>.

(both for and against)”, concludes the British Medical Association.¹⁴⁶

The well-known *Pretty case*, already described above, went through a long judicial journey, having been analysed by the High Court, the House of Lords and the ECtHR. In 2002, another case reached the media and became a milestone in the evolution of the euthanasia legal regime in England.¹⁴⁷ The High Court ruled that the ventilator that was keeping *Miss B* alive could be switched off, turning its back on previous case law. *Miss B* was completely conscious, provided a repeated request and informed consent. As *Miss B*’s defence lawyer stressed out, the legal distinction between his client and Mrs *Pretty* was a “technicality”, which “does not have any bearing on the real world”.¹⁴⁸ *Miss B* was the first British citizen to request withdrawal of life-sustaining treatment while still conscious. All previous cases that had reached English courts up to this point regarded solely patients in persistent vegetative condition.¹⁴⁹

More recently, Lord Joffe made a proposal for an Assisted Dying Bill¹⁵⁰. This bill provided for a competent adult suffering from a terminal disease or a serious, incurable physical illness to request medical assistance to die.¹⁵¹ This Bill was referred to a Select Committee¹⁵², which, in its final report, found that the “Bill cannot be considered adequately in the present session due to shortage of Parliamentary time, and we therefore recognise that it cannot proceed”. The Committee went on saying that, if a Bill with a similar aim is again presented to the House of Lords, it “should distinguish clearly between assisted suicide and voluntary euthanasia and thereby give the House the opportunity to address these two courses of action separately, as the considerations involved in each are very different”. Finally, the report stated that the bill should define better the actions which a doctor may and may not take, as well as set in a more consistent way all requirements. Despite over 80% support from the population to such a bill¹⁵³, even if it had been discussed in the Parliament, it would probably not have found enough support¹⁵⁴, just as it happened in 10 December 1997 to the bill the member of the parliament Joe Ashton proposed.

146 <<http://www.bma.org.uk/ap.nsf/Content/Endoflife~Physicianassistedsuicide>>.

147 *Ms. B. v an NHS Hospital*, Court of Appeal judgement of 22 March 2002.

148 <<http://news.bbc.co.uk/1/hi/health/1890624.stm>>.

149 Inês Nadais, “Cidadã britânica reclama direito à eutanásia”, *Público*, 7 March 2002, p. 35.

150 <<http://www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.htm>>.

151 <http://news.bbc.co.uk/1/hi/uk_politics/2782887.stm>.

152 “Assisted Dying for the Terminally Ill Committee”, <<http://www.publications.parliament.uk/pa/ld/ldasdy.htm>>.

153 *Ibidem*.

154 <<http://news.bbc.co.uk/1/hi/health/4054619.stm>>.

3. New Zealand

In 2003, the Death with Dignity Bill was rejected by the New Zealand parliament, by 60 votes to 57.¹⁵⁵ More recently, a new event again raised the issue of euthanasia in this country: *Andrew Morris*, a man who suffered from progressive bulbar palsy, a motor neuronal disease, died on 9 March 2005, after having starved himself to death.¹⁵⁶ Andrew Morris “planned to stop eating while he could still feed himself”, since he did not wish anyone to be criminally punished for helping him to die.¹⁵⁷ The person in charge of taking care of him, Phillipa Grace, respected the patient’s will and only gave him water until he died; she is now being investigated by the Public Attorney in order to inquire a possible liability.¹⁵⁸

This case is another one that makes us face the extremely thin line between what action should be punishable or not. While it is may be true that Phillipa Grace had the duty of assistance and could be charged with homicide through omission of rescue, it is also obvious that Andrew Morris merely exercised his right to self-determination. It seems to us that this vivid example of patient autonomy has the ability to illustrate how the conservative interpretation of traditional criminal law rules has to be put into cause and, above all, reformed.

4. United States of America (USA)

The right to self-determination of the patient is ranked highly in the USA. The Patient Self Determination Act 1990 imposed an obligation on all physicians delivering medical care in services who receive federal funds to inform patients of their right to refuse treatment and on the possibility of producing a living will.¹⁵⁹ Besides that, all American states have adopted laws recognising to each person the right to express in advance his/her refusal to therapeutic relentlessness, either by producing a living will or by designating a proxy with decision-making power regarding medical issues.¹⁶⁰ The following rights have

155 “I'll starve myself until I die, vows sick man”, The New Zealand Herald, <http://www.nzherald.co.nz/index.cfm?c_id=1&ObjectID=10007151>.

156 “La muerte del 'Ramón Sampedro' de Nueva Zelanda reabre la polémica legal sobre la eutanasia”, <http://www.20minutos.es/noticia/10304/0/eutanasia/ramon/sampedro>.

157 “I'll starve myself until I die, vows sick man”, The New Zealand Herald, <http://www.nzherald.co.nz/index.cfm?c_id=1&ObjectID=10007151>.

158 “La muerte del 'Ramón Sampedro' de Nueva Zelanda reabre la polémica legal sobre la eutanasia”, <<http://www.20minutos.es/noticia/10304/0/eutanasia/ramon/sampedro>>.

159 See <http://thomas.loc.gov>.

160 Service des Affaires Européennes du Sénat, “L'euthanasie - Étude de législation com-

been generally recognised:

- non-resuscitation orders;
- declarations demanding the non-administration or the interruption of life-prolonging procedures;
- delegations to a third party to make all the decisions concerning his/her health.

In the case of patients who do not have the capacity to consent nor have left a living will, withdrawing or withholding medical treatment depends on establishing beyond doubt the patient's will.¹⁶¹

This said, the situation regarding all euthanasia related issues in several states of the USA is extremely controversial. Although euthanasia is forbidden in all states of the USA, there have been numerous cases of court acquittals throughout history, based mostly on the right to self-determination. Moreover, thousands of deaths everyday are alleged to be in some way planned, tolerated or indirectly assisted, probably through the double effect of pain-solving medications that hasten death, or the withdrawal of or failure of start potentially life-prolonging or life-saving treatments. In addition, the financial situation of the patient can also play an important role, since there is no universal medical care. The economic plight of the families of terminally ill patients can be desperate.¹⁶² ¹⁶³

As one can read in the decision *Cruzan v. Director, Missouri Department of Health*, it is agreed that “a protected liberty interest in refusing unwanted medical treatment may be inferred from (...) prior decisions, and that the refusal or artificially delivered food and water is encompassed within that liberty interest”.¹⁶⁴ However, in the lack of a living will, the situation can become more complex. Besides that, the lack of proof regarding the true will of the patient in case of falling into a vegetative state can lead to denial of withdrawal of life-sustaining procedures. In cases of doubt, the states' interest in protecting life can legitimise “heightened evidentiary requirements” and override the

parée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

161 *Re Quinlan*, 70 N.J. 10, 355 A. 2d 647.

162 The New York State task force on life and the law, “When Death is Sought. Assisted Suicide and Euthanasia in the Medical Context”, <<http://www.health.state.ny.us/nysdoh/consumer/patient/preface.htm>>.

163 See, in what regards children in particular, R. L. Marker, *op. cit.*

164 See *Cruzan v. Director, Missouri Department of Health*, 497, U.S. 261 (1990), in K. M. Sullivan and G. Gunther, “Constitutional Law”, fourteenth edition, New York, Foundation Press, 2001, p. 576.

right to liberty of the patient.¹⁶⁵ This perspective is, nevertheless, very much disputed, even among the collective of judges taking such a decision, as one of them stated:

“[If] Nancy Cruzan has no interest in continued treatment, and if she has a liberty interest in being free from unwanted treatment, and if the cessation of treatment would have no adverse impact on third parties, and if no reason exists to doubt the good faith of Nancy’ parents, then what possible basis could the State have for insisting upon continued medical treatment?”¹⁶⁶

In 1994, the voters of Oregon approved for the first time, in referendum, the law legalising assisted suicide. After a long court process, which had the effect of suspending its implementation, the law came into force in November 1997.¹⁶⁷ The Death with Dignity Act made physician-assisted suicide lawful for the first time in the world, so long as it is conforms with certain specifications:¹⁶⁸

- the patient is 18 years of age or older and is a resident in Oregon;
- the patient is terminally ill;

165 *Ibidem*, pp. 575 and 576.

166 *Ibidem*, p. 577.

167 The Federal Controlled Substance Act states that before a controlled substance can be distributed for legitimate medical purposes, one must obtain a license from the Drug Enforcement Administration. This agency had proposed forbidding physicians from prescribing such drugs with the intent of causing death. Although Janet Reno, while attorney general, refused to accept such measure, her successor, John Ashcroft agreed that physicians who prescribed controlled substances for assisted suicide were violating this Act, since assisted suicide was not a legitimate medical practice. Oregon’s practice of assisted suicide was blocked as a consequence of the federal government’s interpretation of this Act (see answer to question II. 8 of COE, *op. cit.*). Although this measure only prohibited the prescription of a particular class of drugs, the result of such prohibition was indeed hindering physicians from practicing assisted suicide: helping patients to commit suicide through the prescription of other drugs could bring serious harm upon them. Several Oregon state authorities, such as its governor, John Kitzhaber, and responsible for justice, Hardy Meyers, protested against this “federal interference without precedents in the Oregon State capacity to regulate medical practice” (“Fim do suicídio assistido no estado americano do Oregon”, *Público*, 8th November 2001, p. 36). The State of Oregon filed a lawsuit against this federal decision and obtained a temporary restraining order against Ashcroft’s ruling. In 2002, the US District Court upheld Oregon’s physician-assisted suicide law, which has remained in force until now despite all appeals meanwhile filed by Ashcroft (Oregon response to U.S. Department of Justice opinion on physician assisted suicide, <<http://www.doj.state.or.us/11072001.htm>>).

168 “The Oregon Death with Dignity Act”, <<http://oregon.gov/DHS/ph/pas/docs/statute.pdf>>.

- the patient has less than six months left to live;
- the patient is of sound mind (competent at the time of the request);
- the patient explored all treatment options;
- the patient made two voluntary requests to die, both orally and written, and witnessed, with a 15 days interval;
- two doctors agree that these conditions are obtained and that the patient does not in anyway suffer from a psychiatric or psychological disturbance (e.g., too depressed) that impairs his/her judgment about seeking to die.

In such cases, patients may obtain a lethal dose of drugs after a fifteen-day waiting period, and can proceed to commit suicide. Doctors may, but are never obliged to, assist by prescribing the barbiturates, but not administer them or carry out any lethal procedure. Doctors are, furthermore, requested to inform the patient of feasible alternatives to assisted suicide, such as comfort care, hospice care and pain control, as well as requesting the patient to inform his/her next-of-kin. Lastly, the patient may rescind his/her request at any time, which is also remembered by the doctor. The possibility of resorting to assisted-suicide is, therefore, left to qualified patients and licensed physicians.

The Oregon Department of Human Services collects and analyses information on how the law works in practice and issues an annual report assessing compliance with the terms of the Act.¹⁶⁹ This is done through a compulsory reporting system, according to which doctors inform these Services of each prescription of lethal medication. When doctors do not comply with these rules, they are subjected to disciplinary action from the Board of Medical Examiners. Furthermore, pharmacists must also be informed of the ultimate use of the drugs prescribed. According to the last report produced by the Oregon Department of Human Services¹⁷⁰, patients requesting lethal medication referred to 3 main concerns: decreasing ability to participate in activities that made life enjoyable, loss of autonomy and a loss of dignity.¹⁷¹ The other possible concerns (financial impact of illness, being a burden, loss of control of bodily functions and inadequate pain control) were given less importance. Although the number of people resorting to physician-assisted suicide has been increasing since 1998, the overall number of terminally ill patients actually us-

169 “FAQ about Physician-Assisted Suicide”: <<http://egov.oregon.gov/DHS/ph/pas/docs/faqs.pdf>>.

170 Department of Human Services, Office of Disease Prevention and Epidemiology, “Seventh Annual Report on Oregon’s Death with Dignity Act”, 10 March 2005: <<http://egov.oregon.gov/DHS/ph/pas/docs/year7.pdf>>.

171 *Ibidem*, p. 5.

ing it only amounts to about one in every 800 deaths (representing 0,125% of the annual deaths).¹⁷² Another important element consists of no unreported cases having been identified, not only according to the authorities, but also to several authors, which can be interpreted as meaning that the Act is well enforced. More importantly, the Oregon Health Division could not find any sign of abuse, nor any influence of financial burden of their disease as a reason for the patients' choice. Finally, the availability of physician-assisted suicide has had the very positive impact of increasing physicians' awareness in regards to end-of-life care options, such as pain medications in the terminally ill, recognition of disorders such as depression and reference of patients to hospices.

Two types of cases are still never satisfied by this law's criteria, since it expressly excludes euthanasia:

- patients who cannot obtain the requisite medication or administer it to themselves (due to paralysis, weakness caused by the medication or inability to swallow);
- patients who are not presently suffering and who are likely to die within six months, but who fear the ravages of a mentally incapacitating condition (such as Alzheimer's disease) that will rob them of the competence needed for any request for physician-assisted suicide to be granted.

Meanwhile, in 1997, two Supreme Court decisions ruled that there is no federal constitutional right to assisted suicide, so it became a policy matter left to each individual state in the USA.¹⁷³ The reasoning of one of them, *Washington v. Glucksberg*¹⁷⁴, supported that the Washington state prohibition against "causing" or "aiding" a suicide did not offend the Fourteenth Amendment to the USA.¹⁷⁵ The Court of Appeal had previously stated that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death" and that the state's ban on assisted suicide was unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians".¹⁷⁶ However, the Supreme Court quashed this decision, claiming that "State's assisted-suicide bans (...)

172 *Ibidem*.

173 *Vacco v. Quill* (521 U.S 793, 117 S.Ct. 2293) and *Washington v. Glucksberg* (521 U.S 702, 117. 2258).

174 521 US 702, 117 S.Ct. 2258.

175 "No State shall (...) deprive any person of life, liberty, or property, without due process of law", <http://www.archives.gov/national_archives_experience/charters/constitution_amendments_11-27.html>.

176 *Cit. in* K. M. Sullivan and G. Gunther, "Constitutional Law", fourteenth edition, New York, Foundation Press, 2001, p. 578.

are longstanding expressions of the State's commitment to the protection and preservation of all human life".¹⁷⁷ The Supreme Court had stated in the *Cruzan case* that "competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death" and that "the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication".¹⁷⁸ Still, in the *Washington v. Glucksberg* decision, the Supreme Court was of the opinion that "the decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection".¹⁷⁹ Besides that, "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause" and it is unquestionable that the "Washington's assisted suicide ban [is] rationally related to legitimate government interests".¹⁸⁰ A concurring opinion argued that, while he "would not say as a categorical matter that these state interests are invalid as to the entire class of terminally ill, mentally competent patients, [he does] not [foreclose] the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought could prevail in a more particularized challenge".¹⁸¹ In any case, the main outcome of this case was that the law banning assisted suicide in the State of Washington was not considered unconstitutional.

In the other case, *Vacco v. Quill*, the court discussed if the New York state's assisted suicide prohibition offended the Equal Protection Clause, since "some terminally ill people – those on life-support systems – are treated differently than those who are not, in that the former may 'hasten death' by ending treatment, but the latter may not 'hasten death' through physician-assisted suicide".¹⁸² Besides that, and also according to the respondents claim, the distinction between refusing life saving medical treatment and assisted suicide is "arbitrary" and "irrational".¹⁸³ However, the Supreme Court found that assisting suicide and withdrawing life-sustaining treatment is a "widely recognized and endorsed" distinction, besides being "certainly rational", even if "the line be-

177 *Cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 578.

178 *Cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 580.

179 *Cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, pp. 580-581.

180 *Cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 581. On the limits of admissibility of the 'statelisation' of the human person, see F. Giunta, *op. cit.*, p. 273.

181 Justice Stevens, *cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 584.

182 Opinion of the Court of Appeals, *cit. in* *Vacco v. Quill*, *cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 588.

183 *Cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 589.

tween the two may not be clear".¹⁸⁴ As a conclusion, the New York state ban on assisted suicide was considered constitutional. However, another concurrent opinion precised that he was "not persuaded that in all cases there will in fact be a significant difference between the intent of the physicians, the patients or the families in the two situations. [In] both situations, [they may be] seeking to hasten a certain, impending death".¹⁸⁵ Furthermore, five out of the nine judges declined to join the opinion of the Court in its entirety, which clearly reveals a still very unsettled situation concerning the exact rules that should govern withdrawal of life saving treatment and assisted suicide in the USA.

Despite this established case law, as well as political and medical opposition, surveys reveal that the majority of Americans are in favour of assisted suicide being legalised. In addition, "governmental interest's in preserving life and promoting respect for the sanctity of human life" must yield before "the patient's strong autonomy" (self-determination) and the "dignity factor", to be included "within the criteria of best interests of any incompetent patient".¹⁸⁶ Lastly, court juries tend not to condemn someone who has helped another to commit suicide. An exception to this trend was the famous case of *Dr. Kevorkian*. In 1998, following the videotaping and broadcasting of the suicide of Don Hewitt with the assistance of Dr. Jack Kevorkian, the debate about euthanasia in the USA was re-launched and public opinion faced again a whirl of arguments in every direction.¹⁸⁷ Dr. Kevorkian, who, already at that time, was known as "Dr. Death" for having been allegedly responsible for more than 120 cases of euthanasia, was convicted of second degree murder and delivering a controlled substance without a license.¹⁸⁸

Of course that the most recent and live memory of the debate over euthanasia in the USA reminds us immediately of the *Terry Schiavi case*. This 41-year-old woman died on 31st March 2005, after 15 years of being in a vegetative state as a consequence of two heart attacks and 13 days of starvation and dehydration. This dramatic case revolved around this issue: Who decides about someone's right to die when that someone is not competent thereto anymore and has not left any living will? After a never-ending entanglement of court processes, appeals and procedural issues, the state circuit court ordered the removal of the life-sustaining feeding tube and the Supreme Court rejected the

184 *Cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, pp. 588 and 589.

185 Justice Stevens *in Vacco v. Quill*, *cit. in* K. M. Sullivan and G. Gunther, *op. cit.*, p. 589.

186 N.L. Cantor, *op. cit.*, pp. 399, 400 and 414.

187 F. Rich (The New York Times), "L'euthanasie, parlons-en!", Courrier International, no. 422, p. 24.

188 <<http://www.pbs.org/wgbh/pages/frontline/kevorkian/law/>>.

appeal against this decision: from that moment on there was no other significant legal resource to avoid the death of Terri Schiavo.¹⁸⁹ Her persistent vegetative state and alleged wishes¹⁹⁰ lead state and federal courts to refuse the feeding tube to be reinserted. What was most disturbing and specific to this case was the media and political attention that it caught. Florida's state senate was called to vote twice on bills concerning directly this case:

- the first time in 2003 to pass what was to be called “Terri’s Law”, which allowed Florida’s governor to stay the judge’s order to withdraw the feeding tube and was later on considered unconstitutional by the Florida Supreme Court;¹⁹¹ and,
- the second time in 2005 to vote on a bill preventing doctors from removing a feeding tube from patients who had not expressed their wishes in writing, which failed.¹⁹²

More importantly, the House and Senate of the USA passed a bill transferring jurisdiction of the case to a US District Court for a federal judge to review. This was a double exceptional measure, be it for the uncommon circumstances that surrounded it, be it for the fact that it was only applicable to this case – a hardly constitutional *ad personam* act. Despite that, it did not produce the expected results: both the US District Court and Circuit US Court of Appeals denied reinserting the feeding tube. This seven years judicial marathon involved 20 rulings and 5 refusals of the Supreme Court to hear the case.¹⁹³ One thing that should be retained is that the majority of the Americans condemned the hasty intromission of Congress in the judicial process¹⁹⁴ and was in favour of the removal of the feeding tube, independently of their political or religious background^{195 196}. Finally, this case also had the consequence of making peo-

189 “May god give grace to our family”, CNN, <<http://edition.cnn.com/2005/US/03/31/schiavo/index.html>>.

190 “Schiavo parents file new court appeal”, CNN, <<http://edition.cnn.com/2005/LAW/03/30/schiavo/index.html>>.

191 “The Terri Schiavo Case Timeline”, CNN, <<http://edition.cnn.com/2005/LAW/03/30/schiavo/index.html>>.

192 “Schiavo parents file new court appeal”, CNN, <<http://edition.cnn.com/2005/LAW/03/30/schiavo/index.html>>.

193 “U.S. Supreme Court rejects Schiavo parent’s appeal”, CNN, <<http://edition.cnn.com/2005/LAW/03/24/schiavo/index.html>>.

194 According to a poll conducted by ABC TV station, 70% of the Americans believe that the president and the Congress should not have interfered in this case, reported the “Corriere della Sera”, 22 March 2005, p. 9, and “La Repubblica”, 22 March 2005, p. 8.

195 63%, according to a poll from ABC TV station, 59% according to Fox TV station, reported the “Corriere della Sera”, 22 March 2005, p. 9, and “La Repubblica”, 22 March

ple much more aware of how to make sure their self-determination right during sickness is respected: during the days of highest controversy around the case of Terri Schiavo, more than 2000 people a day asked the organisation “Aging with dignity”¹⁹⁷, specialised in drafting living-wills, for advice.¹⁹⁸

No matter if this is considered a case of voluntary or non-voluntary euthanasia (depending if one considers proven that Terri Schiavo did express her will to die if she happened to found herself in such medical conditions or not), one doubt certainly raised in many people’s minds: Would it have not been less cruel to resort to a lethal injection than letting Terri Schiavo die to starvation and thirst? Medical data points to the fact that a permanently unconscious patient “cannot sense pain and experiences no suffering” and that “the death [due to termination of artificial nutrition] will neither be painful nor gruesome”.¹⁹⁹ Therefore, since the patient in a permanent vegetative state “is deriving no gain from this biological limbo” and termination of artificial nutrition can be equated with medical treatment, the cessation of medical care “is consistent with the patient’s best interests”, even in the absence of prior instruction from the patient.²⁰⁰ As Cantor concludes, “withholding artificial nutrition from a permanently unconscious patient is consistent with humane standards of care and does not threaten abuse of the disabled”.²⁰¹

2005, p. 8.

196 56%, according to a CNN/USA TODAY/GALLUP poll, from which 62% democrats and 54% republicans, and 51% attend church weekly, 55% monthly and 60% less often: “Poll: Feeding won’t improve Schiavo’s condition”, CNN, <<http://edition.cnn.com/2005/LAW/03/23/schiavo.poll/index.html>>.

197 <<http://www.agingwithdignity.org/>>.

198 Reported by the “La Reppublica”, 22 March 2005, p. 8.

199 N.L. Cantor, *op. cit.*, pp. 381-437 (especially 382).

200 *Ibidem*, pp. 382-383.

201 *Ibidem*, p. 384.

“We must be tolerant of wishes that might be different from our own.
I might prefer to be dead than quadriplegic. You might not.
Does that make one of us right?”²⁰²

John M. Freeman

VI. Attempts at Comparing the Incomparable

The different legal regimes that were described above reveal the deep and irreconcilable differences that characterise this theme in different countries. Even countries that have in common the legalisation of euthanasia, such as the Netherlands and Belgium, have followed two different paths: the first one has modified the penal law regarding homicide following victim’s request and suicide assistance, while the second one opted for not amending the penal code and not referring explicitly to suicide assistance.²⁰³ Besides, in Belgium, the request for euthanasia has to be written and in the Netherlands, it does not.²⁰⁴

One conclusion can be mentioned, as pointed out by a thorough study carried out in this field by the French Senate: Denmark, several Swiss cantons, half of the Australian States or territories and all American States have adopted laws recognising to each person the right to express in advance his/her refusal to therapeutic relentlessness, either by producing a living will or by designating a proxy with decision-making power regarding medical issues.²⁰⁵

Another thing also seems to stand out from the above description of the different legal regimes: the distinction between indirect, passive and active euthanasia is, to most extent, pointless and senseless. As Kennedy points out²⁰⁶, what characterises the so-called indirect and active euthanasia behaviours is the same:

- *intention*: to bring relief to the patient’s pain and provide him/her with a painless death;

²⁰² Freeman, John M., “If euthanasia were licit”, in McMillan, Richard C.; Spicker, Stuart F.; Engelhardt Jr., Tristram Hugo; “Euthanasia and the newborn: conflicts regarding saving lives”, Dordrecht; D. Reidel Publishing Company, 1987, p. 160.

²⁰³ Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 109”, July 2002, <<http://www.senat.fr/lc/lc109/lc109.pdf>>, pp. 4-5.

²⁰⁴ *Ibidem*, pp. 5.

²⁰⁵ Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

²⁰⁶ I. Kennedy, “Il diritto di morire”, in “Una norma giuridica per la bioetica”, a cura di Cosimo Marco Mazzoni, il Mulino, Bologna, 1998, pp. 217-236.

- *motivation*: to assist the patient at the best of the physician's ability;
- *act*: administration of a certain drug;
- *result*: the death of the patient.

In fact, intention is not only aiming at a specific result: the legal notion of intention encompasses as well knowing that a certain result will undoubtedly take place following that action. And it cannot be said that, resorting to the German theory of the “consented risk”, indirect euthanasia remains non-intentional killing as long as the administration of drugs remains within certain limits, otherwise one has, then, to answer what that limit might be. There is, obviously, no limit, since the pain of the patient may not have any such limits and require painkillers until he/she is dead.²⁰⁷ Therefore, indirect, as well as active, cases of euthanasia, are considerably more similar than one may be lead to believe. In addition, the presumed distinction between assisted suicide and the active voluntary euthanasia is, in Kennedy's words, illusory: it easily crumbles both from the factual and from the moral points of view.

Consequently, the existence of different normative and judicial solutions for all these cases lack sufficient legal ground. It is more a question of rhetoric²⁰⁸: neither the means (the administration of a drug), nor the result (the death of the patient) is considered wrong, but the rhetoric and ritual around them make all the difference. The criminal sanction system that enforces this rhetoric and ritual are, then, wrong. Furthermore, the fact that this system aims at protecting the patients is patently ironic, since it is those patients themselves who wish to avoid being protected.

207 F. Giunta, *op. cit.*, pp. 259.

208 In the same sense, see P. Rescigno, “Autodeterminazione e testamento in vita”, in “Una norma giuridica per la bioetica”, a cura di Cosimo Marco Mazzoni, il Mulino, Bologna, 1998, pp. 283.

“I wish merely to call attention to the fact that the issues of euthanasia arise out of a variety of fundamental premises, probably the most important being the extent of our commitment to having a benevolent and rational society.”²⁰⁹

Marvin Kohl

VII. “The future is not ours to see”, but...

Let us suppose that a baby is born with such a defective condition that it is decided that he/she ought not to be treated for the sake of his/her own quality of life. The infant may still survive for a long time. Why would it not be better to give him/her a terminating anaesthetic? It surely seems hardhearted, but is it not kinder than allowing slow deterioration until death arrives? It is even more coherent than allowing for late abortion, since with post-birth euthanasia less pain would be caused to the baby than with late abortion and it would be possible to better evaluate the real defective condition of the baby and determine his/her possibilities of future life-quality, eventually saving the baby’s life after all.²¹⁰

Conceiving the right to life as including the right to oppose it even against his/her holder is arguably compatible with a laic perspective of the State and with the right to self-determination: What kind of society is it that imposes life on people themselves without letting them decide? The right to life and the duty to respect others’ lives should never be at stake, but the duty to live should also be out of the question.

Just as revealing one’s intention to commit suicide is an attempt to ask for help, the demand for euthanasia might also be an alarm about the needless and pointless pain and suffering that so many people are forced to go through. Maybe the main point of all this debate is to call attention to the inadequate treatments given to terminally ill patients. Better palliative care near the end of

209 M. Kohl, “Euthanasia and the Right to Life”, in S. F. Spicker, T. H. Engelhardt Jr., “Transdisciplinary Symposium on Philosophy and Medicine”, 3, Farmington, Conn., 1975, in “Philosophical medical ethics: its nature and significance”, Dordrecht; Boston: D. Reidel Publishing Company, 1977, p. 74.

210 For a comprehensive view of the main problems that medical care personnel dealing with neo-nates have to face, see P. Deconinck, “L’euthanasie en période néonatale”, in Pinsart M.-G. et Susanne C. (éds.), L’euthanasie ou la mort assistée, Bruxelles, De Boeck, 1991, pp. 45-57.

life will always be preferable to death.²¹¹ However, it still remains true that legalising euthanasia would be the best solution for all those people that only desire better care in their time of death: when asking for euthanasia to be administered to them, the family, doctor and hospital will be there to assess the reasons and justification of such request. In doing so, the patient is even likely not to desire death anymore now that he/she is being given care and attention. Ironically, euthanasia can save lives.

Many authors defend the best solution as being not to introduce any amendments in the present prohibition of practices related to euthanasia, i.e., rules punishing homicide upon request and help at suicide should remain fully in force, even if occasionally applied in a more flexible way by the courts in order to take into account the specific circumstances of a case. The clear advantage of this approach is to recognise “the appropriateness of active voluntary euthanasia in individual cases, yet avoiding the dangers and difficulties in drafting legislation to more formally accommodate the practice”. However, it is also true that it “inevitably produces uncertainty and does not adequately protect the position of either doctors or their patients”, besides the fact that “toleration of the discrepancies which presently exist between the law on the books and the law in practice tends to lead to disrespect for the law”.²¹² Finally, accepting refusal of therapeutic relentlessness without envisaging the application of euthanasia, mostly in the case of indirect and passive euthanasia, is very little realistic, since the border between one and the other is extremely thin.²¹³

211 Expounding the relevance of palliative care within the debate on euthanasia, see M. Moulin, “A la recherche de la ‘bonne mort’ perdue ou la lutte des acharnements thérapeutique et législatif”, and J.-F. Malherbe, “Quelques remarques sur l’euthanasie – Euthansie ou soins palliatifs?”, both in Pinsart M.-G. et Susanne C. (éds), L’euthanasie ou la mort assistée, Bruxelles, De Boeck, 1991, pp. 13-34.

212 M. Otlowski, *op. cit.*, pp. 456-457.

213 C. Mélot, “Le non acharnement thérapeutique et l’euthanasie en réanimation à l’aube du troisième millénaire”, Réanim Urgences, 2000, 9: 9-10.

“I know that our hospitals are wonderful. I know that many people have succeeded in making good lives with appalling handicaps. I’m happy for them and respect and admire them. But each man must make his own decision. And mine is to die quietly and with as much dignity as I can muster.”²¹⁴

Ken Harrison, in “Whose life is it anyway?”

VIII. Proposals of Implementation of Progressive Rules

Several authors have concretised specific proposal on how to implement rules that allow the practice of euthanasia while safeguarding the rights and interests of everyone involved.²¹⁵ Freeman described, for example, how an ethics committee could work:²¹⁶

“I propose an ethics committee in each hospital [...] :

- The composition of the committee should include representation from outside the medical community.
- Any situation where death would be considered a benefit by the patient or the family, any situation where active or passive euthanasia is considered desirable, would be reviewed by the committee.
- The wishes and desires of the patient, where available, should be given primacy.
- The desires of the family should be carefully evaluated when the family wishes an end to the patient’s suffering [...].
- [...] the committee should consider this request in light of the patient’s disease, condition and prognosis. It should examine the family’s motives and assure that this is a reasonable decision.
- In no case should the family’s desire for continued care be overruled.
- The committee should act as the patient’s advocate, being aware and sensitive to the fact that everyone will not advocate the same outcome in a given situation [...].

214 B. Clark, “Whose life is it anyway?”, New York, Dodd Mead, 1979, pp. 76-77, *cit. in* H. Biggs, *op. cit.*, p. 106.

215 For a thorough set of possible alternatives of reform, see M. Otlowski, *op. cit.*, pp. 456-493.

216 J. M. Freeman, *op. cit.*, pp. 166-167.

- [...] assure that the decision to end life is reasonable and directed to the patient's benefit – but the committee should not have dogmatic standards.”

Morris also proposed a full “Voluntary Euthanasia Bill”, already in 1970.²¹⁷ This proposal included a whole set of rules safeguarding all consideration worthy interests, such as the need for authorization, a declaration made in advance, the mode of revocation, duties and rights of physicians and nurses (including conscientious objection), as well as their protection, offences, relevance for insurance policies and administration of drugs. This proposal only foresaw voluntary euthanasia for terminally ill or severely brain damaged patients. One must note, of course, that proposing voluntary euthanasia for severely damaged patients is, to say the least, quite daring and easily object of strong criticism.

More recently, a group of American physicians, lawyers and philosophers have proposed the approval of a legal act consenting assistance to death.²¹⁸ This assistance would have to be performed by physicians, could take place under the form of assisted suicide or active of euthanasia, depended upon the request of the patient, and had to be inserted in a comprehensive scheme of assistance to terminal patients. This scheme would include palliative care counsellors, experienced physicians, and regional committees in charge of, namely, monitoring palliative care and euthanasia practice.

Regardless of these proposals, all cases of legislation legalising the practice of active euthanasia or assisted suicide that have been in force so far are undoubtedly high-quality examples of how legal rules manage to reach a very balanced compromise between the interests of all persons involved and the precautionary duties of public and political authorities. This is mostly the case of legislation in Belgium and The Netherlands.

217 A. A. Morris; “Voluntary Euthanasia”, *Washington Law Review*, 1970, pp. 239 ff.

218 F.G. Miller, T.E. Quill, H. Brody *et al.*, “Regulating physician-assisted death”, in *N. Engl. J. Med.*, 331, 1994, pp. 119-123.

“I, as well as some judges and the majority of the people who love life and freedom, think that life is a right, not an obligation (...) denying the private property of our own being is the biggest cultural lie. For a culture that considers sacred private property over things – among which earth and water – it is an aberration denying the most private property of all, our Land and personal Kingdom. Our body, life and conscience. Our Universe.”²¹⁹

Ramón Sampedro

IX. Summing up

Belgium, Denmark The Netherlands and Switzerland make up the group of countries that step forward and admit allowing, at least, “passive euthanasia” or assisted suicide within their borders. However, most any other country accepts the validity of living wills, allow withdrawing of life-sustaining treatments, consider very relevant respect for patients’ autonomy, allow indirect euthanasia or even consent to “assisting dying”.²²⁰ There is a clear trend, at least among the Continental European and Common Law tradition countries, towards an increasing respect for the right to self-determination of the patient. Twenty-six surveys carried out between 1980 and 1989 in fourteen countries have all revealed that the majority of persons are in favour of active euthanasia (from 56% to 84%).²²¹ Another set of twenty-two surveys carried out with physicians has exposed that about 40% of them has been confronted with a request for euthanasia and a fifth to a third of them has acceded to the request.²²² Furthermore, in many countries such as Finland²²³, France²²⁴, Germany²²⁵,

219 *Cit. in José Alves, op. cit.*, p. 34.

220 Service des Affaires Européennes du Sénat, “L’euthanasie - Étude de législation comparée n° 49”, January 1999, <http://www.senat.fr/lc/lc49/lc49_mono.html>.

221 Y. Kenis, “L’euthanasie et l’opinion publique – Un divorce entre les médecins et la société?”, in Pinsart M.-G. et Susanne C. (éds.), *L’euthanasie ou la mort assistée*, Bruxelles, De Boeck, 1991, pp. 38-40.

222 *Ibidem*. See also, M. Fukuda, *op. cit.*, pp. 19-77, where the author concludes that, from the doctors from Boston who participated in the survey he carried out, 74% accepted practicing some kind of indirect euthanasia and 43% did the same in regards to passive euthanasia (pp. 27 and 30). However, 54% of these participants on the survey would not support the legalisation of euthanasia. These values were correspondingly 73%, 11% and 62% in the group of physicians from Tokyo (pp. 40-41 and 47). In both groups of physicians, there was a percentage of 31% of supporters for legalising euthanasia.

223 See Finish answer to question II.3 of COE, *op. cit.*

224 European Union Network of Independent Experts in Fundamental Rights (CFR-CDF),

Spain²²⁶, UK²²⁷ and USA (other than the case of Oregon)²²⁸, common practices could very well be equally considered to constitute, to say the least, passive euthanasia. The clear and dangerous difference that exists between the first and this group of countries is that these practices take place without any regulation or control. We are assisting to a complex social game, where legal and medical terminology and language in general are manipulated and euphemisms are invented in order to accommodate bad moral consciences and avoid political unrest. Hypocrisy reigns.²²⁹

As Freeman sums up, if euthanasia were licit:²³⁰

- a) more individuals would be allowed a “good death”, a death with dignity, quick and without pain and suffering;
- b) embryos and foetuses now aborted, because of the possibility or probability of a severe defect, would survive if they were found to be free of the defect;
- c) more vigorous initial therapy could be used without the fear by physicians, family, and patients that the patient might be forced to survive in an unsatisfactory, limbo-like state;
- d) controls could be imposed on the decision-making process to assure that the decisions were reasonable and tolerable – in contrast to the current secret, sometimes arbitrary, decision-making process that now goes on be-

225 *op. cit.*, p. 41, <<http://www.cpdr.ucl.ac.be/cridho/CFR-CDF.Report2002.en.pdf>>.

226 See German answer to questions I.2, II.20, II.22 and II.23 of COE, *op. cit.*

227 Basic law 41/2002 of 14 November 2002 on the autonomy of patients and the rights and obligations in the area of medical information and records, which includes regulation of living wills, *cit. in* European Union Network of Independent Experts in Fundamental Rights (CFR-CDF), *op. cit.*, p. 34, <<http://www.cpdr.ucl.ac.be/cridho/CFR-CDF.Report2002.en.pdf>>.

228 European Union Network of Independent Experts in Fundamental Rights (CFR-CDF), *op. cit.*, p. 41, note 43, <<http://www.cpdr.ucl.ac.be/cridho/CFR-CDF.Report2002.en.pdf>>.

229 See American answer to question II.21 of COE, *op. cit.*

230 This conclusion is contested by J. Keown, who argues that considering that there is a state of legal hypocrisy in societies prohibiting euthanasia is not accurate. Although the author does use some valid arguments, his reasoning seems somewhat biased and, most of all, does not resist resorting to misleading and manipulative examples, e.g., how can child pornography, bestiality or female circumcision be considered consensual? It would be curious to know what is the position of this author on protection of minors, animal rights or the right of women to physical integrity. (J. Keown, *op. cit.*, pp. 58-69, especially 63).

231 J. M. Freeman, *op. cit.*, p. 165.

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- e) between a patient's family and the physician;
- e) its legalisation could incorporate appropriate controls and review, controls that are lacking in our current decision-making process.

There is no doubt that both the medical profession and public opinion have been moving towards legalising euthanasia. Dramatic cases of AIDS patients²³¹, the decline of medical paternalism and the distance gained from religious obscure perspectives are other reasons that force us all to review our position. Those who follow a religion are free to practice it without requiring those who do not to act the same way. Besides that, there is an abyssal difference between illegality and religious immorality. If law is a social regulation that exists to minimise inconsistency and unpredictability, then it should formulate rules in order to control euthanasia taking place in hospitals throughout the whole world already and to avoid individual *ad hoc* decisions. Euthanasia has always existed and always will, at least in the patient-doctor relation, no matter what the penal or civil law say about it. If we subject euthanasia to a set of requirements, then we will be able to subject anyone who commits abuses to adequate and suitable criminal, civil and disciplinary responsibility.

Many of the cases that call for euthanasia are actually originated by the medical insistence of prolonging life of irreversible coma states and by reanimation processes that should not even have been started. Chances of improvement are in many of these cases basically non-existent; therefore, these situations should be avoided from the start in order to save the families and medical personnel from psychological distress and legal dilemmas. When these situations are not avoided, no one should be further penalised because of bad judgements or insufficient time for a more reasonable decision. Therefore, if a reanimation attempt or the use of a life-saving machine resulted in a vegetative state or the prolonging of unbearable pain, doctors, families and patients should be allowed to suspend the life-saving mechanism and even ask for a lethal injection. The ultimate goal of medicine should eventually no longer be perceived as prolonging life, but promoting the well being and eliminating suffering. Although saving lives should remain the guiding principle, it should yield to compassion and respect for the self-determination of the patient.²³² Lawyers, as well, should gain more sensibility for medical ethical issues in order to allow for a more fruitful exchange of ideas, efficient prevention of conflicts and better solutions.

²³¹ See, e.g., the case of Mr. Steven Barksby, <<http://news.bbc.co.uk/1/hi/england/2276352.stm>>.

²³² C.A. Defanti, *op. cit.*, p. 246.

Euthanasia is, at the end, a problem of conscience, for which some do too little and others do too much. Either way, we cannot forget a basic postulate: the concept of death should always be kept at a high dignity level and it is an eminently personal and intimate moment, the patient's will being the key thought in all this process. We have to respect someone who thinks that there is no point in living if one's life is filled with constant and excruciating pain or if an incurable and terminal disease prevents a meaningful or significant life. We have to protect each individual's freedom to maximal desire satisfaction as long as no one else's equal freedom is violated. Therefore, a person's explicit death wish can make it right to respect his/her freedom by taking his/her life.

When thinking of a title to this article, many different alternatives came to my mind: Euthanasia: "From the right to life to the right over life?", "The right to death?", "The right over death?". All these possibilities seem to entail some truth in them, as well as so many potential legal and ethical problems. However, that should not prevent us from continuing to move from a sacral and afflicted view of life to a quality-oriented concept of life.²³³ Saving people is always right, but not letting them live with dignity and being obsessed with the mere biological survival is wrong. We should also rethink our traditional attitudes towards death. It cannot continue to be seen as always necessarily bad, for which someone has to be punished when inflicting it on another. Life is not so sanctified that it should be preferred to any death. Let us be more realistic about our biological functions. We cannot leave the process of dying to chance and progressive disintegration of the body anymore.

233 In fact, more than having to choose between sanctity or quality of life, our society should conjugate the best of both in the most harmonic way possible, see A. Eser, "Entre la santidad y la calidad de vida", Anuario de Derecho Penal, 1984, pp. 747 ff., *cit. in* M. Casado Gonzalez, *op. cit.*, p. 17.

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