DEATH ON REQUEST

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Abstract
The topics of euthanasia and assisted suicide are of profound importance in terms of law, ethics, religion, and social values. The question whether assisted dying should be legalised is often treated, by judges and commentators alike, as a question which transcends national boundaries and diverse legal systems. In this article we seek to examine the ECtHR's approach, the different legal routes by which attempts are made to legalise assisted dying and improvements in end of life decision making. In this article, we shall try to answer the question of whether or not voluntary euthanasia and assisted suicide are morally and legally acceptable.

***Keywords**: euthanasia, assisted suicide, assisted dying, right to life, ECHR*

1. Introduction

The first substantive right proclaimed by the European Convention on Human Rights (the "*Convention*") is the right to life, set out in Article 2[1]. The right to life is listed first because it is the most basic human right of all: if one could be arbitrarily deprived of one's right to life[2], all other rights would become illusory. The fundamental nature of the right is also clear from the fact that it is "*non-derogable*": it may not be denied even in "*time of war or other public emergency threatening the life of the nation*".

The Convention does not otherwise clarify what "*life*" is, or when it *begins* or *ends*. Indeed, in the absence of a European (or worldwide) legal or scientific consensus on the matter, the Commission (when it existed) and the Court were unwilling to set precise standards in these regards. As the Court put it in the case of Vo v. France[3]:

(...) the issue of when the right to life begins ***comes within the margin of appreciation*** *which the Court generally considers that States should enjoy in this sphere, notwithstanding an evolutive interpretation of the Convention, a "living instrument which must be interpreted in the light of present-day conditions" (...)* ***there is no European consensus on the scientific and legal definition of the beginning of life***.

Rather than imposing a uniform standard, the Commission and ECtHR thus assessed and assess matters relating to the beginning of life only in a marginal way, ***on a case-by-case basis***, while leaving considerable freedom to States to regulate the matters in question themselves, as long as they approach them in an appropriate way, in particular by giving appropriate weight to the various interests at stake and by carefully balancing those interests. This can be noticed from the case-law of the Convention organs on abortion, euthanasia and assisted death. The term of "*abortion*" is well known, but the terms of "*euthanasia*" and "*assisted suicide*" are controversial.

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[1] (*1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. (2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection.*

[2] "*Life*" here means *human life*: neither the right to life of animals, nor the right to existence of "*legal persons*" is covered by the concept;

[3] Vo v. France, Application no. 53924/00;

Hippocrates mentioned *euthanasia* in the Hippocratic Oath, "*To please no one will I prescribe a deadly drug nor give advice which may cause his death*". "*Active euthanasia*" refers to a deliberate act to accelerate the death of a dying patient. Euthanasia comes from the Greek word "*eu*" which means "*goodly*" or "*well*" and "*thanatos*" meaning death[4].

"*Assisted death*" is a model that includes both what has been called *physician-assisted "suicide"* and *voluntary active euthanasia*. It suggests a difference in the degree of involvement and behaviour. "*Physician-assisted suicide*" entails making lethal means available to the patient to be used at a time of the patient's own choosing (*at the patient's autonomous request*). By contrast, *voluntary active euthanasia* entails the physician taking an active role in carrying out the patient's request, and usually involves intravenous delivery of a lethal substance. Physician-assisted suicide is seen to be far easier emotionally for the physician than euthanasia as he or she does not have to directly cause a death; he or she merely supplies the means for the patient's personal use[5].

Despite the fact that *autonomy* has been used in many distinct senses, it seems that in biomedical ethics there is a common core understanding of the meaning of this notion. According to this idea, autonomy means self-government[6]. If a person's decisions, beliefs, desires are due to such external influences as unreflected socialization, manipulation, coercion, and brainwashing, they are not autonomous but heteronomous. If a person's beliefs concerning some matter are false, inconsistent with each other, or she is insufficiently informed about that matter without realizing it, then she is not autonomous with respect that matter. Similarly, if a person's behaviour results from such things as compulsion and weakness of will, then it is not autonomous but heteronomous.

Thus, is there a right to die according to the Convention? Could we interpret that the suicide, assisted suicide and euthanasia are allowed by the Convention?

2. Paper content

2.1. Does the jurisprudence of ECtHR acknowledge the existence of a "*right to die*"?[7]

Article 2 of the Convention requires that everyone's "*right to life*" be "*protected by law*". Apart from the death penalty, it envisages only limited circumstances in which a person can be deprived of this right; none of these relate to suicide or euthanasia. This raises **several difficult and overlapping sets of questions**. *First* of all: when does life – and therefore the right to protection of life by law – end? *Secondly*: is it acceptable to provide palliative care to a terminally ill or dying person, even if the treatment may, as a side-effect, contribute to the shortening of the patient's life? And should the patient be consulted on this? *Third*, may or must, the State "*protect*" the right to life even of a person who does not want to live any longer, against that person's own wishes? Or do people have, under the Convention, not just a right to life, and to live – but also *a right to die* as and when they choose: to commit suicide? And if so, can they seek assistance from others to end their lives? And *fourth*: can the State allow the ending of life in order to end suffering, even if the person concerned cannot express his or her wishes in this respect? Perhaps surprisingly, the first, second and fourth of these sets of questions have not (*yet*) been put to the Commission or the Court – but the case-law on abortion and on the third question does provide some indications of the probable approach of the Court.

The first issue could arise, in particular, in a case in which the authorities in a member State of the Council of Europe had decided to switch off life-support machines at a certain moment when

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[4] Goodman James, *The Case of Dr Munro: Are There Lessons to be Learnt?*, Medical Law Review, 18, Winter 2010, p. 564;

[5] Available at http://www.worldrtd net/taxonomy/term/475;

[6] Jukka Varelius, *Voluntary Euthanasia, Physician-Assisted Suicide, and the Goals of Medicine*, Journal of Medicine and Philosophy, Vol. 31, No. 02, February 2006, p. 122 – 123;

[7] Available at http://www.coe.int/t/dghl/publications/hrhandbooks/index_handbooks_en.asp;

they deemed the person attached to the machines was no longer alive, but where this was disputed by relatives. However, as with the beginning of life, there is no European (or wider) legal or scientific consensus on when this moment is – except perhaps that death is not a moment, but *a process*, which suggests that it is scientifically, and thus arguably also legally, impossible to provide a clear-cut answer to the question. The Court would leave the answer to the question of when life ends – like the question of when life begins – primarily to the States. In practice, in the member States, the issue tends to be whether life-support machines can be switched off even before a person is "*clinically dead*" (whenever that may be), in order not to unduly extend the dying process[8]. The question that arises under the Convention in such cases is whether the law in a member State which allows the switching off of the life-support machines still adequately "*protects*" the right to life of the person concerned. However, even in these terms the issue has not yet come up in the case-law. In view of the case-law on demands for assisted suicide, discussed below, it is likely that the Court, if and when it is faced with this issue, will leave a wide margin of discretion to the States. The issue is closely linked to, indeed shades into, the second question: whether it is permissible to provide palliative treatment to a terminally ill or dying person, if this treatment has the side effect of hastening the patient's death. On this issue, the Parliamentary Assembly of the Council of Europe recommends that the member States should:

ensure that, unless the patient chooses otherwise, a terminally ill or dying person will receive adequate pain relief and palliative care, even if this treatment as a side-effect may contribute to the shortening of the individual's life[9].

It is notable that the Court, in the case of Pretty discussed below, expressly referred to Recommendation 1418 (1999). In view of the apparently wide consensus on this matter, and the express recognition of freedom of choice for the individual in this recommendation and in State practice, the Court is likely to accept that such an approach does not contravene the Convention. The fourth issue – whether euthanasia can be in accordance with the Convention even in the absence of a clear expression of the will of the person concerned – has also not been determined by the Convention organs. Here, too, there is somewhat clearer ground, in the sense that such "*mercy killings*" are clearly not regarded as acceptable in Recommendation 1418 (1999), and in that there are no Council of Europe member States that allow for active termination of life, other than at the request of the patient. Because of this apparent consensus, and given the emphasis which the Court places on "*personal autonomy*" it is possible that the Court, if confronted with this question, would feel that States that would depend on the circumstances of the case. The only cases in this field so far have concerned the third set of questions: whether a seriously physically ill but mentally fit person has a right to choose to die by committing suicide rather than to go on living, and whether, if so, that person can seek assistance from others in the taking of his or her life, or whether the State has the right, or the duty, to intervene to prevent this. The Court has assessed these questions at different times, in different contexts, and by reference not just to Article 2, but also to other articles of the Convention. It has, in particular, linked its considerations under Articles 2, 3 and 8 in a way that is illustrative of its holistic approach to the rights protected in the Convention. The 1984 case of *X v. Germany*[10] concerned a prisoner who had gone on a hunger strike and who was forcibly fed by the authorities. X complained of this treatment, arguing that it constituted inhuman and degrading

[8] An example is a case before the High Court of England in August 2005, in which most of the medical experts argued in favour of withdrawal of life support from a patient, Mr. A, but relatives, backed by one doctor, argued against this. The Judge, Mr Justice Kirkwood ruled against the relatives, on the basis that: "*It is in [Mr A's] best interests that he be allowed a peaceful and dignified death. Everything should be done to support him in that, including hydration and nutrition, but it's not in his best interests that he should continue to be subjected to painful and undignified medical processes which do nothing to improve his terminal condition.*"

[9] Recommendation 1418 (1999), paragraph 9, at (a) (vii); available at http://assembly.coe.int/main.asp?link=/Documents/AdoptedText/ta99/EREC1418 htm;

[10] *X v. Germany*, Application no. 10565/83;

treatment, contrary to Article 3 of the Convention. However, he did not argue that, under the Convention, he had a right to choose to die by starving himself. The Commission dismissed the application in the following terms:

In the opinion of the Commission forced feeding of a person does involve degrading elements which in certain circumstances may be regarded as prohibited by Article 3 of the Convention. Under the Convention the High Contracting Parties are, however, also obliged to secure to everyone the right to life as set out in Article 2. Such an obligation should in certain circumstances call for positive action on the part of the Contracting Parties, in particular an active measure to save lives when the authorities have taken the person in question into their custody. When, as in the present case, a detained person maintains a hunger strike this may inevitably lead to a conflict between an individual's right to physical integrity and the High Contracting Party's obligation under Article 2 of the Convention – a conflict which is not solved by the Convention itself. The Commission recalls that under German law this conflict has been solved in that it is possible to force-feed a detained person if this person, due to a hunger strike, would be subject to injuries of a permanent character, and the forced feeding is even obligatory if an obvious danger for the individual's life exists. (...) The Commission is satisfied that the authorities acted solely in the best interests of the applicant when choosing between either respect for the applicant's will not to accept nourishment of any kind and thereby incur the risk that he might be subject to lasting injuries or even die, or to take action with a view to securing his survival although such action might infringe the applicant's human dignity.

It is notable that the applicant in this case was a prisoner, and that he did not claim a "*right to die*". Prisoners are under stress by nature of their confinement, which may make them suicidal even if they would not normally be, while the State authorities are under a special duty of care towards them.

More pertinent to the general question about the existence of a "*right to die*" are therefore two cases, *Sanles Sanles v. Spain* and *Pretty v. the United Kingdom*. The first of these concerned a man, Mr Sampedro, who had been a tetraplegic since the age of twenty-five and who, from 1993, when he was about fifty, had tried to obtain recognition from the Spanish courts of what he claimed was his right to end his life, with the help of others (including, in particular, his doctor), without interference by the State. However, he died before the proceedings in Spain had come to an end, and the relative he appointed as successor to this claim, Mrs Sanles Sanles, was held by the Spanish courts and by the European Court of Human Rights to have no standing in the matter, i.e., in the latter forum, not to be a "*victim*" of the alleged violation of the Convention.

The issues raised in the *Sanles Sanles* case did at last come directly before the Court in the subsequent case of *Pretty v. the United Kingdom*[11]. The case was brought by a 43-year-old married woman, Mrs Dianne Pretty, who was suffering from a degenerative and incurable illness, motor neurone disease (the "*MND*"), which was at an advanced stage. Although essentially paralysed from the neck down, and incapable of decipherable speech, her intellect and capacity to make decisions were unimpaired. Frightened and distressed at the suffering and indignity she would have to endure if the disease were to run its course, but unable to commit suicide by herself, she wanted her husband to assist her in this. In the United Kingdom, committing suicide is not a criminal offence, but encouraging or assisting someone else to commit suicide is (under the Suicide Act 1961). However, prosecutions can only be brought with the consent of the Director of Public Prosecutions (the "*DPP*"), a senior law officer, who can exercise discretion in the matter. Mrs Pretty therefore sought an assurance from the DPP that he would not prosecute her husband if he were to assist her to commit suicide in accordance with her wishes, but the DPP refused. The United Kingdom courts upheld the DPP's decision not to give the undertaking, after detailed analysis of the case-law of the European Commission and Court of Human Rights. Mrs Pretty then turned to the European Court of Human Rights.

[11] *Pretty v. the United Kingdom*, Application no. 2346/02;

The Court admitted the case and, apart from receiving submissions from the applicant and the respondent Government, also allowed third-party interventions by the Voluntary Euthanasia Society[12] and by the Catholic Bishops' Conference of England and Wales. The Court also quoted parts of paragraph 9 of Recommendation 1418 (1999) of the Parliamentary Assembly of the Council of Europe, already mentioned, in which the Assembly recommends:

(...) 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[13].

The Court was quite dismissive of the claim that Article 2 of the Convention should be read as granting individuals a right to commit suicide. It noted, with reference to earlier case-law on various issues under Article 2, that, "*in certain well-defined circumstances*", the article may impose a positive obligation on State authorities "*to take preventive operational measures to protect an individual whose life is at risk*", and that this also applied to "*the situation of a mentally ill prisoner who disclosed signs of being a suicide risk*". However, as the Court pointed out:

The Court is not persuaded that "the right to life" guaranteed in Article 2 can be interpreted as involving a negative aspect. (...) ***Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life****. The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention. It is confirmed in this view by the recent Recommendation 1418 (1999) of the Parliamentary Assembly of the Council of Europe (...)*[14].

However, the Court was careful to stress that this ruling did not mean that if a particular State does recognise such a right (as does Switzerland, for instance), that would ipso facto be contrary to Article 2; nor did it mean that if a State that did recognise a right to take one's own life were to be held to have acted in accordance with Article 2, that would imply that the applicant, too, should be granted that right:

(...) even if circumstances prevailing in a particular country which permitted assisted suicide were found not to infringe Article 2 of the Convention, that would not assist the applicant in this case, where the very different proposition – that the United Kingdom would be in breach of its obligations under Article 2 if it did not allow assisted suicide – has not been established[15].

The Court clearly felt that the matter should be examined under different articles, and the ultimate decision based on the interplay between them. The Court therefore went on to carefully consider the claim to a right to commit suicide in the face of terrible suffering under Article 3, which prohibits torture, inhuman or degrading treatment or punishment in absolute terms, and Article 8, which guarantees, among other things, respect for "*private life*".

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[12] An United Kingdom organisation favouring voluntary euthanasia;
[13] Pretty judgment, § 24;
[14] Pretty judgment, §§ 39 - 40;
[15] Pretty judgment, § 41;

The applicant had claimed that the suffering to which her illness would inevitably lead was so severe as to amount to "*degrading treatment*" in terms of Article 3; and that the State had a positive duty to take steps to protect her from this, by allowing her to obtain assistance to commit suicide[16]. However, the Court held that "*Article 3 must be construed in harmony with Article 2*", which "*does not confer any right on an individual to require a State to permit or facilitate his or her death*"[17].

Therefore, Article 3, also, did not impose on States a duty to allow actions to terminate life in cases such as hers[18]. The Court took a much more positive approach to Mrs Pretty's case under Article 8. In a way, this became the provision under which the difficult and sensitive issues involved were addressed in the greatest depth and detail.

The Court reiterated, first of all, with reference to earlier case-law on a variety of different issues, that the term "*private life*" in Article 8 "*is a broad term not susceptible to exhaustive definition*"[19]. It then took an important new step, by recognising a new principle of "*personal autonomy*" or "*self-determination*":

Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees[20].

The Court accepted – or rather, was "*not prepared to exclude*" – that Mrs Pretty's wish to "*exercise her choice to avoid what she considers will be an undignified and distressing end to her life*" was covered by the concept of "*personal autonomy*", and that the law preventing her from exercising this choice thus constituted an "*interference*" with Mrs Pretty's right to respect for private life as guaranteed under Article 8 § 1 of the Convention[21].

Recognition of the principle of "*personal autonomy*" enabled the Court to address the issue at the heart of the case: whether this principle protects the right of mentally fit individuals to choose death (if needs be with the assistance of others), or whether "*the principle of sanctity of life*" should – or can be allowed to – override such "*self-determination*". The Court held that it was "*common ground [between the parties] that the restriction on assisted suicide in this case was imposed by law and in pursuit of the legitimate aim of safeguarding life and thereby protecting the rights of others*". The only issue to be determined was therefore whether the interference was "*necessary in a democratic society*"[22].

On the margin of appreciation to be accorded in making this assessment, the Court recalled that this margin "*will vary in accordance with the nature of the issues and the importance of the interests at stake*"[23]. However, the Court disagreed with the applicant that the margin had to be narrow, in line with the Court's case-law in other cases involving intimate personal matters, such as sexual life[24]. Rather, the focus was on the issue of proportionality and prevention of arbitrariness:

It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence. Nor in the circumstances is there anything disproportionate in the refusal of the DPP to give an advance undertaking that no prosecution would be brought against the applicant's husband. Strong arguments based on the rule of law could be raised against any claim by the executive to exempt

[16] Pretty judgment, §§ 44 - 45;
[17] Pretty judgment, § 54;
[18] Pretty judgment, § 55;
[19] Pretty judgment, § 61;
[20] *Pretty* judgment, § 61;
[21] Pretty judgment, § 67;
[22] Pretty judgment, § 69;
[23] Pretty judgment, § 70;
[24] Pretty judgment, § 71;

individuals or classes of individuals from the operation of the law. In any event, the seriousness of the act for which immunity was claimed was such that the decision of the DPP to refuse the undertaking sought in the present case cannot be said to be arbitrary or unreasonable. The Court concludes that the interference in this case may be justified as "necessary in a democratic society" for the protection of the rights of others and, accordingly, that there has been no violation of Article 8 of the Convention[25].

The crucial issue is therefore *one of balance*. Of particular importance is the fact that the law in the United Kingdom which makes it a criminal offence, in principle, to assist another person in committing suicide, can be applied with flexibility and restraint – or even not applied – in individual cases. That flexibility, that legal responsiveness to the specific circumstances, more than anything else, led the Court to its finding of "*no violation*" of Article 8. It would appear that an inflexible law would have been disproportionate and thus contrary to Article 8. After this, the Court quickly dismissed the remaining arguments of the applicant, under Article 9, which protects the right to freedom of thought, conscience and religion, and Article 14, which prohibits discrimination in the enjoyment of the Convention rights. On the former, it held that Mrs Pretty's "*claims do not involve a form of manifestation of a religion or belief*"[26]. On Article 14, it ruled that:

(...) there is, in the Court's view, objective and reasonable justification for not distinguishing in law between those who are and those who are not physically capable of committing suicide. (...) The borderline between the two categories will often be a very fine one and to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse. Consequently, there has been no violation of Article 14 of the Convention in the present case[27].

A few days after the judgment, Mrs Pretty started having breathing difficulties and was moved to a hospice. There, following palliative care, she slipped into a coma and died, on 11 May 2002, twelve days after the ruling.

2.2. Assisted dying in different legislations

The question whether assisted dying (i.e. euthanasia and assisted suicide) should be legalized is often treated, by judges and commentators alike, as a question which transcends national boundaries and diverse legal systems. Greater caution is needed before relying on the experience of one jurisdiction when discussing proposals for regulation of assisted dying in others, and the possible consequences of such regulation.

Assisted suicide is currently illegal in ***Australia***, but was for a time legal in the Northern Territory under the Rights of the Terminally Ill Act 1995[28]. As professor Suzanne Ost mentions[29], a well publicised example of partially *de-medicalised assisted death* occurred in Australia in 1996, during the short period in which assisted suicide and euthanasia were lawful in the Northern Territory. *Dr Philip Nitschke* devised a process of computerised assisted death. He provided patients with intravenous access and connected the infusion tubing to a laptop computer. The patients then had to answer three questions which appeared on the computer screen by pressing certain keys. The final question was as follows: "*If you press this button, you will receive a lethal injection and die in 15 seconds— Do you wish to proceed?*" If the patient answered all the questions affirmatively, the computer automatically switched on a previously prepared solution of a fatal dose of the sedative

[25] Pretty judgment, §§ 76-78;
[26] Pretty judgment, § 82;
[27] Pretty judgment, §§ 88-89, reference to other paragraph in the judgment omitted;
[28] The Rights of the Terminally Ill Act 1995 was passed by the Legislative Assembly of the Northern Territory in July 1995 and repealed by the Australian Commonwealth Parliament in March 1997;
[29] Ost Suzanne, *The de-medicalisation of assisted dying: is a less medicalised model the way forward?*, Medical Law Review, 18, Winter 2010, p. 504;

Nembutal[30]. The use of modern technology might make this example of partially de-medicalised assisted death seem somehow dehumanised.

However, Nitschke stated in an interview that the process allowed him "*to leave the immediate personal space of the patient, so that the family could enter and be closest to the patient when the button was pushed*". Thus, arguably, far from removing the human element, de-medicalising-assisted death in this way can remove the external presence of a doctor and enable the act of dying to be a more personal and private experience for the person to share with those she or he is closest to. This is at least one reason that can be given in support of calls for the de-medicalisation of assisted death.

The "*Euthanasia Act*" legalized euthanasia in ***Belgium*** in 2002, but it did not cover assisted suicide. In 2006, Belgium legalized partial euthanasia with certain regulations. Similarly to the Netherlands, in Belgium, a doctor who performs euthanasia does not commit a crime if he or she ensures that "*the patient is in a medically hopeless situation of persistent and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious or incurable disorder caused by illness or accident*"[31].

In ***Canada***, the debate on euthanasia peaked in 1994 when Sue Rodriguez[32] publicly campaigned for the right to an assisted suicide[33]. However, suicide is not a crime in Canada, but physician-assisted suicide is considered illegal. The Criminal Code of Canada states in section 241(b) that:

Every one who (....) (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and is liable to imprisonment for a term not exceeding fourteen years.

The reason behind its illegality is due to prevent people from "*assisting in suicide*" of those that are not mentally capable of making the decision and because of the "*value that society place on human life*" which "*in the eyes of the law makers, might easily be eroded if assistance in committing suicide were to be decriminalized*".

An article in *People's Daily* reported that nine people from Xi'an City in ***China*** made news when they "*jointly wrote to local media asking for euthanasia, or mercy killings*". These people had *uremia*, a disease due to the failure of the kidneys, and expressed their "*unbearable suffering and [an unwillingness] to burden their families any more*". The article stated because it is illegal for doctors to help their patients die, all that could be done for them was to ask the doctors to ease their pain.

In May 1997, ***Colombian*** courts allowed for the euthanasia of sick patients who requested to end their lives. This ruling came about due to the efforts of a group that strongly opposed euthanasia. When one of their members brought a lawsuit to the Colombian Supreme Court against it, the court issued a 6 to 3 decision that "*spelled out the rights of a terminally person to engage in voluntary euthanasia*". Though physician assisted suicide is legal, the country has no way to document or set

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[30] See Lopez Kathryn Jean, *Euthanasia Sets Sail: An interview with Philip Nitschke, the other "Dr Death"*, National Review, available at http://www nationalreview.com/interrogatory/interrogatory060501.shtml;

[31] Mullock Alexandra, *Overlooking the Criminally Compassionate: What Are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?*, Medical Law Review, 18, Winter 2010, p. 464;

[32] She suffered from the MND (just like Mrs Pretty). For more than two years, Rodriguez captivated the attention of Canadians during her legal challenge for a constitutional right to assisted suicide. The Supreme Court of Canada ultimately denied her this right in a narrow 5-4 ruling in favour of the protection of the sanctity of life *(Rodriguez v. British Columbia,* 1993). Nevertheless, aided by an anonymous physician, she took an overdose of barbiturates and morphine and died in the company of an outspoken Member of Parliament, Svend Robinson. Subsequent to Rodriguez's death, a Special Senate Committee on Euthanasia and Assisted Suicide held public hearings and eventually produced a report recommending that euthanasia and assisted suicide remain criminal offences. In addition to the thousands of written submissions received by the Committee, hundreds of groups and individuals presented oral testimony;

[33] Ogden Russel D. and Young Michael G., *Euthanasia and Assisted Suicide: A Survey of Registered Social Workers in British Columbia*, *Br. J. Social Wk.* (1998) 28, p. 162;

rules and regulations for doctors and patients that want to end their lives. Though it is opposed on religious grounds by many Colombians, many patients have still been able to find doctors to assist them in ending their lives.

In ***France***, the controversy over legalizing euthanasia and physician assisted suicide is not as big as in the United States because of the country's "*well developed hospice care program*". However, in 2000 the controversy over the uncontroversial topic was ignited with Vincent Humbert. After a car crash that left him "*unable to "walk, see, speak, smell or taste*", he used the movement of his right thumb to write a book, "*I Ask the Right to Die" (Je Vous Demande le Droit de Mourir)* in which he voiced his desire to "*die legally*". After his appeal was denied, his mother assisted in killing him by injecting him with an overdose of barbiturates that put him into a coma, killing him 2 days later. Although his mother was arrested for aiding in her son's death and later acquitted, the case did jumpstart a new legislation which states that when medicine serves "*no other purpose than the artificial support of life*" they can be "*suspended or not undertaken*".

Killing somebody in accordance with their demands is always illegal under the German criminal code[34] (section 216, "*Killing at the request of the victim; mercy killing*"[35]). Assisting with suicide by, for example, providing poison or a weapon, is generally legal. Since suicide itself is legal, assistance or encouragement is not punishable by the usual legal mechanisms dealing with complicity and incitement (German criminal law follows the idea of "*accessories of complicity*" which states that "*the motives of a person who incites another person to commit suicide, or who assists in its commission, are irrelevant*"). There can however be legal repercussions under certain conditions for a number of reasons. Aside from laws regulating firearms, the trade and handling of controlled substances and the like (e.g. when acquiring poison for the suicidal person), this concerns three points:

- Free v. manipulated will

If the suicidal person is not acting out of their own free will, then assistance is punishable by any of a number of homicide offences that the criminal code provides for, as having "*acted through another person*" (section 25, par. 1 of the German criminal code). Action out of free will is not ruled out by the decision to end one's life in itself; it can be assumed as long as a suicidal person "*decides on his own fate up to the end (...) and is in control of the situation*". Free will cannot be assumed, however, if someone is manipulated or deceived.

Apart from manipulation, the criminal code states three conditions under which a person is not acting under his own free will:

1.if the person is under 14 years;

2.if the person has "*one of the mental diseases listed in §20 of the German Criminal Code*";

3.a person that is acting under a state of emergency.

Under these circumstances, even if colloquially speaking one might say a person is acting of their own free will, a conviction of murder is possible.

- Neglected duty to rescue

German criminal law obligates everybody to come to the rescue of others in an emergency, within certain limits (section 323c of the German criminal code, "*Omission to effect an easy rescue*"[36]). Under this rule, the party assisting in the suicide can be convicted if, in finding the suicidal person in a state of unconsciousness, they do not do everything in their power to revive them.

- Homicide by omission

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[34] Available at http://bundesrecht.juris.de/englisch_stgb/englisch_stgb html#StGB_000P216;

[35] *(1) If a person is induced to kill by the express and earnest request of the victim the penalty shall be imprisonment from six months to five years.*

(2) The attempt shall be punishable;

[36] Whosoever does not render assistance during accidents or a common danger or emergency although it is necessary and can be expected of him under the circumstances, particularly if it is possible without substantial danger to himself and without violation of other important duties shall be liable to imprisonment not exceeding one year or a fine;

German law puts certain people in the position of a warrantor for the well-being of another (e.g. parents, spouses, doctors and police officers). Such people might find themselves legally bound to do what they can to prevent a suicide; if they do not, they are guilty of homicide by omission.

Until recently, death and dying were considered taboo or inappropriate subjects for discussion in ***Japan***. Attitudes have changed primarily due to a recent case in which a doctor admitted to helping some of his cancer patients die by "*switching or turning off their respirators*". Even though the Yokohama District Court established, in a 1995 ruling, guidelines under which a "*mercy killing*" (active euthanasia) would not be considered murder, it appears that the doctor in this case met some of the guidelines but not all.

According to the ruling, a mercy killing would not be considered a crime if:

- "*the patient was suffering from unbearable pain*";
- "*the death of the individual was inevitable and imminent*";
- "*all alternative measures have been taken to relieve the pain*";
- "*the patient makes a clear statement of his or her desire to shorten his or her life or hasten death*".

The problem that arose from this, in addition to the problem faced by many other families in the country, has led to the creation of "*bioethics SWAT teams*". These teams will be made available to the families of terminally ill patients in order to help them, along with the doctors, come to a decision based on the personal facts of the case. Though in its early stages and relying on "*subsidies from the Ministry of Health, Labour and Welfare*" there are plans to create a non-profit organization to "*allow this effort to continue*".

After failing to get royal assent for legalizing euthanasia and assisted suicide, in December 2008, ***Luxembourg***'s parliament amended the country's constitution to take this power away from the monarch, the Grand Duke of Luxembourg[37]. Euthanasia and assisted suicide were legalized in the country in April 2009[38].

In the ***Netherlands***, assisted dying on request[39] is permissible only where the "*patient's suffering was unbearable, and (...) there was no prospect of improvement"* and both doctor and patient were convinced that *"there was no reasonable alternative in light of the patient's situation*"[40].

South Africa is struggling with the debate over legalizing euthanasia. Due to the under-developed health care system that pervades the majority of the country, Willem Landman, a member of the South African Law Commission, at a symposium on euthanasia at the World Congress of Family Doctors, stated that many South African doctors would be willing to perform acts of euthanasia when it became legalized in the country. He feels that because of the lack of doctors in the country, *"(legalizing) euthanasia in South Africa would be premature and difficult to put into practice (...)*".

It is believed that in the not so distant future ***more countries in Africa***, including Nigeria and Ethiopia, will find reason to follow the laudable examples of Belgium and the Netherlands in legalising active euthanasia[41].

[42]In ***Switzerland***, although euthanasia is illegal, assisted suicide is not an offence in its own right and there are several groups who assist suicide. The most publicised of these is *Dignitas[43],*

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[37] Luxembourg strips monarch of legislative role. Available at http://www.guardian.co.uk/world/2008/dec/12/luxembourg-monarchy;

[38] Luxembourg becomes third EU country to legalize euthanasia. Available at http://www.tehrantimes.com/Index_view.asp?code=191410;

[39] The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002;

[40] Mullock Alexandra, *op. cit.*, p. 464;

[41] Nwafor Anthony O., *Comparative perspectives on euthanasia in Nigeria and Ethiopia*, African Journal of International and Comparative Law 18.2 (2010): 170-191, Edinburgh University Press, p. 191;

[42] Dyer Karen, *Raising Our Heads Above the Parapet? Societal Attitudes to Assisted Suicide and Consideration of the Need for Law Reform in England and Wales,* The Denning Law Journal 2009 Vol 21, p. 42;

whose motto is "*to live with dignity, to die with dignity*". Swiss members of *Dignitas* are able to die in their own homes, but obviously this is not possible for "*suicide tourists*"[44].

Though it is illegal to assist a patient in dying in some circumstances, there are others where there is no offence committed. The relevant provision of the Swiss Criminal Code refers to "*a person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so will, if the suicide was carried out or attempted, be sentenced to a term of imprisonment of up to 5 years or a term of imprisonment"*.

A person brought to court on a charge could presumably avoid conviction by proving that they were "*motivated by the good intentions of bringing about a requested death for the purposes of relieving suffering*" rather than for "*selfish*" reasons. In order to avoid conviction, the person has to prove that the deceased knew what he or she was doing, had capacity to make the decision, and had made an "*earnest*" request, meaning he/she asked for death several times. The person helping also has to avoid actually doing the act that leads to death, lest they be convicted under Article 114: *Killing on request*[45]. For instance, it should be the suicide subject who actually presses the syringe or takes the pill, after the helper had prepared the setup. This way the country can criminalise certain controversial acts, which many of its people would oppose, while legalising a narrow range of assistive acts for some of those seeking help to end their lives.

The status of healthy individuals seeking to end their own lives remains unresolved under Swiss law. As of 2009, *Dignitas* was pursuing the case of a Canadian couple, Betty and George Coumbias, who wished to *end their lives simultaneously*. In July 2009, British conductor Sir Edward Downes and his wife Joan died together at a suicide clinic outside Zürich "*under circumstances of their own choosing*". Sir Edward was not terminally ill, but his wife was diagnosed with rapidly developing cancer.

In March 2010, a television in the United States showed a documentary called "*The Suicide Tourist*" which told the story of Professor Craig Ewert, his family, and *Dignitas*, and their decision to commit assisted suicide using Sodium Pentobarbital in Switzerland after he was diagnosed and suffering with ALS.

Several attempts to legalize assisted suicide have been rejected by the ***UK*** Parliament. In the meantime the DPP has clarified the criteria under which an individual will be prosecuted for assisting in another person's suicide.

Assisted suicide is legal in the three ***American states of Oregon*** (via the Oregon Death with Dignity Act[46]), ***Washington*** (by Washington Death with Dignity Act), and ***Montana*** (through the 2009 trial court ruling *Baxter v. Montana*). There are relatively substantial barriers to the use of some of these provisions.

For instance, in Oregon[47], assisted suicide is available only to those with an imminently terminal illness, which is defined as "*an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months*". The person must be a "resident" of Oregon. A written request for prescription and two oral requests from the patient are also needed to escape criminal liability, plus written confirmation by doctor that the act is voluntary and informed.

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[43] Founded in 1998 by the Swiss lawyer, Ludwig Minelli, Dignitas is a nonprofit organisation set up to assist those with "*medically diagnosed hopeless or incurable illness, unbearable pain or unendurable disabilities*";

[44] For non-Swiss residents, *Dignitas* once rented a flat in an apartment block in the residential suburb of Wiedikon in Zurich. Unsurprisingly there were complaints and they were evicted from the flat. At one point, whilst looking for new accommodation, they assisted the death of a German "*suicide tourist*" in a car park. The organisation currently operates in a business park in the village of Schwerzenbach;

[45] *A person who, for decent reasons, especially compassion, kills a person on the basis of his or her serious and insistent request, will be sentenced to a term of imprisonment*;

[46] Available at http://egov.oregon.gov/DHS/ph/pas/ors.shtml;

[47] The Oregon Death with Dignity Act 1994;

Neither the Romanian legislation recognizes the right to die, the **Romanian** Criminal Code stipulating that:

• *The deed to induce or facilitate a person's suicide, whether suicide or attempted suicide took place, is strictly punished by imprisonment from 2 to 7 years*[48].

• *The abandonment, relegation or leaving without help, in any way, of a child or a person who is not possible to take care of herself by the person who has it in her custody or care, putting in immediate danger, her life, health or physical integrity, is strictly punished with imprisonment from one year to three years or with a day-fine*[49].

Listed below are some major organizations that support assisted suicide: Dignitas, Exit International, Euthanasia Research & Guidance Organizationent, Death with Dignity National Center, Compassion & Choices, World Federation of Right to Die Societies, Final Exit Network, Dying with Dignity, Dignity in Dying, Dying with Dignity Victoria, Dignity New Zealand.

It should be noted that there are many health care professionals, especially those concerned with bioethics, who are opposed to assisted dying due to the detrimental effects that the procedure can have with regard to vulnerable populations and to the fact that *it transforms a healing profession into a killing profession*. This argument is known as the "*slippery slope*" argument[50]. This argument encompasses the apprehension that once assisted dying is initiated for the terminally ill it will progress to other vulnerable communities and may begin to be used by those who feel less worthy based on their demographic or socioeconomic status. In addition, vulnerable populations are more at risk of untimely deaths because, patients might be subjected to assisted dying without their genuine consent. However, recent studies show that the available evidence suggests that the legalisation of physician-assisted suicide might actually decrease the prevalence of involuntary euthanasia.

Also, prejudices against disabled people may be enacted with regards to end of life care. For example, do not resuscitate orders are more frequently issued for those who become hospitalized and previously suffer from severe disabilities. In addition, many people who suffer from lifelong disabilities suffer from "*burn out*", which is a general feeling of depression and sadness that comes as a result of years of intolerance and prejudice. Naturally, those individuals suffering from "*burn out*" are more likely to want to refuse treatment and end their fight for life prematurely.

2.3. Improvements in end of life decision making

Currently only a small fraction of patients, about 15% have clear directions in the form of a living will or a health care proxy in place to advise family members or physicians of their end of life wishes. This leads to uncomfortable questions if the patient suddenly no longer has the ability to speak for themselves when answers are needed to important medical questions. Even if a patient has selected a proxy they may, "*be guilt ridden, wondering whether they acted to hastily or if their decision was inconsistent with the patient's desires*".

In order to preempt some of the difficulties that are associated with end of life care many medical schools and nursing programs now stress the importance of early discussions with the patient about their wishes and planning for the future. Unfortunately, since the views concerning physician assisted suicide are so polarizing, many doctors are reluctant to discuss withholding and withdrawing life sustaining treatment. In fact, in a recent study of 58 physicians, 19 admitted that they did not feel comfortable discussing end of life care with their patients.

In an effort to change the apprehension that is associated with end of life care new techniques are being explored to ensure more *doctor to patient* communication including:

• analyzing the cognitive ability of the patient to make their own decision regarding end of life care;

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[48] Article 182 (1) of the Romanian Criminal Code;

[49] Article 198 (1) of the Romanian Criminal Code;

[50] Available at http://www nytimes.com/2009/09/07/opinion/07douthat html;

- encouraging doctors to initiate end of life conversations;
- making sure that the patient is made fully aware of all options regarding their personal medical treatment;
- providing counseling and support for families of patients especially in situations where a decision to remove life support and/or stop treatment is involved.

In short there are two major ways in which the physicians can more easily be made aware of the wishes of their patients. The first of which simply involves participation in the informed consent process or, "*engaging competent patients in comprehensive discussions of treatment options and likely outcomes*". The second of these methods involves advance care planning which ensures that patients tell their doctors exactly what they wish to be done in case a medical emergency arises in which they are not able to speak for themselves.

3. Conclusions

The topics of euthanasia and assisted suicide are of profound importance in terms of law, ethics, religion, and social values[51].

Should we defend the right of each individual to live by her/his own personal values, and the freedom to make decisions about her/his own life so long as this does not result in harm to others? Currently, the needs and autonomy of patients are often disregarded. Compassionate doctors, who follow the wishes of their terminally ill patients by assisting them to die, risk being charged with assisting suicide or murder. The current system sometimes also results in close relatives being faced with immensely difficult choices: *whether* to assist a loved one who is begging for help to put an end to their suffering knowing that it is unlawful, *or* to deny their loved one the death they want. Is it right that anyone should be put into the position of having to make such choices, or indeed into a position where they believe that they have no other option but personally to end the life of someone they love?

After all, who can say for sure that assisted dying is good or bad? We know what a respectable life means, but we can hardly imagine what means a respectable death. That is the reason why assisted dying provokes in us different reactions.

As regards the religious perspective, it may be of interest to observe here that the late Catholic Pontiff, Pope John Paul II, in spite of his avowed stand against euthanasia, expressed a wish at the terminal days of his life, and which was respected by the College of Cardinals, as widely reported in the news media, to be allowed to die peacefully in the Papal home at the Vatican. Could his pains, suffering and imminent death not have been prolonged by advanced medical technology if he was taken to the hospital? The only reasonable response at that point in time is that prolonging his death has no utilitarian value. By respecting his wish, the Cardinals had either advertently or inadvertently assisted the Pope to die[52].

The domestic policies may merely succeed in encouraging people to seek help abroad, because no meaningful help is available at home[53]. This approach may also encourage people to seek an assisted suicide *sooner* than they might otherwise because of the need to travel abroad to Switzerland whilst they remain able to do so. Unlike other jurisdictions where assisted dying is permitted, certain Swiss cantons allow non-Swiss residents to avail themselves of the services of Swiss assisted suicide organisations such as *Dignitas*.

Within the social and legal debate surrounding assisted death, the focus in recent times appears to have moved away from a doctor's involvement in a clinically assisted death to "*suicide tourism*" and particularly, the matter of relatives "*assisting*" by making travel arrangements and

[51] Ogden Russel D. and Young Michael G., *op. cit.*, p. 161;
[52] Nwafor Anthony O., *op. cit.*, p. 191;
[53] Mullock Alexandra, *op. cit.*, p. 450;

accompanying their loved ones to a country in which, according to local law, they can receive assistance to die. Of course, the question of whether an individual must be suffering from a medical condition in order for assisted death to be legitimate is increasingly being raised.

Ultimately, if a practice judged by many to be undesirable is, in any case, occurring, even those opposed to it may recognize that rather than merely having the opportunity for retrospective appraisal and possible punishment, control through legalisation is a more satisfactory approach[54].

Definitely, the assisted dying is a very delicate subject and a painful problem. Analysing it with freedom and responsibility does not mean to blame its supporters[55]. Whatever the outcome is, it is clear that this area needs much more open debate from all levels of society, not just those groups who hold steadfast but extremist views on either side of the argument.

Finally, we should try to find in ourselves the answer to the first question of this article: *is it possible that human rights are limited to life or can they be extended also to death*?

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[54] Mullock Alexandra, *op. cit.*, p. 470 ;
[55] Carpizo Jorge, Valades Diego, *Derechos humanos, aborto y eutanasia*, Dykinson, 2010, p. 159.