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RIGHT TO DIE? AN ETHICAL AND LEGAL APPROACH.

ABSTRACT.

This work is about suffering. Physical and psychological suffering when a terminally illness has been diagnosed and death approaches, and physical and psychological suffering of those who have endured events that have changed their lives, leaving them physically disabled and dependent forever. It is however a work focused on those persons in these situations that do not want to endure more pain and desire death, but cannot reach it by themselves. It is about whether societies should allow and help those suffering persons to put an end to their pain through assisting them in dying or instead protect their lives until the end. It is about whether regulations should legalise practices as euthanasia and physician-assisted suicide or prohibit them in order to protect the population from potential abuses or defend the sanctity of life. After an overview of pro and con ethical arguments towards euthanasia and physician-assisted suicide, this work intends to make perceptible that none contrary attitude towards legalisation of those practices avoid inconsistencies and all are susceptible of dismissal. However, the European legal scenario presents an almost generalised ban on these end-of-life decisions. The existence of several features in European legislations and mainly the presence of a widespread judicial tolerance enhance incongruities and force a situation where member states will have to confront reality and carry out "introspection processes" in the name of coherency and human dignity.

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Vivo sin vivir en mí,
y de tal manera espero,
que muero porque no muero.

(Santa Teresa de Jesús)

Preliminary reflections.

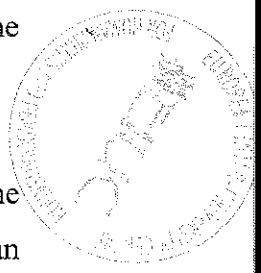
Suffering is present all over the world. Each person can potentially experience it. Some bear it more than others. Some more intensely, some for a longer time, but all feel physical or psychological pain or distress, in different degrees. And sometimes sufferings have remedies but sometimes they do not. Most of us conceive these sensations as an evil that should be avoided or remedied. Some however regard them as a redemption path or simply as the fate that has to be endured.

This work is about suffering. Physical and psychological suffering when a terminally illness has been diagnosed and death approaches and physical and psychological suffering of those who have endured events that have changed their lives, leaving them physically disabled and dependent forever. Most of them want to struggle against death and keep living. Some however do not. "There are situations when life is only suffering, suffering that only ceases when life ceases[1]." This work is about suffering when no improvements in those situations are possible and some persons do not want to live anymore. Each one has its own reasons. Some fear their illnesses' future symptoms, some just want to say goodbye before loosing their intellectual capacities, some feel they have already undergo enough pain and do not wish to bear more suffering, and some could live a long life still but their pain, dependency and impossibility of improvement make them desire death.

This work is about the suffering of those persons that desire death but are unable to perform it themselves. It is about whether societies should allow and help those suffering persons to put an end to their pain through assisting them in dying or instead protect their lives until the end. It is about whether regulations should legalise practices

[1] Paul J. Van der Maas, J.J.M van Delden, L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life*. Amsterdam-London-New York-Tokio. Elsevier, Health Policy Monographs, Special Issue, vol. 22/1 +2, 1992, p 203.

as euthanasia and physician-assisted suicide or prohibit them in order to protect the population from potential abuses.



Sufferings are therefore the underlying issue of this study. They should be hence borne in mind all along the chapters. However, this is not a medical investigation but rather an ethical and legal insight of some end-of-life decisions. This double approach has been chosen because of the complexity and delicacy of the topic: its situation at the crossroads of the private and public spheres (involving therefore feelings, beliefs, ethics and legislation) demand an interdisciplinary approach. The conditions that this study has to ascribe to (namely, length and time) and the knowledge of the author have however limited this investigation to a double ethical and legal approach. The same reasons lead the author to focus in two very precise end-of-life decisions, Active Voluntary Euthanasia (AVE) and Physician-Assisted Suicide (PAS). Despite this selective choice, it is however fundamental to bear in mind at every moment the largest framework of end-of-life decisions to which AVE and PAS belong to, drawing nonetheless carefully the distinctions between them. Finally, a precise geopolitical area, the Council of Europe and its member states, has as well been selected to complete this study and will become particularly relevant in the second part of this work.

Definitions

Moral premises are often accused to underlie definitions concerning end-of-life issues, this being one of the causes leading to the actual diversification of definitions and to the absence of a consensus on exact meanings. This work will try to adopt neutrally-oriented definitions in order avoid such criticisms; the author is however conscious of the inherent limitations of this definitional exercise.

For the purpose of this work, were Active Voluntary Euthanasia (AVE) and Physician-Assisted Suicide (PAS) will be the specific object of study, the following will be the terms of reference:

Active Voluntary Euthanasia (AVE): Positive action carried out by a physician after persistent and determined requests from a patient, consisting in the administration of drugs intending to end the patient's life. A distinction has been forwarded by some

scholars between *Direct AVE,* referring to the administration of drugs directly intending the death of the patient and *Indirect AVE,* alluding the *double effect act,* consisting in the administration of drugs intending to alleviate the patient's pain but however considering the possibility that the quantity of drugs dispensed are likely to hasten the patient's death.

Physician- Assisted Suicide (PAS): Positive action carried out by a physician after persistent and determined requests from a patient, consisting in putting at the disposal of the patient the necessary drugs in order the latter to end his or her life.

Passive Voluntary Euthanasia (PVE): Abstention from carrying out an action through which a patient's life could be prolonged or withdrawal of a treatment's administration.

Non-voluntary Euthanasia (NVE): Positive action carried out by a physician, without any request from a patient, consisting in the administration of drugs intending to end the patient's life.

Involuntary Euthanasia (IVE): Positive action carried out by a physician against the patient's will, consisting in the administration of drugs intending to end the patient's life.

Background

It is furthermore important to stress that the association of a series of factors have entailed particularly important consequences causing an extraordinary impact on end-of-life issues:

Death and the evolution of medicine

Medicine has experienced an unpredictable evolution during this last century. The control and disappearance of previous centuries' massive epidemics has entailed new forms of deaths. Cardiovascular diseases, in a first moment, and cancer, more recently, are the major causes of death in western societies. It is not vain to precise, then, that cancer has been shown to be a cause of death that frequently concurs with end-of-life

decision-making, because it relatively often involves a non-sudden and sometimes protracting dying process[2]. Besides, the modernisation of medical techniques has as well produced an unprecedented ageing of the population, entailing the increase of elderly patients affected by long diseases. Advances in medical technology have furthermore strongly increased the ability of medicine in postponing the death of seriously ill patients, in some occasions reaching intolerable situations for them[3]. This is once more a favourable situation for end-of-life decisions to take place. As we advance technologically, end-of-life issues become a more and more actual and complex problems to deal with[4]. This is in fact one of the reasons why end-of-life issues have been until now primarily a concern of the developed societies. Finally, this evolution of medical sciences has known a parallel evolution in the sphere of the patient's autonomy. While in a first moment, patients had nothing to say concerning their own death, there has been an important development concerning patients' rights[5], among which the increasing importance of their autonomy, primarily manifested through the right to refuse treatments, formally recognised all over western societies. Once more, this area is particularly relevant to the following study.

The evolution of medical techniques also caused crucial consequences in the ways death is perceived. Modern medicine has brought the *technological way of dying*[6], in which

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[2] A. van der Heide, G. van der Wal, Paul. J. van der Maas, B. Onwuteaka-Philipsen *End-of-life decisions in six European countries: a research note* in Albert Klijn, Margaret Otlowski and Margo Trappenburg (eds.) *Regulating physician-negotiated death.* "Journal of the Dutch / Flemish Association for Socio-Legal Studies" The Hague, 2001.

[3] Known as *aggressive medical treatment.* "Science is with its new complexity and extensive ramifications, thus presents a dark side or bright side according to how it is used... It has subsequently become necessary to ensure that the beneficial side prevails" Explanatory report to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine in "Human Rights Law Journal" vol. 18, n1-4, 1997, pp. 135-51.

[4] "Since the escalation of the development of medical techniques that increasingly prolong life, the problem has become more complicated" Theodore S. Orlin, *The right to life/ The right to die: The Rights, Their Interrelationship and the Jurisprudential* in T. Orlin, A. Rosas & M. Scheinin (Eds.), The *Jurisprudence of Human Rights Law: A Comparative Interpretive Approach* (Chapter 4), Åbo, Åbo Akademi University Institute for Human Rights, 2000, chapter 4. See also Parliamentary Assembly. Council of Europe, Doc. 9898. Euthanasia. Social, Health and Family affairs Committee, rapporteur : Mr. Dick Marty. 10 September 2003. Explanatory Memorandum, Introduction 4: "Medical advances have produced no answers in this area, rather the opposite. The latest medical techniques make the problem even more acute."

[5] See for example, Declaration on the promotion of patient's rights in Europe, fruit of the European Consultation on the rights of patients, Amsterdam, 28 to 30 March 1994. World Health Organisation, Regional Office for Europe.

[6] Víctor Méndez Baiges. *Sobre Morir. Eutanasias, derechos, razones.* Madrid, Ed. Trotta, 2002, p 28. Author's translation.

patients lie in institutions, strange and cold places, surrounded by technique and far from their houses. This way of dying, in solitude and privacy is due, together with the evolution of medicine, to the attitude of the developed world towards death, "clearly blocked in our occidental culture." The approaches to death have evolved through the periods of history; the actual time, in western societies, seems to be characterised by the understanding of death as a taboo. The accentuation of the individual character of death and the lack of cultural integration of this event are factors that lead to a social undervaluation of the process of dying. As Méndez Baiges sums up, "our society is very rich in techniques, but poor in arts, we are loss-making in *ars moriendi.*[7]" These particularities have a special relevance when dealing with end-of-life issues: societies are not anymore used to attribute the patient any prominence in its own process of dying but the central role revolve around the medical possibilities of keeping him alive. However, there are some signs of change: modern medicine seems to progressively begin recognising the importance of a peaceful death as an important goal of medicine, in addition to more traditional goals such as curing disease and avoiding premature death. The developments that palliative cares are starting to experience and the relative importance that end-of-life decisions seem to achieve are a significant step forward.

Empirical indications of the performance of end-of-life decisions.

Indeed, empirical data concluding the current performance of end-of-life practices in the fringes of law are more and more present. Despite the scarceness of studies in this field, most of the investigations lead to the same conclusion: end-of-life decisions are a very common reality in modern health care[8]. As it has been pointed out "euthanasia appears to be extensively practised in secret. It is this reality that carries the greatest potential for abuse. Decisions may be taken in a furtive and arbitrary manner. They may depend on

[7] Ibidem 6, p 107.

[8] "Medical end-of-life decisions frequently precede dying in all participating countries. Patients and relatives are generally involved in decision-making in countries in which the frequency of making these decisions is high" in A. van der Heide, G. van der Wal, Paul. J. van der Maas, B. Onwuteaka-Philipsen *End-of-life decisions in six European countries* "The Lancet", vol. 361, 2003."We have shown that ELDs are common in medical practice in Flanders. The strict Belgian law has not prevented physicians from practising euthanasia and other ELDs explicitly intended to shorten life in about 10% of the cases" in Luc Deliens et al. *End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey.* "The Lancet", vol. 356, 2000. "Our study undermines suggestions that the rate at which doctors intentionally end patient's lives without an explicit request is higher in a country where euthanasia is practised openly (as the Netherlands) than in a comparable country which has not allowed euthanasia" in Helga Kuhse et al., *End-of-life decisions in Australian Medical Practice*, "Medical Journal of Australia", vol. 191, 1997.

the "luck of the draw": a sympathetic doctor or a malevolent nurse.[9]". Despite some decisions (active indirect euthanasia, non-voluntary euthanasia) are more widespread than others (active voluntary euthanasia, physician-assisted suicide), an extensive performance of those practices in the shade of law offers the perfect scenario for the performance of pressures and abuses. This situation claims therefore an in-depth analysis of the issues.

Retreat of the Churches' influence and recent legalisation of some en-of-life decisions among Council of Europe's member States.

Other major factors that stress the appropriateness of the moment for openly deal with end-of-life decision-making are the relative retreat of the Churches influence, manifested through the secular character of most European democracies, the lack of a unique position and the consequent divisions among churches towards these delicate topics and the recent legalisation of some end-of-life decisions in two European countries, the Netherlands and Belgium. As it has been forwarded, " If we need any further reason to address the issue of euthanasia, two Council of Europe member states, The Netherlands and Belgium, have adopted legislation which unquestionably poses a challenge to the other states and to this Parliamentary Assembly. This situation obliges us to look at the legal position in the light of what happens in reality.[10] »

To anticipate my conclusion, what will become perceptible after an overview of pro and con ethical arguments towards AVE and PAS is that none contrary attitude towards legalisation of AVE and PAS avoid inconsistencies and all are susceptible of dismissal. Furthermore, despite a generalised European ban towards those practices, a widespread judicial tolerance enhances incongruities. Nevertheless, time and events are forcing a situation were member states will have to confront reality and carry out "introspection processes" in the name of coherency and human dignity.

[9] Parliamentary Assembly. Council of Europe, Doc. 9898, ibidem 4.
[10] Parliamentary Assembly. Council of Europe, Doc. 9898. Explanatory Memorandum, Introduction 5, ibidem 4.

1. Main arguments against legalisation.

Sanctity of Life.

Most of the academic literature addressing the ethical aspects of the legalisation of AVE agrees that one of the most basic, recurrent and strong arguments raised along the historical debate on Euthanasia is the *Sanctity of Life* argument. While, Sayers, for example, argues that the Sanctity of Life argument is a central issue in the debate[11], Dworkin qualifies it as the "most powerful basis for the strong conservative opposition to all forms of Euthanasia throughout the world"[12]. However, this argument that mainly holds that hastening death is wrong because it violates the intrinsic value and sanctity of human life knows two developments. Two visions with different philosophical grounds have been claimed to exist under this same denomination: a religious and a secular one. To analyse them, we will adopt Keown´s terminology: *Sanctity of Life* for the religious version and *Inviolability of Life* for the secular one[13].

a) Sanctity of Life.

The world's great religions share a strong predilection in favour of the preservation of life, although the reasons vary from one tradition to another. Taking into account that the geographic area under consideration (Council of Europe's member states), is debtor to a Judeo-Christian tradition, the Roman Catholic Church' s conception of life[14] and official position have been chosen to illustrate the argument.

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[11] M. Sayers, *Euthanasia: at the intersection of Jurisprudence and the Common Law,* "Criminal Law Journal", 1997, vol.21, p 81.
[12] Ronald Dworkin. *Life´s Dominion: An argument about abortion, Euthanasia, and Individual Freedom, Dying and Living,* Knopf Publishing Group, New York, Paperback/ Vintage books, 1994, p 216.
[13] John Keown. *Euthanasia, Ethics and Public Policy. An argument against legalisation,* Cambridge, Cambridge University Press. 2002, pp 39-51.
[14] The presence of catholic tradition among the member states of the Council of Europe being higher than other Christian traditions, the author has chosen this branch as object of illustration of the Sanctity of Life positions. For more information, see http://www.odci.gov/cia/publications/factbook/fields/2122.html.

The Roman Catholic Church

a) The meaning of life: *"I give the death and I give the life"* (Dt. 32, 39)

The Judeo-Christian traditional doctrine of the *Sanctity of Life* holds that human life is created in the image of God and is, therefore, possessed of an intrinsic dignity which entitles it to protection from an unjust attack. Human life has an intrinsic value because it has been created by the Lord and only He can end it. Human life is also the reflex of the image of God; it cannot be ended without his intervention.

"Human life is sacred because from its beginning it involves" the creative action of God" and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of Life from its beginning until its end: no one can, in any circumstance, claim for himself the right to destroy directly an innocent human being"[15]

"Man's life comes from God; it is his gift, his image and imprint, a sharing in his breath of life. God therefore is the sole Lord of this Life: man cannot do with it as he wills"[16].

"The Lord brings to death and brings to life; he brings down to Sheol and raises up" (1 Sam 2:6). He only can say: "It is I who bring both death and life" (Dt 32:39)"[17]

"God proclaims that he is absolute Lord of the life of man, who is formed in his image and kindness (cf. Gen 1:26-28). Human life is thus given a sacred and inviolable character, which reflects the inviolability of the Creator himself. Precisely for this reason God will severely judge every violation of the commandment "you shall not kill", the commandment which is at the basis of all life together in society"[18]

The idea of human life as a divine property underlies this conception, as Locke believed and Dworkin expresses: "In its most straightforward formulation (...), the appeal to the

[15] Congregation for the Doctrine of Faith, *Instruction on Respect for Human Life in its Origin and on the Dignity of procreation, Donum Vitae,* 22 February 1987. Introduction, n°5: AAS 80, 1988, pp. 76-77, *Catechism of the Catholic Church n° 2258.*
[16] Encyclical letter *Evangelium Vitae (the Gospel of life)*, par. 39: "From man in regard to his fellow man I will demand an accounting" (Gen 9:5): reverence and love for every human life."
[17] Ibidem 16, par 39.
[18] Ibidem 16, par 53.

Sanctity of Life uses the image of property[19]: a person's life belongs not to him but to God"[20].

b) The value of suffering

While there is not a univocal understanding of suffering common to all religions, it is nevertheless the case that the meaning of suffering has been a central concern of much theological reflection. For the Roman Catholic Church, "suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will".[21] The Encyclical Letter *Evangelium Vitae* also underlines the value of the suffering: "Living to the Lord also means recognizing that suffering, while still an evil and a trial itself, can always become a source of good. (...) In this way, the person who lives his suffering to the Lord grows more fully conformed to him (cf. Phil 3:10; 1 Pet 2:21) and more closely associated with his redemptive work on behalf of the Church and humanity"[22]. While recognising that suffering is still an evil, there is however an obvious glorification of the concept of suffering, conceiving it as a path to redemption.

c) Official doctrine

According to this conception of life and suffering and according to the Commandment that results from it, "You shall not kill", the Roman Catholic Church has build its own official doctrine on Euthanasia.

In 1940, under Pius XII, a Holly Office[23] referred directly to Euthanasia, then a dramatically actual issue because of the III Reich's policies[24], with an unavoidable

[19] "If we live, we live to the Lord, and if we die, we die to the Lord. So, then, whether we live or whether we die, we are the Lord's. (Rom 14:7-8)"
[20] Ibidem 12, p 214.
[21] Congregation of the Doctrine of the Faith, Declaration *on Euthanasia*. 5 May 1980.
[22] Ibidem 16, par 67.
[23] Official Vatican statement, 2 December 1940.
[24] In 1939, the III Reich enacted the so-called "*racial health law*". This law legalised the application of Euthanasia to facilitate some Nazi practices: the extermination of lives considered useless for the society (lives considered as burdens (*Ballastexistenzen*) and "empty shells" (*leeren Menschenülsen*). 80.000-100.000 persons died through these eugenic and racial programs, euphemistically defined as euthanasia practices. These practices implied very unpopular attitudes towards Euthanasia, as we can see through the

allusion to the Nazi concept of *useless lives*[25]. Later, Pius XII would be the first pope to refer personally and directly to Euthanasia, in 1947[26], "It is not enough for the heart to be good, sensitive or generous; it has to be wise and strong... One of those false mercies is the one pretending to justify euthanasia and remove men from the purifying and meritorious suffering, not through a laudable and charitable relief, but through death, as it is used with an animal deprived of reason and immortality.". The Concilium Vatican II only mentioned once its official position on euthanasia: its denunciation appears with the condemnation of the suicide and abortion, "the Council therefore condemned crimes against life such as any type of murder, genocide, abortion, euthanasia, or wilful suicide"; "all these things and others of their like are infamies indeed. They poison human society, but they do more harm to those who suffer from the injury. Moreover, they are supreme dishonour to the Creator"[27].

The most recent ecclesiastic Magisterium dealing with Euthanasia are the Declaration on Euthanasia of the Congregation for the Doctrine of faith (1980) and the Encyclical Letter *Evangelium Vitae* (1995). In the first text, which is a result of the multiple questions asked by several Episcopal Conferences, the Congregation states that "No one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the outmost gravity" and therefore, "no one is permitted to ask for this act of killing (euthanasia), either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. Nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity"[28]. The encyclical letter *Evangelium Vitae* includes most of the considerations made by the Congregation of Faith, but deals with them in a stricter tone and has been qualified as "the most vigorous opposition"[29] to

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life, from the time of its conception, even under threat; I will not use my medical knowledge contrary to the laws of humanity".

[25] "It is not allowed to kill directly, under authorities' orders, those that, without having committed any crime deserving death, by the sole fact of their lack of conditions, due to physical or psychical deficiencies, are unable to be useful to the nation and are considerate as a burden and obstacle for its progress and development (...)".

[26] Author's translation.

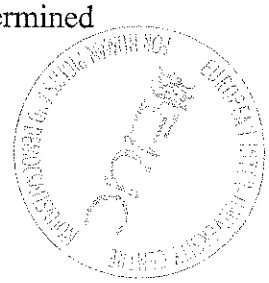
[27] Pastoral Constitution on the Church in the Modern World, *Gaudium et Spes*. Pope Paul VI, 7 December 1965, nº 27.

[28] Ibidem 21.

[29] Courtney S. Campbell, *Euthanasia and Religion,* "UNESCO Courier", 2000, pp.37-40.

euthanasia: "I confirm that euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person." and the attempts to legalise it are due to a "profound crisis of culture, which generates scepticism in relation to the very foundations of knowledge and ethics, and which makes it increasingly difficult to grasp clearly the meaning of what man is, the meaning of his rights and his duties[30]" and to the existence of a "veritable structure of sin". This reality is characterized by the emergence of a culture which denies solidarity and in many cases takes the form of a veritable "culture of death", "This culture is actively fostered by powerful cultural, economic and political currents which encourage an idea of society excessively concerned with efficiency[31]".

Euthanasia is therefore forbidden by the Roman Catholic Church on the grounds of the Sanctity of Life argument. However, there are limits to the prohibition of killing. As Keown[32] states, a line has to be drawn between the *Vitalist* school - holding that human life is an "absolute moral value" and therefore "prohibits its shortening and requires its preservation (...) regardless of the pain, suffering or expense that life-prolonging treatment entails. (...) in short, the Vitalist school of thought *requires human life to be preserved at all costs"*- and the *Sanctity of Life* doctrine- holding that life does not have to be preserved at all costs, that life is not an absolute value[33] and therefore *aggressive medical treatment*[34] is to be prohibited. The *Sanctity of Life* view does not always embrace vitalistic premises; the Roman Catholic Church, one of the most determined advocates of this view, has precised it in its Magisterium.[35] [36]



[30] Ibidem 16, par 11.
[31] Ibidem 16, par 12.
[32] Ibidem 13.
[33] Javier Gafo, *Eutanasia y ayuda al suicidio. "Mis recuerdos de Ramón Sampedro"*. Bilbao, Cristianismo y Sociedad, Desclée De Brouwer, 1999, p 58, referring to "Comisión Episcopal Española para la Doctrina de la Fe", "For Jesus... the biologic and temporal life of the human, despite being a fundamental value, is not an absolute and supreme value.". Author's translation.
[34] "Medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family." In such situations, when death is clearly imminent and inevitable, one can in conscience "refuse forms of treatment that would only secure a precarious and burdensome prolongation of life so long as the normal care due to the dick person in similar cases is not interrupted". Ibidem 16, par 65.
[35] See ibidem 16 and 21.
[36] Regarding the two other monotheistic religious traditions (Judaism and Islam), as Courtney S. Campbell notes, they basically address ethical issues concerning the end of life from a common value perspective. "In particular, discussions center on the values of sovereignty, stewardship, and the self". "Sovereignty denotes that the lives and bodies of persons are created by, and ultimately return to, God"; "through the value of stewardship, we are considered "agents of God", called to carry work of divine

However the religious approaches to euthanasia, constitutional requirements of a secular state impose political limits on religious argumentation. The religious variant of the *Sanctity of Life* argument cannot be the basis of a penalisation regulation in secular democracies. The constraints on religious discourse are based in its sociological inadequacy: in our secular age purely religious appeals will not be sufficient for public moral reasoning. For the sake of general accessibility, then, we may be tempted to do bioethics without recourse to important sources and traditions of meaning in our culture[37]. Even sanctity of life proponents typically appeal to nonreligious reasons, since religious doctrines are no longer as widely accepted as they once were.

Moreover, dissidences in the heart of Christianity in relation of the morality of euthanasia are important and reflect a major weakness. As Robin Gill states, "the Christian tradition condemning medical assistance or action which is intended to end a human life is likely to come under a challenge with Churches and among theologians", "if it was once a debate between Christians and secularists, it is fast becoming a debate among and between Christians"[38]. As Norris asserts, "the dilemma created by modern medicine seem to make such a clear-cut position increasingly difficult to hold"[39]. Even among Catholicism, very dissident voices are setting out the debate[40]

b) Inviolability of Life

"Atheists, too, may feel instinctively that human life has an intrinsic value.[41]" In fact, the secular version of this argument rises as the principal argument of the *Sanctity of Life* conception and it is the more general basis of the international protection of life and prohibition of homicide. As it has been seen, the religious version does not lend itself to arguing for euthanasic behaviours in secular democracies to be made punishable by law. As Dworkin states in *Life Dominion*, "we know however, that the idea that human life is

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intent on earth" and mainly in Jewish and Christian, the notion of "self" is "expressed in the idea that humans are distinctively in the "image of God".

[37] Courtney S. Campbell, *Religion and moral meaning in bioethics.* Hastings Centre Report, July- August 1990.

[38] Robin Gill et al., *Euthanasia and the churches.* Christian ethics in dialogue, Cassel,1998.

[39] Ibidem 38.

[40] For an in-depth study of this issue, see for example, Hans Küng and Walter Jens. *Dying with Dignity: A Plea for Personal Responsibility*, New York, Continuum, 1995 and ibid 38.

[41] Ibidem 12, p 195.

sacred is both more complex, and more open to different and competing interpretations, than its religious use sometimes acknowledges, and we can construct other interpretations of that idea that ground more liberal attitudes towards euthanasia[42]".

The secular belief that human life has an intrinsic value, belief shared by most of us, does not lead in all occasions to anti-euthanasia positions. If it is agreed that human life is inviolable but at the same time its inviolability is not attributed to a divine gift or property, we will then agree that human life is intrinsically valuable and the nature or the persons are responsible of the decisions concerning human lives. For secular ethics, without any reference to religious transcendence, liberty in enhanced as the last point of reference, substituting God as a final horizon. From a non-religious perspective, death and suffering can be conceived as a non-sense, which do not have to be imposed. It is convenient to introduce at this stage the distinction observed by Dworkin, as well as other modern philosophers, between different sources of contribution to human life, namely the *human investment* and the *natural investment*. The relative value attributed to one or the other contribution will lead us to different positions towards AVE. If an absolute dominance is given to the *natural investment* in comparison with the importance accorded to the *human investment*, the result is a total opposition to the practice of euthanasia. This is not however a very common position, as Dworkin advances: "Even people who accept the dominance of the natural investment of life (...) may nevertheless disagree that euthanasia inevitably frustrates nature. They may plausibly believe that prolonging the life of a patient who is riddled with disease or no longer conscious does nothing to help realize the natural wonder of a human life, that nature's purposes are not served when plastic, suction, and chemistry keep a heart beating in a lifeless, mindless body, a heart that nature, on its own, would have stilled. That is a less conservative view because it denies that biological death always cheats nature"[43]. There is then a third position that gives relatively more importance to the *human contribution* than to the *natural investment*. This leads to the acceptance of relative if not absolute autonomy of human beings and therefore to the right to decide on issues concerning the end-of-life. In these cases, it is not wrong to affirm that the *Sanctity of Life* argument leads to pro-euthanasia positions. We can therefore join

[42] Ibidem 12, p 215.
[43] Ibidem 12, p 214.

Dworkin, when he concludes that "the question posed by euthanasia is not whether the sanctity of life should yield to some other value, like humanity or compassion, but how life's sanctity should be understood and respected."[44]

Moreover, despite the intrinsic value of life, some ways of shattering lives are not illegal. Killings justified by wars and the death penalty are two examples of exceptions that are sometimes allowed. How can an absolute value know exceptions? And, even more striking, how can voluntary deaths be forbidden as exceptions and non-voluntary ones recognised?

The Slippery Slope

The *slippery slope* argument is another of the central arguments forwarded by opponents to legalisation. While some authors have considered it as a weak argument[45], others maintain that its disproval is not easy. Here again, before dealing with the nature of the argument itself, a precision has to be made. While the argument is often treated as a whole or compact one, sometimes a distinction is made between the *conceptual* and the *empirical* aspects of the argument, which are often conceived of themselves as two different arguments[46]. We will adopt this distinction with the aim of assuring maximal accuracy.

The *slippery slope* argument forms part of the so-called "doom watcher arguments" and although the supporters of such arguments consider that there are some circumstances in which allowing an individual to die can be morally admissible, they do not believe a law could implement and control such precise circumstances effectively. On consesquencialist grounds, the arguments basically presuppose that if we take a step A (with which we morally agree), we shall be inevitably led to take steps B and C (with

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[44] Ibidem 12, p 217.

[45] "In fact, the very frequency with which such arguments have been deployed can seem almost a point against them" in R.G. Frey, *The fear of a slippery slope* in Gerald Dworkin, R.G. Frey and Sissela Bok, *Euthanasia and Physician-Assisted Suicide, For and Against.* Cambridge University Press, 1998. "Elementary logic textbooks have often listed *slippery slope* arguments as fallacies"; "Logicians usually regard these types of arguments as very weak" in Walter Wright, *Historical analogies, slippery slopes, and the question of euthanasia.* "Journal of law, medicine & ethics", 2000.

[46] For example, ibidem 13, part II, 7 and Rob Schwitters, *Slipping into normality? Some reflections on Slippery Slope* in Albert Klijn, Margaret Otlowski and Margo Trappenburg (eds.), *Regulating physician-negotiated death,* "Journal of the Dutch / Flemish Association for Socio-Legal Studies", 2001.

which we completely disagree). Usually, *slippery slopes* are known for being constructed upon a chain-basis that includes more than one stage (in this case, B and C). The desire to avoid such projected future consequences (B and C) provides adequate reasons for not taking the first step. In other words and as Wright defines such kind of arguments, "Typically, the *slippery slope* arguments claim that endorsing some premise, doing some action or adopting some policy will lead to some definite outcome that is generally judged to be wrong or bad. The *slope* is *slippery* because there are claimed to be no plausible halting points between the initial commitment to a premise, action or policy and the resultant bad outcome."[47] Applied to PAS and AVE, the *slippery slope* argument would imply that accepting PAS or AVE – A - (with which we could morally agree) would lead us progressively to perform AIE – B - and finally NVE – C - (with which we would never agree).

The *conceptual* aspect of the argument is based on the affirmation that it is impossible to maintain PAS and AVE inside the established limits of a given society and avoid its expansion, on the ground of the argument of the similarity in justification. The limits between accepted situations and non-accepted situations would unavoidably become blurred. Let us imagine a society where PAS and AVE are legalised. Strict safeguards are established and one of them is the requirement of an "unbearable suffering". Who settles the limits between an "unbearable suffering" and a "bearable but very hard suffering" that leads the person to desire death? Furthermore, why should a person feeling "unbearable suffering" have the right to decide to put an end to his or her life whether a person feeling "bearable but very hard suffering" could not exercise the same right, considering that the basis of the legalisation is the notion of *autonomy?* These very difficult *grey zones*, where the moral basis appears to be the same but the legal solution is different, leave the supporters of this argument to conclude that, if taken, the first step would inevitably expand through these *grey zones* to a second and third step. This would overall happen in societies in which legal changes are due to an *adjudication system*, that admits much more case by case nuances than a *legalisation system.*

[47] Walter Wright, Historical *analogies, slippery slopes, and the question of Euthanasia.* "Journal of Law, Medicine and Ethics", summer 2000.

On the other hand, the *empirical* aspect of the argument deals with the safeguards a society has to frame to limit the access to death. The argument holds the practical impossibility to frame and enforce safeguards to prevent the slide. How could a society make sure that the will of a PAS or AVE request is not marred? For example, how can we be sure that the request is not due to a situation of depression or to social pressures? How can we make sure that the most vulnerable will not be particularly affected? The supporters of such a version of the *slope* cannot conceive a society where these guidelines are not abused and therefore prefer to avoid establishing them in order not to slide towards involuntary deaths justified by a legal order.

One of the major criticisms that can be claimed against the *conceptual* argument is that the use of the argument of the similarity in justification is misused in this case. According to the proponents, as the principle of autonomy and the feeling of compassion would be the moral basis to allow AVE or PAS, these same moral grounds could be applied to perform gradually IVE or NVE, disregarding the safeguards that a society should be expected to establish in order to avoid the slide (ex. compassion could be alleged to kill people that have not asked to die, and so on). However this similarity in justification does not hold. As Frey writes, "similarity of justification does not operate willy-nilly, in complete disregard of differences between cases[48]". Namely, because the premise of the slippery slope is that safeguards or guidelines would exist. And therefore the strict respect of these safeguards would permit us to avoid descending the slope. The only way it could happen would be through the relaxation and weakening of the required criteria (blurring of the limits of the meaning of concepts like "competent", "will"...) but this weakening process can always be controlled.

Another major criticism holds in the following inconsistency: "the arguments for extending euthanasia to the incompetent could find ample support from international law; the guarantees of non-discrimination in the International Covenant on Civil and Political Rights (ICCPR) are likely to be affected adversely by legalising voluntary euthanasia for the competent". In other words, it is better to forbid the access to a peaceful death to the people that would fulfil the requirements framed by a responsible society (because there are also people that would like to ask for it but cannot because

[48] R.G. Frey, *The fear of a slippery slope* in ibidem 45, pp. 50-51.

they cannot express it) and therefore everyone that would like to die cannot, than allowing the ones that can express their will because it would create an inadmissible discrimination (between those able to express their will and those unable).

Besides, we can agree that the proponents of this argument defend the existence of restrictions to the autonomy of those who fulfil the requirements and have requested PAS or AVE in order to avoid the possibility of killing people that would not want to die. However, the death penalty or deaths at war are not forbidden in many countries despite the existence of the irreversible problem of killing an innocent person. Why when in perfect clear cases, when there is a defined and repeated will to die, all kinds of palliative care and anti-depression treatments have been used, individual requests are proved to be disconnected from any external pressure, it is reprehensible, according to *Slippery Slopes theories* to kill people, whether in involuntary killings this argument does not seem to arise? Why is the fear of killing innocent people so big in those cases, whereas in other cases it does not seem to raise concerns?

The non allowance of PAS and AVE legalisation would favour and perpetuate a general situation where PAS and AVE are performed clandestinely. However the legal threat is, we all agree that clandestine practices take place. Despite the moral disagreement that should be felt towards the conditions in which those practices are sometimes forced to take place, nobody among the holders of this argument seems to worry about the death of people that do not wish it and the possible discriminations, when these practices take place on the fringes of law. Why, if in the first case, the proponents of the *conceptual slippery slope* resort to a catastrophist thought, does nobody take into account where the non-regulation of PAS and AVE can lead us, considering that the circumstances in which the patients and the doctors perform it give an enormous margin of action to immorality and discrimination, due to the lack of control.

Regarding the *empirical* argument of the *slippery slope,* the limelight is the impossibility of framing and enforcing control measures or safeguards. However, as Frey says, "Merely to fear the failure of safeguards is not itself to show the failure of any particular one[49]". According a majority of proponents, the current social reality in

[49] R.G. Frey, *The fear of a slippery slope* in ibidem 45, pp. 51-52.

most of the countries could not guarantee the correct application of the medical and legal safeguards (indeed, problems such as the lack or the bad application of anti-depression treatments and the social inequalities in the access to treatments would prevent due respect of the guidelines). However, accepting that today's social reality in most of the countries under consideration would not allow a perfect application of the conditions does not imply that we cannot reach, with efforts, a situation where the safeguards can be fully respected. "There is nothing about the empirical difficulties (...) that of necessity defies either human ingenuity to address or guidelines to prohibit". "Put differently, this sociological case for why we are doomed to slide down the slope of taking life if we legalise PAS points to empirical or practical difficulties of the sort that, in other areas of life, we meet with empirical or practical solutions. Why is this sort of response simply beyond us when it is PAS that is in question? After all, when we turn to cases of killing that involve the criminal law, we demand quite a bit to show that a killing was a justified one, but no one really believes that because we allow that there can be justified killings in law, our society has reached anarchy or a state of nature. Again, no one really thinks that we should deny any and all claims of a justified killing because we think from the outset that we are doomed to fail in being able to devise, establish, and enforce restrictions on what can be a proper case of justified killing.[50]"

Other social risks

a) *Changes in the physician-patient relationship*

Some authors raise important concerns referring to the changes in the physician-patient relationship that would arise from the legalisation of AVE and PAS. Some have qualified it as "one of the most compelling reasons to oppose euthanasia"[51]. The basic allegation lays on the assumption of the physician as a person unconditionally devoted to respect for the life of its patients. Patients rely on doctors to be cured and physicians are there to protect the patient's well-being[52] and not to make judgments about the

[50] R.G. Frey, *The fear of a slippery slope* in ibidem 45, pp. 51-52.
[51] Nancy W. Dickey, *Euthanasia: a concept whose time has come?* "Issues in Law and Medicine", Spring, 1993. See also, Henk Jochemsen, *The legalization of euthanasia in The Netherlands,* "Ethics and Medicine", vol. 17, number 2, 2001.
[52] Even if most do not swear any more the Hippocratic Oath ("I will follow that system for the benefice of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to

quality and the value of one's life. Therefore, the ability of physicians to perform killings, would transform the social perception of the medical profession. The trust patients place in physicians would be inevitably affected. It has been therefore said that "the separation of killing and curing is an important social differentiation and that it is the duty of society to protect the physician from requests to kill.[53]"

Another cause for concern relating to the physician-patient relationship is the worry that physicians that do not want to perform AVE or PAS would feel pressured to either perform it themselves or refer to a colleague. "If they refuse both they may run into trouble unless they have indicated in an early stage of the terminal phase of the disease that they object to performing euthanasia. Furthermore, health care professionals who reject euthanasia will likely find it difficult to obtain jobs in certain areas of the health care field"[54]

Both these allegations are constructed upon mistaken grounds. Physicians are conceived as persons in charge of assuring patient's well-being and this is a commonly agreed assertion. However, they are also committed in the task of relieving the patient's sufferings[55]. This last commitment can, in certain situations in which the well-being cannot be improved, be the moral basis helping the performance of AVE and PAS. However, physicians will only perform AVE or PAS in concrete cases, in accordance with the safeguards framed. Therefore, the feeling that the abilities of killing and curing of a same person would lead to the general mistrust towards the medical profession lacks of a basis. Besides, the argument that relates to the pressure that could be felt by physicians that oppose and therefore would not like to perform AVE or PAS, is an untenable thesis since any legislation legalising AVE or PAS should underline that physicians are not obliged to perform it[56]. The possible marginalisation of opponent doctors does not constitute a sufficient argument to forbid the legalisation.

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any one if asked, nor suggest any such counsel"), according to these purposes, patients still believe necessity of avoiding death at any cost.

[53] Margaret Mead, quoted in ibidem 51.

[54] Henk Jochemsen, ibidem 51.

[55] The progressive adjudicative permission of AVE in The Netherlands laid on the grounds of an existing "conflict of duties" of the physicians: on the one hand the duty to obey the law that forbid AVE and PAS (art. 40 Penal Code) and in the other hand the duty to alleviate suffering that lead to consider the performance as a "force majeure in an emergency situation" (major precedent, Alkmaar case, 1984).

[56] See the example of the Dutch legislation.

b) *Non further development of palliative cares*

It has furthermore been asserted that the reduction of investments, efforts and creativity would constitute one of the unintended outcomes of the legalisation. Once euthanasia legally settled, research on palliative cares[57] as alternative methods of preventing and alleviating pain would be undermined. Those declarations are often based on utilitarist conceptions of the health-care system and argue that the increasing costs and the need to make choices regarding resource allocation would lead to a growing performance of AVE and PAS.

c) *Economic discrimination*

It has been pointed out that a process of legalisation would inevitably have negative outcomes regarding discrimination between social classes. According to the proponents of this argument the legalisation of AVE and PAS would imply an easy way to discard those unable to assume the costs of palliative cares, discriminating them in relation to those who have health insurances and other means of access to alternative cares at their disposal. This would indeed lead to an intolerable discrimination among society. The problem is not new and the relation between social classes and access to health care has

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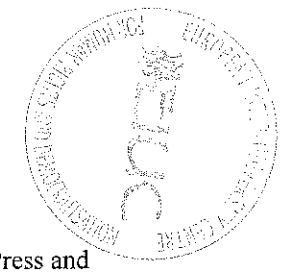
[57] Palliative care understood as defined by the WHO, as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

See, http://www.who.int/cancer/palliative/definition/en/

been the object of many studies. "There is considerable evidence to suggest that the hardening of inequalities between people in recent years has been accompanied by a widening of inequalities in health"[58]. As the ethical aspects of the AVE and PAS legalisation are the object of the present study, the more technical economical and medical aspects will not be tackled. These growing inequalities are morally reprehensible, but would this discrimination take place in the performance of AVE and PAS? Without willing to take a complete naive stand, and affirming that the economical discrimination in health-care is a highly worrying problem towards which implementation programs have to be enforced, the logical consequence of legalising PAS and AVE does not lead us to such nefast behaviour. According to what has been said before, a legalisation would entail the framing and enforcement of a series of safeguards. Those safeguards should logically include the requirement of voluntariness. Therefore, PAS and AVE would not be performed to people not wishing to die, whatever their health state and their economic welfare would be. It has also been stated that the pressure felt by some patients when knowing the costs of their treatment would lead them to request AVE or PAS without really wishing it. For those problems of vitiated consent, psychological means would have to be considered by the guidelines established with the legalisation. As it has been said before, "There is nothing about the empirical difficulties (...) that of necessity defies either human ingenuity to address or guidelines to prohibit". Furthermore, the moral abhorrence of differences in the access of health care and the obligation to overcome it can be found in the Declaration on the promotion of patient's rights in Europe[59]. As a value: 1.6, "Everyone has the right to such protection of health as is afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health", and as a right: 5.1, "Everyone has the right to receive such health care as is appropriate to his or her health need, including preventive care and activities aimed at health promotion. Services should be continuously available and accessible to all equitably, without discrimination and according to the financial, human and material resources which can be made available in a given society".



[58] Ellen Annandale, *The sociology of Health and Medicine. A critical Introduction.* Polity Press and Blackwell Publishers, 1998.
[59] Ibidem 5.

2. Main arguments in favour of legalisation.

Autonomy or self-determination

The value of *autonomy* has traditionally been posed as antithetical to the *sanctity of life.* While new trends tenting to reconcile both views have arisen at the heart of the Christian Community (see, *Sanctity of Life)*, most of scholars find the opposition insurmountable. *Autonomy* rejects any consideration attributing the dominion of human life to superior authorities and holds that the human being, as the holder of rights and duties, is the final determinant of his or her destiny. Therefore, every person has the right to control his or her life as long as it does not interfere with the rights of others. The elements of choice and control are central to this stance. One of the most known formulations of *autonomy* is from John Stuart Mill, who asserted "that the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to the others... Over himself, over his own body and mind the individual is sovereign"[60]. It derives from this vision that a legal prohibition concerning end-of-life decision would suppose an unjustifiable infringement to one's self-determination. Dworkin has qualified as follows: "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny"[61]. This conception of life presents itself as an *open position* which accommodates all attitudes concerning end-of-life decisions. In other words, there are no impositions: those who want to die can die and those who do not want do not have to request of AVE or PAS.

One of the main criticisms raised by opponents to this conception repose on the assertion that the defence of an absolute *autonomy* implies that any request of death has to be attended, regardless of reasons. As Otlowski says, "there would be no need objectively to examine quality of life considerations (...) the sole consideration should be the patient's choice, based on the patient's subjective assessment of his or her own circumstances whether motivated by fear or pain, suffering, dependency or other

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[60] Mary Warnock, *On liberty* in *Utilitarist, Essay on Bentham* 135, quoted in Kumar Amarasekara, *Autonomy, Paternalism and Discrimination: The Darker side of Euthanasia* in *Legal Visions of the 21st century: Essays in honour of judge Christopher Weeramantry,* The Hague, Kluwer International, 1998.
[61] Ibidem 12.

causes"[62]. Indeed, it seems that the adherence of a conception of *autonomy* as the unique moral foundation of the legalisation of AVE and PAS should imply that the performance of these practices should be available to all autonomous persons on request. No safeguards could delimitate the cases where PAS and AVE could be performed in a given society.

Furthermore, defendants of this view do not seem to be consistent with the deep meaning of autonomy, according to some opponent scholars. Accepting the implications of the concept of *autonomy*, a society should abstain from framing safeguards. However, most of the supporters of such a view, will agree with the necessity of establishing guarantees and guidelines for an appropriate performance. Here, the criticisms of paternalism raised by the supporters of AVE and PAS to the opponents (cf. Criticisms to *Sanctity of Life*), will be used in the opposite sense. Why establish safeguards if autonomy does not require them, but on the contrary, rejects them? According to what values are those safeguards settled? As Amarasekara states, "the paternalism that underpins AVE is subtle (...) it exploits the notion of autonomy to justify but imposes many restrictions on carrying out that request. That curtailment of freedom is justified on the basis of a need to install safeguards, but it illustrates the impracticality of basing AVE on patient autonomy"[63].

It has also been reproached that defendant positions of *autonomy* are selfish in the sense that societal implications are not taken into account. According to the opponents, the *autonomy* argument implies that "my life is mine, and therefore, putting an end to it does not have to generate consequences in any one else than me". Amarasekara points out that "it is inaccurate (...) to argue that legalisation merely provides relief for the suffering patient and has no effect on the community", and gives four examples of groups of persons potentially affected by such practices: 1) the sensibilities by those who oppose AVE and PAS on religious, ethical, legal or professional grounds would be affected; 2) the institutions or individuals who are opposed but will see themselves compelled to perform it will find decriminalisation irksome; 3) those who will want to remove the burden they suppose to their families will feel a pressure provoked by

[62] Margaret Otlowski, *Voluntary Euthanasia and the Common Law,* Oxford, Oxford University Press, 2000.
[63] Ibidem 60.

legalisation; 4) those who put pressure on the sick patient because AVE and PAS have been legalised will form the last group. Therefore, the self-regarding feature that proponents of legalisation seem to defend is alleged to be, by the opponents, a misconceived argument. However, if it is true that the legalisation of such practices is not a matter of one person, and that it has social repercussions, it is also true that the moral shock that some critics could undergo does not constitute a sufficient argument for the maintenance of prohibiting laws. As it has also been said, the moral impact under pressure of the feelings that some patients could feel as a consequence of the allowance of such practices should be controlled by the safeguards established in a responsible society.

Discrimination is the last of the main arguments raised against this conception of human life. The fact that allowing the performance of AVE or PAS to patients on the basis of *autonomy* grounds would imply denying it to the incompetent ill-persons because of their inability to express their will. This constitutes, according to the critics, a morally unacceptable discrimination that arises against all Human Rights international instruments[64]

The right for patients to refuse treatment

Most of the major detractors of AVE and PAS have accepted the morality of the refusal of treatment by a patient in concrete circumstances. The Encyclical Letter *Evangelium Vitae*, expressing the position of the Roman Catholic Church, has accepted the possibility of renouncing a treatment, "when death is clearly imminent and inevitable". According to their magisterium it is allowed to "refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted." In the same way, Keown states, "While denying that it could be ever be right for a patient to judge that his life was no longer worth living, they – opponents of VAE, to whom he belongs- would defend the patient's right to judge whether a proposed treatment would be beneficial, as for example by improving the quality of his life. In determining whether a proposed treatment would involve excessive burdens to a particular patient, the views of the

[64] See ibidem 60.

patient are clearly crucial. People differ, for example, in their ability to tolerate pain, and what may be excessively painful for one patient may not be so for another" (...) "Choices by patients which promote the good of health therefore merit respect and it is reasonable to allow patients considerable leeway, given the considerable variation between patients, in deciding what treatments they would find too onerous". This moral consensus around the refusal of treatment (although some groups support it only in cases of the necessity of using "disproportionate and extraordinary means"), lead to regulations all over the world permitting such refusals. In Europe, the Declaration on patient's rights[65], is noteworthy as a synopsis of the national legislations[66]. There is therefore a normative asymmetry between the right to refuse a treatment and the right to AVE and PAS. According to Dworkin, the supporters of the asymmetry argue three main arguments that justify it: 1/ argumental lines based on the nature of medicine, the medical profession and its rules; 2/ the existence of an important moral difference in the consequences of both attitudes; 3/ a moral difference in the intentionality and/or causality between treatment refusal and AVE and PAS. As it has been seen, the arguments lying on the nature of medicine and holding that medical rules forbid a physician to act with the intention of killing or helping a patient to die, are refutable. A tension can arise between the two major commitments of doctors, not killing and alleviating suffering. In case of "conflict of duties", physicians should be allowed to perform AVE or PAS, on the ground of the latter commitment. Besides, it is argued that treatment refusal does not imply any intention of killing from the doctor; it is also argued that, on the contrary, that performing AVE and PAS implies intentionality and the cause of the death is deliberately due to the physician action and these are the grounds of a moral difference. The withdrawal of the tubes holding one's life or permitting the patient's alimentation or breathing is considered as a form of treatment refusal once the treatment has began. There are normally two acts in this action: the administration of sedatives - that normally accompanies the withdrawal - and the withdrawal itself. While the first intends to alleviate the pain, the latter intends to bring the death to the patient. "To be prepared to see the patient dead; to take the step that will ensue to be assuredly produce death; to know as a certainty that death will ensue or be hastened: is this not morally equivalent to intending the patient's death? If so, then there

[65] Ibidem 5.
[66] Article 3, consent / 3.2. "A patient has the right to refuse or to halt a medical intervention. The implications of refusing or halting such an intervention must be carefully explained to the patient".

is little difference here between the supply of pills and the withdrawal of feeding tubes, so far as intending the patient's death is concerned. If one is permissible, why not the other?" It has been tried to prove that those arguments do not hold. If achieved, then, normative asymmetry is invalid.

The right to commit suicide

Although for centuries banned, suicide has known during this last century a general process of decriminalisation. European societies, for different reasons, do no longer consider it any more a criminal offence "There has been a similar change of social attitudes to suicide, once a criminal offence. Now we respect a person's choice to take their own life and avoid making value judgements about them."[67] While the general wave of depenalisations can be due to practical issues such as imputability concerns, it is nonetheless as well a proof of the end of its moral disapproval. However, *Sanctity of Life* views still refuse the morality of this behaviour, for reasons that have already been commented[68]. Most critics of the criminalisation of AVE and PAS advance analogical arguments with suicide to conclude the inconsistency of prohibiting laws. If a human being does have the right to take its own life, he or she should be able to ask for help to perform it when disabled or ill.

It has been however pointed out that the legal tolerance or allowance to commit suicide does not constitute a right but can only be conceived as a liberty, in the sense that it is not legally punishable but there is no provision that recognises it. Despite this nuance, the absence of threat to morality of the first act is either arguable for the second one. Here again the opponents allude to the inconsistency of establishing safeguards. If the analogy holds, and both depenalisations are based on the principle of *autonomy*, then autonomy should not been restricted through series of conditions to meet, in case of AVE and PAS, as it happens with suicide. But this criticism can be overcome. If the request of AVE and PAS reflect an inner will to die, it is due to the suffering provoked by an illness and to the impossibility of improvement. As it has been seen, a conflict

[67] Parliamentary Assembly. Council of Europe, Doc. 9898, ibidem 4.
[68] For example, the traditional opposition of the Roman Catholic Church, expressed by Augustine and others, and more recently confirmed by the Council Vatican II, as "whatever is opposed to life itself, such as any type of murder, genocide, abortion, euthanasia or wilful self-destruction (...) all these things and others of their like are infamies indeed", ibidem 27.

between autonomy and life is faced again. If there were medical hopes of improvement in the illness' evolution, certainly, the will to die would see an end. The framing of safeguards is consistent in the sense that it solves the tension between life and autonomy. If there is no hope of improvement, then autonomy should definitely prevail. When there are serious medical reasons to alleviate suffering and put an end or reduce the effects of the illness, the protection of the life should prevail. Therefore, the restrictions to *autonomy* settled for AVE and PAS do not invalidate the analogical argument with suicide.

Prevention of cruelty

The prevention of cruelty arises as one more argument in defence of legalisation of AVE and PAS. This argument presents the need of alleviating pain and prevents cruel harms as a moral duty. However, other moral duties can be opposed to it, as the duty of physicians to safe lives. Therefore it can be established a potential conflict between these two moral duties. As the Epilogue of the Dutch Remmelink report states, "there are situations in which life is only suffering, suffering that only ceases when life ceases". "Medicine should fight death, but not at all costs. Physicians should not act as medical Don Quixotes"[69]

Formalisation of current practices and end of legal hypocrisies

Other well-known arguments that defend the necessity of legalisation repose on the need of security and control of the practices that nowadays take place in clandestinity and the abolition of legal hypocrisies through the legal recognition of realities. Indeed, it is a worldwide known fact that AVE and PAS are practices performed all around the world, in particular in western societies, where autonomy is conceived as a characteristic value. The simple legal prohibition does not prevent societies from performing it. The consequence is a situation in where the performance is not regulated and often tolerated[70]. The undesirable outcome is a general situation of insecurity and potential abuses. A regulation with established safeguards would undoubtedly bring

[69] Ibidem 1.
[70] Steering Committee of Bioethics (CDBI) of the Council of Europe, *Replies to the questionnaire for Member States relating Euthanasia*, 20 January 2003. http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia.

about security while removing the practices from secrecy. Besides, legalisation would bring coherency between society's realities and its legislation. Laws should be the reflection of the morality of a given society. Considering the expansion of the performance of AVE and PAS and the related expansion of societal acceptance and extended support, a morally correct legal order should avoid hypocrisies while establishing a framework to prevent abuses. Although this argument can be submitted to criticisms alleging its very practical nature, it is still valid, overall if combined with the rest of arguments sustaining legalisation.

Conclusion

After having briefly reviewed the main arguments forwarded by both opponents and supporters of the legalisation of AVE and PAS, and analysed their weaknesses, the stance of this work should be précised. Life arises as an original fundamental value, without which autonomy would not exist. Autonomy is however the element that gives meaning to life, from a secular approach. Both are fundamental values that have to be protected. And none is absolute[71]. During life, autonomy does not often provoke conflicts with life itself. However, it sometimes does. One situation in which those values are confronted is when end-of-life decisions have to be taken. Sometimes autonomy will entail curtailments to life; sometimes life will entail curtailments to autonomy. When terrible sufferings or impossibility of an illness to improve, the action of autonomy should be recognised, as in the cases of refusal of treatment, as a morally accepted curtailment to life. Human life is enough full of sufferings and pain; it seems immoral to impose sufferings that can be avoided, overall once a person request for a life relief. As it is mentioned in the Remmelink Report[72], "there are situations in which life is only suffering, suffering that only ceases when life ceases". Respecting any kind of religious approach to life, we however conceive that a legislation that pretends to embrace citizens from any belief has to detach itself from religious considerations. Everyone should choose according to his or her own beliefs, in the frame settled by the state, frame that should be enough large to respect different positions, in particular in this very sensitive matters of spiritual character. But, then, abuses have to be controlled.

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[71] The protection of life knows exceptions (self-defence, war…) and the principle of autonomy has restrictions due to societal life (collision and harm to other's rights...).
[72] Ibidem 1.

As it has been said, autonomy is here conceived as a non-absolute concept, however of the utmost value. If autonomy is often restricted through daily societal obligations, it can also be restricted in this case, to prevent abuses. Therefore, the framing of a series of safeguards is not inconsistent with the fundamental value of autonomy. Discrimination cannot be claimed when framing conditions as the consent of the patient. Discrimination takes place when equality is not granted to two equivalent cases. It is not the case between competent and incompetent persons. Besides, all efforts have to be made in order to reach health care systems able to provide the best respect to safeguards, including obviously, the abolishment of any discrimination in the access to treatments. Palliative care has to be given a major role in new medical educational levels and research in this field is of the major importance. AVE, PAS and palliative care do not have to be conceived as antithetical concepts, but as complementary. AVE/ PAS will take place when palliative care is not successful. Furthermore, a system of legalization of AVE and PAS would permit an important coherency between reality and law while allowing transparency- eradicating secrecy- and security.

"Once again, the critical question is whether a decent society will choose coercion or responsibility, whether it will seek to impose a collective judgment on matters of the most profound spiritual character on everyone, or whether it will allow and ask its citizens to make the most central, personality-defining judgments about their own lives for themselves"[73]

[73] Ibidem 12, p 216.

I. Global Legal Situation among Council of Europe Member states.

Although international comparative studies on practices and attitudes towards AVE/ PAS are lacking[74], a broad comparative enquiry has been carried out by Dr. Michael Abrams at the request of the Steering Committee of Bioethics (CDBI[75]) of the Council of Europe. The replies to the questionnaire relating AVE /PAS were made public on the 20th January 2003, while the related report elaborated by the expert remains a private possession of the CDBI[76].

The results of the questionnaire reveal an almost generalised prohibition of AVE and PAS, throughout the whole continental Europe.

AVE

Yes	2	-	The Netherlands **(The Termination of Life on Request and Assisted Suicide (Review Procedures) Act**
		-	Belgium**: nearly. Future law, "Proposed law relating to euthanasia".(approved)**

[74] Ibidem 2, p 132. The most known studies carried up until now are generally limited in their territorial scope (e.g. the Netherlands (Paul.J. Van der Maas et al., ibidem 1; Paul.J. Van der Maas et al. *Euthanasia and other medical decisions concerning the end of life,* "The Lancet", 14 September 1991; Paul.J. Van der Maas et al., *Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001,* "The Lancet", vol. 362, 2 August 2003), Flanders, Belgium (Luc Deliens et al., ibidem 8) and Australia (Helga Kuhse, ibidem 8.).)

[75] CDBI, Comité Directeur pour la Bioéthique/ Steering Committee on Bioethics, ibidem 70.

[76] Ibidem 4, III, par. 15

No	**Mentioned in legislation**[77]	*14*	- *Croatia* ***(Penal Code - 1997. Code of ethics – 1996)*** - *Denmark* ***(Legislation: Act on patients' legal rights and entitlements in Denmark and the Danish Criminal Act. The Danish legislation only makes passive euthanasia possible.)*** - *Georgia* ***(Law of Georgia on "Health Care", art. 151: "Medical Personnel, as well as any other person are prohibited to accomplish euthanasia, or participate in it".*** - *Germany* - *Greece* ***(Mentioned indirectly, art. 300 Penal Code)*** - *Hungary* ***(Code of Ethics of the Hungarian Medical Chamber; but "The application of terminal palliative medicine - which is not identical with passive euthanasia - is allowed in certain circumstances. The objective of this medicine is to relieve the physical and mental suffering of the terminally ill patient reaching the final state. The medical doctor, after due consideration, proposes appropriate treatment as well as the non-application of ineffective therapy. Palliative terminal medicine cannot be applied without the informed consent of the patient or his/her relative.")*** - *Ireland* ***(The medical Council Guidelines preclude Euthanasia)*** - *Norway* ***(Under the Norwegian Penal Code section 236 it is prohibited to assist someone who wants to take his or her own life, and this kind of assistance is punishable as complicity in murder. According to section 235 the punishment may be reduced or given a more lenient form, if someone motivated by compassion has killed or assisted in the killing of a terminally ill person.)*** - *Russia* ***(Federal Law "Fundamentals of Legislation of the Russian Federation on Protection of Citizens' Health")*** - *San Marino* ***(Article 150 of the Penal Code 'Homicide on request')*** - *Slovenia* ***(Criminal Code; Code of Medical Ethics and Deontology)*** - *Switzerland* ***(Swiss penal code and medico-ethical directives on the medical care of patients at the final stages of life or suffering from extreme mental disturbances. AVE is not possible, while indirect active euthanasia and passive euthanasia (ASSM Directives) are possible.*** - *United Kingdom* ***(In <u>England & Wales</u>, murder is a common law offence. In the medical setting, R v Cox (1992) confirmed that if a medical professional carried out an action with the intention of ending life, whether or not for compassionate reasons or at the patient's request, this would constitute murder. In <u>Scotland</u> murder is also a common law offence.)*** - *Italy (The only binding legal provision on that matter is the Penal Code. The following articles are more directly connected to the question of euthanasia. Art. 579 (unlawful killing of a consenting party).*

[77] "Legislation" is understood in this context in a broad sense, embracing therefore instruments such as ethical codes, guidelines…

Not Mentioned in legislation	*18*	- *Cyprus* ***(There are no laws that permit Euthanasia, active Euthanasia, passive Euthanasia or assisted Dying. The article 218 of the Criminal Code (amendment) Law 46/1982 prohibits assisted suicide.)***
		- *Czech Republic* ***(There is no use and no definition of the term euthanasia in the current Czech legislation. The current legislation addresses the above mentioned situations in the terms of malefaction or homicide / active euthanasia/ or misprision or insufficient care /passive euthanasia and withholding of life sustaining care/. The term "assisted suicide" is clearly defined by current Czech legislation as "a intentional help a person to terminate his or her life at his or her request" and according to Czech Penal Law is considered to be a crime with possible criminal sanction of imprisonment in the length of 6 month to 3 years.).***
		- *Estonia*
		- *Finland*
		- *France (The prohibition of euthanasia is currently sanctioned by the provisions of the criminal code relating to voluntary homicide even though it is not a specific crime. The specific reserve by the French legislation with respect to the field in which the debate relating to euthanasia is developing is thus not equivalent to an absence of a limiting framework)*
		- *Latvia*
		- *Lithuania*
		- *Luxembourg* ***(The penal code does not specifically address euthanasia. This issue should be considered as coming under the chapter relating to homicide in the penal code.)***
		- *Malta*
		- *Poland* ***(Legal provisions and regulations making euthanasia possible do not exist. Actions of euthanasia constitute a criminal offence (homicide).)***
		- *Portugal* ***(There is only the Criminal Code. However, voluntary euthanasia is covered by Article 134° (homicide at the request of the patient; punishes the perpetrator with 1 to 5 years of prison) and involuntary euthanasia (euthanasia by compassion) is covered in Article 133° (from 1 to 5 years). Both have a sentence much lower than for homicide (from 8 to 16 years) and qualified homicide (from 12 to 25 years).)***
		- *Romania*
		- *Slovakia* ***(No special legislation concerning euthanasia exists in the Slovak Republic. Such practices are outlawed, however, by the existing provisions of the Penal Law (Law No. 141/1961 as later amended). Euthanasia would be considered under this law as taking of an innocent human life (i.e. as a murder; § 219), and/or as not providing necessary professional (life-saving) help, and this way not honouring important professional obligations on the part of the physician or other health professional (§ 224).)***
		- *Spain*
		- *Sweden*
		- *Turkey*
		- *Albania*
		- *Bulgaria*
No answer	*9*	- *Andorra*
		- *Armenia*
		- *Austria*
		- *Azerbaijan*
		- *Iceland*
		- *Liechtenstein*
		- *Moldova*
		- *The former "Yugoslav Republic of Macedonia"*
		- *Ukraine*
Actual members not members at the time of the questionnaire	*2*	- *Bosnia- Herzegovina* - *Serbia and Montenegro*

The table is a reconstruction of the information issued from the replies to questions 4[78] and 5 to the questionnaire relating to Euthanasia prepared by the Steering Committee in Bioethics of the Council of Europe (http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia). Canada and the U.S.A have been excluded from our analysis as they just have an observer status.

PAS

Yes	4	- Estonia - Luxembourg **(Assisted suicide is no more regulated than euthanasia. Since suicide is**

[78] Ibidem 70: Question 4. Do laws relating to euthanasia exist? , 4.a) What is the nature of these regulations (legislation, case-law, custom, ethics…), 4.b) Please give the name or title of the legislation. Question 5. Does the legislation, regulations or other provisions make euthanasia possible?

			not a penal offence, the "accomplice" of a suicide is not prosecuted either, under the condition that the provisions sanctioning the non-assistance of persons in danger are applied.) - The Netherlands - Switzerland **(Yes, if the author is not driven by a selfish motive (cf. Article 115 CPS e contrario)**
No	**Mentioned in legislation**	*16*	*- Croatia **(Penal Code, art. 96)*** *- Cyprus **(Criminal Code (amendment) Law 46/1982, article 218)*** *- Czech Republic* *- Denmark **(The Danish Criminal Act.)*** *- Germany **(Criminal Code)*** *- Greece **(art. 301 Penal Code)*** *- Hungary* *- Norway **(Under the Norwegian Penal Code section 236 it is prohibited to assist someone who wants to take his or her own life, and this kind of assistance is punishable as complicity in murder. According to section 235 the punishment may be reduced or given a more lenient form, if someone motivated by compassion has killed or assisted in the killing of a terminally ill person.)*** *- Portugal* *- San Marino **(art. 151 Penal Code)*** *- Slovakia* *- Slovenia* *- Spain* *- United Kingdom **(Suicide Act 1961:Section 2(1)*** *- **Albania*** *- **France***
	Not mentioned in legislation	*11*	*- Belgium* *- Georgia* *- Ireland* *- Latvia* *- Malta* *- Poland* *- Romania* *- Sweden* *- Turkey* *-Finland* *- Italy*
No answer		*12*	*- Andorra* *- Armenia* *- Austria* *-Azerbaijan* *- Iceland* *- Liechtenstein* *- The former Yugoslav Republic of Macedonia* *- Moldova* *- Ukraine* *- Bulgaria* *-Lithuania* *- Russia*
Actual members not members at the time of the questionnaire		*2*	*- Bosnia-Herzegovina* *- Serbia and Montenegro*

The table is a reconstruction of the information issued from the replies to questions 8[79] and 9 to the questionnaire relating to Euthanasia prepared by the Steering Committee in Bioethics of the Council of Europe (http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia). Canada and the U.S.A have been excluded from our analysis as they just enjoy an observer status.

Despite the questionable quality of the answers to the questionnaire, that turns the enquiry into an incomplete tool of work, the general assertion that an almost totality of the countries forbid practices such as AVE is undeniable. At the time of the

[79] Ibidem 70: Question 8. Do laws relating to assisted suicide exist?, 8.a) What is the nature of these regulations (legislation, case-law, custom, code of ethics...)?, 8.b) Please give the name or title of the legislation, regulations or other provisions. Question 9. Does the legislation, regulations or other provisions make assisted suicide possible.

questionnaire, only the Netherlands had a legal framework that allowed AVE[80]. Belgium announced in the enquiry the imminence of a legal change that would install a framework of permissiveness, provided that the House of Representatives voted-on the proposed law adopted by the Senate on the 25th October 2001. The "Proposed law relating to euthanasia" was finally approved by the Chamber of Deputies and entered into force on the 23rd September, 2002[81].

The same statement is applicable to PAS. Although more member states (4) seem to allow PAS than AVE, they represent however an obvious minority compared to those that have opted for restrictive legislations (at least 23).

However this generalised ban, some considerations are worthy of attention.

1) Judicial tolerance

Notwithstanding the generalised tendency towards prohibitive legislations, there is an almost as clear inclination towards the non-application of the existing criminal sanctions among the countries of the Council of Europe. According to the replies to questions 6.b)[82] and 10.b)[83] it can be asserted that the general practice is to avoid criminal sentences for those accused of performing these practices. As Víctor Méndez Baiges affirms[84], there is a "general line of growth of the state tolerance towards some conducts related with the process of dying (...) that have become apparent in almost all the occidental world during the twentieth century. Rare have been the cases during this century in which the tribunals have imposed significant sentences to those accused of

[80] *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, entered into force on the 1st April 2002. This new law, formalising previous case-law decisions, includes an amendment to article 293 of the Penal Code, provided that established due care criteria are respected. For more information, see John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia & Law in the Netherlands,* Amsterdam University Press, Amsterdam, 1998; Heleen Weyers, *Euthanasia: the process of legal change in The Netherlands. The making of the "requirements of careful practice"* in Albert Klijn, Margaret Otlowski and Margo Trappenburg (eds.), *Regulating Physician-Negotiated Death,* "Journal of the Dutch/Flemish Association for Socio-Legal Studies", ed. by A. Klijn, M. Otlowski and M. Trappenburg, Elsevier, 2001.

[81] For more information, see Parliamentary Assembly. Council of Europe, Doc. 9898, ibidem 4, IV, *The new belgian legislation* and Maurice Adams, *Euthanasia: The process of Legal Change in Belgium. Reflections on the parliamentary debate* in Albert Klijn, Margaret Otlowski and Margo Trappenburg (eds.) *Regulating Physician-Negotiated Death.* "Journal of the Dutch/Flemish Association for Socio-Legal Studies", Elsevier, 2001.

[82] Ibidem 70: concerning AVE, 6. a) Do criminal sanctions exist? b) If so, have they ever been applied?

[83] Ibidem 70: concerning PAS, 10. a) Do criminal sanctions exist? b) If so, have they ever been applied?

[84] Ibidem 6, pp. 44-45. Author's translation.

causing or collaborating with the death of a seriously ill person at its request. If the list of euthanasia's famous cases is checked over, from the pioneer Stanislawa Uminska until the significant case of Timothy Quill, it can be confirmed that almost all of them are more related with judicial tolerance events that with intransigence events." Legalisation is not the only way to accept the performance of those practices. As Gerald Dworkin notes[85], "there are a variety of forms that institutionalisation might take" and one of the forms of institutionalisation is "1. Maintaining the status quo- where it is a crime- but explicitly or tacitly, encouraging prosecutors to exercise their discretion not to prosecute"[86]. The generalised judicial tolerance can be read as a shared tacit acceptance of the performance of those practices. As Méndez Baiges points out, "we could say that a sort of fear seems to go over the whole question of the legislation around the dying process. The principle of tolerance towards certain conducts, that prefers the non-application of some norms to its express derogation, that prefers not to legislate in order not to stimulate, seems to always impose itself to an express legislation in this matter[87]". It should nevertheless be borne in mind that in the Netherlands, an explicit legislation on those issues kept Dutch waiting almost twenty years; a prudent attitude that pretends things to adapt themselves through the years seems to be a general pattern. This generalised understanding with the participants in the performance of AVE and PAS entails however significantly risky consequences:

a) The primacy of law is inevitably and dangerously affected by this gap between positive rules and its application.
b) A system that ignore controls raises as the perfect scenario to carry out the performance of every kind of abuses, as it has been sustained in the first part of this work. (It should be taken into account that those existing harms are those against which non-legalising attitudes want to prevent from.)

As Dick Marty has summed up concisely, "Until very recently these practices have been illegal in most Council of Europe member states, although penal and professional

[85] Ibidem 45, p 65.
[86] The other measures mentioned by Dworkin are: "2.Maintaining the status quo, but allowing as a defence to a prosecution the defence of merciful motive. 3. Maintaining the status quo, but allowing consideration of motive to play a role with respect to sentencing. 4. Legalisation of physician-assisted suicide."
[87] Ibidem 6, p 49. Author's translation.

sanctions are extremely rare by comparison with the number of cases of euthanasia actually carried out. There is thus a striking divergence between the law and what happens in practice. This gap must be reconciled if respect for the rule of law is to be maintained.[88] »

2) Physician's alternatives.

Although AVE and PAS are the sole end-of life decisions tackled along this study, the existence of other physician-negotiated deaths should not be ignored. As Griffiths underlines from its experience in the Netherlands, which undoubtedly corresponds pretty much to most of modern western societies, "of these "physician-negotiated deaths", roughly 9 out of 10 are either due to abstention (refraining from or not initiating further life-prolonging treatment) or to pain relief in amounts likely to accelerate death. Only a small number of all deaths (in the Netherlands, 3.4%; in Belgium, 4.4%), are due to euthanasia, assistance with suicide, and termination of life without an explicit request." As Griffiths continue to remark, "to a considerable extent, a doctor can choose how to bring about a shortening of his patient's life and how to describe what it is that he has done. If one of the possibilities is unattractive for any reason, for example because it is illegal, he accomplishes the same result in another way or under a different name[89]."

3) Flight from public debate

As it can be read from the above tables, the rates of countries that do not have legislations that explicitly refer to AVE or PAS is highly significant. This lack of specific regulations of AVE and PAS and their generalised consideration as homicide, homicide on request, parricide[90]... is indicative of a deficient political and public debate in the respective countries. If a comprehensive public debate had taken place, a more accurate and specific regulation, in a sense or in another, would have been the result. It

[88] Parliamentary Assembly. Council of Europe, Doc. 9898, ibidem 4.
[89] John Griffiths *Comparative reflexions: Is the Dutch case Unique?* in *Regulating Physician-Negotiated Death,* Albert Klijn, Margaret Otlowski and Margo Trappenburg (eds.), "Journal of the Dutch/Flemish Association for Socio-Legal Studies", Elsevier, 2001, p 203.
[90] Ibidem 70, footnotes to questions 4 and 8; Miguel Ángel Núñez Paz, *Homicidio consentido, Eutanasia y Derecho a Morir con Dignidad,* Madrid, Tecnos, 1999, Capítulo II: Homicidio consentido y Eutanasia en el ámbito del Derecho Comparado; C. Roxin, F. Mantovani, J. Barquín, M. Olmedo, *Eutanasia y suicidio. Cuestiones dogmáticas y de Política Criminal,* Madrid, Comares, 2001.

can therefore be concluded that including those practices under general regulations clearly reflect the aim of avoiding to publicly confront such delicate issues, often considered a taboo. Furthermore, although some very familiar cases involving AVE and PAS raise from time to time, increasing public awareness momentarily, the existing judicial tolerance, the intention of preserving privacy and/or the impossibility of affording extended delays before the justice, do not contribute to intensify a social consciousness of the extent of those cases.

Related to this point, the inexistence of empirical studies carried out in a large scale is noteworthy. As the Marty Report remarks and the McNamara Report[91] accept, "empirical data on the rate of euthanasia, physician-assisted suicide, and other end-of-life decisions have greatly contributed to the debate about the role of such practices in modern healthcare[92]. ». As it has also been held, « Data from empirical and observational research on the occurrence and backgrounds of end-of-life decision-making have been introduced into the debate relatively recently. Ethical as well as legal and political reasoning can to a great extent benefit from empirical and observational data on epidemiological knowledge, such as the prevalence of end-of-life decisions and the clinical characteristics of the patients involved.[93] » Nonetheless, as it has already been noted, few are the serious and comprehensive studies carried out concerning those issues, among which Van der Maas, Deliens and Kuhse's studies are important due to its quality and to similar designs, which allow comparative studies between them[94]. Nonetheless this striking lack of investigations is one the one hand a manifestation of a probable will to avoid the confrontation with these uncomfortable issues and on the other hand a patent cause of the above-mentioned lack of public debate, as it will be discussed below.

2. Council of Europe's organs' position.

1) The Parliamentary Assembly and the Committee of Ministers.

[91] Parliamentary Assembly. Council of Europe, Parliamentary Assembly. Council of Europe, Doc. 9923. Euthanasia. Committee on Legal Affairs and Human Rights, rapporteur: Mr. Kevin McNamara, United Kingdom, Socialist Group.
[92] Parliamentary Assembly. Council of Europe, Doc. 9898, ibidem 4.
[93] Ibidem 2.
[94] In the Netherlands (Paul.J. Van der Maas et al., ibidem 1 and ibidem 74), in Flanders, Belgium (Luc Deliens et al., ibidem 8) and in Australia (Helga Kuhse, ibidem 8).

Since relatively early years, the Parliamentary Assembly of the Council of Europe has dealt with end-of-life decisions encouraged by the Committee on Social, Health and Family questions in the framework of the harmonisation of the criteria regarding the sick and dying. The firsts results at the Parliamentary Assembly on those issues are *Recommendation 779 (1976) on the rights of the sick and dying*[95] and *Resolution 613 (1976) on the rights of the sick and dying*[96]. Basing their *raison d'être* on the threats that the progress of medical sciences poses to the integrity and dignity of sick people, they mainly deal with the problem of *aggressive medical treatment*, affirming the importance of the opinion of the sick and their right not to undergo useless and painful prolongations of life. Two considerations should be pointed out regarding those regulations. While focusing on the prolongation of life problem, in the *Recommendation 779 (1976)* the Assembly clarifies its position towards AVE and PAS through its consideration 7: "Considering that the doctor must make every effort to alleviate suffering, and that he has no right, even in cases which appear to him to be desperate, intentionally to hasten the natural course of death". However this clear statement, the *Recommendation* also underlines the importance of the relief of sufferings[97], argument that will be used in other forum to disprove the prohibition of performing AVE and PAS [98]. For more than a decade, initiatives will be left to the European Health Committee and the Ad Hoc Committee of Bioethics, without major events or changes. It is not until 1999 that the Parliamentary Assembly will issue a key statement about end-of-life decisions, on the basis of Mrs. Gatterer report. Recommendation 1418 (1999) *on the protection of the human rights and dignity of the terminally ill and the dying*[99], adopts as cornerstone the arguments and propositions brought together under the Report on the

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[95] Recommendation 779 (1976) *on the rights of the sick and dying*. Assembly debate on 28 January (23rd sitting) (see Doc. 3699, report of the Committee on Social and Health questions). Text adopted by the Assembly on 29 January 1976 (24th sitting)

[96] Resolution 613 (1976) *on the rights of the sick and dying*. Assembly debate on 28 January (23rd sitting) (see Doc. 3699, report of the Committee on Social and Health questions). Text adopted by the Assembly on 29 January 1976 (24th sitting)

[97] "6. Convinced that the duty of the medical profession is to serve mankind, to protect health, to treat sickness and injury, *and to relieve suffering*, with respect for human life and the human person and convinced that the prolongation of life should not in itself constitute the exclusive aim of medical practice, *which must be concerned equally with the relief of suffering*".

[98] See ibidem 55, "conflict of duties" in the Dutch process of legalisation.

[99] Recommendation 1418 (1999) *on the Protection of the human rights and dignity of the terminally ill and the dying*. Assembly debate on 25 June 1999 (24th sitting) (see Doc. 8421, report of the Social, Health and Family Affairs Committee, rapporteur: Mrs. Gatterer; and Doc. 8454, opinion of the Committee on Legal Affairs and Human Rights, rapporteur: Mr. McNamara). Text adopted by the Assembly on 25 June 1999 (24th sitting).

on the protection of the human rights and dignity of the terminally ill and the dying[100], elaborated by the Committee of Social, Health and Family questions as a reaffirmation of the Assembly's position towards AVE and PAS. After calling upon the member states to provide in domestic law the necessary legal and social protection against the threats caused by the developments of medical sciences, the Assembly recommends the encouragement of member states to respect and protect the dignity of terminally ill and dying through: 1) the recognition of protection of a right to palliative care, 2) the protection of self-determination and 3) *the maintenance of the prohibition against intentionally taking the life of terminally ill or dying persons*[101]. A double-step reaction will characterise the Committee of Ministers' reply to this Recommendation. While in a first moment, through an interim reply[102], the Committee of Ministers will limit itself to inform the Assembly by noting that legal positions concerning euthanasia differ from one member state to another, and by reporting the terms of reference given to the Steering Committees on Bioethics and for Human Rights to gather relevant information, in its definitive statement[103], the Committee will carry out an in-depth analysis of the issue. Despite the unconvincing reasoning of the Committee, the conclusion of its assessment is rather clear: its agreement with Resolution 1418 (1999).

However those unchanging official positions, the debate on euthanasia has continued and the Committee on Social, Health and Family questions has carried out an innovative report[104] that, should it be approved as Recommendation or Resolution, would entail a significant change of direction in those organs' approach to the issue. The Marty

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[100] Parliamentary Assembly. Council of Europe, Doc. 8421. Report of the Social, Health and Family Affairs Committee, rapporteur: Mrs. Gatterer, Austria, 21 mai 1999.

[101] It seems that a difference between the English and the French version of this document should be noted. While the point 9.c) of the Recommendation in its French version refers to an "*interdiction absolue* de mettre intentionnellement fin à la vie des maladies incurables et des mourants", the English version allude to respect and protect the dignity of the terminally ill or dying persons "by upholding *the prohibition* against intentionally taking the life of terminally ill or dying persons". The French version, therefore, seem to place a reinforced emphasis in the prohibition.

[102] Doc. 8888. 7 November 2000. Reply from the Committee of Ministers. *Protection of the human rights and dignity of the terminally ill and the dying.* Adopted at he 728th meeting of the Ministers' Deputies (30 October 2000).

[103] Doc. 9404. 8 April 2002. Reply from the Committee of Ministers. *Protection of the human rights and dignity of the terminally ill and the dying.* Adopted at the 790th meeting of the Ministers' Deputies (26 March 2002).

[104] Parliamentary Assembly. Council of Europe, Doc. 9898, ibidem 4. The Social, Health and Family affairs Committee's document is highly questioned by the M. McNamara's report, in Doc. 9923 (ibidem 92).

Report, which discussion at the heart of the Assembly has recently been postponed[105], invites the member states to carry out empirical analysis on end-of-life decisions, encourages them to stimulate a public debate in order to achieve as much transparency as possible, cheers them to promote a comparative analysis of the previous results and a discussion in the framework of the Council of Europe and finally incites them to consider the possibility, at the view of the results of the empirical analysis and considering the previous experiences of The Netherlands and Belgium, of envisaging the introduction of measures aiming to exempt the practice of AVE and PAS from criminal sentences under certain conditions.

2) The European Court of Human Rights (ECtHR)

Despite the European Court of Human Rights (hereinafter referred as ECtHR) has not yet dealt with the specific question of AVE and PAS, as it has been repeatedly recalled[106], a relatively recent high profile case concerning end-of-life decisions has aroused passions all over the Continent and is convenient analysing for this work purpose. *Pretty v. the United Kingdom*[107] shows the tenacity of Diane Pretty, a forty-three years old women suffering from motor neurone disease ("MND"), to challenge the English Suicide Act of 1961.

Knowing that "MND" was a progressive neuro-degenerative disease that would gradually cause a muscular weakness that would affect the voluntary muscles of the body and would finally attains to the control of the breathing, Mrs. Pretty wanted to avoid reaching a state marked by unbearable pain and indignity, due to the asymmetry between her physical and mental capabilities. As the ECtHR stresses in the facts of the case, "the final stages of the disease are exceedingly distressing and undignified". No treatments are effective against it. Those were the reasons why Mrs. Pretty wanted her husband to help her in dying before reaching such terminal stage, due the fact that she would not be able to do by herself. The English Suicide Act from 1961 prevented however such an action through the prohibition to assist others to commit suicide,

[105] Its discussion has been postponed during the second period of sessions. For further information see: www.coe.org.search.workingmaterial

[106] In, e.g., ibidem 103, "Since, as yet there is no case-law of the Court which could provide precise answers to all the questions raised in the Recommendation (referring Recommendation 1418 (1999), (...)".

[107] *Pretty v. United Kingdom,* Application No. 2346/02, April 29, 2002.

provided in its section 2(1). Pretty and her lawyers went through all the local remedies, from writing to the Public Prosecutor[108] to the House of Lords, asking for an undertaking not to prosecute her husband should he assist her to achieve her request. Her application was however dismissed at all national levels, what brought Pretty to sue the United Kingdom before the Strasbourg authorities, where the ECtHR validated in last resort the House's of Lords judgment by unanimity.

The *Pretty case* has attempted to challenge the prohibition of assisting suicide in the United Kingdom through the defy of proving the violation of articles 2, 3, 9 and 8 of the European Convention on Human Rights. A violation of article 14 was as well alleged but will however not be tackled in this study due to the non-independent nature of the protected right.

Concerning the violation of article 2.

"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 taken for the purpose of quelling a riot or insurrection."

In spite of the applicant's more than reasonable submission, mainly holding that article 2 "protected the right to life and not life itself, while the sentence concerning deprivation of life was directed towards protecting individuals from third parties, namely the State and Public authorities, not from themselves"[109], the limited scope that the Strasbourg case-law has been ascribing to article 2 is notorious. While the right basically entails negative obligations that essentially rest on the duty of the state not to interfere with one's life, the ECtHR has however recognised the existence of positive duties[110]. Though, as the Court stresses, the "consistent emphasis in all article 2 cases

[108] Under 2(4) of the Act, proceedings may only be instituted for the offence under 2(1) by or with the consent of the Director of Public Prosecutions.
[109] Par. 35
[110] Some positive obligations referred by the Court are the establishment of effective criminal-law provisions (*L.C.B v. the United Kingdom,* Application No. 23413/94, 9 June 1998.) and even the establishment of preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual (*Osman v. the United Kingdom,* Application No. 23452/94, 28 October

had been the obligation of the state to protect life; there was nothing to suggest the provision was concerned with issues to do with quality of living or what a person chooses to do with his or her life[111]". This argument, based on the precedent, underlines, as Morris notes, "the conservative interpretation of the right to life thus has a remarkably long pedigree" [112]. However as this past-relying motivation is legally insufficient, the main argument held by the Court in order not to consider the possibility to broaden the extent of article 2 should be specified. The accordance of "pre-eminence to article 2 as one of the most fundamental provisions of the Convention" and the strict list of circumstances under which an exception to the right can be justified- long-established list that should be modified in case of accepting one's will as a justifiable cause- seems to be the *prima ratio* for the Court not to consider the applicant's submission. The amendment of these exceptions, that have repeatedly been considered as "exhaustive" by the Court, appears to be the reason at the basis of the ECtHR's decision. Furthermore, although ambiguous, there are some signs of the Court's embracing of *Sanctity of Life* stances, manifested through its assertion in the context of article 8, "Without in any way negating the principle of sanctity of life protected under the Convention (...). This view could therefore also be a ground for such a restrictive conception of article 2. However, its position in the judgement, in the context of article 8 and the lack of any mention in article 2's analysis are indications of a possible compromise solution. Although the conservative position of the Court is highly debatable, its assessment is perfectly coherent in terms of legal precedents.

Concerning the violation of article 3.

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment"

The defence of Mrs. Pretty took article 3 of the ECHR as a focal point in its legal fight against the United Kingdom. While considering the terminal stage of sufferings as a degrading treatment, the applicant recognised the natural origin of her suffering and therefore stressed the lack of direct responsibility of the Government in this sense. She

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1998, *Keenan v. the United Kingdom,* Application No. 27229/95, 3 April 2001.) For further information, conferee to C. Ovey and R.C. White, *The European Convention on Human Rights,* Oxford University Press, 2002.

[111] Par. 39

[112] Dan Morris, *Assisted Suicide under the European Convention on Human Rights: a Critique,* "European Human Rights Law Review", Issue 1, 2003.

however insisted on the existence of recognised positive obligations related to article 3 of the Convention, and based her reasoning on the precedent *D. v. the United Kingdom*[113].Furthermore, the consideration of article 3 as a fundamental and absolute-term conceived right permits her to underline the disproportionate character of the English ban. Agreeing with the applicant on the fundamental character of the right and on its non-derogability (through any particular list of exceptions or via article 15), the Court nonetheless makes use of a reasonably logical argumentation to dismiss Pretty's submissions. On the first hand, though the article at stake was primarily conceived as imposing a negative obligation to refrain from inflicting such intentional and aberrant acts to State agents or public authorities (and most of the cases involving article 3 fitted with this pattern), the Court recognises "has reserved to itself sufficient flexibility to address the application of that article in other situations that might arise"[114]. This "flexibility" has lead to recognise a positive obligation to protect from inhuman or degrading treatments when inflicted between private individuals[115] and in cases in which the health and life of individuals deprived of liberty has been at stake[116]. According to the Court, "the suffering which flows from naturally occurring illness, physical or mental, may be covered by article 3 *where it is or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible"*[117]. In Mrs. Pretty's case, the recognition of a state responsibility would have entailed that the State sanction actions intended to terminate life, what 1) would be unlawful according to the Court's understanding of article 2 and, 2) would imply a potentially dangerous extension of the construction of the concept of treatment, that would go "beyond the ordinary meaning of the word". It should be therefore said that despite its link and reference to the limited understanding of article 2, the Court reasoning is difficultly questionable.

Concerning the violation of article 9.

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[113] *D. v. the United Kingdom,* 1997. The case challenged the envisaged deportation of a drug courier suffering from AIDS at its latest stages. The deportation would have entailed the end of his treatment's pursuance, being therefore considered by the Court as a breach of article 3.
[114] Par. 50.
[115] e.g. *A v. the United Kingdom,* Application No. 25599/94, 23 September 1998.
; *Z and others v. the United Kingdom,* Application No. 29392/95, 10 May 2001.
[116] e.g. *Keenan v. the United Kingdom,* Application No. 27229/95, 3 April 2001.

[117] Par. 52.

"1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in a community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others."

As it has been pointed out, article 9 establishes two different rights upon in which individuals in member states rely, the right to believe ("to freedom of thought, conscience and religion") and the right to be free to manifest those beliefs[118]. Mrs. Pretty, in alleging article 9, intended to demonstrate the violation of the second of those rights through the state prohibition of carrying out the "practice" of what she believed in (assisted suicide). However, as it had been indicated previously by the Commission in the case *Arrowsmith v. the United Kingdom*[119] and recalled in the present case by the Court, the term "practice" as employed in article 9.1 does not cover each act which is motivated or influenced by a religion or belief" and it is logical to conceive limits to what people intend to do in the name of their personal convictions[120]. Here again, the Court's analysis appears to be reasonable and coherent with its previous judgements and interpretation of article 2.

Concerning the violation of article 8.

"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of morals, or for the protection of the rights and freedoms of others."

The Court has gone further away that in the previous analysis in the recognition of interferences by the British Government with article 8 of the ECHR. It is therefore worthwhile to revise particularly thoroughly the scope and the limits of the article, specifically of the "right to respect for his private (...) life[121]", and its controversial

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[118] D. Harris et al., *Law of the European Convention on Human Rights,* Butterworths, London, 1995, p. 360, quoted in ibidem 112, p 73.

[119] *Arrowsmith v. the United Kingdom.*

[120] History and actuality can provide us with multiple examples of aberrant acts committed under a supposedly religious *raison d'être*, practice or observance.

[121] It is worthy to note the particularity of article 8, sole provision conceived in terms of "respect for" formulation. As Harris and Morris observe, "if the intention of the drafters of the Convention in choosing the "respect for" formulation was to suggest a rather weak right, the Strasbourg authorities have taken a

application to the case. Dan Morris's comprehensive article on this issue will be a major guide throughout the whole analysis[122].

a) Applicability

The concept of "private life" in the framework of the article 8 of the Convention has often been qualified as "a broad term not susceptible to exhaustive definition"[123]. It can therefore be though that the Court has avoided giving a comprehensive analysis of the content of such a ubiquitous right. One of the main reasons leading to this option, as it has been conceded in the *Marckx v. Belgium* judgement[124], is probably related to the fact that the Court intends to recognise and protect the interests by the right to respect for private life as and when they are required by the civic life, its progressive social ideals and changing perceptions. Furthermore, it has often been evoked that the Convention is a "living instrument (...) that must be interpreted in the light of present-day conditions[125]". The lack of definition is not however total, since the Court has been pointing out, through the years, different spheres that she has considered embraced by the respect for private life. Indeed, as Ovey and White[126] remark and the Court recalls[127], three major facets of the right to private life have, until now, been acknowledged by the Strasbourg authorities: the first facet would include aspects of physical and social identity, the second would refer to aspects of personal development and the third would concern the right to establish and develop relationships with other human beings and the outside world. It is upon the second of those components, the personal development[128], that Mrs. Pretty's claim was based on, due to her argument supporting the idea that dying was a part of life and determining one's own death was pretty much a matter of developing one's personality. The Court understood Mrs. Pretty's submission as a possible interference with this aspect of the right protected

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quite different view (... and) have interpreted the notion of "respect" as imposing positive obligations upon the states". Ibidem 118, p 360, quoted in ibidem 112.

[122] Ibidem 112.

[123] Par. 61.

[124] *Marckx v. Belgium,* Application No. 6833/74, 13 June 1979.

[125] *Tyrer v. the United Kingdom,* Application No, 5856/72, 25 April 1978.

[126] C. Ovey and R.C. White, ibidem 110.

[127] Par. 62.

[128] For further information concerning the formation of the three-sphere-construction of the right for respect for private life, and for definitions on the meaning given by the Commission (Brüggerman and Scheuten v. Germany) and by the Court (Botta v. Italy) to the personality development facet, see ibidem 112.

under article 8: "The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under article 8 (1)[129]".

b) Justification

The recognition of an interference with Mrs. Pretty's right for private live is not however a sufficient allegation to conclude on the violation of article 8 by the United Kingdom's government, but the first step of the analysis. Indeed, the diptych structure of the article, built in two paragraphs- as the provisions in articles 9, 10 and 11- allows the possibility of justifying interferences and turning them into legitimate intrusions. The state's margin of appreciation is therefore the key element in this second-step process; the Court can only assess its proportionality, supervising whether the justifications respect the reasonability test.

The interference has to comply with the second paragraph's three-step test: be lawful, be necessary in a democratic society and be for the purpose of a legitimated aim. While the measure is provided in article 2(1) of the Suicide Act 1961, having therefore "some basis in domestic law", it also fulfils the jurisprudential requirements related to this lawfulness test, namely, accessibility[130] and precision[131] conditions. Besides, the requirement of pursuing a legitimate aim of those listed in the article is equally satisfied, as the Government has specified its intention of protecting the "rights and freedoms of others", specifically the elderly and vulnerable. The compliance of those two conditions is not thus controversial. On the contrary, the "necessity in a democratic society" condition is much more difficult to attest and the Court's examination of this point is clearly questionable.

As the Court established in the controversial *Handyside v. the United Kingdom* case, to be "necessary in a democratic society" basically implies the existence of a "pressing social need" that justifies the measure, measure that has to be "proportionate to the legitimate aim pursued". Is the ban settled by article 2(1) of the Suicide Act 1961

[129] Par. 67.
[130] "adequately accesible", for further information, see C. Ovey and R.C.White, ibidem 110.
[131] "formulated with sufficient precision", for further information, see C. Ovey and R.C.White, ibidem 110.

"necessary in a democratic society"? Despite the inherent difficulties of a proportionality examination in certain cases, due to the absence of a normative reasoning, there are definite factors and principles which inform Strasbourg thinking in this area. In the following assessment of the proportionality of such a measure, the arguments used by Morris will be utterly followed, as they perfectly express the stance of this work.

a) the "hallmarks" of a democratic society

The hallmarks of a "democratic society", as the Court perceives it, have often been recalled and summed up as "pluralism", "tolerance" and "broadmindedness"[132]. Hence, although individual interest must on occasion be subordinated to those of the group, democracy does not imply that the views of the majority must always prevail. The right to assistance in suicide need not to be acceptable to everyone within a society.

b) the importance of the contended right

The relative importance of the contended right is a key factor in order to analyse the extent of a Government's margin of appreciation. The more essential the aspect of the right is, the less the authorities can be intrusive in it. The Court's statement in the *Dudgeon v. the United Kingdom* case- where the legislation establishing a blanket ban on homosexual activity was at stake- is illustrative and interesting for the present case: "The present case concerns a most intimate aspect of private life. Accordingly, there must exist particularly serious reasons before interferences on the part of the public authorities can be legitimate for the purposes of paragraph 2[133]". Therefore, if it is maintained, as this work does, that dying is a part of life, that it is an exceptionally important to our personal development and, as Dworkin suggests, "peculiarly significant event in the narrative of our lives, like the final scene of a play with everything about it intensified under a special spotlight[134]", we can then conclude that its level of intimacy is comparable to the one under consideration in the *Dudgeon's*

[132] *Handyside v. the United Kingdom,* Application No. 5493/72, 7 December 1976.

[133] *Dudgeon v. the United Kingdom,* Application No. 7525/76, 24 February 1983.

[134] Ibidem 12, p 209.

affair. If the dying process is not to be recognised as an essential element of the personality aspect of the right to respect for private life, then, "the personality right degenerates into something less valuable. Essentially it becomes a collection of related, but separate entitlements to self-expression, which when combined together never amount to anything more than their totality. But this contradicts everything which the Strasbourg institutions have ever said about the protection of personality under article 8. The view taken by them is that the various recognised interests do go to something more. The reason that article 8 protects individual identity, and sexuality, and physical and ethical integrity is not because these things are good in themselves, but because they are essential components of the idea of self-definition and personality *as a whole.*[135]" The logical inference that follows this argumentation is that the Government had a very narrow margin to intervene and its burden to justify the intrusion was significant.

c) the state interest to be protected

As it has been already said, the reason alleged by the Government to maintain the Suicide Act's ban reposes on the aim to protect the "rights and freedoms of others", which basically refers to the potential margin of abuse threatening the sick and elderly that a permissive legislation would entail. This is directly related to the *Slippery Slope* argument that has been, from an ethical point of view, at length considered in the first part of this work. Before tackling a brief empirical approach to this problem, it should be asked, until what point is this threat a real a worrying one and until what extent has the Government of the United Kingdom proved the reality of the threat. Concerning this issue it should be bear in mind that "the proportionality requirement is not satisfied where the government does not provide evidence to show that the claim of necessity (is) made out[136]". *Slippery Slope* arguments have pretended to find in the results of the recent studies carried out in The Netherlands[137] an empirical basis to reaffirm their fears. The findings of the surveys[138] establishing 0.7% in 1995 and 0.6% of deaths without patient's explicit request (according to the interviews) and 0,8% in 1990, 0.7%

[135] Ibidem 112, p 82.
[136] Ibidem 118 quoted in ibidem 112.
[137] Paul J. Van der Maas et. al, *Euthanasia and other medical decisions concerning the end of life* and *Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001,* ibidem 74.
[138] Paul J. Van der Maas et al., Euthanasia *and other end-of-life decisions in the Netherlands in 1990, 1995, and 200,* ibidem 74.

in 1995 and 0.7% in 2001 (according to the death-certificate studies) are adopted by opponents to legalisation as an empirical proof of the reality of *Slippery Slopes'* threats[139]. However, the authors of the studies deny those attitudes, while pointing out after 1995's survey: "obviously our data provide no conclusive evidence in either direction. Five years may be too short a period in which to observe important cultural changes, and our results may be valid only in the context of Dutch culture and the Dutch health care system... Nevertheless, in our view, these data do not support the idea that physicians in the Netherlands are moving down a slippery slope". "More generally, it seems pretty clear that many of the things to which opponents of legalising euthanasia point as the horribles to which legalisation will lead, in fact pre-existed legalisation in the Netherlands and are at least equally frequent in countries where it remains illegal, and if anything are under better control in the Netherlands than elsewhere. In short, there is no *post hoc* here.[140]" In any case the data resulting from the surveys would alert anyone if the authors' correlative explication of the statistics is obviated. It is fundamental to read the results at the light of their clarification in order to avoid misinterpretations. As Morris sums up, "In the 1991 study, for example, the authors note that in more than half of the cases where there was apparently no explicit request, the decision *had*, in fact, been discussed with the patient and the patient *had* in a previous phase of his illness expressed a wish for euthanasia should suffering become unbearable; in the other cases, possibly with a few exceptions, the patients were near to death and clearly suffering grievously, yet verbal contact had become impossible. The decision to hasten death was then nearly always taken after consultation with the family, nurses, or one or more colleagues". We do not have to forget that we basically ignore the rates of ending-of-life decisions without the express request of the patient in countries where those practices are illegal. However, Kuhse's comment concerning the rates in Australia (3.5%), where the practices remain illegal, should be borne in mind: "our study undermines suggestions that the rate at which doctors intentionally end patient's lives without an explicit request is higher in a country where euthanasia is practised openly (as the Netherlands) than in a comparable country which has not allowed euthanasia"[141].

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[139] Henk Jochemsen and John Keown, *Voluntary euthanasia under control? Further empirical evidence from the Netherlands,* "Journal of medical ethics", vol.25, 1999.
[140] Ibidem 89.

[141] Helga Kuhse, ibidem 8.

d) the specificity of the interference

Any interference should, if it is to be justifiable under the second paragraph, specifically address the threat to the state interest adverted to. Therefore, if the threat that justifies a Government's intrusion can be dealt with by less general means, it should do so. In the present case, any mean is less intrusive than a blanket ban, measure that avoids taking into account any specificity of the situation. As Morris has expressed, "the state need not have chosen the *absolutely* least intrusive means of meeting its objective. But it must at least have chosen from a *range* of means which impair the individual's right as little as at all possible"

e) the European consensus

The body of consensus among other members to the Convention concerning a certain issue has sometimes been used as an added factor to consider in a proportionality analysis, without having nonetheless a determining function. As it has been seen above, legal bans on AVE and PAS are the general rule. However, the existence of some permissive legal orders, the generalised judicial tolerance and the flight from public debate are significant factors to be taken into account.

It cannot better be concluded, as Morris does, that "whichever way the variables are arranged, in all cases the scales com down fairly heavily in favour of a determination that 2(1) is disproportionate. This is because of, first, the sheer weight of the importance of the contended right; second, the lack of any conclusive evidence that lifting the ban on assisted suicide would do harm to the vulnerable; third, the fact that even if there is a risk of this, the state may still guard against it by less general, less intrusive means than blanket prohibition; and fourth although there might be no consensus in favour of decriminalising assisted suicide, there certainly is no consensus in prohibiting it *in toto* either."

Despite Pretty's case (husband's assisted suicide) does not perfectly fit with our object of study (physician-assisted suicide), it however reveals the Strasbourg understanding of the related articles. Furthermore, the joint examination of the Council of Europe's

organs positions allows the grasping of their common and conservative stances regarding those issues. As it has been tried to evidence along this work, those postures are highly questionable. Should the Marty report be voted in future Parliamentary Assembly's sessions, those organs' traditional views could be renewed from the inside.

3. Future prospects and recommendations.

According to the general lines of the European backdrop that has been revised, Council of Europe's main organs seem reluctant to embrace end-of-life decisions (namely, AVE and PAS) in the sphere of human dignity and the rights that derive from it. On the contrary, European authorities appear to sustain visions tending to polarise those concepts as antithetic. However, a growing but still very modest wave of legalisation of AVE and/or PAS and a vast inclination towards judicial tolerance are also a reality in this European landscape. As Méndez Baiges has pointed out "(...) it is undeniable that, even in a timid form, legislation concerning the process of dying has known an evolution during these last years"[142]. Besides, although *Pretty v. the United Kingdom* does not definitely embody the decisive step in the direction of bringing those apparently antithetical concepts together, it nonetheless recognises the inclusion of end-of-life decisions in the right to private life's sphere. This opens the path to the Court to, whenever the first case of euthanasia or physician-assisted suicide will be presented before Strasbourg's authorities, consider revising its deficient balance of factors when assessing the proportionality of the interference- in the framework of article 8- and moving forward approaching dignity to end-of-life decisions. In the meantime, a serious and comprehensive "process of introspection" regarding practices and attitudes towards end-of-life decisions should be carried out at national/regional levels.

1) "Process of introspection"

As it has already been mentioned throughout this work, "data from empirical and observational research on the occurrence and backgrounds of end-of-life decision-making have been introduced into the debate relatively recently. Ethical as well as legal and political reasoning can to a great extent benefit from empirical and observational data on epidemiological knowledge, such as the prevalence of end-of-life decisions and

[142] Ibidem 6. Author's translation.

the clinical characteristics of the patients involved[143]". Without the realisation of serious state-instigated investigations such as those carried out in the Netherlands, Belgium or Australia, a proper approach to end-of-life issues cannot strike up. Blanket bans on those issues, underground activities and judicial tolerance... are factors that contribute to the current obscurantism. There is therefore a demanding need of implementation of serious "processes of introspection", that would comprise:

1. The realisation of serious and comprehensive national investigations. An appointed neutral commission that would lead the study as well as the full support from the Ministerial Department of Health, and other eventual Departments concerned, would be necessary. Full previous information on the extent and the motivations of the study from the Ministerial Departments to those concerned professional bodies would be convenient in order to avoid negative reactions and suspicious feelings. Furthermore, the protection of personal data rises as a fundamental key element of any valued research. Two purposes underline this need, namely, the protection of the privacy of all the participants to the enquiry and the security and quality of the obtained data. Indeed, it is essential to guarantee immunity concerning the information given for the investigation purposes to physicians, nurses and relatives of the deceased in order not to entail legal consequences; protection of data of the deceased is either necessary so as to protect both their right to privacy and their relatives and physicians' immunity. Besides, the degree of veracity and transparency of the obtained results will be unquestionably more accurate if protected by such a data protection system, overall considering that the majority of the Council of Europe member states do have prohibitive legal systems, despite the judicial tolerance that they generally practice.

2. The carrying out of such a study would allow an insight into the extent and nature of the practices, lifting therefore the existing taboos on the issue. A triple awareness would subsequently take place: social, medical and political awareness and a triple involvement would be highly desirable.

[143] Ibidem 2.

3. The public debate could therefore start with reliable information to be based on.

4. From a general point of view, this could be considered as a truth revealing exercise, making public what is really taking place in a given society. Probably, although this should be confirmed by the data resulting from the investigations, the proportion of underground abuses would appear to be higher than expected and a general awareness on the need to control such abuses would therefore rise. Two alternatives would then be available, the strengthening of criminal prosecutions on the one hand, and the establishment of a liberalised legal framework, allowing the performance of AVE and PAS when some conditions are met and establishing therefore a strict control system (*a priori, a posteriori,* or both)

Instead of remaining into the current obscurantism concerning the extent and nature of end-of-life practices or waiting for the appropriate political moment to bring about a legislative change concerning those end-of-life decisions without any prior social reflection and awareness, it is especially desirable to start such an "introspection process" in the name of honesty. However, supposing that a sufficient social, medical and political awareness intended to bring about a legal change inclined towards legalisation subjected to certain substantive and procedural conditions, would such a legal transformation work out in any of the Council of Europe member states? Are there necessary social requirements or other premises to settle down a rather unproblematic liberalising regulation? Is Dutch model exportable?

2) Exportability of the Dutch model?

It has often been suggested that the Dutch experience concerning the legalisation of AVE and PAS has been and remain unique and is difficult to be repeated in the circumstances of other countries, even in similar western modern societies. Whether legalising such medical practices in other countries would prove to be such as uncontroversial and unproblematic as in the Netherlands has been tried to be analysed by some experts, among whose Griffiths' assessment[144] is of particular value given its

[144] John Griffiths et al., ibidem 89 and 80, chapter *7.2. Is euthanasia law exportable?*

deep familiarity with the Dutch experience and its features[145]. The Dutch experience has been characterised, along with a lengthy process that has lead to the legal positivation of medical established and jurisprudentially accepted standards[146], by the concurrence of particular social features. The Dutch model is not however the result of a combination of absolutely unique and particular Dutch features but, as Griffiths has attempted to discern, a combination of *"Definitely Not Unique[147]"* features to the Dutch situation, *"Arguably Special[148]"* characteristics about the Netherlands and *"Definitely Unique"* elements of that country. The first group of characteristics, namely the *Definitely Not Unique* ones, correspond, according to Griffiths to the following:

1. modern medicine's ability "artificially" to postpone death long beyond the point at which there is any chance of recovery;
2. increasingly frequent requests by dying patients and those close to them that their doctor help them to put an end in a humane and dignified way to such a situation of medically postponed-death;
3. increasing cultural acceptance of the idea of autonomy of the patient, reflecting itself both in law (e.g. the doctrine of informed consent; recognition of advanced directives) and in medical practice (e.g. the practice of informing a patient of his terminal condition);
4. a modern health care-system in which medical care at the end of life does not impose severe financial burdens on patients and their families;
5. strong support in public opinion for legalisation of euthanasia;
6. strong support among doctors for legalisation of euthanasia
7. a widespread medical practice both of euthanasia and of related ways of shortening the patient's life, such an abstention of pain relief;
8. the presence of "moral entrepreneurs": key individuals promoting legal change.

The *"Arguably Special"* characteristics about the Netherlands can be summed up through the following features:

1. an emphasis on toleration, compromise, practical solutions to morally controversial issues and a general distrust of absolute, ideological positions on public issues;

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[145] John Griffiths, ibidem 80.
[146] For details on the process, see John Griffiths, ibidem 80, chapter *2, Legal Change 1945-1997* and Heleen Weyers, ibidem 80.
[147] Ibidem 89, p 198.
[148] Ibidem 89, p 199.

2. a commitment to social equality and "democracy" (which in Dutch parlance is more than a governmental form and includes broadly the right to have a say in decisions affecting one's life, work, living situation), to social security (reflected in a comprehensive welfare state), and to individualism (not so much in the American sense of "every man for himself" but rather in the sense that everyone is personally responsible for making choices about his life, which ought in principle to be respected by others);
3. ideologically "open" politics, given to inclusive rather than exclusive ways of dealing with radical and potentially threatening ideas or groups, and a political elite inclined not no resist social change but to incorporate it within the existing social and legal structures;
4. a stable multi-party system in which a modest number of nationally-significant parties are, as a result of electoral proportional representation, more or less permanently represented in parliament, none of them with an absolute majority; pressure groups or ideologies can usually "capture" at most one of these parties; political decision-making is necessarily a matter of compromise;
5. a tradition of decentralised decision-making authority and of looking to self-governing groups (such as professional associations) as sources of social control over the activities of their members.

The concurrence of these factors is highly desirable in order to count with an atmosphere prone to a legal change; however, the key aspect- according to Griffiths- that is *particularly unique* and relevant in the legalisation process and its commented success is the active involvement of the medical profession and the importance of its self-regulation[149]. As Griffiths has expressed it, "a medical profession whose leadership took the lead in promoting legalisation of euthanasia and accepted primary responsibility for working out the substantive and procedural conditions under which euthanasia is acceptable". In Belgium instead, the legalisation process has followed a radically different process. Instigated and fully carried out from the top, an important legislative change excluding the Christian-democrats from the government, as it had been the case in the Netherlands, settled down the appropriate conditions for the

[149] For further information concerning the Medical involvement in the process, see Heleen Weyers, ibidem 80, 4. *The contribution of Medical Profession.*

approval of the legalisation law[150]. In a similar society, although much more marked by societal and political influence of catholic thinking[151], the legal change has taken place without the medical profession involved in it. However, its evolution is less likely to be as unproblematic as in its neighbour country. As Maurice Adams notes in its analysis on the process of legal change in Belgium[152], "the absence of the medical profession in the political discussion on euthanasia has been very striking" and as Mortier and Deliens conclude, "there is little organised professional support for the new legislative proposal, although a large number of individual physicians are in favour of the new law as well as of legal control. Legal reform, although necessary, will probably be insufficient to achieve effective control of active life ending not to mention the other, "normal", end-of-life decisions[153]".

These views, far from rejecting the possibility of processes similar to the Dutch, confirm one of the underlying ideas of the "introspection process" defended above: the social, medical and political awareness and involvement as a key element of any future reflection, debate and eventual process of legalisation of end-of-life issues. Dutch process of legalisation is probably not exportable with all and every single feature that characterises it. The criticisms to the system should furthermore be taken into account. It is maybe not desirable to try to reproduce it. It is probably better for every society to find its own way. However, future models should try to learn from Dutch's majors achievements, as the down-top consideration of the issue and its social, medical and judicial involvement and support. For this, an initial "process of introspection" is indispensable. As Griffiths has remarkably stated, "perhaps the most important lesson to be drawn from the Dutch experience does not concern the virtues, defects, dangers, and prospects of the way in which the Dutch have chosen to regulate medical practice that shortens life, nor the problems they have experienced in achieving effective control, but the quality of the Dutch public discussion itself. Perhaps it is not always as profound as one would wish. But nowhere else in the world are these questions being discussed so openly, so systematically, so calmly and thoughtfully, and with such a lack of

[150] Maurice Adams, ibidem 81.
[151] Freddy Mortier and Luc Deliens, *The Prospects of Effective Legal Control on Euthanasia in Belgium. Implications of recent end-of-life studies* in A. Klijn, M. Otlowski and M. Trappenburg, *Regulating Physician-Negotiated Death.* Journal of the Dutch/Flemish Association for Socio-Legal Studies, Elsevier, 2001.
[152] Maurice Adams, ibidem 81.
[153] Ibidem 151.

ideological rigidity as in the Netherlands. Other countries may not choose to go the same way as the Netherlands, but they can hardly fail to learn from the Dutch experience, if only they approach it with modesty, open-mindedness and respect.[154]"

Final Considerations and Recommendations

The *Preliminary Reflections* forwarded the intimate relation of this work with suffering. As the second part of this study evidences, the Council of Europe's organs and its member states pretend to accord importance to suffering. Indeed, there is an important insistence throughout their official positions on the development of palliative cares[155]. This pain-relief comprehensive approach to terminally ill patients represents, without a doubt, an essential and necessary measure in modern medicine. Certainly, the equal access of seriously ill patients to palliative cares, appropriate trainings and education in medicine schools, suitable development of palliative methods in all institutions taking care of terminal cases and an effective cooperation between all those involved in the cares in order to provide the best comprehensive treatment to terminally ill persons should be firmly promoted and implemented. However, "there are situations where life is only suffering, suffering that only ceases when life ceases[156]". There are situations where palliative care is insufficient. There are situations were only death is a relief for a given patient and this patient wishes death. The suffering of those patients give the impression not to be enough relevant for the Council of Europe organs. It seems indeed that those persons that are actually suffering have to be told that nothing can be done to relieve them in order to protect future vulnerable people from suffering[157]. This is however a fake argument, as the first part of this work has tried to demonstrate. Carefully drafted *a priori* safeguards arise as a potentially sufficient guarantee to prevent vulnerable people from dying against their will, dismissing *Slippery Slopes'* threats. An *a posteriori* control mechanism could then also enhance the state monitoring of the safeguards system. Furthermore, the falsity of the protection of the vulnerable argument is confirmed by the real functioning of the banishing system among the Council of Europe's member states. If prohibitive regulations exist in the vast majority of those states, these regulations' application is most often ignored, establishing

[154] Ibidem 80, p 305.
[155] See e.g. Parliamentary Assembly. Council of Europe, Recommendation 1418, ibidem 99.
[156] Ibidem 1, p 203.
[157] Parliamentary Assembly. Council of Europe, Doc. 8421, ibidem 100.

therefore an almost continental situation of judicial tolerance towards end-of-life decisions[158]. This scenario of judicial tolerance is, as it has been repeatedly forwarded all along this work, an appropriate environment for the performance of abuses. The primary alleged argument for prohibiting practices as AVE and PAS, namely the protection of vulnerable from abuses, is therefore discarded from the inside by the European indulgence manifested in a generalised judicial tolerance. The widespread ban of those practices shows the determination of European states in maintaining illusions pretending that nobody decides on death matters. It is however obvious that those decisions take place, and have the governments' approval through its lenience. *Sanctity of life* appeals could therefore be forwarded as the reason underlying European reluctance towards the formal legalisation of AVE and PAS. But once more, inconsistencies arise. Judicial tolerance reveals a societal tacit acceptance of the performance of those practices that does not match with the radical defence of protecting biological life fostered by *Sanctity of Life* positions. Furthermore, the failures of those arguments highlighted in the first part of the work should here again be considered.

What is likely to be hidden under the European almost widespread ban of AVE and PAS is a lack of political will, a fear of tackling extremely delicate matters and a will to preserve an apparently sustainable and unproblematic *statu quo*; as Méndez Baiges points out, "It seems that we collectively assume that there are good and millenary taboos on these death issues that is better for us all not to stir up[159]". However this situation is not unproblematic and still less sustainable.

As it has been repeatedly sustained, this *statu quo* does not offer protection from abuse to those persons that do not wish to die, but contrarily present the perfect conditions for the performance of involuntary euthanasia, which we all abhor, due to the absence of effective controls. Two solutions appear as possible to remedy those dangers: removing the actual European judicial indulgence in order to enhance the strict legal bans on AVE and PAS or establishing a permissive landscape for some end-of-life decisions to take place in determined, clear and controlled situations. As it derives from the arguments maintained along this work, the former does not appear as a suitable option. As

[158] Ibidem 70.
[159] Ibidem 6, p 107. Author's translation.

Dworkin stresses, "making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny[160]." By "upholding the prohibition against intentionally taking the life of terminally ill or dying persons[161]", it has been pretended to protect "the human rights and dignity of the terminally ill and the dying". As this work has tried to evidence, it is not the case for the vulnerable: the current situation favours abuses.

Besides, if lenience permits a major degree of autonomy to accede to one's desired death than a blanket ban, it does however not fit with what we understand as a death with dignity for those terminally ill patients that request death as a relief. Indeed, despite the referred judicial tolerance, legal prohibitions soar above patients and physicians, obliging them to achieve their wishes clandestinely. The dying patient that wishes to end its life as a relief cannot do it openly, in order not to endanger its relatives and medical team, but has to die in the shade, under the suspicion of doing something wrong. How does this way of dying fit with dignity? Once again, by "upholding the prohibition against intentionally taking the life of terminally ill or dying persons[162]", it has been pretended to protect "the human rights and dignity of the terminally ill and the dying". As this work has as well tried to demonstrate, it is neither the case for the terminally ill that have a determined wish to die: their dignity and human rights are not protected but offended.

For these reasons, in line with what has been sustained along this work:

- The Parliamentary Assembly of the Council of Europe and the Committee of Ministers should revise their highly inconsistent position, pretending to protect "the human rights and dignity of the terminally ill and the dying" by "upholding the prohibition against intentionally taking the life of terminally ill or dying persons[163]". Those organs should therefore seriously consider and reflect on the

[160] Ibidem 12, p 217.
[161] Parliamentary Assembly. Council of Europe, Recommendation 1418, ibidem 99; Parliamentary Assembly. Council of Europe, Doc. 8454, ibidem 99; Doc. 9404, Reply from the Committee of Ministers, ibidem 103.
[162] Parliamentary Assembly. Council of Europe, Recommendation 1418, ibidem 99. Doc. 9404, Reply from the Committee of Ministers, ibidem 103.

[163] Parliamentary Assembly. Council of Europe, Recommendation 1418, ibidem 99. Doc. 9404, Reply from the Committee of Ministers, ibidem 103.

data provided by the Steering Committee on Bioethics in its questionnaire concerning Euthanasia and Physician-Assisted Suicide as well as on the report elaborated by Dick Marty, presented to the Assembly on the second period of sessions of 2004, but postponed for future debate.

- The European Court of Human Rights should, when a case involving end-of-life issues reaches its jurisdiction, consider revising its narrow and limited scope of article 2, understanding it as protecting the right to life and not life itself and, as Mrs. Pretty and her barristers forwarded, limiting the sentence concerning deprivation of life towards those situations in whose third parties threaten one's life. Furthermore, concerning article 8, the Court should reconsider the assessment on proportionality carried out in *Pretty v. the United Kingdom*, in order not to fail again in future balances.

- Despite the political compromises hidden behind those conservative positions, the Council of Europe intend to "achieve a greater unity between its members for the purpose of safeguarding and realising the ideals and principles which are their common heritage and facilitating their economic and social progress", "through the organs of the Council by discussion of questions of common concern (...) and in the maintenance and further realisation of human rights and fundamental freedoms[164]". It should therefore make prevail an effective approach towards the protection of human rights, even through a progressive interpretation of its instruments, to a static, obsolete and formal rather than substantial vision of the protection of human rights.

- In accordance with honesty and the aim of an effective protection of human rights, Council of Europe member states should bring about "processes of introspection" in order to
    1. Recollect reliable data on the attitudes and real occurrence of end-of-life practices under their jurisdictions.
    2. Carry out a serious and comprehensive reflection on the results of empirical investigations.

[164] Article 1 of the Statute of the Council of Europe. www.coe.org.

3. Promote a public debate, in accordance with article 28 of the Convention of Human Rights and Biomedicine[165]: "Parties to this Convention shall see to it that the fundamental questions raised by the developments of biology and medicine are the subject of appropriate public discussion in the light, in particular, of relevant medical, social, economic, ethical and legal implications, and that their possible application is made the subject of appropriate consultation."
4. Take the according legislative modifications at the light of the Human Rights requirements.

- Its correspondent place should be given to autonomy, dignity and liberty in a continent of so-called liberal secular democracies. *"Once again, the critical question is whether a decent society will choose coercion or responsibility, whether it will seek to impose a collective judgment on matters of the most profound spiritual character on everyone, or whether it will allow and ask its citizens to make the most central, personality-defining judgments about their own lives for themselves.*[166]*"*

- A progressive legalisation of AVE and PAS will certainly not bring about the answer to all the complex questions related to death and its limits. It will however be a first step in the path to bring clearance to issues involving death and dignity.

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[165] Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. Oviedo, 4.IV.1997.

[166] Ibidem 12, p 216.

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