Parliamentary **Assembly**
Assemblée parlementaire

Parliamentary Assembly
Assemblée parlementaire
COUNCIL OF EUROPE CONSEIL DE L'EUROPE

Euthanasia

Doc. 9898

10 September 2003

Report

Social, Health and Family Affairs Committee

Rapporteur: Mr Dick Marty, Switzerland, LDR

Summary

Where terminally-ill patients undergo constant, unbearable pain and suffering without hope of any improvement in their condition and in response to their persistent, voluntary and well-considered request, some doctors and other medical staff are willing to terminate the life of the patient ("voluntary active euthanasia") or to help him or her take his or her own life ("physician-assisted suicide"). Doctors may also be called upon to decide to withdraw life-sustaining treatment in the knowledge that they are bringing about death ("passive euthanasia"). These widely known facts of medical practice are usually confined to the shadows of discretion or secrecy and, though illegal in most Council of Europe member states, are rarely punished. The Rapporteur believes that it is this reality that carries the greatest risk of abuse and that the divergence between the law and practice must be reconciled if respect for the rule of law is to be maintained.

The Rapporteur believes that nobody has the right to impose on the terminally-ill and the dying the obligation to live out their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it. This right does not imply an obligation on any health worker to take part in an act of euthanasia. Nor can such an act be interpreted as the expression of lesser consideration for human life.

As far as alleged incompatibility of euthanasia with Article 2 ("right to life") of the European Convention on Human Rights is concerned, the Rapporteur points out that this proposition has never been submitted to the judgment of the European Court of Human Rights. However, the Belgian and Netherlands bills enacted in 2002 (allowing doctors who accede to a patient's request for voluntary active euthanasia or physician-assisted suicide to escape prosecution under rigorously regulated and controlled conditions) were submitted for verification to the Belgian and Netherlands Councils of State and found to be compatible with the Convention.

The Governments of the member states of the Council of Europe are asked to collect and analyse empirical evidence about end-of-life decisions, to promote public discussion of such evidence, to promote comparative analysis of such evidence in the framework of the Council of Europe, and, in the light of such evidence and public discussion, to consider whether enabling legislation should be envisaged.

I. Draft resolution

1. Where terminally-ill patients undergo constant, unbearable pain and suffering without hope of any improvement in their condition, some doctors and other medical staff are willing to conduct "voluntary active euthanasia", that is to terminate the life of the patient at his or her persistent, voluntary and well-considered request. Or, under the same conditions, they may agree to help a patient to take his or her own life ("physician-assisted suicide").

2. These widely known facts of medical practice are usually confined to the shadows of discretion or secrecy. Decisions may be taken in an individual and arbitrary manner or in collusion with the patient's family. They often depend on the "luck of the draw", that is, the presence of a sympathetic doctor or nurse. The pressures that can influence end-of-life decisions, which may be exercised by the family for a wide variety of reasons, will be the more pernicious if exercised in the dark and beyond any procedures or control. It is this reality that carries the greatest risk of abuse.

3. Until very recently these practices have been illegal in most Council of Europe member states, although penal and professional 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.

4. This was one reason why the Netherlands and Belgium introduced laws in 2002 allowing doctors who accede to a patient's request for voluntary active euthanasia or physician-assisted suicide to escape prosecution under rigorously regulated and controlled conditions. Specific legislation is designed to bring such practices out of the grey area of uncertainty and potential abuse by establishing strict and transparent procedures, mechanisms and criteria which doctors and nursing staff have to observe in their decision-making.

5. Doctors may also be called upon to decide to withhold or withdraw life-sustaining treatment, again in the knowledge that they are bringing about death ("passive euthanasia"), in particular where the alternative is to attempt to keep the patient alive through stubborn, aggressive treatment without hope of recovery or even an improvement in the patient's condition, a practice moreover condemned in medical ethics, not least when the patient has refused such treatment. Again, member states' legislation and practice in this matter differ, some allowing the practice under specified conditions, others making it illegal. However, it is hard to make an ethical distinction between this practice and those referred to in paragraph 1.

6. Parliamentary Assembly Recommendation 1418 (1999) on *Protection of the human rights and dignity of the terminally ill and the dying*, was based on the premiss that "the vocation of the Council of Europe is to protect the dignity of all human beings and the rights which stem therefrom". Accordingly, the Assembly recommended that member states should "recognise that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death".

7. Nobody has the right to impose on the terminally-ill and the dying the

obligation to live out their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it. This right does not imply an obligation on any health worker to take part in an act of euthanasia. Now we respect a person's choice to take their own life and avoid making value judgments about them. Moreover, this development can in no way be interpreted as the expression of lesser consideration for human life.

8. Whereas palliative care is absolutely essential in attempting to ease the pain of the terminally ill and the dying and should be strengthened in accordance with the recommendations contained in Assembly Recommendation 1418 (1999), unfortunately some patients find it inadequate. Despite remarkable advances, palliative care cannot in all circumstances take away unbearable pain and suffering. In any case the issue goes beyond the alleviation of pain: the degree of patients' own suffering, including mental anguish and loss of dignity that they feel, is something that only they can assess. Individuals suffering in the same situation may take different end-of-life decisions, but each human being's choice is deserving of respect.

9. In view of the above considerations, the Parliamentary Assembly calls on the governments of the member states of the Council of Europe:

i. to collect and analyse empirical evidence about end-of-life decisions involving voluntary active euthanasia, physician-assisted suicide, passive euthanasia and related practices, including public attitudes, the experience of medical practitioners and the jurisprudence of the courts;

ii. to promote public discussion of such evidence, so as to create the greatest possible transparency in an area too often subject to decisions taken by the medical profession without any form of control;

iii. to promote comparative analysis and discussion of such evidence in the framework of the Council of Europe, taking into account in particular the results of the Belgian and Netherlands legislation, notably their effects on practice in the matter of euthanasia;

iv. in the light of such evidence and public discussion, to consider whether legislation should be envisaged, where it has not already been introduced, to exempt from prosecution doctors who agree to help terminally-ill patients undergoing constant, unbearable pain and suffering without hope of any improvement in their condition, to end their lives at their persistent, voluntary and well-considered request, subject to prescribed rigorous and transparent conditions and procedures.

II. Explanatory memorandum by Mr Marty

I. Introduction

1. Euthanasia is an extremely complex issue that brings us to the crossroads of life and death, of free determination and religious belief, and of therapy and medical intervention to bring about death. We find it uncomfortable to address the issue since we must face the end of our own lives. Why should we discuss it again almost four years after the Parliamentary Assembly adopted Recommendation 1418 (1999) on protection of the human rights and dignity of the terminally ill and the dying?

2. Euthanasia is practised every day, as every survey confirms. Since it is a crime in most countries, we are forced to conclude that there is a striking divergence between the law and what happens in practice. Penal and professional sanctions are extremely rare by comparison with the number of occurrences.

3. Euthanasia may take different forms: a piece of equipment may be turned off, treatment may deliberately be refused, or such a large dose of a therapeutic product may be administered that it brings about the patient's death. Life may be terminated at the request of the patient or the patient's family. Should the law intervene in what has been called "the final freedom"?[1]

4. Medical advances have produced no answers in this area, rather the opposite. The latest medical techniques make the problem even more acute.

5. 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.

6. Moreover, although euthanasia has been held by its opponents to be contrary to the European Convention on Human Rights, in particular Article 2 on the right to life, the European Court of Human Rights has never tested this proposition, whereas it has been declared compatible with the Convention by the Belgian *Conseil d'Etat* and the Dutch Council of State.

7. Finally, public opinion polls in several member states show that a majority are in favour of legislation to regulate euthanasia. We as politicians and legislators must somehow respond to this challenge.

II. Definitions

8. To avoid confusion, it is important to be clear about what we mean by the term "euthanasia". Etymologically, it means "a good death". In this report it will be used to mean *any medical act intended to end a patient's life at his or her persistent, carefully considered and voluntary request in order to relieve unbearable suffering*. This corresponds to what is generally referred to as "voluntary active euthanasia".

9. However, in discussion of the issue reference is sometimes made to the concepts of "non-voluntary active euthanasia", where the patient's consent is either unobtainable, perhaps because he or she is unconscious, or simply has not been obtained; and "involuntary active euthanasia", sometimes used to describe an act performed *against* the wish of the patient. It follows from the definition in paragraph 8 that such cases do not correspond to euthanasia.

10. "Passive euthanasia" is a term used to mean the withholding or withdrawal of life-sustaining treatment, again with the intention of ending it, in particular where the alternative is to attempt to keep the patient alive through stubborn, aggressive and pointless treatment, a practice condemned in medical ethics, not least when the patient has refused such treatment. Finally, "physician-assisted suicide" covers situations where a doctor helps a patient to take his or her own life, again at his or her persistent, carefully considered and voluntary request.[2]

III. Recommendation 1418 (1999) and the Committee of Ministers' replies

11. Recommendation 1418 (1999) first observed that the terminally ill and the dying lacked adequate access to palliative care and good pain management. The Assembly therefore encouraged the member states to promote comprehensive palliative care through a series of constructive measures such as the establishment of more palliative care units in hospitals, the development of hospices and

ambulant hospice teams and networks, and specific training for health professionals. The Committee of Ministers replied (Doc. 8888) that the European Health Committee had selected the question of palliative care for detailed study. This was certainly a welcome outcome and we look forward to the results which are due to be published shortly.

12. Recommendation 1418 also asked the member states to protect the terminally ill or dying person's "right to self-determination". But this did not include the right to choose the timing and manner of one's own death. What was meant was spelt out in the accompanying guidelines relating to the patient's rights: to be truthfully and comprehensively informed (or not to be informed) about one's condition; to consult other doctors; not to be treated against one's will, while being protected from undue pressures; to have one's "advance directive" or "living will" observed under specified conditions if incapacitated; to have one's wishes as to specific treatment taken into account as far as possible; and to have one's right to life respected in the absence of a "living will".

13. On the issue of whether the "living will" must be respected, the Committee of Ministers noted (Doc. 9404) that the wording of Article 9 of the Council of Europe's Convention on Human Rights and Biomedicine ("The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account.") reflected the "maximum convergence of views", at the time of drafting, "as regards patient self-determination and medical responsibility".

14. Finally, Recommendation 1418 asked the member states to uphold the prohibition against intentionally taking the life of terminally ill or dying persons, while:

> "i. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member states, in accordance with Article 2 of the European Convention on Human Rights which states that 'no one shall be deprived of his life intentionally';
>
> ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;
>
> iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."

15. In its replies, the Committee of Ministers noted that the legal position on advance refusal of certain treatments and on euthanasia differed between member states. The Committee of Ministers therefore asked its Steering Committee on Bioethics (CDBI) to undertake a survey of their relevant laws and practices. This work has been published (cf. footnote 2). The expert who conducted the survey also wrote an accompanying report, which the CDBI has not made public. Since it was hardly discussed in the CDBI, the expert's report should be published.

16. As far as Article 2 ECHR (right to life) is concerned, the Committee of Ministers replied that its relevance to euthanasia had not been tested.

17. The Committee of Ministers discussed other aspects raised by Articles 3 and 8 ECHR and acknowledged that "in the absence of precise case-law, the question of 'human rights of the terminally ill and the dying', seen from the angle of the Convention, gives rise to a series of other very complex questions of interpretation, such as:

- the question of interplay and possible conflict between the different relevant rights and freedoms and that of the margin of appreciation of the States Parties in finding solutions aiming to reconcile these rights and freedoms;

- the question of the nature and the scope of positive obligations incumbent upon States Parties and which are linked to the effective protection of rights and freedoms provided by the Convention;

- the question of whether the relevant provisions of the Convention must be interpreted as also guaranteeing 'negative rights', as the Court has ruled for certain Articles of the Convention, as well as the question of whether an individual can renounce the exercise of certain rights and freedoms in this context (and, if that is the case, in to what extent and under which conditions)."[3]

18. The Court's position on the issue of whether the right to life implies its negative was clarified in its judgement in the case of Diane Pretty, whereby "Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life. ... The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention".[4] It nevertheless remains that the Court has not tested the proposition that euthanasia is contrary to the Convention. However, the Council of State in both the Netherlands and Belgium have concluded that the legislation on euthanasia introduced in those countries is compatible with the Convention (see below, sections V and VI).

IV. Empirical evidence about end-of-life decisions

19. 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.

20. There have been few large-scale empirical studies in Europe. The best known relate to the Netherlands and Belgium (Flanders). In 1990-1991 a survey of euthanasia and other end-of-life practices in the Netherlands, the first of its kind in a single country, was commissioned by a governmental committee chaired by the Attorney General of the Dutch Supreme Court, Professor Jan Remmelink. A second, almost identical, survey was carried out in 1995-1996, commissioned by the Ministers of Health and Justice, in order to evaluate the new procedure for reporting physician-assisted deaths that had been introduced in 1991. Both surveys were based on two parallel investigations: one involving *interviews* with a random sample of doctors, the other involving *questionnaires* addressed to doctors who had attended deaths identified from a random sample of death certificates.

21. Among the deaths studied in the 1995 survey, 2.3 % of those in theinterview study and 2.4 % of those in the death certificatestudy were estimated to have resulted from euthanasia, as opposed to 1.9 % and 1.7 % respectively in the 1990 survey. The increases were explained by the new reporting procedure introduced in 1991. In 1995, 0.4 % (interview study) and 0.2 % (death certificate study) resulted from physician-assistedsuicide (1990 = 0.3 % and 0.2 %, respectively). The 1995 survey found, in both interview and death certificate studies, that in 0.7 % of cases, life was ended without theexplicit, concurrent request of the patient. In 1990 this figure was not available for the interview study but yielded 0.8 % in the death certificate study.

22. Results from both parts of both surveys showed that in 14.7 to 19.1 % of cases, pain and symptoms were alleviated with doses of opioids that may have shortenedlife. Decisions to withholdor withdraw life-prolonging treatment were made in 20.2 % of cases in 1995 over 17.9 % in 1990 (death certificate study only). For each type of medical decisionexcept those in which life-prolonging treatment was withheldor withdrawn, cancer was the most frequently reported diagnosis.

23. The 1995 survey concluded that since the notification procedure had been introduced in 1991,end-of-life decision making in the Netherlands had changed onlyslightly, in anticipated directions: euthanasia seemed to increase in incidence,and the ending of life without the patient's explicit requestseemed to decrease slightly. Close monitoring of suchdecisions was possible, and no signs of an unacceptableincrease in the number of decisions or of less careful decisionmaking were found, according to the authors.[5]

24. The continuing debate about whether and when physician-assisted dying is acceptable seems to be resulting in a gradual stabilisation of end-of-life practices. The 1990 and 1995 interview and death-certificate studies have been reconducted more recently, showing that no further increase in the rate of euthanasia was found in 2001[6].

25. A comparable survey was conducted in in 1998 in Flanders, Belgium, based on a random sample of death certificates and questionnaires to the attending physicians. Of the 4.4 % of all deaths resulting from the use of lethal drugs, 1.1 % were cases of euthanasia, 0.1 % physician-assisted suicide, and 3.2 % ending of life without the patient's explicit request (extrapolated to an estimated total of 1 796 cases in 1998). In 18.5 % of patients, high-dose opioids were used to alleviate pain and resulted in unintentional death in 13.2 % of cases, but in intentional death in 5.3 % of cases. Decisions to withhold or withdraw potentially life-prolonging treatment were made in 16.4 % of cases. [7]

26. Comparing their results internationally, the authors concluded that "in Flanders the rate of administration of lethal drugs to patients without their explicit request is similar to Australia, and significantly higher than that in the Netherlands". This might be due, they surmised, to the open and regulated approach then already prevalent in the Netherlands.

27. Although such systematic surveys of end-of-life decisions have not been conducted in other European countries, evidence given at the Social, Health and Family Affairs Committee's hearing on euthanasia (Paris, 25 October 2002) revealed that in the United Kingdom almost 60 % of doctors questioned by the *British Medical Journal* had said they had been asked to hasten death; 32 % said they had complied with such a request; and 46 % said they would consider helping someone to die if it were legal to do so.[8] In a 1998 survey carried out by *The Sunday Times*, 14 % of the doctors who answered admitted that they had helped a patient to die at their request. A survey carried out in Norway in 1997 revealed that there were some 20 cases per year.

28. These brief glimpses of medical reality are substantiated by our reading of the daily press. Anecdotal evidence abounds and doctors in many countries admit that they have carried out euthanasia. It may be concluded that there is an urgent need for more scientific research, whatever its limitations, on this important subject.

V. The new legislation in the Netherlands

29. The "Termination of Life on Request and Assisted Suicide (Review Procedures) Act" which came into effect in the Netherlands on 1 April 2002, regulates statutorily and refines policy and practice on euthanasia developed over the previous thirty odd years. The Act built on the findings of State Commissions, scientific studies, public and parliamentary debates and, in particular, case law developed by the courts and accepted by the Government and the Parliament as guidance for prosecution policy in the matter.

30. Essentially, the new Act incorporates an amendment to Article 293 of the Criminal Code to the effect that although any person who terminates another person's life at that person's express and earnest request remains liable to a term of imprisonment not exceeding twelve years or a fifth category fine, such an act shall not be an offence if it is committed by a physician who notifies the municipal pathologist of this act in accordance with the relevant legislation and fulfils the stipulated due care criteria, by which the attending physician must:

a. be satisfied that the patient has made a voluntary and carefully considered request;

b. be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement;

c. have informed the patient about his situation and his prospects;

d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;

e. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in a. to d. above; and

f. have terminated the patient's life or provided assistance with suicide with due medical care and attention.

31. Similarly, any person who intentionally incites another to commit suicide, if suicide follows, is normally punishable under Article 294 the Criminal Code by a term of imprisonment not exceeding three years or a fourth category fine, but commits no offence if the above due care criteria are fulfilled.

32. The new legislation also includes regulations regarding termination of life on request and assisted suicide involving minors. It is generally assumed that minors too have the discernment to arrive at a sound and well-considered request to end their life. Regarding the various age groups, the new legislation links up with the existing legislation concerning medical conduct towards minors. Children of 16 and 17 can, in principle, make their own decisions. Their parents must, however, be involved in the decision-making process regarding the ending of their life. For children aged 12 to 16, the approval of parents or guardian is required.

33. Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so. And he or she may only accede to the request while taking into account the due care requirements mentioned in the Act. The due care requirements must be complied with,

regardless of whether it involves a request from a lucid patient or a request from a non-lucid patient with a declaration of will. In each case the doctor must be convinced that the patient is facing interminable and unendurable suffering. If he or she believes that this is not so, he or she may not accede to the request for euthanasia, no matter what the declaration of will states.

34. In all cases, the physician must report his or her act to the municipal pathologist. The report is examined by one of the five regional review committees [9] to determine whether it was performed with due care. The judgement of the review committee is then sent to the Public Prosecution Service, which uses it as a major factor in deciding whether or not to institute proceedings against the physician in question.

35. If the committee is of the opinion that the physician has practised due care, the case is closed. If not, the case is brought to the attention of the Public Prosecutor. The Public Prosecutor does of course have the power to launch his own investigation if there is a suspicion that a criminal act may have been committed.

VI. The new Belgian legislation

36. The Belgian Law on Euthanasia came into force on 23 September 2002. It built on the Dutch experience, but it has its own specific characteristics. By euthanasia is understood "an act practised by a third party intentionally, ending the life of a person at that person's request."

37. Doctors who practise euthanasia commit no offence if they respect the prescribed conditions and procedures, and have verified that:

- the patient is a person of full age or an emancipated minor, possessing legal capacity and aware of what he/she is doing when he/she formulates the request (which must be made in writing);

- the request is made voluntarily, carefully and repeatedly, and is not the result of outside pressure;

- the patient's medical state is hopeless, and he/she is experiencing constant, unbearable physical or mental suffering, which cannot be relieved and is caused by a serious and incurable injury or pathological condition.

38. Beforehand, doctors must always:

1° inform patients of their state of health and life expectancy, discuss their request for euthanasia with them, and also review with them forms of treatment which are still possible, as well as palliative care and its consequences. They must decide, with patients, that their state admits of no other reasonable solution, and that their request is wholly voluntary;

2° satisfy themselves that patients' physical or mental suffering is permanent, and that their wishes are unchanging. For this purpose, they should talk to patients several times, at intervals which are reasonable in terms of their evolving condition;

3° consult another doctor on the serious and incurable nature of the condition, indicating their reason for doing so. The doctor consulted must inspect the medical file, examine the patient and satisfy

himself/herself that the latter's physical or mental suffering is constant and unbearable, and cannot be relieved, and must prepare a report on his/her findings. The doctor consulted must have no connection with the patient or the patient's doctor, and must have a specialised knowledge of the pathology in question. The patient's doctor must inform the patient of the results of this consultation;

4° if a medical team is providing regular treatment for the patient, his/her request should be discussed with all or some of its members;

5° if the patient so desires, his/her request should be discussed with relatives whom he/she designates;

6° care must be taken to ensure that the patient has been able to discuss his/her request with persons whom he/she wished to talk to.

39. If death is not expected within a short period of time - in other words, for non terminally ill patients, the physician must request a consultation with a third physician, either a psychiatrist or a specialist in the patient's pathology. In that case a delay of at least one month between the request and the act of euthanasia has to be observed.

40. Like the Netherlands, Belgium has established a system of control. The physician has to declare the act of euthanasia to a Federal Evaluation and Control Commission composed of 8 medical doctors (of whom at least 4 academics), 4 lawyers, and 4 persons familiar with the problems of patients suffering from an incurable disease. This Commission has a second function: to establish, every other year, a statistical and evaluation report and to make recommendations.

41. The living will, called "advance declaration", is officially recognised but strictly limited to the state of irreversible unconsciousness of the person.

42. Although no physician is bound to perform euthanasia, a physician who, exercising his or her freedom of conscience, refuses to perform euthanasia, must transfer the patient's medical record to a colleague of the patient's choosing.

43. The law does not allude to "assisted suicide". Thus it does not specify the method to be used by the physician, even though he or she must describe it in the official form to be forwarded to the Federal Evaluation and Control Commission.

44. It is worth dwelling on some of the arguments put forward by the Belgian *Conseil d'Etat*, (Supreme Administrative Court) which underlie its conclusion that the bill (now law) on euthanasia was not incompatible with the provisions of the European Convention on Human Rights. The Court noted in particular, after analysis of the relevant jurisprudence of the European Court of Human Rights, that the positive obligation incumbent on Parties to protect the right to life must be balanced notably against the individual's right of self-determination.[10] This meant that the obligation of the authorities to protect the right to life (Article 2) must be balanced against the right of the individual to be protected from inhuman treatment or punishment (Article 3) and against his or her right to physical and moral integrity, deriving from the right to respect for private life (Article 8). The Convention offered no guidance as to how this conflict between fundamental rights should be resolved.

45. The *Conseil d'Etat* noted that one of the essential characteristics of the debate on euthanasia was that it raised difficult and fundamental ethical questions which necessitated making a choice between opposing ethical conceptions. As to who should make such a choice, the Court referred to a case concerning Norwegian

law on abortion in which the European Commission of Human Rights agreed with the Norwegian Supreme Court in saying:

> "It is not a matter or the courts to decide whether the solution to a difficult legislative problem which the legislator chose when adopting the Act on Termination of Pregnancy of 1978, is the best one. On this point, different opinions will be held among judges as among other members of our society. The reconciliation of conflicting interests which abortion laws require is the legislator's task and the legislator's responsibility. (…) Clearly, the courts must respect the solution chosen by the legislator"[11]

46. As to the question whether the Norwegian law was compatible with Article 2 ECHR, the Commission concluded that:

> « ...assuming that the Convention may be considered to have some bearing in this field, the Commission finds that in such a delicate area the Contracting States must have a certain discretion »….[12]

47. Similarly, it was up to the legislator, exercising his or her discretionary power, to resolve the conflict between opposing ethical conceptions at issue in the debate as to whether or not to decriminalise euthanasia. Judges must respect this power of appreciation of the legislator and could not take his or her place. However, this discretionary power was not unlimited. The obligation to protect the right to life had to be assessed in the light of the conditions and procedures accompanying the law on euthanasia. On this point, the *Conseil d'Etat* was satisfied that the bill (now law) remained within the limits set to the margin of appreciation allowed the national authorities under Article 2 of the Convention.

VII. Swiss law

48. Swiss law is a special case in Europe. There are no specific laws about euthanasia, but the Criminal Code contains measures which may be applied to it. Article 114 lays down that a person who kills another on compassionate grounds may go unpunished. Article 115 specifies that what makes the act punishable is the existence of a selfish motive.

49. Article 114 has been applied only once since 1942. Article 115 is not motivated by medical considerations: originally, in the 19th century, it aimed to exonerate from punishment someone who lent a weapon to a friend wishing to commit suicide, because of an unhappy love affair, for example. Now Article 115 is used for end-of-life issues, which was not at all the legislator's intention. Thus, assistance to suicide goes unpunished, whilst doctors are not allowed to carry out euthanasia and may be sanctioned by their colleagues. According to the Academy which serves as a tribunal for the Swiss medical profession "assistance to suicide does not form part of medical activity". The Academy intends to revise this rule, which is somewhat hypocritical. However, some recent political discussions have shown the difficulty of reaching a consensus on this matter. A Socialist MP from the Vaud canton tabled a motion on the subject in 1984 but the Minister of Justice considered it was too early to legislate. As a result of growing political pressure, the Government set up a group of experts which proposed a series of measures. The Federal Government only agreed to develop palliative care, however. Parliament reacted with various bills which have not been passed. Today the situation is in deadlock, but things may change. A new motion has been accepted asking the Government to encourage palliative medicine and to reopen the euthanasia issue. The Government has no wish to do so, but will be called upon to respond.

VIII. Criticisms levelled at euthanasia and the new legislation in the Netherlands and Belgium

50. The principal arguments against euthanasia and its decriminalisation are, first of all, that euthanasia is deemed to be incompatible with the fundamental human right to life and the concept of human dignity from which it stems. This is the whole thrust of the argument underlying Recommendation 1418 (1999). Prohibition on intentionally causing death is a cornerstone of all social relations, emphasising our fundamental equality. Therefore euthanasia remains a criminal offence in all Council of Europe member states, save under specified conditions in the Netherlands and Belgium. Moreover, it would be contradictory, or at least perverse, to work for abolition of the death penalty and at the same time for acceptance of euthanasia.

51. It is argued that euthanasia is contrary to the will of God as expressed in the Commandment: "Thou shalt not kill". For those unwilling to introduce divine authority into the discussion, it is contrary to medical ethics, including the Roman axiom "primum non nocere" ("first of all do not harm") and the Hippocratic Oath.

52. Opponents also point out that the relationship of confidence that must prevail between doctor and patient would be undermined by the former's power legally to end the latter's life. Moreover, most doctors have received no training in terminating life.

53. Those opposing euthanasia say that terminally ill and dying patients may be suffering not only physically but also mentally, in particular from depression, in which case their decision to ask for euthanasia may not be rational.

54. Finally, from both a logical and a practical point of view, it is said that it is impossible to provide a framework for voluntary euthanasia that will prevent abuse. Pressure may be exerted on the doctor to end the patient's life on non-medical grounds, including lack of hospital beds, the prospect of financial gain, or even political reasons. There will inevitably be a slide down the "slippery slope" from voluntary to involuntary and non-voluntary euthanasia. People will be killed who never asked to die and who could have been helped by palliative care. Indeed, the development of palliative care will make euthanasia unnecessary.

IX. Arguments in favour of euthanasia and its decriminalisation

55. The main arguments for euthanasia and its decriminalisation relate first of all to self-determination or personal autonomy: each individual, out of respect for his or her dignity and value, has a right to take decisions concerning his or her own life and death in accordance with his or her own values and beliefs, and not to have these imposed. It is a question of freedom and equality in the face of death. Similarly, this right does not imply an obligation on any health worker to take part in an act of euthanasia. Freedom of conscience in such matters should prevail.

56. Proponents argue that nobody has the right to impose on the terminally-ill and the dying the obligation to live out their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it. Doctors have long accepted exceptions to the precepts of medical ethics, in carrying out abortions for example. Abortion itself has been legal for many years.

57. 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.

58. Whereas palliative care is absolutely essential in attempting to ease the pain

of the terminally ill and the dying, unfortunately some patients find it inadequate. Palliative care cannot in all circumstances take away unbearable pain and suffering. In any case the issue goes beyond the alleviation of pain: the degree of patients' suffering, including mental anguish and loss of dignity, is something that only they can assess. Individuals suffering in the same situation may take different end-of-life decisions, but each human being's choice is deserving of respect. Depression should not come into it, to the extent that the doctor treating the patient has got to know the case, and the request for euthanasia has been persistently expressed.

59. The fact that the Council of Europe favours abolition of the death penalty is not inconsistent with favouring euthanasia, since the former, barring the exception that proves the rule, is carried out against the will of the individual.

60. Since "passive euthanasia" – withdrawing life-sustaining treatment or sustenance in the knowledge that death will result (an act of commission if ever there was one) – has been admitted as both ethical and legal in certain cases, it is difficult to see the moral distinction between this and active euthanasia.

61. Finally, 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 the "luck of the draw": a sympathetic doctor or a malevolent nurse. The pressures that can influence end-of-life decisions will be more pernicious if exercised in the dark. The gap between law and practice must be reconciled if respect for the rule of law is to be maintained. Abuse will not disappear with legislation (does any legislation eliminate abuse?), but will surely be reduced.

X. Conclusions

62. The debate on euthanasia faces us with two opposing sets of values: one that affirms the individual's right to take decisions concerning his or her own life and death in accordance with his or her own beliefs and values, as long as no harm is done to others, and one that denies this right, since it cannot be fulfilled by a physician without the risk of prosecution. As a liberal, I have a preference for the former. As a lawyer and a legislator, I note that all over the world, doctors are ending the lives of patients, often in secrecy and with a sense of guilt. The law seems to want to ignore this fact of life, whereas it ought to have the courage to address it. Decriminalising euthanasia, rather than keeping the ban, might enable us to better supervise it and also prevent it. By clarifying the situation, we may actually help reduce the incidence of euthanasia. I believe that only supervised procedures and clearly defined rules for its use, in the form of due care requirements, will put an end to the wholly arbitrary system we have today in most European countries.

63. Laying down rules paves the way for a more prudent approach to these practices. Does a patient have the right to ask someone to end his life and, if he cannot articulate the request, should his family be able to do it for him? I believe that the law must set out the framework for such a request, as well as the precautions that need to be taken, particularly as regards obtaining consent and other due care requirements. Openness is a sine qua non of human rights and human dignity. It rarely exists in the case of euthanasia, in particular because many doctors refuse it. We need more widespread public discussion and study of all these issues.

Reference to committee: Doc. 9170, Reference No. 2648 of 25 September 2001

Draft resolution adopted by 15 votes against 12 on 5 September 2003

Members of the committee: *Mrs Belohorská* (Chair), MM Christodoulides (1st Vice-Chairman), Surján (2nd Vice-Chairman), *Mrs McCafferty* (3rd Vice-Chair), Mrs Ahlqvist, MM. *Alís Font*, *Arnau*, Mrs Bargholtz, Mr Berzinš, *Mrs Biga-Friganovic,* Mrs Bolognesi (alternate: *M. Piscitello*), MM. *Brînzan*, Brunhart, Buzatu (alternate: *Ionescu*), *Çavusoglu*, Colombier, *Cox*, *Dees*, *Donabauer*, Drljevic, *Evin*, *Flynn*, Ms Gamzatova, MM. Geveaux, *Giertych*, Glesener, Gonzi, Gregory, *Gülçiçek*, *Gündüz*, Gusenbauer, Hegyi, Herrera (alternate: *Mrs Fernández-Capel*), Hladiy (alternate: *Borzykh)*, Høie, *Ms Hurskainen*, MM. *Jacquat*, Kastanidis, Klympush, *Baroness Knight*, MM. Lomakin-Rumiantsev, Ms Lotz (alternate: *Mrs Rupprecht*), Ms Lucic, MM. Makhachev, *Malachowski*, Manukyan, *Markowski*, Marty, *Maštálka*, Mrs Milicevic, Mrs Milotinova, MM. Mladenov, *Monfils*, *Ouzký*, *Padilla*, Pavlidis, Mrs Pétursdóttir, MM. Podobnik, *Popa*, Poty (alternate: *Timmermans*), Poulsen, Provera (alternate: *Tirelli*), Pysarenko, *Rauber*, *Riester*, *Rigoni*, Rizzi (alternate: *Mrs Paoletti Tangheroni*), Mrs Roseira, Ms Saks, MM. Santos, Seyidov, Mrs Shakhtakhtinskaya, MM. Slutsky, Sysas, Ms Tevdoradze, Ms Topalli, *Mrs Vermot-Mangold*, Mr Volpinari, Mrs Wegener (alternate: *Mr Haack*), MM. Van Winsen (alternate: *Mrs Zwerver*), Zernovski, ZZ…

NB: The names of those members present at the meeting are printed in italics.

Secretariat of the Committee: Mr Mezei, Ms Meunier, Ms Karanjac, Mr Chahbazian

---

[1] François de Closets, *La dernière liberté*, Paris, Fayard, 2000.

[2] The recent survey on euthanasia conducted by Dr Michael Abrams for the Council of Europe's Steering Committee on Bioethics (CDBI) provides interesting information on, among other things, definitions used in the member states, including legal definitions (see *http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/*).

[3] Doc. 9404

[4] *Pretty v. the United Kingdom*, 29 April 2002, §§ 39-40.

[5] Paul J. van der Maas, M.D., Ph.D., Gerrit van der Wal, M.D., Ph.D., Ilinka Haverkate, M.Sc., Carmen L.M. de Graaff, M.A., John G.C. Kester, M.A., Bregje D. Onwuteaka-Philipsen, M.Sc., Agnes van der Heide, M.D., Ph.D., Jacqueline M. Bosma, M.D., LL.M., and Dick L. Willems, M.D., Ph.D., "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995", *The New England Journal of Medicine*, **335**:1699-1705 (November 28), 1996.

[6] "Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001", the Lancet, 17 June 2003

[7] Luc Deliens, Freddy Mortier, Johan Bilsen, Marc Cosyns, Robert Vander Stichele, Johan Vanoverloop, Koen Ingels, "End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey", *The Lancet*, **356**: 1806-11 (November 25), 2000.

[8] Ward, B.J. Tate, P.A. "Attitudes among NHS doctors to requests for euthanasia" *British Medical Journal*, **308**: 1332-1334 (1994)

[9] The regional review committees, already established in the Netherlands before the new legislation,are composed of at least three (or if more always an uneven number of) members: a legal expert as chairman, a doctor, and an expert in the field of ethics or philosophy. For each of the members, one or more substitutes are appointed. To monitor the uniformity of the assessments of the different review committees, the chairs of the committees consult regularly in a meeting attended by representatives of the Council of Procurators-General and the Health Care Inspectorate of the State Supervisory Agency for Public Health.

[10] In this connection, account must be taken of the strength of the will of the person concerned. For example, when an individual is incapable of deciding for himself or herself, the obligation of the authorities is greater than when he or she is capable of making decisions about his or her own life.

[11] European Commission of Human Rights, Decision of 19 May 1992, H.v./Norway, 17.004/90, D.R. vol. 73, (155), p. 168, §1.

[12] Ibid.