

# **DEATH WITH DIGNITY AND EUTHANASIA: COMPARATIVE EUROPEAN APPROACHES**

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## **INTRODUCTION: THE BIRTH OF A PARADOX From philosophical emancipation to technical alienation**

### **1) Euthanasia and cultural tradition**

In the renowned film “ the ballad of Narayama” Shohei Imamura is depicting the life of a rural Japanese village in the XIX th century. Although they still work hard the elderly people have to leave the village and go for their last journey on the mountaintop of Narayama. This cruel tradition is viewed as necessary to protect the life of the community as is the savagery of the natural world in which the community lives. However these terrible conditions do not make those people inhuman. They are simply survivors in a harsh environment.

What is today the meaning of the quest for death with dignity and euthanasia which developed in many countries around the world? Is it also the evidence we live in a harsh environment?

Whatever may be the answer to this question, there is in my view a great difference between the situations described by Imamura in the “Ballad of Narayama” and the present quest for a “good death”. In the Narayama story, euthanasia is part of a tradition concerning the elderly which existed in different cultures and symbolized the respect by humans of what they regard as “the natural cycle of life”. For contemporary people, euthanasia is, on the contrary, the symbol of the emancipation of the individual from religious and cultural beliefs while it is also a rebellion against the power of techno science in the medical field.

### **2) Euthanasia in western countries: from Christianity to Enlightenment**

For long, Christianity has deeply changed the view in Western countries that death was the end of life. It became a new beginning, the resurrection to another life. Life on earth is then just a time of transition to prepare oneself to the eternal life.

Furthermore, life is the gift of God and humans cannot dispose their own life.

Therefore any human intervention in the process of dying, such as compassion killing, is viewed as a sin and morally unacceptable.

Finally, Christianity has often considered the sufferings as a mean to reach or to reveal high human virtues. According to this view, relieving human sufferings and, of course, committing suicide would be something against the religion.

Therefore the religious and the legal prohibitions of suicide coincided till the Enlightenment Revolution when the philosophers promoting the concept of the individual freedom suggested that committing suicide was an act of self decision and should not be punishable. But being emancipated from the diktat of the religion, the individuals became dependant on the development of science and medicine. With the triumph of the Darwinian theory of evolution and the development of

experimental medicine, the limits to improve human life were waived.

From 1800 to 1960, the average life expectancy doubled making medical activities a fight against death. In doing so, the dying process became medicalised. Some infectious diseases clearly disappeared while new surgical interventions, such as organ transplants, may be viewed as some kinds of human resuscitation. Sociologically, medicine has replaced religion and doctors are the new priests of our techno society.

Paradoxically this has created a new fear. The artificial process of dying is replacing death but it is transforming the individuals into artificially supported and suffering bodies relying on medical supervision while the family is left away, making social solidarity and compassion a relic of the past.

### **3) The techno science society and the dying process**

The loneliness of the dying persons and their exclusion from the society of the living through the medicalisation of the dying process explain the request for a global change. There comes the wish to re appropriate our own death, to give a true meaning to the dying process by making it peaceful and respectful of our human dignity. However, as the whole society will have to substantially change minds and habits to reintegrate the idea that dying is part of our life, it is probably easier and more concrete to begin this new fight by establishing some limits to the medical power. This evolution takes place in a very controversial context because it is founded on various and contradictory attitudes. A rights based approach will support both the termination of futile treatment and active euthanasia while a duty-based approach will allow the physicians to accept responding positively to death claims that follow some predetermined criteria and refused others. But progressively, there is a legal clarification between what is still prohibited, what is tolerated and what becomes a liberty or a subjective right that each individual can claim for. While the issue of the termination with a futile treatment is clearly today a matter of individual autonomy, the issue of assisting suicide and euthanasia cannot be solved in a purely human right approach. It is exceptionally admitted in some countries either on a duty –based approach or on compassionate approach.

#### **I RESTORING THE MEANING OF THE DYING PROCESS:**

##### **When palliative care is replacing futile treatment**

The dying process should aim at making the individual and his/her family and relationship to prepare with death by reaching what is essential as human values. And this is no more to the physicians to decide what the best interest of the dying persons is. The physicians are asked to bring more humanity and compassion towards their dying patients by stopping futile treatment and by offering them palliative care that would alleviate their sufferings and allow them to peacefully enjoy the last moments of their life.

#### **A) The right to refuse extraordinary treatment at the end of life:**

##### **Getting rid of the medical paternalistic attitude**

There is a broad consensus that futile life sustaining treatment is an unethical practice and that each individual should have the right to refuse consent to such

treatment.

In reality, this may raise difficulties when the patient is no more in a capacity to express his/her view or consent. Living will or proxy consent may then be considered.

### **1) The unanimous rejection of futile treatment at the end of life**

The rejection of the practice of futile life sustaining treatment is unanimous. Already in 1957 the pope Pius XII declared that “the duty to take the care what are needed to safeguard life and health? does not usually imply to use extraordinary means” (pope Pius XII, declaration to the anesthetists, 24 Nov.1957). Legally, it is considered that the principle of the free informed consent which regulates the medical intervention has a counterpart which allows the patient to refuse a treatment he/she will not approve. Moreover, the evolution of the medical practice at the end of the XXth century has led to a less paternalistic attitude and to a greater and better consideration of the wish of the patient regarding his/her treatment.

**a) European texts** such as the European Union Charter of Fundamental Rights (article 3 recalls that the free informed consent of the person shall be respected) as well as various recommendations ( Recommendation 779 (1976) and Recommendation 1418(1999) of the Parliamentary Assembly )from the Council of Europe, the organisation dealing with human rights and bioethics, emphasise the necessity for doctors “to abstain life-prolonging measures in particular in the case of irreversible cessation of brain function” and “to respect the will of the patient in regard to his treatment”( Recommendation 779 (1976) and the duty for member states to provide in their domestic legislation provisions “against prolongation of the dying process of a terminally ill or dying person against his/her will” (Recommendation 1418 (1999).

**b) Domestic laws or practice** have in all European countries endorsed the right of a patient to refuse treatment at the end of life. But the situation is easier in Anglo-Saxon and Scandinavian countries than it is in Latin and catholic countries.

For example, in **the United-Kingdom**, a competent patient has a right to refuse any medical treatment, even at the risk of his or her life (Richard Ashcroft, Death policy in the United-Kingdom, in Robert H. Blank, Janna C Lerrick (eds.), End-of-life decision making, the MIT press, London, 2005, p 208).

In **Germany**, the federal Court of Justice admitted that omitting life-sustaining measures may be admissible even if the process of dying has not yet begun (Bundesgerichtshof, 1994, Urteil vom 13.09.1994.BGHSt 40,257-272).

In **Denmark**, as in other Scandinavian countries, a physician cannot treat a patient who has refused the treatment (the Medical Profession Act 1992 clearly considers the case of futile treatment at the end of life).

Regarding **France**, refusing unreasonable medical treatment is clearly an absolute right of the patient since the 22 April 2005 Act which acknowledges that each patient may refuse all types of treatment which may well include ventilation, nutrition and hydration.

In **Spain**, the 14 Nov.2002 Act has allowed the regions to pass laws authorising patients to refuse treatment (13 of the 17 regions did by 2006). In Italy, there is no legislation on this point but the termination of a treatment at the request of a competent patient seems to be admitted in practice.

These differences in the practice are even more acute regarding the issue of incompetent persons.

## 2) Refusing futile treatment for incompetent persons

A way to prevent the acute problems posed by incompetent persons may be to consider living wills or proxy consent.

### a) Living will and proxy consent

-The 1999 above mentioned Recommendation by the Parliamentary Assembly of **the Council of Europe** suggests that member states should “ensure that a dying person’s advance directive or living will refusing specific medical treatment is observed. Furthermore,( it recommends) to ensure that criteria of validity as to the scope of instructions given in advance, as well as nomination of proxies and the extent of their authority are defined.”

The only European binding instrument, the 1997 Oviedo Convention on Biomedicine and Human Rights, includes a specific provision (article 9) on “previously expressed wishes”. But the text does not imply that the will of the patient should prevail on all other decisions. It only states that “the previously expressed wishes to 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”.

-Nonetheless, different European countries have adopted legislation which make binding to follow the instructions given by the patient or by his/her proxy.

In **the United -Kingdom and Germany**, both the jurisprudence and the rules of the medical professions are giving force to living wills but in Germany living wills do only apply to persons who are in a terminal stage.

Other countries have adopted specific laws. Since 1992, this is the case in **Denmark** for competent persons over 18 years. In **Switzerland**, several cantons have adopted similar laws (Appenzell-Rhodes, Argovia, Geneva, Lucerne, Neuchâtel, Valais, Zurich...). In Spain , the 21 December 2000 Catalan law was the first to recognize the validity of living wills but today either laws or jurisprudence are approving living wills in all regions .**The Netherlands and Belgium** (since 2002) have also admitted to give effect to the living wills. Finally, **the French Public Health Code** (art L 1111-11, law of 22 April 2005) states that every adult may write a living will regarding the termination of his/her treatment but doctors should only respect those wills that have been written less than 3 years before the treatment takes place.

Among those laws, most of them also admit (Belgium, Patients' Act 2002, Denmark Patients Act 1998, France article L 1111-6 of the Public Health Code, Spain...) that a proxy may be appointed by a competent patient to express the will of the patient once he/she has become unable to express directly his/her own wishes. But restrictions regarding the power of the proxy do apply in some legislation (in the German law and in the UK Draft Bill on Mental Incapacity, for example).

In the absence of any indication about the wish of the unconscious person, the situation remains more controversial.

### **b) Persons who have not previously expressed their will or appointed a proxy**

The decision is then essentially the decision of the doctors. It results in ethical and legal issues raised by what is commonly called passive euthanasia.

Very few European countries have laws that authorize physicians to explicitly stop patients' care in those cases.

In **Denmark**, according to the Medical Profession Act 1992: article 6.5), a doctor is allowed not to treat a dying patient if the treatment may only differ the time of death.

In **France**, the law of 22 April 2005 extends the possibility to stop a treatment to persons unable to express their will even when their life is in danger.

A specific procedure has to be respected: the decision should be taken by a college of doctors and the family or the next of kin should be consulted.

In other countries, some indications can be found either in the case law or in professional guidelines. For example, in the **British** case Airedale NHS trust v. Bland (9th February 1993), the House of Lords ruled that a treatment, including artificial feeding and hydration, on a person who was in a persistent vegetative state since 1989 may be withdrawn. The view of the judges was that "it would have been appropriate to stop the antibiotics treatment as soon as agreement would have existed between the medical team and the family".

In **Germany**, the Supreme Court ruled that passive euthanasia may be practiced on an incompetent patient if the doctor may base his/her decision on the presumed will of the patient. The Incompetent Persons Act 1990 has organized the possibility to appoint a proxy whose decision should be confirmed by a court in case of danger for the life of the incompetent person.

In **Switzerland**, the Academy of medical sciences has reviewed in 1995 its ethical guidelines concerning dying patients. "Passive euthanasia" is allowed which means the possibility not to forego life-sustaining treatment, including artificial feeding and hydration, assisted ventilation and dialysis. But in the absence of advance directives or proxy, the physician should act in conformity with the patient's best interest.

The opinion expressed by the **Portuguese** National Bioethics Commission (7th June 1995) is interesting because it concerns a Mediterranean and catholic country. It is stated that “terminating futile and disproportionate treatments is ethical “and that “although it may reduce the remaining time of living, it shall not be considered as an act of euthanasia”.

Palliative care is another aspect of the quest for a more compassionate and humanistic medicine.

## **B) The palliative care:**

### **An alternative to euthanasia or a step forward in respecting the dignity of the patient**

Although the physicians who are the most opposed to medically assisted suicide argue that easy access to good palliative care will largely solve the problem of euthanasia claims by suffering patients and therefore support the development of palliative care facilities, the history of palliative care in Europe shows that physicians and public health authorities having been long in considering alleviating suffering as a medical priority.

#### **1) The history of palliative care**

It is a recent history which has developed in four steps.

The **first step** of the palliative care movement is rooted in the British model which grew up since the end of the 1960's. In the U-K, the palliative care centers have clearly been established outside hospitals in hospices. At the beginning those institutions were essentially opened to terminal stage cancer patients. This first step is then known as the hospice movement step and its approach is largely an anti medically interventionist movement whose leading pioneer was dame Cicely Saunders.

The **second step** began in 1975 with the opening of the first palliative care unit at the Victoria hospital in Montreal. From there the palliative care movement was progressively incorporated into hospital facilities especially in Europe. It was the starting point of the awareness of health professionals regarding the needs to treat patients' sufferings at the end of life.

In these two steps palliative care services are still largely depending on local initiatives.

The **third step** (from 1980 onwards) is precisely the step of integration of palliative care and palliative care units into the health system, merely for the benefit of cancer patients. This step is the clear evidence that health authorities in Europe had become aware about the necessity to develop palliative care policy.

Finally the **fourth step**, which began with the 1990's, is the step of the expansion of palliative care for the benefit of all patients. This important change in the policy approach to palliative care was largely influenced by the social approach of the aids

pandemic.

This brief historical reminder explains that today palliative care is largely developed in European countries but different approaches and still some practical difficulties, mainly in Eastern Europe.

## 2) European policy approaches to palliative care

In Europe, various member states of the Council of Europe, the intergovernmental organization which gathers 46 European states, has developed in the last decades comprehensive national plans for the development and maintenance of palliative care as an integral part of the health care system. Studies have shown both great differences in the extend to which palliative care is available in Europe and a remarkable similarity in the interest and energy devoted to setting up comprehensive palliative care services.

### a) Western European countries

**The U-K** has been to a large extend the cradle of specific palliative care services in Europe but the strong British hospice movement has always remained outside the National Health System. As at January 2004, they were in the U-K 196 specialist in-patient units, 341 home care services, 343 hospitals based services and 237 day care services.

In **the Netherlands** specific projects for palliative care have started from a pioneering nursing home in Rotterdam in the 1970's. In 1998 the government decided for a program consisting in integrating centers for development of palliative care into the regular health care system.

In **Belgium**, royal decrees have specified that every hospital or nursing home should have a multi-professional palliative care team.

In **Germany**, the organization of palliative care started with the first palliative hospital ward established in 1983 and followed by several hospice initiatives and a government initiative to establish 12 palliative care facilities.

In **Sweden**, although a home based hospice program developed in the 1980's, a 1979 report rejected the idea of stand alone institutions for the dying.

In **Switzerland**, governments of French speaking cantons are more directly involved in palliative care while in German and Italian speaking cantons palliative care is an area for private initiative.

In **France**, the initial process in the organization of palliative care services is the 1986 decision by the minister of health to create palliative care units. But it is only in the 1991 Hospital Act that palliative care has been officially included in the list of services that hospitals should provide to patients.

However the difficulties to give some reality to hospital palliative care units resulted in 1999 by the unanimous voting in Parliament of a new law making the access to palliative care a right of every patient who requires it.

Finally the 2002 Patients' Rights Act has expanded the right to benefit from palliative care to every patient which means that such care should not only be offered by health professionals in hospital facilities but also in private practice.

**Spain** has developed a palliative care plan in 2000 which intends to offer palliative care according to need, to encourage the co-ordination of the levels of health care provision and to ensure equity and stimulate efficiency.

In **Italy**, there has been a development of palliative care since the beginning of the 1970s leading to a large number of hospices but since the mid 2000s the government has given palliative care a prominent place within the "piano sanitario nazionale".

The **Irish** government set up a National Advisory Committee on palliative care which published in 2001 an advice encompassing all aspects of palliative care policies and proposed that palliative care should be a separate area of government funding.

### **b) Eastern and Central European countries**

Recent reports have given some evidence of progress in those countries.

In **Hungary**, the Hungarian Hospice Foundation was founded in 1991 and by 2005 they were 11 hospice inpatients units and 29 hospice home care teams. Since 1994, a national palliative care program has been launched. Benefiting from this experience recommendations for palliative care were adopted in 2004 and in the same year the National Health Care Insurance started a two-year financing pilot program for hospice and palliative services. Finally, palliative care is mentioned in the 1997 Health Care Act.

In **Poland**, since 1991, the Ministry of health has introduced a program to establish palliative care as part of the national health care policy and the use of narcotics for cancer patients is free since 1997.

In **the Czech Republic**, palliative care was established in 2004 as a regular medical specialization.

But other Eastern and Central European countries, such as **Romania**, are still in the process to remove regulatory barriers (regarding the use of narcotics) to palliative care.

### **c) General remarks**

**The role of the volunteer movement** in palliative care should not be neglected but it differs from one country to another.

For example, in **France** and the **Netherlands** volunteers' organizations do not provide palliative care directly while in **Belgium** or in **the U-K** they treat patients through their own units. Finally in **Switzerland** and in **Italy** non profit organizations provide either direct care services or support hospital palliative care units.

In most countries great importance is attached to **public opinion** and the role of governments, professional groups and non-governmental organizations but an adequate knowledge of the needs of the patients is also fundamental in order to develop regional and national strategies.

However in many countries palliative care are still dependent upon the type of disease patients have (cancer patients enjoy greater access) or on socio-economic factors. It is also often unknown from the general public or suffers **a lack of public attention**.

The Council of Europe, which has adopted in 2003 a new Recommendation on the organization of palliative care, took the initiative of the 2005 Belgrade Conference on palliative care to support further initiative to improve and expand the existing services.

## **II ASSISTING SUICIDE AND EUTHANASIA:**

### **Prohibition, compassion, physician's duties and individual right approaches**

If the individuals should take control over the last moment of their life by making known to the doctors about their decisions regarding extraordinary or futile treatment, why should not they give instructions or request assistance to end their life when the sufferings are so great and violate their human dignity?

Why in such circumstances physicians, who have the duty to go along with the dying patients and offer them compassionate treatment, should not be allowed to assist those patients by directly or indirectly helping them to die?

If in the reality we may wonder about the real differences existing between the situations of two competent patients, one having the capacity to commit suicide by his/her own and the other being paralysed by the disease. Ethically and legally those situations are not identical and explain the fact that they may be considered differently. However, the spectrum of approaches is very broad in Europe going from a prohibitive approach to a compassionate approach or an approach based on physician's duties or patients' rights.

#### **A) The prohibitive approach**

This view largely is still broadly expressed in Europe either in domestic legislation or in European law.

##### **1) Prohibitive domestic European legislation**

In **Germany**, the word euthanasia is still taboo and no specific legislation does explicitly mention it. As the German fundamental law is making the right to life an absolute right, lawyers and physicians are unanimous to consider that an act that will

intend to abridge the life of a patient, even on his/her request, is and should stay illegal. But the 1998 new directive of the Federal chamber of physicians, which states that in certain circumstances the physician should help the patients to die with dignity, and a Frankfurt regional court decision of the same year approving the withdrawal of food on a comatose patient have led the Federal Minister of justice to consider that it may be useful to clearly prohibit euthanasia by law. No law has however been adopted till the present time

Assisting suicide is not punishable if the person does not take an active part in the process. In other case, it will be punishable either as a homicide or as failing to assist a person in danger.

In **the U-K**, although the discussion on euthanasia and assisting suicide was very intensive since the 1980s, both are still illegal under the Homicide Act 1957 and the Suicide Act 1961. The various committees that were appointed to look on those issues advised not to change the law. As to the judiciary, in the Airedale case, the House of Lords recalled that giving a lethal drug to a patient was illegal.

In **France**, the consent of the victim does not constitute a defense under criminal law and therefore active euthanasia and assisting suicide may be punishable, according to the circumstances, either as murder, assassination, poisoning or failing to assist a person in danger.

The same prohibition applies in **Russia** and **Italy**.

In **Denmark**, the penal code includes provisions that explicitly sanction homicide on request and assisting suicide.

In **Switzerland**, article 114 of the federal penal code explicitly acknowledges mercy killing but considers that a person who will act by mercy killing at the specific and insistent request of the victim shall however be submitted to imprisonment.

Trying to harmonize European law policy in this field, the Council of Europe has also adopted the prohibitive approach.

## **2) Harmonizing European law on a prohibitive approach**

The two recommendations adopted by the Parliamentary assembly of the Council of Europe respectively in 1976 ( about the rights of dying patients) and 1999 ( about the protection of human rights and dignity of dying persons) exclude the possibility of euthanasia. The Committee of ministers joins in the same view in a resolution adopted on March 2002.

In the same year, the European Court of Human Rights ruled in the Pretty case that the right to life as it is protected by article 2 of the European Convention on Human Rights did not encompass the protection of a right to die.

Nevertheless, as we will discuss further, this decision does not completely close the door to some cases or forms of assisting suicide as it acknowledged that the question was under the scope of article 8 and the principle of autonomy.

Another door is kept opened by the numerous legislations that consider compassionate attitude in the case of euthanasia and assisted suicide.

## **B) The compassionate approach**

The compassionate approach consists in taking into consideration the special circumstances that surround each case of euthanasia and assisted suicide. Therefore this approach is not totally incompatible even with the attitude of those countries which still strictly prohibit in principle active euthanasia and assisted suicide. It allows some flexibility in the application of the law either by waiving the punishment or by sanctioning the case with a lower sanction.

### **1) Lower sanctions**

All the European countries which have maintained a strict prohibition of euthanasia and assisted suicide have indeed the possibility to apply lower sanctions to cases of euthanasia.

In **Germany**, article 216 of the criminal code states that “if anyone has committed a homicide at the explicit and persistent request of the victim, an imprisonment from 6 months to 5 years may sanction this crime” while the sanction is a minimum of 5 years imprisonment without the explicit request of the victim.

In **the U-K**, article 4 of the Homicide Act 1957 allows the qualification for homicide by negligence, which results in a lower sanction, when a person kills another one after they conclude a suicide pact.

In **Italy**, while euthanasia is regarded as a crime, it is in practice sanctioned less than a homicide.

In **France**, although the consent of the victim has no influence on the qualification of the act of euthanasia, the practice reveals that very few cases of active euthanasia or assisted suicide are prosecuted. And among those which came in court, the jury often applies a minimal sentence when it is considered that the case may be regarded as mercy killing. We should also quote a very interesting 2006 decision that decided to stop all legal pursuit on the ground that the person who committed euthanasia acted on irresistible moral influence of the victim!

In 2000 the French National Bioethics Committee suggested to go a step further in changing the criminal procedure. According to the Committee’s opinion, the defendant in a criminal case could raise a plea of defense of euthanasia which would then be subject to scrutiny by an interdisciplinary commission whose task would be to evaluate the probity of the claim as regards as their motivation. It was presumed that the advice by the commission would have been taking in consideration by the judge’s decision.

However the 2005 Act on the end of life has not incorporated this proposal.

## 2) Waiving the sanctions

In **Denmark**, articles 84 and 85 of the criminal code approve reduced sanctions or the waiving of sanctions in particular circumstances, among them if the author has acted under the influence of a strong emotion or when other specific reasons justify it.

In **Switzerland**, art 115 of the federal penal code sanctions the person who “acting on egoist ground would have incited someone to commit suicide or would have assisted this person in committing suicide”. The article is interpreted *a contrario* to mean that a person who will act by mercy cannot be sued. This interpretation serves as the legal basis of assisting suicide practiced in Switzerland.

### C) The decriminalization of active euthanasia:

#### Physician’s duties based approach or patients’ rights approach

##### 1) The physicians’ duties approach

The two European countries that have adopted legislations which legalize active euthanasia have indeed used the physician’s duties approach. It means that when faced to certain circumstances defined by law, the physician will not be sued for homicide. However both in the Dutch and Belgian laws there are some evidence of the role played by the patients’ rights approach.

###### a) The Dutch law

In its **first step** the Dutch legislation, as adopted in 1993, gave a legal framework to an existing situation that was ruled under the jurisprudence of the Supreme Court. Euthanasia and assisting suicide were still prohibited by the criminal code but the physician who practiced euthanasia could use the defense of necessity to claim he acted to stop unbearable sufferings. For this purpose only the law on funerals was modified to make compulsory the declaration of all interruptions of life have to the public prosecutor and to a regional commission whose role was to control *a posteriori* the respect of the criteria defined by the law (a no hope medical situation, unbearable sufferings, no alternative solution, a reiterate request of the patient giving free informed consent, the joint opinion of a second physician, information given to the family).

In the **second step**, the criminal law was changed in 2001 to specify that the physicians who strictly followed the above mentioned criteria cannot be sued for having committed a homicide. An independent review of the case is still made and therefore there is theoretically no right to euthanasia and no obligation for the physician to perform euthanasia and assisted suicide. However, studies about the practice of euthanasia in the Netherlands have shown that there is a clear tendency to move to a subjective approach of euthanasia focusing on the right of autonomy of the patients. For example, unbearable sufferings are no more the only reason to justify the interruption of life but very often the patients express the will to finish with a life which he/she considers as contrary to dignity. They just want to quit the life in full conscious before the terminal stage, leaving a better image of themselves to

their families. The new law takes into account this change in allowing living will containing anticipated request of euthanasia in certain circumstances and will therefore keep the discussion alive on how far the physician can go in accepting euthanasia request.

The Dutch experience is also largely reflected in the Belgian legislation.

### **b) The Belgian law**

The Belgian law was adopted in 2002 and is very much in accordance with the second Dutch law. In both cases when the termination of life is practiced by a physician according to a list of criteria defined by law, the physician is not regarded as committing a homicide. The control procedure is very similar with the fact that in Belgium there is only one national commission. Finally, the Belgian law has also a provision allowing advanced directives. The main difference between the two legislations concerns the request for euthanasia. In Belgium this request should always be written. So in both countries it is possible that the role played by the notion of autonomy will slightly move the application of the law from a physician's duties approach to a patients' rights approach.

## **2) The patients' rights approach**

Outside Europe (Canada, USA) as well as in Europe (U-K), unsuccessful attempts were made to legalize assisted suicide and active euthanasia through the use of constitutionally entrenched human rights documents, namely the US Bill of Rights, the Canadian Charter of Fundamental Rights and Freedoms and the European Convention on Human Rights.

As we mentioned above, the European Court of Human Rights considered in the Pretty case that the right to life could not be interpreted as meaning that it would also encompass a right to die.

But quite apart from the rejection of Mrs. Pretty's case which captured the attention, the court nevertheless recognized that "the way she chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask this too must be respected". Then with the same restraint and clear sightedness, the court gave its reasoning." The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the convention, the court considers that it is under article 8 that notions of the quality of life take on significance". It concluded "the applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end of her life. 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 paragraph 1 of the convention".

Having considered the question of proportionateness, the court in fact found the interference to be reconcilable because "States are entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals" and that "(the) more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy".

Although the patients' rights approach cannot completely be excluded, this approach is unclear regarding its results because the right protected is not the right

to life ( or to die) which deserves a quasi absolute protection but the right of privacy which allows state interference and gives in this area a margin of appreciate to the states.

## **CONCLUSION**

Since the 1970's, the ethical and legal approach to the end of life process has gone through a deep clarification.

There is a general consensus in Europe that the last stage of human life should also benefit from the respect of human dignity and that each individual is entitled to a certain form of autonomy regarding the decisions concerning the end of his/her life. This has clearly resulted in a more balanced decision making process giving to the patient and his family a greater role opposed to the role played by the physician and the health professionals, including the possibility to write advanced directives or to appoint a proxy.

It is today the decision of a competent and fully informed patient to refuse futile treatment, even when there is a lethal risk. In the meantime palliative care, although not yet equitably accessible in all European countries, has become part of the medical treatment that a patient can require.

Concerning active euthanasia and assisted suicide , the European legislations still cover a broad spectrum of views going from the prohibitive approach on one hand to the patients' rights approach on the other hand. Nevertheless, two main changes may be quoted. First, in all legislations the role of the physicians has been better defined both in term of liability and duties. Second, what is still controversial cannot any more be governed by one approach alone but is subject to the influence of different interest: the patient's autonomy, the medical ethics and the role of the state in maintaining common fundamental moral values.