



NEDERLANDSE VERENIGING VOOR RECHTSVERGELIJKING
NETHERLANDS COMPARATIVE LAW ASSOCIATION

Euthanasia and the Criminal Justice System*

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1. Introduction

When it comes to euthanasia and related end-of-life decisions, many countries have had high profile cases. These thought-provoking incidents have attracted attention among large segments of the population and have quite often been publicised abroad as well. It is useful to recall some of these cases in the introduction to the present general report.

The United States was faced with the complicated situation of Terri Schiavo. Terri suffered severe brain damage as a result of cardiac arrest in 1990. Thereafter, she was in a permanent vegetative state. Starting in 1998, her husband moved to get the doctors to stop artificial nourishing. According to Florida's legal system, this could only be allowed when it could be established that Terri herself would have wanted this in this situation. The husband claimed that she would never have wanted to live this way. Her parents disputed this vehemently. The Florida State courts issued no less than three verdicts ordering the medical centre to stop the feeding. In 2003, Florida governor Jeb Bush, brother of the US President, persuaded the State legislature to adopt an Act (quickly labelled as 'Terri's Law') ordering the provision of food and liquids to be recommenced. The Supreme Court of Florida quashed the Act on constitutional grounds. This ruling was appealed several times in the federal court system, but in vain. Finally, the US Supreme Court declined to hear the case. Despite widespread popular protests, the feeding was terminated. Terri Schiavo died on Thursday, 31 March 2005.

In France, 18-year-old Vincent Humbert acted as a volunteer in the fire department, when he was involved in a road traffic accident which paralyzed him virtually completely. Nearly

* Session VA2. National Reports received from: Belgium, Croatia, Finland, France, Germany, Greece, Iran, Israel, Italy, Japan, The Netherlands, Poland, Spain, US.

all of his vital organs were damaged. The only functions which remained intact were his sense of hearing, the ability to think and he was able to move one thumb. The last-mentioned faculty enabled him to express his desire to die. One person read the alphabet and when Vincent moved his thumb the corresponding letter was dotted down. In this way he dictated a letter to the French President Chirac, pleading for the right to die in a dignified manner. The President answered that he sympathized with the young man's situation, but that he was unable to do anything since euthanasia is prohibited. Then Vincent's mother took the law into her own hands. On 24 September 2003 she administered an overdose of sleep-inducing drugs into his bloodstream. Vincent did not die, however, and went into a deep coma. The doctors at first wanted to continue treatment, then after a couple of days thought better of it and ceased providing oxygen and removed the intravenous drip. Vincent passed away. The episode attracted huge media attention both within and outside France. Subsequently, the government established an advisory committee charged with finding more generally acceptable ways of dealing with similar cases in the future. Some time later, the law was amended.

A final example is from The Netherlands. In 1974, a woman called Ineke Stinissen was in the process of giving birth. A caesarean section was deemed to be necessary, and during the operation the anaesthetist made a serious error. She ended up in a comatose state. One year later her husband was convinced that this situation was irreversible. He resorted to the civil courts and demanded that the artificial feeding of his wife be considered as medical treatment instead of merely providing ordinary care. The distinction is important, because medical treatment can be terminated when any continuation is useless according to professional standards, whereas providing care can never be stopped, regardless of the circumstances. After many years of litigation the court finally ruled that providing liquid nourishment is an act of medical treatment. Hence, it allowed the hospital to discontinue the treatment, since there was no prospect of any improvement in the patient's situation. Ineke Stinissen died on 8 January 1990, nearly 16 years after losing consciousness. Many people were upset by this case. It had a distinct impact on subsequent developments with regard to end-of-life decisions in Dutch medical practice.

There are several reasons for starting this general report with some infamous cases of euthanasia.

The first one is that it is cases like these which have fuelled the national as well as the international debate on euthanasia. These are not just legal 'cases'. The examples provide stories full of human interest. In one way or another, they elicit strong feelings among many people.

Consequently, the combined effect of these situations occurring, on the one hand, and the public indignation it provokes on the other, is that medical practice will quite often be affected and/or legal doctrine is reconsidered. In the French and the Dutch example, it ultimately led to a redirection of statutory criminal law.

Thirdly, the examples are worthwhile because they enable us to articulate the values and principles which are really at stake when dealing with medical end-of-life decisions. First and foremost, the right to life itself comes to mind. It is obvious that this most fundamental of all human rights must be the starting point for any discussion on the topic of euthanasia. The right to life may be the natural point of departure, but it is also only one side of the coin. The dreadful examples mentioned above make it abundantly clear that 'human life' means more than just a beating heart and some remaining brain activity. Life in itself cannot adequately be understood without taking into account the value of dignity. This begs the question whether some qualitative elements could or should be included in the concept of human life as the object of legal protection. And then there is the issue of autonomy. The autonomy of the individual human being allows him to have some authority in matters of health and medical treatment. Here again: the question is to what extent this authority can be exercised. How can limits to the right of self-determination be defined and on what grounds can they be justified?

The problem, of course, is that the values and the interests at stake in the debate on euthanasia show some tension. Each of the values can be invoked as a basis for legitimate arguments to support a certain position, but there is always room for opposing claims based on a different interpretation or on one of the other – equally respectable – interests or values. In my perception, this state of affairs has an important implication, which needs to be underlined at this early stage. The examples referred to clearly indicate that many people have vastly diverging opinions on how best to deal with these awkward situations. Strong feelings and heated arguments are the rule rather than the exception. Yet it is important to emphasize that – generally speaking – *all* the participants in the debate on euthanasia basically try to achieve the same goal, which is to respect human life and dignity. As far as I am concerned, the inference is that their views may be challenged and contested, but their motives can hardly be questioned.

And finally, the examples show that many *different* issues can be distinguished in the debate on euthanasia. Vincent Humbert was able to clearly articulate his will. He explicitly and repeatedly requested his life to be ended. The comatose patients could no longer express their wishes. Who, then, is allowed to speak on their behalf? Spouses, parents or children? In what order? And how do we appreciate prior statements (advance directives) by the patient? Can a written expression of will be accepted by the medical profession as definitive? Are there any time-limits attached to the conclusiveness of any such documents? The examples also raise all kinds of questions relating to the doctor-patient relationship. Can medical treatment

be permitted against the wishes of the patient? If so, under what circumstances? Is a physician allowed to stop medical treatment when there is no hope of improving the patient's condition? Is palliative care permitted when it has a predictable life-shortening side-effect?

In sum, the examples are extremely useful to set the stage for a fundamental debate on medical end-of-life decisions. I have received 14 national reports, all more or less based on the same format. I am very grateful to the national rapporteurs for the excellent research they have carried out. The country reports on euthanasia provide an abundance of material and reflections to further this discussion.

I have tried to collate some of the main insights from the country reports in this general report. Section 2 deals with definitional issues. It contains basic information on the way euthanasia has been conceptualized in statutory provisions, in case law, and in legal doctrine. Section 3 concerns the connection between medical treatment and the patient's will. It highlights differing views on the right to request treatment, the right to refuse treatment and the various problems in cases where it is difficult to actually get to know the patient's will. In section 4 the borderline between euthanasia and ordinary medical practice will be explored. It focuses primarily on the grey area separating palliative care from medical end-of-life decisions. Section 5 touches upon the concept of legal certainty. The question to address there is to what extent statutory law offers a higher degree of predictability concerning law enforcement activity than a system primarily governed by the case law of the courts. In section 6 some vital procedural issues are dealt with. In countries where euthanasia has been legalized, special procedural arrangements have been put in place in order to ensure careful and transparent medical conduct. And we will examine how the decision whether or not to prosecute a case of euthanasia is taken in all countries under consideration. Section 7 offers an overview of the empirical findings we have collected from the various jurisdictions. Finally, in section 8 the debate will be concluded. It will summarize the most frequently cited arguments for and against the legalization of euthanasia.

2. Definitional Issues

The first finding that is striking in a domain which is so ridden with controversy is that euthanasia generally does not feature as a statutory concept. The overwhelming majority of the national reports all indicate that the enacted penal codes do not contain a formal definition of euthanasia.¹

The content of the concept has to be drawn from legal literature and from other parts of the legal systems. In some countries, the definition of euthanasia has been developed in the case law.

¹ Belgium and Spain offer exceptions which will be referred to later.

The country reports reflect that many normative claims as to the admissibility of certain acts are discernible in the definition of the concept of euthanasia. Hence, in many countries distinctions are being made between active and passive euthanasia, between voluntary and involuntary euthanasia, and between direct and indirect euthanasia. Before explaining these differentiations in some detail, it has to be observed that there are two countries which have adopted a more monolithic concept of euthanasia. Unsurprisingly, this is the case in Belgium and in The Netherlands, which also happen to be the single jurisdictions where euthanasia is allowed by law when a number of very strict conditions have been met.² In these countries euthanasia is basically conceived as the “termination of life upon the earnest request of the patient”.³ It is interesting to note that from this perspective the notion of ‘involuntary euthanasia’ is a *contradictio in terminus*, and the distinction between active and passive euthanasia loses its relevance. Having said that, the vast majority of the countries dealt with in this general report have rejected the statutory legalization of (active) euthanasia of any kind. So we have to examine how these legal orders make use of the various dichotomies in order to improve our understanding of the phenomenon at hand.

The most frequently adopted distinction is the one between active and passive euthanasia. Sometimes a normative element is attached to the dichotomy, in the sense that the passive variety is permitted, whereas the active mode is considered illegal. In other legal orders both forms of euthanasia are prohibited.

In Germany, for instance, the distinction between principally permitted passive and prohibited active euthanasia is not determined by whether the physician acts or omits to act. According to the national report, the differentiation is determined according to whether the natural course of a terminal illness is not arrested through medical intervention or whether the life of a patient, independent of the natural course of the illness, is prematurely ended by a measure which is not medically indicated. Passive euthanasia is not proscribed by law; yet many physicians are afraid of being prosecuted and consequently the express desire of a patient is often neglected.

The report from Israel describes active euthanasia as medical conduct which accelerates death⁴ by an act of the physician or of the patient with the assistance of the physician. They conceive of passive euthanasia as the withholding of life-saving treatment, e.g.

² The report from Poland refers to a proposal (in November 2004) to legalize euthanasia in a similar way, i.e. impunity for a physician who acts according to a standardized, strictly regulated procedure.

³ The so-called ‘due-care criteria’ which have to be met are essentially the following: a physician will have to: a. be convinced that the patient’s request was made voluntarily and was well-considered; b. be convinced that the patient’s suffering is enduring and unbearable; c. inform the patient about the situation he is in, and about the prospects; d. be convinced, together with the patient, that no other reasonable solution is available; e. consult at least one other, independent physician, who has seen the patient, and who has given his written opinion on the aforementioned criteria; f. exercise due medical care when terminating the patient’s life.

⁴ The element of accelerating death is also essential in the delimitation of active and passive euthanasia under Greek law.

by not initiating or terminating the use of respiratory equipment.⁵ Active euthanasia is unconditionally prohibited; passive euthanasia will be assessed according to the circumstances of the case. Passive euthanasia can be considered as a natural cause of death. It is also argued that issues surrounding passive euthanasia are more of an ethical nature than questions of criminal liability. However, it is also reported that court decisions in this area are not consistent.

Croatia and Poland offer the classical example of making a distinction on the basis of the difference between an act and an omission. Active euthanasia is defined as inflicting a ‘good’ death by means of administering lethal drugs; passive euthanasia means withholding medical treatment with the intention of allowing life to pass away.⁶ Passive euthanasia is legal, unless there is a duty for the physician to interfere or to assist.⁷ Details will be referred to below.

It is significant that Croatia has never had a euthanasia case tried by a criminal court. At the other end of the spectrum, the United States has reportedly tried many such cases. The resulting extensive body of court rulings does not feature the distinction between active and passive euthanasia as a basis to distinguish between acceptable and illegal medical conduct.

Spain offers yet another conceptualization of passive euthanasia. The term has a dual definition. One centres on the absence of treatment or interrupting and aborting life-sustaining treatment. The other focuses on the notion of the medical pointlessness – the futility – of treatment in certain circumstances. If the *lex artis* of the medical professional deems any further action to be useless, then the discontinuation of interventions leading to the loss of life is not a crime. It is important to add that the Spanish report plainly states that passive euthanasia is quite a common occurrence in hospitals.

Japanese legal doctrine distinguishes between no less than 5 different kinds of euthanasia.⁸ The definition of active euthanasia includes an element of will: it is the termination of the physical suffering of the patient by a physician or a close relative by administering lethal drugs *in compliance with a request by the patient*. Similarly, passive euthanasia is conceived as a specific type where the medical doctor does not perform life-prolonging measures *in*

⁵ It is important to emphasize that the Israeli ‘Dying Patients Law’ (2005) seeks the solution in making a distinction between continuous treatment and periodic treatment. For details, *see* the description of art. 21 of the statute in the national report.

⁶ More or less the same distinction applies in Italy. Active euthanasia is an act causing death. Passive euthanasia is allowing a patient to die: non-interference by a person under an obligation to treat the patient and so help save his life.

⁷ In Greece, this is also basically the approach towards passive euthanasia, characterized as an omission. Only a few selected categories of persons can be criminally liable, e.g. a physician who is legally bound to provide treatment, a family member or a third party (a nurse) who was left to provide care, or – according to the national report – the person who caused the life-threatening situation, such as the driver who was involved in a car accident.

⁸ It appears to be relevant to note that this typology was inspired by a German dogmatic publication dating back as far as 1948!

compliance with a request by the patient. According to the Japanese report, this omission is generally considered lawful, since no one can compel prolonging life against the will of the person involved. We will return to this topic later.

The second dichotomy which is used in the pending debate is the distinction between direct and indirect euthanasia. These concepts also play a part in quite a few of the national reports.

The Germans are well known for their precise use of language in legal discourse. Hence it is interesting to note that the German national report explicitly states that active/passive and direct/indirect used to be distinguished in order to make a distinction between prohibited and permitted forms of euthanasia. In recent times, though, the term passive euthanasia has been replaced by the more neutral term 'limited treatment' and the concept of indirect euthanasia is now referred to as alleviating suffering with a life-shortening side-effect. This topic will later be dealt with under the heading of palliative care.

In Croatia, like in all other states, direct euthanasia means personal involvement in causing the death of the patient. Indirect euthanasia can take one of two forms. The first is basically assisted suicide, for instance by providing the patient with the means to terminate his own life. The other is medical treatment with the side-effect of shortening the lifespan of the patient. The latter definition, following the German example, appears to be the dominant one in many countries. Spain and Italy, for instance, also define indirect euthanasia as medical treatment and palliative care with predictable life-shortening implications.

Greek doctrinal opinion is even more intricate. It makes the distinction between 'direct active euthanasia' and 'indirect active euthanasia'. The former concept refers to ending the patient's life by administering lethal drugs. The indirect mode applies when the medication administered is primarily aimed at the amelioration of the dying patient's quality of life, hastening death only as a side-effect.

In Japan, the concept of indirect euthanasia is understood in the same way, but is phrased in different terms: providing painkillers – analgesic drugs – which incidentally accelerate the time of death. The Japanese reporter adds that *naturally the request of the patient is indispensable*. If I see this correctly, this requirement is not exactly 'natural', since Japan is the only jurisdiction where this condition applies in connection with the indirect form of euthanasia.

The third distinction which has to be dealt with is between voluntary and non-voluntary euthanasia. These two concepts appear in fewer national reports. Voluntary euthanasia commonly refers to the termination of life at the explicit and well-considered request of the patient. Non-voluntary euthanasia is present where the patient is not able to make up his mind or is not competent to express his will in this way (Croatia, Poland, Italy). Some countries (like Croatia) further distinguish involuntary euthanasia, which is described as the termination of life against the declared wish of the patient or his representative. It is perfectly clear,

however, that this has got nothing to do with euthanasia. It is without any doubt an ordinary case of criminal homicide. The notion of voluntary euthanasia will further be explored in section 3 below, where the connection between medical treatment and the will of the patient is the subject of our attention.

Before turning to the topic of request and consent, though, it is useful to point to some of the other substantive definitions of euthanasia which have been proposed in the national reports.

The Spanish report is the only one which refers to an explicit definition of euthanasia in the Penal Code. It reads: “to cause or cooperate actively with necessary and direct acts to the death of another person, on the express, serious and unequivocal request of this person and if the victim suffers a grave illness that would necessarily lead to his death or produces serious suffering that is lasting and difficult to alleviate” (article 143.4). In order to avoid any misunderstandings, I add that meeting these conditions does not lead to impunity. The definition is meant to make a distinction between euthanasia and more serious kinds of homicide.

In the Italian national report, the core of the term is described as “the intentional causation of the death of a patient suffering from a severe and incurable disease, in order to put an end to his pain and distress”. According to this definition, three elements can be considered as essential. Euthanasia is a) a type of conduct (bringing about death); b) in a situation of severe illness (an illness with great pain and distress; no prospect of recovery); and c) with a certain motive (compassion).

Interesting as these definitions may be, it appears to be doubtful whether they are really helpful in clarifying the debate on euthanasia. As I see it, the main function of conceptualizing euthanasia is to explain what is meant by the phenomenon. The search for the proper meaning of the concept should not be clouded or obscured by polluting the definition with an entirely different problem, i.e. the question of under what circumstances euthanasia might be justified. And that is exactly what happens by introducing elements into the definition like the kind of suffering (‘unbearable’), the kind of illness (‘severe and incurable’) or the stage of the illness (‘terminal’, ‘death is imminent’) or the motive of the actor (‘compassion’). So, for the sake of analytical clarity, it is probably most fruitful to aim for a neutral descriptive use of the word, and then only in the next stage of the debate to seek to identify circumstances and conditions which may or may not lead us to the conclusion that certain acts of euthanasia could be justified.

Finally, we have to look into the connection with assisted suicide. In many countries assisted suicide is included in the Penal Code as a separate crime. This is for instance the case

in Israël, Croatia, Italy, Japan, most parts of the United States, Belgium and The Netherlands.⁹ In most of these jurisdictions, the maximum penalty for assisted suicide is significantly more lenient than for taking another person's life at that person's request. The Polish legal order is particularly articulate on this topic. The medical profession has a duty to prevent instances of suicide; if a doctor is aware of preparations by the patient to take his own life and the physician does not interfere, he can be held liable for this omission. At the other end of the spectrum, assisting someone in committing suicide is not considered to be a crime in Finland and in Germany. It has to be added, though, that a physician does have an obligation to provide help when the person is unconscious after attempting to take his life. Another noteworthy example is Oregon's 1999 'Right to Death with Dignity Act', as far as I can see the only piece of legislation establishing a right to cause one's own death in strictly defined circumstances. In the American contribution it is reported that in the first six years in which the Act was in effect 265 lethal prescriptions were reported of which 171 were used to commit suicide. Conceptually, the Greek approach to this topic is interesting. The Criminal Code is violated when the perpetrator induces someone to commit suicide or when he assists him in actually doing so. Because, in both cases, death is essentially brought about by the combined actions of the two people involved in causing the death, in Greece it may well be classified as a type of euthanasia.

3. Medical Treatment and the Will of the Patient

Generally speaking, it is fair to say that a patient has a right to medical treatment. If someone's health is impaired, he can request medical care and the physician has an obligation to provide the required treatment. This follows from the Hippocratic oath and, in more practical terms, usually there is also a contractual basis for this doctor-patient relationship.

The right to request medical treatment is relatively undisputed. The patient's right to refuse medical treatment, on the other hand, is slightly more complicated.

I take the American national report as a starting point on this issue. According to the report, the right of control over one's own body and the right to refuse or discontinue medical treatment are settled concepts in the common law tradition. In principle, this also empowers a terminal patient in distress to discontinue the processes prolonging his life. It is important not to confuse this power with the 'right to die'. And, secondly, it must be noted that the right to refuse or discontinue medical treatment is not unrestricted. In the American case law several countervailing state interests have been identified which might be invoked to prevent the exercise of this right. The national reporter groups these under four headings: (a) the ethical

⁹ It has to be observed that in Belgium, where euthanasia is legal when a large number of procedural and substantive conditions have been met, no similar system of authorization exists for situations of assisted suicide. In The Netherlands, euthanasia and assisted suicide are treated in the same way.

integrity of the medical profession (to aid the sick and injured); (b) the protection of the interests of innocent third parties (abandonment of minor children); (c) the preservation of life (symbolically expressing society's regard for the sanctity of life); and (d) the prevention of suicide. These limitations turn out not to have a major practical impact. I quote the American rapporteur's conclusion: "The result is that there is almost no set of circumstances where a competent individual will not have the right to refuse or discontinue any medical procedure, no matter how effective it promises to be, and no matter how drastic the consequences of declining it."

The American example provides a useful benchmark for assessing the other countries in this respect.

In Germany, case law has offered guidance. The 1994 ruling by the BGH in the 'Kempton case' made it clear that the *presumed* will of the patient could have the same effect as the *explicit expression* of the person's will. A desire to forego treatment has to be respected; on the other hand, the principle 'in dubio pro vita' is applied. Depending on the circumstances of the case, prior court approval is sometimes required before stopping life-sustaining treatment. Regardless of the will of the patient, a physician has the right – not an obligation – to cease treatment at a terminal stage of life when it is medically useless to continue. It is argued that statutory provisions are desirable to increase legal certainty in this area.

Israel does have a legislative framework dealing with treatment and the patient's consent. The 1996 Patients' Rights Law establishes the principle that medical treatment should only be administered after obtaining the informed consent of the patient. Treatment without consent is permitted in a limited number of situations, for instance when the patient's life is in great danger. When this occurs, treatment is even possible against the patient's express desire, if an ethics committee, after hearing the patient, has authorized that the treatment be administered, provided that some legal requirements are met, the most significant being that there are reasonable grounds to assume that after the life-saving treatment has been administered the patient would give his retroactive consent. And, here again, futile medical treatment without any healing potential should not be compelled. The 2005 Dying Patients Law again seeks to strike a balance between the competing values: the sanctity of life, the quality of life, the prevention of pain and suffering, and individual autonomy. Basically, the law allows the patient's wish to terminate treatment to be respected: if a dying patient maintains his refusal to accept oxygen, nutrition and hydration by artificial means, he should not be compelled to do so.

Similarly, in 2004 Croatia adopted the Act on the Protection of the Rights of the Patient. A patient does not have an unqualified right to refuse medical treatment. A patient can refuse interventions, except in cases of undeferrable medical treatment whose non-performance

would endanger the patient's life! The Croatian national report argues that it is subject to interpretation whether or not this excludes discontinuing vital treatment for patients with terminal illnesses.

The French Act of 22 July 2005 clearly gives a patient the right to refuse any treatment (including nutrition and artificial respiration). If this would endanger the patient's life, a repeated request is necessary, which will be documented in the medical file.

In the Greek national report, the situation where the patient refuses the commencement or continuation of treatment is dealt with under the heading of 'voluntary passive euthanasia'. The right to refuse is rather absolute: even in urgent situations, requiring immediate medical attention, the will of the patient is the decisive factor.

The Spanish rapporteur argues that the patient has a right to refuse treatment, even after treatment has already commenced. The Penal Code contains a special provision (art. 172) for these situations: if a doctor continues the treatment in spite of the patient's refusal, he would be committing a crime against the freedom of the patient. If the patient is unable to express his will, the physician has to act according to the *lex artis*.

Finally, in Italy the right to refuse medical treatment is governed by case law. According to a Supreme Court ruling doctors have a strict professional obligation to treat a patient and to save his life, regardless of the patient's views. Human life is of greater value than the right to self-determination.¹⁰ On the other hand, there are verdicts by lower Italian courts in which a different approach is adopted. In these decisions the relevance of the preference of the individual patient is acknowledged to a larger extent. And it is worth underlining that the vast majority of the Italian *doctrine* recognises an absolute right for the patient to refuse any medical treatment – even a life-saving one.

The overall picture is clear. In all jurisdictions it is of paramount importance to know the patient's wishes. So the next question to address is how do we know the will of the patient? Of course, this is easy when the person is able to express himself and he is well aware of the circumstances. But how does one proceed when these conditions are absent? Can doctors rely on advance directives, prior written statements? Are these considered to be reliable? And, if so, for how long? Can relatives, next of kin, speak on behalf of the patient? How should infants be dealt with?

In Germany, these questions have attracted dedicated attention. I have already referred to the 'Kempten case' in which a patient had fallen into a persistent vegetative state. In such circumstances, the person's presumed will to forego treatment can be decisive. German lawyers have expressed the need for a legal regulation on the binding nature of written advance directives. This appears to be particularly desirable even though there is widespread agreement that an advance directive, which sets out clear and concrete instructions as to

¹⁰ It has to be noted, though, that this principle was affirmed only as obiter dictum.

specific medical situations and the desired treatment, is legally binding, provided there is no indication of a change of attitude. It is still unclear whether informal, particularly verbal advance directives, are valid.

According to the Israeli Dying Patients Law – which is very sophisticated in this respect – the individual has a right to express his wishes in advance regarding the medical treatment that will be administered to him if he becomes a dying patient and is incapable of expressing his wishes at the relevant time. The person may express his wishes by providing advance medical directives or by appointing a surrogate with a power of attorney and even by a combination of both methods. These directives are valid for a fixed period of five years, with an option for extension. Interestingly, the statute also provides for the establishment of a database in which advance directives and powers of attorney shall be recorded.

Under Croatian law, for patients who are unable to articulate their will (infants, comatose patients etc.) consent to medical treatment, except for undeferrable treatment, ought to be given by their proxies.

In the US both decisional and statutory law recognize three ways to make decisions for incompetent patients. The first one is the express directive, drawn up by the patient when competent. They may either spell out the circumstances in which particular procedures may or may not be used; or they may designate an individual to make the decisions with or without providing some substantive standards to be applied. Of course, the problem is recognized that this method assumes that the patient has not changed his mind since giving the directive and that the circumstances are similar to those expected. The second method is to make a decision in a way that attributes the choice to the patient, i.e. by means of a “substituted judgement”. This concerns the best judgement of the patient’s guardian and family as to whether to discontinue treatment, which he or she believes the principal would have made under the circumstances. The main weakness here, of course, is that no matter how well the surrogate decision-maker knows the patient, it is doubtful to what extent the patient’s wishes can be reproduced by someone else. The third method is based on the concept of the “patient’s best interest”. This objectified standard has been applied in quite a few cases. Paradoxically, this criterion becomes less meaningful in situations where it is most needed: where the incompetence is the result of permanent unconsciousness or a persistent vegetative state.

The Greek national report refers to the question at hand as “one of the most crucial questions regarding passive euthanasia, i.e. what is the precise point in time at which the patient’s will not to adopt life-saving measures must have been affirmed.” Greek criminal law does not recognize so-called “living wills”. It is considered that consent can only be solemn if

it is imparted subsequent to the occurrence of the life-threatening situation. Hence in Greece, the inferred will of a patient can be taken into account only to the benefit of life, never as an argument to justify terminating it.¹¹

In the Spanish legal literature, it is disputed whether or not a ‘will in advance’ can be equated with an ‘express request’ at the time of the actual intervention. In connection with the discontinuation of treatment, wills in advance can be taken into account as long as they do not violate the legal order or the *lex artis*. Importantly, in cases of irreversible coma, when treatment is really useless, doctors are allowed to follow a request by the patient’s family not to apply or to cease treatment. This is deemed to be consistent with the *lex artis*.

Belgian law has legalized euthanasia, which is defined as the termination of life upon express request. The request may take the form of an advance directive. This is the prior request relating to one specific situation of incapacity: the irreversible condition of unconsciousness. Of course, this is particularly relevant for comatose patients who have expressed their wishes in this way. The advance directive has to be reconfirmed every 5 years.

According to Italian law, everyone has a right to designate in advance a person who will assist him and tend to his interests in the event that the person later becomes incompetent. This proxy (“amministratore di sostegno”) can always approve medical treatment, but it is doubtful to what extent he is also permitted to consent to withholding or to withdrawing life-saving treatment. The Italian report describes the Terri Schiavo-like case of Ms Eluana Englaro, in which the court’s approval to stop artificial nutrition and hydration was finally declined after many years. The report concludes: “The Englaro case shows how deep the legal uncertainty is in Italy in this field.”

Under Dutch law, ‘positive advance directives’ are recognized. On the basis of such a request, no euthanasia can be performed, however, when the ‘due care criteria’ referred to above are not met. Advance directives requiring that certain treatment should be forgone, must be respected.

4. Palliative Care

In theory, euthanasia and palliative care are worlds apart. Euthanasia is terminating the life of a person. Palliative care means sustaining life, only taking away (or reducing) pain, anxiety and fear. Defined in this strict way, it is the difference between ending life and improving the quality of life.

In practice, however, things are not always as clear as they appear to be in the conceptualized world of legal and medical theory. There are, for instance, many

¹¹ The Greek reporter rejects the view submitted by other authors, claiming that in cases of irreversible coma further treatment sometimes infringes on human dignity, so that relatives or doctors may apply for a court order to cease treatment.

misunderstandings about the time frame in instances of euthanasia. Suffice it to say that in countries which have legalized euthanasia, the act of euthanasia quite often only reduces the remaining natural life-span of the patient by a number of hours or a couple of days. Conversely, the universally accepted practice of providing palliative care can – depending on the circumstances – also lead to the unavoidable shortening of life. Against this background we have to examine the relationship between the two phenomena in the various jurisdictions.

The litmus test here is the so-called “double effect theory”. This is a theoretical approach to palliative care. In many national reports the theory is referred to in one way or another. The theory in its most general shape holds that palliative care has a double effect: it alleviates suffering (reducing pain, fear and anxiety) and it has a life-shortening side-effect. In some countries this side-effect is accepted, as long as it really is a side-effect and not the true motive behind administering the drugs. In other countries the double-effect theory is rejected, in the sense that pain relief is not allowed if and when the inevitable consequence would be a substantial reduction of the life expectancy of the patient. And then, finally, there are jurisdictions where the situation is unclear in this respect.

The double-effect theory is rejected by Israeli law. The 2005 Dying Patients Law prohibits pain-relieving medication when the outcome will almost certainly be death. Palliative drugs are only allowed as long as there is a reasonable risk to the life of the patient. What is considered to be reasonable depends on the circumstances. The nature and seriousness of the suffering have to be taken into account in this respect. The Greek authors have adopted a very delicate approach in connection with this issue. Their report states that the loss of life engendered as a side-effect of palliative treatment can only be justified according to the notion of ‘socially acceptable risks’. Dogmatically, they still consider this to be a kind of euthanasia, but it is considered justified under strict conditions: a. that the patient is aware of the possible side-effects; b. there is consent by the patient; c. the palliative action is appropriate in terms of medical value to the patient; and d. it is performed *lege artis* by a physician. So here also, the answer is: prohibited, unless

Palliative sedation having as a side-effect the shortening of life is *only tacitly* tolerated in Croatia. If the motive behind the sedation is not the alleviation of suffering, but death, then the physician is criminally liable. Similarly, in Spain some researchers consider this palliative care as ‘indirect euthanasia’,^{12 13} which is not to be punished if the main goal of the treatment is to ease the patient’s suffering. Others reach the same result by a different argument: they

¹² The same conceptual approach can be found in the Italian report. This indirect form of euthanasia is considered to be a crime (“voluntary homicide”). Italian doctrine has found a justification for this act: the conflict of duties. Balancing these conflicting duties, the conclusion is that the quality of life of a particular human being prevails over human life as an abstract value as such.

¹³ In Japan the same terminology applies. This is consistent with the observation in the relevant national report that in Japan people are interested in “death with dignity” rather than euthanasia.

claim that palliative care with an inherent effect of shortening life is not prohibited because it is an ‘allowed risk of the medical activity’. The result is the same: impunity. The Spanish jurisdiction has an interesting novelty. In order to promote predictability and foreseeability, the government¹⁴ has published a list of situations in which treatment with life-shortening side-effects is allowed.¹⁵ In Finland, terminal care has long been accepted in customary law, and this is considered to be reinforced by the patient’s right of self-determination and by the established view of terminal care as a form of legitimate medical treatment.¹⁶

In France, palliative care has been the centrepiece of regulation for decades. In a Statutory Act of July 22, 2005, the ‘double-effect theory’ is manifestly accepted. Treatment with life-shortening consequences is allowed, provided it is administered by a physician to a patient who is severely or terminally ill, and when no alternative form of treatment is available.

It is reported that in Belgium the most common end-of-life decision is the alleviation of pain and symptoms with opioids in doses with a life-shortening effect. As in Croatia and Spain, it is the intention of the physician which makes the difference. According to the Belgian reporters, this distinction is fragile and problematic. Hence, they point to a ‘twilight zone’ between euthanasia and palliative care with life-shortening implications. The reporters regret that this opens up the possibility of hiding cases of euthanasia behind the ‘cover’ of palliative care. I consider this to be an extremely important observation, which might be applicable in many other countries than merely in Belgium alone. The authors furthermore recommend abandoning the element of motive as the criterion for the demarcation of euthanasia and palliative care. Instead, it is the dosage – the amount of drugs administered – which should be decisive: which dosage can be regarded as alleviation, and where does the dosage become lethal and should therefore be labelled as euthanasia?

The situation is least clear in Germany. According to the national report, the alleviation of suffering with the double effect of unavoidably shortening a life is not punishable. But the medical profession has not been adequately informed about this situation. The German reporter argues convincingly that there is a lack of legal certainty on this matter. This gap can only be filled by legislative action.

¹⁴ To be more precise: The Ministry of Health and Consumers, in cooperation with the General Council of the Judiciary.

¹⁵ For the sake of discussion, I quote the list: severe illness, terminal illness, agony, grave and chronic handicapped people, permanent vegetative condition.

¹⁶ In Finland, a conceptually interesting distinction is made between ‘dying care’, ‘terminal care’ and ‘palliative care’; for details I refer to the national report.

5. Role of the Courts and Statutory Provisions. Legal Certainty.

All national reports contain detailed information on the role of the courts and Statutory provisions on euthanasia. It is impossible – and it would be pointless – to collate the wealth of this material in this section. Instead, I will give a broad overview of how the topic is being dealt with in the various jurisdictions.

As has been noted in section 2, the term euthanasia is absent in virtually all the countries under consideration. The phenomenon itself, though, is addressed in nearly every Criminal Code. The most common way to approach the issue is to have a dedicated provision on taking someone's life on request, an act which carries a lower maximum penalty than ordinary homicide. Quite often these more favourable articles have a long history; sometimes they have been introduced more recently.¹⁷ Only in rare instances such as in Iran, is there no special provision whatsoever. In this case, euthanasia is regarded as plain murder; the only recourse left is to allow the judge to take the special circumstances into consideration as mitigating circumstances during sentencing.

Even with the more lenient provisions in place, sooner or later most countries were faced with sad cases in which it was obvious that the defendant had acted in good faith and usually with the best interests of the 'victim' in mind. This is where the role of the courts has become important. The 'hard cases' – examples of which have been mentioned in the introductory section – led the courts to different kinds of responses. I distinguish three main approaches.

One is to exercise great reluctance in accepting any exception to criminal liability in euthanasia cases. Consequently, this attitude of the courts could lead to public indignation and to pressure on the political institutions to take legislative action.

The second is to narrowly define specific defences which can be accepted in clearly demarcated circumstances. The national reports offer many examples of case law on isolated questions (like ceasing life-sustaining treatment when the patient is unable to express his will). The combined effect of these decisions is to create limited areas where the physician is free to exercise discretion and no longer has to fear prosecution and conviction.

And finally, some countries, like Japan and The Netherlands, have witnessed the courts accepting an even more active role. In these systems, the courts have more or less endeavoured to shape a more general set of criteria to assess acceptable types of conduct in the area of end-of-life decisions. In The Netherlands, this body of case law was subsequently translated into statutory provisions. It has to be added, though, that this is by no means a general or a self-evident pattern. In Japan, for instance, the guidance provided by case law has not led to popular support for legislative efforts to legalize some forms of euthanasia.

¹⁷ Croatia, for example (1997).

They want to see it remain in the corner of defences like justification and excuse. By contrast, the Belgian example shows that it is possible to adopt extensive statutory provisions without ‘preparation’ in prior case law.

The next main trend I want to emphasize is that during the past 15 years or so there has been a growing tendency to regulate end-of-life decisions not primarily in Criminal Codes, but in statutes governing the medical profession. It is increasingly the case that issues surrounding euthanasia are being considered as ethical questions and as problems concerning the edges of medical practice. The national reports show many examples of this tendency. I refer, *inter alia*, to the Israeli ‘Dying Patients Law’ and the Croatian ‘Act on the Protection of the Rights of Patients’.¹⁸ Even where the emphasis is still heavily on the Penal Codes – such as in southern Europe: Spain, Italy, Greece – there is growing interest in professional Codes of Conduct for physicians, which also deal with end-of-life decisions.¹⁹ Perhaps the most striking manifestation of this development is exemplified by the countries which have formally legalized well-defined instances of euthanasia. In Belgium as well as in The Netherlands strong efforts have been made to have euthanasia cases primarily assessed and reviewed within a medical framework. Criminal law, and the role of law enforcement officials, is supposed to be of secondary importance.

The conclusion is that the statutory law on end-of-life decisions is often fragmented. In quite a few countries it is obsolete and not in line with popular sentiment. Many key questions therefore remain unanswered or are approached in an inconsistent way by conflicting court rulings.²⁰ Against this background, it is unsurprising that the national reports contain many complaints about the lack of legal certainty in this area. The German report is very pertinent on this matter. It repeatedly calls on legislators to act and it underlines the central role of criminal law in establishing legal security in the field of euthanasia. Similar complaints are voiced in the Greek report. It claims that “the need to adopt guidelines on the above issues is more prevalent than ever, whether the Greek legislature is ready or not.” It is interesting to note that even in Belgium, one of the very few countries with detailed statutory provisions on the legality of euthanasia, there is unease about the legal certainty of the situation. The Belgian national reporters regret the fact that the pertinent legislation only covers euthanasia and does not deal with all the other end-of-life decisions.

¹⁸ The Finnish report also notes this development and provides several examples from Finland and from the supranational level.

¹⁹ Similarly, in Finland the National Board of Health issued the Instructions for Terminal Care (1982).

²⁰ Examples in the reports by Israel, Italy, and others.

6. Procedural Issues

Substantive law and procedural law cannot be completely separated. In many ways they are interlinked. This is also very much the case in the area of euthanasia. As we have seen in the previous sections, all the jurisdictions under consideration have criminalized (certain forms of) euthanasia and related end-of-life decisions by physicians and by other people. Hence quite a number of acts in this area constitute genuine ordinary crimes. On the other hand, we have also noticed that the legal order – or society at large – is at times somewhat embarrassed to deal with these cases as if they were merely ordinary crime. For instance, when a medical doctor has acted very carefully and with the best interests of his patient in mind, it can be a painful matter to subject such a person to the agony of a criminal trial.

So here an important procedural question enters the debate. Does the legal system allow the prosecutor some discretion in taking a decision whether or not to prosecute a case? Typically, some jurisdictions are based on the ‘legality principle’, meaning that every case in which enough evidence is available should be brought before the court. Then there is the alternative system based on the ‘expediency principle’, where the prosecutor has the power to decide not to proceed with the case if prosecution would not serve the general public interest. It is obvious that in the latter system procedural law can serve as a mechanism to correct the shortcomings and inequities of substantive law. It is unfortunate that a number of the national reports do not provide data on the nature of their criminal procedural law.

Countries operating a system based on the German tradition have usually accepted an obligation for the prosecutor to bring every serious case before a court. Such is the case, for instance, in Greece and in Spain.²¹ Alternatively, jurisdictions following the French tradition have normally incorporated the expediency principle. Apart from France itself, this is the case in Belgium and in The Netherlands.

The next procedural issue of extraordinary importance is how do the officials of the criminal justice system obtain information on instances of euthanasia? The main variable here appears to be whether or not there is a duty to report cases of this kind, and if so, whether or not the obligation also extends to the medical professional involved. Many countries have adopted a duty to report cases of euthanasia. Sometimes this also applies to the physician who has carried out the act himself, like in Belgium and in The Netherlands. In other jurisdictions the (potential) suspect is exempted from this obligation to report, apparently observing the principle that no one should be forced to incriminate oneself. This applies, for instance, in Greece and in Spain.²²

²¹ And, of course, in Germany itself. The German report does not address procedural issues; I do not expand on the exceptions to the ‘principle of legality’ which have been accepted in Germany or elsewhere.

²² Similarly, the Croatian report explains that there is no duty for the physician to report his own act of euthanasia, since this would be incompatible with the principle that no one should be forced to incriminate

The duty to report also has yet another significant implication. Reporting the occurrence of euthanasia is only meaningful if and when the physician supplies further information on the nature of the case. Hence, in all systems there is an obligation to respond to further inquiries as to the exact circumstances. This is a rather delicate state of affairs, since it usually concerns medical data which are otherwise extremely confidential because they are covered by the doctor-patient privilege.

There is ample reason to pay special attention to the procedure in euthanasia cases in Belgium and in The Netherlands.

In both countries, substantive law has explicitly legalized euthanasia if and when a number of due care criteria are met. The content of these criteria has been explained in section 2 above. The point to be raised here, however, is what happens after a physician has performed an act of euthanasia. Both countries have developed a detailed 'notification procedure'. First, the physician has to report the fact. In The Netherlands the report is filed with the municipal coroner, in Belgium it is submitted to the Federal Commission on Control and Evaluation on Euthanasia (FCCEE). What matters is that the report (or the annexes) provides detailed information about all the circumstances of the case, thus allowing the reviewer to check whether all the due care criteria have been met. In Belgium this assessment is conducted by the FCCEE, in The Netherlands by so-called regional review committees (RRC). It is important to stress that both authorities have been positioned as a sort of buffer between the physician, on the one hand, and the public prosecutor, on the other. This procedure was created with the dual objective of preventing the stigmatization of the physician and promoting the willingness of the medical profession to report instances of euthanasia. These objectives are also served by the composition of the FCCEE and the RRCs. Both bodies consist of medical professionals, lawyers and experts (be it in the area of incurable patients, in Belgium, or in ethics, as in The Netherlands). Only when these supervising authorities reach the conclusion that the due care criteria have been violated will the case file be sent to the Prosecution Service. And even then prosecution is not the automatic sequel. The Dutch example may suffice to underscore this point. Each case is brought before the Board of the Prosecution Service. If the Board finds that there are ample reasons to contemplate prosecution, it has to refer the file to the competent court for a 'judicial preliminary investigation' to be carried out by an examining magistrate. After the completion of the investigation, the results will again have to be assessed by the Board. They can then decide to either drop the case or to instigate prosecution, but in either situation, prior permission by the Minister of Justice is required! It is obvious that the rationale behind this elaborate decision-making process is to protect the medical profession against the whims or the personal preferences of individual prosecutors, no matter how senior their rank.

oneself. Others, such as the coroner, do have an obligation to report.

7. Empirical Findings. Disciplinary Measures.

Cases of euthanasia occur in every country. The question is: how often and in what ways? Some jurisdictions have taken steps in order to increase transparency in this area. Unsurprisingly, countries where euthanasia has been legalized have greater opportunities to secure cooperation by the medical profession in order to obtain reliable information on what is going on.²³

Perhaps it is safe to regard the Dutch and the Belgian statistical data as a benchmark in fact finding. According to the national report of The Netherlands some 40% of all deaths were preceded by a medical end-of-life decision. On average, just over 2% of all deaths qualify as euthanasia, 0.2% as assisted suicide, 0.7% as the termination of life without explicit patient request. Some 20% of all deaths resulted from a decision to abstain from treatment; a similar part was caused as a side-effect of palliative care. Approximately 10% of all deaths were preceded by terminal sedation.

The numbers in Belgium show remarkable similarities. Euthanasia in 1.1% of all deaths. Physician-assisted suicide: 0.1%. Termination of life without an explicit request by the patient: 3.2%. In 18.5% of cases death could be considered as a side-effect of palliative treatment. And, finally, in 16.4% of all deaths life was terminated due to withholding or withdrawing treatment. The obvious and inescapable conclusion to be drawn here is that euthanasia is only a relatively small part of all the problems surrounding end-of-life decisions. It is the most debated part as well as the most fiercely contested part, but the cited facts indicate that there are convincing reasons to start to pay more intensive attention to the other end-of-life decisions which dominate medical practice in many countries.

Compared to these findings, empirical evidence in many of the jurisdictions under consideration is scarce and scattered. The most significant remarks on 'the law in action' can be summarized as follows.

The German national report cites a survey indicating that an unknown quantity of active euthanasia exists. Estimates range from 3,000 to 19,000 cases. The number of convictions for killing another person at his request has been very low for many years (in 2003, 5 convictions).

Apparently, this observation is indicative of a feature that all of the jurisdictions under consideration have in common. Many national reports explicitly state that few prosecutions are instigated or that only a small number of physicians have been convicted. The observation

²³ The Belgian FCCEE has a dual mandate. It is set up to monitor and control individual cases on the one hand; and it is also charged with evaluating the entire system and the relevant statutory provisions. According to the national report, the FCCEE issued its first annual evaluation report in 2004. It notes that the substantive due care criteria were complied with in each individual case. No amendments to the statutory provisions were suggested.

in the American report is probably universally applicable:²⁴ “It is fair to conclude that physician-assisted suicide, as well as active euthanasia, occurs in hundreds if not thousands of cases every year. Yet there are few prosecutions. (...) In the small number of cases when doctors are brought to trial, convictions turn out to be exceptional. (...) And, in the few cases of conviction (...) lenient sentencing may be expected.”

Because euthanasia is prohibited in most countries, its regular occurrence is sometimes officially denied. Researchers, though, leave no doubt as to the actual situation. For instance, the Croatian report sadly concludes: “euthanasia is most probably taking place every day secretly and without any control”. The Polish report is equally candid: “In the publications issued in Poland on euthanasia, a trustworthy number of euthanasia interventions have not been published. Representatives of the medical profession state that there is a high chance that in some clinical conditions (...) activities undertaken may fall within the term euthanasia, although they are not named as such. Because such treatment had been considered to be offences or crimes committed by medical doctors, they were not revealed as concrete examples in public statements on euthanasia.” In Spain, the prosecution of euthanasia cases is virtually absent because the patients’ families and the medical doctors simply do not notify law enforcement officials of these incidents. A second reason mentioned in the national report is that combating euthanasia is not a priority for the Spanish government.

Euthanasia is not only a criminal offence, it is also an act that can lead to disciplinary measures by the professional peers of the physician. In Belgium and in The Netherlands, where euthanasia has been legalized under strict conditions, any violation of the statutory standards can lead to disciplinary procedures. These procedures can result in the imposition of sanctions like issuing a warning, a censure, a reprimand, suspension of the licence to practice and, ultimately, even being permanently prohibited from practising medicine. The same procedure and the ultimate measure – revocation of the physician’s licence to practice – applies in Croatia and in Spain. A detail of more than symbolic significance: Belgium, Croatia and Spain report that disciplinary sanctions have not yet been imposed in even a single case.

8. Conclusion

No one could expect this general report to culminate in a series of recommendations on how best to regulate the phenomenon of euthanasia. That is clearly impossible. It would also run counter to the very essence of the debate on this topic: it is an extremely complex, multi-layered discourse which is closely connected to many deep-rooted values, culturally

²⁴ The American rapporteur is well aware of this fact: “At the end, the American law *in action* is not unlike that in many other jurisdictions.”

determined convictions and religious beliefs. For this reason it is not even conceivable to identify best practices. In the case of euthanasia, the objectives of comparative law will have to be even more modest than in other areas.

Modest as the objectives may have to be, there can be no doubt that it is useful to analyse the different approaches and solutions adopted by various jurisdictions. Comparing the situation in a number of countries at the very least leads to clarification. If I see it correctly, it clarifies issues, it enables us to ask better – i.e. more precise and more profound – questions, it allows for the improved identification of frictions, and it provides a richer perspective for balancing competing interests and conflicting values.

The national reports comprise a wealth of material. It is striking that large parts of the reports deal with definitional questions. Even in the law, definitional issues are quite often not the most relevant ones. Let me quote Karl Popper on this: “The development of thought since Aristotle could, I think, be summed up by saying that every discipline, as long as it used the Aristotelian method of definition, has remained arrested in a state of empty verbiage and barren scholasticism, and that the degree to which the various sciences have been able to make any progress depended on the degree to which they have been able to get rid of this essentialist method. (This is why so much of our ‘social science’ still belongs to the Middle Ages) (...) The attempt to solve a factual problem by reference to definitions usually means the substitution of a merely verbal problem for the factual one.”²⁵ In general, I happen to agree with this diagnosis. In the area of euthanasia, though, the situation is slightly different. In my view, the elaborate expositions on the definition of euthanasia are quite useful. They allow for a better understanding of the factual problems we are faced with and how to deal with these problems as scholarly researchers and as policy shapers and legislators. The distinctions between active and passive euthanasia, direct and indirect euthanasia, and voluntary and involuntary euthanasia have been extensively discussed. The debate on the *concepts* has revealed the *underlying factual problems* we are seeking to address. Maybe that is one of the key results of comparing the various systems: we can only hope to *address* the issues at stake, without expecting to finally *solve* the problems. The different kinds of euthanasia which have been distinguished in the national reports have furthermore raised our awareness of the relationship between the various questions we have to answer in this domain. The question of what euthanasia is, on the one hand, and the question whether it can be tolerated or excused on the other.

The definitional parts of the national reports are directly related to the underlying substantive issues. When the term euthanasia is defined as death on an explicit and well-considered request, it immediately follows that we have to deal with a range of problems

²⁵ K. Popper, *The Open Society and its Enemies*. Part 2: *The High Tide of Prophecy: Hegel, Marx and the Aftermath* 9 & 295 (5th ed. 1966).

involving 'free will' in difficult medical circumstances. Is a dying patient really able to make up his mind? Can an advance directive be accepted as an expression of will? For what period of time do we consider an advance directive as valid? Can someone else speak on behalf of the dying patient? On what authority could such a third party claim to express the wishes of the patient? Does 'free will' necessarily entail an absolute right to refuse medical treatment, regardless of the circumstances? And if the right to refuse treatment is being recognized to such an extent, and based on the notion of the 'free will' of the patient, why then does not a single country accept the unqualified 'right to self-determination'?

The definitional debates also make it abundantly clear how much confusion there still remains in this area. Passive and active euthanasia. Attractive as this dichotomy may seem at first sight, if we scrutinize the way these concepts are being used in different jurisdictions and in the legal literature, it quickly becomes clear that the distinction is ill-suited as a basis for policy making or for drafting statutory provisions. Yet the many questions which have been raised in the national reports have predominantly led to a call for more legislation. This is one development which is apparently easy to predict. In many countries the desire for legal certainty will lead to new and more detailed legislation. As far as content is concerned, it is likely that more countries will decide to legalize certain types and kinds of euthanasia under strictly defined conditions.²⁶

Would additional legislation really satisfy the need for legal certainty? I do not think so. It would answer some questions, but it would also give rise to many others. The countries which have actually legalized euthanasia offer good examples in this respect. It is precisely in these countries with elaborate – substantive as well as procedural - provisions on euthanasia, where new complaints have been voiced about the underregulation of other end-of-life decisions. And no matter how solid the basic rules on euthanasia may be or might become, there will still be uncertainty as to the exact borderline with medical interventions like palliative care with a life-shortening side-effect. Similar grey areas will remain in determining the legal status of terminal sedation.

In a concluding section, some attention must be paid to the vital importance of transparency. Discussions about euthanasia are virtually meaningless if we do not know what really happens in actual daily medical practice. In order to acquire reliable data, it is imperative to gain the confidence of the medical profession. Physicians are very unlikely to candidly disclose their daily routines if they run the risk of being stigmatized in the criminal justice system. In the absence of an open debate between lawyers and the medical profession, end-of-life decisions will be taken in the dark and without any frame of reference for review or control. On the other hand, we also have to recognize the inherent limitations

²⁶ Finland is one of the countries which are likely to move in that direction. The author of the Finnish national report suggests a 'gradual approach' instead of a binary proposition.

of transparency. Probably the optimum in transparency is reached when there is a clear set of rules on the admissibility of euthanasia and an appropriate procedure for monitoring compliance. Essential in a procedure like this is always the obligation for the physician to report instances of euthanasia and to supply details of the circumstances of the case. Now, there is an inherent weakness in this arrangement. As is pointed out in the Dutch national report, the entire structure for organizing transparency and accountability ultimately depends to a large extent on the voluntary cooperation of the medical profession. When physicians flatly refuse to make any kind of report, there is usually no remedy available. The same applies when medical doctors unilaterally decide to report only those cases where there can be no doubt that all requirements have been met. So, the importance of transparency cannot be overrated; yet it can never be fully achieved.

It has been observed many times that euthanasia is a fiercely debated topic. Interestingly, the debate in various countries differs significantly in nature, in tone and in style. I mention but a few examples. In Greece, euthanasia is a very contentious issue. There is much attention being devoted to it among experts and also in the mass media. Public opinion polls show that the population is fairly equally split between those in favour and those opposing legalization.²⁷ The Greek Orthodox Church is fervently opposed to any attempt to legalize euthanasia. Against this background it is extremely interesting that the issue has never entered the political arena. According to the national report, no political party has ever included euthanasia on its agenda or even uttered an opinion in the context of public debate!²⁸ By contrast, in Spain there is an important social discussion on euthanasia, which also extends to politics. Because of the connection between euthanasia and ideology, it is common for politicians to use this issue in their campaigns to attract votes! There is also fierce debate between the professionals involved, such as lawyers, doctors and ethicists. Opinions are – predictably – divided. The Episcopal Conference of the Catholic Church has – equally predictably – condemned euthanasia, but the Catholic leadership has also supported the idea that life should not be prolonged in an abusive way and that a patient deserves palliative treatment even though this implies the shortening of life! Finally, in Poland public opinion is also fairly evenly split on this issue, with the Catholic Church being strongly opposed to legalization. The most significant aspect of the Polish debate, in my opinion, is the fact that it is postulated to endeavour to approach the topic without emotion, ideological prejudices and one-sided views in order to focus the attention of the interested parties on the real will and interests of the person severely affected by suffering in a terminal state.

²⁷ In Finland, 75-80% are in favour of active euthanasia; in France, the percentage is even 88%!

²⁸ One of the reasons cited for this state of affairs is that euthanasia is not regarded as a tangible social problem, due to its handling in private.

This last sentence leads me to the peroration of this general report. I was particularly impressed by the final section of the American national report. It says, *inter alia*: “What does distinguish American law is its almost universal rhetorical commitment to the sanctity of all life and its rejection of the idea that some lives are not worth living.” I am impressed, because the distinguishing feature lies in the “almost universal” and in the “rhetorical” nature of this commitment. The commitment itself turns out to be not the whole story. In the USA, like in other countries, researchers and others dealing with end-to-life decisions have recognized that the story is more complicated. As the report goes on: “For many Americans, it has been important to be able to end the suffering of loved ones while clinging to a belief in the sanctity of life.” This leads to results which are widely felt to be “tolerable”. Is that not what any country could only aim for? Tolerable outcomes. In comparing the 14 national reports, I have not found a single jurisdiction where the value of human life was taken lightly. There is not a single country where the idea has been accepted that some lives are not worth living. And there is universal compassion with dying patients who have to suffer from pain and anxiety in the final days and hours of their lives. Indifference is completely absent in the area of euthanasia. An ideal solution does not exist here. Every country tries its best to reconcile incompatibles. The search for tolerable results is guided by superseding the choice between pragmatism and dogmatic purity, by balancing moralism and rationalism, and by mixing fundamentalism and moderation. The debate will never stop. The truth will never be found, because it does not exist.

Cite as: Marc Groenhuijsen, *Euthanasia and the Criminal Justice System*, vol. 11.3 ELECTRONIC JOURNAL OF COMPARATIVE LAW, (December 2007), <<http://www.ejcl.org/113/article113-33.pdf>>.