

II. CONSEJO DE EUROPA

II.1. CONVENIOS

Convenio para la Protección de los Derechos Humanos y de las Libertades Fundamentales, hecho en Roma el 4 de noviembre de 1950

Instrumento de Ratificación de 26 de septiembre de 1979
Entrada en vigor de forma general el 3 de septiembre de 1953 y para España el 4 de octubre de 1979
Boletín Oficial del Estado núm. 243 de 10/10/1979
(Arts. 2, 3, 6, 8, 9 y 14)

Convenio relativo a los derechos humanos y la biomedicina, hecho en Oviedo el 4 de abril de 1997

Instrumento de Ratificación de 23 de julio de 1999.
Entrada en vigor de forma general el 1 de diciembre de 1999 y para España el 1 de enero del 2000
Boletín Oficial del Estado núm. 251, de 20/10/1999

Convenio para la Protección de los Derechos Humanos y de las Libertades Fundamentales, hecho en Roma el 4 de noviembre de 1950

Instrumento de Ratificación de 26 de septiembre de 1979
Entrada en vigor de forma general el 3 de septiembre de 1953 y para España el 4 de octubre de 1979
Boletín Oficial del Estado núm. 243 de. 10/10/1979

El Convenio se complementa por 11 Protocolos; de ellos, los Protocolos nº 3 (6 de mayo de 1963), nº 5 (20 de enero de 1966), nº 8 (19 de marzo de 1985) y nº 11 (11 de mayo de 1994) son de reforma; el Protocolo nº 2 (de 6 de mayo de 1963) se considera integrado; el Protocolo nº 9 (de 6 de noviembre de 1990) está derogado y el nº 10 (25 de marzo de 1992) ha quedado sin objeto; los Protocolos Adicional 1º, de 20 de marzo de 1952, 4º (de 16 de septiembre de 1963), 6º (de 28 de abril de 1983) y 7º (de 22 de noviembre de 1984) han reconocido derechos adicionales.

[...]

Título I. Derechos y Libertades

Art. 2. *Derecho a la vida.* 1. El derecho de toda persona a la vida está protegido por la Ley. Nadie podrá ser privado de su vida intencionadamente, salvo en ejecución de una condena que imponga pena capital dictada por un tribunal al reo de un delito para el que la ley establece esa pena.

2. La muerte no se considerará infligida con infracción del presente artículo cuando se produzca como consecuencia de un recurso a la fuerza que sea absolutamente necesario:

a) En defensa de una persona contra una agresión ilegítima.

b) Para detener a una persona conforme a derecho o para impedir la evasión de un preso o detenido legalmente.

c) Para reprimir, de acuerdo con la ley, una revuelta o insurrección.

Art. 3. *Prohibición de la tortura.* Nadie podrá ser sometido a tortura ni a penas o tratos inhumanos o degradantes
[...]

Art. 6. *Derecho a un proceso equitativo.* 1. Toda persona tiene derecho a que su causa sea oída equitativa, públicamente y dentro de un plazo razonable por un tribunal independiente

e imparcial, establecido por la ley, que decidirá los litigios sobre sus derechos y obligaciones de carácter civil o sobre el fundamento de cualquier acusación en materia penal dirigida contra ella. La sentencia debe ser pronunciada públicamente, pero el acceso a la sala de audiencia puede ser prohibido a la prensa y al público durante la totalidad o parte del proceso en interés de la moralidad, del orden público o de la seguridad nacional en una sociedad democrática, cuando los intereses de los menores o la protección de la vida privada de las partes en el proceso así lo exijan o en la medida considerada necesaria por el tribunal, cuando en circunstancias especiales la publicidad pudiera ser perjudicial para los intereses de la justicia.

2. Toda persona acusada de una infracción se presume inocente hasta que su culpabilidad haya sido legalmente declarada.

3. Todo acusado tiene, como mínimo, los siguientes derechos:

a) A ser informado en el más breve plazo, en una lengua que comprenda y detalladamente, de la naturaleza y de la causa de la acusación formulada contra él.

b) A disponer del tiempo y de las facilidades necesarias para la preparación de su defensa.

c) A defenderse por sí mismo o a ser asistido por un defensor de su elección y, si no tiene medios para pagarlo, poder ser asistido gratuitamente por un abogado de oficio, cuando los intereses de la justicia lo exijan.

d) A interrogar o hacer interrogar a los testigos que declaren contra el y a obtener la citación y el interrogatorio de los testigos que declaren en su favor en las mismas condiciones que los testigos que lo hagan en su contra.

e) A ser asistido gratuitamente de un intérprete, si no comprende o no habla la lengua empleada en la audiencia.

[...]

Art. 8. *Derecho al respeto a la vida privada y familiar.*

1 Toda persona tiene derecho al respeto de su vida privada y familiar, de su domicilio y de su correspondencia.

2. No podrá haber injerencia de la autoridad pública en el ejercicio de este derecho, sino en tanto en cuanto esta injerencia esté prevista por la ley y constituya una medida que, en una sociedad democrática, sea necesaria para la seguridad nacional, la seguridad pública el bienestar económico del país, la defensa del orden y la prevención del delito, la protección de la salud o de la moral, o la protección de los derechos y las libertades de los demás.

Art. 9. *Libertad de pensamiento, de conciencia y de religión.*

1. Toda persona tiene derecho a la libertad de pensamiento de conciencia y de religión; este derecho implica la libertad de cambiar de religión o de convicciones, así como la libertad de manifestar su religión o sus convicciones individual o colectivamente, en público o en privado, por medio del culto, la enseñanza, las prácticas y la observancia de los ritos

[...]

Art. 14. *Prohibición de discriminación.* El goce de los derechos y libertades reconocidos en el presente Convenio ha de ser asegurado sin distinción alguna, especialmente por razones de sexo, raza, color, lengua, religión, opiniones políticas u otras, origen nacional o social, pertenencia a una minoría nacional, fortuna, nacimiento o cualquier otra situación.

[...]

Convenio relativo a los derechos humanos y la bio-medicina, hecho en Oviedo el 4 de abril de 1997

Instrumento de Ratificación de 23 de julio de 1999.
Entrada en vigor de forma general el 1 de diciembre de 1999 y para España el 1 de enero del 2000
Boletín Oficial del Estado núm. 251, de 20/10/1999

PREÁMBULO

Los Estados miembros del Consejo de Europa, los demás Estados y la Comunidad Europea, signatarios del presente Convenio;

Considerando la Declaración Universal de los Derechos Humanos, proclamada por la Asamblea General de las Naciones Unidas el 10 de diciembre de 1948;

Considerando el Convenio para la Protección de los Derechos Humanos y de las Libertades Fundamentales, de 4 de noviembre de 1950;

Considerando la Carta Social Europea de 18 de octubre de 1961;

Considerando el Pacto Internacional de derechos civiles y políticos y el Pacto Internacional de derechos económicos, sociales y culturales de 16 de diciembre de 1966;

Considerando el Convenio para la Protección de las Personas con respecto al tratamiento automatizado de datos de carácter personal de 28 de enero de 1981;

Considerando igualmente la Convención sobre los Derechos del Niño, de 20 de noviembre de 1989;

Considerando que la finalidad del Consejo de Europa es la de conseguir una unión más estrecha entre sus miembros y que uno de los medios para lograr dicha finalidad es la salvaguardia y el fomento de los derechos humanos y de las libertades fundamentales;

Conscientes de los rápidos avances de la biología y la medicina,

Convencidos de la necesidad de respetar al ser humano a la vez como persona y como perteneciente a la especie humana y reconociendo la importancia de garantizar su dignidad;

Conscientes de las acciones que podrían poner en peligro la dignidad humana mediante una práctica inadecuada de la biología y la medicina;

Afirmando que los progresos en la biología y la medicina deben ser aprovechados en favor de las generaciones presentes y futuras;

Subrayando la necesidad de una cooperación internacional para que toda la Humanidad pueda beneficiarse de las aportaciones de la biología y la medicina;

Reconociendo la importancia de promover un debate público sobre las cuestiones planteadas por la aplicación de la biología y la medicina y sobre las respuestas que deba darse a las mismas;

Deseosos de recordar a cada miembro del cuerpo social sus derechos y responsabilidades;

Tomando en consideración los trabajos de la Asamblea Parlamentaria en este ámbito, comprendida la Recomendación 1160(1991) sobre la elaboración de un Convenio de Bioética;

Decididos a adoptar las medidas adecuadas, en el ámbito de las aplicaciones de la biología y la medicina, para garantizar la dignidad del ser humano y los derechos y libertades fundamentales de la persona,

Han convenido en lo siguiente:

CAPÍTULO I

Disposiciones generales

Artículo 1. *Objeto y finalidad.*

Las Partes en el presente Convenio protegerán al ser humano en su dignidad y su identidad y garantizarán a toda per-

sona, sin discriminación alguna, el respeto a su integridad y a sus demás derechos y libertades fundamentales con respecto a las aplicaciones de la biología y la medicina.

Cada Parte adoptará en su legislación interna las medidas necesarias para dar aplicación a lo dispuesto en el presente Convenio.

Artículo 2. *Primacía del ser humano.*

El interés y el bienestar del ser humano deberán prevalecer sobre el interés exclusivo de la sociedad o de la ciencia.

Artículo 3. *Acceso equitativo a los beneficios de la sanidad.*

Las Partes, teniendo en cuenta las necesidades de la sanidad y los recursos disponibles, adoptarán las medidas adecuadas con el fin de garantizar, dentro de su ámbito jurisdiccional, un acceso equitativo a una atención sanitaria de calidad apropiada.

Artículo 4. *Obligaciones profesionales y normas de conducta.*

Toda intervención en el ámbito de la sanidad, comprendida la investigación, deberá efectuarse dentro del respeto a las normas y obligaciones profesionales, así como a las normas de conducta aplicables en cada caso.

CAPÍTULO II

Consentimiento

Artículo 5. *Regla general.*

Una intervención en el ámbito de la sanidad sólo podrá efectuarse después de que la persona afectada haya dado su libre e informado consentimiento.

Dicha persona deberá recibir previamente una información adecuada acerca de la finalidad y la naturaleza de la intervención, así como sobre sus riesgos y consecuencias.

En cualquier momento la persona afectada podrá retirar libremente su consentimiento.

Artículo 6. *Protección de las personas que no tengan capacidad para expresar su consentimiento.*

1. A reserva de lo dispuesto en los artículos 17 y 20, sólo podrá efectuarse una intervención a una persona que no tenga capacidad para expresar su consentimiento cuando redunde en su beneficio directo.

2. Cuando, según la ley, un menor no tenga capacidad para expresar su consentimiento para una intervención, ésta sólo podrá efectuarse con autorización de su representante, de una autoridad o de una persona o institución designada por la ley.

La opinión del menor será tomada en consideración como un factor que será tanto más determinante en función de su edad y su grado de madurez.

3. Cuando, según la ley, una persona mayor de edad no tenga capacidad, a causa de una disfunción mental, una enfermedad o un motivo similar, para expresar su consentimiento para una intervención, ésta no podrá efectuarse sin la autorización de su representante, una autoridad o una persona o institución designada por la Ley.

La persona afectada deberá intervenir, en la medida de lo posible, en el procedimiento de autorización.

4. El representante, la autoridad, persona o institución indicados en los apartados 2 y 3, recibirán, en iguales condiciones, la información a que se refiere el artículo 5.

5. La autorización indicada en los apartados 2 y 3 podrá ser retirada, en cualquier momento, en interés de la persona afectada.

Artículo 7. *Protección de las personas que sufran trastornos mentales.*

La persona que sufra un trastorno mental grave sólo podrá

ser sometida, sin su consentimiento, a una intervención que tenga por objeto tratar dicho trastorno, cuando la ausencia de este tratamiento conlleve el riesgo de ser gravemente perjudicial para su salud y a reserva de las condiciones de protección previstas por la ley, que comprendan los procedimientos de supervisión y control, así como los de recurso.

Artículo 8. *Situaciones de urgencia.*

Cuando, debido a una situación de urgencia, no pueda obtenerse el consentimiento adecuado, podrá procederse inmediatamente a cualquier intervención indispensable desde el punto de vista médico a favor de la salud de la persona afectada.

Artículo 9. *Deseos expresados anteriormente.*

Serán tomados en consideración los deseos expresados anteriormente con respecto a una intervención médica por un paciente que, en el momento de la intervención, no se encuentre en situación de expresar su voluntad.

CAPÍTULO III

Vida privada y derecho a la información

Artículo 10. *Vida privada y derecho a la información.*

1. Toda persona tendrá derecho a que se respete su vida privada cuando se trate de informaciones relativas a su salud.
2. Toda persona tendrá derecho a conocer toda información obtenida respecto a su salud. No obstante, deberá respetarse la voluntad de una persona de no ser informada.
3. De modo excepcional, la ley podrá establecer restricciones, en interés del paciente, con respecto al ejercicio de los derechos mencionados en el apartado 2.

CAPÍTULO IV

Genoma humano

Artículo 11. *No discriminación.*

Se prohíbe toda forma de discriminación de una persona a causa de su patrimonio genético.

Artículo 12. *Pruebas genéticas predictivas.*

Sólo podrán hacerse pruebas predictivas de enfermedades genéticas o que permitan identificar al sujeto como portador de un gen responsable de una enfermedad, o detectar una predisposición o una susceptibilidad genética a una enfermedad, con fines médicos o de investigación médica y con un asesoramiento genético apropiado.

Artículo 13. *Intervenciones sobre el genoma humano.*

Únicamente podrá efectuarse una intervención que tenga por objeto modificar el genoma humano por razones preventivas, diagnósticas o terapéuticas y sólo cuando no tenga por finalidad la introducción de una modificación en el genoma de la descendencia.

Artículo 14. *No selección de sexo.*

No se admitirá la utilización de técnicas de asistencia médica a la procreación para elegir el sexo de la persona que va a nacer, salvo en los casos en que sea preciso para evitar una enfermedad hereditaria grave vinculada a sexo.

CAPÍTULO V

Investigación científica

Artículo 15. *Regla general.*

La investigación científica en el ámbito de la biología y la medicina se efectuará libremente, a reserva de lo dispuesto en

el presente Convenio y en otras disposiciones jurídicas que garanticen la protección del ser humano.

Artículo 16. *Protección de las personas que se presten a un experimento.*

No podrá hacerse ningún experimento con una persona, a menos que se den las siguientes condiciones:

- i) Que no exista un método alternativo al experimento con seres humanos de eficacia comparable.
- ii) Que los riesgos en que pueda incurrir la persona no sean desproporcionados con respecto a los beneficios potenciales del experimento.
- iii) Que el proyecto de experimento haya sido aprobado por la autoridad competente después de haber efectuado un estudio independiente acerca de su pertinencia científica, comprendida una evaluación de la importancia del objeto del experimento, así como un estudio multidisciplinar de su aceptabilidad en el plano ético.
- iv) Que la persona que se preste a un experimento esté informada de sus derechos y las garantías que la ley prevé para su protección.
- v) Que el consentimiento a que se refiere el artículo 5 se haya otorgado expresa y específicamente y esté consignado por escrito. Este consentimiento podrá ser libremente retirado en cualquier momento.

Artículo 17. *Protección de las personas que no tengan capacidad para expresar su consentimiento a un experimento.*

1. Sólo podrá hacerse un experimento con una persona que no tenga, conforme al artículo 5, capacidad para expresar su consentimiento acerca del mismo, cuando se den las siguientes condiciones:

- i) Que se cumplan las condiciones enunciadas en el artículo 16, párrafos (i) a (iv).
- ii) Que los resultados previstos del experimento supongan un beneficio real y directo para su salud.
- iii) Que el experimento no pueda efectuarse con una eficacia comparable con sujetos capaces de prestar su consentimiento al mismo.
- iv) Que se haya dado específicamente y por escrito la autorización prevista en el artículo
- v) Que la persona no exprese su rechazo al mismo.

2. De modo excepcional y en las condiciones de protección previstas por la ley, podrá autorizarse un experimento cuyos resultados previstos no supongan un beneficio directo para la salud de la persona si se cumplen las condiciones enumeradas en los párrafos (i), (iii), (iv) y (v) del apartado 1 anterior, así como las condiciones suplementarias siguientes:

- i) El experimento tenga por objeto, mediante una mejora significativa del conocimiento científico del estado de la persona, de su enfermedad o de su trastorno, contribuir a lograr en un determinado plazo resultados que permitan obtener un beneficio para la persona afectada o para otras personas de la misma categoría de edad o que padezcan la misma enfermedad o el mismo trastorno, o que presenten las mismas características.
- ii) El experimento sólo represente para la persona un riesgo o un inconveniente mínimo.

Artículo 18. *Experimentación con embriones «in vitro».*

1. Cuando la experimentación con embriones «in vitro» esté admitida por la ley, ésta deberá garantizar una protección adecuada del embrión.

2. Se prohíbe la constitución de embriones humanos con fines de experimentación.

CAPÍTULO VI

Extracción de órganos y de tejidos de donantes vivos para trasplantes

Artículo 19. *Regla general.*

1. La extracción de órganos o de tejidos para trasplantes sólo podrá efectuarse de un donante vivo en interés terapéutico del receptor y cuando no se disponga del órgano o del tejido apropiados de una persona fallecida ni de un método terapéutico alternativo de eficacia comparable.

2. El consentimiento a que se refiere el artículo 5 deberá ser expresa y específicamente otorgado, bien por escrito o ante una autoridad.

Artículo 20. *Protección de las personas incapacitadas para expresar su consentimiento a la extracción de órganos.*

1. No podrá procederse a ninguna extracción de órganos o de tejidos de una persona que no tenga capacidad para expresar su consentimiento conforme al artículo 5.

2. De modo excepcional y en las condiciones de protección previstas por la ley, la extracción de tejidos regenerables de una persona que no tenga capacidad para expresar su consentimiento podrá autorizarse si se cumplen las condiciones siguientes:

- i) Si no se dispone de un donante compatible capaz de prestar su consentimiento.
- ii) Si el receptor es hermano o hermana del donante.
- iii) Si la donación es para preservar la vida del receptor.
- iv) Si se ha dado específicamente y por escrito la autorización prevista en los apartados 2 y 3 del artículo 6, según la ley y de acuerdo con la autoridad competente.
- v) Si el donante potencial no expresa su rechazo a la misma.

CAPÍTULO VII

Prohibición del lucro y utilización de una parte del cuerpo humano

Artículo 21. *Prohibición del lucro.*

El cuerpo humano y sus partes, como tales, no deberán ser objeto de lucro.

Artículo 22. *Utilización de una parte extraída del cuerpo humano.*

Cuando una parte del cuerpo humano haya sido extraída en el curso de una intervención, no podrá conservarse ni utilizarse con una finalidad distinta de aquella para la que hubiera sido extraída, salvo de conformidad con los procedimientos de información y de consentimiento adecuados.

CAPÍTULO VIII

Contravención de lo dispuesto en el Convenio

Artículo 23. *Contravención de los derechos o principios.*

Las Partes garantizarán una protección jurisdiccional adecuada con el fin de impedir o hacer cesar en breve plazo cualquier contravención ilícita de los derechos y principios reconocidos en el presente Convenio.

Artículo 24. *Reparación de un daño injustificado.*

La persona que haya sufrido un daño injustificado como resultado de una intervención tendrá derecho a una reparación equitativa en las condiciones y modalidades previstas por la ley.

Artículo 25. *Sanciones.*

Las Partes deberán prever sanciones apropiadas para los casos de incumplimiento de lo dispuesto en el presente Convenio.

CAPÍTULO IX

Relación del presente Convenio con otras disposiciones

Artículo 26. *Restricciones al ejercicio de los derechos.*

1. El ejercicio de los derechos y las disposiciones de protección contenidos en el presente Convenio no podrán ser objeto de otras restricciones que las que, previstas por la ley, constituyan medidas necesarias, en una sociedad democrática, para la seguridad pública, la prevención de las infracciones penales, la protección de la salud pública o la protección de los derechos y libertades de las demás personas.

2. Las restricciones a que se refiere el párrafo precedente no podrán aplicarse a los artículos 11, 13, 14, 16, 17, 19, 20 y 21.

Artículo 27. *Protección más amplia.*

Ninguna de las disposiciones del presente Convenio deberá interpretarse en el sentido de que limite o atente contra la facultad de cada Parte para conceder una protección más amplia con respecto a las aplicaciones de la biología y la medicina que la prevista por el presente Convenio.

CAPÍTULO X

Debate público

Artículo 28. *Debate público.*

Las Partes en el presente Convenio se encargarán de que las cuestiones fundamentales planteadas por los avances de la biología y la medicina sean objeto de un debate público apropiado, a la luz, en particular, de las implicaciones médicas, sociales, económicas, éticas y jurídicas pertinentes, y de que sus posibles aplicaciones sean objeto de consultas apropiadas.

CAPÍTULO XI

Interpretación y seguimiento del Convenio

Artículo 29. *Interpretación del Convenio.*

El Tribunal Europeo de Derechos Humanos podrá emitir dictámenes consultivos, con independencia de todo litigio concreto que se desarrolle ante un órgano jurisdiccional, sobre cuestiones jurídicas relativas a la interpretación del presente Convenio, a solicitud de:

El Gobierno de una de las Partes, una vez informadas las demás Partes.

El Comité instituido por el artículo 32, en su composición restringida a los representantes de las Partes en el presente Convenio, mediante decisión adoptada por mayoría de dos tercios de los votos emitidos.

Artículo 30. *Informes sobre la aplicación del Convenio.*

Cualquier Parte, a instancias del Secretario General del Consejo de Europa, proporcionará las explicaciones requeridas acerca del modo en que su legislación interna garantiza la aplicación efectiva de todas las disposiciones del presente Convenio.

CAPÍTULO XII

Protocolos

Artículo 31. *Protocolos.*

Podrán redactarse protocolos de conformidad con lo dispuesto en el artículo 32, con el fin de desarrollar, en los ámbitos específicos, los principios contenidos en el presente Convenio.

Los protocolos quedarán abiertos a la firma de los signatarios del Convenio. Serán sometidos a ratificación, aceptación o aprobación. Un signatario no podrá ratificar, aceptar o aprobar los protocolos sin haber ratificado, aceptado o aprobado el Convenio con anterioridad o simultáneamente.

CAPÍTULO XIII

Enmiendas al Convenio

Artículo 32. *Enmiendas al Convenio.*

1. Las tareas encomendadas al Comité en el presente artículo y en el artículo 29 se llevarán a cabo por el Comité Director para la Bioética (CDBI) o por cualquier otro Comité designado a este efecto por el Comité de Ministros.

2. Sin perjuicio de las disposiciones específicas del artículo 29, todo Estado miembro del Consejo de Europa, así como toda Parte en el presente Convenio que no sea miembro del Consejo de Europa, podrá hacerse representar en el seno del Comité cuando aquél desempeñe las tareas confiadas por el presente Convenio, y si dispone de voto en el mismo.

3. Todo Estado a que se refiere el artículo 33 o que haya sido invitado a adherirse al Convenio de conformidad con lo dispuesto en el artículo 34, que no sea Parte en el presente Convenio, podrá designar un observador ante el Comité. Si la Comunidad Europea no es Parte, podrá designar un observador ante el Comité.

4. Con el fin de tener en cuenta los avances científicos, el presente Convenio será objeto de un estudio en el seno del Comité en un plazo máximo de cinco años a partir de su entrada en vigor, y en lo sucesivo, a intervalos que determinará el Comité.

5. Toda propuesta de enmienda al presente Convenio, así como toda propuesta de Protocolo o de enmienda a un Protocolo, presentada por una Parte, el Comité o el Comité de Ministros, será comunicada al Secretario general del Consejo de Europa, y se transmitirá por mediación del mismo a los Estados miembros del Consejo de Europa, a la Comunidad Europea, a todo Signatario, a toda Parte, a todo Estado invitado a firmar el presente Convenio conforme a lo dispuesto en el artículo 33 y a todo Estado invitado a adherirse al mismo conforme a lo dispuesto en el artículo 34.

6. El Comité examinará la propuesta no antes de dos meses a partir de que le haya sido transmitida por el Secretario general, conforme al párrafo 5. El Comité someterá a la aprobación del Comité de Ministros el texto adoptado por mayoría de dos tercios de los votos emitidos. Una vez aprobado, este texto será comunicado a las Partes para su ratificación, aceptación o aprobación.

7. Toda enmienda entrará en vigor, con respecto a las Partes que la hayan aceptado, el primer día del mes siguiente a la expiración de un período de un mes a partir de la fecha en que hayan comunicado al Secretario general su aceptación cinco Partes, comprendidos al menos cuatro Estados miembros del Consejo de Europa.

Para toda Parte que lo acepte posteriormente, la enmienda entrará en vigor el primer día del mes siguiente a la expiración de un período de un mes a partir de la fecha en que la mencionada Parte haya comunicado al Secretario general su aceptación.

CAPÍTULO XIV

Cláusulas finales

Artículo 33. *Firma, ratificación y entrada en vigor.*

1. El presente Convenio queda abierto a la firma de los Estados miembros del Consejo de Europa, de los Estados no miembros que hayan participado en su elaboración y de la Comunidad Europea.

2. El presente Convenio será sometido a ratificación, aceptación o aprobación. Los instrumentos de ratificación, aceptación o aprobación se depositarán en poder del Secretario general del Consejo de Europa.

3. El presente Convenio entrará en vigor el primer día del

mes siguiente a la expiración de un período de tres meses a partir de la fecha en que cinco Estados, que incluyan al menos a cuatro Estados miembros del Consejo de Europa, hayan expresado su consentimiento en quedar vinculados por el Convenio conforme a lo dispuesto en el apartado precedente.

4. Para todo Signatario que exprese posteriormente su consentimiento en quedar vinculado por el Convenio, el mismo entrará en vigor el primer día del mes siguiente a la expiración de un período de tres meses a partir de la fecha del depósito de su instrumento de ratificación, aceptación o aprobación.

Artículo 34. *Estados no miembros.*

1. Una vez entrado en vigor el presente Convenio, el Comité de Ministros del Consejo de Europa podrá invitar a adherirse al presente Convenio, previa consulta a las Partes, a cualquier Estado no miembro del Consejo de Europa, mediante una decisión adoptada por la mayoría prevista en el artículo 20, párrafo d) del Estatuto del Consejo de Europa, y por unanimidad de los votos de los representantes de los Estados Contratantes que tengan derecho a estar representados en el Consejo de Ministros.

2. Para todo Estado adherente, el Convenio entrará en vigor el primer día del mes siguiente a la expiración de un período de tres meses a partir de la fecha del depósito del instrumento de adhesión ante el Secretario general del Consejo de Europa.

Artículo 35. *Aplicación territorial.*

1. Todo Signatario, en el momento de la firma o en el momento del depósito de su instrumento de ratificación, aceptación o aprobación, podrá designar el territorio o territorios a los que se aplicará el presente Convenio. Cualquier otro Estado podrá formular la misma declaración en el momento de depositar su instrumento de adhesión.

2. Toda Parte, en cualquier momento posterior, podrá extender la aplicación del presente Convenio mediante una declaración dirigida al Secretario general del Consejo de Europa, a cualquier otro territorio designado en la declaración y del que asuma las relaciones internacionales o para el que esté habilitado para adoptar decisiones. El Convenio entrará en vigor con respecto a este territorio el primer día del mes siguiente a la expiración de un período de tres meses a partir de la fecha de recepción de la declaración por el Secretario general.

3. Toda declaración hecha en virtud de los dos apartados precedentes podrá ser retirada, en lo que se refiere a cualquier territorio designado en dicha declaración, mediante notificación dirigida al Secretario general. La retirada surtirá efecto el primer día del mes siguiente a la expiración de un período de tres meses a partir de la fecha de recepción de la notificación por el Secretario general.

Artículo 36. *Reservas.*

1. Cualquier Estado y la Comunidad Europea podrán formular, en el momento de la firma del presente Convenio o del depósito del instrumento de ratificación, aceptación, aprobación o adhesión, una reserva con respecto a una disposición particular del Convenio, en la medida en que una Ley vigente en su territorio no sea conforme a dicha disposición. Las reservas de carácter general no se autorizan según los términos del presente artículo.

2. Toda reserva emitida conforme al presente artículo incluirá un breve informe de la ley pertinente.

3. Toda Parte que extienda la aplicación del presente Convenio a un territorio designado en una declaración prevista en aplicación del apartado 2 del artículo 35, podrá formular una reserva para el territorio de que se trate, conforme a lo dispuesto en los apartados precedentes.

4. Toda Parte que haya formulado la reserva indicada en el presente artículo podrá retirarla por medio de una declaración dirigida al Secretario General del Consejo de Europa. La retirada surtirá efecto el primer día del mes siguiente a la expiración de un período de un mes a partir de la fecha de recepción por el Secretario general.

Artículo 38. Denuncia.

1. Toda Parte podrá denunciar el presente Convenio, en cualquier momento, mediante notificación dirigida al Secretario general del Consejo de Europa.

2. La denuncia surtirá efecto el primer día del mes siguiente a la expiración de un período de tres meses a partir de la fecha de recepción de la notificación por el Secretario General.

Artículo 38. Notificaciones.

El Secretario general del Consejo de Europa notificará a los Estados miembros del Consejo a la Comunidad Europea, a todo Signatario, a toda Parte y a cualquier otro Estado que haya sido invitado a adherirse al presente Convenio:

- a) toda firma;
- b) el depósito de todo instrumento de ratificación, aceptación, aprobación o adhesión;
- c) toda fecha de entrada en vigor del presente Convenio, conforme a sus artículos 33 ó 34;
- d) toda enmienda o Protocolo adoptado conforme al artículo 32, y la fecha en la que dicha enmienda o protocolo entren en vigor;
- e) toda declaración formulada en virtud de lo dispuesto en el artículo 35;
- f) toda reserva y toda retirada de reserva formuladas conforme a lo dispuesto en el artículo 36;
- g) cualquier otro acto, notificación o comunicación que tenga relación con el presente Convenio.

En fe de lo cual, los abajo firmantes, debidamente autorizados a estos efectos, han firmado el presente Convenio.

Hecho en Oviedo (Asturias), el 4 de abril de 1997, en francés y en inglés, siendo ambos textos igualmente auténticos, en un solo ejemplar que será depositado en los Archivos del Consejo de Europa. El Secretario general del Consejo de Europa transmitirá copia certificada conforme del mismo a cada uno de los Estados miembros del Consejo de Europa, a la Comunidad Europea, a los Estados no miembros que hayan participado en la elaboración del presente Convenio y a todo Estado invitado a adherirse al presente Convenio.

<i>Estados Parte</i>	<i>Fecha firma</i>	<i>Fecha depósito instrumento</i>
Chipre -----	30-9-1998	
Croacia -----	7-5-1999	
Dinamarca -----	4-4-1997	10-8-1999
Eslovaquia -----	4-4-1997	15-1-1999
Eslovenia -----	4-4-1997	5-11-1999
España -----	4-4-1997	1-9-1999
Estonia -----	4-4-1997	
Finlandia -----	4-4-1997	
Francia -----	4-4-1997	
Grecia -----	4-4-1997	6-10-1998
Hungría -----	7-5-1999	
Islandia -----	4-4-1997	
Italia -----	4-4-1997	
Letonia -----	4-4-1997	
Lituania -----	4-4-1997	
Luxemburgo -----	4-4-1997	
Macedonia -----	4-4-1997	
ex República de Yugoslavia		
Repúb. Moldova --	6-5-1997	
Noruega -----	4-4-1997	
Países Bajos -----	4-4-1997	
Polonia -----	7-5-1999	
Portugal -----	4-4-1997	
Rumania -----	4-4-1997	
San Marino -----	4-4-1997	20-3-1998
Suecia -----	4-4-1997	
Suiza -----	7-5-1999	
Turquía -----	4-4-1997	

R = Reserva.

Conforme al artículo 36 del Convenio, la República de Turquía se reserva el derecho a no aplicar lo dispuesto en el apartado 2 del artículo 20 del Convenio, que autoriza, en ciertas condiciones, la extracción de tejidos regenerables de una persona que no tenga capacidad para dar su consentimiento, ya que esta disposición es contraria a la prohibición establecida en el artículo 5 de la Ley número 2238, sobre extracción, preservación y trasplante de órganos y tejidos.

El presente Convenio entrará en vigor de forma general el 1 de diciembre de 1999 y para España el 1 de enero de 2000, de conformidad con lo establecido en su artículo 33 del mismo.

Lo que se hace público para conocimiento general.

II.2. TEXTOS ADOPTADOS Y DECLARACIONES

Doc. 10495 8 April 2005 Assistance to patients at end of life
Committee on Legal Affairs and Human Rights

CM(2003)21add2E / 12 February 2003
Steering Committee on Bioethics (CDBI) - Report on laws and/or practices of member states with regard to the issues raised by Parliamentary Assembly Recommendation 1418 (1999) on the protection of the human rights and dignity of the terminally ill and the dying [831 Meeting]

Doc. 9923 23 September 2003 Euthanasia
Committee on Legal Affairs and Human Rights

Recommendation Rec(2003)24 of the Committee of Ministers to member states on the organisation of palliative care

(Adopted by the Committee of Ministers on 12 November 2003 at the 860th meeting of the Ministers' Deputies)

7th Conference of European Health Ministers «Health, Dignity and Human Rights»- 12-13 June 2003 - Oslo, Norway «The role and responsibility of Health Ministers in meeting the challenges of the changes in society and new technology at the beginning of the third millennium»
Final Declaration MSN-7-HF(2003)3 Final version 13 June 2003

Doc. 9898 10 September 2003 Euthanasia
Report Social, Health and Family Affairs Committee

Doc. 9404 8 avril 2002 Protection des droits de l'homme et de la dignité des malades incurables et des mourants

Doc. 9170 4 juillet 2001 Euthanasie. Proposition de résolution

Doc. 8951 3rd édition 14 May 2001 Legalisation of euthanasia in Europe

Written Declaration No. 312

3rd edition, originally tabled on 25 January 2001

Recommendation No. R (2000) 5 of the Committee of Ministers to member states on the development of structures for citizen and patient participation in the decision-making process affecting health care

(Adopted by the Committee of Ministers on 24 February 2000 at the 699th meeting of the Ministers' Deputies)

Recommendation 1418 (1999) Protection of the human rights and dignity of the terminally ill and the dying

Text adopted by the Assembly on 25 June 1999 (24th Sitting).

Recommendation No. R (80) 4 of the Committee of Ministers to the Member States Concerning the Patient as an Active Participant In His Own Treatment

(Adopted by the Committee of Ministers on 30 April 1980 at the 318th meeting of the Ministers' Deputies)

Doc. 10495 8 April 2005 Assistance to patients at end of life

Committee on Legal Affairs and Human Rights

Opinion ¹

Committee on Legal Affairs and Human Rights

Rapporteur for opinion: Mr Kevin McNamara, United Kingdom, Socialist Group

I. Conclusions of the committee

The Committee on Legal Affairs and Human Rights expresses some reservations on the report adopted by the Social, Health and Family Affairs Committee. It wishes therefore to propose several amendments to the draft resolution.

II. Proposed amendments to the draft resolution

The Committee proposes the following amendments:

Amendment A (English text only):

In the draft resolution, paragraph 1, replace «pointed out in» with «recalls».

Amendment B:

In the draft resolution, sub-paragraph 2.ii., delete «even».

Amendment C:

In the draft resolution, paragraph 4, after «genuine policy of» insert «physical, moral and spiritual».

Amendment D:

In the draft resolution, at the end of sub-paragraph 4.i, add the following text: «If, to relieve dying patients' suffering, doctors are obliged to use forms of treatment which may have

the side-effect of shortening their lives, they must so inform those patients if they are conscious, or a relative if they are not. Doctors are not entitled to cause death deliberately;».

Amendment E:

In the draft resolution, at the end of sub-paragraph 5.ii, insert «by the doctor; the doctor must explain to the patient the consequences of the refusal of treatment. He must fully record this in the patient's medical notes;».

Amendment F:

In the draft resolution, sub-paragraph 5.iii., after « «living wills» add «»or «advance decisions» «.

Amendment G:

In the draft resolution, sub-paragraph 6.i., delete «in the Netherlands and Belgium» and replace at the end «other countries» with «member states».

Amendment H:

In the draft resolution, after sub-paragraph 6.ii., insert the following new paragraph:

«make an effort to determine the presumed wishes of patients who are no longer able to express their wishes, including through discussing the issue of advance decisions or through the appointment of a representative mandated by the patient to deal with medical questions («representative for medical matters»). When discussing advance decisions, member states should bear in mind the safeguards around these; advance decisions dealing with life-sustaining treatment should be in writing and properly signed and witnessed;».

Amendment I:

In the draft resolution, after sub-paragraph 6.iii, add the following new sub-paragraph:

«draw up, when they do not already exist, specific recommendations on patients who, without being terminally ill, may request that all treatment be stopped or restricted and on intensive care of the newborn;».

III. Explanatory memorandum

by Mr McNamara

Article 2.1 of the European Convention on Human Rights:

«Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.»

Article 8 of the European Convention on Human Rights:

«1. Everyone has the right to respect for his private and family life.

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

¹ See Doc 10455 tabled by the Social, Health and Family Affairs Committee.

Recent European Case Law

1. Article 2, as set out above, contains a negative restraint on the State but also requires the State to take active steps for the protection of life. In the case of *Osman v United Kingdom*² the European Court of Human Rights stated that:

«The Court notes that the first sentence of Article 2(1) enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. It is common ground that the State's obligation in this respect extends beyond its primary duty to secure the right to life»

2. In *Pretty v United Kingdom*³ the European Court of Human Rights made it clear that euthanasia and assisted suicide were legitimately prohibited by the State under Article 2 of the European Convention on Human Rights (ECHR):

«The consistent emphasis in all the cases before the Court has been the obligation of the State to protect life. The Court is not persuaded that the 'right to life' guaranteed in Article 2 can be interpreted as involving a negative aspect....it is unconcerned with issues to do with the quality of life or what a person chooses to do with his or her life....nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.

«The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention.»

Furthermore, the ECHR did not consider that the UK's blanket ban on assisted suicide is disproportionate in the context of Article 8:

«It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide.»

The Way Forward: Parliamentary Assembly Recommendation 1418 (1999)

3. Rather than adopt the draft resolution currently under discussion, the Assembly Committee and all member States of the Council of Europe should reaffirm Parliamentary Assembly Recommendation 1418 (1999) on 'Protection of the human rights and dignity of the terminally ill and the dying'.

4. As this Recommendation noted, the dignity of terminally ill or dying persons is best respected and protected by:

i. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by member states...

ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.»

5. While recognising the terminally ill or dying person's right to self determination Recommendation 1418 acknowledges

that the obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. Recommendation 1418 calls upon Member States to recognise and protect «a terminally ill or dying person's right to comprehensive palliative care.» Much remains to be done in Member States to secure this right. In these circumstances calls for the decriminalisation of euthanasia as proposed by the rapporteur of the Social, Health and Family Affairs Committee are premature.

6. In paragraph 6 of its explanatory memorandum the rapporteur argues that the subject of euthanasia lies at the crossroads between «free will and religious belief». The implication here is that the two are diametrically opposed when in fact free will and, in particular freedom of conscience, are fundamental to many of the great faiths. Such misleading language should be deleted.

7. In paragraph 7 the rapporteur argues «every survey confirms that euthanasia is practised in many countries, in proportions well in excess of what was previously believed.» The rapporteur frequently makes this assertion (see the draft resolution and paragraphs 34 and 35). At no point in either the draft resolution or the explanatory memorandum does the rapporteur provide substantive evidence to back up his disturbing assertion. Indeed, in paragraph 35 of his explanatory memorandum he argues that «anecdotal evidence abounds». At paragraph 26 the rapporteur acknowledges that «there have been few large-scale empirical studies in Europe». The Parliamentary Assembly must have substantial, independent and well-documented evidence if it is to consider this crucial issue with the seriousness it deserves.

8. The definition of euthanasia attempted in paragraph 8 is inaccurate and conflates legitimate end of life care with euthanasia. Paragraph 8 should be deleted. The definitions provided by the rapporteur in paragraphs 13, 14 and 15 are far more accurate.

9. In paragraph 16 the rapporteur expresses concern about the use of the word «euthanasia». Expressions like «assisted dying» may be preferable for pro-euthanasia advocates as they help avoid the negative connotations that will inevitably be associated with «euthanasia». However, expressions like «assisted dying» blur the boundary between euthanasia and palliative care, the latter being essentially about providing assistance in dying.

10. Euthanasia, in all its forms, can be accurately defined. To avoid any confusion it is essential that this debate is conducted using terminology that can be readily and accurately defined.

11. In paragraph 12 the rapporteur explains that «public opinion polls in several member states show that a majority are in favour of legislation to regulate euthanasia» and that legislators «must somehow respond to this challenge».

12. Notwithstanding the fact that the questions asked in these polls are often loaded and misleading, in several member states public opinion polls have consistently shown that a majority are in favour of capital punishment. Legislators have not responded to this challenge by acceding to popular opinion but by seeking to inform the public of the dangers associated with state-sanctioned killing, not least the fact that the innocent may be victims⁴.

² (1998) 29 EHRR 245

³ Application No. 2346/02; 29th April 2002.

⁴ For example see the MORI website: <http://www.mori.com/mrrr/2002/c020823.shtml>

13. Legislators should respond in the same manner to calls for the legalisation or decriminalisation of euthanasia and assisted suicide.

14. When analysing the empirical evidence from the Netherlands the rapporteur neglects to mention four important points:

15. Firstly, the three surveys which have been conducted in the Netherlands in 1990, 1995 and 2001⁵ demonstrate that the frequency of ending of life without the patient's explicit request has shown no decline over the years studied. In 2001, the most recent year for which statistics are available, 900 out of 3,800 cases of euthanasia or assisted suicide (approximately one-quarter) were without the patient's explicit request.

16. Secondly, the rapporteur fails to mention that according to the latest official report on euthanasia in the Netherlands⁶, only 54% of cases of euthanasia were reported to the regulatory authority and that «life terminating treatment without explicit request of the patient is still seldom reported (less than 1%).» According to a press report, the low notification rate is because doctors wished to avoid the «administrative hassle»⁷ of reporting a euthanasia case and were concerned they might have breached the regulations.

17. Notwithstanding the difficulties in accurately estimating the number of cases that go unreported, this demonstrates that legalizing euthanasia does not necessarily create greater control over the practice. The Dutch situation demonstrates that legalizing euthanasia and assisted suicide, far from introducing greater control, simply introduces more euthanasia and more assisted suicide.

18. This disturbing trend is compounded by the statistics from Flanders, Belgium cited by the rapporteur in paragraph 31. «Of the 4.4% of all deaths resulting from the use of lethal drugs, 1.1% were cases of euthanasia, 0.1% physician-assisted suicide, and 3.2% ending of life without the patient's explicit request. «(emphasis added).

19. Thirdly, it has recently been revealed that euthanasia is being practised on babies and infants in the Netherlands, despite the fact that euthanasia is technically legal in Holland only for patients aged over 12.⁸ Doctors at the Groningen hospital have admitted that at least 22 newborn babies have been put to death since 1997 based on the doctors' own reports to public prosecutors. This information came to light in a recent report in the Dutch Journal of Medicine. The author of the report, Dr. Eduard Verhagen, the head of the paediatrics unit at Groningen University Hospital, said that doctors put to death between 10 and 15 infants a year.

20. Fourthly, in July 2001 the United Nations Human Rights Committee issued a report which expressed carefully-worded concern over the legalization of euthanasia in the Netherlands

and its potential impact⁹ The committee report said «such a practice may lead to routinisation and insensitivity to the strict application of the requirements.» The committee also expressed scepticism over the very few negative assessments made in over 2000 cases of assisted suicide and euthanasia in the Netherlands. The report states: «The large numbers involved raise doubts whether the present system is being used in extreme cases in which all the substantive conditions are scrupulously maintained.» In addition, the UN committee noted that Dutch monitoring of euthanasia detects abuses only after the patient has been killed and called for strengthening of mechanisms to catch violations in advance of death. The Human Rights Committee also urged a scrupulous investigation of reports that newborn infants with disabilities have had their lives ended by medical personnel.

21. Empirical evidence from the Netherlands and Belgium reinforces the argument that it is impossible to set safe bounds to euthanasia so as to ensure that only those who have expressed a persistent, voluntary and well-considered request are put to death.

22. In paragraph 33 the rapporteur cites evidence about the attitude of doctors to the legalisation of euthanasia. In this context it is important to cite the most recent independent survey of UK doctors by the Opinion Research Business (ORB), published on May 13th 2003¹⁰. This survey revealed that:

- Almost three out of four doctors (74%) would refuse to perform assisted suicide if it were legalised.
- A clear majority (56%) also consider that it would be impossible to set safe bounds to euthanasia.
- To the question «As a doctor do you agree with assisted suicide?» 25% agreed, 60% disagreed and 13% were undecided.
- The number who rejected euthanasia was higher – 61% as compared with 22% in favour and 14% undecided.
- Not one palliative care doctor who responded to the survey would practice either euthanasia or assisted suicide.
- 66% of doctors considered that the pressure for euthanasia would be lessened if there were more resources for the hospice movement.

23. In paragraphs 36 to 40 inclusive the rapporteur sets out some of the criticisms levelled at euthanasia and the new legislation in the Netherlands and Belgium. In paragraph 41 the rapporteur goes on to say that the main arguments for euthanasia relate to personal autonomy. It should be noted that respect for personal autonomy is an important argument against euthanasia that the rapporteur neglects to mention.

24. If euthanasia or physician assisted suicide were legalized or partially decriminalized then this would have a profound impact on the personal autonomy of the medical profession who would have to meet the requests for euthanasia and physician assisted suicide.

25. Experience with abortion legislation across the Council of Europe demonstrates that the personal autonomy of medical professionals who have a conscientious objection to euthanasia will inevitably be infringed. In the European states

⁵ G. Van der Wal and P. Van der Maas, Chapter 19 of their report on euthanasia, 2003. See also Dr Bregje D Onwuteaka-Phillipsen et al, 'Euthanasia and other end of life decisions in the Netherlands in 1990, 1995 and 2001', The Lancet, 17th June 2003: <http://image.thelancet.com/extras/03art3297web.pdf>.

⁶ G. Van der Wal and P. Van der Maas, Chapter 19 of their report on euthanasia, 2003. See also Dr Bregje D Onwuteaka-Phillipsen et al, 'Euthanasia and other end of life decisions in the Netherlands in 1990, 1995 and 2001', The Lancet, 17th June 2003: <http://image.thelancet.com/extras/03art3297web.pdf>

⁷ Report from the Expatica news website on 23rd May 2003; www.expatica.com.

⁸ Daily Telegraph, Monday 24th January 2005.

⁹ United Nations Human Rights Committee 72nd Session 27th July 2001; <http://www.unhchr.ch/hurricane/hurricane.nsf/NewsRoom?OpenFrameSet>

¹⁰ Survey on Euthanasia and Assisted Suicide Prepared for 'Right to Life' lobby group. Results from 986 interviews 26th March – 9th April 2003. Opinion Research Business, 9-13 Cursitor Street, London, EC4A 1LL; www.opinion.co.uk.

where abortion has been legalised, there are now very few practising gynaecologists who are opposed to abortion. Abortion is such a standard gynaecological practice that it is nigh impossible to specialise in that field and refuse to carry out abortions. Doctors opposed to abortion have been forced to specialise in other areas where no such ethical conflict arises.

26. If euthanasia and assisted suicide were legalised or decriminalised we would witness a similar phenomenon in geriatric care, in palliative care and in the hospice movement – regardless of whether the legislation contained a conscience clause. Doctors opposed to these practices would gradually be squeezed out.

27. This, in return, would seriously damage trust between the overwhelming majority of patients, who do NOT want to be subject of euthanasia, and their doctors.

28. The UK Parliament's Joint Committee on Human Rights has declared the conscience clause in a Bill which is currently being scrutinized by a House of Lords Select Committee, the Assisted Dying for the Terminally Ill Bill¹¹, to be contrary to the European Convention on Human Rights under Article 9(1), respect for the individual's right to freedom of thought, conscience and religion.

«What must be avoided, in our view, is the imposition of any duty on an individual physician with a conscientious objection, requiring him or her to facilitate the actions contemplated by the Act to which they have such an objection.»¹²

29. The definition of «passive euthanasia» in paragraph 46 is completely at odds with the definition in paragraph 15 («withholding or withdrawal of life-sustaining treatment, with the intention of ending it»). In paragraph 46 the rapporteur concludes that it is «difficult to see the moral distinction» between what he calls passive and active euthanasia.

30. The rapporteur fails to distinguish the fundamental moral difference between whether the intention of the medical staff is to end the patient's life (i.e. to kill him) or to respect the process of dying and to refrain from interfering into it by artificially prolonging the patient's life. Undoubtedly there is a huge moral difference between these two categories, and the Catholic Church obviously only accepts the latter.¹³

31. In paragraph 50 the rapporteur refers to a French Bill on end of life issues and patients' rights. It is important to note that this Bill will not legalise or decriminalise euthanasia or physician assisted suicide. It is perfectly legitimate to withhold or withdraw medical treatment when it is considered that the burdens of such treatment outweigh the benefits, or where the patient is dying and the treatment would be regarded as unduly intrusive and inappropriate or where the risks of such treatment would be excessive. This is what the French Bill appears to provide. The fundamental difference is the purpose

or aim of the action: the purpose is not to cause or hasten death, but death may occur as a side-effect.

32. Similar Government legislation is currently before the UK Parliament. The Mental Capacity Bill deals¹⁴ with end of life decision making and, like the French Bill, legislates for advance decisions or «living wills» as they are more commonly known.

33. Clause 25 of the Mental Capacity Bill provides that where an advance decision relates to life-sustaining treatment it must be in writing, signed by the patient and witnessed. Clause 26 of the same Bill provides that unless a medical professional is satisfied that an advance decision exists which is valid and applicable to the treatment in question he can treat the patient notwithstanding that the treatment given may contradict instructions contained in the advance decision. These are important safeguards.

34. In response to concerns that the Mental Capacity Bill might weaken the UK's legal prohibition on euthanasia and assisted suicide the Government has inserted a clause into the Mental Capacity Bill, Clause 58, which makes clear that the legislation does not affect the law relating to murder, manslaughter or assisted suicide. The Government has inserted a further amendment into the Bill (section 4(5)) to make clear that where decisions are made about life-sustaining treatment the decision maker must not be motivated by a desire to bring about the patient's death.

35. These safeguards against euthanasia and physician assisted suicide introduced by the UK Government into one of its own Bills must be contrasted with the situation in the Netherlands and Belgium. In an attempt to assuage concerns that the Mental Capacity Bill might legalise euthanasia the UK Prime Minister, Tony Blair, recently said; «What is right is to make it clear that someone's life cannot be ended intentionally.»¹⁵

36. In recent months a House of Lords Select Committee has been considering a Bill introduced into the UK Parliament by Lord Joel Joffe that seeks to legalise euthanasia. The Bill is entitled the Assisted Dying for the Terminally Ill Bill.¹⁶ Organisations opposed to the Bill include the British Medical Association, the Royal College of Nursing, the Disability Rights Commission and the Association of Palliative Medicine. Not one of the Royal Colleges that represents medical professionals in the UK has come out in support of the Assisted Dying for the Terminally Ill Bill.

37. As the palliative care movement was pioneered in the UK the rapporteur should take greater note of the position of the palliative care sector on euthanasia and physician assisted suicide. In paragraph 44, the rapporteur argues that «palliative care cannot in all circumstances take away unbearable pain and suffering.» In the UK at least, the palliative care and hospice sectors appear to disagree. Regard should be had to a recent briefing paper on euthanasia and physician assisted suicide by the Association of Palliative Medicine.¹⁷ In an article in the

¹¹ See <http://www.publications.parliament.uk/pa/ld200405/ldbills/004/2005004.htm>.

¹² See Joint Committee on Human Rights; Scrutiny of Bills Fifth Progress Report Session 2003-04 <http://www.publications.parliament.uk/pa/jt200304/jtselect/jtrights/93/93.pdf>.

¹³ By citing a pastoral letter from the Swiss Bishops on euthanasia and support for the dying, 2002, he mentions cases where the physician, without attempting to provoke death, endeavours to relieve a dying person's suffering with palliative treatment whose foreseeable effects will bring about death». He fails to recognise that death occurs in such cases as a side-effect and is not the objective of the action.

¹⁴ <http://www.publications.parliament.uk/pa/ld200405/ldbills/013/2005013.htm>.

¹⁵ http://www.publications.parliament.uk/pa/cm200405/cmhansrd/cm041215/debtext/41215-03.htm#column_1660

¹⁶ see <http://www.publications.parliament.uk/pa/ld200405/ldbills/004/2005004.htm>.

¹⁷ The Patient (Assisted Dying) Bill: A joint briefing paper by the Association for Palliative Medicine and the National Council for Hospice and Specialist Palliative Care Services – May 2003. Presented in the House of Lords on 3rd June 2003.

British Medical Journal the authors conclude that «the desire for euthanasia must not be taken at face value»:¹⁸

«Rather than focusing on assessing the mental competence of patients requesting euthanasia or determining clear legal guidelines, doctors must acquire the skills for providing good end of life care. These include the ability to ‘connect’ with patients, diagnose suffering, and understand patients’ hidden agendas through in-depth exploration. This is especially important as the tenor of care influences patients’ perception of hope and self worth. There is much to ponder over the meaning of a euthanasia request before we have to consider its justification.»¹⁹

Reporting committee: Social, Health and Family Affairs Committee

Committee for opinion: Committee on Legal Affairs and Human Rights

Reference to committee Doc 9898 and reference No 2960 of 30 April 2004

Opinion approved by the Committee on 6 April 2005

Secretaries to the committee: Mr Drzemczewski, Mr Schirmer, Ms Clamer, Mr Milner

Doc. 9923 23 September 2003 Euthanasia Committee on Legal Affairs and Human Rights

Opinion²⁰

Committee on Legal Affairs and Human Rights

Rapporteur: Mr Kevin McNamara, United Kingdom, Socialist Group

I. Conclusions of the Committee

Proposed amendments to the draft resolution:

Amendment A

In paragraph 1 in the second sentence, after the word «condition» replace by the following:

«A small minority of doctors and other medical staff are willing to conduct «voluntary active euthanasia», that is to terminate the life of the patient at his or her request. Alternatively, they may agree to help a patient to take his or her own life («physician assisted suicide»). «

Amendment B

Delete paragraph 2.

Explanatory note: This paragraph is based entirely on supposition.

Amendment C

In paragraph 3 delete the last sentence:

¹⁸ Mak, Y.Y.W. Elwyn, G. and Finlay, I.G. ‘Patients’ voices are needed in debates on euthanasia’, *BMJ* 2003; 327:213-215; (26th July 2003).

¹⁹ *Ibid.*

²⁰ See Doc 9898 tabled by the Social, Health and Family Affairs Committee.

«This gap must be reconciled if respect for the rule of law is to be maintained.»

Amendment D

Replace paragraph 4 by the following:

«The Netherlands and Belgium introduced laws in 2002 allowing doctors who accede to a patient’s request for voluntary active euthanasia or physician assisted suicide following specific and regular procedures to escape prosecution. The law in Belgium has not been in operation long enough to allow for proper evaluation of the operation of the law there. In the Netherlands, euthanasia and physician assisted suicide, although criminal offences until 2002, have been practised for some years on the understanding that doctors would not be prosecuted provided they acted in accordance with a number of criteria. Accordingly, a number of quantitative studies of the rate and major characteristics of these practices have been conducted in 1990 (1), 1995(2) and 2001(3). These have demonstrated a disturbingly high incidence of euthanasia being carried out without the patient’s explicit request and an equally disturbing failure by medical professionals to report euthanasia cases to the proper regulatory authority.»

(1) Van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991; 338: 669-74; Van der Wal G, van Eijk JT, Leenen HJ, Spreeuwenberg C. Euthanasia and assisted suicide, I: how often is it practiced by family doctors in the Netherlands? *Fam Pract* 1992; 9: 130-34.

(2) Van der Maas PJ, van der Wal G, Haverkate I, et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. *N Engl J Med* 1996; 335: 1699-705; Van der Wal G, van der Maas PJ, Bosma JM, et al. Evaluation of the euthanasia notification procedure in the Netherlands. *N Engl J Med* 1996; 335: 1706-11

(3) G. Van der Wal and P. Van der Maas, Chapter 19 of their report on euthanasia, 2003. See also Dr Bregje D Onwuteaka-Phillipsen et al, ‘Euthanasia and other end of life decisions in the Netherlands in 1990, 1995 and 2001’, *The Lancet*, 17 June 2003: <http://image.thelancet.com/extras/03art3297web.pdf>

Amendment E

Replace paragraph 5 by the following:

«Doctors may also be called upon to decide to withhold or withdraw life-sustaining treatment when it is considered that the burdens of such treatment outweigh the benefits, or where the patient is dying and the treatment would be regarded as unduly intrusive and inappropriate or where the risks of such treatment would be excessive. The legitimacy of such conduct is recognised in medical ethics and by the criminal and civil law in member States. Treatment is withheld or withdrawn for ethically and legally acceptable reasons. It should not be confused with voluntary active euthanasia or physician assisted suicide where the intention is to accelerate or cause death by withholding or withdrawing treatment.»

Amendment F

At the end of the paragraph 6, insert the following:

«The Assembly’s recommendation has subsequently been confirmed by the European Court of Human Rights in the *Pretty case*.(1)»

(1) *Pretty v. United Kingdom Application*, No 2346/02; 29 April 2002.

Amendment G

Delete the final sentence of paragraph 7 and insert the following:

«However, to allow patients to ask to be killed fails to protect their dignity and the rights that stem therefrom. Medical professionals working within the palliative care sector have emphasised the fragility of patients' desire for death and the rapid changes that, in their experience, may occur in response to good symptom control or psychological interventions. The dangers of acceding to rare requests for voluntary active euthanasia and physician assisted suicide should not be underestimated.»

Amendment H

In sub-paragraph 9.ii., delete the second part of the sentence as from «in an area too often subject to ...»

Amendment I

Replace sub-paragraph 9.iv by the following:

«iv. once such evidence has been collected and public discussion concluded, to report back to the Parliamentary Assembly for further consideration.»

II. Explanatory memorandum

by Mr McNamara, Rapporteur

1. Two articles of the European Convention on Human Rights (ECHR) protect the right to life:

Article 2.1

«Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.»

Article 8

«1. Everyone has the right to respect for his private and family life.

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

Recent European Case Law

2. Article 2, as set out above, contains a negative restraint on the State but also requires the State to take active steps for the protection of life. In the case of *Osman v United Kingdom*²¹ the European Court of Human Rights stated that:

«The Court notes that the first sentence of Article 2(1) enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. It is common ground that the State's obligation in this respect extends beyond its primary duty to secure the right to life»

3. In *Pretty v United Kingdom*²² the ECHR made it clear that so-called 'mercy killing' of the type envisaged by the Patient (Assisted Dying) Bill was legitimately prohibited by the State under Article 2 of the ECHR:

«The consistent emphasis in all the cases before the Court has been the obligation of the State to protect life. The Court is not persuaded that the 'right to life' guaranteed in Article 2 can be interpreted as involving a negative aspect.....it is unconcerned with issues to do with the quality of life or what a person chooses to do with his or her life.....nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.

«The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention.»

Furthermore, the ECHR did not consider that the United Kingdom's blanket ban on assisted suicide is disproportionate in the context of Article 8:

«It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide.»

The Way Forward: Parliamentary Assembly Recommendation 1418 (1999)

4. Rather than adopt the draft resolution currently under discussion the Assembly Committee and all member States of the Council of Europe should reaffirm Parliamentary Assembly Recommendation 1418 (1999) on 'Protection of the human rights and dignity of the terminally ill and the dying'.

5. As this Recommendation noted, the dignity of terminally ill or dying persons is best respected and protected by:

- «i. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by member states .
- ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;
- iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.»

6. While recognising the terminally ill or dying person's right to self determination Recommendation 1418 acknowledges that the obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. Recommendation 1418 calls upon Member States to recognise and protect «a terminally ill or dying person's right to comprehensive palliative care.» Much remains to be done in Member States to secure this right. In these circumstances calls for the decriminalisation of euthanasia as proposed by the draft report of the Assembly Committee are premature.

7. In paragraph 2 of the draft report the Social, Health and Family Affairs Committee alleges that voluntary active euthanasia and physician assisted suicide «are a widely known fact

²¹ (1998) 29 EHRR 245.

²² Application No 2346/02; 29 April 2002

of medical life, but are usually confined to the shadows of discretion, or even secrecy». The Assembly Committee makes the same allegation in paragraph 2 of the explanatory memorandum. At no point in either the draft report or the explanatory memorandum does the Assembly Committee cite any evidence to back-up these disturbing allegations. It is simply not good enough for the Assembly Committee to make sweeping allegations in this manner. It must substantiate them.

8. Later in paragraph 2, the Assembly Committee argues that «the greatest risk of abuse» is where euthanasia and assisted suicide are practised «beyond any procedures or control». The Committee ignores the fact that according to the latest official report on euthanasia in the Netherlands²³, only 54% of cases of euthanasia are reported to the regulatory authority and that «life terminating treatment without explicit request of the patient is still seldom reported (less than 1%).» Notwithstanding the difficulties in accurately estimating the number of cases that go unreported, this latest report from the Netherlands categorically demonstrates that legalising euthanasia does not necessarily create greater control over the practice.

9. The definition of passive euthanasia in paragraph 5 is misleading («Doctors may also be called upon to decide to withhold or withdraw life sustaining treatment, again in the knowledge that they are bringing about death.») Knowledge that a certain course of conduct may bring about death does not automatically constitute euthanasia. Intention or purpose is the key. If treatment is withheld or withdrawn with the purpose of bringing about death this constitutes passive euthanasia and is, in my judgement, unethical. However, it is perfectly legitimate to withhold or withdraw medical treatment when it is considered that the burdens of such treatment outweigh the benefits, or where the patient is dying and the treatment would be regarded as unduly intrusive and inappropriate or where the risks of such treatment would be excessive.

10. In paragraph 7 the Assembly Committee maintains that to legalise euthanasia «does not imply an obligation on any health worker to take part in an act of euthanasia.» The Committee cites the example of abortion, where doctors «are under no obligation to carry out such operations», to support his argument.

11. However, it is a sad fact that in the European states where abortion has been legalised, there are now very few practising gynaecologists who are opposed to abortion. Abortion is such a standard gynaecological practice that it is nigh impossible to specialise in that field and refuse to carry out abortions. Doctors opposed to abortion have been forced to specialise in other areas where no such ethical conflict arises.

12. If euthanasia and assisted suicide were legalised we would witness a similar phenomenon in geriatric care, in palliative care and in the hospice movement – regardless of whether the legislation contained a conscience clause. Doctors opposed to these practices would gradually be squeezed out.

13. In paragraph 8, the Social, Health and Family Affairs Committee argues that «each human being's choice is deserving of respect» because «despite remarkable advances, palliative care cannot in all circumstances take away unbearable pain and suffering.» It is important to note that, in the United Kingdom

²³ G. Van der Wal and P. Van der Maas, Chapter 19 of their report on euthanasia, 2003. See also Dr Bregje D Onwuteaka-Phillipsen et al, 'Euthanasia and other end of life decisions in the Netherlands in 1990, 1995 and 2001', *The Lancet*, 17 June 2003: <http://image.thelancet.com/extras/03art3297web.pdf>

at least, the palliative care and hospice sectors disagree. Regard should be had to a recent briefing paper on euthanasia and physician assisted suicide by the Association of Palliative Medicine.²⁴ I would also cite a recent article in the *British Medical Journal* in which the authors conclude that «the desire for euthanasia must not be taken at face value»:²⁵

«Rather than focusing on assessing the mental competence of patients requesting euthanasia or determining clear legal guidelines, doctors must acquire the skills for providing good end of life care. These include the ability to 'connect' with patients, diagnose suffering, and understand patients' hidden agendas through in-depth exploration. This is especially important as the tenor of care influences patients' perception of hope and self worth. There is much to ponder over the meaning of a euthanasia request before we have to consider its justification.»²⁶

14. In paragraph 7 of his explanatory memorandum, Mr Marty maintains that «public opinion polls in several member states show that a majority are in favour of legislation to regulate euthanasia» and that legislators «must somehow respond to this challenge».

15. In several member states public opinion polls have consistently shown that a majority are in favour of capital punishment. Legislators have not responded to this challenge by acceding to popular opinion but by seeking to inform the public of the dangers associated with state-sanctioned killing, not least the fact that the innocent may be victims.

16. Legislators should respond in the same manner to calls for the legalisation of euthanasia and assisted suicide. Furthermore, it is vitally important that we listen to the voice of doctors who would be the persons responsible for implementing a policy of state sanctioned killing. An independent survey of United Kingdom doctors by the Opinion Research Business (ORB), published on 13 May 2003²⁷ revealed the following:

- Almost three out of four doctors (74%) would refuse to perform assisted suicide if it were legalised.
- A clear majority (56%) also consider that it would be impossible to set safe bounds to euthanasia.
- To the question «As a doctor do you agree with assisted suicide?» 25% agreed, 60% disagreed and 13% were undecided.
- The number who rejected euthanasia was higher – 61% as compared with 22% in favour and 14% undecided.
- Not one palliative care doctor who responded to the survey would practice either euthanasia or assisted suicide.
- 66% of doctors considered that the pressure for euthanasia would be lessened if there were more resources for the hospice movement.

17. The latest empirical evidence from the Netherlands contained in the official report by Van der Wal and Van der

²⁴ The Patient (Assisted Dying) Bill: A joint briefing paper by the Association for Palliative Medicine and the National Council for Hospice and Specialist Palliative Care Services – May 2003. Presented in the House of Lords on 3rd June 2003.

²⁵ Mak, Y.Y.W. Elwyn, G. and Finlay, I.G. 'Patients' voices are needed in debates on euthanasia', *BMJ* 2003; 327:213-215; (26 July 2003)

²⁶ *Ibid.*

²⁷ Survey on Euthanasia and Assisted Suicide Prepared for 'Right to Life' lobby group. Results from 986 interviews 26 March – 9 April 2003. Opinion Research Business, 9-13 Cursitor Street, London, EC4A 1LL; www.opinion.co.uk

Maas²⁸ notes that the frequency of ending of life without the patient's explicit request has shown no decline over the years studied, 1990, 1995 and 2001. In 2001, the most recent year for statistics are available, 900 out of 3,800 cases of euthanasia or assisted suicide (approximately one-quarter) were without the patient's explicit request.

18. This disturbing trend is compounded by the statistics from Flanders, Belgium cited by Mr Marty in paragraph 25. «Of the 4.4% of all deaths resulting from the use of lethal drugs, 1.1% were cases of euthanasia, 0.1% physician-assisted suicide, and 3.2% ending of life without the patient's explicit request. «(emphasis added).

19. Empirical evidence from the Netherlands and Belgium reinforces the argument that it is impossible to set safe bounds to euthanasia so as to ensure that only those who have expressed a persistent, voluntary and well-considered request are put to death.

20. The poll data in paragraph 27 has been superseded by more recent data from the aforementioned independent survey of doctors by ORB. This survey explodes the idea that people are clamouring for euthanasia. In response to a question asking how many patients had requested euthanasia during the past three years nearly half (48%) of the doctors said not one; 37% quoted less than five; 11% gave numbers between 5 and 10 patients; only 2% gave figures of more than ten. In their comments doctors said that in their experience requests for euthanasia were often «cries for help that have been resolved with good symptom control...they almost invariably want relief from distress».

21. The number of requests from relatives for euthanasia was even lower than from patients themselves. 68% of doctors said that none had approached them in the last three years; 22% quoted less than five such experiences; 5% quoted figures between 5 and 10; and 1% gave numbers of more than ten. 3% said they did not know or that the question was not applicable to them.

22. Nonetheless, a substantial minority of doctors were concerned about possible pressures from families and colleagues if euthanasia and assisted suicide were legalised. Nearly half (47%) felt that if euthanasia and assisted suicide were made legal they would not be confident of being able to exercise their judgment without pressure from relatives. 29% were confident and 24% did not know.

23. In paragraph 28, Mr Marty suggests that his empirical evidence gives us «brief glimpses of medical reality». Certainly, the medical reality in the Netherlands and Belgium is that in addition to voluntary euthanasia, non-voluntary and involuntary euthanasia are being carried out. In addition, the ORB survey provides a far more accurate 'glimpse of medical reality' than anything Mr Marty provides. Further details from the ORB survey can be provided upon request.

24. Mr Marty makes great play of the fact that euthanasia and assisted suicide must be notified to the municipal pathologist «in all cases» (paragraph 34). As we said earlier, this is not being done. Only 54% of euthanasia cases are officially

reported to the Dutch authorities. According to a press reports, the low notification rate is because doctors wished to avoid the «administrative hassle»²⁹ of reporting a euthanasia case and were concerned they might have breached the regulations.

25. The Dutch situation demonstrates that legalizing euthanasia and assisted suicide, far from introducing greater controls, simply introduces more euthanasia and more assisted suicide.

Reporting committee: Social, Health and Family Affairs Committee

Committee for opinion: Committee on Legal Affairs and Human Rights

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

Opinion approved by the committee on 18 September 2003

Secretaries to the committee: Ms Coin, Mr Schirmer, Mr Eupina, Mr Milner

7th Conference of European Health Ministers «Health, Dignity and Human Rights»- 12-13 June 2003 - Oslo, Norway «The role and responsibility of Health Ministers in meeting the challenges of the changes in society and new technology at the beginning of the third millennium»

Final Declaration MSN-7-HF(2003)3 Final version 13 June 2003

Final Declaration

The Oslo Declaration on Health, Dignity and Human Rights

Changes in society and technological innovations are dominant features at the beginning of this millennium. These developments provide new possibilities and create potential risks at the same time. The Council of Europe, with its human rights vocation, has the obligation to defend human rights and dignity. This protection can only be achieved through strong social cohesion, equal rights to health care and an ethical and human rights framework, within which health care is delivered.

We, the European Health Ministers, gathered in Oslo, on 12-13 June 2003:

- recognise that providing appropriate and good quality care is a responsibility of every government in general and particularly Health Ministers; this goes beyond the mere delivery of health services and encompasses the respect of the dignity of the individual, which acquires particular importance in our modern multicultural societies;
- agree that health care services should function within a human rights framework as promoted by the Council of Europe, keeping in mind that vulnerability is not necessarily the lot of certain social groups and restricted to certain age groups, but can hit anybody at any time;
- agree to give high priority to identifying the needs of all

²⁸ G. Van der Wal and P. Van der Maas, Chapter 19 of their report on euthanasia, 2003. See also Dr Bregje D Onwuteaka-Phillipsen et al, 'Euthanasia and other end of life decisions in the Netherlands in 1990, 1995 and 2001', The Lancet, 17 June 2003: <http://image.thelancet.com/extras/03art3297web.pdf>

²⁹ Report from the Expatica news website on 23 May 2003; www.expatica.com

- those individuals and groups who are socially excluded and mobilise the necessary human and financial resources for an appropriate response to their health needs;
- are fully aware of the increasing importance for health issues and health implications to become an integral part of policies and decisions in all sectors of government, due to the constant need to respond to new health problems resulting from social and environmental policies; Ministries responsible for Health must play a leading role in providing evidence on health consequences of policies in other areas;
 - are fully aware that solidarity can no longer be limited to one's own population; it has to be extended to other countries facing similar challenges;
 - agree to increase efficiency and safety in health care through alliances, bilateral or multilateral with other countries, including the public and private sectors, in order to facilitate sharing experiences, knowledge and technology and for carrying out research jointly;
 - commit ourselves to work together to bridge the knowledge gap and to provide a more equal distribution of health technologies, taking into account that the member States undergo to a large extent, but at a different pace, the same changes in society, and should respond politically according to national priorities and possibilities;
 - agree to monitor the advances in information technology and in relevant research for the purpose of appropriate handling of patients' information, with full respect of safety, privacy and confidentiality and to assess their contribution to patients' empowerment;
 - agree to work towards a proper balance between preventive and curative care, with a marked insistence on the development of healthy lifestyles, to stimulate responsibility of individuals towards their own health, and ensure citizen participation in the decision making process concerning health care;

We, the European Health Ministers, call upon the Council of Europe and the European Health Committee (CDSP) in particular:

- to pursue and intensify, in a coordinated fashion, its work on the social, ethical and human rights dimension of health in the delivery and availability of evidence-based health care and related services, and make proposals on possible partnerships aimed at reducing inequalities within and between countries;
- draw up conceptual frameworks for various aspects of the health agenda, their organisation and functioning, including social, ethical and legal aspects.

In pursuing these aims we recognise the following challenges and agree to take into consideration the following policy guidelines:

Challenge 1 – Managing the impact of the changing societies on health, dignity and human rights

1.1. The changing environment

Challenges and problems in health care are not confined within national borders. The outbreak of SARS (Severe Acute Respiratory Syndrome) is only the most recent example that health challenges need a global response.

Modern technology has cut through time and space, with inevitable effects on the market economy. Availability to all who need these products of modern technology is of paramount importance in democratic societies respectful of human rights.

The Council of Europe, with now 45 member States together with the enlargement of the European Union, is contributing to new possibilities for providing health care and social coverage between states.

Options for an effective response

- develop alliances, bilaterally or multilaterally with other countries, including the public and private sectors, to facilitate sharing achievements, knowledge and technology and for carrying out research jointly;
- develop health systems which:
 - guarantee sustainability for future generations;
 - ensure high common standards of quality in health care and health care goods;
 - are effective in combating the old and new epidemics;
 - ensure solidarity, not only within national territories, but also between states.
- develop flexible health policies which take into account a mobile demographic pattern and a health environment with divergent needs and expectations, ensuring better social cohesion by:
 - respecting the cultural values and beliefs of the various components of society with regard to health and health care;
 - establishing a fair balance of financial and human resources between the various categories of the population to ensure that older persons get the necessary care.

1.2. Dignity and vulnerability in a changing society

Few social phenomena in recent decades have undergone profound changes as in health care. Health care is concerned with life and well-being, and both are a priority with individuals and populations. No government can ignore it or the environment in which it is delivered.

It is precisely this environment, which has changed dramatically and increasingly during the last few decades.

Old customs, traditions and ways of living have given way to new ones. During the last few decades Europe has undergone a veritable social revolution in both thinking and behaviour. Demand for health care has changed in number and nature. This change is due to several factors:

- technical and technological achievements in both information and medicine, which has sharpened popular awareness and increased patient expectations;
- major social evolutions: strong individualism, new family structures, new lifestyles, new notions of equity and right to health care;
- political developments, particularly in those countries where the health services were refashioned to suit the market economy;
- demographic changes with ageing populations and multicultural societies.

These developments have highlighted awareness of the vulnerability of each and every individual, not only at specific periods of life (infancy, old age), but through a whole lifetime. They also highlighted the vulnerability of whole groups in society, where social and economical marginalisation adversely affects their health status.

In this new and constantly changing environment, populations, governments, scientists and politicians have been led to question the why and how of the demand, the expectation and

the delivery of health care. Are governments fulfilling their duty in responding to health needs – both preventive and curative of all sectors of the population? Are individuals behaving responsibly? Are technological innovations being used correctly? These questions raise serious ethical questions, affecting basic human rights and the dignity of the individual.

Options for an effective response

- give high priority to identifying the needs of all those individuals and groups who are socially excluded and therefore vulnerable with regard to their health, and mobilise the necessary human and financial resources for an appropriate response;

- Ensure:
- a proper balance between preventive and curative care, with a marked insistence on the development of healthy lifestyles. For this purpose measures should be taken to develop individual responsibility towards one's own health, and ensure citizen participation in the decision making process concerning health care;
- the appropriate training of health personnel to adapt to the social, cultural changes across society and technological developments.

2. Challenge 2 – Managing the impact of new technology on health, dignity and human rights

2.1. Responsible and equitable introduction of new technologies

Innovations, in information technology and medicine, arrive at a higher pace than ever before, but also at a higher cost. This may lead to a widening of the information gap between and within member States, as well as differences in access to medical technologies.

Information means knowledge. We have today a new generation of emancipated patients, empowered by knowledge and a wish to have a voice in medical decision making. The old patronising attitude of the health professional is giving way to a new partnership. The Internet may become a vehicle for democratising health systems.

Medical technology can equally be costly and available only to those that can afford it. This could lead to a weakening of groups that are already vulnerable.

Care has to be taken not to be blinded by technological innovations, and to be aware of the potential adverse effects of commercialisation of technological innovations and research. Not all technological innovations pass the test of cost/efficiency, or quality criteria.

Options for an effective response

- make information technology widely accessible, including to those who are weak and have fewer resources, avoiding a knowledge gap between and within societies;
- take measures to avoid that technological innovations are driven solely by commercial interests; therefore governments should finance developments towards knowledge gain which leads to health gain, for the benefit of all, not only those who can afford it;
- secure equity in access to new medical technology;
- share technological knowledge and information between member States.

2.2. Ethical and human rights challenges of technological innovations

In the past technology helped to master the outside environment; now it can determine the course of the natural evolution of human beings. After the era of technological development in health care, we have now reached the age of the human genome – frightening for many, a door towards a brave new world for others. The application of genetics will have an impact on the organisation of health care. The implications of the introduction of genetic screening and testing for the availability, the organisation and the financing of health services have to be examined by member States.

Societies have to decide about the limits of implementing of the technically possible. Misuse of information technology can violate the right to privacy and confidentiality. Development of human cloning and uncontrolled embryo-based research can be a threat to human rights and dignity.

An abuse of predictive medicine may lead towards creating groups of un-insurable and un-employable citizens.

New options of intervening in the natural course of life as well as possibilities opened by research raise serious ethical issues concerning life and death.

The human rights and dignity of the terminally ill and the dying have to be protected. Persons near the end of life desire to be treated as valued individuals. Palliative care intends to help people with advanced disease to enjoy the best possible quality of life until the end. Palliative care affirms dying as a normal process.

Options for an effective response

- intensify the exchange of views and information on the ethical dimension of medical and information technology with a view to adopting common approaches;
- develop palliative care to make it more readily available to all who need it and cooperate between countries to address the difference in the availability and quality of palliative care throughout Europe.

Doc. 9898 10 September 2003 Euthanasia

Report Social, Health and Family Affairs Committee

Report Social, Health and Family Affairs Committee

Rapporteur: Mr Dick Marty, Switzerland, LDR

Summary

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

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

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

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

I. Draft resolution

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

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

3. Until very recently these practices have been illegal in most Council of Europe member states, although penal and professional sanctions are extremely rare by comparison with the number of cases of euthanasia actually carried out. There is thus a striking divergence between the law and what happens in practice. This gap must be reconciled if respect for the rule of law is to be maintained.

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

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

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

7. Nobody has the right to impose on the terminally-ill and the dying the obligation to live out their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it. This right does not imply an obligation on any health worker to take part in an act of euthanasia. Now we respect a person's choice to take their own life and avoid making value judgments about them. Moreover, this development can in no way be interpreted as the expression of lesser consideration for human life.

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

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

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

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

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

iv. in the light of such evidence and public discussion, to consider whether legislation should be envisaged, where it has not already been introduced, to exempt from prosecution doctors who agree to help terminally-ill patients undergoing constant,

unbearable pain and suffering without hope of any improvement in their condition, to end their lives at their persistent, voluntary and well-considered request, subject to prescribed rigorous and transparent conditions and procedures.

II. Explanatory memorandum by Mr Marty

I. Introduction

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

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

3. Euthanasia may take different forms: a piece of equipment may be turned off, treatment may deliberately be refused, or such a large dose of a therapeutic product may be administered that it brings about the patient's death. Life may be terminated at the request of the patient or the patient's family. Should the law intervene in what has been called «the final freedom»?³⁰

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

5. If we need any further reason to address the issue of euthanasia, two Council of Europe member states, the Netherlands and Belgium, have adopted legislation which unquestionably poses a challenge to the other states and to this Parliamentary Assembly. This situation obliges us to look at the legal position in the light of what happens in reality.

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

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

II. Definitions

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

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

10. «Passive euthanasia» is a term used to mean the withholding or withdrawal of life-sustaining treatment, again with the intention of ending it, in particular where the alternative is to attempt to keep the patient alive through stubborn, aggressive and pointless treatment, a practice condemned in medical ethics, not least when the patient has refused such treatment. Finally, «physician-assisted suicide» covers situations where a doctor helps a patient to take his or her own life, again at his or her persistent, carefully considered and voluntary request.³¹

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

11. Recommendation 1418 (1999) first observed that the terminally ill and the dying lacked adequate access to palliative care and good pain management. The Assembly therefore encouraged the member states to promote comprehensive palliative care through a series of constructive measures such as the establishment of more palliative care units in hospitals, the development of hospices and ambulant hospice teams and networks, and specific training for health professionals. The Committee of Ministers replied (Doc. 8888) that the European Health Committee had selected the question of palliative care for detailed study. This was certainly a welcome outcome and we look forward to the results which are due to be published shortly.

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

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

³¹ The recent survey on euthanasia conducted by Dr Michael Abrams for the Council of Europe's Steering Committee on Bioethics (CDBI) provides interesting information on, among other things, definitions used in the member states, including legal definitions (see http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/).

³⁰ François de Closets, *La dernière liberté*, Paris, Fayard, 2000.

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

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

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

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

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

- the question of interplay and possible conflict between the different relevant rights and freedoms and that of the margin of appreciation of the States Parties in finding solutions aiming to reconcile these rights and freedoms;
- the question of the nature and the scope of positive obligations incumbent upon States Parties and which are linked to the effective protection of rights and freedoms provided by the Convention;
- the question of whether the relevant provisions of the Convention must be interpreted as also guaranteeing 'negative rights', as the Court has ruled for certain Articles of the Convention, as well as the question of whether an individual can renounce the exercise of certain rights and freedoms in this context (and, if that is the case, in to what extent and under which conditions).»³²

18. The Court's position on the issue of whether the right to life implies its negative was clarified in its judgement in the case of Diane Pretty, whereby «Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life. ... The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention». ³³ It nevertheless remains that the Court has not tested the proposition that euthanasia is contrary to the Convention. However,

er, the Council of State in both the Netherlands and Belgium have concluded that the legislation on euthanasia introduced in those countries is compatible with the Convention (see below, sections V and VI).

IV. Empirical evidence about end-of-life decisions

19. Empirical data on the rate of euthanasia, physician-assisted suicide, and other end-of-life decisions have greatly contributed to the debate about the role of such practices in modern healthcare.

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

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

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

23. The 1995 survey concluded that since the notification procedure had been introduced in 1991, end-of-life decision making in the Netherlands had changed only slightly, in anticipated directions: euthanasia seemed to increase in incidence, and the ending of life without the patient's explicit request seemed to decrease slightly. Close monitoring of such decisions was possible, and no signs of an unacceptable increase in the number of decisions or of less careful decision making were found, according to the authors.³⁴

³⁴ Paul J. van der Maas, M.D., Ph.D., Gerrit van der Wal, M.D., Ph.D., Ilanka Haverkate, M.Sc., Carmen L.M. de Graaff, M.A., John G.C. Kester, M.A., Bregje D. Onwuteaka-Philipsen, M.Sc., Agnes van der Heide, M.D., Ph.D., Jacqueline M. Bosma, M.D., LL.M., and Dick L. Willems, M.D., Ph.D., «Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995», *The New England Journal of Medicine*, 335:1699-1705 (November 28), 1996.

³² Doc. 9404.

³³ *Pretty v. the United Kingdom*, 29 April 2002, §§ 39-40.

24. The continuing debate about whether and when physician-assisted dying is acceptable seems to be resulting in a gradual stabilisation of end-of-life practices. The 1990 and 1995 interview and death-certificate studies have been reconducted more recently, showing that no further increase in the rate of euthanasia was found in 2001³⁵.

25. A comparable survey was conducted in 1998 in Flanders, Belgium, based on a random sample of death certificates and questionnaires to the attending physicians. Of the 4.4 % of all deaths resulting from the use of lethal drugs, 1.1 % were cases of euthanasia, 0.1 % physician-assisted suicide, and 3.2 % ending of life without the patient's explicit request (extrapolated to an estimated total of 1 796 cases in 1998). In 18.5 % of patients, high-dose opioids were used to alleviate pain and resulted in unintentional death in 13.2 % of cases, but in intentional death in 5.3 % of cases. Decisions to withhold or withdraw potentially life-prolonging treatment were made in 16.4 % of cases.³⁶

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

27. Although such systematic surveys of end-of-life decisions have not been conducted in other European countries, evidence given at the Social, Health and Family Affairs Committee's hearing on euthanasia (Paris, 25 October 2002) revealed that in the United Kingdom almost 60 % of doctors questioned by the British Medical Journal had said they had been asked to hasten death; 32 % said they had complied with such a request; and 46 % said they would consider helping someone to die if it were legal to do so.³⁷ In a 1998 survey carried out by The Sunday Times, 14 % of the doctors who answered admitted that they had helped a patient to die at their request. A survey carried out in Norway in 1997 revealed that there were some 20 cases per year.

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

V. The new legislation in the Netherlands

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

³⁵ «Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001», the *Lancet*, 17 June 2003

³⁶ Luc Deliëns, Freddy Mortier, Johan Bilsen, Marc Cosyns, Robert Vander Stichele, Johan Vanoverloop, Koen Ingels, «End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey», *The Lancet*, 356: 1806-11 (November 25), 2000.

³⁷ Ward, B.J. Tate, P.A. «Attitudes among NHS doctors to requests for euthanasia» *British Medical Journal*, 308: 1332-1334 (1994).

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

- a. be satisfied that the patient has made a voluntary and carefully considered request;
- b. be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement;
- c. have informed the patient about his situation and his prospects;
- d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
- e. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in a. to d. above; and
- f. have terminated the patient's life or provided assistance with suicide with due medical care and attention.

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

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

33. Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so. And he or she may only accede to the request while taking into account the due care requirements mentioned in the Act. The due care requirements must be complied with, regardless of whether it involves a request from a lucid patient or a request from a non-lucid patient with a declaration of will. In each case the doctor must be convinced that the patient is facing interminable and unendurable suffering. If he or she believes that this is not so, he or she may not accede to the request for euthanasia, no matter what the declaration of will states.

34. In all cases, the physician must report his or her act to the municipal pathologist. The report is examined by one of the five regional review committees³⁸ to determine whether it

³⁸ The regional review committees, already established in the Netherlands before the new legislation, are composed of at least three (or if more always an uneven number of) members: a legal expert as

was performed with due care. The judgement of the review committee is then sent to the Public Prosecution Service, which uses it as a major factor in deciding whether or not to institute proceedings against the physician in question.

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

VI. The new Belgian legislation

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

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

- the patient is a person of full age or an emancipated minor, possessing legal capacity and aware of what he/she is doing when he/she formulates the request (which must be made in writing);
- the request is made voluntarily, carefully and repeatedly, and is not the result of outside pressure;
- the patient's medical state is hopeless, and he/she is experiencing constant, unbearable physical or mental suffering, which cannot be relieved and is caused by a serious and incurable injury or pathological condition.

38. Beforehand, doctors must always:

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

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

3° consult another doctor on the serious and incurable nature of the condition, indicating their reason for doing so. The doctor consulted must inspect the medical file, examine the patient and satisfy himself/herself that the latter's physical or mental suffering is constant and unbearable, and cannot be relieved, and must prepare a report on his/her findings. The doctor consulted must have no connection with the patient or the patient's doctor, and must have a specialised knowledge of the pathology in question. The patient's doctor must inform the patient of the results of this consultation;

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

chairman, a doctor, and an expert in the field of ethics or philosophy. For each of the members, one or more substitutes are appointed. To monitor the uniformity of the assessments of the different review committees, the chairs of the committees consult regularly in a meeting attended by representatives of the Council of Procurators-General and the Health Care Inspectorate of the State Supervisory Agency for Public Health.

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

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

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

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

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

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

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

44. It is worth dwelling on some of the arguments put forward by the Belgian Conseil d'Etat, (Supreme Administrative Court) which underlie its conclusion that the bill (now law) on euthanasia was not incompatible with the provisions of the European Convention on Human Rights. The Court noted in particular, after analysis of the relevant jurisprudence of the European Court of Human Rights, that the positive obligation incumbent on Parties to protect the right to life must be balanced notably against the individual's right of self-determination.³⁹ This meant that the obligation of the authorities to protect the right to life (Article 2) must be balanced against the right of the individual to be protected from inhuman treatment or punishment (Article 3) and against his or her right to physical and moral integrity, deriving from the right to respect for private life (Article 8). The Convention offered no guidance as to how this conflict between fundamental rights should be resolved.

45. The Conseil d'Etat noted that one of the essential characteristics of the debate on euthanasia was that it raised difficult and fundamental ethical questions which necessitated making a choice between opposing ethical conceptions. As to who should make such a choice, the Court referred to a case concerning Norwegian law on abortion in which the European Commission of Human Rights agreed with the Norwegian Supreme Court in saying:

³⁹ In this connection, account must be taken of the strength of the will of the person concerned. For example, when an individual is incapable of deciding for himself or herself, the obligation of the authorities is greater than when he or she is capable of making decisions about his or her own life.

«It is not a matter for the courts to decide whether the solution to a difficult legislative problem which the legislator chose when adopting the Act on Termination of Pregnancy of 1978, is the best one. On this point, different opinions will be held among judges as among other members of our society. The reconciliation of conflicting interests which abortion laws require is the legislator's task and the legislator's responsibility. (...) Clearly, the courts must respect the solution chosen by the legislator»⁴⁰

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

«... assuming that the Convention may be considered to have some bearing in this field, the Commission finds that in such a delicate area the Contracting States must have a certain discretion».⁴¹

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

VII. Swiss law

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

49. Article 114 has been applied only once since 1942. Article 115 is not motivated by medical considerations: originally, in the 19th century, it aimed to exonerate from punishment someone who lent a weapon to a friend wishing to commit suicide, because of an unhappy love affair, for example. Now Article 115 is used for end-of-life issues, which was not at all the legislator's intention. Thus, assistance to suicide goes unpunished, whilst doctors are not allowed to carry out euthanasia and may be sanctioned by their colleagues. According to the Academy which serves as a tribunal for the Swiss medical profession «assistance to suicide does not form part of medical activity». The Academy intends to revise this rule, which is somewhat hypocritical. However, some recent political discussions have shown the difficulty of reaching a consensus on this matter. A Socialist MP from the Vaud canton tabled a motion on the subject in 1984 but the Minister of Justice considered it was too early to legislate. As a result of growing political pressure, the Government set up a group of experts which proposed a series of measures. The Federal Government only agreed to develop palliative care, however. Parliament reacted with various bills which have not been passed. Today the situation is in deadlock, but things may change. A new motion has been accepted asking the Government to encour-

age palliative medicine and to reopen the euthanasia issue. The Government has no wish to do so, but will be called upon to respond.

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

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

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

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

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

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

IX. Arguments in favour of euthanasia and its decriminalisation

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

56. Proponents argue that nobody has the right to impose on the terminally-ill and the dying the obligation to live out

⁴⁰ European Commission of Human Rights, Decision of 19 May 1992, H.v./Norway, 17.004/90, D.R. vol. 73, (155), p. 168, §1.

⁴¹ Ibid.

their life in unbearable suffering and anguish where they themselves have persistently expressed the wish to end it. Doctors have long accepted exceptions to the precepts of medical ethics, in carrying out abortions for example. Abortion itself has been legal for many years.

57. There has been a similar change of social attitudes to suicide, once a criminal offence. Now we respect a person's choice to take their own life and avoid making value judgements about them.

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

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

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

61. Finally, euthanasia appears to be extensively practised in secret. It is this reality that carries the greatest potential for abuse. Decisions may be taken in a furtive and arbitrary manner. They may depend on the «luck of the draw»: a sympathetic doctor or a malevolent nurse. The pressures that can influence end-of-life decisions will be more pernicious if exercised in the dark. The gap between law and practice must be reconciled if respect for the rule of law is to be maintained. Abuse will not disappear with legislation (does any legislation eliminate abuse?), but will surely be reduced.

X. Conclusions

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

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

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

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

Members of the committee: Mrs Belohorská (Chair), MM Christodoulides (1st Vice-Chairman), Surján (2nd Vice-Chairman), Mrs McCafferty (3rd Vice-Chair), Mrs Ahlqvist, MM. Alís Font, Arnau, Mrs Bargholtz, Mr Berzinš, Mrs Biga-Friganoviã, Mrs Bolognesi (alternate: M. Piscitello), MM. Brînzan, Brunhart, Buzatu (alternate: Ionescu), Çavu^oođlu, Colombier, Cox, Dees, Donabauer, Drljeviã, Evin, Flynn, Ms Gamzatova, MM. Geveaux, Giertych, Glesener, Gonzi, Gregory, Gülçiçek, Gündüz, Gusenbauer, Hegyi, Herrera (alternate: Mrs Fernández-Capel), Hladiy (alternate: Borzykh), Høie, Ms Hurskainen, MM. Jacquat, Kastanidis, Klympush, Baroness Knight, MM. Lomakin-Rumiantsev, Ms Lotz (alternate: Mrs Rupprecht), Ms Luëiã, MM. Makhachev, Ma³achowski, Manukyan, Markowski, Marty, Maštãlka, Mrs Miliãeviã, Mrs Milotinova, MM. Mladenov, Monfils, Ouzký, Padilla, Pavlidis, Mrs Pétursdóttir, MM. Podobnik, Popa, Poty (alternate: Timmermans), Poulsen, Provera (alternate: Tirelli), Pysarenko, Rauber, Riester, Rigoni, Rizzi (alternate: Mrs Paoletti Tangheroni), Mrs Roseira, Ms Saks, MM. Santos, Seyidov, Mrs Shakhaktinskaya, MM. Slutsky, Sysas, Ms Tevdoradze, Ms Topalli, Mrs Vermot-Mangold, Mr Volpinari, Mrs Wegener (alternate: Mr Haack), MM. Van Winsen (alternate: Mrs Zwerver), Zernovski, ZZ...

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

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

Doc. 9404 8 avril 2002 Protection des droits de l'homme et de la dignité des malades incurables et des mourants

Recommandation 1418 (1999)

Réponse du Comité des Ministres

adoptée à la 790e réunion des Délégués des Ministres (26 mars 2002)

1. Le Comité des Ministres salue les travaux de l'Assemblée parlementaire qui ont permis d'aboutir à la Recommandation 1418 (1999), consacrée aux questions particulièrement sensibles de la protection des droits de l'homme et de la dignité des malades incurables et des mourants. Il rappelle sa réponse intérimaire, adoptée le 30 octobre 2000, dans laquelle

le il informait l'Assemblée des mandats qu'il avait confiés au Comité directeur pour les droits de l'homme (CDDH) et au Comité directeur pour la bioéthique (CDBI).

2. Ayant étudié de près les informations et l'avis ainsi obtenus, le Comité a pu observer que les Etats membres avaient des approches différentes des questions soulevées dans la recommandation. Ces questions ont de multiples dimensions – éthiques, psychologiques et sociologiques notamment. Le Comité des Ministres, attaché au respect et à la protection des droits fondamentaux de la personne, entend s'en tenir à l'aspect qui constitue le domaine de compétence incontesté du Conseil de l'Europe: la protection des droits de l'homme telle qu'assurée par la Convention européenne des droits de l'homme et la jurisprudence de la Cour européenne des Droits de l'Homme.

3. Certaines des questions soulevées dans la recommandation renvoient à des dispositions fondamentales de la Convention, en particulier ses Articles 2 (droit à la vie), 3 (interdiction de la torture et des peines ou traitements inhumains et dégradants) et 8 (droit au respect de la vie privée et familiale). La jurisprudence de la Cour ne permettant pas, pour le moment, d'apporter des réponses précises à toutes les questions soulevées dans la recommandation, le Comité préfère se limiter aux observations suivantes.

4. Tout d'abord, aux termes de l'Article 1 de la Convention, les Hautes Parties Contractantes s'engagent à reconnaître à toute personne relevant de leur juridiction, les droits et libertés définies dans la Convention. Cette obligation s'impose à toutes les Parties, quelle que soit l'expression de la volonté des personnes concernées. Par conséquent, comme l'a précisé la Cour, les patients qui n'ont plus aucune capacité d'autodétermination restent couverts par les dispositions de la Convention⁴².

5. Il faut avoir cela à l'esprit lorsque l'on examine le «droit des malades incurables et des mourants à l'autodétermination», dont il est notamment question au paragraphe 9 (b) de la recommandation. C'est donc dans ce contexte que le Comité des Ministres se félicite du paragraphe 9 (c) de la recommandation de l'Assemblée, paragraphe qui encourage « les Etats membres du Conseil de l'Europe à respecter et à protéger la dignité des malades incurables et des mourants à tous égards » ...« en maintenant l'interdiction absolue de mettre intentionnellement fin à la vie des malades incurables et des mourants:

«i. vu que le droit à la vie, notamment en ce qui concerne les malades incurables et les mourants, est garanti par les Etats membres, conformément à l'article 2 de la Convention européenne des Droits de l'Homme qui dispose que «la mort ne peut être infligée à quiconque intentionnellement;

ii. vu que le désir de mourir exprimé par un malade incurable ou un mourant ne peut jamais constituer un fondement juridique à sa mort de la main d'un tiers;

iii. vu que le désir de mourir exprimé par un malade incurable ou un mourant ne peut en soi servir de justification légale à l'exécution d'actions destinées à entraîner la mort.»

6. Il ne peut y avoir aucune dérogation au droit à la vie hors celles mentionnées à l'Article 2 de la Convention. En dehors de ces cas, comme l'Assemblée le note au paragraphe 9 (c)(i.),

⁴² Cour européenne des Droits de l'Homme, *Herczegfalvy c. Autriche*, 24 septembre 1992, Séries A N° 244; paragraphe 82.

«la mort ne peut être infligée à quiconque intentionnellement»⁴³. La Cour, cependant, n'a pas encore eu l'occasion de se prononcer sur la manière dont l'Article 2 s'applique aux propositions énoncées au paragraphe 9 (c) (ii.) (iii.).

7. S'agissant des dispositions garantissant la protection de la dignité humaine prévues par l'Article 3 («Nul ne peut être soumis à la torture ni à des peines ou traitements inhumains ou dégradants»), elles ne donnent lieu à aucune dérogation⁴⁴. Il est vrai que la Cour a déclaré «qu'une mesure dictée par une nécessité thérapeutique ne saurait, en général, passer pour inhumaine ou dégradante⁴⁵; mais elle a également souligné que l'assimilation d'un acte à un mauvais traitement relevant de l'Article 3 dépendait «de l'ensemble des données de la cause, notamment de la durée du traitement et de ses effets physiques ou mentaux ainsi que, parfois, du sexe, de l'âge, de l'état de santé de la victime, etc.»⁴⁶ De plus, l'Article 3 impose un certain nombre d'obligations à l'Etat: «Les enfants et autres personnes vulnérables, en particulier, ont droit à la protection de l'Etat, sous la forme d'une prévention efficace, les mettant à l'abri de formes aussi graves d'atteinte à l'intégrité de la personne».⁴⁷

8. Le droit au respect de la vie privée et familiale et prévu par l'Article 8 deviendrait pertinent dans certains cas, mais il n'existe que très peu d'exemples, dans la jurisprudence des organes de Strasbourg, pouvant être rattachés à des questions liées à la dignité des malades dans le cadre de cette disposition.⁴⁸

9. Le double objectif d'un allègement des souffrances sans violation de la Convention peut conduire à l'adoption de mesures nationales très diversifiées. La recommandation appelle l'attention sur celles relatives aux soins palliatifs (voir notamment le paragraphe 9 (a)). Elle ne définit pas les «soins palliatifs», bien que des définitions existent⁴⁹, ni l'expression de

⁴³ «(L'Article 2) garantit non seulement le droit à la vie mais expose les circonstances dans lesquelles infliger la mort peut se justifier; il se place à ce titre parmi les articles primordiaux de la Convention, auquel aucune dérogation ne saurait être autorisée, en temps de paix, en vertu de l'Article 15. Combiné à l'Article 3 de la Convention, il consacre l'une des valeurs fondamentales des sociétés démocratiques qui forment le Conseil de l'Europe. Il faut donc en interpréter les dispositions de façon étroite», Cour européenne des Droits de l'Homme, *McCann et autres c. Royaume-Uni*, 27 septembre 1995, paragraphe 147

⁴⁴ *Herczegfalvy c. Autriche*, paragraphe 82.

⁴⁵ *Ibid*: La Cour a souligné qu'elle devait s'assurer que les éléments établissant cette nécessité étaient suffisamment convaincants.

⁴⁶ Cour européenne des Droits de l'Homme, *Irlande contre Royaume-Uni*, 18 janvier 1978, Série A N° 25, paragraphe 162.

⁴⁷ Cour européenne des Droits de l'Homme, A. c. *Royaume-Uni*, 23 septembre 1998, paragraphe 22. Les Etats doivent donc prendre des mesures législatives ou de toute autre nature pour faire en sorte que les personnes relevant de leur juridiction, en particulier les plus vulnérables – dont font partie les malades incurables et les mourants – ne soient pas soumises à des traitements inhumains ou dégradants. D'ailleurs, dans une affaire au caractère très exceptionnel, la Cour a estimé que l'expulsion d'un malade en phase terminale du Sida vers un pays aux conditions sanitaires défavorables constituerait un traitement inhumain, parce que cette expulsion exposerait l'intéressé à un risque réel de mourir dans des circonstances particulièrement douloureuses. Cour européenne des Droits de l'Homme, D. c. *Royaume-Uni*, 2 mai 1997, Rapports 1997/III., N° 37, paragraphes 53 - 54

⁴⁸ Cour européenne des Droits de l'Homme, *Herczegfalvy c. Autriche*, paragraphe 86; Commission européenne des droits de l'homme, X c. *Autriche* N° 8278, 18 DR 154 à 156 (1979) (analyse sanguine), *Peters c. Pays Bas* N° 21132/93, 77-A DR 75 (1994) (analyse d'urine).

⁴⁹ L'Organisation mondiale de la santé définit les soins palliatifs comme étant «l'ensemble des soins actifs donnés aux malades dont l'affection ne répond au traitement curatif. La lutte contre la douleur et autres symptômes, et la prise en considération des problèmes psychologiques, sociaux et spirituels, sont primordiaux. Le but des soins

«traitement anti-douleur» mentionnée au paragraphe 7 (i.) - à juste titre, selon le Comité, étant donné la difficulté d'inscrire des concepts aussi larges dans une définition européenne uniforme. Le Comité se réfère à ce propos aux travaux du Comité européen de la santé sur les soins palliatifs⁵⁰.

10. Le Comité est donc en mesure de conclure que plusieurs des propositions faites par l'Assemblée parlementaire aux Etats membres, invités notamment à s'attacher davantage à l'allègement de la souffrance humaine, pourraient permettre de mieux protéger les droits de l'homme et la dignité des malades incurables et des mourants, à condition que les articles de la Convention européenne des droits de l'homme dont il est question dans la présente réponse soient respectés.

11. Cependant, du fait de l'absence de toute jurisprudence précise, la question des «droits de l'homme des malades incurables et des mourants» vue sous l'angle de la Convention soulève une série d'autres problèmes d'interprétation extrêmement complexes, concernant notamment:

- la question des interactions et des conflits possibles entre les droits et les libertés pertinentes en l'espèce et celle de la marge d'appréciation dont disposent les Etats Parties pour trouver des solutions permettant de concilier ces droits et libertés;
- la question de la nature et du champ des obligations positives incombant aux Etats Parties et celle de savoir lesquelles sont liées à la protection effective des droits et des libertés prévus par la Convention;
- la question de savoir si les dispositions pertinentes de la Convention doivent être interprétées comme garantissant également les «droits négatifs», comme la Cour en a décidé pour certains articles de la Convention⁵¹ et celle de savoir si une personne peut renoncer à l'exercice de certains droits et libertés dans ce contexte (et, si tel est le cas, dans quelle mesure et sous quelles conditions).⁵²

12. S'agissant de la législation et des pratiques des Etats membres dans les domaines traités dans la recommandation, le Comité directeur pour la bioéthique travaille à l'élaboration d'un rapport, conformément au mandat que lui a confié le Comité des Ministres. Ce rapport devrait être achevé en 2002 et sera transmis à l'Assemblée en temps utile. Le CDDH, pour sa part, suivra attentivement l'évolution de ces questions.

13. S'agissant des questions liées aux soins palliatifs, auxquelles l'Assemblée a consacré une partie importante de sa recommandation, le Comité européen de la santé (CDSP) a réalisé une étude de la situation portant sur de nombreux pays d'Europe et attachant une importance particulière aux activités de l'ECEPT (Eastern and Central European Task Force on Palliative Care). Le CDSP a entrepris la préparation d'un projet

palliatifs est d'obtenir la meilleure qualité de vie possible pour les malades et leur famille» (citation extraite du rapport de l'Assemblée parlementaire du Conseil de l'Europe sur la protection des droits de l'homme et de la dignité des malades incurables et des mourants, Doc. 8241, 21 mai 1999. Rapporteur: Mme Edeltraud Gatterer)

⁵⁰ Ces travaux sont évoqués dans la réponse intérimaire adoptée par les Délégués des Ministres le 30 octobre 2000.

⁵¹ Les Articles 9 et 11 notamment (impliquant respectivement la liberté de ne pas avoir de religion et la liberté de ne pas s'associer avec d'autres). (On se reportera par exemple aux documents suivants: Cour européenne des droits de l'homme, *Buscarini et autres c. Saint Marin*, 18 février 1999, paragraphe 34, et Cour européenne des droits de l'homme, *Sigurdur Sigurjonsson c. Islande*, 30 juin 1993, paragraphe 35).

⁵² Cour européenne des Droits de l'Homme, *Herczegfalvy c. Autriche*, 24 septembre 1992, Séries A N° 244; paragraphe 82

de recommandation sur ce sujet. Les résultats de ces travaux seront portés à la connaissance du Comité des Ministres à la fin de 2002.

14. Le Comité des Ministres tient à faire savoir à l'Assemblée que les propositions formulées dans sa Recommandation 1418 (1999) ont apporté une importante contribution à la réflexion menée dans ce domaine. Il se félicite par ailleurs des contacts qui ont été établis entre le Président de la Sous-commission compétente de l'Assemblée et le Président du Comité d'experts sur l'organisation des soins palliatifs.

Recommendation 1418 (1999) Protection of the human rights and dignity of the terminally ill and the dying⁵³

(Extract from the Official Gazette of the Council of Europe – June 1999)

1. The vocation of the Council of Europe is to protect the dignity of all human beings and the rights which stem therefrom.

2. Medical progress, which now makes it possible to cure many previously incurable or fatal diseases, the improvement of medical techniques and the development of resuscitation techniques, which make it possible to prolong a person's survival, to defer the moment of death. As a result the quality of life of the dying is often neglected, and their loneliness and suffering ignored, as is that of their families and care-givers.

3. In 1976, in its Resolution 613, the Assembly declared that it was «convinced that what dying patients most want is to die in peace and dignity, if possible with the comfort and support of their family and friends», and added in its Recommendation 779 (1976) that «the prolongation of life should not in itself constitute the exclusive aim of medical practice, which must be concerned equally with the relief of suffering».

4. Since then, the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine has formed important principles and paved the way without explicitly referring to the specific requirements of the terminally ill or dying.

5. The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. This respect and protection find their expression in the provision of an appropriate environment, enabling a human being to die in dignity.

6. This task has to be carried out especially for the benefit of the most vulnerable members of society, a fact demonstrated by the many experiences of suffering in the past and the present. Just as a human being begins his or her life in weakness and dependency, he or she needs protection and support when dying.

7. Fundamental rights deriving from the dignity of the terminally ill or dying person are threatened today by a variety of factors:

⁵³ Assembly debate on 25 June 1999 (24th Sitting) (see Doc. 8421, report of the Social, Health and Family Affairs Committee, rapporteur: Mrs Gatterer; and Doc. 8454, opinion of the Committee on Legal Affairs and Human Rights, rapporteur: Mr McNamara).

- i. insufficient access to palliative care and good pain management;
- ii. often lacking treatment of physical suffering and a failure to take into account psychological, social and spiritual needs;
- iii. artificial prolongation of the dying process by either using disproportionate medical measures or by continuing treatment without a patient's consent;
- iv. the lack of continuing education and psychological support for health-care professionals working in palliative medicine;
- v. insufficient care and support for relatives and friends of terminally ill or dying patients, which otherwise could alleviate human suffering in its various dimensions;
- vi. patients' fear of losing their autonomy and becoming a burden to, and totally dependent upon, their relatives or institutions;
- vii. the lack or inadequacy of a social as well as institutional environment in which someone may take leave of his or her relatives and friends peacefully;
- viii. insufficient allocation of funds and resources for the care and support of the terminally ill or dying;
- ix. the social discrimination inherent in weakness, dying and death.

8. The Assembly calls upon member states to provide in domestic law the necessary legal and social protection against these specific dangers and fears which a terminally ill or dying person may be faced with in domestic law, and in particular against:

- i. dying exposed to unbearable symptoms (for example, pain, suffocation, etc.);
- ii. prolongation of the dying process of a terminally ill or dying person against his or her will;
- iii. dying alone and neglected;
- iv. dying under the fear of being a social burden;
- v. limitation of life-sustaining treatment due to economic reasons;
- vi. insufficient provision of funds and resources for adequate supportive care of the terminally ill or dying.

9. The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects:

- a. by recognising and protecting a terminally ill or dying person's right to comprehensive palliative care, while taking the necessary measures:
 - i. to ensure that palliative care is recognised as a legal entitlement of the individual in all member states;
 - ii. to provide equitable access to appropriate palliative care for all terminally ill or dying persons;
 - iii. to ensure that relatives and friends are encouraged to accompany the terminally ill or dying and are professionally supported in their endeavours. If family and/or private networks prove to be either insufficient or overstretched, alternative or supplementary forms of professional medical care are to be provided;
 - iv. to provide for ambulant hospice teams and networks, to ensure that palliative care is available at home, wherever ambulant care for the terminally ill or dying may be feasible;
 - v. to ensure co-operation between all those involved in the care of a terminally ill or dying person;
 - vi. to ensure the development and implementation of quality standards for the care of the terminally ill or dying;
 - vii. to ensure that, unless the patient chooses otherwise, a terminally ill or dying person will receive adequate pain relief and palliative care, even if this treatment as a side-effect may contribute to the shortening of the individual's life;

viii. to ensure that health professionals are trained and guided to provide medical, nursing and psychological care for any terminally ill or dying person in co-ordinated teamwork, according to the highest standards possible;

ix. to set up and further develop centres of research, teaching and training in the fields of palliative medicine and care as well as in interdisciplinary thanatology;

x. to ensure that specialised palliative care units as well as hospices are established at least in larger hospitals, from which palliative medicine and care can evolve as an integral part of any medical treatment;

xi. to ensure that palliative medicine and care are firmly established in public awareness as an important goal of medicine;

b. by protecting the terminally ill or dying person's right to self-determination, while taking the necessary measures:

i. to give effect to a terminally ill or dying person's right to truthful and comprehensive, yet compassionately delivered information on his or her health condition while respecting an individual's wish not to be informed;

ii. to enable any terminally ill or dying person to consult doctors other than his or her usual doctor;

iii. to ensure that no terminally ill or dying person is treated against his or her will while ensuring that he or she is neither influenced nor pressured by another person. Furthermore, safeguards are to be envisaged to ensure that their wishes are not formed under economic pressure;

iv. to ensure that a currently incapacitated terminally ill or dying person's advance directive or living will refusing specific medical treatments is observed. Furthermore, to ensure that criteria of validity as to the scope of instructions given in advance, as well as the nomination of proxies and the extent of their authority are defined; and to ensure that surrogate decisions by proxies based on advance personal statements of will or assumptions of will are only to be taken if the will of the person concerned has not been expressed directly in the situation or if there is no recognisable will. In this context, there must always be a clear connection to statements that were made by the person in question close in time to the decision-making situation, more precisely at the time when he or she is dying, and in an appropriate situation without exertion of pressure or mental disability. To ensure that surrogate decisions that rely on general value judgements present in society should not be admissible and that, in case of doubt, the decision must always be for life and the prolongation of life;

v. to ensure that – notwithstanding the physician's ultimate therapeutic responsibility – the expressed wishes of a terminally ill or dying person with regard to particular forms of treatment are taken into account, provided they do not violate human dignity;

vi. to ensure that in situations where an advance directive or living will does not exist, the patient's right to life is not infringed upon. A catalogue of treatments which under no condition may be withheld or withdrawn is to be defined;

c. by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

i. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member states, in accordance with Article 2 of the European Convention on Human Rights which states that «no one shall be deprived of his life intentionally»;

ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

Text adopted by the Assembly on 25 June 1999 (24th Sitting).

II.3. JURISPRUDENCIA

Case off Pretty v. The United Kingdom

Case Of Zoon v. The Netherlands

Case of Glass v. The United Kingdom

Sanles Sanles v. Spain

Originating Body Court (Fourth Section)

Document Type Judgment (Merits)

Published in Reports of Judgments and Decisions 2002-III

Language ENGLISH ; FRENCH

Title CASE OF PRETTY v. THE UNITED KINGDOM

Application Number 2346/02

Importance Level 1

Represented by N/A

Respondent State the United Kingdom

Date of Judgment 29/04/2002

Conclusion No violation of Art. 2 ; No violation of Art. 3 ;
No violation of Art. 8 ; No violation of Art. 9 ; No violation of Art. 14

Articles 2-1 ; 3 ; 8-1 ; 8-2 ; 9 ; 14 ; 36-2 ; 41

Separate Opinions No

Law at Issue Suicide Act 1961, section 2(1) and 2(4)

Strasbourg Case Law Valašinas v. Lithuania, no. 44558/98, (Sect. 3), ECHR 2001-VIII, § 117 ; X. and Y. v. the Netherlands judgment of 26 March 1985, Series A no. 91, p. 11, § 22 ; Young, James and Webster v. the United Kingdom judgment of 13 August 1981, Series A no. 44, § 52 ; Z. and Others v. the United Kingdom [GC], no. 29392/95, ECHR 2001-V

External Sources Parliamentary Assembly Recommendation 1418 (1999)

Keywords «DEGRADING TREATMENT» DISCRIMINATION «FREEDOM OF THOUGHT» «INHUMAN TREATMENT» «INTERFERENCE-{ART 8}» LIFE «NECESSARY IN A DEMOCRATIC SOCIETY-{ART 8}» «NON-DEROGABLE RIGHTS AND FREEDOMS» «POSITIVE OBLIGATIONS» «PROTECTION OF THE RIGHTS AND FREEDOMS OF OTHERS-{ART 8}» «RESPECT FOR PRIVATE LIFE»

Press release issued by the Registrar

235

29/4/2002

The European Court of Human Rights has today notified in writing its Chamber judgment¹ in the case *Pretty v. the United Kingdom* (application no. 2346/02). The Court unanimously found the application admissible and held that there had been:

- no violation of Article 2 (right to life) of the European Convention on Human Rights,
- no violation of Article 3 (prohibition of inhuman or degrading treatment or punishment),
- no violation of Article 8 (right to respect for private life),
- no violation of Article 9 (freedom of conscience), and
- no violation of Article 14 (prohibition of discrimination).

1. Principal facts

Diane Pretty is a United Kingdom national, born in 1958 and living in Luton. She is dying of motor neurone disease, a degenerative disease affecting the muscles, for which there is no cure.

The disease is now at an advanced stage; the applicant is paralysed from the neck downwards and her life expectancy is very poor. However, her intellect and capacity to make decisions are unimpaired. Given that the final stages of the disease are distressing and undignified, she wishes to be able to control how and when she dies and be spared that suffering and indignity.

Although it is not a crime to commit suicide in English law, the applicant is prevented by her disease from taking such a step without assistance. It is however a crime to assist another to commit suicide under section 2 § 1 of the Suicide Act 1961. Ms Pretty wishes to be assisted by her husband in committing suicide, but the Director of Public Prosecutions (DPP) has refused her request to guarantee her husband freedom from prosecution if he does so. Her appeals against that decision have been unsuccessful.

2. Procedure and composition of the Court

The application was lodged with the European Court of Human Rights on 21 December 2001. The Court decided on 22 January 2002 to give priority to the case and to communicate the application to the United Kingdom Government as matter of urgency². On 19 March 2002 the Court held a public hearing on the admissibility and the merits of the case, which Ms Pretty and her husband, Brian Pretty, attended.

Judgment was given by a Chamber of seven judges, composed as follows:

Matti Pellonpää (Finnish), President,
Nicolas Bratza (British),
Elisabeth Palm (Swedish),
Jerzy Makarczyk (Polish),
Marc Fischbach (Luxemburger),
Josep Casadevall (Andorran),
Stanislav Pavlovschi (Moldovan), judges,
and also Michael O'Boyle, Section Registrar.

3. Summary of the judgment

Complaints

The applicant complains, under Article 2 of the Convention, that it is for the individual to choose whether to live and that the right to die is the corollary of the right to live and also protected. Accordingly there is a positive obligation on the State to provide a scheme in domestic law to enable her to exercise that right.

She also complains under Article 3 that the United Kingdom Government is obliged not only to refrain from inflicting inhuman and degrading treatment itself, but also to take positive steps to protect persons within its jurisdiction from being subjected to such treatment. The only effective step

available to protect the applicant in this way would be an undertaking not to prosecute her husband if he assisted her to commit suicide.

She further relies on Article 8, arguing that this explicitly recognises the right to self-determination, and Article 9, complaining that the failure to give the undertaking and provide a lawful scheme for allowing assisted suicide violates her right to manifest her beliefs. Under Article 14, she argues that the blanket prohibition on assisted suicide discriminates against those who are unable to commit suicide without assistance, whereas the able-bodied are able to exercise the right to die, under domestic law.

Decision of the Court

Admissibility

The Court considered that the application as a whole raised questions of law which were sufficiently serious that their determination should depend on an examination of the merits. It accordingly declared the application admissible.

Merits

Article 2

The Court recalled that Article 2 safeguarded the right to life, without which enjoyment of any of the other rights and freedoms in the Convention was rendered nugatory. It covered not only intentional killing, but also the situations where it was permitted to use force which resulted, as an unintended outcome, in the deprivation of life. The Court had moreover held that the first sentence of Article 2 § 1 enjoined States not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. This obligation might also imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life was at risk from the criminal acts of another individual.

In its case-law in this area the Court had placed consistent emphasis on the obligation of the State to protect life. In these circumstances it was not persuaded that «the right to life» guaranteed in Article 2 could be interpreted as involving a negative aspect. Article 2 could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor could it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.

The Court accordingly found that no right to die, whether at the hands of a third person or with the assistance of a public authority, could be derived from Article 2. There had therefore been no violation of that provision.

Article 3

It was, the Court noted, beyond dispute that the respondent Government had not, themselves, inflicted any ill-treatment on the applicant. Nor was there any complaint that the applicant was not receiving adequate care from the State medical authorities. The applicant had claimed rather that the refusal of the DPP to give an undertaking not to prosecute her husband if he assisted her to commit suicide and the criminal law prohibition on assisted suicide disclosed inhuman and degrading treatment for which the State was responsible. This claim however placed a new and extended construction on the concept of treatment. While the Court had to take a dynamic and flexible

approach to the interpretation of the Convention, any interpretation had also to accord with the fundamental objectives of the Convention and its coherence as a system of human rights protection. Article 3 had to be construed in harmony with Article 2. Article 2 was first and foremost a prohibition on the use of lethal force or other conduct which might lead to the death of a human being and did not confer any claim on an individual to require a State to permit or facilitate his or her death.

The Court could not but be sympathetic to the applicant's apprehension that without the possibility of ending her life she faced the prospect of a distressing death. Nonetheless, the positive obligation on the part of the State which had been invoked would require that the State sanction actions intended to terminate life, an obligation that could not be derived from Article 3. The Court therefore concluded that no positive obligation arose under Article 3 in this context and that there had, accordingly, been no violation of that provision.

Article 8

The applicant was prevented by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life. The Court was not prepared to exclude that this constituted an interference with her right to respect for private life as guaranteed under Article 8 § 1.

The Court recalled that an interference with the exercise of an Article 8 right would not be compatible with Article 8 § 2 unless it was «in accordance with the law», had an aim or aims that was or were legitimate under that paragraph and was «necessary in a democratic society» to attain such aim or aims.

The only issue arising from the arguments of the parties was the necessity of any interference and those arguments had focussed on its proportionality. In this connection the applicant had attacked the blanket nature of the ban on assisted suicide.

The Court found, in agreement with the House of Lords, that States were entitled to regulate through the operation of the general criminal law activities which were detrimental to the life and safety of other individuals. The law in issue in this case, section 2 of the Suicide Act, was designed to safeguard life by protecting the weak and vulnerable and especially those who were not in a condition to take informed decisions against acts intended to end life or to assist in ending life.

The Court did not consider that the blanket nature of the ban on assisted suicide was disproportionate. The Government had stated that flexibility was provided for in individual cases by the fact that consent was needed from the DPP to bring a prosecution and by the fact that a maximum sentence was provided, allowing lesser penalties to be imposed as appropriate. It did not appear to be arbitrary for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allowed due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence.

Nor in the circumstances was there anything disproportionate in the refusal of the DPP to give an advance undertaking that no prosecution would be brought against the applicant's husband. Strong arguments based on the rule of law could be raised against any claim by the executive to exempt individuals or classes of individuals from the operation of the law. In any event, the seriousness of the act for which immunity was claimed was such that the decision of the DPP to refuse the undertaking sought could not be said to be arbitrary or unreasonable.

The Court concluded that the interference could be justified as «necessary in a democratic society» for the protection of the rights of others. There had therefore been no violation of Article 8.

Article 9

The Court observed that not all opinions or convictions constituted beliefs as protected by Article 9 § 1. The applicant's claims did not involve a form of manifestation of a religion or belief, through worship, teaching, practice or observance as described in the second sentence of the first paragraph. The term «practice» did not cover each act which was motivated or influenced by a religion or belief. To the extent that the applicant's views reflected her commitment to the principle of personal autonomy, her claim was a restatement of the complaint raised under Article 8. The Court concluded that there had been no violation of Article 9.

Article 14

For the purposes of Article 14 a difference in treatment between persons in analogous or relevantly similar positions was discriminatory if it had no objective and reasonable justification, that is if it did not pursue a legitimate aim or if there was not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. Discrimination could also arise where States without an objective and reasonable justification failed to treat differently persons whose situations were significantly different.

There was, in the Court's view, objective and reasonable justification for not distinguishing in law between those who were and those who were not physically capable of committing suicide. Cogent reasons existed for not seeking to distinguish between those who were able and those who were unable to commit suicide unaided. The borderline between the two categories would often be a very fine one and to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse.

Consequently, there had been no violation of Article 14.

Originating Body Court (Fourth Section)
Document Type Judgment (Merits)
Published in Reports of Judgments and Decisions 2000-XII
Language English

Title CASE OF ZOON v. THE NETHERLANDS

Application Number 29202/95
Importance Level 1
Respondent State the Netherlands
Referred by Commission
Date of Reference 03/11/1998
Date of Judgment 07/12/2000
Conclusion No violation of Art. 6-1 and Art. 6-3-b
Articles 6-1 ; 6-3-b
Separate Opinions No
Law at Issue Code of Criminal Procedure, Articles 345 § 3, 359 § 1 and 365 § 1
Strasbourg Case Law Reinhardt and Slimane-Kaïd v. France judgment of 31 March 1998, Reports of Judgments and Decisions 1998-II, p. 659, § 88 ; Vacher v. France judgment of 17 December 1996, Reports of Judgments and Decisions 1996-VI, p. 2147, § 22
Keywords «ADEQUATE TIME» «CRIMINAL PROCEEDINGS» «PREPARATION OF DEFENCE»

Press release issued by the Registrar

877
7/12/2000

CHAMBER JUDGMENTS CONCERNING FINLAND AND THE NETHERLANDS

The European Court of Human Rights has today notified in writing the following two Chamber judgments:

(1) Valle v. Finland 1 (no. 28808/95) Friendly settlement

Tapio Valle, a Finnish national, complained in relation to his compulsory psychiatric care, that the restrictions on him relating both to visits and telephone calls were unlawful and that he had not had an effective remedy against measures to restrict telephone calls from his lawyer. He invoked Articles 8 (right to respect for private and family life) and 13 (right to an effective remedy) of the European Convention on Human Rights. The case has been struck out following a friendly settlement in which 20,000 Finnish marks (FIM) is to be paid for any non-pecuniary damage and FIM 7,930 for costs and expenses. The judgment is available only in English.

(2) Zoon v. the Netherlands (no. 29202/95) No violation Article 6 §§ 1 and 3 (b)

Herman Olivier Zoon, a Netherlands national, complained that, when he had to decide whether or not to lodge an appeal, he did not have access to a written copy of the fully reasoned first-instance court judgment against him. He was charged with murder, falsification of a death certificate and prescriptions and forgery following his statement that he had performed euthanasia on, and at the request of, one of his patients. After having found that the applicant could have had access to a judgment in abridged form, the European Court of Human Rights held unanimously that there had been no violation of Article 6 §§ 1 (right to a fair and public hearing) and 3 (b) (right to adequate time and facilities for preparation of defence) of the Convention. The judgment is available only in English.

Originating Body Court (Fourth Section)
Document Type Judgment (Merits and Just Satisfaction)
Published in Reports of Judgments and Decisions 2004-II
Language ENGLISH ; FRENCH

Title CASE OF GLASS v. THE UNITED KINGDOM

Application Number 61827/00
Importance Level 1
Represented by N/A
Respondent State the United Kingdom
Date of Judgment 09/03/2004
Conclusion Violation of Art. 8 ; Non-pecuniary damage - financial award ; Costs and expenses partial award - Convention proceedings
Articles 8-1 ; 8-2 ; 41
Separate Opinions Yes
Strasbourg Case Law Beyeler v. Italy, just satisfaction [GC], no. 33202/96, 28 May 2002, § 27 ; Herczegfalvy v. Austria, judgment of 24 September 1992, Series A no. 244, pp. 27-28, §§ 88 91 ; Odièvre v. France [GC], no. 42326/98, ECHR 2003-I ; Pretty v. the United Kingdom, no. 2346/02, §§ 61 and 63, § 68, ECHR 2002-III ; X and Y v. the Netherlands, judgment of 26 March 1985, Series A no. 91, p. 11, §§ 22-23 ; Y.F. v. Turkey, no. 24209/94, § 33, 22 July 2003
External Sources Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine
Keywords «INTERFERENCE-{ART 8}» «NECESSARY IN A DEMOCRATIC SOCIETY-{ART 8}» «PRESCRIBED BY LAW-{ART 8}» «RESPECT FOR PRIVATE LIFE»

Press release issued by the Registrar113
9/3/2004**CHAMBER JUDGMENT IN THE CASE OF GLASS v. THE UNITED KINGDOM**

The European Court of Human Rights has today notified in writing a judgment¹ in the case of *Glass v. the United Kingdom* (application no. 61827/00).

The Court held unanimously that there had been a violation of Article 8 (right to respect for private life) of the European Convention on Human Rights.

Under Article 41 (just satisfaction) of the Convention, the Court awarded the applicants 10,000 euros (EUR) for non-pecuniary damage and EUR 15,000 for costs and expenses. (The judgment is available only in English.)

1. Principal facts

The applicants, Carol and David Glass, are both United Kingdom nationals. David, born in 1986, is severely mentally and physically disabled and requires 24-hour attention. Ms Glass is David's mother and legal proxy.

In July 1998 David was admitted to St Mary's Hospital, one of two hospitals belonging to the Portsmouth Hospitals National Health Service Trust. Following an operation to alleviate an upper respiratory tract obstruction, David suffered complications, became critically ill and had to be put on a ventilator. During his treatment, Ms Glass was informed by hospital staff that David was dying and that further intensive care would be inappropriate. However, David's condition improved and he was able to return home on 2 September 1998.

On 8 September 1998, when David was re-admitted to the hospital with a respiratory tract infection, doctors discussed with Ms Glass the possible use of morphine to alleviate distress. Ms Glass expressed her opposition, telling doctors that if David's heart stopped she would expect resuscitation including intubation. Dr W. considered that this would not be in David's best interests, and stated in his notes that a «second opinion», if necessary from the courts, was needed. Dr H. also noted that «in the event of total disagreement we should be obliged to go to the courts».

David's condition deteriorated. On 20 October 1998 the doctors treating David considered that he was dying and recommended that diamorphine be given to him to relieve his distress. Ms Glass did not agree that her son was dying and was very concerned that the administration of diamorphine (previously morphine had been mentioned) would compromise his chances of recovery. Ms Glass voiced her concerns at a meeting with the doctors at which a police officer was also present.

She subsequently asked to take David home if he was dying, but a police officer advised her that if she attempted to remove him, she would be arrested. David was given a diamorphine infusion at 7 p.m. on 20 October 1998.

A dispute broke out in the hospital involving other family members and the doctors. The family members believed that David was being covertly euthanased and attempted to prevent the doctors from entering his room. The hospital authorities called the security staff and threatened to exclude the family from the hospital by force.

A «Do Not Resuscitate» (DNR) order was put in the first applicant's medical notes without consulting Ms Glass.

The following day Ms Glass found that her son's condition had deteriorated alarmingly and was worried that this was due to the effect of diamorphine. The family demanded that diamorphine be stopped. Dr W. stated that this was only possible if

they agreed not to resuscitate David. However, the family tried to revive David and a fight broke out between members of the family and the doctors. While the fight was going on, Ms Glass successfully resuscitated David.

Police were summoned to the hospital. Dr W. and Dr A. and several police officers were injured and all but one of the children on the ward had to be evacuated.

David's condition improved and he went home on 21 October 1998.

Ms Glass applied unsuccessfully for judicial review and permission to appeal to the Court of Appeal concerning the decisions taken by the hospital authority.

The General Medical Council found that the doctors involved had not been guilty of serious professional misconduct or seriously deficient performance and that the treatment complained of had been justified. The Crown Prosecution Service did not bring charges against the doctors involved for lack of evidence.

2. Procedure and composition of the Court

The application was lodged on 5 June 2000 and declared partly admissible on 18 March 2003.

Judgment was given by a Chamber of seven judges, composed as follows:

Matti Pellonpää (Finnish), President,
Nicolas Bratza (British),
Josep Casadevall (Andorran),
Rait Maruste (Estonian),
Stanislav Pavlovski (Moldovan),
Javier Borrego Borrego (Spanish),
Elisabet Fura-Sandström (Swedish), judges,

and also Françoise Elens-Passos, Deputy Section Registrar.

3. Summary of the judgment²***Complaint***

The applicants argued that United Kingdom law and practice failed to guarantee the respect for David's physical and moral integrity required by Article 8 of the Convention (right to respect for private life). In particular, the decisions to administer diamorphine to David against his mother's wishes and to place a DNR notice in his notes without her knowledge interfered with both their rights under Article 8.

They also maintained that leaving the decision to involve the courts to the discretion of doctors was a wholly inadequate basis on which to ensure effective respect for the rights of vulnerable patients.

Decision of the Court***Article 8***

The Court considered that the decision to impose treatment on David in defiance of his mother's objections gave rise to an interference with his right to respect for his private life, and in particular his right to physical integrity. It considered that it was not required to examine whether the treatment concerned gave rise to an interference with Ms Glass's right to respect for her family life.

The Court found that the interference was in accordance with the law. The regulatory framework in the United Kingdom was firmly based on the duty to preserve the life of a patient, save in exceptional circumstances. The same frame-

work prioritised the requirement of parental consent and, save in emergency situations, required doctors to seek the intervention of the courts in the event of parental objection.

The Court also considered that the action taken by the hospital staff pursued a legitimate aim. It was intended, as a matter of clinical judgment, to serve David's interests. The Court rejected any suggestion that it was the doctors' intention unilaterally to hasten David's death whether by administering diamorphine to him or by placing a DNR notice in his case notes.

In deciding whether the interference was necessary in a democratic society, the Court considered that the situation which arose at St Mary's Hospital between 19 and 21 October 1998 could not be isolated from the earlier discussions between members of the hospital staff and Ms Glass about David's condition. The doctors at the hospital were obviously concerned about Ms Glass' reluctance to follow their advice, in particular their view that morphine might have to be administered to her son. Both Dr W. and Dr H. had found that recourse to the courts might be necessary.

It had not been explained to the Court's satisfaction why the trust did not at that stage seek the intervention of the High Court. The doctors at that time all shared a gloomy prognosis of David's capacity to withstand further crises and they were left in no doubt that their proposed treatment would not meet with the agreement of his mother. Admittedly, Ms Glass could have brought the matter before the High Court. However, the Court considered that the onus was on the trust to take the initiative and to defuse the situation in anticipation of a further emergency.

The Court accepted that the doctors could not have predicted the level of confrontation and hostility which in fact arose on 18 October 1998. It was nevertheless the case that the trust's failure to make a High Court application at an earlier stage contributed to the situation.

That being said, the Court was not persuaded that an emergency High Court application could not have been made by the trust when it became clear that Ms Glass was firmly opposed to the administration of diamorphine to David. The trust was able to secure the presence of a police officer to oversee the negotiations with Ms Glass but, surprisingly, did not consider making a High Court application even though it would have been possible at short notice.

The Court considered that the decision of the authorities to override Ms Glass's objection to the proposed treatment in the absence of authorisation by a court resulted in a breach of Article 8.

In view of that conclusion, the Court did not consider it necessary to examine separately the applicants' complaint regarding the inclusion of the DNR notice in David's case notes without her consent and knowledge. It stressed, however, that the notice was only directed against the application of vigorous cardiac massage and intensive respiratory support, and did not exclude the use of other techniques, such as the provision of oxygen, to keep David alive.

Originating Body Court (Fourth Section)

Document Type Decision

Published in Reports of Judgments and Decisions 2000-XI
Language French

Title SANLES SANLES v. SPAIN

Application Number 48335/99

Importance Level 1

Represented by MARTINEZ, J.A., lawyer, Barcelone ; MAZON COSTA, J.L., lawyer, Murcie

Respondent State Spain

Date of Introduction 20/04/1999

Date of Decision 26/10/2000

Conclusion Inadmissible

Articles 2 ; 3 ; 5 ; 6 ; 8 ; 9 ; 14 ; 34 ; 35-3

Keywords «RATIONE PERSONAE» «REASONABLE TIME»
VICTIM

THE FACTS

The applicant is a Spanish national. She was born in 1936 and lives in Porto do Son, Corunna (Spain). She was represented before the Court by Mr Jorge Arroyo Martínez and Mr José Luis Mazón Costa, of the Barcelona and Murcia Bars respectively.

A. The circumstances of the case

The facts of the case, as submitted by the applicant, may be summarised as follows.

On 12 January 1998 Mr Ramón Sampedro Cameán («Mr Sampedro»), who had been tetraplegic since the age of twenty-five following an accident on 23 August 1968, died a voluntary and painless death after having sought recognition from the Spanish courts since April 1993 of his right not to have the State interfere with his decision to end his life in that way.

Those proceedings, which he had instituted in the Barcelona civil courts, ended with a decision of the Constitutional Court of 18 July 1994 dismissing his amparo appeal on the ground that the remedies in the ordinary courts had not been properly used because the applicant had failed to bring his case in the courts with territorial jurisdiction. That decision was examined by the Commission, which declared the application (no. 25949/94) inadmissible on 17 May 1995 for non-exhaustion of domestic remedies.

The applicant, Mr Sampedro's sister-in-law, is the heir legally appointed by him to continue the proceedings which he had instituted while he was alive.

On 12 July 1995 Mr Sampedro brought an action (jurisdicción voluntaria) in the Court of First Instance of Noia (Corunna) requesting:

«... that my general practitioner be authorised to prescribe me the medication necessary to relieve me of the pain, anxiety and distress caused by my condition without that act being considered under the criminal law to be assisting suicide or to be an offence of any kind; I fully accept the risk that such medication might entail and hope thus to be able, at the appropriate time, to die in dignity.»

In a judgment of 9 October 1995 the Barcelona Court of First Instance refused Mr Sampedro's request, holding that Article 143 of the Criminal Code did not allow a court to authorise a third party to help a person to die or to bring about that person's death.

Mr Sampedro appealed. In a decision (auto) of 19 November 1996, the Corunna Audiencia provincial upheld the judgment on the basis of Article 15 of the Constitution and the Constitutional Court's interpretation of that Article (see Relevant domestic law and practice, below), Articles 17 and 3 of the Civil Code, Article 409 of the former Criminal Code, and Article 143 of the new Criminal Code.

Mr Sampedro then lodged an amparo appeal with the Constitutional Court on the basis of the rights to human dignity and the free development of the personality, to life and to physical and psychological integrity, and to a fair trial (Articles 10, 15 and 24 of the Constitution). The appeal was registered on

16 December 1996. On 10 March 1997 Mr Sampedro was given twenty days in which to submit his final observations.

In the early hours of 12 January 1998 Mr Sampedro died, assisted by one or more anonymous persons. Criminal proceedings were instituted against a person or persons unknown for aiding and abetting suicide.

After Mr Sampedro's death, the applicant informed the Constitutional Court on 7 April 1998 that she intended to continue the proceedings instituted by Mr Sampedro in her capacity as his heir.

On 4 May 1998 the applicant reworded as follows the grounds of appeal submitted by Mr Sampedro in support of his amparo appeal in order to adapt them to the new situation arising as a result of his death: «[that] the Audiencia [provincial] should have acknowledged [Mr Sampedro's] right for his general practitioner to be authorised to administer him the medication necessary...».

In a decision of 11 November 1998 the Constitutional Court discontinued the proceedings and refused the applicant the right, in her capacity as Mr Sampedro's heir, to continue the proceedings brought by him. It did not rule, however, on the applicant's allegation regarding the excessive length of the proceedings in the Constitutional Court, which had still been pending at the time of Mr Sampedro's death. The following is an extract from the court's judgment:

«It must be acknowledged that our legal system allows continuity in the exercise of actions for the recognition and protection of certain personal rights by heirs and other persons after the death of the person bringing the action. Such is the case for actions concerning civil status, such as establishing descent ... and those concerning civil protection of the right to honour, personal and family privacy and personal image (section 6(2) of Institutional Law 1/1982 of 5 May 1982). Those substantive legal conditions do not suffice, however, to justify Mrs Sanles's request to continue the proceedings merely on the basis of the declaration contained in Article 661 of the Civil Code...»

There are two aspects to the right granted under that provision to continue legal proceedings: (a) it concerns legal rights and relations that are not exhausted in themselves but are projected onto the family group, extending beyond the holder of the right to other persons affected by the court decision recognising or remedying the right infringed, and, essentially, (b) ... not successors to legal proceedings under succession law, but successors *ope legis*, in so far as expressly provided for by law.

That said, in the case of the right to die in dignity by euthanasia without the intervention by a third party constituting a criminal offence, which was the right in respect of which Mr Sampedro lodged his amparo appeal, the above conditions are not met. There is no explicit legal provision to that effect (Article 661 of the Civil Code being limited to indicating the time at which succession takes effect) and the case does not concern rights such as a personal honour, reputation, image or privacy, the effects of which are not confined to the holder of the right but extend to his family circle or relatives. On the contrary, it is here a request of a «strictly personal» nature and inextricably linked to the person exercising it as «an act of will concerning that person alone» (Constitutional Court Judgment ("CCJ") 120/1990, seventh ground, and CCJ 137/1990, fifth ground).

In the light of the foregoing, the request to continue the proceedings must be rejected. The applicant's claim lapsed from the moment at which Mr Sampedro Cameán, the appellant, died and his heir, Mrs Manuela Sanles Sanles, cannot continue to rely on it in the constitutional proceedings. Our conclusion is further supported by the nature of an

amparo appeal in constitutional proceedings, which has been established for the purpose of challenging actual and effective breaches of fundamental rights. As stated in the CCJ 114/1995, an amparo appeal «is not a proper remedy for requesting and obtaining an abstract and generic decision determining declarative claims which concern allegedly erroneous interpretations or incorrect applications of constitutional provisions, but only and exclusively those claims which are intended to re-establish or protect fundamental rights in the event of an actual and effective breach» (second ground).»

B. Relevant domestic law and practice

1. Civil Code

Article 661

«Heirs shall inherit all the rights and obligations of the deceased by the fact of his death alone.»

2. Criminal Code

Article 409 (former Code)

«Anyone who helps or encourages another to commit suicide shall be liable to a prison sentence [of six to twelve years]; if he assists to such an extent that he causes the death, he shall be liable to a prison sentence of twelve to twenty years.»

Article 143 (new Code)

2. Anyone who performs an act necessary to assist another to commit suicide shall be liable to a prison sentence of two to five years.

3. If that assistance causes the death, the person providing it shall be liable to a prison sentence of six to ten years.

4. Anyone who, at the express, genuine and unequivocal request of a person suffering from a serious terminal illness or one causing him serious permanent and intolerable suffering, causes that person's death or actively performs an act necessary to assist him to die shall be liable to a sentence in the first or second category below the one provided for in paragraphs 2 and 3 of this Article.»

3. Institutional Act 1/82 of 5 May 1982 for the protection of honour, privacy and image

Section 6

«1. Where the holder of the infringed right dies without having been able to bring, either himself or through his legal representative, an action under this Act, on account of the circumstances in which the infringement occurred, the action may be brought by the persons referred to in section 4 [the person designated in the will or, failing that, the spouse, descendants, ascendants and brothers...]

2. Those persons may continue an action previously instituted by the holder of the infringed right when he dies.»

4. Case-law of the Constitutional Court

Judgment no. 120/90 of 27 June 1990

«... The right to life is, accordingly, an inherently positive and protective one which cannot therefore be considered as a right of freedom encompassing the right to die. It is not, however, inconsistent with that principle to acknowledge that, in

so far as life is a personal asset forming an integral part of a person's freedom, an individual can dispose of his own life. However, such an example of «licence to act» (agere licere), in the sense of taking one's own life or accepting one's own death, is an act permissible by law but not in any way a subjective right allowing an individual to solicit support from the public authorities to overcome resistance to his desire to die; still less is it a fundamental subjective right in respect of which that possibility would extend over and above even legislative resistance, which cannot reduce the essential content of a fundamental subjective right.

Accordingly, Article 15 of the Constitution, as in force, cannot be construed to guarantee the individual a right to his own death...»

COMPLAINTS

The applicant submitted that Mr Sampedro's decision to request medical assistance to put a painless end to the suffering brought about by his paralysis fell fully within the scope of the right to private life guaranteed by Article 8 of the Convention. In her submission, the State's interference, in the form of prohibitions laid down in the Criminal Code on assisting an individual to end his life, was unjustified.

The applicant maintained that Mr Sampedro had been claiming the right to a dignified life, or to non-interference with his wish to put an end to his undignified life, because his total paralysis had been a source of accumulated and intolerable suffering for him. She alleged that there had been a violation of Articles 2 and 3 of the Convention.

Relying on Articles 5 and 9 of the Convention, the applicant also complained of interference by the State with the exercise of Mr Sampedro's right to freedom and to freedom of conscience.

The applicant considered it paradoxical at the least that a decision to commit suicide should be respected by the State, whereas assisting an invalid to commit suicide was punishable under the criminal law. She relied on Article 14 of the Convention.

The applicant complained, lastly, of an infringement of Mr Sampedro's right to a fair hearing. Mr Sampedro had, she alleged, been the victim of a denial of justice in that the Constitutional Court had refused her the right to continue the legal proceedings, especially as a criminal investigation had been commenced after Mr Sampedro's death against the persons who had allegedly helped him to die. Furthermore, Mr Sampedro's case had not been heard within a reasonable time by the Constitutional Court. The applicant argued that the amparo appeal had been lodged on 16 December 1996 and had still been pending at the end of March 1997. Mr Sampedro died on 12 January 1998 and judgment was delivered on 11 November 1998 without any priority having been given to it. She relied on Article 6 of the Convention.

THE LAW

Relying on Articles 2, 3, 5, 6, 8, 9 and 14 of the Convention, the applicant requested recognition of the right to a dignified life or a dignified death, or to non-interference with Mr Sampedro's wish to end his life, his total paralysis resulting in intolerable suffering for him. She also complained of interference by the State with the exercise of Mr Sampedro's right to freedom and to freedom of conscience, and of the inequality under the criminal law between suicide and assisting an invalid to commit suicide. She complained, lastly, of the unfairness and length of the proceedings in the Constitutional Court.

a. With regard to the substantive rights relied on by the applicant, the Court has previously held that, under Article 35 § 1 (former 26) of the Convention, the rules of admissibility must be applied with some degree of flexibility and without excessive formalism (see the *Cardot v. France* judgment of 19 March 1991, Series A no. 200, p. 18, § 34). Account also has to be taken of their object and purpose (see, for example, the *Worm v. Austria* judgment of 29 August 1997, Reports 1997-V, § 33) and of those of the Convention in general, which, in so far as it constitutes a treaty for the collective enforcement of human rights and fundamental freedoms, must be interpreted and applied so as to make its safeguards practical and effective (see, for example, the *Ya'ava v. Turkey* judgment of 2 September 1998, Reports 1998-VI, § 64).

The Court reiterates that the system of individual petition provided under Article 34 of the Convention excludes applications by way of *actio popularis*. Complaints must therefore be brought by or on behalf of persons who claim to be victims of a violation of one or more of the provisions of the Convention. The concept of victim must, in theory, be interpreted autonomously and irrespective of domestic concepts such as those concerning an interest or capacity to act. In order for an applicant to be able to claim to be a victim of a violation of the Convention, they must be able to show that they have been directly affected by the impugned measure (see, for example, the *Open Door and Dublin Well Woman v. Ireland* judgment of 29 October 1992, Series A no. 246, § 44). However, victim status may exist even where there is no damage, such an issue being relevant under Article 41 of the Convention, for the purposes of which pecuniary or non-pecuniary damage flowing from the breach must be established (see, for example, the *Wassink v. the Netherlands* judgment of 27 September 1990, Series A no 185, § 38, and the *Ilhan v. Turkey* [GC] judgment, no. 22277/93, § 52).

In the light of the foregoing, the Court notes that the issue whether the applicant may or may not claim compensation on her own account is distinct from the issue whether she can validly lodge the application. The applicant stated in her application, moreover, that she was complaining on behalf of Mr Sampedro, of whom she was the heir, and that Mr Sampedro, on account of his death, was no longer in a position to continue himself the proceedings instituted in the Constitutional Court on the basis of Articles 10, 15 and 24 of the Constitution.

The Court notes the Constitutional Court's ruling to the effect that certain actions for the recognition and protection of personal rights, such as an action relating to civil status or civil protection of the right to honour and to private and family life, may be continued by heirs and other persons after the applicant's death. The Constitutional Court held, however, that *locus standi* under Article 661 of the Civil Code to continue legal proceedings concerns only successions *ope legis* (sic), that is, where expressly provided for by law. In respect of the alleged right to die in dignity without the commission of euthanasia by a third party constituting an offence, which was the right in respect of which Mr Sampedro had lodged his amparo appeal, the Constitutional Court found that there was no specific legal provision to that effect and that it did not extend to Mr Sampedro's family circle or relatives.

The Court considers it important to point out from the outset that it is not required to rule on whether or not there is a right under the Convention to a dignified death or a dignified life. It notes that the action (*jurisdicción voluntaria*) brought by Mr Sampedro in the Spanish courts was for recognition of his right to have his general practitioner prescribe him the medication necessary to prevent the suffering, distress and anxiety caused by his condition without that act being considered under the criminal law to be assisting suicide or to be an offence of any

kind whatsoever. Admittedly, the applicant may claim to have been very affected by the circumstances surrounding Mr Sampedro's death despite the lack of close family ties. However, the Court considers that the rights claimed by the applicant under Article 2, 3, 5, 8, 9 and 14 of the Convention belong to the category of non-transferable rights. Consequently, the applicant cannot rely on those rights on behalf of Mr Sampedro in the context of his action in the domestic courts.

Referring to the decision given by the Constitutional Court in this case, the Court reiterates that the purpose of an amparo appeal is to protect individuals from actual and effective infringements of their fundamental rights. It is not a proper remedy for requesting and obtaining an abstract decision on claims concerning allegedly erroneous interpretations or incorrect applications of constitutional provisions, but only and exclusively claims intended to re-establish or protect fundamental rights where an actual and effective violation has been alleged. It cannot hold the Spanish authorities responsible for failure to comply with an alleged obligation to have a law passed decriminalising euthanasia. It notes, moreover, that Mr Sampedro ended his days when he wanted to and that the applicant cannot be substituted for Mr Sampedro in respect of his claims for recognition of his right to die in dignity, since such a right, supposing that it can be recognised in domestic law, is in any event of an eminently personal and non-transferable nature.

The Court concludes that the applicant cannot act on Mr Sampedro's behalf and claim to be a victim of Articles 2, 3, 5, 8, 9 and 14 of the Convention, as required by Article 34.

It follows that this part of the application is incompatible *ratione personae* with the provisions of the Convention for the purposes of Article 35 § 1 and must be rejected in accordance with Article 35 § 4.

b. With regard to the applicant's complaint about the length of the proceedings, and even supposing that the applicant can claim to be a victim, the Court considers that the period to be taken into consideration runs from 12 July 1995, the date on which Mr Sampedro lodged his application with the Court of First Instance of Noia for the prescription of medication necessary to prevent pain, distress and anxiety and which might, at the appropriate time, bring about his death. The Court considers, further, that the period in question extended to 11 November 1998, the date of the Constitutional Court's decision declaring

his amparo appeal inadmissible. The period to be taken into account by the Court is thus three years and four months.

According to the Court's case-law, the reasonableness of the length of proceedings is to be assessed on the basis of the circumstances of the case and having regard to the criteria laid down by the Court's case-law, in particular, the complexity of the case, the conduct of the applicant and the conduct of the relevant authorities.

The Court has not noted any periods of inactivity which were particularly attributable to the applicant. With regard to the State's conduct and, in particular, to that of the judicial authorities, the Court notes that, in the applicant's submission, Mr Sampedro's case was not heard within a reasonable time in the Constitutional Court because his amparo appeal was lodged on 16 December 1996 and was ready at the end of March 1997. Mr Sampedro died on 12 January 1998 and judgment was delivered on 11 November 1998, without any priority having been given to it.

The Court notes, however, that that lapse of time does not at first sight appear excessive, having regard to the circumstances and the novelty of the case, and having regard to the fact that the proceedings in question were for recognition of an alleged right to die in dignity, a right not recognised by domestic law. It considers that the length of the proceedings, when considered overall, appears acceptable, having regard to the fact that at the time of Mr Sampedro's voluntary death, a little less than thirteen months had elapsed since he had lodged his appeal, and that the Constitutional Court's decision following the applicant's request to continue the proceedings was delivered ten months later.

The Court considers that, in view of the circumstances of the case, the proceedings were not sufficiently long for it to be concluded that there has been an appearance of an infringement of Article 6 § 1 of the Convention. It follows that this part of the application is manifestly ill-founded and must be rejected in accordance with Article 35 § 4 of the Convention.

For these reasons, the Court unanimously
Declares the application inadmissible.

Vincent Berger Georg Röss
Registrar President