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Assisted Dying in Europe

A comparative law and governance analysis of four national and
 two supranational systems

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PART ONE

SETTING THE SCENE

1

INTRODUCTION

TERMINOLOGY¹

Throughout this work, voluntary active euthanasia (VAE) is understood as the termination of the life of another person at the latter's explicit request.² Assisted suicide (AS) refers to the voluntary termination of one's own life by self-administering drugs with the assistance of another person.³ Both of these definitions presuppose the existence of valid informed consent.⁴ The single term 'assisted dying' is used in this study to describe both VAE and AS.⁵

¹ For a discussion on 'definitional concerns' regarding end-of-life decisions, see S.W. Smith, *End-of-Life Decisions in Medical Care. Principles and Policies for Regulating the Dying Process* (Cambridge University Press, 2012) 11-13.

² This definition of VAE is: (a) the definition of *euthanasia* in the Dutch Penal Code (Article 293) and is considered, according to Griffiths, Adams and Weyers, as 'the standard in international literature.' See J. Griffiths, M. Adams, and H. Weyers, *Euthanasia and Law in Europe* (Hart, 2008) 76; (b) the 'commonly accepted' definition of *euthanasia* according to the French National Consultative Ethics Committee for Health and Life Sciences, see CCNE, *Opinion No. 121: The End of Life, Personal Autonomy, the Will to Die* (30 June 2013) 43; (c) is the recognised definition for *active euthanasia* according to the Swiss National Advisory Commission on Biomedical Ethics, see NEK-CNE, *Opinion No.9/2005 Assisted Suicide* (27 April 2005) 10; and (d) is the preferred definition for *voluntary euthanasia* according to a House of Lords Select Committee in the UK, see House of Lords, *Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill* [HL], vol. I, Report, HL Paper 86-I (London: The Stationery Office, 2005) 14. In light of this, the use of the adjectives 'voluntary active' before the word 'euthanasia' is still preferred here to emphasise the commonality between the prominent definitions of 'euthanasia' in the four nations, and to distinguish between certain definitions of 'euthanasia' that do not follow this international standard, see for example MP Battin, L. P. Francis and B. M. Landesman (eds), *Death, Dying and the Ending of Life* (Vol. II, Aldershot: Ashgate Publishing, 2007) 5-8.

³ Generally speaking, there is somewhat less confusion about the use of the term 'assisted suicide'. On this, see Smith, *ibid* 13.

⁴ According to a prominent and widely consulted medical textbook in the English language (*Goldman's Cecil Medicine*), there are four requirements for valid informed consent: (i) mental capacity, (ii) disclosure, (iii) understanding, and (iv) voluntariness. See E.J. Emanuel, 'Bioethics in the Practice of Medicine' in L. Goldman and A.I. Schafer (eds) *Goldman's Cecil Medicine* (24th edn, Elsevier-Saunders, 2012) 7.

⁵ This use of the single term 'assisted dying' to mean both VAE and AS, only, but not other types of end-of-life decisions is not universal. However, it is defined in this way: (i) in certain leading academic literature on the topic, see Smith (n 1) 13; P. Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007) 6; S.A. McClean, 'Assisted Dying: The View from the United Kingdom' in D. Birnbacher and E. Dahl (eds)

Both VAE and AS should be clearly distinguished from certain medical behaviour that potentially shortens life (MBPSL),⁶ which are often attributed to the word ‘euthanasia’: *passive* euthanasia (honouring a patient’s refusal of treatment, or withholding/withdrawing treatment due to ‘medical futility’)⁷ and *indirect* euthanasia (the provision of medical treatment to alleviate a patient’s pain, which has life shortening effects).⁸ These types of behaviours are largely considered in western liberal democracies, under certain circumstances, as permissible medical practice⁹ and are not covered by the term ‘assisted dying’ in this work. Note must also be made of the distinction made here between ‘assisted dying’ and another type of behaviour that terminates life: *non-voluntary* euthanasia¹⁰ – this is the termination of life without an explicit and voluntary request. This behaviour is generally treated as murder or manslaughter, possibly subject to some type of defence of justification. *Non-voluntary* euthanasia, just like *passive* and *indirect* euthanasia, is not a behaviour covered by the term ‘assisted dying’ in this study.

OUTLINE OF THIS STUDY

On 11 September 2015, two mobilized groups demonstrated outside the Palace of Westminster, London.¹¹ One group held placards that read: “*Ditch the Death Bill.*” The other group held placards that read: “*Give me choice over my death.*”¹² On 21 January 2015,

Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective (Springer, 2008) 113; (ii) in certain research groups on the topic, see The Commission on Assisted Dying, *The Current Legal Framework on Assisted Dying is inadequate and incoherent...* (Demos: London, 2011); and (iii) in certain legislative proposals on the topic, see Assisted Dying for the Terminally Ill Bill, House of Lords, HL Bill 36, 9 Nov. 2005.

⁶ This abbreviation ‘MBPSL’ is taken from Griffiths, Weyers and Adams (n 2) 1-2; and Lewis (n 5) 6.

⁷ See Smith (n 1) 12; Lewis (n 5) 5; M.F.A. Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press Oxford) 6.

⁸ See Griffiths, Weyers and Adams (n 2) 76; Otlowski, *ibid* 8.

⁹ ‘Permissible’ here does not necessarily mean such behaviour is subject to control or procedural regulation. Research on the law in various European nations, Australia, and the United States shows that ‘permissible’ may be understood to mean that a death resulting from one of these end-of-life decisions can be reported as a ‘natural’ one and the case is subject to no specific control through the criminal law. See Smith (n 1); D. Birnbacher and E. Dahl (eds), *Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective* (Springer, 2008); Griffiths, Weyers and Adams (n 2).

¹⁰ See Griffiths, Weyers and Adams (n 2) 76; Otlowski (n 7) 7.

¹¹ This is the meeting place for the two houses of Parliament of the United Kingdom.

¹² J. Bingham, ‘Right to die: MPs reject Assisted Dying Law’, *The Telegraph* (London, 11 Septmeber 2015). Available at <www.telegraph.co.uk/news/uknews/assisted-dying/11857940/Assisted-dying-vote-in-House-of-Commons.html> Last accessed 24.01.2016.

two similar groups demonstrated outside the Palais Bourbon, Paris.¹³ One held placards that read: “*soulager mais pas tuer.*” The other held placards that read: “*droit de mourir dans la dignité.*”¹⁴

These public demonstrations are not new or unique phenomena. But they do present tangible examples of what certain political scientists understand as *the* inherent feature of public policy on assisted dying:¹⁵ they present a basic conflict of first principle considerations. This is not to say that *a posteriori* reasoning is a non-existent or a less important feature of public policy on the matter. Practical considerations (such as the viability of procedural safeguards) or processes of instrumental rationality (such as empirical data on the frequencies and characteristics of similar end-of-life medical behaviour)¹⁶ may also play an important role. However, notwithstanding these more temperate features, public policy on assisted dying is inevitably shaped, to some degree, by strong first principle standpoints. This observation may seem banal to some, but it is submitted here as an important point of departure. Heichel, Knill and Schmitt show how the inherently principled nature of public policy on assisted dying leads to a number of peculiarities.¹⁷ It affects (i) *public policy output* on the matter - the direct result of the decision-making process - i.e. the content of particular legal rules, prosecution guidelines, judicial verdicts, etc.; (ii) *public policy effect* - the stages and consequences of policy

¹³ This is the meeting place for the lower house of Parliament in France.

¹⁴ See ‘Fin de vie: Valls appelle les parlementaires au “rassemblement”’, *Le Monde* (Paris, 21 January 2015). Available at: <www.lemonde.fr/sante/article/2015/01/21/fin-de-vie-valls-appelle-les-parlementaires-au-rassemblement_4560814_1651302.html> Last accessed 24.01.2016.

¹⁵ C. Mooney, ‘The Politics of Morality Policy: Symposium Editor’s Introduction’ (1999) 27(4) *Policy Studies Journal* 675-680; C. Knill, ‘The study of morality policy: analytical implications from a public policy perspective’ (2013) 20(3) *Journal of European Public Policy* 312; S. Heichel, C. Knill, and S. Schmitt, ‘Public policy meets morality: conceptual and theoretical challenges in the analysis of morality policy change’ (2013) 20(3) *Journal of European Public Policy* 319. Note that in these particular works, not only is a basic conflict of first principles identified as the inherent feature of public policy on VAE and AS, but also as the inherent feature of public policy on (i) certain controversial life and death issues, such as abortion, assisted reproduction, and embryo research; (ii) certain issues of sexual behaviour, such as same-sex marriage, prostitution and pornography; and (iii) particularly addictive behaviour or substance abuse, such as gambling and drug consumption.

¹⁶ For some examples of such data, see C. Seale, ‘Hastening death in end-of-life care: a survey of doctors’, (2009) 69(11) *Social Science and Medicine* 1659-1666; A. van der Heide and others, ‘*Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Second Evaluation: Termination of Life on Request and Assisted Suicide]’ (The Hague: ZonMw, December 2012) 42; EURELD, ‘Forgoing Treatment at the End-of-life in 6 European countries’ (2005) 165 *Archives of Internal Medicine* 401-407; E. Ferrand, ‘Requests for euthanasia and palliative care in France’, (2011) 377(9764) *The Lancet* 467-468; S. Fischer and others, ‘Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians’, (2009) 139(23-24) *Swiss Medical Weekly* 33-338.

¹⁷ See Heichel, Knill and Schmitt (n 15) 323-330.

implementation and evaluation - i.e. how the legal rules, prosecution guidelines, judicial verdicts, etc., actually tackle the real problem; and (iii) *public policy change* - the potential reform of public policy output - i.e. the flexibility to alter the content of particular legal rules, prosecution guidelines, judicial verdicts, etc., in light of their effects.

It is submitted here that two examples of these peculiarities appear to be acutely emerging and re-emerging across Western and Southern Europe over the last decade. And both relate to public policy change. These are: (i) that shocking individual cases are, almost singularly, putting the legality of assisted dying on the political agenda, and (ii) that popular public opinion on the matter has yet to impact public policy output.

Regarding the first peculiarity; the most likely trigger for policy change, if there is to be any change, is emotive high profile legal trials and media coverage of suffering individuals. This is evident from the reactions to the European Court of Human Rights (ECtHR) decision in *Pretty v the UK* (2002),¹⁸ in *Haas v Switzerland* (2009),¹⁹ in *Gross v Switzerland* (2013),²⁰ and to various national decisions, such as: the 2003 'Humbert case' in France,²¹ the 2006 'Welby case' in Italy;²² the 2007 'Echevarria case' in Spain;²³ the 2014 'Nicklinson case' in England,²⁴ and the 2014 'Fleming case' in Ireland.²⁵ One commonality between these decisions is that none of them formally directed the parliamentarians to change their respective legal rules on assisted dying. Another commonality is that notwithstanding such displays of judicial restraint, the media exposure of the cases alone had a substantial impact in mobilizing public support both for and against legal change. This is hardly surprising. The facts behind these individual cases centred on tragic instances of human suffering and were - indeed still are - highly

¹⁸ *Pretty v. the UK* (App. no. 2346/02) ECHR, 29 April 2002.

¹⁹ *Haas v Switzerland* (App. no. 31322/07) ECHR, 20 January 2011.

²⁰ *Gross v Switzerland* (App. no. 67810/10) ECHR 14 May 2013 (Second Section); *Gross v Switzerland* (App. no. 67810/10) ECHR 30 September 2014 (Grand Chamber).

²¹ *Humbert/Chaussoy*, Tribunal de Boulogne sur Mer, 27 February 2006, *Le Monde* (1 March 2006).

²² *Welby*, Tribunal of Rome, 16 December 2006, *Giurisprudenza di merito* 2007:996; Tribunal of Rome, 22 October 2007, *Bioteca* 2007(3):5.

²³ 'Inmaculada Echevarría, tetrapléjica: 'Lo único que pido es la eutanasia, no es justo vivir así'' *El Mundo* (19 October 2006); 'Una enferma de 51 años pide una inyección que le pare el corazón'. *El País* (18 October 2006).

²⁴ *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin); *Nicklinson and Lamb v Ministry of Justice* [2013] EWCA Civ 961; *R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent)*; *R (on the application of AM) (AP) (Respondent) v Director of Public Prosecutors (Appellant)*; *R (on the application of AM) (AP) (Appellant) v Director of Public Prosecutors (Respondent)* [2014] UKSC 38.

²⁵ *Fleming v Ireland & ors* [2013] IESC 19.

salient and technically straightforward to comprehend for most people in society. The public reaction to these cases may be understood as collective expressions of what Birkland calls ‘external shocks in the form of moral shocks.’²⁶ Such shocks should in turn, according to Birkland and Knill, provide a window of opportunity for policy change.²⁷

This last point relates to the second peculiarity mentioned above. Public reaction to individual cases has, so far, stopped short of turning the political appetite *to discuss* the public policy on assisted dying into a political hunger *to change* the public policy on assisted dying. Popular opinion that emanates from the tragic cases and the mainstream media discourse thereon, has not translated into a direct alteration in political-decision making. Even critics of legal change make no objection to the increasingly overwhelming public support evident in Western Europe, the US, and Canada towards legalising assisted dying. As one such critic puts it:

“Over the past four decades, public opinion polling in western liberal democratic nations has seen support for the legalization of euthanasia gradually increase from around 40 per cent of the population (e.g., 40–47 per cent from the 1940s to the 1960s) to a majority 70 per cent and above of the population (e.g., 75–80 per cent in the 1990s and beyond).”²⁸

Perhaps unsurprisingly, not all political actors and democratic institutions have remained formally unmoved. In Europe, parliamentarians have ratified a change in the legal policy on assisted dying in the Netherlands (in 2002), Belgium (in 2002) and Luxembourg (in 2008). In the United States, state legislatures have ratified a change in the legal policy on assisted suicide in Oregon (in 1997), Washington (in 2008), Vermont (2013) and California (effective mid-2016). However, despite the strong public support for change in western liberal democratic nations, the vast majority of central political actors and democratic institutions therein have remained formally unmoved.

In light of these peculiarities, one could argue that neither proponents nor opponents of policy change in such nations are satisfied. For the proponents, it seems to be a case of “so

²⁶ T.A. Birkland, *After Disaster: Agenda Setting, Public Policy, and Focusing Events* (Washington, DC: Georgetown University Press, 1997). Knill (n 15) 324.

²⁷ Ibid.

²⁸ M.J. Johnstone, *Alzheimer’s Disease, Media Representation and the Politics of Euthanasia* (Ashgate Farnham, 2013).

near, yet so far” – value orientations relevant to assisted dying are shifting in their favour²⁹ and there appears some room for judicial activism in defining the concrete substance of related individual rights-based claims, but still there is no concrete change in policy output. For the opponents of policy change meanwhile, it seems to be a case of withstanding the relentless legal (mostly individual rights-based) challenges, but for how much longer? On this particular point, note must be made of some recent developments. On 6 February 2015, the Canadian Supreme Court overturned a century old criminal ban on assisted suicide.³⁰ And on 4 May 2015, a High Court in Pretoria, South Africa granted judicial leave to a 65-year-old man with terminal prostate cancer to receive lawful physician assisted suicide.³¹ These are landmark decisions that, arguably, demand some formal reaction from the respective political institutions.³² Either way (should there be a formal political reaction or not), the consequences of these decisions will be carefully watched by proponents and opponents of policy change around the world.

Based on these preliminary observations – that individual cases of assisted dying are the key drivers of public and political debate on the issue, and that there appears an increasing amount of public but not political or judicial support for public policy change – this work submits that the controversies surrounding individual cases of assisted dying are unlikely to subside whilst the policy stalemate is likely to remain.³³ Moreover, it is

²⁹ See Griffiths, Weyers and Adams (n 2) 523-524, whereby a number of studies are presented to support this claim, such as: R. Inglehart, *Modernization and Postmodernization. Cultural, Economic and Political Changes in 43 Societies* (Princeton University Press, 1997) 139; R. Inglehart, M. Basañez and A. Moreno, *Human Values and Beliefs: A Cross-Cultural Sourcebook. Political, Religious, Sexual and Economic Norms in 43 Societies: Findings from 1990-1993 World Values Survey* (Ann Arbor, University of Michigan Press, 1998); L. Halman, R. Luijkz and M van Zundert, *Atlas of European Values* (Leiden, Brill, Tilburg University Press, 2005); H. Weyeres, ‘Legal Recognition of the Right to Die’ in: A. Garwood-Gowers, J. Tingle and K. Wheat (eds), *Contemporary Issues in Healthcare Law and Ethics* (Elsevier: Edinburgh, 2005) 253-267. See also C. Welzel, *Freedom Rising: Human Empowerment and the Quest for Emancipation* (Cambridge University Press, 2013).

³⁰ *Carter v. Canada* (Attorney General), 2015 SCC 5, [2015] 1 S.C.R. 331.

³¹ *Stransham-Ford v. Minister of Justice And Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230; 2015 (4) SA 50 (GP) (4 May 2015).

³² These decisions are likely to require (or at least, arguably ought to require) a formal reaction from the respective legislative bodies for two cumulative reasons: (i) they are judicial decisions that represent an acute departure from the established decisions of the respective legislatures on a particularly sensitive and controversial policy issue; and (ii) the substantive and procedural safeguards required to ensure the change in the law does not result in abuse (considering the potentially fatal consequences of abuse in permitting assisted suicide) requires careful, timely consideration and deliberative debate.

³³ In some nations this is acutely true in the short term. For example, the English Supreme Court (in July 2014) narrowly refused to declare the criminal ban on assisted suicide incompatible with human rights after a highly publicized and emotive individual claim. While, the lower house of the English Parliament (in September 2015) convincingly voted against a Private Members’ Bill allowing assisted suicide for terminally ill persons.

submitted here that in order to constructively inform the relentless legal policy debates on assisted dying,³⁴ some comparative *au courant* inter-disciplinary legal analysis is required. Those judges and parliamentarians who are faced with the issue, must be informed of:

- (i) different public policy outputs concerning assisted dying - i.e. the content of different legal rules, prosecution guidelines, judicial verdicts, etc. in other jurisdictions;
- (ii) the different public policy effects - i.e. how these different legal rules, prosecution guidelines, judicial verdicts, etc., succeed or fail to achieve their stated objectives; and
- (iii) different experiences surrounding public policy change – i.e. what has been done, if anything, to alter or reform these different legal rules, prosecution guidelines, judicial verdicts, etc., in light of their effects.

This work offers itself as a small but novel contribution towards such an endeavour. It does so by way of a comparative '*law and governance*' analysis. This methodological approach is explained at length in **Chapter Two**, see Section 2.3., below. In short, it is a (descriptive, critical and prescriptive) comparative analysis of the actors and institutional architecture in the creation, application and enforcement of formally binding rules on assisted dying in different jurisdictions. Moreover, it is a comparative analysis carried out in light of a particular theory of normative ethics. This theoretical aspect is also explored in detail in **Chapter Two**, see Section 2.2., below.

Each of the four nations selected for analysis – England, France, Switzerland and the Netherlands - provide a distinct public policy output approach to assisted dying. These approaches are examined in **Chapter Three**, but for now a quick overview of their divergences shall suffice to justify their *a priori* comparative value. England represents a jurisdiction in which voluntary active euthanasia (VAE) and assisted suicide (AS) are formally prohibited by the criminal law. France represents a jurisdiction in which VAE is formally prohibited by the criminal law, while AS is considered a crime only in certain circumstances under the general duty to rescue. Switzerland represents a jurisdiction in

³⁴ Be it debates in the parliamentary, courtroom or public forum setting.

which VAE is prohibited by the criminal law, but AS is conditionally decriminalised and performed, largely, by laypersons. Whilst the Netherlands represents a jurisdiction in which both VAE and AS have been legalised and decriminalised under certain conditions, and may only be performed by medical practitioners.³⁵ Moreover in all four nations, questions over public policy on assisted dying have been at the centre of very recent legal and political discourse. In England and France, this discourse is reflected in a number of high profile court cases and parliamentary proposals. In Switzerland, attention towards the number of non-Swiss residents travelling to Zurich to avail of assisted suicide has scarcely been out of the media in the past decade and has triggered a high number of political initiatives. While in the Netherlands, the increasing number of patients who suffer from psychiatric and mental disorders receiving VAE has attracted recent public attention, the question of extending VAE and AS to elderly persons ‘tired of life’ has received both public and political attention, and recently the question of whether lay persons can be legally excused for performing AS has been brought before the Dutch courts. Moreover, the Dutch policy approach, in general, is frequently cited by both sides of the debate and by mainstream media in other countries, and for this reason, it cannot be omitted from examination.³⁶

It may be said, of course, that a number of other jurisdictions also lend themselves to comparative analysis or have *a priori* comparative value when it comes the law on

³⁵ Some scholars are keen to clarify that VAE and AS are not ‘legalised’ in the Netherlands but are instead merely ‘decriminalised.’ This argument depends on how one defines the term ‘legalisation’ and ‘decriminalisation.’ Arguably, ‘legalisation’ determines the question of whether a certain behaviour is lawful or not, and leaves open the question of what rules thereby remain (i.e. a behaviour that under certain circumstances is lawful may well remain, as a rule, prohibited by criminal law); ‘decriminalisation’ determines the specific form of control to which a certain behaviour is subjected and leaves open the question of whether the behaviour is lawful or not (i.e. certain behaviour may not be deemed a criminal offence, but may still be prohibited by administrative law, private law, or professional standards). It may be said, in light of this, that in the Netherlands the ‘legalisation’ of VAE and AS was eventually followed (but not inevitably followed) by ‘decriminalisation’. Simply put, VAE and AS were effectively ‘legalised’ in 1984 (by the judicial recognition of the general defence of *force majeure* in the context of a doctor’s conflict of duties) and then ‘decriminalised’ in 2002 (by the Review Procedures for the Termination of Life on Request and Assisted Suicide Act along with an amendment of the Criminal Code). Therefore, agreement is not had with scholars who insist that VAE and AS in the Netherlands are not ‘legalised’ but only ‘decriminalised’ – they are understood here as both. See J. Griffiths, ‘Euthanasia and assisted suicide should, when properly performed by a doctor in an appropriate case, be decriminalised’, in A. Alghrani, R. Bennett and S. Ost (eds) *Bioethics, Medicine and the Criminal Law* (Cambridge University Press, 2012) 16-17.

³⁶ Due to the considerable process of legal change and the history of the discussion on assisted dying in the Netherlands, studying the Dutch approach provides ample material to draw from. For this reason the Netherlands was selected for analysis rather than Belgium and Luxembourg, as the representative nation that permits both VAE and AS.

assisted dying. This is indeed true, but it may equally be said that a comparativist must draw a line somewhere. In light of Kohn's typology of approaches to cross-national comparisons in sociological studies,³⁷ the line drawn in this study is justified by treating each selected country:

- (i) as an 'object of analysis' in an idiographic way. One aim here is to understand what is distinctive (or not) about how the law on assisted dying is created, subjected to reforms, applied and enforced in each country;
- (ii) as 'a context of study' for examining general hypotheses. One aim here is to understand if certain actors and institutional architectures have a positive or negative impact on the creation, reform, application and enforcement of the law on assisted dying, particularly in light of the law's objectives; and
- (iii) as 'a unit of analysis' to explain patterns of similarities and, particularly, differences between countries within a common framework. One aim here is to explain why certain western European liberal democratic nations³⁸ design, reform, apply, or enforce the law on assisted dying in a different or similar way.

In light of these aims, and the recent political and legal developments mentioned in each nation in the previous paragraph, it may be said that the selection of England, France, Switzerland and the Netherlands provides potentially suitable cross-national comparisons.

As for the structure of this work, **CHAPTER TWO**, as mentioned above, explains the chosen theoretical and methodological framework. It commences with a legal-philosophical perspective on the 'dual nature' of law in general and the 'dual nature' of the law on assisted dying in particular. It purports that two distinct, yet interdependent, stages of inquiry are needed when studying the law on assisted dying - firstly an adequate theory of normative ethics, and then secondly a comparative '*law and*' analysis. In response to the first need, von der Pfordten's theory of normative individualism is applied alongside a Rawlsian type of original position. In response to the second need, the characteristics of a 'comparative law and governance analysis' are set out. As briefly touched on in the

³⁷ M.L. Kohn, *Cross-national research in sociology* (Sage Publications, 1989).

³⁸ For a historical and contemporary discussion of common frameworks shared by Western European liberal democracies, from economic, social and cultural arrangements to political patterns see P. Hogwood and G.K. Roberts, 'European politics today - Second edition' (Manchester University Press, 2013) 1-38.

preceding paragraphs, this comparative form of analysis looks (descriptively, critically, and prescriptively) at the role of various actors and institutional structures in the creation, application and enforcement of the law on assisted dying.

The following four chapters (*Part II* of this study) make up what is termed: 'Law and governance on the national level'. **CHAPTER THREE** is entitled 'the law in the books.' It provides a descriptive explanation of the most relevant legal formants surrounding an act of assisted dying (namely criminal and disciplinary rules) in England, France, Switzerland, and the Netherlands. No normative position is taken at this point in the study. **CHAPTER FOUR** is entitled 'the law in action.' It presents (i) the limited empirical evidence on assisted dying in the aforementioned jurisdictions, and (ii) the application and enforcement of the law on assisted dying *vis à vis* judicial, prosecutorial and medical disciplinary decisions in the aforementioned jurisdictions. **CHAPTER FIVE** comparatively critiques discrepancies between the law in the books and the law in action. Here the analysis shifts from a descriptive one to a more critical analysis. **CHAPTER SIX** examines the political actors and institutional processes responsible for creating and reforming the law. Normative and prescriptive assertions are made here in light of the law and governance framework outlined in Chapter Two and the findings made in Chapter Five.

The final part of this work (*Part III*) is termed: 'Law and governance on the European level.' Here, as the title suggests, the focus of attention moves beyond state borders. It looks at what role actors and institutional structures at the European level - namely, those in the Council of Europe and the European Union - have, or may have, on national legal policies on assisted dying. **CHAPTER SEVEN** focuses on the Council of Europe (the CoE) and is broken into two sub-sections. The first sub-section provides a general overview of judicial governance *vis à vis* the ECtHR; a descriptive evaluation of the ECtHR's five high profile decisions on assisted dying; a critique of these decisions in light of the ECtHR's governance function, and some brief conclusions. The second sub-section provides a general overview of multi-level governance by the relevant institutional pillars of the CoE; a descriptive evaluation of non-binding policies (in the form of recommendations, reports, resolutions and opinions) on the legality of assisted dying made by the Parliamentary Assembly, the Committee of Ministers, the Steering Committee on Bioethics, the (former) Social, Health and Family Affairs Committee, the Committee on Legal Affairs and Human

Rights, and certain International Non-Government Organisations of the CoE; it then offers a critique of these policies in light of the CoE's more multi-level governance function; and some brief conclusions.

CHAPTER EIGHT focuses on the European Union (the EU). It first sets out a number of arguments as to why we should take EU governance and its potential effect on national assisted dying laws seriously. It then closely analyses two forms of EU governance – judicial governance *vis à vis* the Court of Justice of the European Union (the CJEU) and network governance *vis à vis* epistemic communities. The former analysis carefully fleshes out a hypothetical preliminary ruling whereby EU economic free movement rules are used to challenge a national blanket ban on assisted dying. Although this is a controversial claim (at first sight, it is simply the commercial commodification of death), it does, on closer examination, evidence the normative capacity of the EU to bring principles of procedural good governance to the fore in judicially reviewing national laws on assisted dying. The latter analysis looks at 'new governance' mechanisms that EU institutions and Member States have introduced in the domain of health-care, namely the Open Method of Co-ordination (the OMC) and joint action strategies.

Finally, the **CONCLUSIONS** of this work brings together the theoretical and comparative parts to make a number of recommendations on the relationship between law and governance on assisted dying. In short, it attests to the need for meaningful public-private actor involvement in the law, on both the national and trans-national level. The reliance on public actors alone - be it parliamentarians, public prosecutors or members of the judiciary - *to determine the content* of the legal policy on assisted dying and *to implement* the legal policy on assisted dying has resulted in a number of practical problems which cannot be excused, particularly (but not exclusively) in light of the normative ethical framework set out in **CHAPTER TWO**. On a more immediate pragmatic note, there is a need (i) for further European-wide empirical research on the frequencies of all types of end-of-life medical behaviour, (ii) for professional medical associations to take responsibility for acts of assisted dying, and (iii) for policy-makers, and indeed all of those involved in public discourse on the matter, to balance their attention between the ideological questions (such as whether assisted dying is right or wrong) and questions more concerned with

instrumental rationality (such as how the current legal policies actually succeed or fail to achieve their objectives).

2

THEORY AND METHODOLOGY

There is no one comparative law method.¹ It appears that the eager comparativist cannot escape some criticism, regardless of what method she or he uses.² On the one hand, attempts to compare are accused of being ‘abstract, worded in general terms and sometimes downright vague.’³ On the other hand, an overly sophisticated, detailed method risks deterring the reader.⁴ Adams and Bomhoff allude to this and identify a type of ‘missing middle’ between two methodological extremes.⁵ Considering this, early stage legal researchers may be somewhat excused for not knowing where to start in their comparative endeavour. With an abundance of options, comes an abundance of pitfalls. At the same time however, positive opportunities may arise out of methodological

¹ There are various methods of comparative law. See, amongst others: M. Siems, *Comparative Law* (Cambridge University Press, 2014); M. Adams and D. Heirbaut (eds), *The Method and Culture of Comparative Law – Essays in Honour of Mark van Hoecke* (Hart, 2014); M. van Hoecke, ‘Preface’ in M. Van Hoecke (ed), *Methodologies of Legal Research. Which Kind of Method for Which Kind of Discipline?* (Hart, 2011) v-vi; P. Feyerabed, *Against Method* (London and New York: Humanities Press, 1975) 46; G. Frankenberg, ‘Critical comparisons: Re-thinking Comparative Law’ (1985) 26 *Harvard International Law Journal* 411; F. Stone, ‘The End to Be Served by Comparative Law in the United States’ (1999) 4 *Revue Internationale de droit Compare* 1041, 1042ff; M. Adams and J. Griffiths, ‘Against “comparative method”: explaining similarities and differences’ in M. Adams and J. Bomhoff (eds) *Practice and Theory in Comparative Law* (Cambridge University Press, 2012) 279.

² This is, of course, not just true of comparative legal scholarship. For a good example in the domain of comparative political science and the omnipresent problems of endogeneity: See A. Prezworski, ‘Is the science of comparative politics necessary?’ in C. Boix and S. Stokes (eds), *The Oxford Handbook of Comparative Politics* (Oxford University Press, 2007).

³ See K. Lemmens, ‘Comparative law as an act of modesty: a pragmatic and realistic approach to comparative legal scholarship’ in M. Adams and J. Bomhoff (eds) *Practice and Theory in Comparative Law* (Cambridge University Press, 2012) 304; See also J. Bell, ‘Legal Research and the Distinctiveness of Comparative Law’ in M van Hoecke (ed) *Methodologies of Legal Research. Which Kind of Method for what kind of discipline?* (Oxford: Hart Publishing, 2011) 175; R. Cotterrell, ‘Comparative Law and Legal Culture’ in M. Reimann and R. Zimmerman (eds) *The Oxford Handbook of Comparative Law* (Oxford University Press, 2006).

⁴ See V. V. Palmer, ‘From Lerotholi to Lando: Some Examples of Comparative Law Methodology’ (2005) 53 *American Journal of Comparative Law* 261, 285. See also B. Fauvarque-Cosson, ‘Development of Comparative Law in France’ in M. Reimann and R. Zimmerman (eds), *The Oxford Handbook of Comparative Law* (Oxford University Press, 2006).

⁵ M. Adams and J. Bomhoff, ‘Comparing Law: Practice and Theory’, in M. Adams and J. Bomhoff (eds) *Practice and Theory in Comparative Law* (Cambridge University Press, 2012).

ambiguity. A legal comparativist aware of the practical need to look beyond the laws in the books and the law altogether,⁶ and also aware of the limitations on disciplinary consensus, has arguably less reason to be apologetic for methodological innovation. In the pursuit of mutual learning and best practices, alternative ideas to compare and differentiate concrete phenomena should not be deterred. However true or uncontroversial this may be, the very different question of *how* one can be innovative and credible when comparing remains to be answered.

This study by no means claims to hold the key for discovering an entirely innovative comparative legal method, or more specifically an entirely innovative comparative “*law and*” approach, but it equally does not shy away from the challenge of setting out an alternative means to compare and differentiate the law on assisted dying. It commences with an assumption followed by Smits,⁷ Valcke,⁸ and Adams and Griffiths⁹ concerning the nature of comparative enquiry: if one begins with a question supported by a certain body of theory, then the methodology will follow suit. **CHAPTER ONE** above set out a number of reasons why policy output, policy effect and policy change on assisted dying deserve renewed and refocused comparative attention. This Chapter presents a body of theory, the questions that subsequently arise (or at least the questions that become more explicit), and then a methodology that may help to answer these questions.

⁶ '[C]omparative law is an *école de vérité* which extends and enriches [sic] the “supply of solutions” and offers the scholar of critical capacity the opportunity of finding the “better solution” for his time and place.’ K Zweigert and H Kötz, *An Introduction to Comparative Law* Vol I (T Weir tr, 2nd edn, Oxford University Press, 1987) 15. See also: A. Colombi Ciacchi, ‘Comparative Law and Governance: Towards a New Research Method’ in A. Colombi Ciacchi and others (eds) *Law and Governance – Beyond the Public-Private Law Divide* (Eleven International, 2013) 223. See also V.V. Palmer (n 4); P. Zumbansen, ‘Transnational comparisons: theory and practice of comparative law as a critique of global governance’ in M. Adams and J. Bomhoff (eds) *Practice and Theory in Comparative Law* (Cambridge University Press, 2012) 186, 211; G Frankenberg, ‘Critical Comparisons: Re-thinking Comparative Law’ (1985) 26 *Harvard International Law Journal* 413.

⁷ J.M. Smits, ‘Rethinking Methods in European Private Law’ in M. Adams and J. Bomhoff (eds) *Practice and Theory in Comparative Law* (Cambridge University Press, 2012).

⁸ C. Valcke, ‘Reflections on Comparative Law Methodology – getting inside contract law’ in M. Adams and J. Bomhoff (eds) *Practice and Theory in Comparative Law* (Cambridge University Press, 2012).

⁹ See Adams and Griffiths (n 1) 280.

2.1 ETHICS FIRST, THEN GRUB¹⁰

This study is based on the assumption that the question facing policymakers¹¹ as to whether assisted dying should be legal or illegal,¹² hinges on two types of incremental arguments: first principle-based arguments, and then control-based arguments. This is an assumption influenced by Alexy's theory on the dual dimension of law itself.¹³ This theory claims that, on the one hand, there is an *ideal* (moral) *dimension* of law defined by substantive principles. On the other hand, there is a *real* (positive/social fact) *dimension* of law – i.e. regulated procedures to guarantee the achievement and enforcement of the ideal dimension. This latter dimension is defined by balancing substantive principles of justice with formal concerns of authoritative issuance and social efficacy.

The constitutional adjudication of a criminal ban on assisted dying provides a straightforward example of how Alexy's theory applies in practice. One judge may interpret abstract values and principles laid down in a constitution or a human rights

¹⁰ This is a twist on German playwright Bertolt Brecht's metaphorical reply to the order of survival and morality: 'Grub first, then ethics'.

¹¹ This may also be read more expansively, as: 'the question facing *participants* in the legal system': i.e. judges, parliamentarians, legal counsel, legal scholars, etc. The 'participant's perspective' of the law is distinct from the 'observer's perspective'. The former perspective is not just interested in a description of the law (like the latter perspective is) but it is also *necessarily* interested in the legal solution to a societal problem. See R. Alexy, 'Between Positivism and Non-Positivism? A Third Reply to Eugino Bulygin' in J.F. Beltán, J.J. Moreso and D.M. Papayannis (eds) *Neutrality and Theory of Law* (Springer, 2013) 228-230.

¹² This is a question either directly or indirectly examined in the majority of literature (legal, medical, and philosophical) on assisted dying. This literature is too enormous to be listed here, but some of the recent major works include: S. Halliday, 'Comparative reflections upon the Assisted Dying Bill 2013: a plea for a more European approach' (2013) *Medical Law International* 135-167; T.E. Quill and F.G. Miller (eds) *Palliative Care and Ethics* (Oxford University Press, 2014); E. Jackson and J. Keown, *Debating Euthanasia* (Hart Publishing, 2012); S.W. Smith, *End-of-Life Decisions in Medical Care. Principles and Policies for Regulating the Dying Process* (Cambridge University Press, 2012); S.J. Youger and G.K. Kilmsma (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012); R. Tallis, 'Should the Law on Assisted Dying be Changed? Yes', (2011) 342 *British Medical Journal* d2355; N.M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton University Press, 2009); J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008); P. Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007); R. Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge-Cavendish, 2007); R. Young, *Medically Assisted Death* (Cambridge University Press, 2007); S. McClean, *Assisted Dying Reflections on the Need for Law Reform* (Abingdon: Routledge-Cavendish, 2007); M.P. Battin, *Ending Life: Ethics and the Way We Die* (Oxford University Press, 2005); R. Cohen-Almagor, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing* (Kluwer-Springer, 2004); K.M. Foley and H. Hendin (eds) *The Case against Assisted Suicide: For the Right to End-of-Life Care* (Baltimore MD, John Hopkins University Press, 2004); R. Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (Yale University Press, 2002); J. McMahan *The Ethics of Killing: Problems at the Margins of Life* (Oxford University Press, 2002); H. Watt, *Life and Death in Healthcare Ethics: A Short Introduction* (Routledge, 2000).

¹³ R. Alexy, 'The Dual Nature of Law' (2010) 23(2) *Ratio Juris* 167-182.

treaty so as to preclude a *prima facie* legal right to assisted dying.¹⁴ In such a case, the question of what balance is required in the real dimension of the law is largely answered by the conclusion already reached on the ideal dimension. In other words, once assisted dying is interpreted as contrary to fundamental substantive values and principles in the legal system, then authoritative issuance and social efficacy demand positive rules prohibiting the behaviour.

On the contrary, another judge may interpretatively assume a different ideal dimension of the law on assisted dying. She may interpret the same fundamental substantive values and principles in the legal system so as to enshrine a *prima facie* legal right to assisted dying. Having done so, the question of the real dimension of the law remains to be answered. Here the judge may decide that the provision of assisted dying is impossible to adequately and safely regulate.¹⁵ In this case, the *prima facie* right to assisted dying is understood as justifiably restricted for reasons of authoritative issuance and social efficacy. Alternatively, the judge may decide that it *is* possible to provide for assisted dying while implementing an effective¹⁶ control system protecting vulnerable people. In this case, the substantive and procedural content of the real dimension of the law – i.e. the positive rules allowing for assisted dying - must then be somehow fleshed out.

In response to these two dimensions of the law, this study is divided into two distinct stages of inquiry. First it addresses the general principled based arguments - the ideal dimension of the law - on assisted dying, whereby a *normative ethical framework* is set out. Then it addresses the control based arguments - the real dimension of the law - on

¹⁴ For some real examples of this, see: (i) the relatively recent landmark Irish Supreme Court decision on the constitutionality of the state ban on assisted suicide. The Irish Court concluded that ‘insofar as the Constitution, in the rights it guarantees, embodies the values of autonomy and dignity and more importantly the rights in which they find expression, do not extend to a right of assisted suicide’. *Fleming v. Ireland & Ors* [2013] IESC 19, para 114; and (ii) the House of Lords decision in the well known *Pretty* decision, where all the Law Lords (with the exception of Lord Bingham) concluded that there is no right to assisted suicide engaged by Article 8 of the European Convention of Human Rights. *Pretty v. DPP* [2001] UKHL 61, para 26. This was, as is well known amongst human rights lawyers, a particular aspect of the decision that was overturned by the European Court of Human Rights.

¹⁵ This was the case in the Irish High Court decision prior to (and indeed contrary to) the Supreme Court decision mentioned above (ibid). The High Court decided that it was possible to discern a right to assisted suicide from the ‘moral framework’ envisaged in the Irish Constitution, and was then left with the question of legal control in light of the societal risks associated with that right. It held the risks were too high and could not be adequately mitigated by the law. The criminal ban was essentially deemed proportionate once concerns of authoritative issuance and social efficacy were weighed up against the ‘moral framework’ of the Irish constitution. *Fleming v. Ireland & Ors* [2013] IEHC 2, paras 48-77.

¹⁶ Spaak points out (referring to the work of Hart, Raz, Kelsen and Alexy) that the thesis of social efficacy ‘has it that the existence of law presupposes that it is *effective*.’ See T. Spaak, *A Critical Appraisal of Karl Olivecrona's Legal Philosophy* (Springer, 2014) 250.

assisted dying, whereby critical attention is paid to different positive legal rules in England, France, Switzerland and the Netherlands, the implementation and evaluation of these rules, and the reform/attempted reform of these rules (on the national and European level). For this a “*comparative law and*” framework is set out.

However before addressing these frameworks in detail, some conceptual and analytical clarification is needed. The above paragraph makes a claim about the relation between morality and the content of positive legal rules. Moreover, it is a conceptual claim that essentially shapes the analytical structure of this research:¹⁷ it requires that *first* a normative ethical analysis is carried out to justify or criticize the ideal (moral) dimension of the law on assisted dying, *and then* a comparative inter-disciplinary legal analysis is needed to justify or criticize the real (positive) dimension of the law on assisted dying. The first element of this claim – that the law on assisted dying has a moral dimension that can only be judged by some theory of normative ethics – is in need of immediate justification.¹⁸ The relation between law and morality as understood here, and as already mentioned above, is inspired by certain (but not all) aspects of Alexy’s non-positivist theory on the ‘dual nature’ of law. Moreover it is not, as argued below, a conceptual understanding that necessarily contradicts certain legal positivists theories, at least as far as the law on assisted dying is concerned.¹⁹

¹⁷ The value of conceptual clarification in legal research should not be undermined, on this see D. Von der Pfordten, ‘About Concepts in Law’ in J. Hage and D. von der Pfordten (eds) *Concepts in Law* (Springer, 2009) 17-33.

¹⁸ The second element of this claim – that the law on assisted dying has a real (positive) dimension that can only be judged by some type of comparative inter-disciplinary legal analysis - is discussed in detail at a later point (see heading 2.3. in this Chapter).

¹⁹ To some readers this may appear paradoxical but there are, of course, many positions on the relation between law and morality in between these two (positivist and non-positivist) ends of the spectrum. Both of these theories have many variants, contemporary and classic. As a result, it is arguably a futile task to select one version as emblematic or as entirely distinct from the other. For an example of the argument that there is ‘no simple grand divide’ between legal positivism and natural law, see: N. McCormack, *H.L.A. Hart* (Stanford University Press, 1981) 162.

(i) Moral judgements must play some role in determining certain constitutional conflicts

Legal positivists assert that the existence and content of law depends on social facts and not on its moral merits²⁰ (what is known as the *separability thesis*).²¹ This does not mean positivists discard the existence or importance of certain merits in the law.²² There are a number of contingent connections between law and morality from a legal positivist stance. Connections such as: moral principles may be a part of law,²³ laws often make moral claims of its subjects²⁴ and that law is justice-apt.²⁵

As for questions about moral constraints on legal validity, mention must be made of the distinction between ‘inclusive positivists’ (associated with Hart, Coleman, and Waluchow) and ‘exclusive positivists’ (associated with Raz and Shapiro). The former, in some sense, subscribe to a type of *incorporation thesis*.²⁶ This means that morality may not just have a merely contingent relationship with law in all instances, but there may be a tempered case for a relationship of dependency. The indeterminate or conflicting nature of certain legal rules is understood to require judges to be granted some (value based) ‘discretion’.²⁷ Coleman succinctly sums up Hart and other inclusive positivists on this point: ‘[m]orality can be a condition of

²⁰ For a snippet of some of the seminal works on legal positivism, from classic to contemporary, see: J. Bentham, *A Fragment on Government* (Burns and Hart (eds), 1977); J. Austin, *The Province of Jurisprudence Determined* (J. Murray, 1832); H.L.A. Hart, *The Concept of Law* (2nd edn, Clarendon Press) 185-186; H. Kelsen, *Pure Theory of Law* (The Law Book Exchange Ltd., 1967); J. Raz, *The Authority of Law* (Clarendon Press, 1979).

²¹ See H.L.A. Hart, ‘Positivism and the Separation of Law and Morals’ in *Essays In Jurisprudence and Philosophy* (Clarendon Press, 1983), first published (1957) 593(71) *Harvard Law Review*; J. Gardner, ‘Legal Positivism: 5 ½ Myths’ (2001) 46 *American Journal of Jurisprudence* 199; J. Coleman, ‘Negative and Positive Positivism’, (1982) 11 *Journal of Legal Studies* 139; M. van Hees, *Legal Reductionism and Freedom* (Springer, 2000) 27-43.

²² See heading 4.2. entitled: ‘The Separability Thesis’ in L. Green, ‘Legal Positivism’, *The Stanford Encyclopedia of Philosophy* (Fall 2009 Edition). Available at (fixed URL): <<http://plato.stanford.edu/archives/fall2009/entries/legal-positivism/>>. Last accessed 29.01.2016.

²³ H. Kelsen, *Essays in Legal and Moral Philosophy* [edited by O. Weinberger, translated by P. Heath] (Reidel, Dordrecht, 1973) 34; Hart (n 20) 193-200.

²⁴ M. Kramer, *In Defense of Legal Positivism: Law Without Trimmings* (Oxford: Clarendon Press, 1999) 83-89.

²⁵ Green (n 22).

²⁶ See R.B. Kar, ‘Hart’s Response to Exclusive Legal Positivism’, (2007) 95 *Georgetown Law Journal* 399; J. Coleman, ‘Incorporationism, Conventionality and the Practical Difference Thesis’ in J. Coleman (ed) *Hart’s Postscript: Essays on the Postscript to “The Concept of Law”* (Oxford University Press, 2001) 99-149.

²⁷ For example, Hart states ‘[i]n some legal systems, as in the United States, the ultimate criteria of legal validity explicitly incorporate principles of justice or substantive moral values’. See Hart (n 20) 204.

legality: [...] the legality of norms can sometimes depend on their substantive (moral) merit, not just their pedigree or social source.’²⁸

The term ‘discretion’ as used above, of course, does not mean arbitrary discretion. For Hart, and indeed Coleman, the interpretation of constitutional values such as ‘due process’ and ‘freedom of speech’ may not be fully determined by law but may be guided by law.²⁹ In other words, morality becomes a part of law because the positive sources/rule of recognition in that legal system make it so (explicitly or implicitly).³⁰ Raz, in rejecting this *incorporation thesis* and thus, ultimately, rejecting inclusive legal positivism,³¹ argues that courts may indeed have a moral duty to amend or even abandon part of existing law (in cases where the legal rule would lead to injustice). Moreover for Raz, such amendment or abandonment is done by applying moral principles that are simply not part (explicitly or implicitly) of positive sourced based rules.³² From Raz’s and Shapiro’s perspective: morality does not become part of law, instead ‘there is a gap in the law, and the law directs the adjudicator to some non-legal standards upon which decisions should be made.’³³

Whether a legal positivist subscribes to the inclusive or exclusive type is not overly important here. The fundamental point is that the leading literature on positivism (inclusive and exclusive) may be read to claim that the correct answer to what the law is, in certain cases, requires a reliance on moral standards (be it standards that are explicit/implicit in the rule of recognition or that are extra-legal altogether). This is particularly so when abstract constitutional principles and rights are at play. From this perspective, there is only a short step from positivism to certain

²⁸ See Coleman (n 26) 99-100.

²⁹ See L. Green, ‘The Concept of Law Revisited [Book Review of *The Concept of Law*, Second Edition, by H. L. A. Hart]’ (1996) 95(6) *Michigan Law Review* 1706.

³⁰ See J. Coleman, *The Practice of Principle: In Defence of a Pragmatist Approach to Legal Theory* (Oxford University Press, 2003).

³¹ On this, and also Shapiro’s criticisms of Hart’s inclusive legal positivism, see Kar (n 26) 401; See also J. Raz, *Ethics in the Public Domain: Essays in the Morality of Law and Politics* (Oxford University Press, 1995) 220-231.

³² Raz, *ibid*, 238-253. See also J. Raz, *The Concept of a Legal System: An Introduction to the Theory of a Legal System* (Clarendon Press, 1980) 215: ‘[...] sometimes the courts are instructed by law to recognize the validity of a certain reason only if it is not unjust or morally undesirable to do so. On occasion such instructions result in a situation whereby a contract, for example, is legally valid only if it is morally unobjectionable. In such a case the validity of individual contracts is not based on ‘social facts’ only. To ascertain the validity of a particular contract one has to engage in moral argument.’

³³ D. Priel, ‘Farewell to the Inclusive-Exclusive Debate’ (2005) 25 (4) *Oxford Journal of Legal Studies* 676.

theories of non-positivism. On this latter school of thought, which is preferred here, only two theories will be briefly mentioned – natural law and legal interpretivism.

On the one hand, natural law theories³⁴ seek to give an account of the facticity of law. On the other hand, they seek to answer questions that remain central to understanding law.³⁵ The classic doctrine of natural law has three general characteristics, it speaks of a law of ‘nature’ that is:³⁶ (i) discoverable by reason; (ii) universal and immutable; and (iii) a ‘higher law’ that has a relationship of superiority over laws promulgated by political authorities. For natural lawyers, in contrast to legal positivists, there is a necessary dependency between morality and positive source-based law (the *necessity thesis*).³⁷

As mentioned above, Alexy argues that law must be seen as having a dual nature: an ‘ideal’ (moral) dimension and a ‘real’ (positive/social fact) dimension.³⁸ The ideal dimension of law is supported by the ‘correctness argument.’ This goes as follows: all individual legal norms, legal decisions as well as legal systems as a whole, necessarily raise some *claim to correctness*,³⁹ which is a claim in itself to *moral correctness*. Once a decision is made on this correctness, *vis à vis* moral arguments of justice, then that decision, as Alexy’s argument goes, must become more ‘positivist in nature’.⁴⁰ This latter step brings about the real dimension of law. In determining this real dimension of the law, a balance is needed – and thus a more comprehensive claim to correctness is also needed. A balance between, on the one hand, the substantive (moral) arguments of justice that informed the ideal

³⁴ Some of the seminal works on this theory, from classic to contemporary, include: T. Aquinas, *Selected Political Writings* (D’Entreves (ed), Dawson trans, 1959) 103-180; J. Locke, *Second Treaties of Government* (Gough (ed), 1976, Chpt 2, 7-9, 19; L. Fuller, *The Morality of Law* (revised ed., New Haven and London, Yale University Press, 1969); J. Finnis, *Natural Law Theories and Natural Rights* (1st edn, Oxford: Clarendon Press, 1980).

³⁵ J. Finnis, "Natural Law Theories", *The Stanford Encyclopedia of Philosophy* (Fall 2014 Edition). Available at (fixed URL) <<http://plato.stanford.edu/archives/fall2014/entries/natural-law-theories/>> Last accessed 29.01.2016..

³⁶ J.W. Harris, *Legal Philosophies* (2nd edn, Oxford University Press, 2004) 7.

³⁷ J. Finnis, *Collected Essays: Volume IV, Philosophy of Law* (Oxford University Press, 2011) 7.

³⁸ Alexy, (n 13). See also R. Alexy, ‘Some Reflections on the Ideal Dimension of Law and on the Legal Philosophy of John Finnis’ (2013) 58(2) *The American Journal of Jurisprudence* 97–110.

³⁹ When Alexy speaks of ‘law making claims’, this, of course, is not meant in the literal sense. He argues that claims are made on behalf of the law, by it’s ‘representatives’ so to speak - such as, but not exclusively, by legal officials.

⁴⁰ Alexy (n 13) 173.

dimension, and on the other hand, arguments based on the formal principle of legal certainty (*Rechtssicherheit*).⁴¹

Readers familiar with the work of Dworkin and Hegel will see obvious commonalities between natural law theory and legal interpretivism – namely they both reject the *separability thesis* set forth by legal positivists.⁴² As Dworkin put it: ‘jurisprudential issues are, at their core, issues of moral principle.’⁴³ For advocates of legal interpretivism, identifying the content of a particular legal norm depends on constructing a story⁴⁴ – it is an interpretative endeavour. This endeavour can be relatively predictable or entirely complex. On the one hand, the story must fit within existing positive rules, as enacted by legal institutions. On the other hand, if two or more competing stories equally fit within the existing source-based rules, then some principle-based judgment is required to make one story ‘fit best’ within the context of the legal system.⁴⁵ In Dworkinian language, this is ‘law as integrity’ i.e. interpretation via principled consistency.

In light of this summary reading of positivist and non-positivist theories, the first conceptual standpoint taken here should not be seen as overly controversial. In short, judges, lawyers and legal researchers cannot be restricted to ask analytical questions (what are the current practices of the law) and normative questions about the internal coherence of the law, they must also ask normative questions about how law serves the broader pursuit of justice. Positivists and non-positivists diverge on the necessary significance and nature of the last type of normative questions. It is, however, argued here that this divergence is minimal (if not irrelevant) when certain constitutional conflicts arise. In other words, it cannot be denied that source-based rules at the highest constitutional level allow for more

⁴¹ Determining the real dimension of the law according to Alexy, and as mentioned above, must take into account ‘authoritative issuance and social efficacy’, which presupposes institutionalization or social facts of some sort. *Ibid.*

⁴² Equally of course, readers familiar with both theories can point to differences – for example, Dworkin and Hegel’s theory of law do not claim, as certain natural law theorists do, that there is a fixed, immutable standard of justice. On this and other distinctions and similarities, see: T. Brooks, ‘Between Natural Law and Legal Positivism: Dworkin and Hegel on Legal Theory’, (2007) 23(3) *Georgia State University Law Review* 7.

⁴³ R Dworkin, *Taking Rights Seriously* (Harvard University Press, 1987) 7.

⁴⁴ R. Dworkin, *Law’s Empire* (London, Fontana, 1986) 228–38. For an excellent analysis of Dworkin’s theory of interpretation, see: A Marmor, *Interpretation and Legal Theory* (2nd edn, Hart, 2005) 27-44.

⁴⁵ As Dworkin put it in his final monograph: ‘The law includes not just enacted rules, or rules with pedigree, but justifying principles as well.’ See R. Dworkin, *Justice for Hedgehogs* (Harvard University Press, 2011) 402.

than one answer to determine (or reform) the law on certain issues, such as abortion, embryo research, same-sex marriage, or assisted dying. The legal standpoint on these issues must depend on some moral reasoning and notions of justice, however consistent or inconsistent such reasoning or notions may turn out to be.

(ii) What is morally correct does not determine what is legally valid, and vice versa

The standpoint made directly above does not claim that the morality of a particular conduct is absolutely determinative of how that conduct is treated *vis à vis* the law. Nor does it, of course, claim that all conduct considered lawful is therefore morally correct. The current state of the law (in its ideal or real dimension) may, 'for historical or practical reasons, be less than perfect.'⁴⁶ The law should be fair, but sometimes it is not. The law should protect the most vulnerable, but sometimes it does not. This is the *moral fallibility thesis*.⁴⁷ For Lyons, this thesis is a 'regulating principle' that places the justificatory burden of proof on those that deny it.⁴⁸

(iii) There may be more than one 'correct' answer to the ideal dimension of the law

By no means does this study claim that a *consensus* is likely on whether certain behaviour (especially regarding life-or-death issues, such as embryo research, abortion and assisted dying) is ever morally 'correct'. It is claimed here, however, that the 'correct' ideal dimension of a particular legal policy may be difficult to identify but nonetheless possible to identify.⁴⁹ Furthermore, this 'correctness' is

⁴⁶ J. Bell, 'Legal Research and the Distinctiveness of Comparative Law' in M. Van Hoecke (ed) *Methodologies of Legal Research. Which Kind of Method for What Kind of Discipline?* (Hart, 2011) 157.

⁴⁷ L. Green, 'Positivism and the Inseparability of Law and Morals' (2008) 83 *New York University Law Review* 1035.

⁴⁸ D. Lyons, *Ethics and the Rule of Law* (Cambridge University Press, 1984) 63.

⁴⁹ As Dworkin states: 'The live question is not whether moral or ethical judgments can be true, but which are true.' Dworkin (n 45) 25.

not dependent on consensus.⁵⁰ Agreement is had with Alexy's *discourse theory*.⁵¹ This holds that a normative proposition can only be correct if it can be the result of a procedural theory of practical rationality. In short, it requires a line of discourse that comprises of 'rules that demand non-contradiction, clarity of language, reliability of empirical premises, and sincerity, as well as rules and forms that speak to the consequences, and to balancing, universalizability, and the genesis of normative convictions.'⁵²

One of the problems with such discourse, aside from its attainability, is that it may produce more than one 'correct' answer. However this is not a problem unique to Alexy's thesis. It is what Rawls terms as 'reasonable disagreement.' Not all moral questions can be definitively resolved by moral arguments. However, if we accept the conceptual dual nature of law (as is done here), then a statement of law is never an absolute moral claim. Concerns over authoritative issuance and social efficacy must also be considered, and may indeed help in striking a balance between different yet valid, normative propositions. On this point, there may be more than one 'correct' answer to the real dimension of the law also.

(iv) The ideal dimension of law requires an adequate theory of normative ethics

To help identify what is or is not morally correct in general, one may turn to normative ethics. This in turn allows us to justify or criticize the ideal dimension of law. A multitude of theories are available to choose from. Four usual suspects stand out: ⁵³ deontology, ⁵⁴ contractualism, ⁵⁵ utilitarianism (or

⁵⁰ Ibid, 23-39.

⁵¹ Alexy's discourse theory was greatly inspired by the work of Habermas, see: R Alexy, 'A Discourse-Theoretical Conception of Practical Reason' (1992) 5 *Ratio Juris* 1; R Alexy, 'Justification and Application of Norms' (1993) 6 *Ratio Juris* 157. See also (in German) P. Gril, *Die Möglichkeit praktischer Erkenntnis aus Sicht der Diskurstheorie. Eine Untersuchung zu Jürgen Habermas und Robert Alexy* (Berlin, 1998).

⁵² Alexy (n 13) 172.

⁵³ These usual suspects are laid out by von der Pfordten, see: D. von der Pfordten, 'Five Elements of Normative Ethics – A General Theory of Normative Individualism' (2012) 15 *Ethical Theory and Moral Practice* 449-471.

⁵⁴ See a number of works by Kant such as *Critique of Pure Reason* (1781); *Metaphysics of Morals*' (1797).

⁵⁵ For the seminal works on this theory, see *inter alia*: T. Hobbes, *Leviathan* (MacPherson (ed) 1968); J. Locke, *Second Treaties of Government* (Gough (ed) 1976); J.J. Rousseau, *On the Social Contract* (Dover Thrift Editions, Courier Corporation, 2012); and J. Rawls, *A Theory of Justice* (Revised Edition, Harvard University Press, 2009). Arguably, Rawls's 'contract' is more Kantian, as he (i) seeks principles everyone would agree

consequentialism),⁵⁶ and virtue ethics.⁵⁷ This chapter does not set out to attack these traditional theories, nor is it monistic,⁵⁸ relativist,⁵⁹ pluralist⁶⁰ or sceptical⁶¹ in its choice.⁶² Instead, it presents the value of supplementing von der Pfordten's 'general theory of normative individualism'⁶³ with a Rawlsian-type thought experiment to help fix the moral content of the legal policy on assisted dying. It is not claimed here that this is *the only* appropriate ethical framework, or that the legal policy question on assisted dying may be resolved *entirely* by such a framework.

It provides – if successful – one set of rational, coherent statements regarding the 'ideal dimension' of the law on assisted dying. It reaches a position that may be re-evaluated, justified, and criticized, and moreover that may be (indeed, must be, as far as legal-policy makers are concerned) balanced against the 'real dimension' of the law. In other words, distinct pragmatic concerns about *how* to go about enforcing the 'ideal dimension' of the law on assisted dying very much remain to be considered. However, as these dual dimensions of the law are considered here as conceptually distinct, they will be treated as analytically distinct and addressed in turn (see **Section 2.4**, entitled: 'The Practical Control of Assisted Dying').

to, rather than principles no-one could reasonably reject, and (ii) sets the general social framework for a liberal society, rather than determining moral principles.

⁵⁶ For the seminal works on this theory, see *inter alia*: J. Bentham, *A Fragment on Government* (Burns and Hart (eds) 1977); J. Bentham, *An Introduction to the Principles of Morals and Legislation* (Burns and Hart (eds), 1970); J.S. Mill, *Utilitarianism* (Lindsay (ed), 1960).

⁵⁷ For the seminal works on this theory, see *inter alia*: Aristotle, *The Nicomachean Ethics* (Translated by H. Rackham, Harvard University Press, 1982) and St. T. Aquinas, *Selected Political Writings* (D'Ebtrevés (ed) Dawson trans, 1959).

⁵⁸ It does not insist on only one of the traditional major theories and attempt to insulate and defend it from other major theories. Certain elements of each of the major four major schools of thought are understood here to overlap.

⁵⁹ It does not trace ethics back to entirely divergent sources, and thus allow for contradictory ethical justifications.

⁶⁰ It is not pluralist in the sense that several or all traditional theories are entirely upheld.

⁶¹ It does not claim that given the abundance of different ethical theories, that any attempt to make use of normative ethics is futile.

⁶² This choice, and the four stances just mentioned, are inspired by von der Pfordten (n 53).

⁶³ *Ibid*.

2.2 THE 'IDEAL DIMENSION' OF THE LAW ON ASSISTED DYING

2.2.1 NORMATIVE INDIVIDUALISM AND THE ORIGINAL POSITION

Normative individualism, as conceptualized by von der Pfordten,⁶⁴ contains two main principles:

1. The principle of individuality: the basic moral relation only exists between individuals.

*"Only individuals can be the ultimate point of reference of moral obligations and hence the justificatory source of morals and ethics. Collective entities such as nations, peoples, societies, communities, clans, families, or eco-systems, etc. cannot fulfil this function. Accordingly, like the obligated actor the obligating other has to be an individual in the last instance."*⁶⁵

2. The "all-principle":

In the last instance, justifications of actions or decisions have to take into account *all* individuals affected⁶⁶ by an action or decision, i.e., all "moral patients."⁶⁷

This individualistic focus is consistent with a number of leading ethical theories: contractualism,⁶⁸ Kant's categorical imperative,⁶⁹ and even (to a more limited extent)

⁶⁴ See von der Pfordten (n 53) 449-471. For his work in the German language on this see: D. Von der Pfordten, 'Fünf Elemente normativer Ethik: Eine allgemeine Theorie des normativen Individualismus' (2007) 61(3) *Zeitschrift für Philosophische Forschung* 283 – 319.

⁶⁵ This principle is premised upon von der Pfordten's understanding of the meaning and aim of ethics, whereby: the aim is to solve instances of conflicting concerns and to justify guiding categorical obligations, not just to provide recommendations. He argues that although individuals undeniably live in a social context, categorical obligations must have their ultimate source outside the collective. If the collective is the ultimate point of reference then the normative relation between the moral agent and moral patient (the affected individual) remains an *internal* one, which does not presuppose 'categorical, action-constraining obligations.' Also, in response to Raz's view that 'the ideal of personal autonomy entails that collective goods are at least sometimes intrinsically valuable', von der Pfordten states that autonomy or any other value is not absolutely good but only relatively good depending on the concerns, aims and desires of the individual. Thus autonomy 'is not intrinsically good, [...] but only justified insofar as it is embraced by the individuals concerned.' See (n 53) 452.

⁶⁶ Note: that the word 'affected' here refers to the relation between the action in question and the morally relevant properties of the individual, both logically and practically. Ibid.

⁶⁷ All individuals who have morally significant properties, and therefore have aims, desires, needs etc., are taken into account. Ibid.

⁶⁸ Hobbes, Locke, Rousseau, Rawls – although all distinct theories of contractualism - all commence in some form with *individuals* who form social contracts.

⁶⁹ Persons (understood as *individuals*) are never to be used as a means, but must always be treated as an end.

with classic utilitarianism.⁷⁰ The centrality of the individual's aims, needs and desires in this ethical theory does not result in support for an ultra-minimal state as proposed by Nozick or Gauthier. Nor is it to be equated with 'liberalism' or 'de-regulation'. Instead it is a theory that may or may not justify 'liberalism' or 'deregulation'. Moreover, such a basic paradigm (premised on the 'principle of individuality' and the 'all principle') is entirely consistent with both the substantive and functional aspects of human rights.⁷¹

What is arguably the most novel contribution of this theory is the generalizing meta-principle offered to find or guide the application of concrete traditional principles. Von der Pfordten claims that existing deliberative principles are valid to a certain degree, but are arguably too abstract (such as the contractual principle⁷² and the discursive principle⁷³), or they are too unyielding (such as the maximization principle⁷⁴). An alternative starting point, albeit in need of further specification, is offered in the form of the '*principle of self- and other-relativity of individual concerns*'. This purports that:

“The more the origins or the realization of the concerns or the interests of a morally considerable individual depend on others or a community, the more the respective concerns and interests have to be relativized in the process of deliberation, and the more the community may decide according to its common goals.”

⁷⁰ Considerations of the 'pleasure' and 'pain' of *individuals* is the first concern. Admittedly, utilitarianism quickly turns away from an individualistic-centered approach as it does not take into account the interests of single individuals at *the end* of deliberation. In other words when the principle of utility is satisfied, there is no assurance that account is taken of each affected individual, and it is thus contrary to normative individualism. See (n 53).

⁷¹ The substantive aspects are: basic values such as dignity, freedom and autonomy of the individual must be explicitly or implicitly protected; human rights are inherent to all individuals; and human rights must be protected against all encroachments (by public and private powers). While the functional aspects are: any measure with the ability to impede upon a protected human right must be founded on law, be backed up by a legitimate reason, be necessary for the needs of the democratic society and be the sole adequate means of achieving such a legitimate reason (principle of proportionality). See R. Arnold, 'Reflections on the Universality of Human Rights' in R. Arnold (ed) *The Universalism of Human Rights* (Springer: Dordrecht, 2013).

⁷² For example, Scanlon's version of the contractual principle broadly argues that an action is only a moral one if it can be justified against other actions by reasons 'that cannot be reasonably rejected', and says little about *how* concerns are actually to be balanced or deliberated upon. Note that in the following paragraphs, limited elements of another version of the contractual principle (Rawls's original position and the maxi-min rule) are considered useful for the case at hand. T.M. Scanlon, 'Contractualism and Utilitarianism' in A. Sen and B. Williams, *Utilitarianism and beyond* (Cambridge University Press, 1982).

⁷³ This, arguably, involves claims only to reconstruct the implicit normative orientations that guide individuals.

⁷⁴ Here there are a number of instances where the concerns of individuals may be subjected to collective maximization. Hence, this principle may of no use in many cases.

Individual concerns (or interests) are dependent upon others or the community in two ways; (i) historically and retrospectively,⁷⁵ and (ii) instrumentally and prospectively.⁷⁶ To deliberate between the conflicting concerns, von der Pfordten offers a continuum of relative dependence, also known as a 'tripartite scheme of zones'. At one end of the continuum, there are concerns that do not depend much or at all on others for realization – 'concerns localized within the symbolic boundary of the body'⁷⁷ - for example: mental and bodily integrity. These concerns fall within what is called '*the individual zone*.' It is essential that such concerns 'remain unaffected by relativizing deliberations as much as possible', and that the principle of equality is used to balance any conflicting individual concerns. At the other end of the continuum, it may be said that there are concerns highly or entirely dependent upon others, for example shared activities, access to economic infrastructure or the functioning of public transport systems. These concerns fall within what is called '*the social zone*.' When concerns of the *social zone* come into conflict with each other, it is argued that a more maximizing principle should be used. In the middle of this continuum, there are individual concerns that partially depend upon others, for example the freedom of speech, the freedom of profession or the freedom of religion. These concerns fall within what is called '*the relative zone*.' When concerns of the *relative zone* come into conflict, it is considerably more difficult to apply one guiding or balancing principle. This is equally true when concerns from different zones come into conflict - for example: when concerns of *the individual zone* (such as mental integrity) clash with concerns of *the relative zone* (such as the freedom of speech), or when concerns of *the relative zone* (such as the freedom of profession) clash with concerns of *the social zone* (such as the interest in maintaining economic infrastructure).

However, once one can relate the degree to which a particular individual interest is dependent on the community, a broad paradigm for deliberation may become apparent. A number of factors must be considered, not just the relative dependence, but also the importance for the bearer and the content of the interests. Generally, concerns of *the individual zone* have priority⁷⁸ – they are not to be readily considered subordinate to

⁷⁵ 'A certain shared practice figures as a necessary condition for the development of a certain concern'. See (n 53) 468.

⁷⁶ 'A certain practice can only be realized with others or in a particular community with its particular institutions'. Ibid.

⁷⁷ Ibid 469.

⁷⁸ Ibid.

concerns located in the *relative* or *social zone*. Greater weight of justification is required for concerns that move away from this end of the continuum. In this sense, concerns of *the relative zone* have priority over the concerns of *the social zone*. This normative standpoint, thus, supports a cautious type of liberal paradigm;⁷⁹ whereby communal interests (and consequently coercive power *vis à vis* legal and political decisions) must overcome a context dependent ‘presumption of individual liberty.’

Unsurprisingly, the concerns involved in an act of assisted dying are not easy to categorize into the tripartite scheme of zones. From a simple instrumental perspective, the phenomenon fits into *the relative zone*:⁸⁰ in other words, the actual realization of an individual’s desire for assistance in dying demands the involvement and mutual decision of at least one other individual in the community (i.e. the assistor).⁸¹ From the more complex perspective of content, assisted dying involves concerns profoundly and deeply situated in the *individual zone* (one’s own physical and mental integrity, dignity, self-determination, and desire to be free from suffering), but it also involves concerns rooted in the *social zone* (the communal interest to discourage suicide, to ensure adequate funding for curative treatment, to uphold the value of human life and to protect vulnerable persons). Deliberating between such conflicting concerns is far from straightforward and more often invites absolutist, uncompromising standpoints - be it from an overly individualistic or overly communal outlook. Accepting the reasoning above that the ideal dimension of the law on assisted dying should respect the contextual presumption of individual liberty (i.e. be justified with ultimate reference to the affected individual – the ‘principle of individuality’, whilst taking into due account the relative communal concerns – the ‘all principle’); this Chapter argues that, from this point of departure, a useful means of neutral mediation between the individual and communal concerns is to apply a type of

⁷⁹ Note, ‘liberal’ here does not mean de-regulation. The removal of general restrictions justified in the name of the ‘community’, and thus the protection of liberty, often gives rise to increased and more specific regulation than before, see N. Elias *The Civilizing Process: The History of Manners and State Formation and Civilization* (Oxford, Blackwell, 1993); See also P. Kapteyn. *Taboe, ontwikkelingen in macht en moral in Nederland* [Taboo, Developments in Power and Morality in the Netherlands] (Amsterdam: Arbeiderspers, 1980).

⁸⁰ For example, Callahan argues that assisted dying should be understood as a social act: ‘It requires the assistance of someone else and could not take place without it’. D. Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (Washington: Georgetown University Press, 2000) 104. In similar vein, Salem says that ‘[...] there is a paradox underlying physician-assisted suicide. It is conceived of as an intimate, existential act and indeed a response to modern medicine, but at the same time it is a request for the complicity of physicians (and society)’. T. Salem, ‘Physician-assisted suicide: promoting autonomy – or medicalizing suicide?’ (1999) 29(3) *Hastings Center Report* 31.

⁸¹ See S. McClean, *Reflections on the Need for Law Reform* (London: Routledge, 2007).

rational choice theory. Thus, attention now turns to a Rawlsian-inspired thought experiment.

Although Rawls sought to identify the principles of justice that determine the basic framework (*vis à vis* institutions) that should govern a society, his political conception of justice is often viewed as a type of moral conception. It is not necessary here to discuss or agree with Rawls's theory of justice in general.⁸² In light of the above observations based on normative individualism, only (limited) methodological elements of Rawls's thought experiment are understood to have a specific function here. This function is: to help derive an *impartial premise (fair procedure)* for deliberating between the relative self- and communal – interests surrounding assisted dying. Nonetheless, a very brief and relevantly narrow introduction to the celebrated moral and political philosopher's work may be excused.

Rawls's famous thought experiment is known as 'the original position.'⁸³ The most striking feature of this purely hypothetical position is the *veil of ignorance*, whereby no one person knows her place in society, class position or social status, nor does one know her fortune in the distribution of natural assets and abilities, intelligence and strength, historical facts about her society or its population, wealth, resources, religious institutions, etc.⁸⁴ The idea is to render obsolete any subjective personal considerations that are morally irrelevant. This hypothetical position does not impose new obligations, but is to help us work out what we now think⁸⁵ – in the case at hand, to explicate the requirements of our moral position (and ultimately, to help justify or criticize the ideal dimension of the law) on assisted dying.

If balancing between relative conflicting individual and communal interests, parties in the original position may be understood as rational in a formal or 'thin' sense that is characteristic of the theories of social choice.⁸⁶ In rational choice theory there are a

⁸² In this respect, there is no need to discuss or agree with Rawls's view on social contract theory, the subject of justice, on the (two) principles of justice, on duties and obligations, and so on.

⁸³ See J. Rawls, *A Theory of Justice* (Revised Edition, Belknap Press: Harvard University, 1999) 102-160. See also S. Freeman, 'Original Position' *The Stanford Encyclopedia of Philosophy* (Fall 2014 Edition), Edward N. Zalta (ed.), Available at <<http://plato.stanford.edu/archives/fall2014/entries/original-position/>>. Last accessed 29.01.2016.

⁸⁴ Rawls, *ibid*, 118.

⁸⁵ S. Freeman, *Collected Papers: John Rawls* (Harvard University Press, 1999) 402.

⁸⁶ "Even though the parties are deprived of information about their particular ends, they have enough knowledge to rank the alternatives." see Rawls (n 83) 123. For Rawls the rational choice of the parties is

number of potential strategies available. Rawls advocates a heuristic device known as the ‘*maximin rule*’:⁸⁷ this means we play it as safe as possible when making fundamental decisions. The maximin rule requires one to look at the worst that could happen under various choices of action and then choose the action with the best-worst-case outcome. In other words, we select the alternative whose worst outcome leaves us better off than the worst outcome of all other alternatives. To follow this rule in trying to reach a justified moral position on assisted dying, we must focus on the worst outcomes that may arise in a society effectively regulated by that moral position.

Before we turn our attention to the relevant moral principles surrounding assisted dying (Section 2.2.2), and the competing moral positions taken (Section 2.2.3), it is useful to summarise/reflect on the broad normative framework that is hereby adopted:

- (i) an adequate moral decision on the provision of assisted dying must consider individuals as the ultimate point of reference (the ‘principle of individuality’);
- (ii) due account must be taken of all individuals that are probably or logically affected by that decision (the ‘all-principle’);
- (iii) any restriction on the individual’s control over the manner of his/her death in the name of communal concerns must face the burden of justification;
- (iv) in order to decide if the restriction is justified, an impartial ‘original position’ is of benefit;
- (v) all individuals in the original position know that any individual is potentially susceptible to unbearable and incurable suffering, and that any individual may be susceptible to undue influence;⁸⁸

made subject to reasonable (moral) constraints. ‘They are resourceful, take effective means to their ends, and seek to make their preferences consistent. They also take the course of action that is more likely to achieve their ends. And they choose courses of action that satisfy more rather than fewer of their purposes.’ See Freeman (n 85). See also J. Rawls, *Justice as Fairness: A Restatement* (Harvard University Press 2001) 87.

⁸⁷ See Rawls (n 83) 133.

⁸⁸ This explicit piece of knowledge does not contradict the individual’s impartiality – indeed, in Rawls’s original position, the parties *do* know facts about psychology, economics, biology and other social and natural sciences. In other words, they may know facts about the nature of medicine and biology (that certain illnesses cause unbearable suffering and are incurable) and the nature of society (that certain factors may play a role in diminishing one’s true autonomy – be it third party pressure or financial issues). What the individuals do not know is the nature of *their* health or the society that *they* may become a member of. In other words, the parties do not know if they will or will not fall severely ill, or will or will not be exposed to undue influence to end their life.

- (vi) in order to balance the competing individual and communal interests a heuristic device in the form of the maximin rule may be used.

2.2.2 PRINCIPLES OF ASSISTED DYING

Before adopting the original position and applying the above mentioned heuristic device in the hope of reaching an impartial standpoint, closer consideration is paid to the competing interests surrounding assisted dying. These competing interests are presented in the form of different interpretations of three moral principles central to the assisted dying debate. They are: (i) the principle of autonomy, (ii) the principle of beneficence, and (iii) the principle of respect for life. An appeal to these principles is not necessarily an appeal to existing legal rights.⁸⁹ However, as explained in Section 2.1. above, it is submitted that the balancing of these principles is intrinsic to the ‘ideal dimension’ of any claim to a legal right to assisted dying, a legal right namely in the form of a *prima facie* constitutional or human right.⁹⁰ For now, it is sufficient to say that the proceeding overview demonstrates how each principle, in their moral form, may be framed to support (for better or for worse) either side of the normative ethical debate.

(i) The Principle of Autonomy

The principle of autonomy is central to any ethical discussion on assisted dying.⁹¹ Although it may be readily taken for granted, there are *two* instances of autonomy that

⁸⁹ See CHAPTER 7 of this book, which specifically addresses the issue of assisted dying from the perspective of (human) rights based claims. Note that the principle of dignity, a principle of increasing importance in discussions about assisted dying, is considered to fall largely within the discussion on the instrumental form of the principle of autonomy here. For an insightful analysis of the principle of dignity in its own right, see Halliday (n 11).

⁹⁰ This section is inspired by Penney Lewis’s insightful enumeration of rights-based arguments both in favour of and against the legalization of assisted suicide. See Chapter Two in P. Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007). It must also be noted that a number of the scholarly references made throughout this section were brought to my attention thanks to this Chapter by Lewis.

⁹¹ The principle of autonomy is widely accepted and discussed in both medical and legal ethical debates on assisted dying: See J. Griffiths, A. Bood, and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam University Press, 1998) 169; Lewis, *ibid*, 23; T. Beauchamp & F. Childress, *Principles of Biomedical Ethics* (Oxford University Press, 1989) 68; M. Donnelly, *Healthcare Decision-making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2014); H.M. Dupuis, *Wel of niet behandelen? Baat het niet, dan schaadt het wel* [To treat or not to treat? If it does not help, it does not hurt], (Baarn: Ambo, 1994);; R. Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge-Cavendish, 2007) 13; See also the published statement by French intellectuals, ‘Declaration collective de

arise in every case of assisted dying: (i) the autonomous decision of the person who desires assistance in ending her own life, and (ii) the autonomous decision of the person willing to assist in bringing about that person's death. The immediate focus here is only on the former instance of autonomy (that of the person seeking assistance), but it is worthy to keep the latter instance in mind.⁹² As we will see, recourse to the principle of autonomy in the assisted dying debate is far from straightforward. It is a principle readily invoked to justify assisted dying but it may also be understood paternalistically, whereby assisted dying is framed as a *threat* to individual autonomy.

According to Leenen, the Dutch author of the influential Handbook of Health Law, autonomy is an intrinsic, natural right of human beings:

‘The foundation of the right to decide for yourself is the principle of the free, autonomous human being who has an inherent dignity that deserves unconditional respect, and who is entitled to dispose over his own life.’⁹³

Similarly, for the late American legal philosopher Neeley, self-determination in deciding how and when to die is imperative:

‘The decision to exit life by one's own choice is more fundamental to the concepts of autonomy, freedom, and liberty than any other, for pivotal to the control of one's own life is the choice of electing to forego continued life.’⁹⁴

The principle of autonomy can also be understood in a more instrumental form. In other words, ‘a commitment to freedom’ or autonomy to make decisions may safeguard other

desobeissance civique’, in *France Soir* (12 Jan 1999) and *Liberation* (13 Jan 1999), among the signatories were Pierre Courdieu, Pierre-Gilles de Gennes, Hubert Reeves and Françoise Giroud.

⁹² The latter instance of autonomy is relevant when we come to **CHAPTER 7** and **CHAPTER 8** of this book. In short, it is relevant (i) to framing assisted dying as a ‘non-interference’ legal right (*vis à vis* Article 8 of the European Convention of Human Rights), which imposes (according to the jurisprudence of the European Court of Human Rights) a *correlative prima facie* duty not to interfere with the assistor's autonomy to fulfill the voluntary request of the right holder, and (ii) to understanding a controversial EU (and EU-Swiss) free movement claim, namely the free movement of services (contractual autonomy) between a doctor in Dignitas or the Benelux region and a patient from abroad.

⁹³ See H.J.J. Leenen, *Handboek gezondheidsrecht. Deel 1: Rechten van mensen in de gezondheidszorg* [Handbook of Health Law. Volume 1: Individual Rights in the Context of Medical Care] (3rd ed., Alphen a/d Rijn: Samson H.D Tjeenk Willink) 38.

⁹⁴ G. S. Neeley, *The Constitutional Right to Suicide: A Legal and Philosophical Examination* (New York: Peter Lang, 1994) 80.

basic values 'such as moral pluralism or dignity.'⁹⁵ According to Dworkin '[...] a true appreciation of dignity argues [...] for individual freedom, not coercion, for a regime of law and attitude that encourages each of us to make mortal decisions for himself.'⁹⁶ Wallace and Eser describe the failure to protect autonomy in decisions involving life and death as a failure to protect all other (albeit perhaps less significant) decisions: 'If one must live or die as the state dictates, how much are the remaining choices worth?'⁹⁷

Most advocates of the principle of autonomy, particularly in the context of assisted dying, do not purport that it exists without any limitations. Oftentimes, John Stewart Mill's 'harm principle' is endorsed: *in the absence of harm to others* that could outweigh the commitment to freedom in the particular instance, individuals must be left alone to do as they wish.⁹⁸ Identifying the limits to the principle of autonomy, or identifying what extension of autonomy is likely to cause 'harm to others' in the context of assisted dying, is subject to intense debate.

For Leenen one way to circumscribe harm to others is to ensure, via adequate regulation, that each expression of autonomy is truly autonomous and not one effected by the desires of a third party:

'When a decision has such far-reaching consequences as the termination of life with the assistance of another, [the legislator] must enact rules to guarantee the voluntariness of the request and to eliminate the risks due to the fact that another person [...] is involved.'⁹⁹

This position assumes, like the majority of proponents of assisted dying, that the desire for assistance in dying can be considered autonomous – but not always. Richards claims that such a suicide in itself can only be autonomous when 'the person's plans, assessed

⁹⁵ See Lewis (n 90) 21, where reference is made to T.H. Engelhardt and M. Malloy, 'Suicide and Assisted Suicide: A Critique of Legal Sanctions (1982) 36 *SW L.J.* 1010-11. Lewis alludes to this instrumental argument in regard to the liberty-based derivation of a right to suicide or a right to assisted suicide. She treats the autonomy-based derivation of a right to assisted suicide as distinct. In this study, the liberty-based argument and the autonomy-based argument are largely treated as one of the same, based on one common sentiment – the value of individual freedom.

⁹⁶ R. Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: A.A. Knopf, 1993) 233-239.

⁹⁷ S. E. Wallace and A. Eser, 'The Rights of Personhood' in S.E. Wallace and A. Eser (eds) *Suicide and Euthanasia: The Rights of Personhood* (University of Tennessee Press, 1981) 101.

⁹⁸ See J.S. Mills, *On Liberty* (C.V. Shields, ed) (Indianapolis: Bobbs-Merrill, Library of the Liberal Arts, 1956) (1st edn, 1859) 13.

⁹⁹ See Leenen (n 93).

and subject to revision in terms of standards and arguments to which he or she gives free and rational assent, are better satisfied by death than by continued life.¹⁰⁰ On a similar note, Soeteman argues that the requirement of 'unbearable and hopeless suffering' provides the necessary protection to ensure that that a wish for assistance in dying is an autonomous one:

'It can function as part of a pragmatic operationalization of the condition that it must be reasonably clear that there was nothing wrong with the request.'¹⁰¹

For others, the difficulty in objectively identifying this standard of suffering, or in finding a 'stopping point' to the principle of autonomy in ending one's own life, alludes to the high risk of entirely undermining a patient's autonomy and justifies an outright prohibition on assisted dying. Johnson expresses concerns over the potential for coercion,¹⁰² while Pellegrino and Marzen point, respectively, to dangers of 'societal and interpersonal forces' or 'a climate of sanctioned suicide' in a place where assisted dying is available.¹⁰³ Another dilemma faced by those who invoke the principle of autonomy in the assisted dying debate, is the 'paradox' argument by Kass,¹⁰⁴ Alesandro¹⁰⁵ and Doerflinger.¹⁰⁶ This argument states that it is entirely contradictory to invoke autonomy as a justification for an action that terminates any future use of that very principle. Put rather bluntly, this argument reads as 'corpses have no choices.'¹⁰⁷

(ii) The Principle of Beneficence

As implied in Soetman's argument above, one way to limit the consequences of an autonomy-based argument for assisted dying is to rely upon the principle of beneficence. In this case, the autonomous will of the individual for assistance in dying is not enough in

¹⁰⁰ D. Richards 'Constitutional Privacy, The Right to Die and The Meaning of Life: A Moral Analysis' (1981) 22 *Wm. & Mary L. Rev.* 327.

¹⁰¹ A. Soeteman, 'Zelfbeschikking en uitzichtloze noodsituatie [Autonomy and the idea of a situation of irreversible necessity]' (1986) 7 *Filosofie en Praktijk* 69.

¹⁰² See for one example M. Johnson, 'Voluntary Active Euthanasia: The Next Frontier?' (1992) 8 *Issues in Law & Medicine* 343, 344; For Johnson, the autonomy to avail of assisted suicide may turn into a cover for "not the protection of a freely chosen 'right to die' but the encouragement, perhaps by coercion to exercise that 'right' as the only option."

¹⁰³ E. D. Pellegrino, 'Compassion Needs Reason Too', (1993) 270(7) *J. Am. Med. Ass'n* 874, 875; T. J. Marzen et al. 'Suicide: A Constitutional Right?' (198) 24 *Duq. L. Rev.*, 146.

¹⁰⁴ R. Kass, 'Is There a Right to Die?' (1993) 23(1) *Hastings Center Rep* 39-40.

¹⁰⁵ J.A. Alesandro, 'Physician Assisted Suicide and New York Law' (1994) 57 *Alb. L. Rev.* 819, 923.

¹⁰⁶ R. Doerflinger, 'Assisted Suicide: Pro-choice or Anti-life?' (1989) 19(1) *Hastings Center Rep* 16, 17.

¹⁰⁷ *Ibid.*

itself; it must also be deemed an act of kindness or mercy. This principle provides not just a proportionate limitation upon the autonomy of the person seeking death, but also a moral justification for the involvement of the assistor.¹⁰⁸ He/she may only assist when it is kind or merciful to do so. Equally, there is a very different way of understanding this principle: whereby entirely overriding the autonomy of the person seeking death (i.e. rejecting his/her autonomous wish to die) is an act of beneficence. Both of these arguments raise a fundamentally difficult question: how do we define what is a benevolent act?

The term 'beneficence' may be used in a broad sense (understood as an act of mercy, kindness or charity) or in a very broad sense (understood as any act to benefit or promote the welfare of other persons).¹⁰⁹ The latter understanding is usually adopted in ethical theory. In David Hume's theory of moral psychology and virtue ethics, benevolence – as opposed to self-interest and egoism - is the central 'principle' of human nature.¹¹⁰ For Mill, the concept of utilitarianism is based on a particular absolute standard of beneficence – the maximization of benefit. Kant opposes this utilitarian understanding of the principle of beneficence, but he does consider benevolence as a universally valid principle (or maxim) of moral duty, albeit an 'imperfect duty'.¹¹¹ Singer demands an even stronger duty to act benevolently, to the extent that his position is often accused of exceeding the limits of ordinary moral obligations.¹¹² Other philosophers such as Bernard Gert see it as a commendable moral ideal, but not as a general obligation. Most theorists, however, agree that the principle ought to have a particular meaning (obligation wise) in the context of *role-assigned duties*, such as duties that arise in professional ethics. This argument is particularly understandable when we speak of bio-ethics and professional ethics in the medical domain, a domain of acute relevance to the debate on assisted dying. Childress

¹⁰⁸ See Singer, who claims that it should be recognised that respect for autonomy does not need to bear the entire moral load, since an appeal to the patient's best interests can shoulder some of the burden. P. Singer, *Practical Ethics* (2nd edn, Cambridge University Press, 1993).

¹⁰⁹ See T. Beauchamp, 'The Principle of Beneficence in Applied Ethics', *The Stanford Encyclopaedia of Philosophy* (winter 2013 Edition).

¹¹⁰ Although Hume did not deny all aspects of the egoist's claims, e.g. the absence of impartial benevolence in human motivation. He understood the mixture of benevolence and self-love varies by degree from person to person. See D. Hume, *An Enquiry concerning the Principles of Morals*, (ed) T. L. Beauchamp (Oxford, 1998).

¹¹¹ Both Kant and Mill understood the principle to impose an 'imperfect duty'. In other words, only in some instances are beneficent actions 'morally required', while in other instances discretion may be had. See I. Kant, *Ethical Philosophy*, 2nd edn., J.W. Ellington (trans.) (Indianapolis: Hackett Publishing, 1994); J.S. Mill, *Utilitarianism and On Liberty in the Collected Works of John Stuart Mill* (University of Toronto Press, 1969)

¹¹² P. Singer, *Practical Ethics* (2nd edn, Cambridge University Press, 1993).

and Beauchamp, famously identify beneficence as one of the four core values of bioethics.¹¹³ For Pellegrino, beneficence is the sole foundational principle of professional medical ethics. A doctor owes a duty to act in a manner that promotes the welfare of her patient.¹¹⁴ This is somewhat uncontroversial, but identifying what medical behaviour is deemed to promote the welfare of the patient is certainly not.

Veatch, like Pellegrino, understands the principle to require a doctor to do everything possible to postpone death.¹¹⁵ In similar vein, Callahan argues that the job of medical staff is 'to tend to the medical interests of their patients – killing can never have a *medical* justification.'¹¹⁶ Of course, not all agree with this singular objective of medicine. For Dupuis, arguments by Veatch and Pellegrino are considered manifestations of the moral fallacy: 'what can be done, must be done.'¹¹⁷ As Griffiths, Bood and Weyers state: 'preventing inhuman suffering and respecting the autonomy of the patient could equally well be considered basic aims of medicine.'¹¹⁸ With the incredible advancement of medical technology, it is pertinently clear that the absolute preservation of life will not always be in the patient's best interest. From such perspective, the use of modern technology may conflict with the principle of beneficence. This raises the ethical question of what criteria (if any) is suitable in deciding what is in the patient's 'best interest' when she requests assistance in dying.

De Haan, Huxtable and Moller advocate a type of 'joint view' solution: the doctor seeks to respect the patient's earnest wish to die, and should only act on this once it is established that the patient is 'suffering unbearably and hopelessly.'¹¹⁹ Widdershoven describes this as a deliberative model, which is fundamentally different from an approach in which either the informative model (patient autonomy) prevails or the paternalist model (the 'doctor knows best') prevails.¹²⁰ It is premised on a mutual agreement between the

¹¹³ See Beauchamp and Childress (n 91).

¹¹⁴ E.D. Pellegrino, 'Doctors Must Not Kill' (1992) 3(2) *Journal of Clinical Ethics*.

¹¹⁵ R.M. Veatch, *A Theory of Medical Ethics* (Basic Books, 1981) Chapter 1.

¹¹⁶ D. Callahan, 'When Self-determination Runs Amok' (1992) 22(2) *Hastings Center Rep*, 52.

¹¹⁷ See Dupuis (n 91).

¹¹⁸ See Griffiths, Bood and Weyers (n 91) 161.

¹¹⁹ J. De Haan, 'The ethics of euthanasia: Advocates perspectives', 16(2) *Bioethics* 154-172; M. Moller and R. Huxtable, 'Euthanasia in the Netherlands: the case of "life fatigue"' (2001) 151 *New Law Journal* 1600.

¹²⁰ G.A.M. Widdershoven, 'Beyond Autonomy and Beneficence: The Moral Basis of Euthanasia in the Netherlands' (2002) (2) *Ethical Perspectives* 96-102.

physician and the patient, meaning it is premised not only on a voluntary request but some degree of objective (medical) justification. From this perspective, autonomy and beneficence are interdependent justificatory principles. Interestingly, this 'joint view' provides a response to the conceptual slippery slope argument.¹²¹ This slippery slope argument goes as follows: allowing physicians to actively hasten the life of a patient who is suffering unbearably and hopelessly will, by the force of logic, result in allowing physicians to perform non-voluntary assisted dying. However, the 'joint view' solution to permit assisted dying is clearly premised upon two justifying principles - the principle of autonomy *and* the principle of beneficence. If there is no autonomous wish then the act cannot be permitted, and thus it is, according to Griffiths, Adams and Weyers, 'incoherent' to maintain that the force of such logic will demand that non-voluntary assisted dying be allowed.¹²²

(iii) The Principle of Respect for life

This principle is readily equated with religious ideology and the concept of 'sacredness' or 'sanctity'. According to Judeo-Christian tradition,¹²³ the 'sanctity of life' principle purports that 'all innocent human lives are absolutely inviolable and equally valuable, and that the intentional termination of such lives is always morally wrong.'¹²⁴ This is but one formulation of the principle of respect for life. Dworkin strongly asserted that there is another formulation - a secular 'idea that human life is sacred.'¹²⁵ For a number of secular theorists the term 'sacred' may be too much, but the essence remains the same: human life is intrinsically and instrumentally valuable as revealed by the exercise of reason (rather than by religious beliefs).¹²⁶

¹²¹ This is, of course, not a response to arguments of an empirical slippery slope or a moral change slippery slope. These are discussed in more detail in **CHAPTER 6**, below.

¹²² See J. Griffiths, M. Adams, and H. Weyers, *Euthanasia and Law in Europe* (Hart, 2008) 514.

¹²³ Stemming from the 5th Commandment of the Decalogue "Thou Shall not Kill", a part of Mosaic Law adopted by Christian and Islamic morality.

¹²⁴ H. Kuhse, 'Sanctity of Life, Voluntary Euthanasia and the Dutch Experience: Some Implications for Public Policy' in K. Bayertz (ed) *Sanctity of Life and Human Dignity* (Springer, 1996) 19.

¹²⁵ For Dworkin, a complex chain of reasoning means most individuals believe it is 'intrinsically regrettable when human life, once begun, ends prematurely. We believe, in other words, that a premature death is bad in itself.' See R. Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (London: Harper Collins, 1993) 163.

¹²⁶ See A. Fisher, 'Theological aspects of euthanasia' in J. Keown (ed) *Euthanasia Examined. Ethical, Clinical and Legal Perspectives* (Cambridge University Press, 1995) 316; and J.F. Keenan, 'The concept of sanctity of life and its use in contemporary bioethical discussion' in K. Bayertz (ed) *Sanctity of Life and Human Dignity* (Dordrecht: Kluwer Academic Publishers, 1996).

Although the secular ‘respect for life’ is usually understood to support an argument in favour of a limited form of assisted dying, it may also be used as an argument against assisted dying.¹²⁷ In the former case, respect for life ensures that the preference of the individual’s normative preference for assistance in dying must be honoured, but only in limited situations which do not undermine the value of life. In the latter case, the principle is relied upon to restrict that freedom because life is *per se* characterized as being always worthy of preservation. From this perspective, a type of duty to live or remain alive comes into play. Rosenblum, Forsythe and Callahan conclude that the right to life is of special character and cannot be waived.¹²⁸ Balin argues that respecting the autonomy to end one’s own life is inconsistent with the ‘integrity of the person.’¹²⁹ This argument has been subject to rigorous criticism. Kluge, Battin and Leenen, to name just a few, understand this to impose an unjustifiable ‘duty to live.’¹³⁰ Feinberg argues that the relinquishment is of the *object* of the right to life (one’s life), and not the relinquishment of the *right* itself.¹³¹ Similarly Soeteman reasons that ‘inalienability means essentially that one may not and cannot dispose of the right [to life], which is something different from disposing of life itself.’¹³²

To help clarify this ‘duty to live’ or ‘respect for life’ debate, one may take a step back, contextualize the discussion by looking at all end-of-life medical behaviour, and ask the broader question: if the ‘duty to live’ or the principle of ‘respect for life’ are to be understood as absolutes in the debate at hand - in the religious or secular sense that it allows for no exception to the moral impermissibility of VAE or AS - then how does this reasoning justify the moral permissibility of other end of life behaviour - such as the withholding/withdrawing of life-prolonging treatment and/or the administration of pain relief that shortens life?¹³³ There are two forms of moral distinctions commonly used to

¹²⁷ See K. Yull, *Assisted Suicide: The Liberal, Humanist Case Against Legalization* (Palgrave Macmillan, 2013).

¹²⁸ V.D. Rosenblum and C.G. Forsythe, ‘The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing?’ (1990) 6 *Issues in Law and Medicine*, 3, 23; D. Callahan, ‘When Self-determination Runs Amok’ (1992) 22(2) *Hastings Center Rep*, 52.

¹²⁹ E.M.H. Hirsch Ballin, ‘Over het leven beschikken [Autonomy with respect to life]’, *Rechtsfilosofie en Rechtstheorie* 13, 182-187.

¹³⁰ See E-H. Kluge, *Biomedical Ethics in a Canadian Context* (Prentice-Hall Canada, 1992) 264-5; M.P. Battin, *The Least Worst Death: Essays in Bio-ethics on the End of Life* (Oxford University Press, 1994) 280-1; H.J.J. Leenen, ‘Assistance to Suicide and the European Court of Human Rights; the Pretty Case’ (2002) 9 *European Journal of Health Law* 257, 259.

¹³¹ J. Feinberg, *Rights, Justice and the Bounds of Liberty* (Princeton University Press, 1980) 143 -151.

¹³² A. Soeteman, ‘Zelfbeschikking en uitzichtloze noodsituatie [Autonomy and the idea of a situation of irreversible necessity]’ (1986) 7 *Filosofie en Praktijk*, 57-74.

¹³³ Behaviour not consider to be ‘assisted dying’ as defined here.

answer this question: (i) the '*killing v letting die*' distinction,¹³⁴ and (ii) the '*intention v foresight*' distinction.

Regarding the first distinction, a number of reoccurring arguments are provided. First, it is said that in the case of *killing*, the death of the patient is 'caused' by the doctor. *Letting die*, on the other hand, allows nature (or God's will) to take its course. The second argument is that *killing* is a violation of the duty not to harm (non-maleficence), while *letting die* is at worst a violation of the duty to help (beneficence). Third, it is some times argued that in the case of 'letting die' there exists a possibility that a third party may intervene, while the administration of a lethal injection would result in certain death.

Rachels, along with Griffiths, Bood and Weyers vehemently challenge each of these arguments. In response to the first point above, 'the cause' of any death is the 'outcome of a complex intermingling of circumstance', and to *morally* exclude omissions from such 'a complex is completely arbitrary and assumes exactly what needs to be proved.'¹³⁵ Also, as Rachels argues, if it is decided that 'letting' someone die is the correct thing to do, then 'we have decided that in *this* instance death is no greater evil than the patient's continued existence.'¹³⁶ Followed to its logical conclusion this argument claims that if it is right in the circumstances *to let* someone die, then the normal objections for not wanting to cause that someone's death cannot therefore apply. In relation to the second argument in the above paragraph, two problems are pointed out by Griffiths, Weyers and Adams. First, letting die may also be a violation of a duty not to harm, and second, the assumption that the duty not to harm weighs more heavily than the duty to help is rather unconvincing in the medical context – where the duty towards patients is precisely to help. Taking account of the medical context also provides the basis for two reasons to reject the third argument made above regarding the '*killing v letting die*' distinction. First, there are many instances where letting die will result in certain death (for example not providing a blood transfusion or not performing resuscitation). And secondly, 'a doctor who lets a patient die does so in the expectation that a third party will *not* intervene.'¹³⁷ Despite its political popularity (as we will see in **CHAPTERS FIVE AND SIX** below), the strong *moral* distinction

¹³⁴ Also known as the 'act v omission' distinction.

¹³⁵ Griffiths, Bood and Weyers (n 91) 159.

¹³⁶ J. Rachels, *The End of Life* (Oxford University Press, 1986) 115.

¹³⁷ Griffiths, Bood and Weyers (n 91) 160.

between *killing and letting die*, particularly in the medical context, is evidently questionable – at least from a consistency perspective.

As for the second moral distinction that seeks to justify the difference between assisted dying and other end of life behaviour – i.e. the distinction between *intention and foresight* - the main argument is deceptively clear cut and famously expressed in the ‘doctrine of double effect’.¹³⁸ This is a doctrine developed by Thomas Aquinas and strongly influenced by the Judeo-Christian understanding of the sanctity of life mentioned above. In regard to assisted dying, the idea is that in cases where a doctor administers pain relief that he knows (foresees) will cause/hasten the patient’s death, it is not morally wrong if he did *not intend* death. This does not mean that death (the bad consequence) is understood as a means to achieve the goal of alleviating pain (the good consequence), instead death is strictly understood as a mere undesired side effect. Furthermore, according to this doctrine: the administration of the same drug, but with the doctor’s intention to cause death in order to put an end to a person’s patient’s suffering is morally impermissible. Griffiths, Weyers and Adams point to two problems here. First, the morality of the behaviour is determined by how one *describes* it (either with ‘death as a side-effect’ or with ‘death as a means’). It is arguably futile to distinguish a ‘side effect’ from a ‘means’ and morally arbitrary to regard either one of these possible descriptions as necessarily preferred over the other. And secondly, according to the doctrine of double effect the permissibility of a certain act is not determined on the basis of what the actor *objectively does*, but on purely *subjective motivations* known only to the actor. Furthermore, Rachels argues that the ‘rightness or wrongness of an act is determined by the reasons for and against it’; only after one has taken account of these reasons, and decided that an act is permissible on those grounds, does the question of intention arise.¹³⁹ Relying on the *insight v foresight* distinction to maintain that VAE or AS are violations of the principle of respect for life but that the administration of pain relief which may drastically shorten (or even terminate) life is not a violation of said principle is questionable – like the *killing v*

¹³⁸ C. Foster, J. Herring, K. Melham and T. Hope, ‘The Double Effect Effect’, (2011) 20 *Cambridge Quarterly of Healthcare Ethics*, 56-72; T.A. Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (Clarendon Press, 2006); A. McGee. ‘Finding a way through the ethical and legal maze: Withdrawal of medical treatment and euthanasia’ (2005) 13 *Medical Law Review* 357–85.

¹³⁹ Rachels (n 136).

letting die distinction, this is particularly questionable from a consistency perspective in the medical context.

It is evident from this brief explication that any moral distinction between assisted dying on the one hand, and withholding/withdrawing life-prolonging treatment or shortening life with pain killers on the other hand, is a difficult one to maintain. It is submitted here that there are two inherently consistent moral positions on assisted dying which stem from the principle of respect for life. One is based on the notion of vitalism, i.e. that the presence of merely biological human life must always be striven for. This position purports that *all* forms of behaviour (medical or otherwise) that shortens or terminates life are morally wrong. The other is based on the notion that respect for life requires *all* behaviour that shortens or terminates life to be justified depending on the circumstances, best interests and wishes of the patient.

2.2.3 BALANCING THE RELATIVE PRINCIPLES

It is quite clear that a consensus on the conflicting formulations of the above principles is not likely. Each principle can be, and frequently is, interpreted to support either side of the assisted dying ethical debate. For example, the principle of autonomy can be understood to justify *protecting the freedom* to define one's own death, or from another perspective to justify *protecting one from the freedom* to define one's own death (an invariably irrational exercise of autonomy). The principle of beneficence may be used to argue that death can never promote an individual's welfare, and that it is therefore contrary to the principle of beneficence to allow assisted dying. The same principle may also be used to advocate the exact opposite, that in certain circumstances it is contrary to the individual's welfare to resist death, and not to provide some assistance. Equally, the principle of respect for life is manifestly indeterminate and open to absolutist, conflicting claims.

In light of this, it is claimed here that the normative framework fleshed out above (in Section 2.2.1) may be of use. This framework states that:

- (i) an adequate moral decision on the provision of assisted dying must consider individuals as the ultimate point of reference (the 'principle of individuality');

- (ii) due account must be taken of all individuals that are probably or logically affected by that decision (the 'all-principle');
- (iii) any restriction on the individual's control over the manner of his/her death in the name of communal concerns must face the burden of justification;
- (iv) in order to decide *if* the restriction is justified, an impartial 'original position' is of benefit;
- (v) all individuals in the original position know that any individual is potentially susceptible to unbearable and incurable suffering, and that any individual may be susceptible to undue influence;¹⁴⁰
- (vi) in order to balance the competing individual and communal interests a heuristic device in the form of the maximin rule may be used.

Having briefly alluded to the main principles surrounding assisted dying and their conflicting interpretations, we may now turn to the hypothetical original position and apply the maximin rule. From this starting point, we may look (from behind a veil of ignorance) at three types of societies effectively 'regulated' by different moral positions on assisted dying. Then we may assess the worst case outcome in each society to determine which presents the *best* worst case outcome. The first society (**society A**) subscribes to the moral position that assisted dying is *always permissible*. The second society (**society B**) subscribes to the moral position that assisted dying is *partly permissible*.¹⁴¹ And the third society (**society C**) subscribes to the moral position that assisted dying is *never permissible*.

In **society A**, the *worst* case scenario is that: due to the entire lack of a prohibition or any safeguards, some individuals may be more easily pressured into requesting death against their true wishes or some individuals may readily avail of assisted dying without being offered any alternative options to alleviate their suffering. In **society B**, assistance is only permitted provided it is performed by a doctor, the patient's request is evaluated, and she is suffering unbearably and hopelessly according to relatively objective medical standards. Here the *worst* case scenario is that: the safeguards are insufficient in

¹⁴⁰ As stated above, this explicit piece of knowledge does not contradict the individual's impartiality – see (n 88).

¹⁴¹ 'Partly permissible' here means that an intentional act of killing may still be abhorred, but also justified in exceptional circumstances and subject to some form of safeguards (outlined below in the next paragraph).

protecting some individuals from requesting an assisted death against their autonomous wishes or from being offered all alternative options to alleviate their suffering. Vulnerable individuals may still, despite the safeguards, ‘fall through the safety net’ so to speak. In **society C**, assisted dying is *never permissible*. As explained above, to be morally consistent this position means that all forms of medical behaviour that end or shorten life are not permissible.¹⁴² Here, the worst case scenario is: that some individuals will die from excruciating and incurable pain against their earnest wishes, *and* the total prohibition is insufficient in protecting individuals from requesting an assisted death against their autonomous wishes or from being offered alternative options to alleviate their suffering.¹⁴³ Thus, people may die in excruciating pain against their will and vulnerable individuals may still, despite the total prohibition, ‘fall through the safety net’. Closer attention will now be paid to which is the *best-worst-case* outcome.

Let us start by looking again at the worst outcome in **society A**. It is almost innately obvious that rational individuals would not permit assisted dying in absolutely all circumstances, without any procedural or substantive safeguards. This approach pursues an isolated individualistic understanding of the principles of autonomy and respect for life: it is a society that assumes each self-sovereign individual is immune to the undue influence of others, or worse, it is a society that does not care if they are immune or not to such influence. No weight is given to communal concerns or principles, such as protecting the autonomy of vulnerable persons or discouraging the needless ending of life. The ‘all principle’, mentioned above, is all but ignored. Given that any individual could potentially be susceptible to undue pressure to choose an early death (due to unforeseen illness, social setting, economic factors, etc.), no representative in the original position would rationally object to taking some steps to minimize such a risk (whether these steps are presented in the form of a total prohibition on assisted dying or through a limited

¹⁴² See the discussion entitled: ‘Principle of Respect for Life’ in the preceding section, which concerns the validity of the ‘*killing v letting die*’ distinction and the ‘*intention v omission*’ distinction. In short, one may argue that there should exist a **Society D**, whereby assisted dying is never permissible but other end of life practices are permissible – however, it is argued in the above section that this reasoning is *not* morally consistent or coherent (as Griffiths, Bood, Weyers and Rachels also claim). For this reason it must be dismissed as a rational moral alternative in the original position or as Alexy would put it: as falling outside the remit of a valid ‘procedural theory of practical rationality.’

¹⁴³ To deny this latter outcome means that one assumes a total prohibition, even in the worst case scenario, remains totally effective in ensuring no individuals are put at risk. This is simply not a rational position.

prohibition). To say otherwise does not take due account of all individuals in that society who may probably or logically be affected.

In **society B**, death is not avoided at all costs but the worst outcome is that individuals die against their earnest wishes or do not avail of alternative options to end their unbearable suffering. Such a scenario is obviously contingent upon an unknown circumstance or probability: the *quality of the safeguards* in place. In this society, it cannot of course be guaranteed that the safeguards will always be respected (and that every vulnerable person is thereby protected). This is an equally relevant observation concerning **society C** – in this society, it also cannot be guaranteed that a blanket ban will always be respected (and that every vulnerable person is thereby protected). There is an unknown probability at play here too. The distinction between the worst case scenario of **society B** and **society C**, given the knowledge one has in the original position, emanates from the added *certainty* (not probability) that some individuals will develop unbearable and incurable illnesses.¹⁴⁴ In **society C**, this means that individuals are certain to suffer, and will do so against their sincere autonomy. Moreover, no relief could be accepted in ‘letting persons die’ or ‘speeding up death with pain relief’ in this society – here, essentially either a vitalistic stance must be adopted or a morally inconsistent one.¹⁴⁵ The latter stance cannot be accepted in any adequate theory of normative ethics or procedural theory of practical rationality. While in the former stance, an isolated communitarian understanding of the principles of autonomy and respect for life are pursued. No weight is ultimately given to the individual understanding of self-determination, bodily integrity and the decision to avoid suffering (the ‘principle of individuality’). Put differently, rational individuals in **society C** accept that not just protecting vulnerable persons but the absolute preservation of mere biological existence is worth the certainty of some individuals suffering unbearably against their autonomous wish. **Society B** on the other hand, despite running the same unknown risk of failing to protect every vulnerable individual, could not be accused of certainly subjecting other individuals to suffer unbearably and incurably against their autonomous wish. In this society, those individuals may receive assistance

¹⁴⁴ Parties in the original position know, from basic facts of human psychology, that some individuals will be more susceptible to undue influence to end their lives (which is not a probability) – but this does not say anything about the practical ability or inability of safeguards to reduce this practice (this remains a probability). Thus, the worst case scenario is a control based concern, which is also a concern that may be leveled at a complete prohibition of the behaviour.

¹⁴⁵ This is concluded from the above discussion on the principle of ‘respect for life’.

in dying. Both **society B** and **society C** run the inevitable risk of being unable to protect every individual from non-voluntary assisted dying – thus both cannot avoid undermining, to some unknown extent, the communal concern of protecting all vulnerable persons. But only **society C** also guarantees that some persons suffering unbearably and untreatably will do so against their earnest wish – thus only in this society is the individual's claim for autonomy and beneficence undermined. On this basis, the *best-worst-case* outcome facing individuals in the original position – taking into account the 'principle of individuality' and the 'all principle' is that of **society B**. In the wider context of this normative ethical framework, one may conclude: a hypothetical society 'regulated' by the moral decision that assisted dying may be permitted in certain circumstances (where persons make an autonomous request and are suffering unbearably and untreatably) leads to a *better-worse-case outcome* than a hypothetical society regulated by the moral decision that assisted dying must never be permitted. Moreover, this claim ought to justify or criticize one's interpretation of the 'ideal dimension' of the law on assisted dying.

For the representatives in the original position to still favour the *best-worst-case* outcome of **society C** over that of **society B**, the only justification left, is: *Yes, some individuals will suffer unbearably and hopelessly against their wishes – and this is morally wrong. But it is a necessary evil, as partly permitting assisted dying will, or is at least more likely, to result in a greater evil (more non-voluntary cases of assisted dying) than entirely prohibiting it in the first place.* This is not taking a position on the first-principle issue (i.e. from Alexy's legal-philosophical perspective, the 'ideal dimension' of the law) – it is a stance on the positive legal policy (i.e. the 'real dimension' of the law). It holds that the morally correct thing may be superseded by concerns over a suitable control framework. It is not meant here that these concerns are irrelevant or that this standpoint is incorrect, rather the contrary may be said. As stated in Section 2.1, the right thing to do - decided by a type of original position/maximin, normative individualistic method just used, or otherwise - is not always easy to secure *via* positive legal policy. However, this is a distinct matter of inquiry that must build upon the recognised *prima facie* morality of assisted dying.

The above normative standpoint may be used to justify or criticize legal and political decisions on the 'inner dimension of the law' on assisted dying. The focus of this study now shifts away from the ideological discussion (concerning whether it is right or wrong

to assist in another individual's wish to die) to a more policy-orientated discussion (concerning whether we can control this behaviour adequately in light of the obvious dangers). This leads us onto the next phase of this study – an inter-disciplinary 'comparative law and' analysis.

2.3 THE 'REAL DIMENSION' OF THE LAW ON ASSISTED DYING

In light of the previous section on the principle-based arguments over assisted dying (the 'ideal dimension of the law on assisted dying'), we must now address the significant control-based arguments. In other words, we must now look at the law on assisted dying from the perspective of authoritative issuance and social efficacy. At this point, there is a clear policy-orientated research question: what do we know about the 'real dimension' of the law on assisted dying in different jurisdictions? At the expense of stating the obvious; to beg this question and further evaluative questions on what control system works best inevitably begs the need for comparative legal research of some sort. As Sacco puts it: 'the primary and essential aim of comparative law as a science [...] is better knowledge of legal rules and institutions'.¹⁴⁶ Any discussion on the suitability of a particular legal policy requires some measurement against another legal policy. According to Bell:

"[t]he very activity of looking at more than one legal system raises questions about the justifiability of differences and whether they achieve the purposes of the law equally effectively and these are normative questions."¹⁴⁷

Moreover, comparative legal research provides not only the means to identify and normatively evaluate differences or similarities in two or more legal systems, but also the means to *explain* them. According to Adams this type of comparative research 'readily calls for an interdisciplinary approach'. This is not a controversial methodological statement.¹⁴⁸ According to Glendon, Carozza and Picker, 'comparative law is by its very

¹⁴⁶ R. Sacco, 'Legal Formants: A Dynamic Approach to Comparative Law' (1991) 39 *The American Journal of Comparative Law* 5.

¹⁴⁷ J. Bell, 'Legal Research and the Distinctiveness of Comparative Law' in M. Van Hoecke (ed), *Methodologies of Legal Research. Which Kind of Method for What Kind of Discipline?* (Oxford: Hart Publishing, 2011) 158.

¹⁴⁸ Legal research in itself is rarely an entirely autonomous discipline. Even traditional interpretative methods of legal research have arguably, whether explicit or not, some form of interdisciplinary grounding. C.J.J.M Stolker, *Rethinking the Law School: Education, Research, Outreach and Governance* (Cambridge University Press, 2015).

nature an interdisciplinary field.¹⁴⁹ Similarly, Mattei claims ‘sophisticated comparative scholarship can be produced only by interdisciplinary efforts’. In response to these calls, Siems develops a useful starting point for comparative lawyers to contextualize their interdisciplinary efforts.¹⁵⁰ His study loosely sets out three related dimensions, which the comparatist must in some way appreciate: (i) relevant areas of law (such as constitutional, administrative, contract, tort, etc.), (ii) relevant differences between legal regimes (such as national, or supra-national) and (iii) relevant approaches to legal knowledge (incorporating the underlying history, economics, politics or culture of the law).

This study follows the above general line of inquiry. It contends that a critical understanding of what the ‘real dimension’ of the law on assisted dying is in any one jurisdiction necessitates some comparative interdisciplinary research. Legal methods alone will not suffice; some external discipline is also required. As Van Klink and Taekema point out: the aspiring legal interdisciplinary researcher must have some reason for picking his or her choice of external discipline.¹⁵¹ In this study, the choice logically follows from the questions being asked. As mentioned in the **INTRODUCTION** above, this work sets out to compare (i) public policy outputs concerning assisted dying (the content of different legal rules, prosecution guidelines, judicial verdicts, etc.); (ii) relevant public policy effects (how these legal rules, prosecution guidelines, judicial verdicts, etc., succeed or fail to achieve their stated objectives); and (iii) any subsequent public policy changes (what has or needs to be done, if anything, to alter or reform these legal rules, prosecution guidelines, judicial verdicts, etc., in light of their effects). Such a holistic inquiry into the real dimension of the law on assisted dying (defined by its authoritative issuance and social efficacy) necessitates some input from political science *and* sociology. This input may ultimately take the form of a ‘perspectivist integrated’ inter-disciplinary method¹⁵² or a more ‘extensive integrated’ interdisciplinary method.¹⁵³ Either way, there

¹⁴⁹ M.A. Glendon, P. Carzola, C.B. Picker, *Comparative Legal Traditions in a Nutshell* (3rd edn, West Academic Publishing, 2008) 11.

¹⁵⁰ M. Siems, *Comparative Law* (Cambridge University Press, 2014) 8.

¹⁵¹ Van Klink and Taekema, ‘On the Border. Limits and Possibilities of Interdisciplinary Research’ in B.M.J. van Klink and H.S. Taekema (eds) *Law and Method. Interdisciplinary Research into Law* (Tübingen: Mohr Siebeck 2011) 22.

¹⁵² According to van Klink and Taekema: ‘[s]uch research switches between two disciplines, using the concepts and methods of each. The conclusions will also be perspectivist: there is not a coherent single answer, but a necessary co-existence of two disciplines.’ *Ibid.*

¹⁵³ This ‘research process itself contains elements from both disciplines and the researcher welds together the concepts and methods from each or applies a more general methodological approach to both.’ *Ibid.*

must be some integration of perspectives between the mentioned disciplines. The type of integration adopted here arguably falls more within the latter interdisciplinary method. It comes in the form of what Colombi Ciacchi terms a ‘comparative law and governance’ analysis.¹⁵⁴

2.3.1. A ‘COMPARATIVE LAW AND GOVERNANCE’ ANALYSIS

There is a large discussion on governance in political and social science,¹⁵⁵ and, of course, a large discussion on the concept of law in jurisprudence and legal philosophy. Indeed, the literature on these concepts may implicitly overlap, but the different fields are often so diverse that it is not always straightforward to highlight commonalities or differences therein. In this sense, legal scientists, political scientists and sociologists may end up sitting at ‘separate tables’,¹⁵⁶ having separate conversations about law and governance. This does not come as a great surprise. ‘Law’ and ‘governance’ are highly contested concepts whose meaning and inter-relationship cannot be simply assumed or taken for granted.¹⁵⁷ This study does not propose – or seek to embark on the already vast debate – that one general conceptual understanding of either term is necessarily more accurate than the myriad of other understandings available. Instead, it ‘casts the net wide’ so to speak, and tentatively provides some minimum content for both concepts and for their interrelationship.

“**Law**” is a social phenomenon. It is conceptualized here in a broad functional sense:¹⁵⁸ as one specific means¹⁵⁹ to mediate between conflicting interests. As explained in the above

¹⁵⁴ Colombi Ciacchi (n 6) 221–236.

¹⁵⁵ This was not always the case, see J. Pierre and B.G Peters, *Governance, Politics and the State* (Basingstoke: Macmillan, 2000); K. Van Keersbergen and F. Van Waarden, ‘Governance as a bridge between disciplines: Cross-disciplinary inspiration regarding shifts in governance and problems of governability, accountability and legitimacy’ (2004) 43 *European Journal of Political Research* 143–171.

¹⁵⁶ This analogy is taken from Gabriel Almond’s seminal work on how the discipline of political science has become divided against itself. G.A. Almond, *A Discipline Divided: Schools and Sects in Political Science* (Sage, 1989).

¹⁵⁷ See N. Walker and G. de Burca, ‘Reconceiving Law and New Governance’, *EUI Working Paper Law*, Vol. 10, 2007, 1.

¹⁵⁸ Legal commentaries commonly support their descriptions of the law by references to the purposes and functions of the law, see J.W. Harris, *Legal Philosophies* (2nd edn, Oxford University Press, 2004) 67.

¹⁵⁹ Law must be differentiated from other social norms (for example mere clubhouse rules to important political processes) as a *specific instrument* to mediate between conflicting interests. Regarding the latter example, the fundamental claim of the *CLS* movement that ‘the law is inseparable from politics’ is hereby rejected. See von der Pfordten, ‘What is Law? Aims and Means’ (2011) 97 *Archive for Philosophy of Law and Social Philosophy* 151.

section, this 'means' may be said to contain two dimensions. On the one hand, it makes a claim to some normative decision (this is *the ideal dimension* of the law). On the other hand, it claims to achieve and enforce this normative decision (this is the *real dimension* of the law). It contains certain distinct characteristics: (1) some voluntary norms but also some *categorical obligations*, whereby it is not necessary to have obtained the agreement of those obligated as a necessary condition; (2) it has, unlike morality, *external sources* – such as judging, ordering, agreeing, voting; and (3) although, it is marked by a certain *formality*, it does not necessitate that this formality may only be derived from the state. This requirement of formality may well be satisfied by non-state law:¹⁶⁰ as is the case with Sharia law, the law of customs, the emerging law of cyberspace¹⁶¹ etc. Regarding assisted dying, a wide range of legal rules or 'formants'¹⁶² are relevant.¹⁶³ These range from not only statutory provisions, case-law and prosecution guidelines, but also to professional disciplinary rules, hospital standards and policy decisions by professional associations and ethics committees.

'**Governance**' is also a social phenomenon. The increasingly prominent notion of governance¹⁶⁴ in contemporary political and social science has, according to Levi-Faur,¹⁶⁵ at least four general conceptualisations: as a structure, as a process, as a mechanism, and

¹⁶⁰ For more on non-state law, see M. Hertogh, 'What is Non-State law? Mapping the Other Hemisphere of the Legal World' in J. van Schooten and J.M. Verschuuren (eds) *International Governance and Law: State Regulation and Non-State Law* (Edward Elgar, 2008).

¹⁶¹ See J.P. Mifsud Bonnici, *Self-Regulation in Cyberspace* (T.M.C. Asser Press, 2008).

¹⁶² See R. Sacco, 'Legal Formants: A Dynamic Approach to Comparative Law' (1991) 39 *The American Journal of Comparative Law* 1-34.

¹⁶³ Also an act of assisted dying may involve a host of legal consequences, stemming from criminal law, constitutional law, contract law, tort law, human rights law, and even (as demonstrated in CHAPTER 8 of this book) EU free movement law.

¹⁶⁴ As a scholarly endeavour, the concept of governance was radically popularized thanks to the growing interest in law and economics in corporate governance in the 1970s. See the seminal publication of O. Williamson, *Transaction Costs Economics: Governance of Contractual Relations* (University of California, 1979). For an insight to the scholarly origin and growth of governance, see D. Levi-Faur, 'From Big Government to Big Governance' in D. Levi-Faur (ed) *The Oxford Handbook of Governance* (Oxford University Press, 2012).

¹⁶⁵ Levi-Faur, *ibid.*

as a strategy.¹⁶⁶ Conceptualised as a 'structure', governance signifies a system of rules,¹⁶⁷ regimes of judicial decisions and administrative practices,¹⁶⁸ or any institutionalised mode of social co-ordination.¹⁶⁹ Studying governance as a structure therefore is not limited to the study of government but may include the study of networks, markets and private standards.¹⁷⁰ Conceptualised as a 'process', governance signifies the on-going steering and co-ordination of institutional capacity in policy making.¹⁷¹ From such perspective, studying the dynamic practice and the exercise of policy making is of particular interest. Conceptualised as a 'mechanism' governance signifies different procedures of decision-making. Here, five main mechanisms of decision making may be identified and subject to study: decision-making *via* monetized exchange, non-monetized exchange, command, persuasion and/or solidarity.¹⁷² Conceptualised as a 'strategy', governance signifies the 'design, creation and adaptation of governance systems.'¹⁷³ A study from this perspective often focuses on the decentralization of power, a shift away from the formal institutions of government towards the creation of more collaborative, informal systems of governance.

The term 'governance' is conceptualized in this study in a way that incorporates certain elements of each of the above meanings.¹⁷⁴ For the purpose of this study, the starting definition of 'governance' is: decision making to steer and co-ordinate activity¹⁷⁵ by formal or informal groups or institutions.¹⁷⁶ Social groups, collective entities and human

¹⁶⁶ T.A. Börzel, *Governance without Government: False Promises or Flawed Premises?* (SFB Governance Working Paper Series, Berlin: Freie Universität Berlin: SFB, 2010); J. Pierre and B.G. Peters, *Governance, Politics and the State* (Basingstoke: Macmillan, 2000); A. Héritier and M. Rhodes (eds) *New Modes of Governance in Europe: Governing in the Shadow of Hierarchy* (Houndmills: Palgrave Macmillan, 2011); B. Jessop, 'Metagovernance' in M. Bevir (ed) *The Sage Handbook of Governance* (Thousand Oaks, CA: Sage, 2011) 106–123; A.M Kjær, *Governance* (Cambridge: Polity, 2004); S. Bartolini, 'New modes of governance: An introduction' in A. Héritier and M. Rhodes (eds) *New Modes of Governance in Europe: Governing in the Shadow of Hierarchy*, (Houndmills: Palgrave Macmillan, 2011) 1–18.

¹⁶⁷ J.N. Rosenau, 'Governance in the twenty-first century' (1995) 1 *Global Governance* 13–43.

¹⁶⁸ L.E. Lynn, C.J. Heinrich, and C.J. Hill, *Improving Governance: A New Logic for Empirical Research* (Washington DC: Georgetown University Press, 2001) 7.

¹⁶⁹ T. Risse, 'Governance in Areas of Limited Statehood' in D. Levi-Faur (ed) *The Oxford Handbook of Governance* (Oxford: OUP, 2012) 699.

¹⁷⁰ Levi-Faur (n 164).

¹⁷¹ See Pierre and Peters (n 166) 14; and J. Kooiman, *Governing as Governance* (London: Sage, 2003)

¹⁷² Levi-Faur (n 164).

¹⁷³ T. Barkay, 'Regulation and voluntarism: A case study of governance in the making' (2009) 3 *Regulation and Governance*, 360–375.

¹⁷⁴ For an overview of these definitions of 'governance', see Levi-Faur (n 164).

¹⁷⁵ See Pierre and Peters (n 166); and Kooiman (n 171).

¹⁷⁶ See J.N. Roseanu, 'Governance in the 21st Century' 1995 (1) *Global Governance* 13-43; M. Zürn, S. Wälti, and H. Enderlein, 'Introduction' in: Zürn, Wälti and Enderlein (eds) *Handbook of Multi-level Governance*

relationships are all subjects of governance.¹⁷⁷ Command and control by public actors in the modern democratic state, namely by government, is only one form of governance. In accordance with Kazancigil's definition, governance is 'policy making with or without politics.'¹⁷⁸ Such a broad understanding of 'governance' may result in the examination of not only the relevant *actors* and *institutional architecture (formal or informal)* in policy and decision-making, but also the nature of the *instruments (formal or informal)* that thereby arise. At the most abstract level, this is what is meant by a 'governance analysis'. The scope of such analysis obviously requires a degree of reductionism and focus. In this study, the focus is narrowed down to *instruments* that only possess the characteristics of 'law' as outlined above. In sum, a "*law and governance analysis*" is: an analysis (be it descriptive, critical and/or prescriptive) of the actors and institutional architecture (formal or informal) in the creation, application and enforcement of formally binding rules.

2.3.2 A LAW AND GOVERNANCE TAXONOMY

Building on the above definitions, it is possible to identify a number of distinct, highly abstract, relations between law and governance. On the whole, these relationships are dependent-variable along a continuum of formal institutions and actors (impositional style) to informal institutions and actors (consensual style). Two forms of relativity are of particular interest here: (i) governance *through* the law and (ii) governance *in* the law.¹⁷⁹ For the purposes of this study, the focus is one particular manifestation of the former: '*public governance through the law*', and one particular manifestation of the latter: '*public-private governance in the law*'.

(Cheltenham: Edward Elgar, 2010) 1-13; T. Risse, 'Governance in Areas of Limited Statehood' in D. Levi-Faur (ed) *The Oxford Handbook of Governance* (Oxford: OUP, 2012).

¹⁷⁷ See A. Colombi Ciacchi and D. von der Pfordten, 'Exploring the Relationship between Law and Governance: a Proposal' in A. Colombi Ciacchi (ed) *Governance Meets Law* (forthcoming 2016).

¹⁷⁸ A. Kazancigil, 'Governance and science: market-like modes of managing society and producing knowledge' (1998) 50 *International Social Science Journal* 69 et seq.

¹⁷⁹ See Colombi Ciacchi and von der Pfordten (n 177), who also identify two further relations - 'Governance as law', which involves decision and policy-making predominately by private actors that results in a type of non-state law. This governance is at the more informal end of the continuum, whereby private actors are solely/mainly responsible for the creation, application and/or enforcement of the law. Examples of this are *lex mercatoria* or the ICANN system of control (management of internet domain names, regional internet registries etc.). And also, 'Governance against the law', which covers societal self-organisation in breach of the law. This mode of governance is entirely informal and has a conflicting relationship with law.

'Public governance *through* the law' is at the more impositional end of the continuum. This means the creation, application and enforcement of the law is predominately in the hands of central political institutions (parliaments, executives and bureaucracies), central political actors (parties and unions), and/or the judicial branch. In this context, the 'through' relation means that law functions as an instrument for public actors to govern society or societal groups. This can manifest itself in various ways on the national or the supra-national level.¹⁸⁰

'Public-private governance in the law' refers to the hybrid interaction between public and private actors in the creation, application and/or enforcement of the law. In this context, the 'in' relation means that hybrid public-private actor decision-making is positively embedded in the law. This mode of governance therefore still necessitate some decision making by central government institutions, political actors or the judicial branch, but in a more 'consensual style'. We are now sliding down the continuum, whereby central formal institutions and actors considerably rely upon informal ones (such as professional experts, stakeholders, NGOs), and vice versa. This can also manifest itself on the national or supra-national level.

¹⁸⁰ Some examples of this at the European Union level: lawmaking via the 'Classic Community Method', the definition of EU monetary policy by the European Central Bank (ECB); or in competition law, where the Commission can conduct investigations, impose sanctions, and take legal recourse to the European Court of Justice (CJEU) against cases of suspected distortions of competition caused by member states and anti-competitive practices of private actors. See P. Craig and G. de Burca, *EU Law: text, Cases and Materials* (Oxford University Press, 2011) 158-180; see also J. Scott and D. Trubek, 'Mind the Gap: Law and Governance in the EU' (2002) 8 *European Law Journal* 1.

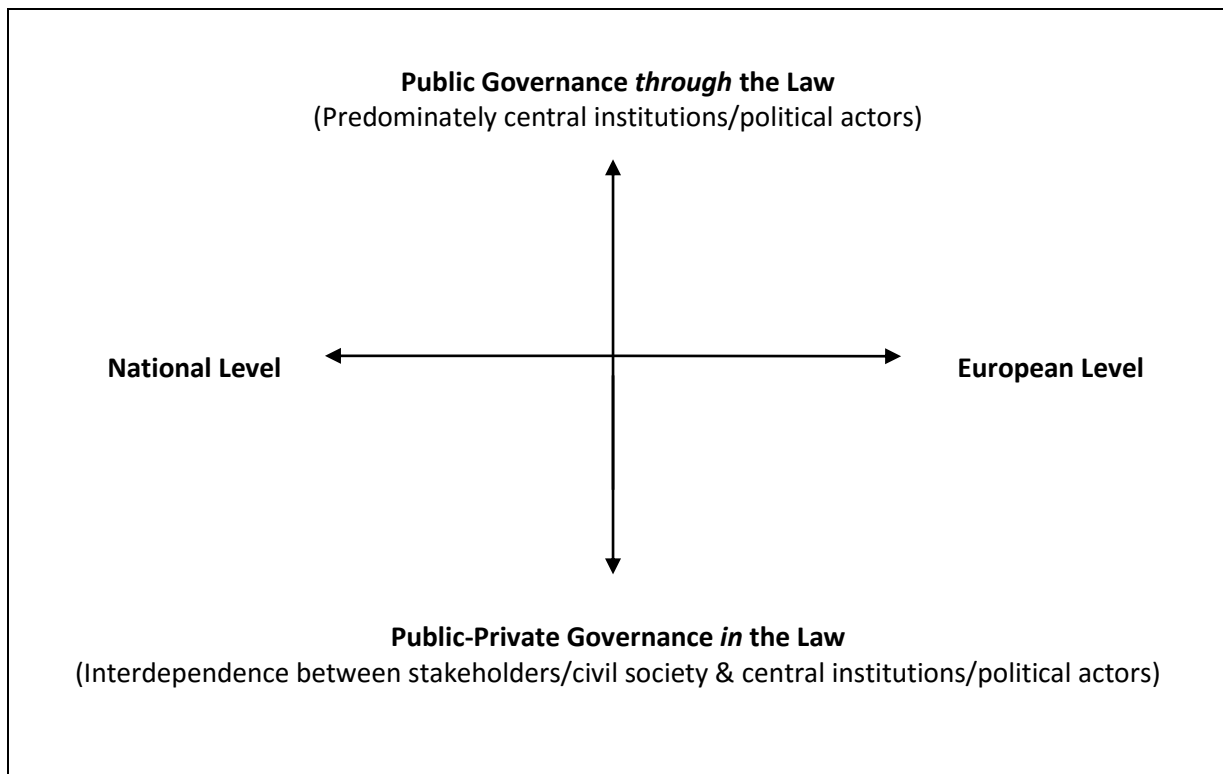


Figure 1.1.

In light of this abstract taxonomy (*Figure 1.1.*), closer attention is now paid to five particular observations that are pertinent to the broader subject matter at hand. Moreover, these observations highlight the value of adopting a *law and governance* analysis (as defined in the preceding sub-section).

(i) The nature of the relationship between law and politics, and thus the broader mode of governance such relationship fits within, is dependent on the ‘policy sector’ that is in question.¹⁸¹ Legal policies concerning sensitive social issues require a strong democratic process to take account of the individual normative preferences within the community.¹⁸² This is a largely uncontroversial statement. On the one hand, strong democratic processes internalize dissent and mediate between different fundamental views of ‘the good life.’¹⁸³

¹⁸¹ Agreement is had here with van Ommeren: ‘The Law and Governance approach works well on the level of policy sectors of the society.’ See F.J. van Ommeren, ‘Governance and the Public-Private Law divide in the Netherlands’ in: A. Colombi Ciacchi *et al.* (eds.), *Law and Governance – Beyond the Public-Private Law Divide* (The Hague: Eleven International, 2013) 19.

¹⁸² See A. Heritier, ‘Elements of democratic legitimation in Europe: an alternative perspective’ (1999) 6 *Journal of European Public Policy* 278.

¹⁸³ For an interesting read on ‘the good life and a good polis’, see K. Inamura, *Justice and Reciprocity in Aristotle’s Political Philosophy* (Cambridge University Press, 2015) 39-62.

Political systems that provide ‘an equal voice for every citizen,’¹⁸⁴ albeit abstracted through the development of political parties,¹⁸⁵ not only justify the legal policy output on sensitive social issues but provide for its constant renegotiation.¹⁸⁶ Thus, the determination of such policies generally demands some type of democratic governance; some type of decision making shaped by a robust political community. On the other hand, the voluntary and coercive authority to ensure compliance and enforcement of these sensitive social policies is also legitimized by the self-authorship of the democratic process.¹⁸⁷ These are, in an ideal sense, the benefits of ‘politicization of the law.’¹⁸⁸ The national political body (the parliament and executive branches of government) legitimizes the creation, application and enforcement of the law. This logic readily applies to the majority of public policy, public health and public safety issues, and explains why governance beyond the state (i.e. beyond a robust political community) on such issues is greeted with a plethora of distrust and caution.¹⁸⁹ The European Union (EU), for example, has an infamously dubious democratic institutional structure¹⁹⁰ and a lack of robust political space which quite often justifies a ‘hands-off’ sentiment over national public policies.¹⁹¹

¹⁸⁴ F. de Witte, ‘Sex, drugs and EU law’ (2013) 50(6) *Common Market Law Review* 1549.

¹⁸⁵ See S. Stjerno, *Solidarity in Europe: the History of an Idea* (Cambridge University Press, 2005) 345.

¹⁸⁶ M. Dani, ‘The partisan constitution and the corrosion of European constitutional culture’ (2013) 68 *LSE ‘Europe in Question’ Discussion Series Paper* 16; See J.T. Checkel, ‘Norms, institutions and national identity in contemporary Europe’ (1999) 43 *International Studies Quarterly* 83.

¹⁸⁷ D. Chalmers, ‘European restatements of sovereignty’, (2013) *LSE Law, Society and Economy Working Papers* 10.

¹⁸⁸ J. Ferejohn, ‘Judicializing Politics, Politicizing Law’, (2002) 65(3) *Law and Contemporary Problems* 41-67. Note that for the purpose of this study, the term ‘politicization’ is not defined merely as ‘a state of controversy in which political parties mobilize support by dramatizing an issue and increasing the stakes of policy decisions’ as defined in I. Engeli and others, *Morality Politics in Western Europe: Parties, Agendas and Policy Choices* (Palgrave Macmillan, 2012) 41. Here, it is understood in a much broader sense. An issue is ‘politicized’ when it is greatly affected or becomes dependent on the influence of democratic political processes. Thus, if the creation or reform of a law on a particular issue is entirely controlled by (or left to the control of) politicians and central government institutions, it is thereby politicized – this is regardless of whether a party mobilizes support for it or not, or regardless of whether it is explicitly on the political agenda or not.

¹⁸⁹ This is why, for example, there exists express Treaty derogations from EU free movement law protecting these sensitive communal issues.

¹⁹⁰ The requirement of a strong democratic process is essential to take account of the citizens’ normative preference regarding controversial public policies. The limited powers and the digressively proportionate composition of the European Parliament, the insulation of the European executive, the absence of genuine European political parties and the absence of a European public sphere are just a few reasons why the EU does not meet this requirement. See F. de Witte, *Justice in the EU – The Emergence of Transnational Solidarity* (Oxford University Press, 2015) 34-39.

¹⁹¹ *Ibid.*

(ii) It may be argued that the ‘politicization of the law’ on sensitive social issues, as just described, also demands the reciprocal ‘constitutive juridification of politics.’¹⁹² Here the law provides formal procedural rules on how to pass or effectuate political acts,¹⁹³ content rules that limit political power and protect individual rights,¹⁹⁴ enhanced judicial governance¹⁹⁵ and institutional rules giving one part of a political system exclusive competence relative to another.¹⁹⁶ Depending on the policy issue and institutional sensitivities at hand, the degree of judicialization (the most obvious type of constitutive juridification)¹⁹⁷ of any given political process may vary.¹⁹⁸ As Schmid states: ‘adjudication [...] is always influenced by the political, economic and social circumstances under which it operates.’¹⁹⁹ This is not necessarily an undesirable influence, instead it is often indispensable in order for the law to keep in touch with social realities. Note in this regard that the judicial arm of the EU - the Court of Justice of the European Union (CJEU) - which provides a unique and often controversial type of *European* judicialization of politics. Here, state politics may be, and often is, drastically curtailed when the market integration project is perceived to be undermined by national policy choices (be it choices based on ‘public policy’ or ‘imperative public interests’). In turn, the CJEU receives a fair

¹⁹² See L.C. Blichner and A. Molander, ‘Mapping Juridification’, *European Law Journal* 14 (2008) 36-54. The concept of ‘juridification’ in general is understood here to include the five dynamics recognised by Magnussen and Banasiak: constitutive juridification, the expansion of law, conflict-solving by reference to law, increased judicial power, and legal framing.’ See A.M. Magnussen and A. Banasiak, ‘Juridification: Disrupting the Relationship between Law and Politics?’, *European Law Journal* 19(3) (2013) 325-339; L.C. Blichner and A. Molander, ‘What is Juridification?’ *ARENA Centre for European Studies*, University of Oslo, Working Paper, No.14, 2005; J. Habermas, *The Theory of Communicative Action* (Vol. 2, Boston: Beacon Press, 1987) 359.

¹⁹³ See F. Michelman, ‘Constitutional Legitimation for Political Acts’, *Modern Law Review* 66(1) (2003) 1-15.

¹⁹⁴ H.S. Aasen, S. Gloppen, A.M. Magnussen, and E. Nilssen, *Juridification and Social Citizenship in the Welfare State* (Edward Elgar, 2014).

¹⁹⁵ See A. Stone Sweet, ‘Judicialization and the Construction of Governance’, in: M. Shapiro and A. Stone Sweet (eds) *On Law, Politics and Judicialization*, (Oxford: Oxford University Press, 2002) 71; C. Neal Tate and T. Vallinder, *The Global Expansion of Judicial Power* (New York: New York University Press, 1995) 2; J.H.H. Weiler, ‘A Quiet Revolution, the European Court of Justice and its Interlocutors’, (1994) 26(4) *Comparative Political Studies* 512; R. Hirschl, *Towards Juristocracy. The Origins and Consequences of the New constitutionalism* (Harvard University Press: Harvard, 2007). See R.H. Fallon Jr., ‘The Core of an Uneasy Case for Judicial Review’, (2008) 121 *Harvard Law Review* 1693-1736.

¹⁹⁶ See Habermas (n 192).

¹⁹⁷ The concept ‘judicialization’ is used here to refer to judicial power in a process of juridification. See Tate and Vallinder, (n 195); Stone Sweet (n 195); J. Nergelius, ‘North and South: Can the Nordic States and the European Continent Find Each Other in the Constitutional Area—or are They too Different?’ in M. Scheinin (ed) *Welfare State and Constitutionalism—Nordic Perspectives* (Nordic Council of Ministers: Copenhagen, 2001).

¹⁹⁸ See R. Hirschl, ‘The Judicialization of Politics’ in G.A. Caldeira, R.D. Kelemen, and K.E. Whittington (eds), *The Oxford Handbook of Law and Politics* (Oxford University Press, 2008).

¹⁹⁹ C.U. Schmid, ‘Judicial Governance in the European Union: the ECJ as a Constitutional and a Private Law Court’, in (eds) E. O. Eriksen, C. Joerges, and F. Rödl *Law, Democracy and Solidarity in a Post-national Union: the Unsettled Order of Europe* (Routledge, 2008) 85-105.

share of attention²⁰⁰ and criticism for not respecting its institutional position *vis à vis* national democratic processes.²⁰¹

(iii) According to certain political scientists, assisted dying, abortion, LGBT rights, embryo research, in-vitro fertilisation, pornography, and gambling fall within a unique class of public policy. They are referred to as ‘morality policies.’²⁰² Such policies may be discernible from other policies (such as economic policies or other social policies) on the grounds that they are shaped by dissent over a polity’s basic values, are hardly susceptible to compromise, are often considered salient and relatively comprehensible, regulation is more often based on general criminal law norms instead of an issue-specific framework, and the debate (political, public or otherwise) tends to be determined more by moralistic/principled argumentation rather than by instrumental rationality.²⁰³ Moreover, political processes in particular have a complex, often unhealthy, relationship with morality policies. This complex relationship manifests itself in a number of ways:

(a) One of the inherent characteristics of morality policies is that they inevitably raise concerns over basic human rights and the determination of individual freedoms. In this sense they provide a breeding ground for judicial activism.²⁰⁴

²⁰⁰ The number of work dedicated to CJEU is too enormous to mention, instead a number of important recent works may be mentioned: M. Adams and others, *Judging Europe’s Judges: The Legitimacy of the Case Law of the European Court of Justice* (Hart, 2013); M. Dawson, B. de Witte and E. Muir, *Judicial Activism and the European Court of Justice* (Edward Elgar, 2013).

²⁰¹ For a defence of European judicial governance interfering with sensitive state politics see, A. McCann, ‘The CJEU on Trial: Social Justice and Economic Mobility’ (2014) 22(5) *European Review of Private Law*, 729-767.

²⁰² See C.Z. Mooney and R.G. Schuldt, ‘Does Morality Policy Exist? Testing a Basic Assumption’ (2008) 36(2) *Policies Studies Journal* 199-218; D.P. Haider-Markel, ‘Morality Policy and Individual-Level Political Behaviour, The Case of Legislative Voting on Lesbian and Gay Issues’ (1999) 27(4) *Policies Studies Journal* 735-749; J.F. Camobreco and M.A. Barnello, ‘Democratic Responsiveness and Policy Shock: The Case of State Abortion Policy’ (2008) 8 *State Politics and Policy Quarterly* 48-65; M.K. Omori, ‘Moral Panics and Morality Policy: The Impact of Media, Political Ideology, Drug Use, and Manufacturing on Methamphetamine Legislation in the United States’, (2013) 43(4) *The Journal of Drug Issues* 517-534; D. Aarons, ‘Between Public Policy and Private Morality: A Bioethical analysis of Abortion and Legislative Reform’, (2012) 61(3) *Social and Economic Studies* 187-198; R.T. Tatalovich, A. Smith, and M.P. Bobic, ‘Moral Conflict and the Policy Process’, (1994) 6 *Policy Currents* 1-7.

²⁰³ M.J. Johnstone, *Alzheimer’s Disease, Media Representations and the Politics of Euthanasia* (Ashgate, 2013) 178; C. Mooney, ‘The politics of morality policy: Symposium editor’s introduction’ (1999) 27(4) *Policy Studies Journal* 675-800; C. Mooney and R. Schuldt, ‘Does morality policy exist? Testing a basic assumption’ (2008) 36(2) *The Policy Studies Journal* 199-217; G. Mucciaroni, ‘Are debates about ‘morality policy’ really about morality? Framing opposition to gay and lesbian rights’ (2011) 39(2) *The Policy Studies Journal* 187-215; B. Norrander and C. Wilcox, ‘Public opinion and policymaking in the States: The case of post-roe abortion policy’ (1999) 27(4) *Policy Studies Journal* 702-22; C. Knill, ‘The Study of Morality Policy: Analytical Implications from a public policy perspective’ (2013) 20(3) *Journal of European Public Policy* 315.

²⁰⁴ ‘Judicial activism’ is understood here as it is described by M. Zamboni: ‘a judicial activity directed at stretching the formal structures and letter of the law (in particular at the constitutional level) in order to fill

However, any judicialization of morality policies depends acutely on the particularities of the political structure and the political culture.²⁰⁵ On the one hand, the polarizing nature of morality policies and the associated ‘high political costs’²⁰⁶ may result in a considerable ‘hands-off’ approach by government and legislative actors. In such cases, policy decisions may be deliberately left by the politicians to the judges.²⁰⁷ On the other hand, morality policies – as generally stated above in regard to sensitive social policies – demand certain benefits of ‘politicization’, i.e. careful mediation and renegotiation through processes more democratic than the courtroom route. In such cases, decisions fixing (or even effecting) the content of morality policies may, by way of cautious judicial deference, be left exclusively for politicians to reach.

(b) Despite the point above, traditional democratic processes may not bring about the necessary legal reform of morality policies. First, elected representatives may not be held to account for gaps between stated policy goals and actual policy results.²⁰⁸ Morality policies cut across the classic left-right party political orientations, which means that if they are not ‘framed’ in a particular way they are likely to be absent from the political agenda.²⁰⁹ As a result, a ‘hands-off’ approach can go unpunished at the polls. Second, and not unrelated to the first point, powerful interest groups (including organized religious institutions) may significantly mitigate the effect of public opinion on morality policies, with political parties positioning themselves to attract the energies of such groups rather than the median voter.²¹⁰

(c) Fundamental challenges arise even if morality policies do appear on the political agenda. Democratic self-authorship may expose (albeit to varying decisive

the gaps left by politicians.’ M. Zamboni, ‘Markers vs. Makers: Are Constitutional Courts Legal or Political Actors?’ in: (eds) S. Comtois and K. de Graaf, *On Judicial and Quasi-Judicial Independence* (Den Haag, Boom Juridische uitgevers, 2013) 71.

²⁰⁵ S. Heichel, C. Knill and S. Schmitt, ‘Public policy meets morality: conceptual and theoretical challenges in the analysis of morality policy change’ (2013) 2(3) *Journal of European Public Policy* 329.

²⁰⁶ *Ibid.*

²⁰⁷ *Ibid.*

²⁰⁸ P. Cowley, *Conscience and Parliament: Moral Issues in British Politics* (Frank Cass, 1998); Heichel, Knill and Schmitt (n 205) 328.

²⁰⁹ *Ibid.*

²¹⁰ See Norrander and Wilcox (n 203).

degrees) the fundamental interests of directly affected individuals to absolutist, ill-informed and/or entirely unaffected factions of the community.²¹¹ Furthermore, political processes intended to mediate between different fundamental views of ‘the good life’ are susceptible to status quo bias.²¹² As a result, the law on certain morality policies is likely to remain obstinate, regardless of its results.

(d) The net consequence of the above (a) to (c), is that national political actors and institutions may sharply turn from the legitimate gate-keepers of morality policies into the legitimate gate-closers of morality policies – avoiding legal reform and side-stepping the need to take a public, formal stance on the issue. This ‘over-politicization’ may undermine both the principled dimension of the law (i.e. the ideal dimension of the law), and the authoritative issuance and social efficacy of the law (i.e. the real dimension of the law). This study presupposes that if the dynamics between law and politics on morality policies results in such disadvantages, a commensurate change in the relationship must be justified

(iv) In order to harness any over-politicization of morality policies (as outlined above), we may take a step back and conceptually situate state politics into a governance framework. In other words, we may consider various modes of creating and enforcing morality policies that are more suitably distanced from the inadequacies of central political institutions and actors. It may well be that more expert involvement reduces the principled nature of the debate (placing more focus on the *means* to achieve the principled aims), and that wider stakeholder involvement reduces the sense of apathy that fosters inaction by political actors and institutions. This is not an ‘anti-political’ stance. Openness to the idea of greater private actor (stakeholder or expert) involvement in decision and policy making on such issues does not mean that representative democracy needs replacing. It merely begs us to focus on what modes of implementing wider participation in the law are available, if any. It is not a task that should be underestimated. This type of ‘de-politicizing’ or, more accurately ‘re-politicizing’, of a morality policy places strains on

²¹¹ I. Engeli, C. Green-Pedersen and L. Thorup Larsen, *Morality Politics in Western Europe: Parties, Agendas and Policy Choices*, (Palgrave, Macmillan, 2012).

²¹² J.M. Nebel, ‘Status Quo Bias, Rationality, and Conservatism about Value’ (2015) 125(2) *Ethics* 449-476; A. Gutmann, D.F. Thompson, *The Spirit of Compromise: Why Governing Demands It and Campaigning Undermines It* (Princeton University Press, 2014). See also C. Knill, and J. Tosun, *Public Policy: A New Introduction* (Palgrave Macmillan, 2012).

fundamental normative demands. The reliance on experts raises questions over input legitimacy, accountability and certainty. Moreover this re-politicization of the law may go too far, which is of particular concern to manifest (life or death) morality policies. It is not inconceivable that civil society, expert or stakeholder involvement may not only counterweight the tyranny of the state, but it may entirely undermine democratic processes and become a type of non-state tyranny in itself.²¹³

(v) A cautious governance perspective that suggests itself is a modified state-centred one²¹⁴ – whereby it is recognised that the state must transform to utilize the capacity of private actors (experts, stakeholders) in the policy process, but the central government institutions and political actors are still considered to play the leading role. In this sense, governance helps to develop a more capable state. Taking a more radical turn, we could think beyond this state-centred focus and adopt a governance perspective that demands a ‘hollowing out of the state’.²¹⁵ From this perspective, central government institutions and political actors have ‘lost their grip’ or should ‘lose their grip’ on the monopoly of pursuing morality policies. The focus here is on the capacity of inter-organizational networks made up of governmental and societal actors with no sovereign actor able to steer. A third, even more radical view (depending on the morality policy at hand), adopts the idea of ‘de-governance’²¹⁶ – whereby not just a hollowing out of the state is required, but also the hollowing out of alternative spheres of authority. This intuitively gains little support in relation to manifest morality policies (i.e. those relating to life or death policies), and is more commonly referred to in business to business type regulation. Levi-Faur, admittedly in the context of EU regulatory regimes and not in regard to morality policies, presents an alternative to these more radical ideas: he labels it as ‘a state centred multi-level governance’ approach.²¹⁷ In light of the abstract concepts and taxonomy presented above, this governance perspective need not be exclusive to EU regulatory regimes, and may also be beneficially applied to national morality policies. Here the state uses private actors to improve its own unique capabilities, expanding to meaningfully

²¹³ M. W. Foley and B. Edwards, ‘The Paradox of Civil Society’, (1996) 1(3) *Journal of Democracy* 38-52.

²¹⁴ See Pierre and Peters (n 166) 12

²¹⁵ M. Bevir, ‘Governance as theory, practice, and dilemma’ in M. Bevir (ed) *The Sage Handbook of Governance* (Thousand Oaks, CA: Sage, 2011) 1-16.

²¹⁶ See Levi-Faur (n 164) 11.

²¹⁷ See D. Levi-Faur ‘The governance of competition: The interplay of technology, economics, and politics in European Union and Telecom Regimes’ (1999) 19 *Journal of Public Policy* 175-207.

incorporate hybrid private and public forms of regulation, *and* is willing to diversify beyond the state to compare standards, best practices, ranking, etc.

Returning to the specific issue at hand, it is clear that assisted dying is a highly polarizing matter. It involves an often uncompromising conflict in the polity's moral values, it is controversial and news-worthy, it is widely salient and susceptible to emotional subjectivity, and public discourse (on both sides of the debate) often focuses on sensationalist media reports over scientific studies.²¹⁸ The majority of Contracting Parties to the Council of Europe have addressed the real dimension of the law on assisted dying in a similar way.²¹⁹ Only four of these nations consider assisted dying *not* to be worthy of a blanket criminal ban.²²⁰ Accordingly it may be expected that in these nations the law on assisted dying is equated with state command-and-control, characterized by the decisive role of central institutions and actors – the government, the legislature, public prosecution services and law enforcement officers. Numerous questions arise, particularly in light of the normative ethical standpoint made in Section 2.2.3 and the complex relationship between politics and morality policies made above, such as: what are the consequences of 'pubic governance through the law' in terms of achieving the objectives of the legal policy on assisted dying? Does it result in a better balancing of individual and communal interests? Would a governance 'shift' to within the state (e.g. civil society, experts, and stakeholders) be a step in the right or wrong direction? Is it unthinkable to accept a governance 'shift' beyond the state on such a controversial issue (such as a shift towards European judicial governance)?

To shed some light on these questions, the proceeding chapters comparatively examine particular law and governance approaches to assisted dying. The focus is on England, France, Switzerland, and the Netherlands, and then beyond the state to consider the Council of Europe (CoE) and the European Union (EU). On the national level , analytical

²¹⁸ For example, the pro-assisted dying movement may look to focus on the particular severities of an individual case, without acknowledging the difficulties in creating a legal policy that covers less clear-cut cases. While the anti-assisted dying movement may look to focus on the failure of the entire legal policy in the Netherlands or Belgium on the basis of highly rare, less clear cut cases.

²¹⁹As the European Court of Human Rights put it: '[...] the vast majority of member States seem to attach more weight to the protection of the individual's life than to his or her right to terminate it.' See *Hass v Switzerland* (App no. 31322/07) ECHR, 20 January 2011, para. 55

²²⁰ In the Benelux nations, VAE and AS are subject to exceptions in the criminal law, and may be lawfully performed. In Switzerland, only AS is subject to an exception in the criminal law, and may be lawfully performed.

and normative insight into the creation, application and enforcement of law on assisted dying is provided for each mentioned state. On the supranational level, analytical and normative attention is paid to the possibilities and limitations of CoE and EU powers in this area.

PART TWO

LAW AND GOVERNANCE ON THE NATIONAL LEVEL

3

THE LAW ‘IN THE BOOKS’

The legal landscape surrounding assisted dying is complex. This section provides a descriptive explanation of the most relevant legal formants (namely criminal laws and disciplinary rules) concerning an act of assisted dying in England, France, Switzerland, and the Netherlands. No normative position is taken at this point in the study.

3.1 ENGLAND

(i) Voluntary Active Euthanasia

VAE has no specific status in English law. It falls under the general criminal offence of murder,¹ a conviction for which carries a mandatory life sentence. To establish liability for murder, it must be proven that the defendant unlawfully killed another person (*actus reus*) with the intention (*mens rea*) to kill that person or to cause that person grievous bodily harm. The former criterion requires evidence of some affirmative action that causes death (as applicable in the definition of VAE).² In regards to the latter criterion, that of ‘intention’, it may be said: if, upon consideration of all the evidence, death is the aim or purpose of the accused’s actions (direct intent) or, if it is a known virtual certainty of the accused’s actions (oblique intent), then it may be inferred that he/she had the

¹ See *R v Inglis* [2011] 1 WLR 1110, para 37, per Lord Judge CJ; see *Airedale NHS Trust v Bland* [1993] AC 789, 885, per Lord Browne-Wilkinson: “the doing of a positive act with the intention of ending life is and remains murder”; See *R (on the application of Nicklinson and another) v Ministry of Justice* [2014] UKSC 38, para 17, per Lord Neuberger: ‘mercy killing involves the perpetrator intentionally killing another person, and therefore, even where that person wished to die, or the killing was purely out of compassion and love, the current state of the law is that the killing will amount to murder or (if one or more of the mitigating circumstances are present) manslaughter.’ In English law, murder is a common law offence but some amendments have been made by way of statutory legislation, most significantly by the Homicide Act 1957.

² It must be noted that there are limited exceptions to this ‘act requirement’ for the offence of murder – an omission of breach of duty that causes death. In short, the *actus reus* for murder may be satisfied if the defendant’s failure to act was in breach of a legal duty to act, if that failure to act was voluntary, and that the victim’s death was caused by this omission to act. See W. Wilson, *Criminal Law* (5th edn, Pearson, 2014).

intention (*mens rea*) to kill.³ Depending on the circumstances, an act of VAE may be considered a form of voluntary manslaughter.⁴ In other words, it may be considered a killing with the intent for murder but where a partial defence applies, such as diminished responsibility. This offence carries a maximum sentence of life imprisonment. In terms of determining guilt or innocence, it is irrelevant if the victim had consented to being killed⁵ and it is irrelevant whether the offender's motives were entirely merciful.⁶ The motives of the accused, however, are relevant in determining the term of the life sentence. In this respect, the Criminal Justice Act 2003 states that it may be a mitigating factor if there was 'a belief by the offender that the murder was an act of mercy.'⁷ For both a charge of murder and manslaughter it is irrelevant that the victim may have been dying or that death was, in any event, imminent. There are no special defences which doctors may rely on for VAE, so they, like all persons, face the same criminal liability under English law.

Regardless of a charge of murder or manslaughter, a physician who performs VAE may face disciplinary charges. In such a case, the General Medical Council (GMC) is the responsible body. The most recent guidance by the GMC on end-of-life care was issued in 2010. It explicitly states that doctors 'must obey the law prohibiting killing ('including euthanasia').⁸ In 2011, the Deputy Chief Executive of the GMC Paul Philip explained to an

³ *R v Nedrick* [1986] 1 WLR 1025; *R v Woollin* [1999] 1 AC 82.

⁴ Note that aside from voluntary manslaughter, there are three forms of 'involuntary manslaughter.' However, for these to apply in a case of VAE would mean that the prosecution cannot prove that the accused had the intention to kill or cause grievous bodily harm. The three forms of involuntary manslaughter are: (i) a killing by conduct that the defendant knew involved a risk of killing or causing serious harm ('reckless manslaughter'); (ii) a killing by conduct that was grossly negligent given the risk of killing ('gross negligent manslaughter'); and (iii) a killing by conduct taking the form of an unlawful act involving a danger of some harm to the person ('unlawful act manslaughter'). See Wilson (n 1).

⁵ *Bland* [1993] AC 789, 890 (Lord Mustill). Otlowski neatly sums up the rationale behind the criminal law prohibition on consent to death: '[T]he common law tradition has always been to uphold life as sacred and inalienable [...] The preservation of life has consequently been accorded priority over the autonomy of the individual and consequently, as a matter of public policy, the consent of the victim has never been recognized as a defence to a criminal homicide.' See M. Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press, Oxford, 1997) 21.

⁶ *Bland* [1993] AC 789, 867 (Lord Goff), 890 (Lord Mustill). This is entirely consistent with general criminal law principles, whereby intention is central to the requirement of *mens rea*. Although there is a certain degree of uncertainty surrounding the determination of intention, it is largely accepted that the leading authority is that set out in *Woollin* (n 3). According to the English Law Commission: "The jury may [...] find that the defendant ("D") intended the result if D thought it would be a certain consequence (barring some extraordinary intervention) of his or her actions, whether he or she desired it or not." See Law Commission, *Murder, Manslaughter and Infanticide*, Law Com, no. 304, Project 6 of the Ninth Programme of Law Reform: Homicide, November 2006.

⁷ Criminal Justice Act 2003, s 269, Sch 21, [11 (f)].

⁸ General Medical Council, *Treatment and Care Towards the End-of-life: Good Practice in Decision-making*, 2010.

independent Commission on Assisted Dying that the GMC's policy position on the matter is simply determined by the law: '[a]ssisted dying is unlawful and therefore we have hitherto not considered or opined in relation to the matter.'⁹ A doctor found guilty by the GMC fitness to practice disciplinary panel¹⁰ may have his or her name removed from the medical register and thus his or her licence to practice removed.

(ii) Assisted Suicide

According to Section 2 of the 1961 Criminal Law (Suicide) Act,¹¹ it is an offence to do an act capable of encouraging or assisting the suicide or attempted suicide of another person. Moreover, it is also an offence if the act was intended to encourage or assist suicide or an attempt at suicide. It is an offence that carries a maximum of 14 years imprisonment. The same Section also states that no proceedings shall be instituted without the consent of the Director of Public Prosecutions (DPP). In other words, once the suspect's actions have been investigated and the evidential stage has been passed (to demonstrate the suspect had intentionally performed an act capable of assisting a suicide), the DPP may consent or decline to prosecute depending on what is in the 'public interest.'¹² To help do so, the DPP has publically issued a 'policy for prosecutors'¹³ to assess in specific cases whether a prosecution may be in the public interest or not.

According to the policy, a prosecution is 'more likely to be required' if:

1. the victim was under 18 years of age;
2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;

⁹ See Commission on Assisted Dying, 'Transcript of evidence from Paul Philip, Deputy Chief Executive and Jane O'Brien, Head of Standards and Ethics, General Medical Council.' Available at: <commissiononassisteddying.co.uk/wp-content/uploads/2011/03/Transcript-of-Oral-Evidence-from-the-GMC.pdf>. Last accessed on 28.01.2016.

¹⁰ The burden of proof in such cases is on the 'balance of probabilities', which is distinctly lower than the criminal law burden of proof: 'beyond all reasonable doubt'.

¹¹ Amended by Section 59 of the Coroners and Justice Act 2010.

¹² This DPP discretion is not unique to the offence of assisted suicide, there are a vast number of offences in English criminal law whereby a prosecution does not follow automatically whenever an offence is believed to have been committed.

¹³ Policy for Prosecution in Respect of Cases of Encouraging or Assisting Suicide issued by the DPP in February 2010, and updated in October 2014, available at: <www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html>. Last accessed on 28.01.2016.

3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
7. the suspect pressured the victim to commit suicide;
8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. the suspect had a history of violence or abuse against the victim;
10. the victim was physically able to undertake the act that constituted the assistance him or herself;
11. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;
12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;
13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
14. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;
15. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

According to the policy, a prosecution is 'less likely to be required' if:

1. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
2. the suspect was wholly motivated by compassion;

3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

The DPP explicitly states that this policy does 'not in any way "decriminalise" the offence of encouraging or assisting suicide.'¹⁴ In other words, nothing in the policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she assists or encourages another's suicide.¹⁵ Moreover, the DPP makes clear in the same policy statement that it remains an offence when the assistance or encouragement is committed in England and Wales but the suicide (or attempted suicide) occurs abroad.

In light of this policy, the Medical Protection Society (the MPS)¹⁶ state that a doctor who produces a medical report for the purpose of being sent to Dignitas 'would be liable for prosecution.'¹⁷ The General Medical Council (the GMC) holds a similar position, stating more generally that 'the fact that the DPP decides not to prosecute because of the application of the public interest test [...] does not make it lawful and if a doctor commits a crime we would need to look at that as a breach of our guidance.'¹⁸ This may mean the doctor in question would face an investigation under the GMC's fitness to practice procedures and ultimately face the GMC disciplinary panel. However, according to the MPS: 'the request for medical records is different.'¹⁹ Doctors have a duty to disclose the patient's medical records upon request in accordance with the Data Protection Act,

¹⁴ Ibid, para 6.

¹⁵ Ibid.

¹⁶ A non-profit organisation that provides in-house legal and ethical advice to medical professionals.

¹⁷ See the Commission on Assisted Dying, Oral evidence from Dr Field on behalf of the Medical Protection Society. Available at: <www.commissiononassisteddying.co.uk/read-evidence>. Last accessed on 28.01.2016.

¹⁸ See the Commission on Assisted Dying, Oral evidence, oral evidence from Paul Phillip and Jane O'Brien, General Medical Council. Available at: <www.commissiononassisteddying.co.uk/read-evidence>. Last accessed on 28.01.2016.

¹⁹ In order for any patient to be able to avail of assisted suicide in Dignitas (Switzerland), it is required that the Swiss doctors have access to the patient's medical records.

'regardless of the fact that they know how these records are going to be used.' The GMC was unwilling to make a stance on this issue, stating that a subject access request under the Data Protection Act 'is not a matter of good practice, or professional conduct.'

3.2 FRANCE²⁰

(i) Voluntary Active Euthanasia

VAE is not a specific offence in French law. It may be considered either a general act of voluntary homicide (*meurtre*)²¹ or a specific act of poisoning,²² which both carry a maximum sentence of 30 years imprisonment. To establish liability for the former, it must be proven that the defendant killed the victim by means of a positive act (*actus reus*)²³ and in doing so, possessed the requisite specific intention (*dol spécial*) to kill.²⁴ To establish liability for the latter, there is no need for the victim to have actually been killed (the offence is committed on the administration of the poison) and it may not be necessary that the accused had the special intention to cause any harm by administering the poison, but simply had a general intention to engage in the wrongful conduct (i.e. to administer the poison).

Neither French statute nor case-law provide any definitive definition of intention (general or special), thus one must turn to authoritative French legal writing (*la doctrine*). It is said

²⁰ For recent French literature on this specific topic and end of life issues in general, see N. Chaplain, B. Beignier and P. Letellier, *L'euthanasie* (University Presses de France: PUF, 2012); F. Galichet, *Mourir Délibéré? Pour une sortie réfléchie de la vie* (Presses Universitaires de Strasbourg, 2014); F. Violla and others, 'Affair Vincent L.: les maux de la fin', *Médecine & Droit* (October, 2014); J.C. Fondras, 'La sédation au stade terminal dans le débat français: analyse et mise au point' (2014) 13(2) *Médecine Palliative Soins de Support - Accompagnement - Ethique* 97-103; R. Karplus, 'Euthanasie: réflexions d'un médecin', (2014) 136(4) *Nouvelle Revue Théologique* 596-605. C. Borella and X. Ducrocq, 'Le droit de choisir sa mort: ultime liberté? Regard philosophique sur les enjeux actuels liés à la fin de vie', *Médecine Palliative Soins de Support - Accompagnement - Ethique* (October, 2014); L. Boissinot and others, 'Euthanasie et/ou suicide médicalement assisté: réflexion sur la nouvelle responsabilité du pharmacien hospitalier', (2014) 72(2) *Annales Pharmaceutiques Françaises* 82-89; A. Attias and others, 'Comment le débat sur la fin de vie et l'euthanasie est-il traité par la presse française?' (2013) 32(1) *Annales françaises d'anesthésie et de réanimation*; B. Ekanga, *À propos du suicide assisté et de l'euthanasie aujourd'hui* (Bloomington, 2013).

²¹ Art. 221-1, *Code Pénal* [Penal Code]. Available to read in full at: <www.legifrance.gouv.fr/affichCode.do?cidTexte=LEGITEXT000006070719>. For an English translation, see: <www.legifrance.gouv.fr/Traductions/en-English/Legifrance-translations>.

²² Art. 221-5, *Code Pénal*.

²³ See 'Deuxième partie: l'infraction; Section 1: L'élément matériel' in X. Pin, *Droit pénal général 2016* (7th edn, Dalloz, 2015).

²⁴ See C. Elliot, *Fench Criminal Law* (UK Willian Publishing, 2001) 64; M.E. Badar, *The Concept of Mens Rea in International Criminal Law* (Hart, 2013) 160; J.R. Spencer, 'Intentional Killings in French Law' in: (ed) J. Horder, *Homicide Law in a Comparative Perspective* (Hart, 2007) 43.

by certain scholars on French law, that in order to possess the special intention required for the crime of murder, the accused must have either desired to cause death or have been aware that his/her voluntary act will - certainly or almost certainly - cause death, even if it that result was not truly desired.²⁵ As concerns an act of VAE, if a person administers a lethal dose with the intention of terminating the life of another, or performs such an act aware that it will 'almost certainly' terminate the life of another (a result forbidden by the law), it will amount to *meurtre* under the French penal code. It is irrelevant in finding guilt whether an act of killing was upon the deceased's voluntary request, and if the distinction between *dol général* and *dol spécial* is as redundant as a number of scholars argue, then it is equally irrelevant if it was motivated by a sense of benevolence.²⁶

A doctor who performs VAE in France may not only face criminal charges but may also face disciplinary charges. The French National Medical Council (*Conseil de l'Ordre des medecines en France*, hereafter 'CNOM') is responsible for drafting and ensuring compliance with the mandatory principles and rules of medical practice. These principles and rules are set out in the French Medical Code of Ethics (*Code de deontologie medicale* – hereafter 'CSP').²⁷ Article 38 of said code states that a doctor 'has no right to deliberately bring about a patient's death.'²⁸ In their formal explanatory notes,²⁹ the CNOM justify this

²⁵ See Spencer (n 24). See also J. Pradel, *Manuel de Droit pénal général* (14th edn 2002) 502, which reads: 'the agent knows that his voluntary act will cause (certainly or almost certainly) a consequence that is not truly desired. Our case-law, without saying so expressly, accepts this notion and assimilates *dol indirect* and *dol direct*; so a murder may exist by reason of the knowledge that the blows could result in death (*peuvent donner la mort*) as well as in the desire to produce the precise result, which is the extinction of a life.' See for a more recent confirmation of this viewpoint, Pin (n 23): '[a]insi dans le meurtre l'animus necandi (*dol special*) est inherent a intention de ne pas respecter l'interdit du meurtre (*dol general*): les deux notions se confondent donc.'

²⁶ There is no provision for the defence of consent in the French penal code. Elliot explains that the reasoning for this 'is that generally criminal sanctions are not imposed purely in the interests of a single victim, but in the interests of society as a whole, and therefore it is not in the hands of one individual to permit the commission of such criminal conduct.' See Elliot (n 25) 127. As for motive: "[o]nce the will to engage in the criminal conduct is established, it is irrelevant to deduce motives that were driving the person's conduct. French criminal law reiterates the irrelevance of motive for the qualification of criminal conduct." I. Marchuk, *The Fundamental Concept of Crime in International Criminal Law – A Comparative Law Analysis* (Springer, 2014).

²⁷ The latest edition of the French Code of Medical Ethics (the CPS) is from November 2012 and is available at: <www.conseil-national.medecin.fr/sites/default/files/codedeont.pdf>. Last accessed on 28.01.2016. Note that the CPS is an integral part of the French Public Health Code (*Code de la Santé Publique*). The provisions of the CPS are mandatory for all doctors on the medical register who perform a medical procedure pursuant to Article L. 4112-7 of the French Code of Public Health.

²⁸ 'N'a pas le droit de provoquer délibérément la mort.'

²⁹ These notes can, according to the Preface of the CSP, be considered an integral part of the code but 'are not legally binding rules. These can only be adopted in the course of disciplinary proceedings and their legality is subject to legal review by the French Council of state.'

stance by claiming the European Convention of Human Rights ‘formally condemns’ VAE and that the Council of Europe in Recommendation 1418 recommends upholding the total prohibition of VAE.³⁰ Also at the end of the code, the modern form of the Hippocratic Oath is pronounced. Of particular relevance here are the following sentences: ‘I shall do everything in my power to alleviate suffering. I shall not prolong life out of obstinacy. I shall never deliberately bring about death.’ In a suspected case of VAE, a number of bodies (the Departmental Councils of the CNOM, The Minister of Health, The Departmental Director of Health, the public prosecutor, doctors’ associations, and/or an individual doctor) may submit a complaint to the CNOM’s disciplinary chambers of first instance.³¹ The possible sanctions range from a warning, to censure, to temporary or permanent suspension from a public medical post, to temporary or permanent suspension or erasure from the Register. Appeals may be heard to the disciplinary section of the National Council of the CNOM and then finally to the *Conseil d’Etat*.

(ii) Assisted Suicide

As suicide is not a criminal offence under French law,³² a person (doctor or otherwise) who is complicit or assists in a suicide cannot be criminally liable as an accomplice to a crime. However, it is a crime if a person incites another to commit suicide under Article 223-13 of the Criminal Code. It carries a maximum sentence of three years’ imprisonment and a fine of up to 45,000 euro. This offence was added to the Criminal code in 1987 as an immediate response to the re-issuing of a popular book that gave instructions on how to successfully commit suicide, entitled: *Suicide, mode d’emploi*. It is an offence that operates in the context of media and publications as opposed to direct personal assistance with suicide.³³ Assisted suicide may also be framed as a criminal offence on the ground of a ‘duty to rescue’.³⁴ This offence only applies in the case of imminent danger (*peril imminent*) and is subject to the discretion of the public prosecutor. Legal literature, largely

³⁰ For a critical look at this Council of Europe Recommendation, see Sections 7.3.2. and 7.3.3, in CHAPTER SEVEN of this study.

³¹ This chamber sits in the Regional Council and has 9 regular members and an equal number of substitutes elected by the Departmental Council of the CNOM. There are also a number of advisors such as a legal expert, the local Director of Public Health, A Professor of Medicine, a medical officer from the national health care insurance system (Sécurité social), and a representative of the salaried doctors.

³² Suicide has ceased to be a crime in France since the Revolution in 1799.

³³ See C. Jacquinot, ‘Application de la loi sur l’incitation au suicide [Application of the Law on Inciting Suicide]’ *La Gazette du Palais*, 2 October 1995, 954; S. Hennette-Vauchez, ‘France’ in J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008) 386.

³⁴ Art. 223-6, *Code Pénal*.

in light of a 1973 *Cour de Cassation* decision,³⁵ deems that a clear refusal to avail of (medical) assistance in a case of attempted suicide will absolve the would-be assister from her liability for failing to rescue.³⁶

Moving away from criminal liability, if a suicide involves only the prescription of drugs and not the presence of the doctor at the moment the drugs are actually administered, the only other sanction under French law would be disciplinary.³⁷ Article 40 of the CSP (*Code de deontologie medicale*) states: 'a doctor must refrain from imposing on his patient any unjustified risk.' Pending disciplinary proceeding before the relevant CNOM disciplinary chambers, a doctor who assists in a patient's suicide may face a warning, censure, temporary or permanent suspension from a public medical post, or erasure from the Register.

3.3 SWITZERLAND³⁸

(i) Voluntary Active Euthanasia

VAE is a specific crime under Article 114 of the Swiss Penal Code.³⁹ It is recognised as compassionate 'killing on request' (*Tötung auf Verlangen*) and is treated as a less reprehensible form of intentional killing. The maximum sentence is three years

³⁵ Cour de Cassation, chambre criminelle, 3 January 1973, available at: <<http://www.legifrance.gouv.fr/WAspad/Visu?cid=86820&indice=1&table=CASS&ligneDeb=1>>

³⁶ See S. Henneute-Vauche (n 33).

³⁷ Art. 40, *Code de la santé publique*. See also Henneute-Vauche, *ibid*.

³⁸ For recent Swiss literature on this specific topic and end of life issues in general, see G. Bosshard, 'Sterbehilfe' in C. Knipping and others (eds) *Lehrbuch Palliative Care* (Hans Huber Verlag: Bern, 2014); B. Kiefer, 'Euthanasie et autres dérangeantes questions' (2014) 10(418) *Revue médicale suisse* 464; A. Lüthie, *Lebensverkürzung im medizinischen Kontext. Behandlungsbegrenzungen und Leidenslinderung: Ein strafrechtlicher Regelungsvorschlag* (Zurich: Schulthess Juristische Medien, 2014); C. Schwarzenegger and others, 'Attitudes towards euthanasia and assisted suicide in Switzerland: results of a national study' in A. Kuhn and others (eds), *Kriminologie, Kriminalpolitik und Strafrecht aus internationaler Perspektive, Festschrift für Martin Killias zum 65* (Bern: Stämpfli, 2013). See for less recent, but nonetheless important literature regarding Swiss law on assisted dying: S. J. Ziegler, 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process', (2009) 37(2) *Journal of Law, Medicine and Ethics* 318-330; G. Bosshard, S. Fischer, and W. Bär, 'Open Regulation and Practice in Assisted Dying', (2002) 132(37-38) *Swiss Medical Weekly* 527-534; S. A. Hurst and A. Mauron, 'Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians', (2003) 326(7383) *BMJ* 271-273; S.J. Ziegler and G. Bosshard, 'Role of Non-governmental Organisations in Physician Assisted Suicide' (2007) 334(7588) *BMJ* 295-298; G. Bosshard, E. Ulrich, and W. Bär, '748 Cases of Suicide Assisted by a Swiss 'Right-to-Die' Organization' (2003) 133(21-22) *Swiss Medical Weekly* 310-317.

³⁹ Art. 114 *Strafgesetzbuch* [Penal Code]. Available in English at <www.admin.ch/ch/e/rs/311_0/>. Last accessed 28.01.2016.

imprisonment. This lesser crime of killing on request is thereby distinguished in the Swiss criminal code from other forms of intentional killing, such as: murder (*Mord*);⁴⁰ manslaughter (*Totschlag*);⁴¹ inciting and assisting another persons suicide (*Verleitung und Beihilfe zum Selbstmord*),⁴² and the residual form of intentional killing (*Vorsätzliche Tötung*).⁴³

Aside from criminal charges, a doctor who performs VAE may also face disciplinary charges. The professional medical-ethics guidelines explicitly state that VAE is a crime and ‘even if seriously requested, the killing of a patient must be refused by the physician.’⁴⁴ These guidelines are drafted by the Swiss Academy of Medical Science (*Académie Suisse des Sciences Médicales* – hereafter ‘SAMS’)⁴⁵ and are incorporated in the Code of the Swiss Medical Association (*Fédération des médecins suisses* – hereafter ‘FMH’).⁴⁶ These guidelines are binding not only for FMH members but also for all medical practitioners in Switzerland. The observance of these guidelines and regulations is supervised by the professional commissions of the cantonal medical associations as well as the by the Association of Swiss Assistant and Senior Physicians (*Association suisse de médecine-assistant(e)s et chef(fe)s de clinique - VSAO*).⁴⁷ A doctor found guilty of performing VAE may face a range of sanctions,⁴⁸ from reprimands to penalties to exclusion from the FMH to notification of the cantonal public authorities.

(ii) Assisted Suicide

According to Article 115 of the Penal Code, any assistance in another person’s suicide is punishable only if the assistor had ‘selfish’ motives. If the assistor did act out of selfish

⁴⁰ Art 112 *Strafgesetzbuch* [Penal Code]. This offence requires that the motive, method or the circumstances of the act are particularly shocking.

⁴¹ Article 113 *Strafgesetzbuch* [Penal Code]. This offence requires that there is evidence of extreme (and excusable) emotions or conditions, or the accused was in a state of profound mental confusion.

⁴² Article 115 *Strafgesetzbuch* [Penal Code]. This offence is dealt with under the next heading.

⁴³ Article 111 *Strafgesetzbuch* [Penal Code]. This provision applies should no aggravated or mitigated form of intentional killing otherwise apply.

⁴⁴ Swiss Academy of Medical Science, *Medical Ethical Guidelines: End-of-life care* (2013) 9. All the medical-ethical guidelines issued by the SAMS are available online: <www.samw.ch>. Last accessed 28.01.2016.

⁴⁵ Within this organisation, the Central Ethics Committee (the ‘CEC’) is specifically responsible for drafting up the ethical guidelines.

⁴⁶ Article 17 *Standesordnung der FMH* [Code of Professional Conduct of the FMH]. For an overview of professional codes of conduct for Swiss physicians, see: A. Buchler and T. Gachter, *Medical Law in Switzerland* (Kluwer Law International, 2011) 81.

⁴⁷ *Ibid.*, 82.

⁴⁸ Listed in Article 47 *Standesordnung der FMH* [Code of Professional Conduct of the FMH].

motives, he or she may face up to 5 years imprisonment. Thus, in order to be lawful, it is not necessary that the assistor is a doctor or that there is a medical precondition, he or she must merely have acted without any self-interest and the person who commits suicide must have had decisional capacity. There is also no stipulation in the Penal Code that in order for AS not to be a criminal offence, the recipient of the assistance may only be a Swiss national or resident.

Any involvement of a doctor in terms of prescribing a lethal drug for the purpose of suicide is further subject to Section 11 of the Narcotics Law,⁴⁹ and thus to established rules of medical practice. Under these rules, it is necessary for doctors to examine the patient personally before writing such a prescription. The professional ethics guidelines set out by the SAMS state that a doctor's decision to provide AS 'must be respected'.⁵⁰ The medic must check for a number of preconditions: namely, that the patient is nearing the end of life; alternative possibilities have been discussed and offered; the patient has full capacity; and the final action leading to death is taken by the patient him/herself. A number of court decisions (from Cantonal Administrative Courts to the Swiss Federal Supreme Court)⁵¹ have played a role in refining the role of doctors in performing AS by stipulating a number of requisite conditions, such as: the doctor has an obligation to ascertain the patient's competence to make such a decision, is required to examine the patient in person, and must identify 'a condition [that is] indisputably leading to death.' The Federal Supreme Court have also stipulated that a patient suffering with an incurable, permanent and serious mental health disorder may also qualify for assisted suicide, subject to a report by an expert in psychiatry that that the patient's judgment is still rational.⁵²

There are four 'right to die'⁵³ organizations (RTDs) that provide assisted suicide in Switzerland: (i) *Exit Deutsche Schweiz*, the German Swiss Exit Association founded in Zurich in 1982; (ii) *Exit Association pour le Droit de Mourir dans la Dignité (Exit ADMD)*,

⁴⁹ *Betäubungsmittelgesetz* [Narcotics Law], *BetmG*, SR 812.121.

⁵⁰ Swiss Academy of Medical Sciences, *Medical Ethical Guidelines: End-of-life care* (2013) 9.

⁵¹ See for some examples: Federal Court, 11 June 2009, Decision 6B_48/2009. *Verwaltungsgericht des Kantons Zürich* [Zurich Administrative Court], *Entscheid der 3. Kammer VB Nr 99.00145*, 1999; and *Verwaltungsgericht des Kantons Aargau* [Aargau Administrative Court], *Entscheid BE 2003.00354-K3*, 2005.

⁵² *Schweizerisches Bundesgericht* [Federal Supreme Court of Switzerland], *Entscheid 2A.4812006*, 2006.

⁵³ These are non-profit organisations consisting of volunteers who are mostly clergymen, social workers or nurses. See S. Ziegler and G. Bosshard, 'Role of Non-governmental Organisations in Physician Assisted Suicide' (2007) 334(7588) *BMJ* 295-298.

the French Swiss Exit Association founded in Geneva in 1982; (iii) *Dignitas*, a splinter group of *Exit Deutsche Schweiz*, founded in Zurich in 1998; and (iv) *Exit International*, which is also a splinter group of *Exit Deutsche Schweiz* founded in 1997 in Bern. There are no specific federal rules concerning the practices of RTDs. Instead, each is subject to their own 'internal guidelines'. *Exit Deutsche Schweiz* and *Exit ADMD* require a person seeking assistance to be permanently resident in Switzerland or to have Swiss citizenship. *Dignitas* and *Exit International* offer assistance to persons not resident and persons without Swiss citizenship. All four RTDs place greater conditions – often referred to as 'self-imposed restrictions' – than those set out in Art.115 of the Swiss Penal Code. The person seeking assistance must be terminally ill, suffering from a disease with hopeless prognoses, with unbearable symptoms, or with unacceptable disabilities.⁵⁴ A number of procedural steps/due diligence rules must be satisfied according to the RTDs internal guidelines – such as the submission of medical diagnosis, the carrying out of a personal interview, discussion about alternatives, information on the role of the assistant in preparing the drug, a notification sent to local police services, and the carrying out of an *ex post* 'legal inspection'.⁵⁵

There is also no federal or cantonal rule specifically dealing with the provision of AS in hospitals or nursing homes. In such case, recourse is had to their own criteria. Not all hospitals and nursing homes permit AS. Most hospitals in the French speaking region do allow *Exit ADMD* to provide assistance to their residents.⁵⁶ Some permit right to die societies on to the premises only for those who are terminally ill and unable to travel (*Lausanne University Hospital* and *Geneva University Hospital*). A number of hospitals in German speaking Switzerland have adopted a 'neutral' approach (like in *Zurich Cantonal University Hospital*), whereby no medic of the hospital should provide assistance in suicide, but the patient may seek it elsewhere and, if necessary, be transported in order to receive the assistance.

⁵⁴ See the conditions as set out by *Dignitas* (available at: <www.dignitas.ch/index.php?option=com_content&view=article&id=20&Itemid=60&lang=en>), by *Exit Deutsche* (available at: <www.exit.ch/freitodbegleitung/bedingungen/>), and by *Exit ADMD* (available at: <www.exit-geneve.ch/conditions.htm>). Last accessed 28.01.2016.

⁵⁵ *Ibid.* See also Ziegler (n 38).

⁵⁶ G. Lewy, *Assisted Death in Europe and America: Four Regimes and their Lessons* (Oxford University Press, 2011) 104.

3.4 THE NETHERLANDS⁵⁷

(i) Voluntary Active Euthanasia and Assisted Suicide

In April 2002, the Termination of Life on Request and Assisted Suicide Act (hereafter referred to as the '2002 Act' or 'the *Wtl*') came into effect.⁵⁸ This allows a physician to perform voluntary active euthanasia (VAE) and assisted suicide (AS), provided he or she complies with the statutory due care criteria and notifies the municipal coroner. Thus, VAE and AS remain criminal offences⁵⁹ if carried out by any person other than a physician, or if carried out by a physician but not in accordance with the substantive and procedural conditions laid down in the 2002 Act. These conditions stipulate that in order for an act of VAE or AS to be lawfully performed:⁶⁰

- the physician must be convinced that the patient's request is 'voluntary and carefully considered'⁶¹
- the physician must be convinced that the patient's suffering is 'unbearable' and with 'no prospect of improvement'⁶²
- the physician must inform the patient concerning his situation and his prospects
- the physician and the patient must be convinced that there is no reasonable alternative in light of the patient's situation
- the physician must consult at least one other independent physician, who must see the patient and give a written opinion on the due care criteria [i.e. the preceding four items]
- in terminating the patient's life or providing assistance with the patient's suicide, the physician must act in accordance with medical due care and attention

⁵⁷ For relatively recent Dutch scholarly work on the issue of assisted dying, see: J. Legemaate and I. Bolt, 'The Dutch Euthanasia Act: Recent Legal Developments' (2013) 20 *European Journal of Health Law* 451-470; S.T. Youngner and G.K. Kimsma, *Physician Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012); S. van de Vathorst, 'Euthanasie' (2014) 158 (16) *Nederlands Tijdschrift Voor Geneeskunde* 732; G. den Hartogh, 'De definitie van euthanasie in het onderzoek naar medische beslissingen bij het levenseinde' (2013) 88(13) *Nederlandsch juristenblad: weekblad behorende bij de Nederlandsche jurisprudentie*, 798.

⁵⁸ *Wet Toetsing Levensbeeindiging op verzoek en hulp bij zelfdoding (Wtl)* [the Termination of Life on Request and Assisted Suicide (Review Procedures) Act].

⁵⁹ Under Article 293 and 294 of *Wetboek van Strafrecht, Sr.* [Penal Code], respectively.

⁶⁰ See Sec. 2(1) *Wet Toetsing Levensbeeindiging op verzoek en hulp bij zelfdoding (Wtl)* [the Termination of Life on Request and Assisted Suicide (Review Procedures) Act].

⁶¹ In Dutch: 'vrijwillig en weloverwogen verzoek'.

⁶² In Dutch: 'uitzichtloos en ondraaijlijk lijden van de patient'.

Furthermore, the physician must report the case to the municipal coroner, whereby the report is passed on to one of the five Regional Review Committees (RRCs) for assessment of compliance. It is important to note from the outset that no physician is ever obligated to grant a request for VAE or AS. In case the physician should refrain, he/she can refer a patient to a colleague. However, there is no duty to directly refer to another physician who is willing to comply with the request.

The open nature of the norms laid out in the 2002 Act is quite clear. The statutory void is filled in by a combination of legal formants: judicial decisions, professional medical guidelines and the RRC's '2015 Code of practice' and 'jurisprudence' – i.e. annual reports on the number of assisted dying cases, an overview of their characteristics and a detailed (but anonymous) account of particularly complex cases. These formants play the leading role in reducing the gap between practice, diverse situations and what is permitted within the exception to the criminal law. A number of the crucial substantive and procedural conditions, listed above, will now be discussed in turn (highlighted in bold for distinction purposes).

Concerning the due diligence of the **'voluntary and carefully considered request'**, the RRC code of practice⁶³ and case-law⁶⁴ distinguish a number of requisite aspects. The voluntary nature of the request must consist of: (i) the 'internal' aspect, where the patient is mentally competent; this means the patient must be able to understand the relevant information about his or her situation and prognosis, to weigh the possible alternatives, and to realise the consequences. The RRC further stated that competence 'is not an all or nothing' concept. A patient may, simultaneously, be mentally competent for one decision (for example, a request for VAE or AS), and not mentally competent for others (such as managing finances).⁶⁵ The voluntary nature of the request must also consist of (ii) the 'external' aspect, where there is an absence of pressure or unacceptable influence from others. In principle, the doctor must speak privately with the patient about his/her decision. The well-considered nature of the request means that the patient has clear

⁶³ RRC, *Code of Practice (2015)* 11.

⁶⁴ See A. van der Heide and others., *'Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Second Evaluation: Termination of Life on Request and Assisted Suicide]' (The Hague: ZonMw, December 2012) 42.

⁶⁵ RRC (n 63) 12.

insight into his or her illness and the decision is based on full information.⁶⁶ Caution is required if the patient expresses doubt and it is crucial in this respect that the request is a consistent one. In all circumstances, the request must be a voluntary and well-informed one. Aside from this specific due care requirement, a physician must comply with the more general requirement for 'informed consent' in the Law on Contracts for Medical Treatment (WGBO).⁶⁷ The patient's request is not required to be in writing according to the 2002 Act,⁶⁸ and a verbal request may suffice. However various official reports by the RRC⁶⁹ and the Royal Dutch Medical Association (KNMG)⁷⁰ state a preference for the request to be recorded in written form.

The 2002 Act also allows for an **advanced written directive/request** (*wilsverklaring*) for VAE.⁷¹ This means a physician may carry out a patient's request for VAE where the latter is no longer capable of expressing his/her wishes, provided these wishes were written down in an advance directive at a time when the patient was still decisionally competent.⁷² The KNMG recently described this in an official position paper as the most 'controversial' element of the 2002 Act and 'problematic in practice.'⁷³ According to the 2012 RRC Annual Reports an advanced directive may apply in the following circumstances: (i) if the patient is in a reduced state of consciousness⁷⁴ or is in a reversible

⁶⁶ Ibid.

⁶⁷ *Wet Geneeskundige Behandelings Overeenkoms* [The Law on Contracts for Medical Care]. Which is included in the Civil Code as Title 7, Arts 446-8.

⁶⁸ See the RRC, *Annual Report 2012*, 12.

⁶⁹ For example: see *ibid.* See also, the RRC, *Annual Report 2009*, 10.

⁷⁰ For example: see KNMG, '*Standpunt federatiebestuur KNMG inzake euthanasie 2003* [Position of the Federal Board of the NMG concerning Euthanasia 2003], (Utrecht, 2003), the authority of which was re-affirmed more recently in KNMG, 'The role of the physician in the voluntary termination of life: KNMG position paper' (Utrecht, 2011). See also in respect of the written request: KNMG, '*Tijdig spreken over het levenseinde* [Timely talk about the end of life] (2012) 13.

⁷¹ This is conditional upon proof that the patient was aged sixteen or over when he drew up the declaration and was still mentally competent in doing so. See Section 2(2) of the *Wtl.*

⁷² See Section 2(2) *Wtl.* See RRC, *Annual Report 2009*: Case 4, 5, and 6

⁷³ KNMG, '*Standpunt Federatiebestuur KNMG inzake euthanasie (2003) met nadere uitleg (2012)*' ('Federation Board of the KNMG position on euthanasia (2003) with explanations (2012)').

⁷⁴ See the specific professional guidelines in such cases: KNMG, '*Richtlijn euthanasie bij een verlaagd bewustzijn* [Euthanasia directive in cases of reduced consciousness] (2010, Utrecht). This Guideline deals specifically with the situation where, after the attending physician has consulted an independent physician and is ready to carry out VAE, the patient – spontaneously or unintentionally, as a result of medication to reduce pain or dyspnea – falls into a state of reduced consciousness. According to the Guideline, the physician may proceed with the VAE if the patient is still suffering unbearably. This is determined using the Glasgow Coma Scale (GCS). The Guideline also allows the physician to proceed if the patient unintentionally falls into a coma resulting from the administration of medication to alleviate pain or dyspnea. While such a coma is in principle reversible, it is understood as inhumane to wake the patient simply so that he can confirm he is again, or still, suffering unbearably. In these situations set out in the Guideline, the physician may proceed with the euthanasia without again consulting an independent physician. Although the patient

coma, but has clear written instructions⁷⁵ and can still perceive his or her suffering as unbearable;⁷⁶ or (ii) if the patient has clear written instructions and later becomes incapable of expressing his will or is decisionally incompetent.⁷⁷

In cases whereby the patient has dementia or psychiatric problems, the RRC and the KNMG have recommended extra caution and stressed the importance of obtaining reports from more than one expert, particularly if there is any doubt surrounding the nature of the request *vis à vis* the advanced directive.⁷⁸ In cases where the patient cannot communicate, the physician must be convinced ‘in the light of the situation described in the patient’s advance directive and the current situation – and having regard to the entire process that the physician has gone through with the patient,’⁷⁹ that the patient still wishes for his life to be terminated. As for the independent consultant, who may not have seen the patient make the request in person, he or she must determine the nature of the request ‘based on information provided by the attending physician, the medical records, an advance directive, the patient’s behaviour and expressions of his wishes since the directive was written, and statements by others, such as the patient’s family.’⁸⁰

A voluntary and well considered request for assisted dying may be made by a **mentally competent patient who is a minor**. Here the same age requirements for informed consent in the Law on Contracts for Medical Treatment (WGBO) apply.⁸¹ For patients aged between twelve and sixteen, the consent of the parent(s) and/or the legal guardian is required.⁸² For those aged seventeen or eighteen, the parent(s) and/or guardian must be involved in the decision process.⁸³ In these cases, the KNMG have explicitly stressed the need for great care in the consideration of the request.

is no longer able to express his wishes immediately prior to euthanasia, an advance directive is not required. See RRC *Annual Report 2012*, 21.

⁷⁵ The RRC advises, although it is not mandatory, that a directive for VAE is drawn up in good time and is as detailed as possible – preferably handwritten by the patient in which he or she describes the circumstances in which he or she would want VAE to be carried out. See RRC, *Annual Report 2012*, 13.

⁷⁶ See the RRC, *Annual Report 2012*, 12. For an example of such a case see ‘Case 15’ therein.

⁷⁷ Ibid. For an example of such a case, see Case 4, *ibid*.

⁷⁸ See RRC, *Annual Report 2013*, 18-20. See the KNMG ‘The Role of the Physician in the Voluntary Termination of Life: Position Paper’ (2011) 7; See also the KNMG (n 70).

⁷⁹ RRC, *2012 Annual Report*, 12.

⁸⁰ RRC, *Annual Report 2012*, 12

⁸¹ See RRC, *Annual Report 2012*, 13. See the KNMG (n 70) 40.

⁸² See Section 2(4) *Wtl*.

⁸³ See Section 2(3) *Wtl*.

As for the criterion of ‘unbearable and lasting suffering’, the KNMG and the RRC make it clear that both aspects are inevitably challenging. The manner of **determining ‘unbearable suffering’** may be viewed as two-fold. On the one hand, there is a clear subjective element to take into consideration, as put by the KNMG position paper: ‘[i]t is up to the patient to make clear what the nature of the unbearableness of *his own* suffering is.’ The RRC also emphasise the individual experience inherent in the concept of suffering, an experience specific to one’s personality, medical history, values and (physical and mental) capacity.⁸⁴ For this reason the patient’s individual biography is important in assessing whether he or she is suffering unbearably. On the other hand, this subjective consideration is somewhat mitigated – the unbearable suffering must be at least ‘understandable’ (*invoelbaar*) to a physician and to an independent consultant (and thus also to the RRC), in accordance with medical professional experience. This is laid out clearly in decisions of the Dutch Supreme Court and the RRCs, which have stated that suffering must be predominately based on a ‘medically classifiable disease or disorder’⁸⁵ or ‘have a medical dimension.’⁸⁶

The determination of **whether the patient’s condition is ‘lasting’** is dependent on the absence of any prospect of improvement, i.e. when there is no reasonable alternative form of treatment. The RRC have made clear that this does not require that a patient must take every possible form of palliative treatment available, instead the doctor must be satisfied that any refusal is reasonable.⁸⁷ To identify this reasonableness, according to the RRC, there is an overlap with the ‘unbearable’ criterion: ‘if the patient’s suffering is incurable and the symptoms cannot be alleviated to the extent that the suffering is no longer unbearable’ then it may be determined that there is no prospect of improvement.⁸⁸ The

⁸⁴ RRC (n 63) 14.

⁸⁵ See: Hoge Raad (Supreme Court of the Netherlands), December 24, 2002, NJ 2003, 167 (‘the Brongersma case’).

⁸⁶ RRC, *Annual Report 2012*, 17, see also Case 7 therein. Note also that the KNMG have strongly ‘emphasised that the presence of a medical basis is and must always be an absolute criterion when assessing suffering within the context of a request to end life.’ See KNMG, ‘The Role of the Physician in the Voluntary Termination of Life: Position Paper’ (2011) 26.

⁸⁷ For example, see the RRC, *Annual Report 2013*, 42: ‘Dat wil niet zeggen dat de patient iedere mogelijke (palliatieve) behandeling moet benutten.’

⁸⁸ See the RRC *Annual Report 2012*, 16; See also the RRC *Annual Report 2010*, 11; ‘Second Evaluation: Termination of Life on Request and Assisted Suicide’ (The Hague: ZonMw, December 2012) 42. The 2015 RRC Code of Practice provide some guidance in determining the reasonableness here, namely account

often-supposed requirement that the patient must be in the ‘terminal phase’ or that the illness is ‘terminal’ or ‘life-threatening’ is not included in the 2002 Act.⁸⁹

There is also no statutory restriction to unbearable or lasting suffering of a purely ‘somatic’ origin.⁹⁰ The RRC calls for ‘great caution’ in determining the suffering experienced by **patients with dementia or a psychiatric illness**.⁹¹ In regard to dementia-related cases, unbearable suffering may be considered as the ‘awareness of the deterioration in their personality, functions and skills that is already taking place, coupled with the expectation that this will get worse, eventually leading to utter dependence and total loss of self.’⁹² In any case of VAE involving psychiatric illness or dementia, the RRC requires that the physician who carries out the assistance not only consults an independent physician but also one or more experts, including a psychiatrist.⁹³ In this respect, the Dutch Psychiatric Association (NVvP) published a 92 page ‘*Directive dealing with the request for assisted suicide by patients with a psychiatric disturbance*.’⁹⁴ It explicitly draws attention to the ‘logical vulnerability’ of psychiatric patients⁹⁵ and the high potential for disturbed awareness,⁹⁶ but that it is nonetheless possible that a patient suffering from a psychiatric illness is ‘capable of full awareness of [his or her] illness to come to an informed decision to commit suicide.’⁹⁷ The NVvP directive specifies in detail how a psychiatric patients are to be cautiously assessed under each substantive and procedural requirement as set out in the 2002 Act.

should be had to the number of treatments that a patient has already undergone, the possible side effects of treatment, the stage of the disease process and the patient’s age, and physical and mental capacity.

⁸⁹ And is thus not required by the RRC: See RRC, *Annual Report 2012*: Case 7, whereby multiple geriatric syndromes can also be deemed to cause unbearable suffering with no prospect of improvement.

⁹⁰ Note: it is, of course, still required that the patient is decisionally competent.

⁹¹ In accordance with the dicta of the *Hoge Raad* (Supreme Court of the Netherlands) June 21, 1994, NJ 1994, 656 (the ‘Chabot case’).

⁹² See RRC, *Annual Report 2009*, 15: Case 4, 5 and 6. See also RRC, *Annual Report 2010*: Case 6, 7 and 8.

⁹³ RRC, *Code of Practice (2015)* 18; see also RRC, *Annual Report 2012*: Case 8; whereby a patient had been treated unsuccessfully for 30 years for severe, recurring depression. Her suffering was deemed unbearable and with no prospect of improvement.

⁹⁴ Nederlandse Vereniging voor Psychiatrie, *Richtlijn omgaan met het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis* (De Tijdstroom, Utrecht, 2009). Available at: <http://steungroeppsychiaters.nl/wp-content/uploads/Richtlijn-hulp-bij-zelfdoding_NVvP-2009.pdf>. Last accessed 28.01.2016.

⁹⁵ *Ibid*, 30.

⁹⁶ *Ibid*, 32.

⁹⁷ *Ibid*.

As for the statutory **criterion of independent consultation**, the consultant and the patient should not be direct colleagues in a medical practice, have a personal relationship, or be in a hierarchical professional relationship. Nor should the consultant have been involved in the past treatment of the patient. The KNMG and the RCC repeatedly recommend the use of SCEN⁹⁸ consultants for independent assessment⁹⁹ – SCEN is an organisation set up by the KNMG and funded by the Ministry of Health that provides for specially trained advisors and consultants in assisted dying issues (medical, legal and ethical). In 2012, the KNMG issued specific guidelines for SCEN physicians: ‘*Good support and consultation on euthanasia*’.¹⁰⁰ Note must also be made of the directive published jointly by the KNMG and the Royal Dutch Association of Pharmacists (KNMP) on ensuring due medical care in the performance of the assisted dying: ‘*Implementing euthanasia and assisted suicide*’.¹⁰¹ The directive specifies the means, dosage and/or method to be used in order for the VAE¹⁰² and AS¹⁰³ to be carried out ‘effectively and safely’. If the doctor fails to follow the recommended method and cannot reasonably justify the substance or dosage used, he or she will face further questioning from the RRC. This evidences the need for sufficient record-keeping. Despite the obvious pre-requisite of record-keeping in order for the RRC to make an assessment, the 2002 Act does not explicitly make mention of this important criterion. The issue is addressed in the “Guidance for co-operation between doctors, nurses and caregivers [in cases] of euthanasia (2006)”, which stresses the demands of explicitly justifying and demonstrating ‘what decisions were taken and why.’¹⁰⁴

The 2002 Act also established a **notification procedure**, whereby the physician is obligated to inform the municipal medical coroner of every instance of assisted dying

⁹⁸ SCEN is an abbreviation for *Steun en Consultatie bij Euthanasie in Nederland* [Support and Consultation Euthanasia in the Netherlands].

⁹⁹ See RRC (n 63) 18; See KNMG, *Position Paper: The Role of the Physician in the Voluntary Termination of Life* (2011) 42.

¹⁰⁰ KNMG, *Goede steun en consultatie bij euthanasia* [Good support and consultation on euthanasia] (2012)

¹⁰¹ KNMG/KNMP, *Richtlijn Uitvoering euthanasia en hulp bij zelfdoding* [Directive for implementation of euthanasia and assisted suicide] (2012).

¹⁰² The Directive states that VAE should be performed by an intravenous administration of a coma-inducing agent, followed by an intravenous administration of a muscle relaxant agent. It also states that physicians should guarantee that a patient is in a deep coma at the time of administration of the muscle relaxant.

¹⁰³ The doctor must remain with the patient until he or she is deceased, or in a close proximity so that he can intervene immediately should any complications arise.

¹⁰⁴ KNMG, *Handreiking voor samenwerking artsen, verpleegkundigen en verzorgenden bij euthanasia* (*Guidance for co-operation between doctors, nurses and caregivers [in cases] of euthanasia*) (2006) 16-17

based on a pre-defined 'reasoned report' containing all circumstances of the case at hand.¹⁰⁵ The coroner does not turn the report over to the Public Prosecutor Service, but to the relevant RRC.¹⁰⁶ This Committee determines, on examination of the report, if the applicable criteria of due care have been complied with.¹⁰⁷ If the RRC is satisfied that the due care criteria have been met, then the doctor is notified and the case is finalised. If there has been a failure of compliance with the due care criteria, the RRC notifies the Board of Procurators General of the Public Prosecution Service (PG) and the Health Care Inspectorate (OM). Both may follow up the matter, and the reporting physician (and/or consultant) may be subjected to follow up questioning, or criminal and disciplinary investigation.

The nature of the physician's failure to comply with the due care criteria largely determines the nature of the investigation. On the one hand, the PG policy focuses on investigating substantive breaches (such as no presence of voluntary request or unbearable suffering). It may initiate criminal charges, conditionally dismiss the case or unconditionally dismiss the case. If a voluntary and careful request is absent, then the physician's behaviour does not fall under the 2002 Act and he or she is, in principle, criminally liable for murder. On the other hand, the OM is largely understood as responsible for the more procedural breaches (such as the consultation process). The sanction that may be imposed, by the relevant Medical Disciplinary Boards (*regionale tuchtcolleges*),¹⁰⁸ depends on the nature of the failure to comply with the due care criteria. The accused may receive a warning, a reprimand, a fine, a (temporary) suspension or withdrawal from the medical register. Such a decision may be appealed to the Central

¹⁰⁵ Section 7(2) *Wet op de lijkbezorging* [the Burial and Cremation Act].

¹⁰⁶ There are five RRCs in the Netherlands, which serve five judicial regions. They consist of three members (and three substitutes): a lawyer (who is the chair), a physician, and an ethicist. Before contacting the relevant RRC, the coroner makes an on-site visit, checks the facts of the physician's report, gathers the relevant medical info, and contacts the prosecution services to receive allowance for burial or cremation. A model report has been made available pursuant to a general administrative order [*algemene maatregel van bestuur*] based on the Burial and Cremation Act, this was recently amended: Bulletin of Acts, Orders and Decrees 2009, 204. See Kimsma and van Leeuwen (n 57) 192-202.

¹⁰⁷ The competence and procedures of the committees are to be found in a number of documents: the Law of 2002, the Order in Council pursuant to the Law (Order in Council of 6 March) 2002, *Staatsblad* 2002 nr 141, the guideline promulgated on 18 June 2003 by the chairmen of the Review Committees pursuant to art 5 of the Order in Council, and the Regional Review Committee Code of Practice 2015.

¹⁰⁸ These Boards consist of two legally qualified members and three health professional members. They have the power to summon witnesses and experts and their attendance is compulsory. The complainant and the accused may invite witnesses and experts but their attendance is not obligatory when summoned by the Board.

Disciplinary Board (*centraal tuchtcollege*) and then, if necessary on a point of law, to the Dutch Supreme Court (*Hoge Raad*).

4

THE LAW ‘IN ACTION’

In examining the governance dimension of a particular law, it is not enough to look at what the rules are (**CHAPTER THREE**, above), but it is also essential to account for what happens to them ‘in action’. This chapter presents, in the respective jurisdictions: (i) the limited¹⁰⁹ empirical evidence on assisted dying, and (ii) the application and enforcement of the law on assisted dying. In terms of the former, agreement is had here with van der Heide regarding the role of empirical data: ‘observational studies on the characteristics of practice cannot be used to prove that [those] who engage in practices that hasten death were right or wrong.’¹¹⁰ Instead, empirical data plays a more modest supportive role in informing the debate on a given regulatory approach. As for the latter, the focus turns to relevant judicial decisions (the classic source of the law in action),¹¹¹ prosecution decisions and medical disciplinary decisions. This is, for the moment, also a descriptive endeavour. By ‘merely’ identifying these decisions here, different national solutions on concrete instances of assisted dying may be critically compared elsewhere – in this respect, see **CHAPTER FIVE**.

¹⁰⁹ ‘Limited’ in the sense that the data on such (essentially criminal) behaviour is inherently unreliable and that the data is not equally available across the four jurisdictions studied. For example, empirical data on frequencies of assisted dying in France is minimal in comparison to the data available in the Netherlands.

¹¹⁰ A. Van der Heide, ‘Physician Assistance in Dying Without an Explicit Request by the Patient’ in S.J. Youngner and G.K. Kimsma (eds), *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 144.

¹¹¹ A. Colombi Ciacchi, ‘Comparative Law and Governance: Towards a New Research Method’ in A. Colombi Ciacchi et al. (eds) *Law & Governance – Beyond the Public-Private Law Divide?* (Eleven International, 2013).

4.1 EMPIRICAL EVIDENCE OF ASSISTED DYING

4.1.1. ENGLAND

The leading statistical research on end of life decisions in England, dating from the early 1990's, 2006 and 2009 comes from Professor Clive Seale.¹¹² In his latest representative survey, 3,733 medical practitioners working throughout the UK responded to an anonymous questionnaire. Out of the total number of deaths attended by the respondents, 0.21% involved the 'termination of life with an explicit request from the patient', in other words VAE. Taking into account the annual deaths attended by the responding doctors, this survey estimates approximately 151 deaths were due to VAE.¹¹³ Extrapolating this to the annual population of total UK deaths,¹¹⁴ approximately 1,070 deaths may be a result of VAE per year. There were no reported cases (in the survey) of actual physician assisted suicide. In response to further questions in the survey, it is relevant to point out that 2% (approx. 1,440 of the 72,071) of the reported deaths were a result of pain alleviating treatment, which was 'partly intended to end life', while another 15.1% (approx. 10,880 of the 72,071) with the knowledge of 'probable or certain hastening of end of life'.

Acknowledging the inherent difficulties in such questionnaires regarding accuracy, they do provide some degree of indication that VAE is occurring in secret.¹¹⁵ Furthermore, it is demonstrated that a high number of deaths resulted from pain alleviation in the knowledge of probable or certain hastening of life. The survey did not suggest higher levels of life shortening actions, or higher levels of sedation, for the very elderly or for those recorded as having dementia.¹¹⁶

¹¹² Professor of Medical Sociology at Queen Mary University of London. See 'written evidence' given by C. Seale to the Commission on Assisted Dying - Available at <www.commissiononassisteddying.co.uk>. See: C. Seale, 'National survey of end-of-life decisions made by UK medical practitioners', *Palliative Medicine* 20 (2006) 3-10; C. Seale, 'Hastening death in end-of-life care: a survey of doctors', (2009) 69(11) *Social Science and Medicine* 1659-1666; C. Seale, 'End-of-life decisions in the UK involving medical practitioners' (2009) 23(3) *Palliative Medicine* 198-204.

¹¹³ Note the confidence interval (CI) level of these estimates is 95%.

¹¹⁴ According to the Office for National Statistics, there were 509,090 deaths registered in England and Wales that year.

¹¹⁵ Furthermore, such surveys indicated the large number of MBSL occurring; of which VAE is only a small part.

¹¹⁶ C. Seale written evidence to the Commission on Assisted Dying 'Hastening death in end-of-life care: a survey of doctors.' Available at: <www.commissiononassisteddying.co.uk/>. Last accessed 28.01.2016.

It is also relevant to take into account instances that did not involve medical professionals, i.e. the occurrence of ‘mercy killings’ (typically by a family member). Again it is difficult to obtain a holistic picture via empirical data (given the obvious illegal nature of the behaviour), but Home Office records show that from 1990/91 to 2004/05 there were a total of 57 homicide cases that can be described as ‘mercy killing’. Regarding AS, 101 cases have been brought to the attention of the DPP between April 2009 and October 2014.¹¹⁷ A large number of these cases involved what has become known as ‘suicide tourism’. This occurs when a patient travels abroad to a jurisdiction where he or she is legally permitted to commit suicide in the presence of family/friends and an experienced end of life caregiver. The most popular choice of jurisdiction is Switzerland, where AS is lawful, provided there exists evidence that the assister’s motive was not ‘selfish’ (see the Chapter above on Swiss law). Dignitas, one of the best known and most criticized associations, recorded 893 members from the UK alone.¹¹⁸ From 1998 to December 2013, a total of 244 Britons have actually availed of assistance in dying at said clinic.¹¹⁹

4.1.2 FRANCE

A 2010 anonymous survey¹²⁰ funded by the Ministry of Health provides an indication of the frequency of assisted dying in France. The results are based on a representative sample of 4,891 deaths. It found 0.2% of these deaths were preceded by the use of a drug to deliberately end life at that patient’s request. Considering there are approximately 500,000 deaths a year, this survey indicates that around 1,000 of these deaths are a result of VAE (physician performed).

Furthermore, 28.1% of deaths in the survey involved the intensification of treatment to alleviate pain, knowing that the decision may or will hasten death (0.8% with the intention of hastening death and 27.3% with ‘the knowledge that the decision may hasten

¹¹⁷ Cases of assisted suicide are recorded centrally by Crown Prosecution Services, and are available at: <www.cps.gov.uk/publications/prosecution/assisted_suicide.html>. Last accessed 28.01.2016.

¹¹⁸ Statistics on ‘Accompanied suicide of Members of Dignitas, by year and by country of residency’, see: <<http://dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2013.pdf>>. Last accessed 28.01.2016.

¹¹⁹ Ibid.

¹²⁰ S. Pennec and others, ‘End-of-life Medical Decisions in France: a death certificate follow up five years after the 2005 Act of Parliament on Patients’ rights and end of life’, (2012) 11(25) *BioMed Central Palliative Care*. Available at: <www.ncbi.nlm.nih.gov/pmc/articles/PMC3543844/>.

death'. 18.8% of the deaths involved the withholding or withdrawing of life prolonging treatment (1.5% with the intention of hastening death and 17.3% with 'the knowledge that the decision may hasten death'). No physician-assisted suicides were recorded. Also it must be noted that between 1998-2013, a total of 159 patients have travelled from France to Dignitas in Switzerland to commit suicide.¹²¹

Aside from this survey (notably the first and only one of its kind in France to offer comparative data on end-of life decision making), there are a number of other sources that provide empirical evidence concerning VAE. According to a 2014 study, based on an analysis of patient files in a Parisian palliative care hospital,¹²² 195 of the total studied 2,157 patients (9%) expressed a wish to die and 61 (3%) specifically requested VAE.¹²³ Another study in 2011 of 761 medical charts in various teaching hospitals found there were 7 (0.9%) repeated requests for VAE.¹²⁴ A 2005 report estimated 2,000 annual cases of VAE,¹²⁵ while other studies make mention of the 'widespread use' of sedative drugs in high dosages.¹²⁶ A Parliamentary working committee in 2004 explicitly acknowledged the practice of clandestine VAE.¹²⁷

4.1.3 SWITZERLAND

There have been a number of empirical studies carried out regarding end of life practices in Switzerland. According to a European study (EURELD) based on an anonymous questionnaire method sent out to physicians (resulting in a study of 3,355 deaths in Switzerland), 0.27% of deaths attended by the respondents were understood as VAE.¹²⁸ 0.36% were recorded as AS. In 92% of these AS cases, a 'right-to-die' organisation (RTD) was involved. Ending of life without the patient's explicit request occurred in 0.42% of

¹²¹ See Dignitas Statistics (n 10).

¹²² Of these, 96% of the patients were in the terminal phase of cancer.

¹²³ F. Guirimand, 'Death wishes and explicit requests for euthanasia in a palliative care hospital: an analysis of patients files' (2014) 13(53) *BMC Palliative Care*.

¹²⁴ E. Ferrand, 'Requests for euthanasia and palliative care in France', (2011) 377(9764) *The Lancet* 467-468.

¹²⁵ J.P. Wagner, 'Table ronde— Droits des malades et fin de vie—L'accompagnement de la fin de vie' Se'nat, *Travaux de la commission des affaires sociales*, 2 fe'v. 2005.

¹²⁶ P. Lewis, 'Assisted Dying in France: The Evolution of Assisted Dying in France: A Third Way?' (2006) 14 *Medical Law Review* 44-72; N. Aumonier and others, *L'euthanasie* (PUF, 2001) 19.

¹²⁷ *Respecter la vie, accepter la mort*, Rapport no. 1708 de la mission d'information parlementaire sur l'accompagnement de la fin de vie, *Assemblée Nationale*, 1 (2004) 145.

¹²⁸ EURELD, 'End-of-life decision-making in six European countries: descriptive study', published online June 17, 2003, available at <image.thelancet.com/extras/03art3298web.pdf>. Last accessed 28.01.2016.

deaths. In 54% of cases involving 'the administration of drugs with the explicit intention of hastening death' (cases defined in the study as including the following acts: VAE, PAS and the ending of life without the patient's explicit request), life was estimated to be shortened by one week to one month.¹²⁹ According to the Federal Statistical Office, the number of Swiss residents who have availed of AS rose from 187 to 508 between 2003 and 2012.

In context with other end of life medical behaviour, the same EURELD survey mentioned above shows that 22% of deaths studied involved the administration of pain relief with 'possible life shortening effect' and 28% involved 'non-treatment decisions', such as withholding or withdrawing life prolonging treatment.¹³⁰ However, another EURELD study estimated that 41% of all deaths attended by the respondents were preceded by a 'non-treatment' decision.¹³¹ In both surveys the incidence of such behaviour in Switzerland was the highest in Europe.

A study based on all reported suicides in two right to die organisations (RTDs) in Zurich – Dignitas (D) and Exit Deutsche Schweiz (E) - from 2001 to 2004 found:¹³² '[m]ore women than men were assisted in both organisations (D: 64%; E: 65%). Dignitas provided more assistance to non-residents (D: 91%; E: 3%), younger persons (mean age in years: D: 64.5; E: 76.6), and people suffering from fatal diseases such as multiple sclerosis and amyotrophic lateral sclerosis (D: 79%; E: 67%).' Of the suicides facilitated by Dignitas, 94.5% occurred in an apartment rented by the RTD for this purpose and 5.1% occurred at the patient's home. By contrast, 61% of the suicides facilitated by Exit Deutsche Schweiz occurred at the patient's home, 34% in an apartment rented by the RTD, and 4.8% in an institution such as a hospital or nursing home.

¹²⁹ EURELD, *ibid.* In 17% of cases, the estimated life shortening effect was less than 1 week, while 29% of cases it was estimated to be more than one month or unknown.

¹³⁰ *Ibid.*

¹³¹ EURELD, 'Forgoing Treatment at the End-of-life in 6 European countries' (2005) 165 *Archives of Internal Medicine* 401-407.

¹³² See S. Fischer and others, 'Suicide assisted by two Swiss "right to die" organisations' (2008) 34 *Journal of Medical Ethics* 812. Data for this study was obtained from the official body responsible for the investigation of all extraordinary deaths in Zurich, namely assisted suicides facilitated by Exit Deutsche Schweiz and Dignitas.

Further empirical data comes from the RTDs themselves. *EXIT Deutsche Schweiz* has approximately 73,000 members and receives more than 2,000 requests for PAS annually. According to its website, it has approved 600 requests and physicians performed approximately 450 cases of assistance.¹³³ According to a study by the Institute of Social and Preventative Medicine, there were 927 deaths assisted by non-physician volunteers in *Exit Deutsche Schweiz* during the years 2003 to 2008.¹³⁴ Its French speaking counterpart, *Exit ADMD (Association pour le Droit de Mourir dans le Dignité)*, has 20,196 members and has assisted in 330 deaths during the years 2003 to 2008. Dignitas, known for providing assistance to non-resident and/or non-Swiss nationals, has assisted in 1,701 deaths during the years 1998 to 2013.

The 'Bosshard study' in 2003 found that 78.9% of the assisted suicides involved patients suffering from fatal diseases (such as cancer, or cardiovascular disease).¹³⁵ Another study analysed reported cases of AS by RTD organisations in the city of Zurich (between 2001 and 2009) in order to identify the physician's reason (ph) for prescribing the drug and the patient's reason (p) for wanting AS.¹³⁶ The most often cited reasons were to relieve pain (ph: 56%, p: 58%), concerns for long term care (ph: 37%, p: 39%), neurological symptoms (ph: 35%, p: 32%), immobility (ph: 23%, p: 30%), control of circumstances over death (ph: 12%, p: 39%), loss of dignity (ph: 6%, p: 38%), weakness (ph: 13%, p: 26%), inability to engage in activities that make life enjoyable (ph: 6%, p: 18%), and insomnia and loss of concentration (ph: 4%, p: 13%).

4.1.4 THE NETHERLANDS

The Netherlands is one of the few Member States where relatively reliable data on the incidence of assisted dying is available. Empirical data from 1990 to 2014 (at the time of writing) has been obtained via nation-wide studies¹³⁷ and annual reports of the Regional

¹³³ See <www.exit.ch/en/exit-at-a-glance/>. Last accessed 28.01.2016.

¹³⁴ Institute of Social and Preventive Medicine (ISPM), 'Suicide assisted by right-to-die associations: a population based cohort study' (Feb 2014) *International Journal of Epidemiology* 1-9.

¹³⁵ 21.1% involved a non-fatal diagnosis (such as rheumatoid arthritis or osteoporosis). See G. Bosshard, E. Ulrich and W. Bar, '747 Cases of Suicide Assisted by a Swiss Right-to-die organisation' (2003) 133 *Swiss Medical Weekly* 310-317.

¹³⁶ S. Fischer and others, 'Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians' (2009) 139(23-24) *Swiss Medical Weekly* 33-338.

¹³⁷ There have been five major national studies since 1990, see: P. van der Maas and others, *Medische beslissingen rond het levenseinde: het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake*

Review Committees.¹³⁸ However desirable, it will not be possible to go into this data in great detail here. Instead a brief outline will be given.

Data consistently identifies that the majority of patient requests for assisted dying are not performed (3-4 per 10 explicit requests are performed).¹³⁹ According to death certificate surveys, this is mostly due to the patient dying before the request could be acted upon or due to the fact that the physician was not satisfied that the due care criteria could be met.¹⁴⁰ Notwithstanding this, there has been a steady increase of assisted dying cases in the Netherlands. According to the 2013 Annual Report, the RRCs received 4,829 reports of assisted dying. This is an increase in cases by 15% compared to 2012.¹⁴¹ Of these cases,

Euthanasie [Medical Decisions Concerning the End of Life: the Research for the Committee to Study Medical Practice concerning Euthanasia] (The Hague: Sdu Uitgeverij, 1991); G. van der Wal and P. van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde: de praktijk en de meldingsprocedure* [Euthanasia and Other Medical Decisions in Connection with the End of Life: Medical Practice and the Reporting Procedure] (The Hague: Sdu Uitgevers, 1996); G. van der Wal and others, *Medische besluitvorming aan het einde van het leven: de praktijk en de toetsingsprocedure euthanasie en het Verslag van de begeleidingscommissie van het evaluatieonderzoek naar de medische besluitvorming aan het einde van het leven* [Medical Decision Making at the End of Life: Medical Practice and the Assessment Procedure for Euthanasia] (Utrecht: de Tijdstroom, 2003); B. Onwuteaka-Philipsen and others, *Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Evaluation of the Termination of Life on Request and Assisted Suicide (Review Procedure) Act of 2002] (The Hague: ZonMw, 2007); A. van der Heide and others, *Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [2nd Evaluation of the Termination of Life on Request and Assisted Suicide (Review Procedure) Act of 2002] (The Hague: ZonMw, 2012). For some other leading English-language publications on these Dutch studies, see: P.J. van der Maas and others, 'Evaluation of the notification procedure for physician-assisted death in the Netherlands' (1996) 335 *New England Journal of Medicine* 1706-171; B.D. Onwuteaka-Philipsen and others, 'Euthanasia and other end-of-life decisions in The Netherlands in 1990, 1995 and 2001' (2003) 362 *The Lancet* 395-399; B.D. Onwuteaka-Philipsen et al., 'Dutch experience in monitoring euthanasia' (2005) 331 *British Medical Journal* 691-693; A. van der Heide, 'End-of-life practices in the Netherlands under the Euthanasia act' (2007) 356 *New England Journal of Medicine* 1957-1965; B.D. Onwuteaka-Philipsen, 'The Unreported Cases', in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 123-136.

¹³⁸ *Regionale Toetsingscommissies Euthanasie, Jaarverslag* [Euthanasia Regional Review Committees, Annual Report]. These reports will hereafter be referred to as 'RRC Annual Report(s)'. These reports from 2002-2013 are available at <www.euthanasiacommissie.nl/archiefjaarverslagen.asp>. Last accessed 28.01.2016.

¹³⁹ H. Roeline and W. Pasman, 'When Requests Do Not Result in Euthanasia or Assisted Suicide' in S.J. Youngner and G.K. Kimsms (eds), *Physician-Assisted Death in Perspective* (Cambridge University Press, 2012) 149.

¹⁴⁰ A. Van der Heide and others., *Euthanasie en andere medische beslissingen rond het levenseinde: Sterfgevallenonderzoek 2010* [Euthanasia and other end of life medical decisions: Death survey 2010] (The Hague: ZonMw, 2012) 19; Note also: the results of a 2005 study: 'In about two thirds [of cases], the request did not lead to euthanasia or physician assisted suicide being performed, in 39% because the patient dies before the request could be granted and in 38% because the physician thought the criteria for due care were not met', see Onwuteaka-Philipsen and others, 'The last phase of life: who requests and who receives euthanasia or physician-assisted suicide?' (2010) 48(7) *Medical Care* 596-603.

¹⁴¹ RRC *Annual Report 2013*, 6. According to the RRC *Annual Report 2012*, there were 4,188 reported cases. This is an increase of 13% compared to 2011. RRC *Annual Report 2011* = 3,695 total cases; RRC *Annual Report 2010* = 3,136 total cases; RRC *Annual Report 2009* = 2,636 total cases.

the frequency of VAE has been consistently higher than that of AS. In 2013, VAE accounted for 93.2% of reported cases, 5.92% of cases were AS, while 0.86% of cases involved a combination of both.¹⁴² It is difficult to accurately identify the percentage these reported cases represent the actual number of assisted dying cases being performed. Research stated in 1990 that only 18% of all cases were being reported.¹⁴³ This figure was increasingly recorded at 41% in 1995, to 54% in 2001, to 80% in 2005,¹⁴⁴ but it decreased to 77% in 2010.¹⁴⁵

Since the introduction of the RRCs in 1998 and the 2002 codified exception to the criminal law, the reporting rate has increased.¹⁴⁶ There still, however, remains a number of unreported cases. Van Tol explains (on the basis of empirical data) the reasoning behind these 'covert' cases as a lack of cognitive solidarity.¹⁴⁷ In other words, there is a disconnect between those measuring/controlling what doctors do and what doctors perceive as necessary to report. Data suggests uncertainty in the physician's mind about whether the administration of high dose opioids (rather than the drugs recommended for VAE)¹⁴⁸ constituted VAE or pain relief with life shortening effect.¹⁴⁹ According to

¹⁴² RRC Annual Report (2013) 39. Data consistently suggests that if patients are given the choice, they prefer to have their doctors do the procedure, see C. Gamondi, C. Domenico Borasio, C. Limoni, N. Preston and S. Payne, 'Legalisation of assisted suicide: a safeguard to euthanasia?', *The Lancet* 384(9938) (2004).

¹⁴³ B. Onwuteaka-Philipsen and others, *Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* (n 29) 176.

¹⁴⁴ A. Van der Heide, *Euthanasie en andere medische beslissingen rond het levenseinde: Sterfgevallenonderzoek 2010* (n 29) 41.

¹⁴⁵ A. Van der Heide and others, 'Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding' (n 29) 103. See also B. Onwuteaka-Philipsen and others, *Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*, (n 29) 102, 112, 116, 119, 174.

¹⁴⁶ Prior to 1998, physicians were required to report cases of VAE or AS directly to the public prosecutors. Certain Dutch scholars speculate that placing the criminal prosecution services at a greater distance, and the RRCs jurisprudence may have encouraged physicians to report more frequently. See B.D. Onwuteaka-Philipsen, 'The Unreported Cases' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective* (Cambridge University Press, 2012) 127.

¹⁴⁷ D. Van Tol, 'Grensgeschillen: een rechtssociologisch onderzoek naar het classificeren van euthanasie en ander medisch handelen rond het levenseinde' PhD Dissertation, University of Groningen, 2005. See also: G. Den Hartogh 'Mysterieuze cijfers: meldingspercentage van euthanasie kan niet meer stijgen' *Medisch Contract* 58 (2003) 1063-6. See also G. Den Hertogh, 'How Successful Is the Dutch Regulation of Euthanasia?' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective* (Cambridge University Press, 2012) 360-365.

¹⁴⁸ The Royal Dutch Society for the Advancement of Pharmacy (KNMP) recommends the use of specific drugs for VAE and AS: the administration of a barbiturate to induce a coma, followed by a muscle relaxant that causes the death of the patient. See Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie (KNMP), *Toepassing en bereiding van euthanatica* ['Application and preparation of drugs for euthanasia'] (The Hague: KNMP, 1998).

¹⁴⁹ '[B]y far the largest difference between reported and unreported cases lies in the drugs used, in combination with the designation given by the physician' See B.D. Onwuteaka-Philipsen, 'The Unreported Cases' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective* (Cambridge University Press, 2012) 135.

alternative analyses whereby the opioid cases are subtracted from the empirical studies, the 54% reporting rate in 2001 rises to 90%;¹⁵⁰ the 80% reporting rate in 2005 rises to 99%;¹⁵¹ and the 77% reporting rate in 2010 rises to 92%.¹⁵²

The data over the past 10 years consistently shows a willingness by the majority of physicians to carry out assisted dying if necessary. The 2012 national study revealed that only 14% of physicians deem it 'unthinkable' to perform VAE or AS (with 23% of these physicians believing assisted dying should be criminally prohibited).¹⁵³ The same study identified that in 2011, 60% of physicians had performed an act of assisted dying at some stage of their professional career.¹⁵⁴ This was an increase from 51% in the 2005 study.¹⁵⁵ While 56% of physicians in 2011 agreed with the statement that: 'every patient has the right to end his life' – this was an increase from 47% in 2005. Doctors attitudes are, however, not always as permissive as the formal rule allows. There does appear some reluctance from physicians to carry out VAE or AS on a patient experiencing non-somatic based suffering. The number of physicians (1-3%) who carried out assisted dying on psychiatric patients is considerably lower than in non-psychiatric cases.¹⁵⁶ Also 86% of geriatric specialists were against an act of assisted dying in cases of advanced dementia,¹⁵⁷ while only 29% of physicians found it conceivable to carry out an act of assisted dying on patient's suffering from a psychiatric illness.¹⁵⁸ Interestingly, only 37% of the geriatric specialists in the 2012 study were aware that a written advanced directive for VAE that fully satisfies the statutory due care criteria may be legally respected.¹⁵⁹

In terms of the physicians who have admitted terminating life without a request, the data shows a decrease from 27% in 1990 to 5% in 2011.¹⁶⁰ Conversely, the number of

¹⁵⁰ Den Hartogh 'Mysterieuze cijfers: meldingspercentage van euthanasie kan niet meer stijgen' (n 39). Another analysis by national researchers showed that the reporting rate in 2001 was approximately 70%. See M. Rurup and others, 'Trends in gebruikte geneesmiddelen bij euthanasie en samenhang met het aantal meldingen [Trends in the Use of Drugs for Euthanasia and their Relationship to the Number of Reported Cases]' (2006) 150 *Nederlands Tijdschrift voor Geneeskunde* 618–24.

¹⁵¹ J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008) 204.

¹⁵² See van der Heide and others, *Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* (n 29) 232.

¹⁵³ *Ibid*, 85.

¹⁵⁴ *Ibid*, 80.

¹⁵⁵ *Ibid*, 86.

¹⁵⁶ *Ibid*, 233.

¹⁵⁷ *Ibid*, 145. Note: 51% of said specialists did recognise that it may be permitted in 'exceptional cases.'

¹⁵⁸ *Ibid*, 151.

¹⁵⁹ *Ibid*, 146.

¹⁶⁰ *Ibid*, 105.

physicians entirely opposed to this behaviour increased from 41% in 1990 to 90% in 2011.¹⁶¹ This figure corresponds with the data on instances of the terminating life without a request by physicians, which decreased from 0.8% in 1990, to 0.7% in 2001, to 0.4% in 2005, to 0.2% in 2010.¹⁶² In terms of other end-of-life medical behaviour, according to the 2012 national study, there was: an increase in the number of potentially life-shortening acts due to the intensification of pain management (36% of all deaths in 2010 as compared to 25% in 2005);¹⁶³ an increase in the number of withholding/withdrawing life-prolonging treatment (18% of all deaths in 2010 as compared to 16% in 2005);¹⁶⁴ and an increase in continuous deep sedation (12.5% of all deaths in 2010 as compared to 8% in 2005).¹⁶⁵

Valuable information may also be obtained by examining the characteristics of deaths due to assisted dying. In 2010, it was reported that in 21% of actually performed cases, the estimated life shortening effect was one month or more, this was slightly higher than in previous years (approx 8-16%).¹⁶⁶ The majority of cases appear to shorten life by less than one month.¹⁶⁷ According to the 2013 RRC Annual Report, in 74.3% of reported cases (3,588) the predominant medical condition was cancer;¹⁶⁸ in 4.6% of cases (223) it was cardiovascular disease; in 6.1% of cases (221) it was disorders of the nervous system; in 3.6% of cases (174) it was lung disease; in 2.0% of cases (97) it was dementia; in 0.8% of cases (42) it was psychiatric illness; and in 5.1% of cases (251) it was a combination of multiple aging complaints. This data is largely in line with previous reports. Although the reports are increasing, the proportion of underlying causes remain rather constant.¹⁶⁹ However, there are two particular types of reported causes – dementia and psychiatric

¹⁶¹ Ibid, 105.

¹⁶² Ibid, 106. Note that according to the 2012 national study: “the main reason for the termination of life in these cases were (severe) pain or other symptoms in the patient and the lack of any prospect of improvement. In the majority of cases, although the patient had not [made an] expressly request, the doctor had discussed it with the patient.” Ibid, 285.

¹⁶³ Ibid, 285. The same 2012 study states that it is important to note that ‘in more than half of these cases’, the physician indicated that his or her actions ‘probably’ did not have any life-shortening effect.

¹⁶⁴ Ibid, 285.

¹⁶⁵ Ibid, 285.

¹⁶⁶ Ibid, 233.

¹⁶⁷ Ibid, 285. In 2005, 50% of these estimated to have shortened life by less than one week, see Onwuteaka-Philipsen and others, *Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*, (n 29) 103, 113, 117, 120.

¹⁶⁸ According to the RRC *Annual Report 2013*, the condition and number of reported cases of assisted dying were as follows: cancer = 3,588; cardiovascular disease = 223; disorders of the nervous system = 294; lung disease = 174; Dementia = 97; Psychiatric = 42; multiple aging complaints = 251.

¹⁶⁹ See van der Heide and others, *Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* (n 29) 84.

suffering – that have noticeably increased.¹⁷⁰ In 2013 alone there were 97 reported dementia cases while between 2003-2009 there were a total of 42 reported dementia cases. In 2013 alone there were 42 reported cases involving psychiatric illness, while between 2003-2009 there were a total of 22 such cases.

As for the type of physicians who perform assisted dying, a general practitioner (GP) performed 88.6% of all cases reported in 2013,¹⁷¹ while 78.6% of cases were carried out in the patient's home.¹⁷² Since March 2012, a controversial End-of-life Clinic [*Levensindekliniek*, hereafter "ELC"] came into operation. Described in the 2012 RRC Annual Report as a 'peripatetic euthanasia team', it is an initiative by the Dutch Association for Voluntary Euthanasia (NVVE) to lawfully help patients who cannot find a physician willing to otherwise perform VAE or AS. In 2012, the number of cases reported by a doctor working at the ELC totalled 32,¹⁷³ while in 2013 this figure increased to 107 – all of which were considered by the RRC to have met the criteria of due diligence.¹⁷⁴

Statistics regarding the type of patients availing of assisted dying shed some (albeit reasonably limited) light on the risk legalisation incurs for vulnerable members of society and the potential 'slippery slope' to an increase in non-voluntary termination of life. As noted above, the frequency of life-ending acts without an explicit request has decreased since VAE and AS have been legalised (from 0.8% of all deaths in 1990 to 0.2% in 2010).¹⁷⁵ Also, there appears no clear evidence for a higher frequency of assisted dying among the elderly, people with low educational status, the poor, the physically disabled or

¹⁷⁰ RRC *Annual Report 2012* = 42 reported cases of dementia; RRC *Annual Report 2013* = 97 reported cases of dementia. RRC *Annual Report 2012* = 14 reported cases of psychiatric suffering; RRC *Annual Report 2013* = 42 reported cases of psychiatric suffering. In 2011, these figures were 49 and 13, respectively.

¹⁷¹ Reporting doctors according to the RRC *Annual Report 2013*: general practitioner = 4,281; medical specialist in hospital = 213; specialist in geriatric medicine = 193; trainee medical specialists = 13; doctor with different background.

¹⁷² In 240 cases, the patient died in hospital, in 160 cases in a nursing home, in 268 cases in a care home, in 295 cases in a hospice and in 66 cases elsewhere (e.g. at a family member's home). See RRC *Annual Report 2013*, 39.

¹⁷³ RRC, *Annual Report 2012*, 6.

¹⁷⁴ RRC, *Annual Report 2013*, 9.

¹⁷⁵ In a 1990 study, 0.8% of deaths studied were a result of ending of life without an explicit request. In 1995 and 2001 it was 0.7%, in 2005 it was 0.4%, and in 2010 it was 0.2%. In all the studies, the most common reason given by physicians for not discussing the decision with the patient was due to the fact that patient was comatose or unconscious (31-48%). Less common reasons were that the patient had been a neonate (5-21%); and incompetent due to dementia (1-16%).

chronically ill, minors or racial or ethnic minorities, compared with background populations.¹⁷⁶

As for guidelines and practices in hospitals and nursing care homes, data suggests that information with regard to advanced VAE directives and due care is not optimal.¹⁷⁷ Other studies, report the (illegal) involvement of nurses in the direct performance of VAE and AS.¹⁷⁸ In 1998, a body of independent specially trained euthanasia consultants for doctors (known as SCEN) was established.¹⁷⁹ These consultants provide before-the-fact assessments regarding the nature of the patient's voluntary request and suffering. According to the 2012 national study, 74% of assisted dying cases involved a SCEN consultant.¹⁸⁰ In 2013, there were a total of 5,704 registered consultations by 487 SCEN

¹⁷⁶ M.P Battin and others, 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups' (2007) 33(10) *Journal of Medical Ethics* 591-7. See also N. Steck and others, 'Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review' (2013) 52(10) *Medical Care* 938-944. The last mentioned study identified some common characteristics between legal systems that conditionally allow assisted dying (namely the Netherlands, Belgium, Luxembourg, Switzerland, and Oregon): 'the typical person who dies with assistance was a well-educated male cancer patient'. In the Netherlands, the highest percentage (3.5%-5.6%) was seen among deaths in individuals under 64 years of age, while in Oregon PAS was most common in those aged 25-34 years (140.8 per 10,000 deaths), see *ibid*, 941.

¹⁷⁷ See the conclusions of B.A.M. Hesselink and others, 'Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis' (2012) 38 *Journal of Medical Ethics*. According to other studies, the majority of Dutch physicians and medical students in the Netherlands did not know that advanced euthanasia directives were legal (under certain circumstances). See also Onwuteaka-Philipsen and others., *Evaluatie: Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*, (n 29); B.A. Hesselink and others, 'Education on end-of-life care in the medical curriculum: students' opinions and knowledge' (2010) 13 *Journal of Palliative Medicine*.

¹⁷⁸ A questionnaire responded to by 532 nurses revealed: in 45.1% of cases, the nurse was the first with whom patients discussed their request for assisted dying; in 78% of cases, consultation between physicians and nurses took place. In 15.4% of cases nurses themselves administered the euthanatics with or without a physician. See G.G. van Bruchem-van de Scheur, A.J. van der Arend, H. Huijer Abu-Saad et al., 'Euthanasia and assisted suicide in Dutch hospitals: the role of nurses' (2008) 17 *Journal of Clinical Nurses* 1138-44. See also for a study of nurses in Flanders carried out in 1998 (the Dutch speaking part of Belgium): J.J. Bilsen and others, 'Involvement of nurses in physician-assisted dying' (2004) 47(6) *Journal of Advanced Nursing* 583-91.

¹⁷⁹ For a detailed discussion on SCEN (*Steun en Consultatie bij Euthanasie in Nederland* – in English: Support and Consultation with Euthanasia in the Netherlands'), see G.K. Kimsma, 'Euthanasia Consultants – Professional Assessment Before Euthanasia and Physician-Assisted Suicide in the Netherlands' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective* (Cambridge University Press, 2012) 181-190. See also Y. Van Wesemael and others, 'Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium' (2009) 9 *BioMed Central Health Services Research* 220. The Royal Dutch Medical Association (RDMA) provided a protocol to organise the functioning of euthanasia consultants; see Royal Dutch Medical Association, 'Goede Steun en consultatie bij euthanasia' ['Good support and consultation for euthanasia'] (2012); B.D. Onwuteaka-Philipsen and others., *Evaluatie van SCEN: Wat is goede steun en consultatie? Mogelijkheden voor verdere professionalisering* ['Evaluation of SCEN: What is good support and consultation? Opportunities for further professional development'] (Den Haag: ZonMw, 2010).

¹⁸⁰ See A. Van der Heide and others, 'Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding' (n 29) 192.

doctors.¹⁸¹ In 15.1% of reported cases in 2013, the SCEN consultant did not consider the due care criteria to be complete. In 72.5% of the consulted cases, assist dying occurred. The specific data on these consults shows the ratio for male to female patients is 50.2% to 49.8% respectively, that the last performed consultation was most often at the patient's home (76.8%), and the main condition causing the suffering was some form of cancer (70.6%).¹⁸²

Out of the 38,768 cases of assisted dying reported to the RRCs from 1999 to 2013,¹⁸³ a total of 74 of the physicians (0.19% of cases) were deemed not to have acted in accordance with the due care criteria (so called 'not careful' verdicts).¹⁸⁴ According to the 2012 national study, the RRCs asked for further information in 22% of all cases in 2010, which is a rise from 6% in the 2007 study.¹⁸⁵ As of the time of writing, no criminal prosecutions have arisen from a 'not careful' verdict. Between 1999 and 2006, only 2 cases resulted in sanctioning via medical proceedings (one resulting in a reprimand and one resulting in a conditional discharge).¹⁸⁶ Between 2007-2011, 27 'not careful' verdicts resulted in an unconditional discharge and 6 cases resulted in a conditional discharge¹⁸⁷ (i.e. the condition being that the doctor is warned that he could be prosecuted for his misstep if he acts in a similar way again).¹⁸⁸ The majority of cases which did not satisfy the due care

¹⁸¹ SCEN, Spiegelinformatie 2013 (KNMG, 2014) 3; In 2012 there were 4801 registered SCEN consultations; in 2011 there were 4,457, in 2010 there was 3,669, and in 2009 there was 3,164.

¹⁸² Ibid, 3.

¹⁸³ Note that at the time of writing, the 2014 RRC Annual Report has not been published. However, 113 cases reported in 2014 have, in the meantime, been made publically available on the RRC website. See: <www.euthanasiecommissie.nl/oordelen/oordelen2014vo/>. Last accessed 28.01.2016. Of these cases, 17 were deemed 'careful' without any need for a follow up with the reporting physician, 92 were deemed 'careful' after a follow up with the reporting physician and/or named consultant, and 4 were deemed 'not careful'.

¹⁸⁴ See the archive of RRC Annual Reports, available at: <www.euthanasiecommissie.nl/archiefjaarverslagen.asp>. Last accessed 28.01.2016; See also, Van der Heide and others., 'Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding' (n 29); G.K. Kimsma and E. van Leeuwen, 'Reviews after the Act: The Role and Work of Regional Euthanasia Review Committees' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012).

¹⁸⁵ Van der Heide and others., 'Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding' (n 29) 16.

¹⁸⁶ See Griffiths, Weyers and Adams (n 43) 214.

¹⁸⁷ Van der Heide and others., 'Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding' (n 29) 217. 1 case = problems with the medical due diligence in carrying out the assistance;

¹⁸⁸ G. den Hartogh, 'The Regulation of Euthanasia – How Successful is the Dutch System?' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 351.

criteria related to the independence of the consulted doctor¹⁸⁹ and careful medical execution, a smaller number regarded the voluntary nature of the request, and the presence of alternative treatment.¹⁹⁰ Furthermore, a total of 10 people have travelled (as of 2014) from the Netherlands to Dignitas in Switzerland for assisted suicide since 1998.

4.2 APPLICATION AND ENFORCEMENT OF THE LAW

4.2.1 ENGLAND

Due to the absolute criminal nature of assisted dying in England, it is natural that top-down command-and-control ensues in the application and enforcement of the law (in light of the abstract taxonomy in **CHAPTER TWO**, this could be called public governance *through* the law). As will become evident below, the only actors involved in the application and enforcement of the law are public¹⁹¹ – namely, members of the judiciary, public prosecutors, and law enforcement officers.

One of the first court cases to deal with VAE in England was the 1957 case of *R v Adams*.¹⁹² The physician administered large doses of morphine and heroine in order to ease the suffering of a terminally ill elderly patient who died as a result. The Court applied the doctrine of ‘double effect’ and acquitted the physician of murder. This doctrine states that a physician who prescribes pain relief that he knows will hasten the patient’s death, will not be guilty of murder *unless* his primary purpose was to cause the patient’s death.

The reluctance to criminally charge a physician acting out of compassion was evident again in the *R v Ludwig* case.¹⁹³ Dr. Ludwig gave his patient, who was in the terminal stages of cancer, a mixture of potassium chloride and lignocaine. This was ‘to treat uncontrollable pain’. The patient died a few minutes after the administration. Despite

¹⁸⁹ H. Weyers, ‘The Legalization of Euthanasia in the Netherlands’ in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 55; G. den Hertogh, *ibid*, 370.

¹⁹⁰ For a discussion on the reports from 1999 to 2006 see ‘Principle Grounds for a finding of ‘not careful’, in Griffiths, Weyers and Adams (n 43) 206. As for an overview of the ‘not careful’ reports between 2007 and 2011, see van der Heide and others, ‘*Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*’ (n 29) 214. Also, see RRC *Annual Reports* from 2002 to 2013.

¹⁹¹ Arguably, one unique exception to this arises when private actors are required to act as jurors in trials before the Crown Court and Criminal Circuit Court.

¹⁹² *R v Adams* (unreported). See H. Palmer, ‘Dr. Adams trial for murder’ (1957) *CrimLRev* 365.

¹⁹³ See *The Times* (16 March 1990).

initially prosecuting Dr. Ludwig, the prosecutor offered no evidence against him during the proceedings, resulting in a not guilty verdict. Notwithstanding the certain foreseeability of fatality given the dosage administered, it was held that he did not intend the death - i.e. the Court applied the doctrine of 'double effect'.

Two years later in *R v Cox*,¹⁹⁴ a rare occasion occurred whereby the court convicted the accused physician, Dr Cox. The deceased, who was a patient of the accused, had rheumatoid arthritis, complicated by gastric ulcers, gangrene, and body sores. She was crippled from her condition and in great pain. Furthermore, there appeared to be evidence of a persistent request from the deceased for help in ending her life. However, unlike the *Adams* and *Lodwig* cases where the physicians faced a charge of murder, Dr Cox was charged with attempted murder. This was because the deceased's corpse had been cremated before the police investigation could prove actual causation. Nonetheless, he was found guilty due 'to the most clear and compelling evidence' from his own records that he did not just foresee, but in fact intended to cause her death. In sentencing, Justice Ognall proclaimed that Cox had betrayed his unequivocal professional duty and required, as a matter of principle, to be handed down a term of imprisonment. He was given a 12-month prison sentence, 'but in recognition of the fact that the public interest would not be served immediately' it was suspended. Furthermore, the General Medical Council (GMC) did not erase his name from the medical register and merely censored his conduct while undergoing re-training.

Mention must also be made of the more recent *Dr Martin* trial. The physician in question had been accused of accelerating the death of three patients. Despite, being acquitted of the criminal charges by the Teesside Crown Court, the GMC (in disciplinary hearings) found that in two of those instances the administration of drugs 'more than minimally or trivially contributed to the deaths' of the patients, and that the injections given by Dr Martin 'were not clinically justified.'¹⁹⁵ He was accordingly struck off the Medical Registrar.

¹⁹⁴ *R v Cox* [1992] 12 BMLR 38 (Winchester Crown Court).

¹⁹⁵ N. Bunyan, 'GP Howard Martin accused of ending the life of more patients', *The Telegraph*, 30 July 2010; See also 'Dr. Howard Martin: timeline of investigation in patient deaths', *The Telegraph*, 14 March 2013.

As regards recent instances of ‘mercy killing’, one particular high profile court decision must be noted.¹⁹⁶ In the 2010 *Gilderdale* decision,¹⁹⁷ a 12 person jury in Lewes Crown Court found a mother not guilty of the attempted murder of her daughter. The deceased was suffering unbearably from a severe irreversible form of ME causing her to lose over half her bone density. Food and liquid were provided through a tube and the maximum permissible morphine for pain management was given by a timer-controlled syringe. Over the 21 years she suffered from this condition, she repeatedly requested assisted suicide.¹⁹⁸ Despite the accused’s guilty plea to assisted suicide and the advice of the trial judge to pursue a charge of this offence, the DPP chose instead to file for the charge of attempted murder. Upon a verdict of not-guilty, said judge (Mr Justice Bean) exercised ‘his freedom to comment on the values underpinning the law’,¹⁹⁹ by paying tribute to the jury for showing ‘decency’ and ‘humanity’ and questioning the merit of applying the charge of assisted suicide to the defendant.²⁰⁰

Regarding the 101 investigations of AS brought to the attention of the prosecution authorities,²⁰¹ 69 were not proceeded with by the DPP and 16 cases were withdrawn by the police. There are currently 10 on-going investigations, and 1 case of assisted attempted suicide has been successfully prosecuted. Regarding the single prosecution, the accused was handed a 12 year jail sentence after being found guilty of knowingly helping the victim attempt suicide, by supplying the means (a lighter and petrol) to set himself a light. This was quite an exceptional case in light of the others, which all involved –in stark contrast to this case - a merciful motive. Moreover, a number of 101 investigations mentioned above, involved ‘suicide tourism’, whereby sufficient evidence existed to

¹⁹⁶ See also the 2010 Criminal Court of Appeal decision in *Inglis* [2010] All ER (D) 140; where the defendant was convicted of murder. In this instance of ‘mercy killing’, the deceased was in a severe coma and unable to make a voluntary request.

¹⁹⁷ See *R v Kay Gilderdale* (Lewes Crown Court, 2010) see BBC report available at <http://news.bbc.co.uk/2/hi/uk_news/england/sussex/8479211.stm>. Last accessed 28.01.2016.

¹⁹⁸ She did attempt to commit suicide on her own a number of times but due to her disability had failed, causing further injury and suffering.

¹⁹⁹ S. Shetreet and S. Turenne, *Judges on Trial: The Independence and Accountability of the English Judiciary* (Cambridge University Press, 2013) 373.

²⁰⁰ C. Gammell and T. Whitehead, ‘Why was Kay Gilderdale in court charged with attempted murder?’, *The Telegraph*, 12 May 2014, available at <www.telegraph.co.uk/news/uknews/crime/7077426/Why-was-Kay-Gilderdale-in-court-charged-with-attempted-murder.html>. Last accessed 28.01.2016. The prosecution’s decision was also criticized in mainstream media and by other members of the judiciary. See for example, See, A. Hirsch, ‘Kay Gilderdale case: A clear verdict on the law’s confusion on assisted suicide’, *The Guardian*, 25 January, 2010.

²⁰¹ The following data on such cases is from the Crown Prosecution Central records (n 9).

prosecute²⁰² but having weighed up the factors, the DPP decided against sanctioning such behaviour in the ‘public interest’.

A number of high profile and indeed tragic, individual claims have come before the High Court, the Court of Appeal and the Supreme Court, all seeking a declaration that the current law on VAE and AS is incompatible with the Human Rights Act 1998 (namely the right to private life).²⁰³ Recently a claim was also made, for the first time, seeking to permit the defence of necessity (i.e. the termination of life as the only means to end suffering) should a doctor perform VAE. Both of these claims were rejected.²⁰⁴ The claim to extend the defence of necessity was refused by the Divisional Court and the Court of Appeal, as it would effectively create a fundamental change in the law – a change deemed beyond the power of the Court to bring about.²⁰⁵ The Court of Appeal added the defence of necessity in such cases would be ‘wholly unsustainable’ given the importance of the ‘sanctity of life’ principle in common law and, moreover, that there is ‘no right, fundamental or otherwise, to require the State to allow others to assist you to die or to kill you.’²⁰⁶ As for the human rights based claim, it was consistently held, prior to the Supreme Court decision in 2014, that it would be inappropriate for the Courts to declare the current law incompatible with human rights.²⁰⁷ However in the (somewhat landmark) 2014 Supreme Court decision, Lady Hale and Lord Kerr did argue, contrary to the other seven judges, that the current ban on assisted suicide *is* incompatible with the right to respect for private life protected by Article 8 of the European Convention on Human Rights (ECHR).²⁰⁸ In the same

²⁰² In these cases, the DPP has the choice to prosecute family members and/or doctors who assist in helping a person travel to Switzerland for assisted suicide.

²⁰³ See *Pretty v Director of Public Prosecutions* [2001] EWHC Admin 788 (QB); *Pretty v DPP* [2002] 1 AC 800 (HL); *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45; *Nicklinson v Ministry Of Justice* [2012] EWHC 2381 (Admin); *Nicklinson and Lamb v Ministry of Justice* [2013] EWCA Civ 961; *R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent)*; *R (on the application of AM) (AP) (Respondent) v Director of Public Prosecutors (Appellant)*; *R (on the application of AM) (AP) (Appellant) v Director of Public Prosecutors (Respondent)* [2014] UKSC 38.

²⁰⁴ *Nicklinson v Ministry Of Justice* [2012] EWHC 2381 (Admin).

²⁰⁵ *Nicklinson v Ministry Of Justice* [2012] EWHC 2381 (Admin), para 75; *Nicklinson and Lamb v Ministry of Justice* [2013] EWCA Civ 961, para 56. Note that this claim based on the defence of necessity was not pursued by the applicants in the appeal before the Supreme Court.

²⁰⁶ *Nicklinson and Lamb v Ministry of Justice* [2013] EWCA Civ 961, paras 54-63.

²⁰⁷ For example; See *Nicklinson and Lamb* [2013] EWCA Civ 961, per Lord Chief Justice at Para. 155: ‘Parliament represents the conscience of the nation. Judges, however eminent, do not; [...] we cannot suspend or dispense with primary legislation’; *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin), per Lord Justice Toulson: ‘Some will say the Judges must step in to change the law. Some may be sorely tempted to do so. But to do so here would be to usurp the function of Parliament in this classically sensitive area.’ See *Nicklinson* [2014] UKSC 38, Para. 116; Lord Goff at 865 D/H and Lord Mustill in *Bland* at 896F, Lord Hobhouse in *Pretty* at Para. 120 and Lord Hope in *Purdy* at Para. 26.

²⁰⁸ See *Nicklinson* [2014] UKSC 38,, per Lady Hale, para 300; and per Lord Kerr, para 327.

decision, Lord Neuberger, Lord Mance, and Lord Wilson, although refusing to declare said law incompatible with the ECHR in this particular instance, did not rule out the possibility of a declaration of incompatibility being made in the future once Parliament has been given time to assess the issue.²⁰⁹ Ultimately, it was made clear by all the Supreme Court judges in this case (also by the dissenting judges, Lady Hale and Lord Kerr)²¹⁰ that any reform of the law on assisted dying is most preferably an issue for Parliament.

4.2.2 FRANCE

Similar to England, the blanket ban nature of assisted dying in France means it remains in the stronghold of public governance *through* the criminal law. Here the only actors involved in the application and enforcement of the law are the judiciary, public prosecutors and law enforcement officers.²¹¹

In the *Duffau*²¹² case, a doctor instantly ended the life of a 92 year-old patient who was 'suffering unbearably' with an injection of potassium chloride, upon the patient's request.²¹³ Disciplinary charges were brought before the *Conseil de l'Ordre des medecines en France*. On appeal, he was found guilty of intentionally causing his patient's death – an intention the doctor admitted to having.²¹⁴ He was handed a one year suspension, which

²⁰⁹ See *Nicklinson* [2014] UKSC 38, per Lord Neuberger, para 108-116, 188; see also Lord Mance, para 186 - 190; and Lord Wilson, para 202. For an excellent commentary on this decision, see: E. Wicks, 'The Supreme Court Judgement in *Nicklinson*: One Step Forward on Assisted Dying; Two Steps Back on Human Rights' 23(1) *Medical Law Review* 144-156.

²¹⁰ *Nicklinson* [2014] UKSC 38, per Lady Hale, para 300: "Like everyone else, I consider that Parliament is much the preferable forum in which the issue should be decided. Indeed, under our constitutional arrangements, it is the only forum in which a solution can be found which will render our law compatible with the Convention rights." Per Lord Kerr, para 327: "In making that declaration we do not usurp the role of Parliament. On the contrary, we do no more than what Parliament has required us to do."

²¹¹ Arguably, one unique exception to this arises when private actors are required to act as jurors in trials before the *Cout of Assize*.

²¹² See *Duffau*, Conseil Régional de l'Ordre des Médecins de Midi-Pyrénées, Section Disciplinaire, 19 sept. 1998, *Procureur de la République de Millau/Direction Départementale des Affaires Sanitaires et Sociales c. Dr. Jean Paul Duffau; Conseil D'État*, 29 December 2000, no. No. 212813. For an online version of this decision go to: <http://basedaj.aphp.fr/daj/public/index/display/id_theme/403/id_fiche/9389>. Last accessed 28.01.2016

²¹³ Evidenced by doctor in question and attending medical staff.

²¹⁴ Lewis makes mention of a number of cases reported in the media, which came before a jury at a Cour d'Assises, resulting in acquittals or suspended sentences: "C. assises Ille-et-Vilaine, 11 mars 1998, Dict. perm. Bioéthique et Biotechnologies, Bull. Dict. perm., no 61, [8504] (five year suspended sentence given to defendant who had performed euthanasia); C. assises du Rhône, 12 fév. 2001, cited in Aumonier, supra n. 5, 106 (one year suspended sentence given to husband who had killed his seriously ill wife); C. assises de l'Herault, reported in Libération, 2 fév. 1996, 6 and (1997) 8 J. Int'l de Bioéthique 113 (five year

was upheld by the *Conseil d'État*. Article 3 of the European Convention on Human Rights (preventing inhuman and degrading treatment) and the constitutional principle of human dignity were both rejected by the *Conseil d'État* as possible exceptions to allow for the intentional termination of life when a patient is suffering unbearably and incurably. Despite being aware of the disciplinary decision, the prosecution authorities refused to open a criminal investigation or initiate any criminal charges.

In 2003, the highly publicized *Humbert*²¹⁵ case fuelled numerous government discussions, public opinion surveys and media reports. A 22-year-old had been left mute, blind and paralyzed from a car accident. He unequivocally expressed his desire for assistance in ending his life,²¹⁶ which he described as a 'living death'. His mother injected him with barbiturates before his physician injected him with potassium chloride, resulting in death. Both faced criminal charges. However, the court followed the DPP's request to dismiss the trial, 'given the particular moral circumstances'. The judge held that both of the accused acted out 'of love' and 'compassion' and in light of the public reaction; an order of *non-lieu* must be issued.²¹⁷ Both were exonerated of the charges.

In the 2007 *Tramois* case, a doctor and nurse were prosecuted²¹⁸ for providing a lethal injection to a cancer patient in the terminal phase, upon her request. According to the case report, she was suffering despite massive doses of morphine. She had tremors, urinary incontinence, constant fever, sores, nausea, depression, anxiety and a bowel obstruction, which caused vomiting excrement. The *Cour d'assises* finally acquitted the nurse. The doctor, however, was found guilty of murder and sentenced to a symbolic one-year suspended jail sentence. It was not recorded on her criminal record and both medics eventually returned to work - having also served disciplinary suspensions from the Medical Council.

suspended sentence given to mother who had killed her 23 year old autistic daughter).’ Also for a discussion of two earlier disciplinary decisions (in 1985 and 1986), whereby the accused doctors (charged with causing the death of their patient’s life) were acquitted in the absence of admission, see Lewis (n 18) 46-47.
²¹⁵ See *Le Monde* (26 September 2003); See also ‘Closure of the case of Vincent Humber by the Courts’, in: C. Renee and J.P Swazey, *Observing Bioethics* (Oxford University Press, 2008).

²¹⁶ Recorded via functional lines of communication (hearing and right thumb) in a letter to then president Jacques Chirac.

²¹⁷ See R.C. Fox and J.P. Swazey, *Observing Bioethics* (Oxford University Press, 2008) 49 - specifically in relation to bioethics in France.

²¹⁸ The son of the deceased, who like his father refused to bring civil charges, declared he was "*sad and disgusted*" by the decision to bring the two women before a court "*as criminals*".

In June 2014, the *Cour d'assises* in Pau acquitted *Dr Bonnemaïson* of administering poison to hasten the death of seven patients. Despite the fact that the accused doctor had used a 'banned poison', the jurors held that 'it had not be proven' that by administering the sedatives that he intended to kill his patients.²¹⁹ It was accepted that he had taken 'medically justified' steps to end the agony of seven patients who only had a short period of life expectancy left. The public prosecutor of Pau has made an appeal to overturn the decision; however, at the time of writing a trial date has not yet been decided.

As in England, the French judiciary²²⁰ has also faced individual claims seeking for the prohibition on VAE to be overturned. In 2008 a Dijon court²²¹ rejected a claim to permit VAE with a lethal dose of barbiturates provided the patient's suffering was untreatable and unbearable. This rejection was, according to the Court, based on the clear prohibition in the criminal code and the inability to usurp the legislators' preference. It was made clear that French judicial decisions are limited to a narrow interpretation of the criminal code and may not set precedent for the future, effectively creating new law.²²²

4.2.3 SWITZERLAND

Unlike the English and French approach, the Swiss approach to assisted dying may be divided from the outset into two. On the one hand, the application and enforcement of the law on VAE is dominated by public actors (police officers, prosecution services, and the courts) – it is a case of public governance *through* the criminal law. On the other hand, the application and enforcement of the law on AS is initially in the hands of private actors ('right-to-die' organisations – 'RTDs'²²³ and medical professionals), with public actors (police and prosecutors) playing a secondary role. In contrast to England and France, the

²¹⁹ J. Lichfield, 'Nicolas Bonnemaïson Trial: French doctor who denied "playing God" is cleared of patient euthanasia', *The Independent*, 30 June 2014. See also 'Euthanasie: le docteur Bonnemaïson acquitté', *Le Monde*, 25 June 2008.

²²⁰ Rather exceptionally, both President Chirac and President Sarkozy have also received direct individual pleas to allow for VAE – from Humbert and Sebiré.

²²¹ *Chantel Sebiré* decision. See 'La justice rejette la demande d'euthanasie active formulée par Chantal Sébire' in *Le Monde* (18.03.2008).

²²² See C. Elliot, 'France', in K.J. Heller and M.D. Dubber (eds) *The Handbook of Comparative Criminal Law* (Stanford University Press, 2011).

²²³ These private associations play a more central role than physicians in facilitating an AS since they continually provide information to the public, screen members, acquire the prescription, assess decisional capacity and then contact the police and other relevant authorities after the performance of an AS. See Ziegler, 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process', (n 39) 324; Ziegler and Bosshard, 'Role of Non-governmental Organisations in Physician Assisted Suicide' (n 39).

application and enforcement of the law on AS in Switzerland is more a case of ‘public-private governance *in the law*’. The following paragraphs provide an overview (i) of how the de-centralized rules on AS work in practice, and (ii) of how the rules on both VAE and AS have been applied and enforced by Swiss courts and tribunals.

As empirically evident from section 4.1.3 above, the RTDs play the leading role in providing AS. Given the wide permissible scope of the Penal Code and the lack of specific Federal or Cantonal-level rules, those ‘lay helpers’ working for the RTDs have greatly shaped how the Swiss law on AS is applied in practice. They are responsible for drafting and complying with their own internal guidelines when providing AS. Leaving aside requirements of Swiss nationality or residency (which Dignitas and Exit International do not insist upon), the procedural and substantive steps followed by the four RTDs when providing AS are largely similar.²²⁴

Step 1: RTD assesses request for assisted suicide

All relevant medical reports, including a certificate confirming faculty of judgment, must be obtained and reviewed. An in-person interview between an RTD lay helper and the requestor is arranged where questions, concerns and alternatives are discussed. Provided the requestor reconfirms his desire for AS, the lay helper will request a doctor (be it a general practitioner, the attending physician, or a consultant doctor working at the RTD) to examine the requestor and prescribe a lethal drug if deemed suitable.

Step 2: The doctor’s examination and prescription of a lethal drug

The examining doctor will not prescribe the lethal drug until he has assessed the requestor’s (in this context, the patient’s) medical condition and decisional capacity. Under Swiss statutory law, adults and older adolescents are presumed to possess decisional capacity. However, according to the current SAMS guidelines, the doctor is responsible in these cases to check ‘the patient is capable of making the decision, his wish has been well thought out, without external pressure, and he persists in this wish.’ Swiss

²²⁴ See the conditions as set out by Dignitas (available at: <www.dignitas.ch/index.php?option=com_content&view=article&id=20&Itemid=60&lang=en>), by Exit Deutsche (available at: <www.exit.ch/freitodbegleitung/bedingungen/>), and by Exit ADMD (available at: <www.exit-geneve.ch/conditions.htm>). Last accessed 28.01.2016. See also Ziegler, *ibid* 323-325; Ziegler and Bosshard, *ibid* 297; Lewy (n 57) 88-109.

statutory law does not require the person who receives AS to have a particular kind of suffering or medical diagnosis, but again SAMS guidelines dictate otherwise. The doctor must check if the 'patient's disease justifies the assumption that he is approaching the end of life' and that '[a]lternative possibilities for providing assistance have been discussed and, if desired, have been implemented.' As outlined in Section 3.1.3, above, the Federal Supreme Court has verified that these more stringent conditions must be met by the examining doctor. If the doctor has made these checks and is satisfied that patient's medical condition and decisional capacity, he may then under the Swiss Law on Therapeutic Products, prescribe the lethal drug used for AS (namely, sodium pentobarbital).

Step 3: Assistance itself

The RTD usually, obtains the prescription and stores the drug until the day of use. On the agreed date of suicide, at a location organised by the RTD (rented premise) or at the patient's home, the RTD worker will again assess the patient's decisional capacity. If satisfied with the patient's assertion to die, the RTD worker will prepare the lethal drug for consumption. The patient must be able to take the final step on their own. There are three general options: drink the barbiturate dissolved in water, administer it via a gastric tube or open the tab of an infusion stopcock.

Step 4: Post-mortem verification

Once the suicide has occurred, the RTD lay helper informs the local police service of an 'extraordinary death'. This results in a standard legal inspection, whereby the police arrive at the scene, normally with a medical officer of the state health department and clarify whether all applicable legal provisions have been observed. It is not uncommon for the lay helper to have recorded the suicide for evidential purposes.²²⁵

Of course, the above is how the provision of AS occurs if the general law (statutory and judicial), RTD internal guidelines and SAMS guidelines are adhered to by the relevant actors (RTD workers, examining doctors, police inspectors, and forensic officers). There

²²⁵ See the procedure for assisted suicide on the respective right to die organisations homepage: For Exit Schweiz see: <www.exit.ch/en/faq/>; for Dignitas see: <www.dignitas.ch/index.php?option=com_content&view=article&id=22&lang=en>; for EXIT ADMS see: <www.exit-geneve.ch/>. Last accessed 28.01.2016.

have, however, been various media scandals about the manner in which AS was provided by RTDs – namely involving processes and lay workers associated with Dignitas.²²⁶ There have also been reports and empirical evidence of patients who received AS despite doubts over whether their ‘medical disease justifies the assumption that they were approaching the end of life.’²²⁷

However, there have only been a small number of trials and medical disciplinary charges for persons accused of performing AS not in accordance with the law. There have also only been a small number of trials for persons accused of going one step further than AS and, in effect performing VAE.

In 1990, an *Exit* volunteer was convicted for killing two people who had expressed their desire to die. He suffocated them with a plastic bag after their attempted suicide via ingesting lethal barbiturates had failed. He was handed a suspended six month sentence.²²⁸ In 2004, the Zurich Administrative Court revoked a doctor’s licence to prescribe controlled substances. He had prescribed, more than once, a lethal substance to be used in a suicide without making a personal assessment of the recipient.²²⁹ In a similar case the same year, the Aargau Administrative Court revoked a doctor’s licence for failing to make a careful medical diagnosis. In this case the doctor had also failed to write a medical report.

In 2007, a psychiatrist (Peter Baumann)²³⁰ was found guilty on two counts by the Criminal Court in Basel: for performing AS with selfish motives (a crime under Art. 115 of the Penal Code), and for an act of negligent manslaughter (a crime under Art. 117 of the Penal Code).

²²⁶ There have been claims that assisted suicide has been practiced by Dignitas workers in a car at a parking lot, using a plastic bag and helium gas. There have also been claims that Dignitas ‘does not give people enough time to reconsider their wish to die.’ Reports ‘that people have received the lethal drug the same day on which they arrived in Switzerland, and after only a short interview.’ See R. Andorno, ‘Nonphysician-Assisted Suicide in Switzerland’ (2013) 22(3) *Cambridge Quarterly of Healthcare Ethics* 249.

²²⁷ Namely, cases involving ‘double suicides’, whereby one partner or spouse is not terminally ill. See Andorno, *ibid.* See also British conductor dies with wife at assisted suicide clinic. *The Guardian* 2009 July 14; available at <www.guardian.co.uk/society/2009/jul/14/assisted-suicide-conductoredward-downes>. Last accessed 28.01.2016.

²²⁸ *Verwaltungsgericht des Kantons Zürich* [Zurich Administrative Court], *Entscheid der 3. Kammer VB Nr 99.00145*, 1999.

²²⁹ *Verwaltungsgericht des Kantons Aargau* [Aargau Administrative Court], *Entscheid BE 2003.00354-K3*, 2005.

²³⁰ Peter Baumann was well-known in the media for his controversial views on assisted dying. He resigned as a member of the RTD ‘Exit’ and set up his own RTD called ‘*Suizidhilfe*’, which defended the view that patients who are categorized as mentally ill also have the right to assistance in ending their lives. See; Peter Baumann, ‘Beihilfe zum Suizid kann eine ärztliche Handlung sein’ (2001) 82 *Schweizerische Ärztezeitung*: 296–98.

The former charge was due to the Court's finding that he had broadcast the provision of an assisted suicide in order to gain self-publicity, and this was deemed a selfish motive.²³¹ The latter charge was due to his apparent failure to assess the competency of a patient with a mental illness before providing him with assistance in committing suicide.²³² The Court of Appeal in Basel amended the Criminal Court's judgement. It found that Baumann was guilty of intentional (not merely negligent) homicide as he had expected and accepted that the patient was mentally incompetent. For this he was handed a sentence of four years imprisonment. Regarding the second charge, the Court of Appeal did not consider that he had performed AS with 'selfish motives', and acquitted him on this point. In 2009, the Swiss Federal Court upheld the decision of the Court of Appeal.²³³ On 3 February 2010, Mr Baumann was pardoned by the Basel Cantonal Parliament with 69 votes to 7.

A more recent trial regarding an act of assisted dying – this time VAE - was the *Berener* case in 2010.²³⁴ The accused, Daphne Berner, was a doctor and member of Exit ADMD. She was requested to assist in the suicide of a 41-year-old patient suffering from a rare degenerative neurological disorder. By the time of the agreed date of the assisted suicide, the patient's physical condition had worsened to an unexpected degree. She was too weak to properly release (by foot) the installed device which would allow the lethal substance to be administered into her system (via an intravenous line). Essentially, this meant that she was no longer physically capable of committing suicide, assisted or not. Ms Berner asked the patient to confirm her wish to commit suicide, in which she responded with a clear "now." Ms Berner released the device to allow the lethal substance in the patient's system, who died as a result minutes later. Ms Berner's releasing of the substance was done upon the final signal of the patient, which was a symbolic pressing on the original release mechanism (note: the patient could indeed press this mechanism, but not sufficiently enough to release the device herself). Following the patient's death, Ms Berner called the police and explained the sequence of events. As a result, she was charged with

²³¹ As Lewry and Bosshard state, this was a 'noteworthy finding' as before this decision the common legal understanding was that "selfish motives" had to do with "material benefits." See Lewy (n 57) 109; G. Bosshard, 'Die Tätigkeit der Sterbehilfsorganisationen und die Rolle des Arztes' in C. Rehmann-Sutter (ed) *Beihilfe zum Suizid in der Schweiz: Beiträge aus Ethik, Recht und Medizin* (Bern: Peter Lang, 2008) 476.

²³² See R. Spöndlin, 'Suizidhelfer muss hinter Gitter. Neue Gesetzesauslegung in der Schweiz [Suicide assistant to jail. New Interpretation of Swiss Law]', *Soziale Medizin* (2 July 2007).

²³³ Federal Court, 11 June 2009, Decision 6B_48/2009.

²³⁴ Le Tribunal de police, Canton de Neuchâtel, 'Distinction entre assistance au suicide et meurtre sur demande de la victime. Circonstances justificatives', Ref: POL.2010.19 / mad; Ref. MP: MP.2009.4683-BOU.

the offence of murder at the request of the victim (Article 114 of the Penal Code). On December 6 2009, she was acquitted of said charge by *le Tribunal de police* in Boudry, Neuchâtel. The Court stated ‘in the very specific circumstances’ at hand, Ms Berner was in a ‘state of necessity’ (a defence under Article 17 and 18 of the Penal Code) and that she had acted in a justifiable manner to ‘preserve the dignity and self-determination of her patient.’

Another controversial trial occurred involving a doctor in the same Canton in 2014. This time the case concerned an act of assisted suicide. An 88-year-old man who, according to medical expertise, ‘probably had cancer that made life unbearable’, but who refused to undergo a medical examination or to consider any alternative treatments, was able to receive AS. Moreover, only eight days had passed from the day he joined the RTD Exit to the day he received AS. The patient’s doctor (Dr Freiburghaus) was held to have violated Article 26 of the Law on Narcotics (and thus Article 86 of the Penal Code), along with the SAMS (professional medical) guidelines by prescribing a lethal substance ‘without knowing his patient’s conditions.’ The Criminal Court in Neuchâtel, however, acquitted the doctor of these charges.²³⁵ It stated that: what is meant is by knowledge of the patient’s condition is not clear from the jurisprudence of the Swiss courts, but that ‘total’ knowledge can never be achieved. According to the Court, the fact that two other medics would have made the same prognosis (of a rectum tumour), that such a prognosis is largely based on the patient’s history and behaviour (not necessarily a physical examination), and that the patient was 88 years old with full capacity and strongly determined to end his own life (he had previously attempted suicide and made clear his intention to do so again), then it could not be said the doctor infringed the above legal provisions.

Just as in England and France, individual attempts to challenge the law have also been made before the highest courts in Switzerland. In 2006, the Swiss Supreme Court was faced with a case involving a man with advanced bipolar disorder desiring suicide (with the help of Dignitas) but unable to obtain a prescription for a lethal medication.²³⁶ He claimed that even if no physician would prescribe the lethal medication (in accordance

²³⁵ La Cour Pénale, ‘Assistance au suicide non punissable’, No. dossier: CPEN.2013.75, 23.04.2014. RJN 2014, 260.

²³⁶ BGE 133 I 58, November 2006. Available at www.bger.ch.

with professional guidelines) he still had the autonomous right to obtain the required medication directly himself. The Swiss Court agreed that he had a right to determine his own death, but it was not a personal liberty that extended to override the regulation of narcotic dispensation. It was ultimately held that RTDs and their interaction between patients may be limited in this respect by legitimate state interests. Since this decision, two well-known human rights-based challenges (which are discussed in more detail in **CHAPTER SEVEN**, below) were brought before the Swiss Federal Supreme Court and, eventually, before the European Court of Human Rights (the ECtHR). In *Haas v Switzerland* (2011), the Grand Chamber of ECtHR decided that the rule upheld by the Swiss court requiring a prescription for a lethal drug (sodium pentobarbital) to be based on a psychiatric assessment had a legitimate aim, and was not a violation of the applicant's rights under Art. 8 ECHR.²³⁷ In the 2014 *Gross v Switzerland* case, a Chamber of the ECtHR (i.e. a Chamber of the ECtHR that hears the case before the Grand Chamber) held that there had been a violation of Article 8 due to the unclear nature of Swiss law as to when AS is permitted or not.²³⁸ The case was referred to the Grand Chamber at the request of the Swiss government. Here it was held that the decision at the first hearing before the ECtHR was not legally valid (and thus not legally binding) as the applicant was found to have abused the right of individual application by misleading the Court.²³⁹

4.2.4 THE NETHERLANDS

In comparison to England and France, the approach to permit assisted dying under certain conditions in the Netherlands has meant that the application and enforcement of the law mandates *public-private* actor interdependence. In comparison to Switzerland where only AS is permitted, this interdependence takes a very different form. Indeed, what is similar is that the professional medical bodies at the national level have a great deal of responsibility and room for self-regulation. There exist numerous policies and protocols published by Dutch medical associations on assisted dying, while health care institutions, hospitals and nursing homes may also have their own policy on the behaviour. The KNMG

²³⁷ *Haas v. Switzerland*, no.31322/0, ECHR 2011.

²³⁸ *Gross v. Switzerland*, no. 67810/10, ECHR 2013

²³⁹ *Gross v. Switzerland* [GC], no. 67810/10, ECHR 2013. The patient had in fact died before the first hearing at the ECtHR. The Grand Chamber found that the applicant had 'intended to mislead the Court on a matter concerning the very core of her complaint. In particular, she had taken precautions to prevent information about her death from being disclosed to her counsel, and thus to the Court, in order to prevent the latter from discontinuing the proceedings in her case.'

alone has published over 20 relevant professional guidelines on assisted dying and other MBPSL.²⁴⁰ Also, as in Switzerland, the prosecutors and courts may of course still be called upon to act in the final instance. What is distinct with the Dutch approach to the application and enforcement of the law is the statutory role of doctors in self-reporting, *ex ante* control by expert consultants and *ex post* assessments by non-criminal regional review bodies that precedes (and determines) any involvement of police officers, prosecution authorities and court action.

Attention to the application and enforcement of the law in the Netherlands *prior to the 2002 law* will be touched upon in **CHAPTER SIX** below, which looks at how formal legal change was effected. Here attention is paid to the application of the control system in practice *post* the 2002 Act. In particular, the Annual Reports of the Regional Review Committees (RRCs) and the nation-wide studies provide a solid vantage point to assess the application and enforcement of the law.²⁴¹

In practice, the majority of assisted dying cases demonstrate institutionalised consultation *vis à vis* specially trained physicians. This means SCEN (explained in Section 3.4, above) has come to play an increasingly central role at the early stages of the decision-making process. The data shows that physicians have successfully relied on SCEN consultants for queries on legal questions, technical questions on carrying out the assistance, on dealing with pressure from the patient/family/general environment, and on palliative care options.²⁴² The RRC, and quite obviously the KNMG,²⁴³ have consistently encouraged the use of SCEN consultants. Couple this with the available empirical data and it may be said the application of the law on assisted dying has developed, to a large degree, into a *de facto* system of *ex ante* control.

As for actual reporting, the majority of physicians (87% in 2011)²⁴⁴ use the 2009 standard report form.²⁴⁵ Instead of declaring the death as ‘natural’ on the death certificate, the

²⁴⁰ For a full list of these publications, see: <http://knmg.artsennet.nl/Publicaties/KNMGpublicaties-op-trefwoord/Levenseinde.htm>. Last accessed 28.01.2015.

²⁴¹ There are well over a hundred (anonymized) cases involving particularly complex, new or borderline situations that are available in the reports. These cases are made available for the purpose of providing guidance and clarity for physicians in similar future situations.

²⁴² See SCEN, *Spiegelinformatie SCEN 2013* (KNMG, 2013) 8.

²⁴³ SCEN is a subsidiary body of the KNMG.

²⁴⁴ Van der Heide and others, ‘*Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*’ (n 29) 181. 11% used an older version of the report form.

²⁴⁵ Available on SCEN website, see: <https://www.euthanasiecommissie.nl/procedure/proceduretekst.asp>

physician hands the assisted dying report to the municipal medical coroner. These coroners then make an on-site visit, check the facts of the report, receive the relevant medical papers, and contact the prosecution to receive allowance for burial or cremation. Finally, they send these papers to the appropriate RRC.²⁴⁶

Under the RRC 'new working procedures' adopted in 2011,²⁴⁷ an incoming notification is recorded and examined by an experienced member of the secretariat ('secretary') who estimates the likelihood that the review committee will have further questions regarding the notification (i.e. if the submitted report is 'straightforward' or not).²⁴⁸ Notifications are considered straightforward if an experienced secretary, on receiving the papers (at the start of the review procedure), can establish with a high degree of certainty that the due care criteria have been complied with and that the information provided is so comprehensive that it raises no questions.²⁴⁹ Notifications deemed 'straightforward' are then sent electronically to the three regional committee members (a lawyer, a physician and an ethicist) for assessment. If all three members confirm that the notification is a straightforward case, which means they have no further questions and the due care criteria have been complied with, the findings on the notification can be finalised. However, if one regional committee member has questions with regard to the notification, the file will be sent to all committee members for plenary discussion at a monthly meeting.

If the committee have any doubts about the report, the reporting physician (and in a smaller number of cases the consultant physician) will be contacted in written form, by telephone or, if necessary, requested for an in-person interview.²⁵⁰ In terms of review and sanctions, most of the cases reported to the RRC are relatively straightforward and clear to assess – the information is largely deemed adequate and the legal norms (based on the test of reasonableness)²⁵¹ are often understood as fulfilled.²⁵² This is despite the

²⁴⁶ See Kimsma and van Leeuwen (n 76) 194.

²⁴⁷ See the heading "New working procedure" in the RRC *Annual Report 2011*, 5.

²⁴⁸ Ibid.

²⁴⁹ Ibid.

²⁵⁰ According to the 2012 national study, 91% of cases whereby the RRC required more information involved the reporting physician, 5% the consultant physician, and 4% both. Van der Heide, et al., '*Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*' (n 29) 183.

²⁵¹ The physician must make it plausible that he could 'reasonably conclude' that the statutory due care requirements were complied with – see RRC *Annual Report 2010*, 7.

²⁵² See Kimsma and van Leeuwen (n 76) 194.

inevitable abstraction of notions such as ‘unbearable suffering’ and ‘voluntary, well considered request’.²⁵³

The RRCs evaluative approach is, according to Kimsma and van Leeuwen based on a four-fold ‘framework of analysis’:²⁵⁴ (i) objectification: a conflict of duties (relieving suffering v protecting life) must be demonstrated on the facts presented; (ii) individualization: recognition of unique circumstances and individual experiences play a central role; (iii) abstraction: the cause of the suffering (psychic or somatic) is not the essential factor, the essential factor is the degree of suffering and how it is experienced by the patient; and (iv) medical classification: the patient’s suffering should, nonetheless, have a basis in some medically classifiable somatic or psychiatric disease.

The focus here (descriptive in nature) now turns to three of the more controversial talking points with regard to the RRCs decisions: first, reports submitted by physicians working for the ‘End-of-Life clinic’; and second, cases whereby patients suffered from dementia or psychiatric conditions. Then attention turns to reported cases where the reporting physician was found ‘not careful’ and to non-medical cases where prosecution services or the Medical Inspectorate were involved.

(i) The End-of-Life Clinic

The End-of-Life Clinic (described above in Section 4.1.4 and hereafter referred to as the ‘ELC’) has received both professional²⁵⁵ and academic²⁵⁶ criticism. Opponents of the clinic restate a position generally assumed as valid before the enactment of the 2002 law: the

²⁵³ These material conditions/ substantive norms are intentionally open-ended. ‘The flexibility and freedom to develop new interpretation was explicitly encouraged during the political debate in the Dutch Parliament’. See Kimsma and van Leeuwen (n 76) 198-199.

²⁵⁴ Each connected with a landmark court case, which are discussed in CHAPTER 6 below. See Kimsma and van Leeuwen, *ibid*, 196. See also E. Pans, *De normatieve grondslagen van het nederlandse euthanasierecht [The normative foundations of the Dutch euthanasia jurisprudence]* (Wolf Legal Publishers, 2006).

²⁵⁵ The RDMA expressed its apprehension regarding the clinic at an early stage of its formation: ‘it is only in such a long-term treatment relationship that a bond of trust between patient and physician can develop. [...] The End-of-Life Clinic’s mobile teams assess the request for euthanasia in isolation from other care requirements and the patient’s medical history. The RDMA considers this to be undesirable.’ J. Legemaate and I. Bolt, ‘The Dutch Euthanasia Act: Recent Legal Developments’ *European Journal of Health Law* 20 (2013) 451-470. The RDMA statement may be read at: <knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/KNMG-huiverig-voor-Levenseindekliniek-1.htm>. Last accessed 28.01.2016.

²⁵⁶ For example, den Hartogh raises some interesting questions regarding the legality of the association, see G.A. den Hartogh, ‘Levenseindekliniek binnen de grenzen van de wet?’ (2011) 35 *Tijdschrift voor Gezondheidsrecht* 212-216.

treating doctor must be the same doctor who actually performs the VAE or AS.²⁵⁷ This is a stance premised on doubts and concerns over the doctor-patient relationship (or rather the potential lack thereof) when the ELC is involved. However the RRC²⁵⁸ and the Minister of Health,²⁵⁹ dismiss this stance. The open norms of the 2002 Act are not understood to require that the termination of life on request should only be carried out by the physician who is treating the patient. What is decisive in the RRC's interpretation of compliance is whether 'the doctor has such a relationship with the patient as to permit him to form a judgment concerning the requirements of due care.'²⁶⁰

In all 139 reported cases of assisted dying involving the ELC dating up to 2013,²⁶¹ the due care criteria were understood as fulfilled. According to the RRC reports, a cautious procedure for both the outpatient phase (intake and assessment) and implementing phase (when termination of life actually occurs) presented no reasonable ground to find a case of 'not careful'.²⁶² However in three cases reported in 2014 involving the ELC, a verdict of 'not careful' was reached.²⁶³ All three involved patients suffering from psychiatric conditions (discussed in the sub-section below). In May 2015, the Dutch judiciary faced (for the first time) a clash between the wishes of the patient and actions of the ELC on the one hand, and the internal policy-making of a nursing home on the other. The patient was an 80-year-old woman who had suffered a brain haemorrhage and was, as a result, left paralysed and completely dependant on care. She was placed in a Christian-based nursing home in her hometown province of Zeeland. After requesting assistance in

²⁵⁷ See H. Weyers, 'Physician Assisted Death in Western Europe: the legal and empirical situation' in T.E. Quill and F.G. Miller (eds) *Palliative Care and Ethics* (Oxford: Oxford University Press, 2014) 290.

²⁵⁸ See RRC *Annual Report 2012*, 9 and CHAPTER 2, above. Note that the RRC discuss all reported cases from the ELC at the monthly meetings between the regional committees.

²⁵⁹ Note full position: Minister of Health, Welfare and Sport. In a letter to the House of Representatives in February 2011, said Minister reasoned that no *de jure* obstacle existed prohibiting such clinics. Any question of compatibility is dependent on whether the physician's activities fall within the boundaries of the law. Also, the Minister did not exclude the exceptional performance of assisted dying in such a clinic on patients suffering from dementia or psychotic disorders. See Parliamentary Documents II 2010-2011, 32647, No. 1, 2; Parliamentary Documents II 2011-2012, 32647, No. 4, 25.

²⁶⁰ Weyers (n 149).

²⁶¹ This is a total figure according to the 2012 and 2013 RRC Annual Reports.

²⁶² In response to a patient's request for assisted termination of life, a written questionnaire is requested, as is access to medical data in order to compile a record. A trained nurse and doctor then examine the record, meetings are arranged with the patient to assess the nature of the suffering and the request. Attempted contact is made (most often successfully) with the patient's treating doctor – a SCEN consultant is then contacted and consulted, before the case is presented to internal multidisciplinary consult group and reviewed entirely once again before any performance of assisted dying takes place. See 2012 RRC *Annual Report* 6.

²⁶³ Case 1, 2, and 5. These verdicts are available at <www.euthanasiecommissie.nl/oordelen/oordelen2014vo/>. Last accessed 28.01.2016.

dying, the physicians at the nursing home concluded that she did not have the requisite mental competence to satisfy the statutory criteria for assisted dying. Unhappy with this result, the patient (with the assistance of her family) contacted the ELC for help in dying. As a result, three more physicians (one general practitioner, a SCEN consultant and a psychiatrist) evaluated her and deemed that she had the requisite mental capacity to avail of assisted dying. Despite suffering from some cognitive issues, her wish to die was judged as voluntary, well considered and sufficiently persistent. Nonetheless, the director of the nursing home objected to any attempt to remove the patient from the institution. The District Court of Zeeland West-Brabant decided the care institution could not keep the woman there against her competent will, and so long as the due care criteria were satisfied then she had the liberty to seek assistance in dying. This decision was upheld by the Appeal Court in Utrecht.²⁶⁴

(ii) Dementia and Psychiatric Illnesses

In cases of non-physical suffering, two of the central criteria to lawfully carry out assisted dying - a 'voluntary and well-considered request' and the presence of 'unbearable and hopeless suffering' - become inevitably controversial. As early as 1994, the Dutch Supreme Court (in the *Chabot* decision) held: non-somatic suffering can support a lawful request for assistance with suicide – as far as the justification of necessity is concerned, the source of a patient's suffering is irrelevant.²⁶⁵ In 2002, the Supreme Court made clear that to fall within the exception to the criminal law,²⁶⁶ the source of the suffering may indeed be psychiatric but that it must be predominantly due to a 'medically classified disease or disorder.'²⁶⁷ For almost a decade after this decision, the issue of assisted suicide for non-somatic suffering received more attention than perhaps its actual frequency demanded. However, this is no longer the case. Since 2009, the RRCs have been

²⁶⁴ ECLI: NL: RBMNE: 2015: 2870.

²⁶⁵ This position goes back to the Report of the State Commission on Euthanasia (1985).

²⁶⁶ Note that at the time of this decision, the 2002 Act was being debated in the Parliament, and was formally just a legislative bill. The decision was, however, embraced by the Government and many members of the Parliament and the need for a medically classifiable disease or disorder is a crucial (albeit not explicit) condition in the 2002 Act.

²⁶⁷ Note: The RRCs stress that the concept 'weary/tired of life' [*levensmoe*] as presented in a number of reports is distinct from the meaning attributed to the term in popular debate. In the RRC case-law, it is held that any weariness of life must be predominantly due to a medically classifiable illness or condition. See RRC *Annual Report 2010*, 6-7. A combination of old age afflictions, the experiences of pathological grief or clinical depression were deemed to capable of falling within the scope of what is unbearable suffering 'in a medical context'. See RRC *Annual Report 2009*, 22-23 (Case 9); *Annual Report 2011*, 28-29 (cases 10 and 11); *Annual Report 2011*, 33-34 (Case 13); *Annual Report 2012*, 19-20 (Case 8).

increasingly confronted with reported dementia and psychiatric cases, or so called 'special cases'.²⁶⁸ Note that although the frequency of such cases have increased, they may, in the bigger picture of assisted dying cases, still be considered relatively uncommon.

Concerning the voluntary and well considered nature of the request, the RCC consider it 'important to consult not only an independent physician but also one or more experts, including a psychiatrist.'²⁶⁹ All of the reported cases concerning patients with psychiatric problems in the annual reports (which date up to and including 2013) were deemed in compliance with the law, with the RRC stressing the need for the physician's response to be 'considered especially carefully.'²⁷⁰ However, as stated in Section 4.1.3, in three cases concerning psychiatric patients reported in 2014, the RRC reached a verdict of 'not careful.' In the first two cases, the reporting physicians failed to adequately consult a psychiatrist to determine the voluntary nature of the request. In the third case, the patient suffered from severe tinnitus – although the RRC considered the suffering to be unbearable enough to justify assistance in dying, it was not satisfied that there was no alternative treatment. No criminal or disciplinary charges were brought against the physician after further investigation.

As for the dementia cases, the issues that arise depend on the development of the illness. In early-stage dementia, the main concern is determining if a patient is experiencing 'unbearable suffering'. According to the 2012 RRC Annual Report, '[w]hat makes their suffering unbearable is often their perception of the deterioration that is already taking place in their personality, functions and skills, coupled with the realisation that this will only worsen and eventually lead to utter dependence and total loss of self. Being aware of their disease and its consequences may cause patients great and immediate suffering.'²⁷¹ In the majority of reported dementia cases, the patients were in the early stage of dementia. The RRCs were satisfied in all reported cases that the patient could competently assess their prognosis and had reasonable insight into their future (expected loss of orientation and personality). Each dementia case was deemed as a real and painful combination that may be medically classifiable as 'unbearable'. In 2012, one case was

²⁶⁸ See the 'Foreword' of the RRC *Annual Report 2012*. For an increase in the numbers see the preceding heading on empirical data.

²⁶⁹ *Ibid*, 11.

²⁷⁰ RRC *Annual Report 2012*, 12. See Case 4 for an example of a case involving dementia that was deemed in accordance with the due care criteria.

²⁷¹ RRC *Annual Review 2012*, 18.

however considered 'not careful' due to concerns over the independent assessment.²⁷² No prosecution was initiated after further inquiries into the case. In late-stage dementia (less common in the reported cases than early-stage dementia), the main concern is the acceptability of an advanced written request. The RRCs acknowledge that in such cases decisional competence is less likely to be present and that 'it is essential there is a record of the patient expressing the wish for euthanasia in the past, namely a clear advance directive written by the patient when still decisionally competent, which incontrovertibly applies to the situation at hand'.²⁷³ One case regarding an advanced written request was deemed 'not careful' (the second dementia case to be deemed so in 2012). The concern in this case was a lack of proof regarding the repeated discussions. Again, no prosecution charges were deemed necessary in light of further investigation. This last point brings us neatly onto the next sub-heading – the consequences of 'not careful' decisions.

(iii) 'Not careful' RRC verdicts, the Health Care Inspectorate and Public Prosecution Service

As evident from the above analysis, the RRCs are willing to be relatively flexible in finding the behaviour of a physician as 'careful'. This is the case even if there are doubts as to whether his or her actions in carrying out the act of assisted dying were entirely in conformity with the legal requirements. The observation made by Griffiths, Adams and Weyers in 2008 that the RRC 'decision-making procedure is designed to ensure that the judgment "not careful" will only be given in cases where it is indubitably deserved'²⁷⁴ arguably still holds true. There have been 79 cases (from 1999-2013) where a judgment of 'not careful' was found. The majority of these cases raised concerns over whether the consultation was adequate (independence of the consultant, timing of the consultation) and whether the actual assistance was carried out in accordance with due medical care.²⁷⁵ Since 2013, a brief (pre-annual report) summary of the 'not careful' judgments have been made available online (5 in 2013 and 4 in 2014).²⁷⁶

²⁷² RRC *Annual Review 2012*, 12-13.

²⁷³ *Ibid.*

²⁷⁴ Griffiths, Weyers and Adams (n 43) 135.

²⁷⁵ On the principal ground for a finding of 'not careful' between 1998-2007, see Griffiths, Weyers and Adams (n 43) 206; as for the not careful cases between 2007-2011, see A. van der Heide and others (n 29) 214; for the years 2012, 2013 and 2014, see the RRC website.

²⁷⁶ The 2014 Annual Report has not been published at the time of writing.

The role of the Prosecution Service (OM) and the Health Care Inspectorate (IGZ) in the application and enforcement of the law on assisted dying is minimal. To date, there have been no criminal prosecutions arising from ‘not careful’ RRC verdicts. In 2004, one case resulted in a reprimand in medical disciplinary proceedings²⁷⁷ and another case resulted in a warning upon appeal.²⁷⁸ In all 34 ‘not careful’ decisions between 2007 and 2011, an interview was held between the reporting physician and the IGZ.²⁷⁹ 12 of these decisions required an interview between the reporting physician and the local prosecutor. 6 cases were dismissed conditionally by the OM and 28 cases were dismissed unconditionally. Of the 6 conditional dismissals, 2 cases were concerned with the question of unbearable suffering and alternative treatment, 1 case was concerned with the nature of the independent consultation and the remaining 3 were concerned with the execution of the request. According to the 2012 national study, the motivation behind the decision not to entirely dismiss these 6 cases was based on the severity and magnitude of the observed carelessness, the chance of recurrence and the impression that the physician had drawn enough lessons from what happened. No medical disciplinary charges were brought by the IGZ. According to the 2012 and 2013 RRC Annual Reports, all of the ‘not careful’ verdicts resulted in unconditional dismissals by the OM and no medical disciplinary charges were brought by the IGZ.²⁸⁰

Moving away from decisions made by the RRCs, there have been a small number of criminal prosecutions and medical disciplinary proceedings for doctors who performed assisted dying outside the scope of the 2002 Act,²⁸¹ as well as several convictions of lay persons for assisting suicide.²⁸² A number of these lay persons (sometimes known as ‘suicide-consultants’) work voluntarily for organisations that give advice and support for people contemplating suicide. In one case the suicide consultant was sentenced to twelve

²⁷⁷ Regional Disciplinary Tribunal Zwolle, no 15/2004, 18/5/2006; *Staatscourant* 17/6/2006, no 136, 32; *Tijdschrift voor Gezondheidsrecht* 30: 543-6 (2006); *Medisch Contact* 62: 694-6 (2007).

²⁷⁸ Central Disciplinary Tribunal, no 90/2006, 5/12/2006; *Tijdschrift voor Gezondheidsrecht* 31: 165-70 (2007) *Medisch Contact* 62: 694-6 (2007).

²⁷⁹ A. van der Heide and others (n 29) 218.

²⁸⁰ See the Appendix II of the Dutch language versions of the 2012 and 2013 RRC Annual Reports.

²⁸¹ Most notably the conviction of Dr Sutorius (in the *Brongersma* case); whereby it was upheld by the Supreme Court in 2002 that there must be a ‘medically classified disease or disorder’ for a doctor to be able to rely on the defence of necessity. See also the *Vencken* case LJN: AU0211, Court of Appeal, ‘s-Hertogenbosch, 20-000303-05, where it was held by a medical disciplinary tribunal: that the doctor’s requisite record-keeping was inadequate. No sanction was imposed. See T. Sheldon, ‘Two test cases in Holland clarify law on murder and palliative care’ 2004 329(7476) *BMJ* 1206.

²⁸² See S. Ost and A. Mullock, ‘Pushing the Boundaries of Lawful Assisted Dying in the Netherlands? Existential Suffering and Lay assistance’ (2011) 18(2) *European Journal of Health Law* 163-189.

months of which eight were conditional. The Court of Appeals took the position that the consultant had over-stepped many boundaries and there was fear for repetition.²⁸³ More recently, Gerard Schellekens, the ex-chairman of SVL (Voluntary Life Foundation) was found guilty of knowingly violating the 2002 Act. Although not a doctor, Schellekens aided an 80-year-old woman, who had been suffering from Parkinson's disease for 15 years, to end her own life. The Court emphasised that the Dutch legislation evidenced the legislature's intention that AS should only be lawful under medical supervision and where a doctor's decision would be scrutinised afterwards. He was sentenced to a one year suspended prison sentence.²⁸⁴

In October 2013, Albert Heringa was found guilty for assisting in the suicide of his 99 year old mother.²⁸⁵ Heringa, a non-medic, had assisted his elderly mother because she had persistently claimed to be tired of old age, and could not find a willing physician to help fulfil her request. Despite a guilty verdict by the District Court of Gelderland, no punishment was handed down as the Court was satisfied that Heringa had acted out of love. The Arnhem-Leeuwarden Court of Appeal, however, overturned this decision and decided to acquit Heringa of any wrongdoing.²⁸⁶ It held, despite the fact that Heringa was not a physician, that in such exceptional circumstances the defence of necessity (action taken in the face of a conflict of duties)²⁸⁷ could be successfully invoked to avoid criminal liability. According to the Appeal Court, the accused had to choose between the legal duty to respect life²⁸⁸ and the 'unwritten moral obligation/duty of care for his 99 year old mother to help realize her desire for a painless, peaceful, and dignified death.' Unlike the established legal doctrine on assisted dying, whereby the accepted conflict of duties must be that faced by a doctor - facing on the one hand, the duty to respect life, and on the other hand, the *medical* duty to relieve suffering – the acceptance of the defence of necessity in the case of a lay person represents a landmark change. It is evident from the Court's

²⁸³ See *Tijdschrift voor Gezondheidsrecht* 2004, 173-8.

²⁸⁴ Hof Arnhem 17 februari 2012, LJN BV6139, annotation by TM Schalken.

²⁸⁵ Rechtbank Gelderland, 06/950537-10. This is a well known case, commonly termed the 'Moek' case. The accused recorded the suicide and his assistance therein. It was broadcast on a Dutch television network in Feb 2010.

²⁸⁶ ECLI: NL: GHARL: 2015: 3444; The full judgment is available (in Dutch) at: <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:GHARL:2015:3444&keyword=euthanasie>. Last accessed 28.01.2016.

²⁸⁷ As provided for in Article 40 of the Penal Code, which states that an actor is not guilty of an offence if it was 'the result of a force he could not be expected to resist [overmacht].'

²⁸⁸ As reflected in Article 293 and 294 of the Penal Code.

reasoning that such a decision is considered an 'exceptional' one due to the clear facts of the case: the assistance and the acts preceding the assistance were provided with due care and were well documented (it was, in fact, broadcast on national television); the voluntary, competent and certain nature of the deceased's request was verified by her physician and members of the NVVE; and also the deceased was suffering 'very serious physical and psychological suffering, which measured by today's standards, would have a high degree of probability' of complying with the 2002 Act (meaning, by today's standards, the AS could have been performed lawfully by a physician). This decision, somewhat unsurprisingly, has been appealed to the Supreme Court by the prosecution authorities. At the time of writing, no date on the appeal hearing has been set.

5

THE LAW ‘IN THE BOOKS’ V THE LAW ‘IN ACTION’

The purpose of **PART II** of this study is to move away from, but by no means discard, the ideological discussion on whether assisted dying is right or wrong. Here the focus is on the policy-orientated discussion of how such behaviour can be controlled to prevent abuse. The previous two Chapters described the legal control frameworks in England, France, Switzerland and the Netherlands, focusing on both the law in the books and the law in action. Building upon these descriptions, this Chapter comparatively critiques the application and enforcement of the law in light of their respective formal claims and objectives. First, England and France will be looked at together due to the commonalities in the approach to not only the legal policy on assisted dying, but also the application and enforcement of that policy. The more distinct legal policy approaches and effects in Switzerland and the Netherlands are then addressed.

5.1 COMPARING THE APPLICATION AND ENFORCEMENT OF THE LAW IN LIGHT OF ITS FORMAL CLAIMS AND OBJECTIVES

5.1.1 ENGLAND AND FRANCE

From the few VAE cases that have come before prosecutors and courts in England and France, one can identify discrepancies between the law in the books and the law in action. Although the result sought (not to criminally sentence a compassionate physician or family member) may be commendable, the means to achieve this result are questionable. In both jurisdictions, VAE is formally considered an act of murder. In England, it is an established principle of criminal law that intent for an act of murder may be inferred even

if the evidence does not indicate a purpose to kill but instead indicates an awareness that death or serious bodily harm was virtually certain to occur.¹ Under French law, a person may be considered to have the *mens rea* for murder if he intends another's death to be the result of his act (*dol direct*) or he is aware that his voluntary act will cause, certainly or almost certainly, another's death even if not truly desired (*dol indirect*).² In both jurisdictions, a desire or primary purpose to kill may be irrelevant (at least as far as finding guilt is concerned) once it is established that the death as a result was virtually certain to happen. However as evident above in Section 4.2.1 and 4.2.2, some type of subjective understanding of 'intent' in criminal law has been adopted in the case-law in both jurisdictions. A doctor in England who intends to bring about the death of a patient (and there is explicit evidence of this intention in medical records, discussions with other medics, or otherwise) by injecting a large dose of diamorphine – albeit as the only means to end the patient's unbearable suffering – is likely to be found guilty of murder. However, a doctor who testifies that he only intended to relieve the patient's pain with the same dosage of diamorphine, and who foresaw death as a virtually certain consequence of the administration of that dosage, is likely to be found not guilty of murder.³ While in France, a doctor or family member, who is aware that his/her actions will certainly cause another's death, may be acquitted of murder on the grounds of compassion - despite the prevailing understanding of *l'element morale* for murder in French case-law. The making of such a distinction, arguably, creates a doctrinal tension in both jurisdictions between the more *objective* meaning of intent in criminal law and the more *subjective* concept of intent used to resolve cases of VAE.⁴

It is submitted here that the defence of necessity provides a more coherent explanation for exempting criminal liability, applying – objectively - to situations where a doctor is faced with the choice of leaving a patient without adequate relief, or administering what

¹ *R v Woollin* [1999] 1 AC 82; See also *R v Nedrick* [1986] 3 All ER 1. See the seminal definition of murder at common law by Sir Edward Coke, *Institutes of the Laws of England*, 3rd Part (London, 1641) 47; See also Otłowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press) 15, 31.

² See J. Pradel, *Manuel de Droit pénal général* (14th edn 2002) 502.

³ In England, see the *Dr. Adams*, *Dr. Ludwig* and *Dr. Martin* decisions (Section 4.2.1. above); whereby the respective doctors were found not guilty despite the fact that they administered morphine and potassium, respectively, with fatal (certainly foreseeable) consequences.

⁴ In France, see the *Humbert* and *Bonnemaison* decisions (Section 4.2.2. above); whereby the accused medics were acquitted of murder charges against them due their overwhelming compassion to alleviate suffering and 'moral aspects of the situation' despite the certain foreseeability that their actions would cause death.

is certain to be a fatal dose as the only means to relieve severe untreatable pain.⁵ However, in neither France nor England is the defence of necessity likely to be applied by the Courts. In the former jurisdiction, the reason being is the limited wording of the French criminal code – necessity may only be applied when the act is, *inter alia*, required ‘to ensure the safety of the person.’⁶ Both Lewis and Hennette-Vauchez argue that it is unlikely that a judge in France will accept the idea that killing someone is a means to ensure his or her ‘safety.’⁷ In England, the defence of necessity is, in principle, available in a case of assisted dying.⁸ But it was firmly rejected by both the Divisional Court and the Court of Appeal in 2014.⁹ It was rejected on two main grounds. Firstly, to ensure institutional appropriateness i.e. there was an expressed need for judicial deference to Parliament to bring about such an essential change in the law. And secondly, according to the Court of Appeal, assisted dying could not be justified in light of the status of the sanctity of life principle in common law and the non-existence of any fundamental right ‘to require the State to allow others to assist’ a person to die or ‘to kill’ a person. Leaving aside (i) the failure of the Court’s reasoning to take account of the problems with the doctrine of double effect and (ii) the Courts method in identifying the existence of a *prima facie* fundamental right to assisted dying under the European Convention on Human Rights, this reasoning too easily dismissed the fact that English common law already excuses, albeit in circumstances different to that of VAE, the taking of human life in cases of duress and necessity.¹⁰

Whilst in the majority of VAE cases in England and France doctors have escaped criminal liability, there have also been a few, highly similar, cases in which convictions (and

⁵ S. Ost, ‘Euthanasia and the Defence of Necessity: Advocating a More Appropriate Legal Response’, in C.A. Erin and S. Ost (eds) *The Criminal Justice System and Health Care* (Oxford University Press, 2007); M. Watson, ‘A Case of Medical Necessity?’, *New Law Journal*, 149/6891 (1999). Watson argues that ‘The doctrine of double effect is irrational, impossible to reconcile with other aspects of criminal law, and produces inconsistent decisions.’

⁶ Article 122-7 of the Penal Code.

⁷ Lewis argues that the unlikelihood of the defence of necessity succeeding in this context is further confirmed by the duty to rescue (in Article 223-6 of the Penal Code) and by the fact that a (potentially conflicting) duty to relieve suffering has not been recognized in the relevant civil, administrative or disciplinary contexts. See P. Lewis *Assisted Dying and Legal Change* (Oxford University Press, 2007) and S. Hennette-Vauchez ‘France’ in J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008).

⁸ See Ost (n 5).

⁹ *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin); *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961. See section 4.2.1. above.

¹⁰ On this see fact in English law, see M. Bohlander, ‘Of Shipwrecked Sailors, Unborn Children, Conjoined Twins and Hijacked Airplanes—Taking Human Life and the Defence of Necessity’ (2006) 70(2) *Journal of Criminal Law* 147–61. See also Ost (n 5).

disciplinary sanctions) have ensued. Thus, the attempts described above to circumvent the harshness of the law are not uniformly applied. In France, public authorities have, on occasion, been made aware that a doctor or lay person has performed VAE but refused to initiate any criminal prosecution.¹¹ However when *Dr. Tramois* performed VAE in circumstances akin to those that went unnoticed, she was criminally prosecuted and handed a one year suspended jail sentence. Similarly, the *Dr. Cox* case was a rare instance where a Court in England did not avoid imposing a criminal sentence (albeit, a 12-month suspended sentence). This lack of consistency is difficult to normatively justify. Moreover, qualifying VAE as an act of murder, by definition, makes it a serious offence. Yet on the rare occasions when a guilty verdict of murder is reached, the sentence is minimal given the 'public interest' not to seriously sanction such behaviour - at most a suspended jail sentence is handed down. This suggests a disconnect between common views of reprehensibility and the formal severity of the law. VAE remains an illegal and covert practice (somewhat empirically evident) that is occasionally permitted on unconvincing legal grounds or, if punished, done so in a superficial manner. In sum, the law in England and France condones, in an irregular and *ex post* manner, the unregulated practice of VAE.

As for the English and French approach to assisted suicide (AS), a number of legal policy factors and legal policy effects must be emphasised. First, there is a greater disdain for close medical (read: professional) assistance over lay person assistance. In England, the Director of Public Prosecutions formal policy states that criminal prosecution is more likely if the suspect was acting as a healthcare professional *and* the patient was in his or her care. While in both England and France, if a doctor prescribes drugs to a patient for the purpose of that patient's suicide he or she is liable to face disciplinary sanctions. Second, AS in both jurisdictions may be, in practice, permitted by the criminal law regardless of the patient's condition (treatable or not). Provided the assistor acted 'compassionately' (in England) or did not incite the suicide (in France) it is unlikely that he or she will face prosecution - no regard is given here to the patient's degree of suffering. Note in the English case that this does not mean that the compassionate assistor will not

¹¹ As particularly evident in the *Daffau* case (Section 4.2.2.) - whereby, the doctor was found guilty of intentionally ending the life of his patient in disciplinary proceedings before the French Medical Council, yet not criminally investigated. Lewis also make the interesting argument that: "[m]ost probably many such charges are diverted away from the criminal courts through the operation of prosecutorial discretion, or downgraded by prosecutors anxious to avoid a jury trial and possible acquittal." See P. Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007) 113.

face criminal investigation, it means he/she is likely (due to the DPPs guidelines) to be found unworthy of prosecution after such investigation. And third, by prohibiting professional assistance and generating legal uncertainty, the English and French legal policies on AS, arguably, promote 'suicide tourism' to fill in the gap. As recognized above, 273 English patients and 194 French patients (at the time of writing) have travelled to Dignitas in Zurich for assisted suicide over the past ten years. This is hardly a satisfactory phenomenon. One, the 'Swiss option' is limited to patients who can afford the costs, and two, it is limited to those who are physically capable of travelling (relatively able bodied persons) from their home to Zurich. This 'option' quite simply accommodates a discriminatory undertone. Also, evidence has been given that some patients who fear due to their progressive illness that they may not be able to physically travel in a few months, feel compelled to travel and thus end their life far earlier than otherwise desired.¹²

5.1.2 SWITZERLAND AND THE NETHERLANDS

Moving on to the Swiss approach to AS itself, a number of critical remarks may also be made about discrepancies between 'the law in the books' and 'the law in action'. As alluded to above, there is no federal-level regulation of AS. 'The law in the books' comes from a variety of sources. Nonetheless, it appears that the reporting rate of AS directly to the criminal authorities is quite good when right-to-die organisations (RTDs) are involved.¹³ The RTDs internal guidelines and policies appear relatively well respected. However true this may be, certain problems arise from such a fragmented delegation of responsibility in the day-to-day application of the law. It is difficult to ignore (due to the degree of media attention) a number of problems that arise regarding the actual practices of certain RTDs. Dignitas in particular has been at the centre of much criticism and has had a number of disputes with public authorities. In 2008, the organisation had an injunction granted against it from working next to a busy brothel,¹⁴ and soon after it was

¹² Report by Commission on Assisted Dying, (n 82) 101. Available at: <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363>. Last accessed 28.01.2016.

¹³ See in regard to *Dignitas* and *Exit*: the rate of reported AS corresponds with the empirical data carried out by EURELD on the occurrence of AS in Switzerland. See Bosshard, 'Switzerland' in J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008) 479.

¹⁴ See M. Leidig, 2008. 'Suicide 'factory' reopens - next to a brothel' *The Guardian*, 16th March.

widely condemned for using helium gas to circumscribe legal restrictions on obtaining the standard narcotic for AS.¹⁵ It has also been on the end of allegations by ex-employees. One accused the organisation of being a 'production line of death concerned only with profits.'¹⁶ These controversies evidence two reoccurring, underlying problems with the RTDs – transparency and motives.

As for the former problem, although the actual act of assistance is recorded and relevant documents are reviewed by police, the events preceding the act or potential act are somewhat opaque. Questions remain as to what manner the RTD's 'suicide assistants' decide especially difficult cases? What training and supervision of the assistants is provided? What relationship does the prescribing doctor have with the voluntary association? What is the financial breakdown of these 'non profit' organisations?

This last question raises a specific issue – the motives of RTDs and the (non)application of the Swiss Penal Code. In short, the general understanding by the Swiss prosecutors, courts and legislators of 'selfish motives' as stated in Art 115 of the Penal Code is questionable. It is generally understood that benefiting materially from a person's suicide is a selfish motive.¹⁷ Nonetheless, the reality is that RTDs, although formally 'non-profit organisations' consisting of volunteers, do charge quite hefty medical and legal fees. Dignitas may cost anywhere in the region of €4,000 for preparation fees, up to €10,000 in case of taking over duties such as funerals, medical costs and official/administrative fees.¹⁸ With no public access to the financing of such organisations, one may ask two

¹⁵ H. de Quetteville, 2008, 'Dignitas uses gas, plastic bag in assisted death' *The Telegraph*, 20 March.

¹⁶ See P. Sawyer 2009. 'Dignitas founder accused of profiting from assisted suicides', *The Telegraph*, 10 January.

¹⁷ On this legal position, see Swiss National Advisory Commission on Biomedical Ethics, 'Assisted Suicide – Opinion no.9/2005'. Available at: <www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/suizidbeihilfe_en.pdf>. Last accessed on 28.01.2016. See also the descriptive account of the origins of the Swiss law on AS by S.A. Hurst, where it is stated: the conclusion of the debate amongst Swiss legislators (namely, the Swiss Federal Council in 1918), 'was that there was indeed a 'wrong-making feature' in some cases of suicide assistance, and that this was what ought to be punished. In cases where the person assisting suicide stood to gain from the death of the assisted person, this should constitute a crime.' See S.A. Hurst, 'Doctors and suicide assistance. International questions and the Swiss context' in S.A. Hurst and F. Mathwig (contributors) and C. Kinf (ed), *Folia Bioethica: Suizidhilfe in der Schweiz – zur Kontroverse um eine angemessene ärztliche Rolle* (SGBE-SSEB, Basel, 2013) 39. See also G. Bosshard, 'Die Tätigkeit der Sterbehilfsorganisationen und die Rolle des Arztes' in C. Rehmann-Sutter (ed) *Beihilfe zum Suizid in der Schweiz: Beiträge aus Ethik, Recht und Medizin* (Bern: Peter Lang, 2008) 476.

¹⁸ The Dignitas website breaks down the general costs, which are provided in Swiss Franc, British Pound and US dollar. Here the costs are converted into Euro (not including tax): (i) the preparation of an accompanied suicide = advanced payment of 3,200 EUR; (ii) doctor's consultation = 1,000 EUR; (iii) costs for completing an accompanied suicide = 3,200 EUR; (iv) funeral and registry office expenses = 2,000 EUR.

legitimate questions: why are the standard fees so high for a non-profit organisation? And, given the amounts involved (i.e. that the costs are above mere expenses for drugs or standard consultation time, such as a €1,000 doctor consultation fee), is it reasonable to maintain that certain individuals are not materially benefiting?

Another issue with the Swiss approach is that of substantive equality. The Swiss Federal Supreme Court recognised the underlying idea behind the Swiss law on assisted dying is that autonomous individuals have the right to decide the time and manner of their own death.¹⁹ As Hurst recently explained: the Swiss model ‘rests on the recognition that our lives ultimately belong to us, that there is such a thing as “rational suicide”, and that assistance in such cases is not blameworthy. [...] The law limits itself to defining a space within which free consenting individuals may do as they please.’²⁰ However the current system limits this space (and the liberty right therein) to only those who have a certain physical capability (i.e. persons who can take the final act themselves). Although, the RTDs have fully utilized modern technology in order to minimize this group of persons (i.e. by availing of various methods that only require a small amount of physical capability to self-administer the lethal drug), the reality remains that certain individuals, regardless of their terminal or unbearable suffering cannot avail of the right to assisted dying by simple fact of their physical capacity. In this sense, the Swiss legal policy on assisted dying maintains an indirectly discriminatory practice. The tragic realities of this practice were exposed in the *Berner* case.²¹ A patient suffering from an unbearable and incurable illness, and with an unequivocal decision to die had experienced a rapid decline in her physical capabilities. Having prepared herself for her last moments of life, surrounded by loved ones ‘on her deathbed’ (in the words of the Neuchâtel court), all she had to do was exert enough pressure with her foot onto a wooden plate in order to indirectly release a lethal substance into her body (via an intravenous line). But she was, on the day, physically too weak for this. Swiss law, in such case, requires an abandonment of the suicide for this reason, and for this reason alone. According to the judgement of the Court ‘all persons present emphasized that in the circumstances, and at that moment, it would have been absolutely inhuman not to provide assistance when she asked.’ This example highlights

The organisation also gives a maximum price of approx 10,000 euro See also A. Gentleman, 2009. ‘Inside the Dignitas House’ *The Guardian*, 18th November.

¹⁹ See *Schweizerisches Bundesgericht* [Federal Supreme Court of Switzerland], *Entscheid* 2A.4812006, 2006.

²⁰ Hurst (n 17).

²¹ See the decision of *Le Tribunal de police* in the Canton of Neuchatel, set out in Section 4.2.3, above.

the injustice in normatively limiting the right to assisted dying to those who are sufficiently physically able – to those who have that little bit more strength in their right foot at the moment it counts.

Keeping the actual judgment in the *Berner* case in mind, we can see a noteworthy (and largely well-received) reluctance by a Swiss court to avoid enforcing the clear letter of the law. VAE was allowed to go unpunished and the explicit prohibition against killing on request (Article 115 of the Penal Code) was defeated. According to the Court, to decide against the clear letter of the law was ‘legitimate [...] to safeguard the autonomy of [the patient’s] will, to preserve [her] dignity and put an end to [her] suffering.’ If this is ‘legitimate’, then the maintaining of an explicit statutory prohibition against killing upon request must be seriously re-evaluated. It is possible to leave the law as it is, and for courts to invoke the defence of necessity (set out in Article 17 and 18 of the Penal Code) on a case-by-case basis – indeed, it was on said legal provisions that the Neuchâtel court’s decision was grounded. The defence of necessity, as explained above, is a more commendable judicial tool the doctrine of double effect (invoked, on occasion, by the English courts) to avoid punishing certain acts of VAE. Nonetheless, it is still not an entirely satisfactory solution. What does such a case-by-case approach say about the ‘autonomy, dignity and suffering’ of the next patient who has a doctor less willing to breach the Penal Code? What assurance does the next doctor, who is willing to breach the Penal Code in order to avoid an ‘absolutely inhumane’ outcome, have that she will not come before a less activist judge than the one in the *Berner* case? From a simple legal certainty perspective, the logic of accepting the arguments behind the *Berner* judgment – i.e. accepting that certain conditions should ‘justify’ an act of VAE²² - but not seeking to change the Penal Code accordingly is certainly questionable.

As for the Netherlands, there are also considerable issues with the legal policy on assisted dying and its workings in practice. First, data (albeit limited data) suggests that guidelines in hospitals and nursing homes regarding advanced directives for VAE and the due care criteria do not reflect the complete picture.²³ A number of institutional guidelines are

²² The Court considered the following conditions to justify the use of necessity: that if a patient’s suffering is ‘physically and psychologically intolerable... [can] not be relieved by palliative care’, will lead to her ‘death in the near future’, and the patient is ‘in full possession of her mental faculties, has expressed [an] unequivocal [...] will to die’, then these conditions justify a gesture like that of the accused’

²³ B.A.M. Hesselink and others, ‘Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis’ (2012) 38 *Journal of Medical Ethics* 35-42.

stricter than the 2002 law²⁴ – namely, in 79 per cent of guidelines a written advanced directive is always necessary and in 19 per cent consideration must be had to ‘life expectancy’.²⁵ The stricter guidelines are either a deliberate choice by the institutions, or the result of under-awareness of the legal boundaries. To protect the substantive freedom to choose a different healthcare institution, patients and physicians should be made explicitly aware (preferably in the relevant guidelines) that the internal rules go beyond the requirements of the law. Better dissemination of the 2002 law and more clarity on what distinguishes VAE from pain relief with life shortening effect is also required amongst health care professionals.²⁶ The latter would be particularly useful to help improve the accuracy of the reporting rate.

Second, close attention needs to be paid to the role of nursing staff in institutional practice guidelines. The majority of hospitals and nursing homes recognise the role of the nurse in the consultation and decision making process, but research also identifies that less than half of the guidelines actually outline the role of the nurse in the performance of assisted dying.²⁷ Given that certain empirical evidence suggests the direct performance of assisted dying by nurses (however minimal or not) this seems a reasonable concern.

Third, there is an inherent difficulty in realising a fundamental criterion of the law: the determination of what is ‘unbearable suffering.’²⁸ The RRCs recognise that suffering is a subjective experience, originating in bodily symptoms (e.g. pain, itching, nausea) or functional losses (e.g. sight, balance, memory, digestion). Although the RRCs insist that in assessing ‘suffering’ the physician must adopt the patient’s point of view – they equally

²⁴ By no means is it considered against the law for a medical institution to issue stricter or more restrictive guidelines. Furthermore, no doctor in the Netherlands may face a legal duty to perform VAE or AS. See also the European Resolution 1763, 2010 (1), adopted by the Parliamentary Assembly of the Council of Europe, ‘The right to conscientious objection in lawful medical care’. This states: ‘no person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to (among other things) euthanasia.’

²⁵ Some guidelines categorically excluded certain types of patients: 30 per cent of nursing homes were estimated to exclude cases of dementia and 25 per cent also excluded incompetent patients. See Hesselink (n 23).

²⁶ Data indicates that the majority of physicians and medical students are unaware of the permissibility of assisted dying by an advanced written directive. See Ibid.

²⁷ Ibid.

²⁸ See H. Wijsbek, ‘The Subjectivity of Suffering and the Normativity of Unbearableness’ in: *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (n 5) 319. The RRC quite succinctly summed up the difficulty in determining what suffering actually is: ‘Suffering is a complex experience, like pain, love hope or despair. It is a fundamental part of human life, and can often be recognized as such more readily than it can be put into words.’ See RRC Annual Report 2007, 16ff.

maintain a degree of objectification must be possible.²⁹ Leaving aside this contested standpoint³⁰ and notwithstanding the validity of Cassell's seminal definition of suffering³¹ (as physically and/or psychologically-based), extreme caution must be taken in borderline cases. This is particularly so in cases involving psychiatric disorders, dementia and advanced written directives. Careful attention should be had to the warning expressed by Hertogh that severe dementia inevitably weakens the existence of reciprocity³² in decision-making and may unveil a discrepancy between the current legislation and actual practice. Further research is needed not only from the requesting patient's perspective but also on how the health care professionals (physicians, psychiatrists and involved nurses) experience the patient's suffering (i.e. inferences related to socio-economic and cultural backgrounds, patient ethnicity, patient diagnosis, gender, relationship status, the assisting medic's age, experience or speciality).³³

Fourth, in light of the need to ensure that careful consideration is given to the voluntary nature of any request for assisted dying (particularly, but not exclusively, in borderline psychiatric cases), the recent *Heringa* decision (see Section 4.2.4, above) by the Court of Appeal is of notable concern. This was the first decision in which the defence of necessity was extended to justify the performance of assisted dying by a lay person and not a medic. Although the evidence in this particular case suggests that the deceased could have availed of assisted dying from a medic (at least by 'today's standards'), it is still a decision that marks a substantial move away from the established legal doctrine – i.e. that only a physician can lawfully perform VAE or AS. The role of the treating physician and the independent physician is crucial – it reduces the likelihood of botched suicides or botched assistance (and thus unnecessary suffering), it also increases the likelihood of identifying

²⁹ See also the position of the RDMA (Royal Dutch Medical Association) *Standpunt Hoofdbestuur* (Position paper of the Board) (1995): whereby the physician is obliged to objectively assess the suffering, and via careful communication turn it into an inter-subjective agreement with the patient.

³⁰ A notable opponent to this view is Beijk, who believes suffering can only be subjective. See M.M. Beijk, 'Unbearable Suffering: What Is It, What Causes It, and Who Determines It?' *Medisch Contact* 53(2008) 825–827.

³¹ As 'a state of distress induced by a threat of the loss of intactness or the disintegration of a person from whatever cause'. E. Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: OUP, 1991).

³² It has, according to Hertogh, great potential to undermine the mutuality and intersubjectivity legally required in a conviction that assisted death is the only way left. See C.M.P.M. Hertogh, 'Unbearable Suffering and Advanced Dementia: The Moral Problems of Advanced Directives for Euthanasia' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 221.

³³ The idea for such research is inspired by M.E. Duffy, 'A theoretical and empirical review of the concept of suffering' in P.L. Starck and J.P. McGovern (eds) *The Hidden Dimension of Illness: Human Suffering* (New York: The National League for Nursing Press, 1992) 299.

unknown psychiatric disorders, and also increases the likelihood that all reasonable alternatives to treat the suffering have been properly evaluated. The Court of Appeal's decision will come before the Supreme Court in the coming months, and for these reasons it is arguably more preferable that said decision is overturned in favour of maintaining the established legal doctrine.

The relationship between the law *in the books* and the law *in action* is, evidently, not perfect in the Netherlands. Smith rightly observes however that the Dutch system, like the English, French, Swiss or any other regulatory system, cannot be expected to achieve the 'illusionary goal' of perfect obedience.³⁴ The approach in the Netherlands, notwithstanding its very real shortcomings and the exceptional Court of Appeal *Heringa* decision (which is at the time of writing subject to appeal before the Supreme Court), is more likely to protect vulnerable people than a policy formally prohibiting but inconsistently permitting covert acts of assisted dying. This is not so much a credit to the Dutch system as a discredit to the English, French, and Swiss systems. Griffiths, Weyers and Adams succinctly sum up the Dutch approach as 'better than in other countries for which information is available, and it has been getting more encompassing and more refined.'³⁵ A number of points may be made here to support this statement.

First, one of the main criticisms of the Dutch approach is based on an apparently alarming rise of non-voluntary assisted dying cases. From the limited data available, there appears a modest decline in such behaviour. Of the few European studies on the frequency of end of life behaviour (EURELD studies), the termination of life without a request is not higher in the Netherlands than in other countries where assisted dying remains illegal. According to the national studies, this figure has consistently decreased (see Section 4.1.3). Second, by refusing to allow assisted dying to remain predominantly the responsibility of lay persons, the Netherlands has acquired a system of control (albeit imperfect) over the requirements of due care. Doctors in the Netherlands are, unlike in England, France and Switzerland, subject to 'regulatory pressure.'³⁶ Systems for the transmission of legal information and standardisation of reporting are in place, such as medical journals, local protocols and the SCEN programme of trained advisors and consultants. The latter

³⁴ S.W. Smith, *End-of-Life Decisions in Medical Care. Principles and Policies for Regulating the Dying Process* (Cambridge University Press, 2012) 10.

³⁵ J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008) 520.

³⁶ *Ibid*, 516.

programme in particular has proven to be a highly efficient *ex ante* system of control. Third, by removing the immediate threat of criminal prosecution and placing a 'buffer' (i.e. the Regional Review Committees) between the physician and the medical inspectorate/prosecution services, there appears positive results on the reporting rate. Fourth, no evidence exists of a slippery slope towards the victimisation of the vulnerable. Empirical evidence shows the current safeguards are utilised quite well to protect patients in quite extreme circumstances (the majority of instances involve terminally ill cancer patients suffering in the final phase). As regards the rise in the number of assisted dying cases, this in itself says nothing regarding the effectiveness or suitability of the system of control.

Finally, one may look at the lack of prosecutions for assisted dying in the Netherlands arising from the 'not careful' verdicts by the RRC and reason that it is a control system with no bite. However, agreement is had here with den Hartogh that if one is looking for convictions as a sign of efficient control, then they have misunderstood the rationale behind the Dutch system.³⁷ It is based on the co-operation and willingness of reporting physicians - it is not a system designed 'to catch crooks'. The primary form of control is prospective; the physician submits a report that he or she knows will be examined and accepts the potential of facing further questioning (non-criminal questioning, at least initially). Having said all this, close attention is still required to ensure that the number of unreported cases of assisted dying remains low, and that sufficient attention and resources are given to palliative care and curative care. Recognizing the risks of 'transplanting' the Dutch experience of assisted dying onto jurisdictions of different socio-political traditions,³⁸ the English, French and Swiss policy makers can still learn from the identified commonalities or differences in how Dutch law is applied and enforced.

³⁷ G. den Hartogh, 'The Regulation of Euthanasia – How Successful is the Dutch System?' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 372.

³⁸ Dutch historical, cultural and political characteristics cannot be ignored. See M. Trappenburg and H. Oversloot 'The Dutch Social Fabric: Health Care, Trust and Solidarity' in S.J. Youngner and G.K. Kimsms (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 99-123.

6

THE POLITICS BEHIND THE LAW ON ASSISTED DYING

The above comparative analysis focused on the ‘law in the books’ v the ‘law in action’; however, in order to adopt the law and governance perspective described in **CHAPTER TWO**, attention must be given to the actors and institutions responsible for creating and reforming the respective laws. This allows one to make more than just descriptive remarks (see **CHAPTER THREE** and **CHAPTER FOUR**) and critical comparative remarks (see **CHAPTER FIVE**), but also prescriptive ones. Accordingly, this Chapter builds upon two interconnected positions deduced from the above: (i) a formal blanket ban whereby assisted dying is *ex post* and sporadically condoned is insufficient as a legal control framework to adequately protect the vulnerable, and (ii) a legal framework whereby assisted dying is permitted in certain pre-defined circumstances and subject to *ex ante* and *ex post* controls is preferable.

It was argued in **CHAPTER TWO** that when manifest morality policies arise, such as assisted dying, the relationship between central political institutions/actors and the law is a peculiar one. The *politicization of the law* on such policies brings indispensable benefits. Self-authorship of the democratic political process may provide: (i) a robust means to internalize dissent and mediate between different fundamental values within a polity; (ii) an equal voice for every citizen, albeit abstracted through the development of political parties, (iii) input legitimacy to policy formulation and the justification for its constant renegotiation, and (iv) the voluntary and coercive authority to ensure or increase compliance and enforcement of that policy. Equally, however, the *politicization of the law* on manifest morality policies brings about potential pitfalls. Self-authorship of the democratic political process may simply not materialize or may not result in normatively

just outcomes. Instead: (i) high political costs may deter the government or the legislator from formally engaging with sensitive, polarizing issues; (ii) majority public opinion may be mitigated by powerful interest groups – such as dominant religious institutions; and (iii) policy-output and policy change may be more susceptible to status quo bias and ideological argumentation rather than empirical observations and rational instrumentalism.

If we combine the peculiarities between law and central political actors/institutions on morality policies with the observations made in **CHAPTER FIVE** (on the discrepancies between the law in the books and the law in action on assisted dying) then some key questions arise. First, what do we know about the recent relationship between central political actors/institutions and the law on assisted dying in the four nations studied? And second, to reduce identified discrepancies between the ‘law in the books’ and the ‘law in action’, is it beneficial to turn our focus towards the wider law and governance dimensions of assisted dying (i.e. to focus on the potential role of not just formal, but also informal, actors/institutions in the creation, application and enforcement of the law)? To help answer these questions, a descriptive account of some of the major political initiatives and processes concerning the law on assisted dying in England (6.1), France (6.2), Switzerland (6.3) and the Netherlands (6.4) is hereby provided. This is followed by critical comparative remarks on these initiatives and processes, and some tentative prescriptive remarks (6.5) on the wider law and governance dimensions of assisted dying.

6.1 ENGLAND

In 1994, the House of Lords Select Committee on Medical Ethics - a special committee reporting to the indirectly elected upper house of the English parliament - concluded that there should be no change in the law on intentional killing.¹ It outlined that it was not possible to set secure limits on VAE and that ‘it would be next to impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law was not abused.’² The committee believed that any change in the law to allow VAE is essentially a ‘message which society sends to vulnerable and disadvantaged people [...] to seek death.’³

¹ Select Committee on Medical Ethics. Report. London: HMSO, 1994. (House of Lords paper 21-I).

² Ibid, para 238.

³ Ibid, para 239.

The issue of VAE did not appear again on the English political agenda until shortly after the millennium. Between 2003 and 2006, a number of private members bills⁴ proposing rules very similar to those in the Dutch 2002 Act were put before the House of Lords. All of these Bills were introduced by the same member of the House, Lord Joffe. The first (2003) Bill was entitled the *Patient (Assisted Dying) Bill* and it included provisions for a competent adult, who was suffering unbearably as the result of a terminal or serious, incurable and progressive illness, to receive medical help to die at his or her own request. It provided for the provision of both AS and VAE. It also provided for a ‘monitoring commission and reporting requirements’ with a highly similar composition⁵ and jurisdiction as the Dutch RRCs. The Bill was given a second reading but did not proceed any further, meaning it was not subject to any scrutiny at the committee stage. The second (2004) Bill introduced before the House of Lords was entitled the *Assisted Dying for the Terminally Ill*. It differed from the former Bill in two main ways: it included a requirement for a discussion with applicants regarding the option of palliative care and it was, as its title suggests, limited to terminally ill patients. In light of these changes, the Academy of Medical Royal Colleges adopted a neutral stance on the ethics of the Bill, but did raise concerns over certain provisions.⁶ Having succeeded to get through the first and second reading of the House, it was subject to a report by a Select Committee.⁷ The Committee carried out an exhaustive examination of the safeguards set out in the Bill and made a number of recommendations, such as: the need to carefully distinguish between AS and VAE; the need to set out procedural guidelines on how a doctor is to provide AS and VAE; the need for any qualifying condition based on ‘terminal illness’ to be in line with the realities of clinical practice; the need to assess psychological health in determining the

⁴ Lord Joffe proposed (i) the *Patient (Assisted Dying) Bill* in 2003 [HL Bill 37] – available at: <http://www.publications.parliament.uk/pa/ld200203/ldbills/037/2003037.pdf>; (ii) the *Assisted Dying for the Terminally Ill Bill* [HL Bill 4] in 2004 – available at: <http://www.publications.parliament.uk/pa/ld200405/ldbills/004/2005004.pdf>; and (iii) the *Assisted Dying for the Terminally Ill Bill* [HL Bill 36] in 2005 and 2006 – available at <http://www.publications.parliament.uk/pa/ld200506/ldbills/036/06036.i.html>. Last accessed 28.01.2016.

⁵ Although not the same requisite composition: each monitoring commission was to consist of one medical practitioner; one lawyer; and not one ethicist (like in the Dutch RRC) but one lay person with experience in caring for a person with a terminal illness.

⁶ House of Lords – Select Committee on the Assisted Dying for the Terminally Ill Bill. Volume 1: Report (HL Paper 86-I) 10. Available at: <http://www.publications.parliament.uk/pa/ld/ldasdy.htm>. Last accessed 28.01.2016.

⁷ House of Lords – Select Committee on the Assisted Dying for the Terminally Ill Bill, Volume 1: Report (HL Paper 86-I). Available at: <http://www.publications.parliament.uk/pa/ld/ldasdy.htm>. Last accessed 28.01.2016.

voluntary nature of a request; the need for the criterion of suffering to be more ‘objective’ and to meet the medical standards of ‘unbelievable’ or ‘intractable’ distress, rather than the subjective experience of ‘unbearable’ suffering; the need to carefully set out how alternative palliative care options are assessed and communicated to the patient; and the need to adequately protect the doctor’s right to conscientious objection, particularly in multi-disciplinary teams.

However, as the Parliament was dissolved (for the 2005 UK general election) the Bill lapsed. Lord Joffe subsequently re-introduced his *Assisted Dying for the Terminally Ill* Bill in 2006. The select committee expected this and recommended that any re-introduction of said Bill should, following a formal second reading, be sent directly to a committee of the whole House of Lords for examination. This recommendation was not followed. When presented with the 2006 Bill, the House voted (148 to 100) in favour of further delaying the second reading for a period of six months. This was an indirect way of indicating opposition to the Bill, as the six months delay would (and indeed did) make it impossible for any progress to be made on the issue in that Parliamentary session. This was noted as a somewhat unusual parliamentary move at that stage of a Bill’s passage – the last time a vote was made on a Private Members’ Bill at the second reading stage and denied closer examination at the committee stage was back in 1998.⁸

In 2013, a private members’ bill entitled the *Assisted Dying Bill* was introduced to the House of Lords, this time by Lord Falconer.⁹ The content of this Bill was shaped by the findings of a privately-funded research group – entitled the ‘Commission on Assisted Dying.’¹⁰ It was also a Bill largely modelled on the assisted suicide law in Oregon.¹¹ Thus it was (despite its arguably misleading title) solely limited to permitting AS unlike Lord Joffe’s Bill, which also sought to allow VAE. The Bill differed further from Joffe’s Bill in that it did not provide for reporting (beyond death certification) nor did it establish any

⁸ For eight years prior to this sitting, the House had not ‘divided’ (read: voted) on the Second Reading of a Private Member’s Bill. Prior to this occasion, according to Lord Carlile of Berriew, this had occurred once in 1990, twice in 1991, twice in 1994, four times in 1995, once in 1997 and once in 1998.

⁹ For an excellent assessment of the Assisted Dying Bill 2013 and the problems therein, see S. Halliday, ‘Comparative reflections upon the Assisted Dying Bill 2013: a plea for a more European approach’ (2013) 12(3) *Medical Law International* 135-167.

¹⁰ The Commission was established following a tender from two private individuals, Bernard Lewis and the recently deceased Terry Prachet both advocates of assisted dying), with support provided by think-tank Demos. The credibility of this commission may be seriously questioned given its ‘nature and constitution’, on this, see Halliday, *ibid.*

¹¹ The relevant legislation in Oregon is the Death with Dignity Act (1997).

‘monitoring commission’ but instead gave a general requirement for the Chief Medical Officer to ‘monitor the operation of the Act, including compliance with its provisions and any regulations or code of practice made under it.’ Like Lord Joffe’s Bill, it applied only to terminally ill patients; two doctors must be involved in the assessment; and it included a conscientious objection clause. It did not get past the first reading in 2013 and was reintroduced to the House of Lords by Lord Falconer in 2014. On this occasion it successfully passed through the first and second readings of the House.

In between the two formal readings, the English Supreme Court handed down a clear indication that it is *not* inappropriate for a court to declare the criminal ban on AS is incompatible with the UK Human Rights Act (the domestic statute incorporating the European Convention on Human Rights and the ECtHR’s jurisprudence thereon).¹² In this instance, the Court refrained from doing so. The decision to not make such a declaration was (according to a majority of the Court) only in order to provide ‘Parliament the opportunity to consider the position in light of this judgment.’¹³ Shortly after this demonstration of conditional judicial restraint, Lord Falconer’s Bill reached the committee stage in the House of Lords. However, due to the substantial amount of proposed amendments, the Bill lapsed before it could be moved to the report stage.¹⁴ Of the 175 amendments, only 13 were given time for debate. The most notable amendment was the need to satisfy a Judge of the Family Division of the High Court that there was a voluntary, clear, settled and informed wish to die.

On 4 June 2015, Lord Falconer introduced a new version of his *Assisted Dying Bill*. In this revised version, the above-mentioned amendment was included from the outset – AS may only be provided if the person ‘receives consent from a High Court (Family Division) judge.’¹⁵ This Bill failed to get selected for a second reading in the House of Lords. However, MP Rob Marris introduced the same *Assisted Dying Bill*¹⁶ before the House of Commons,¹⁷ which did get selected for a second reading on 11 September 2015. The Bill

¹² *Nicklinson* [2014] UKSC 38. See Section 4.2.1, above.

¹³ *Ibid*, para 116.

¹⁴ During committee stage every clause of the Bill has to be agreed to and votes on any amendments can take place. All suggested amendments have to be considered, if a member wishes, and member can discuss an for as long as they want. The government cannot restrict the subjects under discussion or impose a time limit. This is a key point of difference with procedure in the House of Commons.

¹⁵ Assisted Dying Bill [HL] Explanatory Notes. Available at: <http://www.publications.parliament.uk/pa/bills/lbill/2015-2016/0025/en/160025en.pdf>

¹⁶ Assisted Dying (No. 2) Bill 2015-16.

¹⁷ The directly elected lower house of Parliament.

was rejected by a strong majority – 330 voted against and 118 in favour.¹⁸ It was the first time in over twenty years that any serious debate on legalising assisted dying occurred in the directly elected house of representatives in England. In 2012, there was a debate on the suitability of the current DPP policy on AS.¹⁹ The motion (tabled by MP Richard Ottaway) was in favour of maintaining said policy and it was passed without a vote. During this Commons debate, MP Joan Ruddock proposed an amendment to invite the government to consider whether the DPP’s policy should be put on a firm statutory basis. This proposal was rejected without a formal vote.

6.2 FRANCE

In France, the first Bill proposing legislation of VAE and AS was presented (but not discussed) in Parliament in 1978.²⁰ In 1991, a governmental advisory council - the National Consultative Committee on Ethics (*Comité consultatif national d’éthique*, hereafter the ‘CCNE’) – released an opinion rejecting the legalisation of VAE and AS.²¹ In 2000, the CCNE reversed this conclusion in favour of an ‘exception’ in the Criminal Code for VAE.²² No immediate political reaction ensued. However, as a result of the *Humbert* case²³ in 2003 (discussed in Section 4.1.2, above) and the resulting public debate, the issue of assisted dying was soon at the high-profile end of the French political spectrum. The ‘Parliamentary Mission for Information on End-of-life Supportive Care’ was created,

¹⁸ Full debate available at: <http://www.publications.parliament.uk/pa/cm201516/cmhansrd/cm150911/debtext/150911-0001.htm#15091126000003>

¹⁹ Full debate available at: <http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120327/debtext/120327-0002.htm>

²⁰ It was a draft Bill presented by Henri Caillavet, senator and president of the leading French right-to-die association ADMD (*Association pour le Droit de Mourir dans la Dignité*). Sénat, Documents, 1977-78, proposition de loi no. 301 relative au droit de vivre sa mort.

²¹ The CCNE have released a number of publications related to end-of-life, in particular: Opinion N° 59, May 1998, ‘Report on Ageing’; Opinion N° 63, January 2000, ‘End of Life, Ending Life, Euthanasia’; Opinion N° 65, September 2000, ‘Ethical Considerations Regarding Neonatal Resuscitation’; N° 87, April 2005, ‘Treatment Refusal and Personal Autonomy’; Opinion N° 108, November 2009, ‘Ethical Issues in Connection with the Development and Funding of Palliative Care’; Opinion N° 121, ‘The End of Life, Personal Autonomy, the Will to Die’.

²² Opinion n° 63, January 27th 2000, ‘End of life, Ending life, Euthanasia.’ The exception sought was to give judges the possibility of putting an end to all further legal proceedings, depending on the circumstances of, and the motivation for, the act of VAE.

²³ Vincent Humbert was a young man suffering from post-traumatic locked-in syndrome, who made a number of public pleas to be lawfully assisted in dying. When his mother and doctor eventually acceded to his request, they were criminally charged but found not guilty by jury trial.

consisting of politicians, jurists, ethicists, clergymen, ministers, physicians and caregivers involved in intensive care and palliative care, and representatives of civil society.²⁴ After a 9-month inquiry, 60 statements by individuals, and a 600-page report, the Parliamentary Commission proposed a law on "Patients' rights and the end of life."²⁵ In 2005, a new law providing certain rules on end of life medical practices was adopted. It became known as 'Leonetti's law', and formally set out the following:²⁶ the patient's right to refuse treatment must be respected (even if life is at stake); advanced written directives must be taken into consideration (it stopped short of making them legally binding); and the use of medically futile treatment ('*acharnement thérapeutique*') must be prohibited. The Leonetti law did not affect the criminal prohibition on VAE.

Since 2008, a number of bills seeking to legalize VAE and AS have been proposed by individual Members of Parliament. In November 2009, a draft Bill entitled: '*Droit de finir sa vie dans la dignité*' ['A right to end life in dignity'] was introduced before the French National Assembly (directly elected lower house).²⁷ It proposed to lawfully permit assisted dying for adults who are at an advanced or terminal phase of a serious and incurable disease. It required that at least four doctors evaluate the nature of the patient's condition and request, and it proposed the establishment of an *ex post* evaluation procedure by regional review committees. This *proposition de loi* also required advanced directives for assisted dying to be considered lawful, and made explicit provision allowing doctors to make a conscientious objection. It was rejected at the first reading by a vote of 326 to 202.

In January 2011, a Members' Bill identical to the 2009 Bill was approved by a select committee on Social Affairs in the Senate (indirectly elected upper house), however the full Senate rejected the Bill later that year by a vote of 170 to 142.²⁸ During the campaign for the 2012 presidential election which followed soon after, Francois Hollande pointed

²⁴ A. Baumann and others, 'Ethics review: End of life legislation – the French model' (2009) 13 *Critical Care* 204.

²⁵ F.J.P. Lemaire, 'A law for end of life care in France?' (2004) 30(11) *Intensive Care Medicine* 2120.

²⁶ Loi n° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie. (JORF n°95 du 23 avril 2005) 7089. Code de la Santé Publique 2005.

²⁷ For a preparatory report on the Bill, see: <http://www.assemblee-nationale.fr/13/rapports/r2065.asp>

²⁸ *Proposition de loi relative à l'aide active à mourir*. For a full version of this Bill, see: <http://www.senat.fr/leg/pp109-659.html>; For a media report on this Bill, see: <http://www.publicsenat.fr/lcp/politique/euthanasie-senat-enterre-texte-ressuscite-debat-70587>. Last accessed 28.01.2016.

towards legal reform, claiming ‘all adults in an advanced or terminal phase of a terminal illness, causing an unbearable physical or mental suffering, which can not be appeased, may request, in specific and strict conditions, to benefit from medical assistance to end their life with dignity.’²⁹ Upon his election in 2012, President Hollande created the ‘Commission for the Reflection on the End-of-Life in France.’ The 197-page report that followed, which became commonly known as the ‘Sicard Report’,³⁰ recommended against legalizing VAE. It essentially feared a slippery slope, both conceptually³¹ and legally.³² Regarding its conclusions on AS, the report considered this behaviour as ‘totally different’ to VAE and recommended that it may be permitted only as a last resort, under specified conditions.³³ Following on from the ‘Sicard Report’, President Hollande sought a report from the the CCNE (National Consultative Committee on Ethics, mentioned above) to further benefit the promised debate on assisted dying. In its formal Opinion, the CCNE

²⁹ Original in French: “toute personne majeure en phase avancée ou terminale d’une maladie incurable, provoquant une souffrance physique ou psychique insupportable, et qui ne peut être apaisée, puisse demander, dans des conditions précises et strictes, à bénéficier d’une assistance médicalisée pour terminer sa vie dans la dignité.” François Hollande (proposition 21 de son programme présidentiel en 2012). See: <http://www.lefigaro.fr/assets/fin-de-vie/index.html>. Last accessed 28.01.2016.

³⁰ This name was due to the Commission’s chair, Didier Sicard – a former President of the National Consultative Committee on Ethics. The official title was: Commission de Reflexion sur la fin de vie en France, ‘Penser solidairement la fin de vie – Rapport a Francois Hollande President de la Republique Francaise’ (18 Dec 2012).

³¹ Ibid, 95: “La commission ne voit pas comment une disposition législative claire en faveur de l’euthanasie, prise au nom de l’individualisme, pourrait éviter ce basculement.” [‘The Commission cannot see how clear legislation in favour of euthanasia, formulated in the name of individualism, could fail to bring about this changeover’] – note the ‘changeover’ the report is referring to is the ‘deep commitment to a society’s concept of what its medical services’ missions should be, [...] universal duty of humane care and support, to an act which is so universally controversial.’

³² Ibid, 95: “Elle rappelle au demeurant que tout déplacement d’un interdit crée d’autres situations limites, toujours imprévues initialement et susceptibles de demandes réitérées de nouvelles lois.” [The Commission recalls that any change on the (total) prohibition creates other limited situations, always unforeseen situations and requests for new laws.’

³³ Ibid, 94-95. This position was justified by pointing to evidence from New Orleans (where AS is a legal but a rarely used last resort). The conditions the Report recommended, should the French Parliament legislate on AS, where: *S’assurer que la personne demande de manière explicite et répétée sa volonté de finir sa vie par une telle assistance; Reconnaître par une collégialité médicale l’existence de la situation en fin de vie de la personne malade; S’assurer que la décision de la personne en fin de vie, sera prise, - dans la mesure où celle-ci est en capacité d’un geste autonome, - dans la mesure où celle-ci est informée, libre dans son choix, - dans la mesure où celle-ci a un réel accès à toutes les solutions alternatives d’accompagnement et de soulagement de la douleur physique et psychique, - dans la mesure où celle-ci est informée des conditions concrètes du suicide assisté,- dans le cadre d’un échange collégial pluridisciplinaire associant le malade, ses proches, le médecin traitant, un médecin non engagé dans les traitements en cours, et un soignant accompagnant le malade; Requérir la présence du médecin traitant, ou en cas d’objection de conscience de ce dernier, du médecin prescripteur, lors du geste et de l’agonie; Garantir l’objection de conscience des pharmaciens; S’assurer que les médicaments utilisés satisfont aux exigences de la réglementation et de la sécurité sanitaires et pharmacologiques; S’assurer de l’absence d’un calendrier préétabli de l’accomplissement du geste; S’assurer d’une remontée d’informations (nature de la maladie, motifs de la décision, déroulement du geste) transmis par le médecin à une structure nationale chargée de faire un rapport annuel retraçant l’ensemble des remontées d’information.*

concluded that there should not be a change in the law to legalize the provision of AS or VAE.³⁴ This is a clear reversal from its previous Opinion in 2000 (which recommended that VAE be exceptionally excused in the Criminal Code).³⁵ The 2013 CCNE Opinion (like the ‘Sicard Report’) did, instead, recommend adapting the current law to provide ‘a right to terminal sedation in the last few days of life.’

In January 2015, another Bill (by MP Véronique Massonneau) was introduced to the National Assembly – again seeking to permit VAE and AS subject to the same substantive and procedural conditions³⁶ as the previous Bill before the National Assembly. After a day of debating, the Bill was sent back to the select committee on Social Affairs, with 25 (of the 56 voters present) rejecting its text. In March 2015, the National Assembly approved (by 436 votes to 34 votes) a Members’ Bill (introduced by Jean Leonetti and Alain Claeys) entitled: *Nouveaux droits des personnes en fin de vie* [‘New rights for patients at the end of life’]. Most notably, this Bill did not make any provision for assisted dying. Instead, it followed the recommendation set out in the 2013 CCNE Opinion. The Bill sought to allow a patient, with a short life expectancy and in intractable pain, to enter deep sedation until death, upon his or her request. Moreover, in such instances the Bill provided that all life-prolonging treatment must be stopped, including artificial hydration and nutrition. In June 2015, this Bill was put before the Senate. It was rejected by 196 votes to 87 votes.

6.3 SWITZERLAND

In terms of Swiss political developments seeking to effect legal change, there is little to be said on VAE and a substantial amount to be said on AS. In both cases, however, Swiss politicians have expressed their preference for maintaining the status quo.

³⁴ CCNE Opinion N° 121, ‘The End of Life, Personal Autonomy, the Will to Die’ 53-54. It stated: ‘Some members of the CCNE consider assisted suicide and euthanasia should, at least in certain circumstances, be legalized [...] however, the majority in the Committee considers that such legislation is not advisable: apart from the fact that any development in that direction appears to be — particularly in the light of similar experience in other countries — very difficult to stabilise, there would be a significant risk of compromising the solidarity and fraternity which are the safeguards of life in a society marked by numerous individual and collective frailties and notable shortcomings in end-of-life policies.’

³⁵ CCNE Opinion No. 63 (n 21), 45

³⁶ Substantively speaking, it was not limited to terminally patients or to physical suffering. Procedurally speaking, it also required independent consultation and an *ex post* regional review committee. For a preparatory report on this Bill, see: <www.assemblee-nationale.fr/14/propositions/pion2435.asp>. Last accessed 28.01.2016.

In 1994, an individual member of the lower house of parliament (*Nationalrat/Conseil National*) proposed the decriminalisation of VAE under certain specified circumstances.³⁷ The motion was changed to a postulate (i.e. a non-binding resolution that called for an expert report) and after two years, it was approved by the *Nationalrat*.³⁸ As a result, the Federal Council³⁹ established a multi-disciplinary working group (consisting of experts in law, medicine and ethics). In its 1999 report, this working group concluded that it should not be a criminal offence for a person (note: not just a physician but any person) to provide VAE to a terminally ill person whose suffering is unbearable and untreatable.⁴⁰ The Federal Council did not agree. In a statement released in 2000, it welcomed the impending Parliamentary debate on the expert working group's findings but it also took the stance that VAE must remain a crime.⁴¹ The Federal Council claimed to have reached this conclusion 'in light of the Christian foundation' of Swiss society.

The 1999 working group's findings were presented in December 2001 before the *Nationalrat* in the form of the 'Cavalli Initiative'.⁴² The initiative was rejected by 120 votes

³⁷ No. 94.3370 – Motion: Sterbehilfe. 'Ergänzung des Strafgesetzbuches', submitted by Victor Ruffy on 29.09.1994. Under this proposed motion, VAE would cease to be a crime if the following conditions are met: 1. The deceased person had made a serious and persistent request to die [*'Der Tod der betreffenden Person ist auf deren ernsthaftes und eindringliches Verlangen herbeigeführt worden'*]; 2. The deceased has suffered from an incurable, irreversible disease for which a fatal outcome has been predicted and which is connected to intolerable physical and psychological suffering [*'Die verstorbene Person hat an einer unheilbaren, irreversibel verlaufenden Krankheit gelitten, für die ein tödlicher Ausgang prognostiziert worden ist und die mit unerträglichen körperlichen und seelischen Leiden verbunden ist'*]; 3. Two certified and independent doctors have both confirmed that the conditions of point 2 are satisfied [*'Zwei diplomierte und sowohl voneinander wie gegenüber dem Patienten unabhängige Ärzte haben zuvor beide bescheinigt, dass die Voraussetzungen nach Ziffer 2 erfüllt seien'*]; 4. The competent medical authority is satisfied that the patient has been adequately informed, is of sound mind and has repeatedly sent the request for euthanasia [*'Die zuständige ärztliche Behörde hat sich vergewissert, dass der Patient angemessen informiert worden ist, urteilsfähig ist und das Gesuch um Sterbehilfe wiederholt gestellt hat'*]; 5. The euthanasia must be made by a federally qualified doctor whom the applicant has chosen himself among his doctors [*'Die Sterbehilfe muss von einem eidgenössisch diplomierten Arzt geleistet werden, den der Gesuchsteller selber unter seinen Ärzten ausgewählt hat.'*]

³⁸ G. Lewy, *Assisted Death in Europe and America: Four Regimes and their Lessons* (Oxford: Oxford University Press, 2011) 113.

³⁹ Note that the Swiss Federal Council is the seven-member executive council of the federal government, and serves as the Swiss collective head of state.

⁴⁰ Arbeitsgruppe Sterbehilfe [Task Force on Assisted Dying] 1999 'Bericht an das Eidgenössisches Justiz- und Polizeidepartement [Report to the Federal Office of Justice and Police]'. Note that it also recommended that 'passive and indirect euthanasia should be explicitly regulated in the law' rather than merely by SAMS professional ethical guidelines.

⁴¹ Bericht des Bundesrates vom Juli 2000 zum Postulat Ruffy (PDF, 109.15 KB), Medienmitteilung vom 5. Juli 2000. Available at: <www.bj.admin.ch/dam/data/bj/gesellschaft/gesetzgebung/archiv/sterbehilfe/ber-ruffy-d.pdf>. Last accessed 29.01.2016.

⁴² *Strafbarkeit der aktiven Sterbehilfe*. Neuregelung [Punishability of Voluntary Active Euthanasia. Revision]. *Parlamentarische Initiative* [Parliamentary Initiative] 00.441. Available at <www.parlament.ch/afs/data/d/bericht/2000/d_bericht_n_k12_0_20000441_01.htm>. Last accessed

to 56, with a clear preference expressed for the current ban on VAE.⁴³ This preference not only departed from the findings of the 1999 report, but it also departed from the report by the Committee for Legal Affairs of the National Assembly, which recommended that VAE should go unpunished in certain circumstances.⁴⁴ In the same parliamentary sitting, a diametrically opposed proposal (known as the ‘Vallender Initiative’) sought to restrict the practice of RTD organisations (to persons who are legally resident in Switzerland) and to prohibit doctors from prescribing lethal drugs. It was also rejected (by 117 votes to 58).⁴⁵

From 2001 to 2008, a considerable number of motions and initiatives on regulating other types of medical behaviour that shortens life, including on AS, were introduced to the Swiss Parliament. None of them, however, succeeded in reforming the law. The main legislative proposals were: (i) the ‘Zach Motion’ before the *Nationalrat* in 2001,⁴⁶ proposing state-level legislation on ‘indirect active and passive euthanasia’ to compliment the non-binding professional medical rules; (ii) the ‘Vallender Motion’ before the *Nationalrat* in 2002,⁴⁷ this time proposing that access to AS should be limited to Swiss residents, that RTDs should be subject to licensing and registration requirements, that two doctors should be required to verify the nature of the request, and that there is a ban on advertising for RTD clinics; (iii) a motion before the *Ständerat* (the upper house of Parliament) in 2003, verifying that the Federal Council has the mandate ‘to submit proposals for a statutory regulation of indirect active and passive euthanasia’;⁴⁸ (iv) the ‘Egerszegi Initiative’ before the *Nationalrat* in 2006, seeking statutory regulation on indirect active and passive euthanasia to be drawn up, along with regulation overseeing RTDs;⁴⁹ (v) the ‘Hansreudi Motion’ and the ‘Glanzmann motion’ in 2007 before the

28.01.2016.

⁴³ M. Rosenberg ‘Sterbehilfe soll nicht straffrei werden [Voluntary Active Euthanasia Must not be Decriminalised]’ *Neue Zürcher Zeitung* (2001).

⁴⁴ Bericht der Kommission für Rechtsfragen vom 2. Juli 2001, 01.407 n: Pa. Iv. Vallender. Verleitung und Beihilfe zur Selbsttötung. Neufassung von Artikel 115 StGB. Available at: <www.parlament.ch/sites/kb/2001/Kommissionsbericht_RK-N_01.407_2001-07-02.pdf>. Last accessed 28.01.2016

⁴⁵ Ibid.

⁴⁶ G. Zäch, Sterbehilfe. Gesetzeslücke schliessen statt Tötung erlauben, 01.3523 – Motion. Available at: <www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20013523>. Last accessed 28.01.2016.

⁴⁷ D. Vallender, Sterbehilfe und "Sterbetourismus"02.3500 – Motion. Available at: <www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20023500>. Last accessed 28.01.2016.

⁴⁸ Kommission für Rechtsfragen SR, Sterbehilfe und Palliativmedizin, 03.3180 – Motion. Available at: <www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20033180>. Last accessed 28.01.2016.

⁴⁹ No. 06.453 – PARLAMENTARISCHE INITIATIVE REGELUNG DER STERBEHILFE AUF GESETZESEBENE.

Ständerat and the *Nationalrat*, respectively, seeking federal-level regulation of RTDs;⁵⁰ and (vi) the “Reudi motion’ before the *Nationalrat* in 2008, proposing that the State criminally prohibit AS altogether.⁵¹

During these debates, the Federal Council made clear that it did not support any immediate change in the law on assisted dying. Its arguments were extensively illustrated by a 2006 report by the Department of Justice and Police (a report the Federal Council readily invoked to defend its position post-2006).⁵² Both the Federal Council and this report opposed any statutory regulation of the RTDs activities. A number of reasons were put forward in defence of this reluctance to reform the law, such as: specific regulation relating to AS would be impractical because each individual case is different; professional medical guidelines are more adequate in practice; the problem is not the lack of existing legal rules but the lack of enforcement of these rules; the cantonal and municipal authorities already have the means to prevent abuse in cases of AS; any statutory regulation of RTDs on the Federal-level would result in a ‘bureaucratization of assisted death’ and the state would be ultimately seen as rubber-stamping ‘officially licensed assistants in suicide.’⁵³ These arguments were in stark contrast with the recommendations given by the Swiss National Advisory Commission on Biomedical Ethics (‘NEK-CNE’).⁵⁴ In sum, said Advisory Commission recommended minimum legal regulations to ensure that: ‘(a) before any decision to proceed with assisted suicide, adequate investigations are carried out for each individual case; (b) nobody can be obliged to assist a suicide; (c) assisted suicide is not carried out if suicidality is a manifestation or symptom of a mental disorder; (d) [...] a minority view: assisted suicide is not carried out in children and adolescents; and (e) right-to-die organizations are subjected to state supervision.’

⁵⁰ No. 07.3163 – *MOTION GESETZLICHE GRUNDLAGE FÜR DIE AUFSICHT ÜBER DIE STERBEHILFEORGANISATIONEN; NO 07.3626 – MOTION AUFSICHT ÜBER DIE STERBEHILFEORGANISATIONEN.*

⁵¹ No. 08.3300 – *Motion, Anstiftung und Beihilfe zu Selbstmord unter Strafe stellen.*

⁵² Eidgenössisches Justiz-und Polizeidepartment, ‘Sterbehilfe und Palliativmedizin – Handlungsbedarf für den Bund?’ (Vorentwurf vom 31. Januar 2006). Available at: <www.bj.admin.ch/dam/data/bj/gesellschaft/gesetzgebung/archiv/sterbehilfe/060131_ber-sterbehilfe-d.pdf>. Last accessed 28.01.2016.

⁵³ *Ibid*, 64-73.

⁵⁴ Swiss National Advisory Commission on Biomedical Ethics (NEK -CNE), ‘Assisted suicide’; opinion no. 9/2005. Berne: NEK-CNE, 2005.

By late 2007, there were some signs of legal reform towards state-level regulation of AS. First, the Minister of Justice and Police was replaced in the national elections with a new Minister (Eveline Widmer-Schlumpf) strongly opposed to suicide tourism and in favour of state action to guarantee minimum standards for the RTDs.⁵⁵ The previous year, the *Kantonsrat* (Cantonal Parliament) of Zurich only just rejected a proposal to prohibit suicide tourism (80 votes in favour to 82 against). Said Cantonal Parliament voted more convincingly in favour of demanding that the Federal Council take responsibility for legislating on RTDs (94 to 56). While soon after, the *Grosse Rat* (the Cantonal Parliament) of Aargau had voted to demand a prohibition on commercial RTDs, 'especially in the form of suicide tourism.'⁵⁶ Furthermore, in 2009 a unique agreement was made between the General Public Prosecutor of the Canton of Zurich and the RTD organisation *Exit*.⁵⁷ It planned to achieve financial transparency, including a ban on profit, a small maximum payment (€416) for expenses, and the obligation to have *Exit's* financial statement monitored by a recognized auditor. It also limited assistance to those 'with severe suffering as a result of a disease.' This agreement, however, was declared invalid by the Supreme Court in July 2010.⁵⁸ The Court concluded that such an agreement lacked a legal basis (any regulation that fundamentally affects 'the right to life' is a matter for the Federal legislature only) and it was not in accordance with domestic law (it entails an undue extension of Article 115 of the Criminal Code).

In 2009, two more legislative proposals were brought before the Federal Council. One set out new substantive and procedural rules for those assisting suicide (option 1),⁵⁹ while the second proposal sought a complete ban on AS (option 2).⁶⁰ The former proposal was supported by the Federal Council, meaning it was the first time the national government formally supported legal change on AS. Before setting a date for a vote, a consultation

⁵⁵ See Lewy (n 37) 126.

⁵⁶ 'Kantonsinitiative gegen Sterbetourismus', Swiss Info., June 17, 2008. Lewy, *ibid*, 124.

⁵⁷ "Vereinbarung über die organisierte Suizidhilfe," between Ober staats anwalt schaft des Kantons Zurich and Exit Deutsche Schweiz.

⁵⁸ BGE 136 II 415. "Pro-life societies brought the case before the Federal Court, arguing that the agreement was contrary to the Constitution." See Andorno (n118) 253.

⁵⁹ The act of suicide must be done on the basis of a clear and voluntary decision; two medical reports from two independent doctors are required in order to check the nature of the request and to confirm that the patient suffers from a physical disease that is incurable and will result in death in a short period of time (non-terminally ill patients and mentally ill patients are thereby excluded); the 'suicide helper' must demonstrate any alternatives to suicide; assistance in suicide must be a non-profit endeavor; and the 'suicide helper' must complete an *ex post* report with all the details of the case in order to facilitate any investigation of law enforcement agencies.

⁶⁰ Bundesrat schickt zwei Varianten in die Vernehmlassung - Organisierte Suizidhilfe soll geregelt werden

process was established.⁶¹ In sum, a ‘clear majority’ of Cantons, political parties and interested organisations agreed that there was a need for explicit Federal-level legislation on the provision of AS.⁶² There was, however, less consensus on what form this legislation should take. For some participants, option 1 was too complex, unclear and/or discriminatory (e.g. unfair to suffering non-terminally ill patients). While for others, option 2 represented an unacceptable restriction on the right to self-determination. In June 2011, the Federal Council decided (on the basis of a follow up report by the Department of Justice and Police) against a change in the law. It cited the following main reasons: the current law in force (Article 15 of the Criminal Code and the related laws on narcotics) was sufficient to ensure the request was truly voluntary; a change in the law (in favour of option 1) would legitimize the RTDs; and that the status quo offers a more flexible balance between the State’s duty to protect and respect personal freedom.⁶³ This decision by the Federal Council came some months after a referendum on the law on assisted suicide in the Canton of Zurich. 85% of the 278,000 voters opposed the option of banning assisted suicide altogether, while 78% opposed the proposal to outlaw it for non-Swiss residents only.

6.4 THE NETHERLANDS

In the Netherlands, the legal norms on assisted dying were not formulated in a hierarchical manner.⁶⁴ The current law is a result of significant interaction between the medical profession (individual doctors and the Royal Medical Association - the ‘KNMG’),⁶⁵ interest groups (in particular the Association for Voluntary Euthanasia - ‘NVVE’), the Executive, the Parliament, the Health Council, the State Commission on Euthanasia, the

⁶¹ Available at: <https://www.bj.admin.ch/bj/de/home/gesellschaft/gesetzgebung/archiv/sterbehilfe.html>

⁶² 22 Cantons, 8 political parties and 54 organizations affirmed a need for legislative action, while 4 Cantons, 5 parties and 16 organizations stated that the current law is enough to prevent abuses. For a detailed report on the conclusions of the consultation, see: <https://www.bj.admin.ch/dam/data/bj/gesellschaft/gesetzgebung/archiv/sterbehilfe/ve-ber-d.pdf>

⁶³ Bundesrat fördert weiterhin Suizidprävention und Palliative Care - Suizidhilfe: Stärkung des Rechts auf Selbstbestimmung. Available at: https://www.bj.admin.ch/bj/de/home/aktuell/news/2011/ref_2011-06-29.html

⁶⁴ See H. Weyers, ‘The Legalization of Euthanasia in the Netherlands; Revolutionary Normality’ in S. J. Youngner and G.K. Kimsma, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 34-68; See also H. Weyers, *Euthanasie: Het proces van rechtsverandering* [‘Euthanasia: The process of legal change’] (Amsterdam: Amsterdam University Press, 2004).

⁶⁵ Interchangeably referred to as the ‘KNMG’.

Rommelink Commission (appointed by to carry out empirical research), academics, the judiciary, the prosecutorial authorities, the medical disciplinary tribunals, the Medical Inspectorate, and the 'public'.⁶⁶ A detailed account of Dutch legal reform on assisted dying is beyond the scope of this chapter,⁶⁷ instead some key moments will be highlighted.

In the 1970s, Dutch cultural change⁶⁸ and advances in medical technology brought the topic of assisted dying into the public spotlight.⁶⁹ The first landmark decision was the *Postma case*.⁷⁰ It involved a GP (Dr Postma) who had been criminally charged for ending her mother's life with an injection of morphine upon her mother's request.⁷¹ The deceased had previously suffered a cerebral haemorrhage, which left her paralyzed on one side and in need of care in a nursing home. During the trial, the Medical Inspector testified that it is acceptable, according to medical standards, that a patient may die sooner due to the administration of pain relief. This was, he claimed, provided the patient is incurably ill, is suffering unbearably (mentally or physically), has expressed the wish to die, and he/she is in the terminal phase of the illness. The Court largely accepted the Medical Inspectorate's arguments. It did not however, agree with the condition that the patient must be in the terminal phase of his/her illness.⁷² Notwithstanding that Dr Postma had satisfied these conditions, the Court handed down a suspended one year sentence – it held that the administration of an immediately lethal injection was disproportionate in tackling the mother's suffering.

The *Postma* case attracted considerable public attention and reaction. The KNMG and the Health Council both announced their formal opposition to VAE.⁷³ Newly established

⁶⁶ See J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008).

⁶⁷ See J. Griffiths, A. Bood and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam University Press, 1998) 43-86.

⁶⁸ A general shift towards more secularization, individualization and democratization.

⁶⁹ Just as in England and France today, the early debate in the Netherlands did not always conceptually distinguish 'euthanasia' from other similar types of MBSL.

⁷⁰ *Nederlandse Jurisprudentie* 1973, no. 183: 558.

⁷¹ The termination of life on request is a specific crime under Dutch law – Article 293 of the Criminal Code.

⁷² The court rejected this condition because it knew of the existence 'of many cases of incurable illness or accident-caused disability, combined with serious physical and/or mental suffering, where the patient is otherwise healthy and can continue living in this state for years. It is not the court's view that such suffering should be denied the relief described by the expert witness' (see 13 *Nederlandse Jurisprudentie* 1973).

⁷³ KNMG (Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunst). 1973. Voorlopig standpunt van het hoofdbestuur inzake het euthanasievraagstuk [Provisional position of the governing board with respect to the question of euthanasia]. *Medisch Contact* 19: 587-588; Gezondheidsraad. 1972. Interim-advies inzake euthanasia [Interim advice concerning euthanasia]. The Hague: Ministerie van Volksgezondheid en Milieuhygiëne.

interest groups published their opinions on the matter – the NVVE (Dutch Association for Voluntary Euthanasia) and the SVE (Foundation for Voluntary Euthanasia) voicing their support for assisted dying, while the NAV (a pro-life Dutch Association of Physicians) voiced their opposition to the behaviour. Another high profile case arose in 1981, commonly known as the *Wertheim* case. The accused was a 76-year-old assisted dying activist charged with assisting in the suicide of a 67-year-old woman. The Court decided that despite the criminal prohibition on AS, it is an act that may go unpunished if certain criteria are met (which the accused did not satisfy in this case). In short, for the assistor to avoid criminal liability, the Court held that it must be evident: that the person was suffering unbearably (be it mentally or physically); that he/she had an enduring and voluntary desire to die; that he/she was well informed about his/her situation and available alternative options; that there was no alternative means to improve the situation; that the persons death did not cause unnecessary suffering to others; and that a doctor must be involved.⁷⁴ Soon after, the Committee of Procurators General announced that its prosecution policy was to be based on the conditions outlined in *Postma* and *Wertheim*.⁷⁵

In 1982, the State Commission on Euthanasia was established to report on future national policies (namely, legislation and implementation) concerning assisted dying.⁷⁶ Before its report was finalised, a member of the *Tweede Kamer* (the lower house of Parliament) introduced a Bill to reform the criminal ban on assisted dying.⁷⁷ This legislative proposal (hereafter, the *Wessel-Tuinstra* Bill) contained substantive and procedural conditions similar to the those set out in the above mentioned case-law.⁷⁸ It also made express mention of the role of nurses who act on the instruction of a doctor performing assisted dying and it laid out a conscientious objection clause. It was decided that any Parliamentary action on the Bill was to be postponed until the State Commission's report was made available.

However, before this report was made available, a number of important developments occurred. First, the executive board of the KNMG published a position paper setting out

⁷⁴ *Nederlandse Jurisprudentie* 1982, nr. 63: 223.

⁷⁵ Second Chamber of Parliament, Appendix, 1981–1982, 1757.

⁷⁶ See Weyers (n 63) 69.

⁷⁷ Second Chamber of Parliament 1983–1984, 18 331, nr. 2 and 3.

⁷⁸ See the final version of the proposed law of 8 March 1986 (Second Chamber of Parliament, 1986-1987, 18 331 no.38). See Appendix I-C-2 Griffiths, Bood and Weyers (n 67) 316.

the following:⁷⁹ it was not concerned with the *permissibility* of VAE or AS, both were simply deemed as facts of life; it clearly defined VAE;⁸⁰ it dropped the distinction between VAE and AS; it emphasized that only doctors should be allowed to perform either VAE or AS; and that, in doing so, certain minimum criteria must be satisfied.⁸¹ Then the Supreme Court handed down a landmark decision – the *Schoonheim* case. It involved a GP (Dr Schoonheim) who had performed VAE on a 95-year-old bedridden patient. The stance of the KNMG laid the groundwork for the Court to conclude that a doctor who complies with the requirements of due care set out by the KNMG can successfully invoke the legal justification of necessity (conflict of medical duties).⁸² Upon appeal, Dr Schoonheim was acquitted for performing VAE.

In 1985, the State Commission on Euthanasia released its report.⁸³ It formulated criteria highly similar to those in the above-mentioned case-law and KNMG report. Moreover, it urged the government and the Parliament to clarify the current legal situation by introducing new statutory legislation. The government did not fully endorse the notion of legal change, at least at that time. Instead it indicated that it would support a modified version of the ‘Wessel-Tuinstra Bill’, modified in the sense that an additional limitation on the lawfulness of VAE was inserted – that there was ‘a concrete expectation of death.’⁸⁴ The Parliament choose not to endorse this Bill and instead referred the matter to the Council of State (constitutionally established advisory body to the government) for advice. The Council of State decided against changing the criminal code to permit for physician assisted dying – but did suggest for the due care criteria (set out in the Commission’s report) to be incorporated in separate legislation outside of the criminal code.⁸⁵

⁷⁹ KNMG, ‘Standpunt inzake euthanasie [Position on euthanasia] (1984) 30 *Medisch Contact* 990–997.

⁸⁰ As ‘conduct that is intended to terminate another person’s life at his or her explicit request’

⁸¹ The request for euthanasia must be voluntary; the request must be well-considered; the patient’s desire to die must be a lasting one; the patient must experience his or her suffering as unacceptable; the doctor concerned must consult a colleague.

⁸² See Griffiths, Weyers, and Adams (n 65) 31; Griffiths, Bood and Weyers (n 66) 63.

⁸³ Staatscommissie Euthanasie, *Rapport van de Staatscommissie* [Report of the State Commission on Euthanasia] (vol. 1, The Hague: Staatsuitgeverij, 1985).

⁸⁴ Second Chamber of Parliament 1985–1986, 19 359, nr. 2

⁸⁵ Second Chamber of Parliament 1985–1986, 18331, nr. 43. This stance was repeated in the Council of State’s 1987 report, see Gezondheidsraad. 1987. *Advies inzake zorgvuldigheidseisen euthanasie* [Advice concerning the due care criteria for euthanasia]. The Hague: Ministerie van Volksgezondheid en Milieuhygiëne.

Without any political resolution on the matter at that time, the courts were inevitably left to deal with the issue once again, and did so in a number of important trials. In the *Pols* case (whereby a psychiatrist performed VAE on a 73 year old friend suffering from multiple sclerosis), the Supreme Court rejected the defence of ‘medical exception’ entirely and found that the defence of necessity could be accepted, but not *in casu* as the accused doctor had not consulted any colleagues on the matter.⁸⁶ In the *Admiraal* case (whereby an anaesthetist performed VAE on a patient suffering from multiple sclerosis), the District Court acquitted the accused of any criminal wrongdoing, as he had carefully followed the substantive KNMG guidelines. Soon after this decision, the Minister of Justice notified the KNMG that doctors who comply with the ‘requirements of careful practice’ published in the 1984 KNMG report would not face criminal prosecution.⁸⁷ By the late 1980s, the issue in the Netherlands was more about how to effectively control assisted dying and less about the permissibility of assisted dying.

In 1989, the centre-right government was replaced by a centre-left government and Wessel-Tuinstra’s Bill was put on hold. It was agreed that any legislative proposals concerning assisted dying should await the findings of a specific commission established to research the current practice of assisted dying⁸⁸ – the so called Rimmelink Commission.⁸⁹ In return for the co-operation of doctors in carrying out this research, the Minister of Justice and the KNMG agreed on a reporting procedure for cases of assisted dying.⁹⁰ In sum, this agreement meant that a doctor who performed assisted dying may not file a ‘natural’ death certificate but must notify the coroner of what he has done, while the Procurators-General instructed that the police investigation units should be as discreet as possible. The Rimmelink Commission published its finding in 1991 – somewhat calming ‘wild speculations’ concerning the frequencies of assisted dying.⁹¹ In

⁸⁶ *Nederlandse Jurisprudentie* 1987, nr. 607. 30. *Tijdschrift voor Gezondheidszorg* 1987, nr 35.

⁸⁷ *Nederlandse Jurisprudentie* 1987, nr. 608. This was further confirmed in a 1988 case, see *Nederlandse Jurisprudentie* 1988, nr. 157

⁸⁸ Second Chamber of Parliament 1988–1989, 21 132, nr. 8 (coalition agreement): 47; Second Chamber of Parliament 1989–1990, 20 383, nr. 13: 2.

⁸⁹ Officially known as ‘The Commission Appointed to Carry out Research Concerning Medical Practice in Connection with Euthanasia’, but more commonly known after its chairman and the Advocate General at the Supreme Court at the time.

⁹⁰ *Second Chamber of Parliament 1990-1991*, 21, 800, no. 23: 2.

⁹¹ P. van der Maas, J. van Delden, and L. Pijnenborg. *Euthanasia and Other Medical Decisions Concerning the End of Life* (Amsterdam: Elsevier, 1992). See Weyers (n 63) 51.

1994, a new coalition government was formed – comprised of political parties⁹² which had all supported the Wessel-Tuinstra 1984 Bill. Despite this, no direct legislative proposal was put forward. Instead, a second round of nation-wide empirical research on the behaviour was initiated.

In the meantime, the courts again filled in the legislative void. In the *Chabot* case, the Supreme Court repeated its earlier decision that the defence of necessity may be used to exonerate criminal liability for assisted dying even in cases of non-somatic suffering. But in such cases, it is crucial that there is a report from an ‘independent medical expert who has at least seen and examined the patient himself’.⁹³ Soon after this decision, the results of the second national study were published. The focus of concern was not the frequency of assisted dying cases but the effectiveness of the control system, namely the poor reporting rate. As a response to this, it was decided that a ‘buffer’ (i.e. the Regional Review Committees – explained above in Section 3.1.4) should be placed between the reporting doctor and the criminal authorities. The members of these Committees were delegated sole responsibility for creating uniform procedural guidelines for investigating compliance.⁹⁴ In the same year, SCEN, a body of expert doctors on assisted dying (discussed in Section 3.1.4), was set up by the KNMG and financed by the Ministry of Health to provide an extra system of *ex-ante* control.

In 1998, the issue of statutory legislation for assisted dying reappeared on the political agenda – largely due to an upcoming general election. The same parties made up the new coalition government and introduced a Bill entitled: ‘The Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2002’. It proposed little more⁹⁵ than to codify the legal norms already established over the past 25 years. In the Bill’s preamble, the focus was on transparency of assisted dying and legal certainty, rather than on the value of patient self-determination. The Bill was discussed between February 2000 and April 2001. Despite the various concerns raised (namely regarding advanced written requests, the position of minors, and nature of unbearable suffering due to complaints of

⁹² These parties were: the Social-democratic PvdA, the right-wing liberals VVD, and the left-wing liberals D66.

⁹³ *Nederlandse Jurisprudentie* 1994, nr. 656: 3154

⁹⁴ Note that since 2002, a judgment from this Committee that a reported case of assisted dying satisfies the conditions, now formally ceases the review and the prosecution authorities will not investigate the case.

⁹⁵ The only genuinely new provisions concern a) the legality of euthanasia pursuant to a prior written request by a person who has become incompetent, and b) the position of minors.

an 'existential' nature), it was approved in the lower house (140 votes in favour to 40 votes against) and in the upper house (46 votes in favour to 28 against).

The Parliamentary debate was closely linked with a high profile court case that was on-going at the same time – the *Brongersma* trial.⁹⁶ The main issue in this case was whether lawful assisted dying should be available to persons who do not suffer from a 'medically classified disease or disorder' but still 'experience life as unbearable'. The Supreme Court rejected this claim. It held that the defence of necessity cannot be applied in such cases – there must be a clinically diagnosed disease or condition in order to fall within the permissible scope of a doctor's professional competence. This specific issue reappeared on the political agenda as recently as 2011, when a citizens' initiative (acquiring over 100,000 signatures) called *Uit Vrije Wil* (Out of Free Will) sought to change the law to allow persons over the age of 70 receive assisted suicide. The initiative was not supported by the KNMG⁹⁷ and, after consideration by Parliament, it was rejected.

6.5 A CRITICAL COMPARISON

A number of comparable observations may be made from studying the political debates and processes above:

(i) There was a lack of contextualization of end-of-life behaviour in the English, French and Swiss political discourses. Acts of assisted dying were not sufficiently considered as part of a wider, complex phenomenon of medical behaviour that shortens life. This, intentionally or not, widened the vacuum for ideological inconsistency - or what Rachels would rather bluntly term 'a perversion of moral reasoning'.⁹⁸

This inconsistency is evident in the following brief examples. Many French and English politicians attested to the real fear of socially accepting VAE and AS, while welcoming the existing social acceptance of other types of medical behaviour that shortens life. As recent as 2015, the representatives in the French National Assembly voted against a *proposition*

⁹⁶ *Nederlandse Jurisprudentie* 2003, nr. 167.

⁹⁷ See the KNMG position paper, accessible at:

<http://knmg.artsennet.nl/Diensten/knmgpublicaties/KNMGpublicatie/Positionpaper-The-role-of-the-physician-in-the-voluntary-termination-of-life-2011.htm>. Last accessed 28.01.2015.

⁹⁸ J. Rachels, 'Active and Passive Euthanasia' (1975) 292(2) *N Eng J Med* 79.

de loi allowing for VAE and AS, but it overwhelmingly voted in favour of allowing for terminal sedation accompanied by the withdrawal of artificial nutrition and hydration.⁹⁹ In the various English House of Lords debates over the past 10 years and the more recent House of Commons debate, those opposed to allowing assisted dying readily pointed to the more satisfactory alternative of ‘pain relief’ that may even shorten life quite drastically.¹⁰⁰ In Switzerland, all of the legislative proposals before the Parliament (at least since the ‘Cavalli Initiative’ in 1999) concerned the regulation of AS or ‘indirect active and passive euthanasia’ – the regulation of VAE was rarely on the political agenda. Moreover, the legislative proposals on AS were all rejected at the highest political level. The Federal Council eventually made clear its preference not to over-medicalize the provision of AS or to ‘legitimize’ how the RTDs (largely, non-medical lay helpers) operate.

Arguably, each of these standpoints favoured by the political representatives in England, France and Switzerland rely on dubious moral distinctions. The French National Assembly essentially championed the *act v omission* distinction (also known as the *killing v letting die* distinction). It rejected both VAE and AS, but accepted terminal sedation without artificial nutrition or hydration – the latter was deemed morally (and therefore legally) acceptable as it does not kill the patient, the underlying terminal disease kills the patient. The English House of Lords and House of Commons maintained the *intention v foresight* distinction. It rejected both VAE and AS but accepted the administration of pain relief that may (drastically) shorten the patient’s life – the latter was deemed morally (and therefore legally) acceptable as the doctor’s primary intention is to relieve pain, not to kill. While the Swiss *Nationalrat* and Federal Council maintained a distinction between VAE and AS to deem the latter, but not the former, as morally (and legally) acceptable. Moreover, the Swiss Federal Council sees AS as morally and legally acceptable, but not to

⁹⁹ As mentioned above, the voting result was 436 to 34 in favour of the latter (terminal sedation) Bill, while the former (assisted dying) Bill was effectively rejected (sent back to the first Committee Stage) by a vote of 25 to 20. For just some examples of the reasons behind this preference for terminal sedation over assisted dying: see the speech of Ms. Marisol Touraine, (Minister of Social Affairs, health and women’s rights) on 29 January 2015 during the National Assembly debate on the Massoneau Bill. Available at http://www.assemblee-nationale.fr/14/dossiers/respect_choix_fin_vie_patients.asp; See the speeches of: Mr Bernard Perrut, Mr Frédéric Reiss, Mr Jean Leonetti, Mr. Nicolas Dhuicq, and Mr. Patrice Martin-Lalande on 10 March 2015 in the the National Assembly debate on the 2015 Leonetti Bill. Available at http://www.assemblee-nationale.fr/14/dossiers/nouveaux_droits_personnes_fin_vie.asp

¹⁰⁰ For examples of this, see: in the 2006 House of Lords debate on Lord Joffe’s Bill, the speeches of: Lord Ahmed, Column 1250; the Earl of Onslow, Column 1256; Lord Warner, Column 1286; Baroness Morris of Bolton, column 1272. Also in the 2014 House of Lords debate on Lord Falconer’s Bill, see the speeches of Baroness Finlay of Llandaff (CB), Column 792; Lord Stirrup, Column 820.

the extent that it should be considered a medical activity or subject to state-level regulation. As argued in detail in **CHAPTER TWO**, the above moral distinctions (between killing v. letting die, intention v. foresight, and VAE v. AS), or the Swiss standpoint that AS should be morally accepted by the state but not carefully regulated or considered a medical activity, cannot be maintained in a rational ‘ideal dimension’ of the law on assisted dying.¹⁰¹

In comparison to England, France and Switzerland; the political discourse in the Netherlands, over time, avoided the ideological pitfalls of not placing VAE and AS into a wider context of medical behaviour that shortens life. In 1990, the Dutch government established a research commission (the ‘Rommelink Commission’) to provide insight into the extent and characteristics of all ‘acts or omissions by doctors which shorten life of a patient, with or without an explicit and serious request.’¹⁰² This broad empirical research has been systematically carried out over the past two decades to inform, and to subsequently pacify, the political debate on assisted dying.

(ii) There was an evident confusion, particularly in the English and French political debates, between concerns of a slippery slope in legal control (based on empirical argumentation), a slippery slope in moral change (based on speculative argumentation) and a slippery slope as a matter of logic (based on conceptual argumentation). The use of these different forms of argumentation in the above parliamentary debates perpetuated the disregard for similar control concerns inherent in permitting (although not regulating) ‘morally legitimate’ forms of medical behaviour that shortens life. This also detracted from the discrepancies in the legal status quo (a blanket ban on assisted dying) and the application of such a ban in reality (see **CHAPTER FIVE**, above). Regarding claims of a slippery slope in legal control, a considerable amount of parliamentarians¹⁰³ were

¹⁰¹ See above: Section 2.2. The Ideal Dimension of the Law on Assisted Dying. And in particular therein, see: Section 2.2.2. – Part III on the ‘Principle of Respect for Life’, and Section 2.2.3. The Balancing of the Relative Principles.

¹⁰² *Second Chamber of Parliament 1989-1990*, 20 383, no. 13: 2.

¹⁰³ For some examples of this in the House of Lords debate on Lord Falconer’s 2015 Bill, see the speech by The Lord Bishop of Bristol, Column 831; Baroness Masham of Ilton, Column 865; Baroness Grey-Thompson, Column 824. Viscount Colville of Culross (CB), column 854; Lord Crisp (CB), Column 852; Lord Browne of Belmont (DUP), Column 855. The full text of this debate is available at: <http://www.publications.parliament.uk/pa/ld201415/ldhansrd/index/140718.html#contents>. For examples of this in the French National Assembly, see the debate on the 2009 (assisted dying) Bill: Marc Bernier (19 Nov); Michèl Vaxes (18 Nov); and also the debate on the 2015 (assisted dying) bill: Ms. Jacqueline; Mr. Fraysse Xavier Breton (29th Jan);

opposed to legal reform premised on ‘evidence’ from other jurisdictions – particularly from the Netherlands. Indeed, there are concerns over the Dutch law on assisted dying and its application (see **CHAPTER FIVE**, above) but it is not a jurisdiction that provides evidence of the inherent potential for abuse or inevitable failing of safeguards (see in particular Section 4.1.4., above). Regarding the arguments of a slippery slope in moral change - alluded to by both sets of parliamentarians¹⁰⁴ - these are claims simply based on a fear of the moral judgments of future generations and future policy-makers. The argument, as Griffiths puts it, goes as: if *we* allow A, *they* will eventually allow B (which *we* but not *they* find abhorrent). Speculation on future moral reasoning, and indeed the hope of binding future moral reasoning based on this speculation, is a more than dubious basis to determine present day public policies. And finally, certain parliamentarians alluded to the conceptual slippery slope argument.¹⁰⁵ This goes: if we allow A on the basis of a particular justifying principle, then we must also allow B if it is necessarily justified by that same principle. For example, if we rely on the principle of autonomy to legalise assisted suicide, then we cannot limit lawful assistance to those who act autonomously *and* suffer unbearably. It must be provided for all persons who can act autonomously. This slippery slope argument cannot be maintained if allowing A is based on more than one principle (which is the case with assisted dying in the Netherlands). This conceptual response exposes ‘the one law, one principle fallacy’.¹⁰⁶ In short, if we allow assisted suicide on the basis of two mutually exclusive principles, autonomy *and* beneficence, then it does not logically follow (conceptually speaking) that we cannot limit lawful assistance to those who act autonomously *and* suffer unbearably.

¹⁰⁴ For recent examples of this in the House of Lords debate on Lord Falconer’s 2015 Bill, see the speech of: Lord Hylton (CB) Column 845; Baroness Kennedy of The Shaws (Lab), Column 873: legalising assisted dying ‘will change the moral landscape [...] We must be careful about creating huge moral changes.’; Lord Carlile of Berriew (LD), Column 907; Lord Cormack (Con), Column 807: “if we go down this road (of legalising VAE), this will be merely the first stage [...] I realised that I do not wish us to embark down that road, which will end when it will be entirely permissible for anybody to do virtually anything.’ See also the speech by Lord McColl of Dulwich (Column 1284) in the 2006 House of Lords debate on Lord Joffe’s Assisted Dying Bill. As for examples of this argumentation in the French debates see: the National Assembly debates on the 2015 (terminal sedation) Bill, speeches by: Marc Le Fur (1st Meeting 11th March); also the debates on the 2015 (assisted dying) Bill: Ms. Marion Maréchal-Le Pen.

¹⁰⁵ For an example in the English debates, see in the 2014 House of Lords debate on Falconer’s Assisted Dying Bill: the speech by Lord Harries of Pentregarth, Column 806; Baroness Sherlock (Lab), Column 888; Lord Rowe-Beddoe (CB), Column 883. For an example of this in the French debate, see in the 2015 (terminal sedation) Bill: Xavier Breton.

¹⁰⁶ For example: Joffe’s Bill was only “founded on the principle of autonomy” (according to Report by House of Lords Select Committee).

(iii) The governments in all four nations were keen to avoid supporting any serious reform of the law on assisted dying,¹⁰⁷ despite strong public support to do so.¹⁰⁸ And when confronted with the issue, different (legitimate but in some instances rare) political tactics were used to delay parliamentary voting on the issue. Although the political strategy of *avoidance* - especially when ideological issues are at hand - may not be overly surprising in itself, it is key to note that some instances of political avoidance may be more or less beneficial than others.

In England, the law on assisted dying has only been debated once in the past 20 years in the House of Commons (the directly elected parliamentary chamber). This debate came about through a Private Members' Bill explicitly lacking government support. Moreover, it came less than one year after a majority in the English Supreme Court pressed the Parliament to redress the status quo - which the latter overwhelmingly decided not to do. As for the House of Lords, none of the numerous assisted dying bills introduced therein over the past decade have ever reached a vote at the third reading stage (most ran out of parliamentary time, either due to the sheer number of substantial amendments made after the second reading or the due to the limited timing of the debates). Notably in 2006 when Lord Joffe's Bill was before the Lords, the exceptional decision to vote at the second reading stage was taken. This effectively meant the Bill could not go to the committee or the report stage for closer scrutiny. In France, only two Bills allowing for assisted dying have been introduced to the National Assembly (the directly elected house of Parliament). When the first of these Bills was before the Assembly for a vote, 'la réserve des vote'¹⁰⁹ was used by the government (by the Minister of Health). This was used to delay voting, as they feared the result would be unfavourable.¹¹⁰ Regarding the second Bill introduced to

¹⁰⁷ In the case of the Netherlands, this is true at least until 2002. Also the Swiss Federal Council briefly supported serious reform of the law (state-level regulation of RTDs) in 2009, but dropped this support in 2011 after a follow up report by the Department of Justice and Police.

¹⁰⁸ For statistics on public opinion in England dating from the 1980's to the present day see, Commission Report on Assisted Dying, available at <www.demos.co.uk> 60-62. For related data on France, see S. Hennette-Vauchez, 'France' in J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart, 2008). On the French public opinion, see also the 2013 CCNE Opinion above. For evidence of Swiss public opinion, see the Institute of Criminology, Zurich University study, available at: <http://www.swissinfo.ch/eng/swiss-want-a-say-on-how-to-end-their-lives/28250486>.

¹⁰⁹ For a mainstream report on this, see <www.lexpress.fr/actualite/politique/les-deputes-ps-quittent-l-hemicyle-lors-du-debat-sur-l-euthanasie_829693.html>; <blogs.lexpress.fr/cuisines-assemblee/2009/10/16/abus_de_la_reserve/>.

¹¹⁰ As one French commentator stated, this use of 'la réserve' displayed: 'the government still has the means to whistle the end of recess and to toe the line MEPs UMP . They know that their re-election depends largely on the victory of Nicolas Sarkozy and that this requires a united front behind the head of state'

the National Assembly, only 56 of the total 577 députés of the house were actually present to vote. In Switzerland, the Federal Council has often been accused of not responding to public opinion or the demands of cantonal parliaments by maintaining its refusal to federally regulate RTDs (right-to-die organizations).¹¹¹ While in the Netherlands, a number of successive governments (dating up to the 2002 coalition), delayed codifying the legal norms on assisted dying - namely by referring the issue to advisory commissions.

From the above observations, at least two important questions arise. The first is: *why* is political avoidance of legal reform on assisted dying (in whatever form it may take) not an uncommon phenomenon in all four nations? Majone's general explanation of elected representatives is a good starting point. He maintains that 'most political scientists can safely assume that the main goal of elected politicians is to maximize their probability of being re-elected.'¹¹² They prefer to support distributive policies serving special interest groups rather than policies that are simply more efficient. In order for citizens' preferences and the actual effects of policy decisions to constrain legislators' actions, the issue 'must be framed in a way that allows citizens to reward or punish their representatives' for making/sustaining inefficient decisions.¹¹³ If politicians are forced to take public positions on specific policies, voters can hold them accountable for the positions they take and for the effects they produce. As Arnold puts it: too wide a gap between stated objectives and actual results should invite 'punishment at the polls'.¹¹⁴ There is (as stated in **CHAPTER FIVE** above) a gap between the stated objectives and actual results regarding the law on assisted dying in England, France and Switzerland. Whilst in the Netherlands, there was (as pointed to in Section 6.4., above) a sustained period of political avoidance prior to 2002 to amend the criminal code, and thus avoidance to recognise in statute the realities of the substantive and procedural rules that were already allowing for assisted dying.

This leads us to the second question: why do politicians not feel it necessary to take a stance towards legal policy change in England, France and Switzerland (or in the case of the Netherlands, did not feel it necessary prior to 2002) despite gaps between their formal

¹¹¹ See Lewy (n 37) 122.

¹¹² G. Majone, 'The Common Sense of European Integration' (2007) 13(5) *Journal of European Public Policy*, 623.

¹¹³ *Ibid.*

¹¹⁴ R.D. Arnold, *The Logic of Congressional Action* (New Haven CT: Yale University Press, 1990).

policy decisions and the results that follow? To help answer this, policy framing and the role of special interest groups in inducing political action or inaction clearly warrants attention. There are, at least, three special interest groups of particular relevance here: (a) professional medical associations, (b) organised religious groups, and (c) ‘right to die’ organisations. Aside from the role of special interest groups, another factor that arguably effects political avoidance on the issue of assisted dying is the peculiarities of the political institutional structure, namely, the nature of the separation of powers. This is examined in turn (see sub-heading (iv), below).

(a) Professional medical associations

Weyers convincingly illustrates that legal change permitting assisted dying does not require a formal positive stance from relevant medical associations (see in the case of Belgium) but it may be assumed that where such associations ‘are vigorously opposed, legalization is less likely, even if values of the general public seem to point to legal change’.¹¹⁵

In England, the General Medical Council refuses to take a position on the legal policy concerning assisted dying, ‘neutral or otherwise’ – it merely insists that its members follow the law.¹¹⁶ However, the British Medical Association (trade union for doctors) and the Royal College of Surgeons are officially opposed to the legalization of VAE and PAS.¹¹⁷ In France, the *Académie Nationale de Médecine* are formally opposed to assisted dying becoming part of a physician’s task.¹¹⁸ The same position was adopted by the *Conseil National de l’Ordre des Médecins* (the National Medical Association) and the *Société Française d’Accompagnement et de Soins Palliatifs* (SFAP) (the French Society for Palliative Care).¹¹⁹ In Switzerland,

¹¹⁵ See Griffiths, Weyers and Adams (n 65) 525.

¹¹⁶ See the General Medical Council’s response to the DPP’s consultation on assisted suicide, available at: <www.gmc-uk.org/guidance/5643.asp>. Last accessed 28.01.2016.

¹¹⁷ See the British Medical Association’s statement, available at: <http://www.bma.org.uk/news-views-analysis/news/2014/july/bma-reiterates-opposition-to-assisted-dying>. See the Royal College of Surgeon’s briefing to the House of Lords, available at: <www.carenotkilling.org.uk/public/pdf/hl-second-reading-rcs-briefing-july-2014.pdf>. Last accessed 28.01.2016.

¹¹⁸ See their reply to the Conseil d’Etat’s referral, available at: <www.academiemedecine.fr/wp-content/uploads/2014/05/Reponse-saisine-Conseil-Etat-22-04-14.pdf>.

¹¹⁹ As confirmed in the National Consultative Ethics Committee, ‘CCNE Report on the public debate concerning end-of-life’ (October 21st 2014) 46.

Académie Suisse des Sciences Médicale (the Swiss Academy of Medical Sciences - SAMS) allow for AS as part of a physician's role via their formal guideline on end-of-life care¹²⁰ (in the sense that such a role is not considered part of a physician's duty but it must be respected as a 'personal moral decision'¹²¹ if provided). The SAMS consider the law on AS as somewhat too permissive, and formally specifies in its guidelines more stringent criteria than the general requirements set out in the Penal Code – namely, end of life must be imminent based on the patient's condition. In the same guidelines, the SAMS reject VAE ('killing on request'), simply citing the criminal nature of such an act.¹²² The code of *La Fédération des médecins suisses* (The Swiss Medical Association - FMH) adopts the SAMS guidelines and formally declares VAE as 'incompatible with medical ethics'.¹²³ In 2010, the SAMS issued a policy statement¹²⁴ rejecting two proposals set out by the Federal Council to reform the law on AS - 'option 1' set out greater substantive and procedural Federal-level rules¹²⁵ for those assisting suicide, while 'option 2' sought a complete ban on AS.¹²⁶ The SAMS stressed that the former would 'institutionalise assisted suicide as a medical activity', which is contrary to the SAMS's repeated stance that AS 'falls under the responsibility of society and that it can not be delegated to the medical body.' It also feared that the latter option (prohibiting the current RTDs and lay person help therein) would indirectly increase the pressure faced by

¹²⁰ See Swiss Academy of Medical Sciences, 'Medical-ethical guidelines on end-of-life care' (2014), It states in Provision 4.1: [...] in the final phase of life, when the situation becomes intolerable for the patient he or she may ask for help in committing suicide and may persist in this wish. In this borderline situation a very difficult conflict of interests can arise for the physician. On the one hand assisted suicide is not part of a physician's task, because this contradicts the aims of medicine. On the other hand, consideration of the patient's wishes is fundamental for the physician-patient relationship. This dilemma requires a personal decision of conscience on the part of the physician. The decision to provide assistance in suicide must be respected as such."

¹²¹ Académie Suisse des Sciences, 'Problèmes de l'assistance médicale au suicide Prise de position de la Commission Centrale d'Éthique (CCE) de l'ASSM' (2012).

¹²² Ibid., Provision 4.2.

¹²³ Fédération des médecins suisses, 'Code de déontologie de la FMH', Art. 17.

¹²⁴ Académie Suisse des Sciences 'Prise de position de l'Académie Suisse des Sciences Médicales concernant les propositions de modifications relatives à l'assistance organisée au suicide dans le Code pénal suisse et le Code pénal militaire' [Policy Statement of the Swiss Academy of Medical Sciences on the proposals to change organized assisted suicide under the Swiss Penal Code] (2010).

¹²⁵ The act of suicide must be done on the basis of a clear and voluntary decision; two medical reports from two independent doctors are required in order to check the nature of the request and to confirm that the patient suffers from a physical disease that is incurable and will result in death in a short period of time (non-terminally ill patients and mentally ill patients are thereby excluded); the 'suicide helper' must demonstrate any alternatives to suicide; assistance in suicide must be a non-profit endeavor; and the 'suicide helper' must complete an *ex post* report with all the details of the case in order to facilitate any investigation of law enforcement agencies.

¹²⁶ Bundesrat schickt zwei Varianten in die Vernehmlassung - Organisierte Suizidhilfe soll geregelt werden.

medics to perform AS. The SAMS did propose legislation monitoring RTDs – advocating for rules subjecting such organisations to authorization requirements and checks regarding due diligence. In the Netherlands, *Koninklijke Nederlandse Maatschappij ter Bevordering van de Geneeskuns* (the Royal Dutch Medical Association - the KNMG) considered both AS and VAE as acceptable medical practices – subject to criteria of due care - long before Dutch politicians ratified the law allowing for assisted dying.¹²⁷ This policy position by the KNMG has remained constant for the past three decades. Other professional medical associations in the Netherlands (such as the Royal Dutch Association for Pharmacy¹²⁸ and the Dutch Association of Psychiatry¹²⁹) have not only supported the legality of assisted dying, but also play a role in specifying the permissible role of their respective members in its provision (within, of course, the general confines of the statutory law).

Assuming the nature and importance of formal ethical stances adopted by professional medical associations, the degree to which they are representative should be queried. In other words, does the formal stance of the association on the matter reflect the stance taken by the majority of its members? In May 2015, a survey of 1,000 GPs in England and Wales found that 39% of respondent's would support a change in the law allowing for assisted dying, while 20% were neutral on the issue.¹³⁰ A 2011 study in the UK shows that 24.9% of doctors are willing to perform AS and 22.7% are willing to perform VAE.¹³¹ While a UK survey of doctors' attitudes in 2008 showed 35.2% of respondent's supported physician-assisted suicide for the terminally ill, and 34% believed that doctors should be able to

¹²⁷ See the position paper published by the Executive Board of the KNMG in 1984. A year after this publication, the same Board proposed a change in the law. See H. Weyers, 'The Legalization of Euthanasia in the Netherlands; Revolutionary Normality' in S. J. Youngner and G.K. Kimsma, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 42-43.

¹²⁸ Koninklijke Nederlandse Maatschappij ter Bevordering der Pharmacie [the Royal Dutch Association for Pharmacy – KNMP], who have issued guidelines on the role of its members in cases of assisted dying, see: KNMP, 'Toepassing en bereiding van euthanatica' [Application and Preparation of Euthanatica] (The Hague, 1994); KNMP, 'Toepassing en bereiding van euthanatica' [Application and Preparation of Euthanatica] (The Hague, 1998); KNMP, 'Toepassing en bereiding van euthanatica' [Application and Preparation of Euthanatica] (The Hague, 2007).

¹²⁹ Nederlandse Vereniging voor Psychiatrie [The Dutch Association for Psychiatry - NVP], who issued the following: NVP, 'Het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis: richtlijn hulp bij zelfdoding' [The Request for Assistance with Suicide in the Case of Patients with a Psychiatric Disorder: Guideline for the Psychiatrist]. Revised version of NVP 1998.

¹³⁰ A survey carried out by medeConnect; available at <www.hpad.org.uk/press-release/patients-trust-doctors-assisted-dying/>.

¹³¹ R McCormack and others, 'Attitudes of UK doctors towards euthanasia and physician-assisted suicide: a systematic literature review' (2012) 26(1) *Palliative Medicine* 23.

perform VAE for such patients.¹³² In September 2015, a number of highly respected health care professionals in the UK¹³³ published a written declaration claiming that they ‘represent the many thousands of healthcare professionals who no longer want to be misrepresented by opponents to a change in the law.’ In this respect, note must be made of the organisation of Healthcare Professionals for Assisted Dying in the UK. This organisation has criticised the British Medical Association for refusing to debate assisted dying at its 2014 Annual Representative Meeting, ‘in spite of 23 motions being submitted to the Agenda Committee on the subject.’¹³⁴

In France, a 2013 telephone survey of 605 practising doctors, carried out by *Conseil National de l’Ordre des Médecins*, found that 60% of respondents were in favour of VAE (with 37% willing to participate) and 39% were in favour of AS (with 28% willing to participate).¹³⁵ A 2003 French survey suggests that 46.5% of neurologists and 44.8% of GPs agree with the statement that VAE should be

¹³² C. Seale “Legalisation of euthanasia or physician-assisted suicide: survey of doctors’ attitudes” (2009) 23 *Palliat Med* 205.

¹³³ The statement was published in a letter to the Guardian, available at: <www.theguardian.com/society/2015/sep/08/medical-profession-views-on-assisted-dying-bill>. The signatories to this statement were: Dr Jacky Davis *Chair, Healthcare Professionals for Assisted Dying; member, BMA council*; Dr Sheila Adam MD FRCP FFPH FRCGP *Former deputy chief medical officer of England*; Dr Aileen K Adams FRCA *Past president of Royal College of Anaesthetists*; Prof Peter Armstrong FRCR FRCP FMedSci *Past president of Royal College of Radiologists*; Prof Sue Atkinson CBE FFPH *Former regional director of public health for London*; Prof Martin Bobrow FRCP FRCPath FMedSci FRS *Founding fellow of Academy of Medical Sciences; life president of Muscular Dystrophy UK*; Fiona Caldicott FRCPsych FMedSci *Past president of the Royal College of Psychiatrists and British Association of Counselling and Psychotherapy*; Graeme Catto FRCP FRCGP FMedSci *Past president of the General Medical Council*; Prof June Clark DBE FRCN *Past president of the Royal College of Nursing*; Prof Jill Macleod Clark PhD FRCN *Former chair of the UK Council of Deans of Health*; Harriet Copperman SRN; Prof Lindsey Davies FFPH FRCP *Past president of the Faculty of Public Health*; Terence English FRCS *Past president of the Royal College of Surgeons and the British Medical Association*; Prof Godfrey Fowler FRCP FRCGP *Emeritus professor of general practice, University of Oxford*; JA Muir Gray FRCPSGlas FCLIP *Chief knowledge officer of the NHS*; Prof Sian Griffiths OBE FRCP FHKAM *Past president of the Faculty of Public Health*; Peter Lachmann ScD FRS FRCPath FMedSci *Past president of Royal College of Pathology*; Prof David Mant FRCGP, FRCP, FMedSci *Emeritus professor of general practice, University of Oxford*; Henry Marsh MA FRCS *Neurosurgeon*; Dr John Mitchell FRCP; Yvonne Moores FRSN *Former chief nursing officer of England*; Dr Rajesh Munglani FRCA FFPMA *Editor in chief of the Journal of Observational Pain Medicine*; Prof Adrian Newland CBE FRCP FRCPath *Past president of Royal College of Pathology and the British Society of Haematology*; Christopher Paine DM FRCP FRCR *Past president of the British Medical Association*; Lesley Rees FRCP *Former director of education at Royal College of Physicians*; Prof Glenis Scadding MD FRCP *President of the UK Semiochemistry Society*; Prof Raymond Tallis FRCP; FMedSci *Emeritus professor of Geriatric Medicine, University of Manchester*; Margaret Turner-Warwick FRCP *Past president of Royal College of Physicians*; Dr Graham Winyard FRCP FFPH *Former deputy chief medical officer of England*.

¹³⁴ On this point, see <www.hpad.org.uk/opinion-healthcare-professionals/>.

¹³⁵ Enquête IPSOS du 10 au 23 janvier 2013 Présentation à l’Assemblée Générale des Présidents et Secrétaires Généraux des Conseils Départementaux et Régionaux du 9 février 2013, ‘Enquête auprès des médecins sur la « fin de vie » pour le Conseil National de l’Ordre des Médecins’

legalised under the same conditions as in the Netherlands.¹³⁶ During the *Tramois* trial (see Section 4.2.2.), over 2,000 doctors signed a petition supporting a law allowing for VAE.¹³⁷

In Switzerland, a survey of Swiss physicians in 2015¹³⁸ found that 77% of the respondents considered PAS to be justifiable in principle, while 22% were fundamentally opposed to it. The same study also identified an ambivalence in doctors' attitudes regarding the end-of-life criterion as a necessary condition for physician-assisted suicide in the SAMS guidelines.¹³⁹ An international study published in 2005 found that 61% of respondent Swiss doctors answered in the affirmative to the question: should a person have the right to hasten the end of his or her life.¹⁴⁰ The same study found that 56% of said doctors agreed with the statement that '[t]he use of drugs in lethal doses upon the explicit request of the patient is acceptable for patients with a terminal illness with extreme uncontrollable pain or other distress.'¹⁴¹

In the Netherlands, the professional opinion of individual doctors has been studied periodically in the national surveys on assisted dying practice. To the statement: '[e]veryone has the right to self-determination concerning life and death', 56% of physicians in 2012 agreed, 47% in 2005 agreed; 56% in 2001 agreed; and 52% in 1995 agreed.¹⁴² Griffiths, Weyers and Adams claim that 'a better indication of professional opinion is probably given by doctors' statements about their own

¹³⁶ P. Peretti-Watel and others, 'Doctors' opinions on euthanasia, end of life care, and doctor-patient communication: telephone survey in France' (2003) 7415 *BMJ* 327.

¹³⁷ See: <http://news.bbc.co.uk/2/hi/europe/6457289.stm>

¹³⁸ S. Brauer, C. Bollinger, and J.D. Strub, 'Swiss Physicians' attitudes to assisted suicide: A qualitative and quantitative empirical study' (May 2015) 145 *Swiss Medical Weekly* 14142. Note that the authors of the study making the following proviso: "Due to the response rate and the wide variation of respondents from one professional speciality to another, the findings and interpretations presented should be regarded as applying only to the group of physicians who are interested in or are particularly affected by the issue of assisted suicide. They cannot be generalised to the whole body of physicians in Switzerland."

¹³⁹ *Ibid.* The written survey identified a discrepancy 'between the view of a clear majority that assisted suicide is also acceptable for patients not at the end of life and the simultaneously expressed view that this criterion should be maintained in the SAMS Guidelines as a prerequisite for assisted suicide'.

¹⁴⁰ S. Fischer and others, 'Swiss Doctors' Attitudes towards End-of-Life Decisions and their Determinants' (2006) 135 *Swiss Medical Weekly* 373; G. Miccinesi and others, 'Physicians' Attitudes towards End-of-Life Decisions: A Comparison between Seven Countries' (2005) 60 *Social Science & Medicine* 1965.

¹⁴¹ *Ibid.*

¹⁴² A. van der Heide et al., '*Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Second Evaluation: Termination of Life on Request and Assisted Suicide]' (The Hague: ZonMw, December 2012) 87.

(likely) behaviour.¹⁴³ To the question whether they have performed VAE or AS: 60% of physicians answered in the affirmative in 2011; 51% in 2005; 57% in 2001; and 53% in 1995.¹⁴⁴ As for the percentage of physicians who have never performed, but are willing to: in 2011, this figure stood at 25% of physicians; 33% in 2005; 32% in 2001; and 35% in 1995.¹⁴⁵ As for those physicians who 'will never perform and never refer the patient to another physician', in 2011 this figure stood at 0.8% of physicians, 1% in 2005, 1% in 2005, and 3% in 1995.¹⁴⁶

There is no indication from these Dutch studies of a gap between the views of individual doctors (or at least the majority of) and the formal position taken by their medical associations in favour of assisted dying. As for the studies in England, France and Switzerland, there is data (however less reliable) to suggest a gap between the views of the individual doctors and the position taken by their medical associations against assisted dying. It would, however, be inaccurate to claim that the current empirical data on the views of individual doctors is conclusive on this point (i.e. that the data echoing individual support for legal reform may be extrapolated to be representative of the majority of physicians in the respective jurisdictions). What is less inconclusive, nonetheless, is that the leading professional medical associations in England, France and Switzerland are unwilling to frame the issue of assisted dying as the responsibility of their members. This, arguably, gives politicians in England, France and Switzerland a type of 'get out of jail card' with their electorate.¹⁴⁷ They can justify their legislative inaction or political avoidance tactics by not only relying on the polarized nature of the debate, but by also relying on the formal unwillingness of the medical profession to support legal reform. Two points arise from this claim.

On the one hand, it is understandable for political actors to defer responsibility onto medical associations to decide whether or not their members should take a leading role in the provision of assisted dying. To insist that they take

¹⁴³ Griffiths, Weyers and Adams (n 65) 27.

¹⁴⁴ A. van der Heide and others, *'Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Second Evaluation: Termination of Life on Request and Assisted Suicide] (The Hague: ZonMw, December 2012) 86.

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ In the sense, that there is a gap between policy objectives and policy effects, and that public opinion in each of the jurisdictions seems to support a change in the law on assisted dying.

responsibility would entirely usurp the representative role of such associations. On the other hand, however, this formal apathy or opposition to legal reform by medical associations (a stance which may be legitimately questioned as representative or not of the majority of doctors in the associations) cannot excuse *political* inaction to rectify serious discrepancies between the law in action and the law in the books. One could argue that relying on this apathy or opposition is a manifestation of Majone's theory on the self-interest of politicians in their re-election chances. In short, politicians in England, France and Switzerland are perhaps supporting a legal policy that serves a special and traditionally powerful interest group - national medical associations¹⁴⁸ - rather than a policy that ultimately serves the public interest. Moreover, in response to concerns of usurping the representative role of resistant medical associations, legal reform on assisted dying that better serves the public interest (i.e. that only allows doctors to provide such assistance) may of course leave those doctors unwilling to participate in its provision well enough alone (whether such doctors represent the majority or not). In other words, no doctor may ever be forced by law to partake in act of assisted dying, but those who are willing (however few) may, under pre-defined and strict conditions, do so without fear of prosecution.

The above argument still begs the question of why the *Dutch* politicians, considering the relatively long standing public support of the national medical association towards reforming the law (dating from the mid-1980s onwards), waited until 2002 to enact a statute permitting assisted dying? If politicians - in their quest for re-election - more often support policies that serve (or at least do not upset) special interest groups rather than support policies that are efficient, then the inaction of Dutch politicians prior to 2002 can hardly be explained (even partly - like in England, France and Switzerland) as an example of not wanting to upset a powerful interest group (i.e. the national medical association). One

¹⁴⁸ Arguably it serves the interests of professional medical associations, the formal representatives of individual medics, in a two-fold manner: it shields those members who are performing assisted dying from stringent legal obligations and it shields those who refuse from any sense of professional responsibility. It is no secret that medical associations are generally opposed to stringent legal obligations and constraints on their members' actions. For example, see the reaction of the French Medical Association to the 2002 Patients' Right Bill, where the basic right for patients to obtain medical information prior to any form of treatment was contested as overly complicated and counter-productive. See: Hennette-Vauchez, 'France' in: Griffiths, Weyers and Adams, *Euthanasia and Law in Europe* (n 65) 525, 371-394.

potential explanation for their inaction may instead be related to political cleavage structures and the second type of special interest group mentioned above – organised religious groups. Indeed, this line of reasoning may not only go some way to explaining why Dutch politicians waited until 2002 to formally reform the ban on assisted dying, but it may also explain why the issue of reform was so strongly on the Dutch political agenda in the first place.

(b) Organised religious groups

Notwithstanding fundamental differences between the major religious groups in the four nations,¹⁴⁹ all of them share a doctrinal belief in the sanctity of life.¹⁵⁰ It is largely on the basis of this belief that these religious groups formally favour a legal prohibition on assisted dying. The impact of these groups on political action or inaction towards reforming the law on assisted dying may be examined on two levels: a macro-level and a meso-level.¹⁵¹

On the macro-level, we may consider religious denomination of the electorate as ‘proxies for values prevailing in society.’¹⁵² The more a religious doctrine is prevailing in a particular electorate, the more influential that doctrine will be in the elected officials cost-benefit considerations. On the meso-level, religious groups may be considered as ‘institutional actors’ with a direct structural position

¹⁴⁹ The largest religious groups in all four nations are Christian-based. According to the 2016 CIA World Factbook (available at: <www.cia.gov/library/publications/resources/the-world-factbook/>.), in the UK: 59.5% of the population are Christian (includes Anglican, Roman Catholic, Presbyterian, Methodist), 4.4% Muslim, 1.3% Hindu, 2%; in France: 63-66% of the population are Christian (overwhelmingly Roman Catholic); 7-9% Muslim; 0.5% - 0.75% Jewish; 0.5%-0.75% Buddhist; in the Netherlands: 28%, of the population are Roman Catholic, 19% Protestant (includes Dutch Reformed 9%, Protestant Church of The Netherlands, 7%, Calvinist 3%), other 11% (includes about 5% Muslim and lesser numbers of Hindu, Buddhist, Jehovah's Witness, and Orthodox); and in Switzerland: 38.2% are Roman Catholic, 26.9% are Protestant, 5.6% other Christian, 5% Muslim, 1.6% other.

¹⁵⁰ H.T. Engelhardt and A.S. Iltis, ‘End-of-life: the traditional Christian view’ (2005) 366 *Lancet* 1045; S.H. Firth, ‘End-of-life: A Hindu View’ (2005) 366 *Lancet* 682; A. Sachedina, ‘End-of-life: The Islamic View’ (2005) 366 *Lancet* 774

¹⁵¹ S. Heichel, C. Knill, and S. Schmitt, ‘Public policy meets morality: conceptual and theoretical challenges in the analysis of morality policy change’ (2013) 20(3) *Journal of European Public Policy* 325-326.

¹⁵² *Ibid.*

(perhaps even advantage)¹⁵³ in influencing morality policies.¹⁵⁴ The key factor on this level of analysis is whether a religious group has the ability to articulate its interests through a strong religiously-affiliated political party. According to Green-Pedersen, Engeli, and others: the existence of a conflict between religious parties and secular parties (i.e. some religious cleavage) in the state party system is decisive on whether or not morality policies are framed in a way that places them on the political agenda.

Starting with the *macro-level* approach, we must ask: are the electorate in England and France – the nations with the most restrictive laws on assisted dying of the four studied here – more religious than the electorate in the Netherlands and Switzerland? The answer would appear to be not only in the negative but rather on the contrary. In England and France, data measuring ‘levels of religiosity’, consistently shows that the electorate there are the least religious of the four nations. Summing up various studies: 71% of respondents from the UK believe ‘religion is not important in their life’, 73% of the respondents from France shared this view, 66% from the Netherlands, and 56% from Switzerland;¹⁵⁵ 48.8% of respondents from the UK associated themselves as members of a religious denomination, only 24% of the respondents from France shared this view, 44% in the Netherlands, and 67.8% in Switzerland;¹⁵⁶ all four nations showed a low frequency of church attendance, but the average in the UK and France was marginally lower than in the Netherlands and Switzerland;¹⁵⁷ to the question of ‘how religious would you say that you are [on a scale from 0 (not at all religious) to 10 (very religious)], the average respondent from the UK answered 4.2, the average respondent from France answered 3.7, while in the Netherlands this figure

¹⁵³ Some political scientists have argued that the ‘high public esteem for the values articulated by the Church and their independence from economic interests give organized religion a structural advantage compared to other lobbying organizations.’ See M.A. Schwartz and R. Tatalovich, ‘Cultural and institutional factors affecting political contention over moral issues’ (2009) 8(1) *Comparative Sociology* 76–104.

¹⁵⁴ M. Minkenberg, ‘The policy impact of Church–State relations: family policy and abortion in Britain, France, and Germany’, (2003) 26(1) *West European Politics* 195–217; C.M. Warner, *Confessions of an Interest Group: The Catholic Church and Political Parties in Europe* (Princeton University Press, 2000).

¹⁵⁵ Gallup poll on ‘Religion’. Available at <www.gallup.com/poll/1690/religion.aspx>.

¹⁵⁶ O. Knutsen, ‘The Religious Cleavage in 24 European Countries – A Comparative Study’, Paper for IPSA International Conference on “Is there a European Model of Governance?” in Luxembourg, March 18-20, 2010, 19. Available at <www.sv.uio.no/isv/personer/vit/stvok1/The%20religious%20cleavage%20ESS%201-3%20with%20tab.pdf>.

¹⁵⁷ Ibid.

was 5.0, and in Switzerland it was 5.3.¹⁵⁸ All in all, these studies show that elected officials in all four nations, particularly in England and France, are unlikely to be rewarded for supporting policy positions that reinforce religious doctrine. Considering that politicians in England and France have, in effect, reinforced the religious doctrine on assisted dying (by voting to maintain a criminal blanket ban), this macro-level finding does not fit neatly with Majone's theory on their re-election interests overshadowing effective policy making. Moreover, it fails to explain why elected officials in societies displaying higher levels of religiosity (the Netherlands and Switzerland) have enacted legal policies that conflict with religious doctrine on the matter. However, if we look at the effect of religious groups on political action or inaction on the *meso-level*, then the picture looks somewhat different.

On the the meso-level, we must ask: is the political party system in any of the four nations characterized by the existence of a religious cleavage?¹⁵⁹ In attempting to shed light on why certain issues feature prominently on the political agenda in some nations and not in others, some political scientists have pointed to different theories of political party competition.¹⁶⁰ Riker has, in particular, developed two principles underlying a type of deliberate confrontation tactic.¹⁶¹ In sum, this occurs when one political party (a) gets the other political parties to focus on a particularly divisive issue – i.e. draw the voters' attention away from issues that all parties largely agree upon (the dispersion principle); and (b) takes voters, who support their party's stance on a more divisive issue, away from the other parties who hold a strong conflicting stance on this issue (the dominance principle).

¹⁵⁸ Ibid.

¹⁵⁹ C. Green-Pedersen, 'The conflict of conflicts in comparative perspective: euthanasia as a political issue in Denmark, Belgium, and the Netherlands' (2007) 39(3) *Comparative Politics* 273–91; I. Engeli, C. Green-Pedersen, and L.T. Larsen (eds) *Morality Politics in Western Europe: Parties, Agendas and Policy Choices* (Basingstoke: Palgrave Macmillan 2012).

¹⁶⁰ M. Considine, 'Making Up the Government's Mind: Agenda Setting in a Parliamentary System' (July 1998) 11 *Governance* 297-317; I. Budge and D. Farlie, 'Party Competition? Selective Emphasis or Direct Confrontation? An Alternative View with Data' in H. Daalder and P. Mair (eds) *West European Party Systems: Continuity and Change* (London: Sage, 1983) 267-305; D. Robertson, *A Theory of Party Competition* (London: Wiley, 1976); H. Kitschelt, 'Political Opportunity Structure and Political Protest: Anti-Nuclear Movements in Four Democracies' (January 1986) 16 *British Journal of Political Science* 57-85; Green-Pedersen (n 158); Engeli, Green-Pedersen, and Larsen (n 158).

¹⁶¹ W. Riker, *The Strategy of Rhetoric: Campaigning for the American Constitution* (Yale University Press, 1996).

To increase the chances of getting the electorates' attention and to engage the other political parties in a conflict over the issue, it is hugely beneficial to link it to an existing conflict in the party system.¹⁶² Some parties gain more from this strategy – namely, those who appear to represent the prevailing values of the electorate on the divisive issue. As a corollary, some parties have more to lose – namely, those who support the status quo and do not want the issue to receive attention. However, 'if the issue can be related to a conflict that is already accepted as politically important', it is problematic for any party to simply ignore it. Furthermore, if the issue is linked to an existing conflict in the party system, that conflict will determine the political positions taken on it (e.g. religious or secular positions). These positions may no longer be passively promoted (by simply resting on the unchallenged status quo) but instead they must - once seriously challenged in the electoral and parliamentary arena - be actively promoted and defended. The results of this confrontation may be unknown (e.g. religious cleavage may result in more or less restrictive morality policies), but at the very least, the divisive issue will be on the political agenda and, importantly, both sides of the debate will have formal political party support.

The type of cleavage (conflict in the state's party system) most required in order for assisted dying to appear on the political agenda is a conflict between religious and secular values (as opposed to a conflict between national identities, class structures, or centre-periphery relations).¹⁶³ The Netherlands offers a fine example of this, with 'its system of coalition governments, the religious versus secular conflict is almost constantly present.'¹⁶⁴ Moreover, the Christian Democratic Party (CDA) has often been the largest party in the Dutch Parliament. This has been attributed to its 'moderating role in society and its success in

¹⁶² Green-Pedersen (n 159) 275.

¹⁶³ 'Non-material issues such as euthanasia can be interpreted as a matter of Christian versus secular morality and thus linked to existing cleavages between religious and secular political parties': Griffiths, Weyers, Adams (n 65) 526; '[i]n order for a morality issue to appear on the policy agenda, the nation-state's party system needs to be characterized by a conflict between religious parties and secular parties': S. Heichel, Knill, and Schmitt (n 150) 326.

¹⁶⁴ A. Timmermans and G. Breeman, 'Morality Issues in the Netherlands: coalition Politics under Pressure', in I. Engeli, C. Green-Pedersen, and L.T. Larsen (eds) *Morality Politics in Western Europe: Parties, Agendas and Policy Choices* (Basingstoke: Palgrave Macmillan 2012) 35-59.

creating a welfare state along the lines of social capitalism, not to its views on morality policies.’¹⁶⁵

During the 1970s and 1980s, a number of high-profile court cases on assisted dying occurred, a substantial right-to-die organisation had mobilized, and a majority of public opinion in the Netherlands supported assisted dying in clearly specified cases.¹⁶⁶ In order to threaten the CDA’s electoral basis and to highlight a fundamental tension between the particular religious and secular coalition government in place at the time, opposition parties in the Chamber of Representatives (*Tweede Kamer*) had the incentive to place assisted dying on the political agenda. Meanwhile, as long as the CDA remained a key coalition partner in the government, negative agenda setting on the matter (a combination of ‘avoidance’¹⁶⁷ and ‘forbearance’)¹⁶⁸ was preferred over adopting substantive solutions. Religious-secular coalition partnerships - be it between the CDA and the the Social Democrats (PvdA) or the CDA and the Liberals (VVD) - were committed ‘to refrain from playing high politics on the issue and not risk the life of the government’.¹⁶⁹ The 1994 election, however, produced the first Dutch government whereby no confessional party was represented – a coalition between VVD, PvdA and D66 was formed (the so-called ‘purple’ coalition). This government opted not to immediately introduce the Bill it had promised during the electoral campaigns, choosing instead to commission another investigation on the extensiveness of assisted dying. But when the following 1998 elections came around, a Bill to reform the Penal Code and formalise the law on assisted dying was introduced by parliamentarians of all three parties in the ‘purple coalition’. This Bill – and its subsequent enactment - brought an end to the previous negative agenda setting. According to Green-Pedersen the three decades of politics leading to legal reform on assisted dying in the Netherlands was the culmination of the ‘attempts of non-Christian democratic parties to use the issue to fight Christian democratic political

¹⁶⁵ Gree-Pedersen (n 159) 277.

¹⁶⁶ See World Values Survey/European Values Study 1981-2008.

¹⁶⁷ This strategy of avoidance occurred by postponing consideration of the issue (i.e. referring it to an expert committee) and by redefining the issue in a way that makes it appear less of a political/State-level issue and more as a ‘technical’ medical one. See Griffiths, Weyers, and Adams (n 65) 14.

¹⁶⁸ This policy of forbearance was, in effect, a tacit political compromise between actually reforming the Penal Code on assisted dying and strictly applying it in practice. See Timmermans and Breeman (n 163) 53.

¹⁶⁹ Timmermans and Breeman (n 163) 52.

dominance. Once this strategy partly succeeded [...] the governments without Christian democratic participation had to honour their earlier focus on the question by legalizing euthanasia.’ In sum, the political avoidance of the issue during the 1970s, 1980s and early 1990s and the eventual enactment of the 2002 law were both driven by coalition structures and political competition in a party system characterized by religious cleavage.¹⁷⁰

The Dutch party system may be contrasted with that in England, where there is an absence of a religious-secular conflict line. Morality policies, such as assisted dying, quite simply do not fit the left-right dichotomy that defines party politics there.¹⁷¹ Larsen, Studlar and Green-Pedersen conclude that it is for this reason none of the major political parties pay much attention to such policies. Their research on morality issues in British party manifestos from 1964-2010¹⁷² backs this statement up, where there was not ‘a single word on euthanasia’ therein. Parties more often identify morality policies as ‘conscience issues’ and no party whip positions are adopted.¹⁷³ This means proposals to reform the law on morality policies are, in effect, dependent on the introduction of Private Member’s Bills (PMBs) by individual MPs (who are unlikely to be holding a leadership position). As Larsen and others state: ‘the chances of PMBs being enacted are slim since the government and the largest official opposition party [...] control the overwhelming amount of legislative time and devote it to prioritized “party political” differences.’¹⁷⁴ As we have seen in Section 6.4. above, this is strikingly evident in relation to the various PMBs introduced on assisted dying to the House of Lords.

¹⁷⁰ Timmermans and Breeman (n 163) 35; Green-Pedersen (n 159) 279.

¹⁷¹ The left-right conflict in Britain, while more muted in recent years, remains largely a class-based conflict focused on the economy, redistribution, and the welfare state. L.T. Larsen, D.T. Studler, and C. Green-Pedersen, ‘Morality Politics in the United Kingdom: Trapped between Left and Right’ in I. Engeli, C. Green-Pedersen, and L.T. Larsen (eds) *Morality Politics in Western Europe: Parties, Agendas and Policy Choices* (Basingstoke: Palgrave Macmillan 2012) 119.

¹⁷² Cowley’s study of general election campaigns also evidenced this lack of formal political attention to morality issues. P. Cowley, ‘Britain: Taking the Politics Out of Morality’ in C.Z. Mooney (ed) *The Public Clash of Private Values: The Politics of Morality Policy* (Chatham: Chatham House, 2001) 215-18.

¹⁷³ Although ‘free votes’ are often allowed and there is essentially no party completion on morality issues, it is generally the case that Labour and Liberal MPs are more permissive on such issues than Conservative MPs when, and if, faced with a vote. See Cowley, *ibid*; P. Cowley and M. Stuart, ‘Divisions in the Conservative Party on Conscience Issues: A Rejoinder to Plumb and Marsh’ (2011) 64 (4) *Parliamentary Affairs* 777-80; A. Plumb and D. Marsh ‘Divisions in the Conservative Party on Conscience Issues: A Response to Cowley and Stuart’ (2011) 64 (4) *Parliamentary Affairs* 769-76.

¹⁷⁴ Larsen, Studler, and Green-Pedersen (n 169) 118.

In France, the existence or absence of a religious cleavage in the the political party system is more complex. Although there is no equivalent to a major Christian Democratic party, or any type of party seeking to mobilizing religious voters under one roof, 'the church has been associated with the political right since the ancien régime.'¹⁷⁵ A number of studies found that despite considerable shifts in the economy, long-standing secular attitudes and the party system in general, class and religious affiliations in France are generally assumed to have continued to shape patterns of voting¹⁷⁶ - nonreligious manual workers align with the left-wing parties, and Catholic knowledge workers align with the right-wing parties.¹⁷⁷ However, most of the studies supporting this assumption have focused on restricted numbers of elections or a limited time-span. Gougou and Roux, in contrast, assessed the change in religious (and also class) voting from 1962-2007 and came to a quite different conclusion.¹⁷⁸ Post-election survey data covering five decades of French politics found a long-running decline in religious voting congruent with a long-running decline of party polarization on morality issues. This decline in party competition on morality issues may be true to an extent, but it does not mean party-affiliation is irrelevant in explaining the recent politics behind attempts to reform the law on assisted dying. Section 6.3. above, evidences that more members of the Socialist Party (centre-left) are actively in favour of a legal policy permitting assisted dying than members of the Republican Party (centre-right, formerly known as the UMP). In 2009 and 2015, Private Member's Bills seeking to allow assisted dying under strict conditions were introduced to the National Assembly – both were introduced by members of the Socialist Party. In 2011, the Senate debated a similar Members' Bill which was introduced by 51 members of the Socialist Party and two members of the Green Party. In the debates

¹⁷⁵ H. Kriesi, and others, *New Social Movements in Western Europe – A Comparative Analysis* (University of Minnesota Press, 1996) 12.

¹⁷⁶ R.J. Dalton, S.C. Flanagan, and P.A. Beck (eds) *Electoral Change in Industrial Democracies: Realignment or Dealignment?* (Princeton University Press, 1984); D. Boy and N. Mayer (eds.) *L'électeur à ses raisons* (Paris: Presses de Sciences Po) 101–38.

¹⁷⁷ G. Michelat and M. Simon, *Classe, religion et comportement politique* (Paris: Presses de la Fondation Nationale des Sciences Politiques et Editions Sociales, 1977); G. Michelat and M. Simon, 'Religion, Class, and Politics' (1977) 10 *Comparative Politics* 159–86.

¹⁷⁸ F. Gougou and G. Roux, 'Political Change and Cleavage Voting in France – Class, Religion, Political Appeals, and Voter Alignments, 1962-2007' in G. Evans and N.D. de Graaf (eds) *Political Choice Matters: Explaining the Strength of Class and Religious Cleavages in Cross-National Perspective* (Oxford University Press, 2014) 244-276.

that ensued in the electoral and parliamentary arenas, it was quite apparent that the strong majority of Republican members opposed the reform, which was indeed supported by the strong majority of Socialist members. However, any argument that this evidences a developing case of deep-rooted party polarization on assisted dying have been tempered by the 'End-of-life Bill' introduced in 2015 – a Bill that would have allowed for terminal sedation until death and not assisted dying. This Bill, co-drafted by Socialist MP Alain Claeys and Republican MP Jean Leonetti, was seen as an attempt to reach a compromise between the two major parties. It was indeed an attempt which succeeded in the National Assembly, where the overwhelming majority voted in its favour. On this basis, it would hardly be accurate to say that the lack of a clear religious cleavage in the French party system has resulted in assisted dying getting scant attention from politicians (which is arguably more so the case in England). However, the lack of a clear religious/secular party conflict in which assisted dying can be linked to, arguably, leaves political parties more likely to drop the issue and reach a compromise akin to the 2015 'Leonetti-Claeys' Bill.

Switzerland also offers a unique example of the effect religious groups have on political (in)action on assisted dying. There is a significant and deep-rooted cleavage between religious positions (represented by the Christian Democrats) and secular positions (represented by the Social Democrats, the Liberals, and the Greens) in the party system.¹⁷⁹ This conflict line is one of the key drivers behind 'both the politicization of morality issues and policy change' in Switzerland.¹⁸⁰ In this respect, note must also be made of some other key factors, such as the late secularization of society and the use of direct democratic devices.¹⁸¹ In comparison to other morality policies (on issues such as assisted reproductive technologies, abortion, same-sex marriage, and embryo research), assisted dying was the last to be placed on the political agenda. However, as we have seen in Section 6.3., there has been a substantial amount of political attention given to this issue over the past two decades. The majority of political initiatives have focused solely on AS and not

¹⁷⁹ H. Kriesi and A.H. Trechsel, *The Politics of Switzerland* (Cambridge University Press, 2008)

¹⁸⁰ I. Engeli and F. Varone, 'Morality Politics in Switzerland: Politicization through Direct Democracy' Right' in I. Engeli, C. Green-Pedersen, and L.T. Larsen (eds) *Morality Politics in Western Europe: Parties, Agendas and Policy Choices* (Basingstoke: Palgrave Macmillan 2012) 88.

¹⁸¹ *Ibid*, 90.

on VAE. This may be explained by two factors: on the one hand, with AS already legal most secular actors who may have an interest in actively politicizing VAE do not feel the need to do so; and on the other hand, the number of foreigners coming to Switzerland specifically to receive AS and controversies over the provision of AS in general has focused the religious/secular party conflict towards that issue alone. The Christian Democrats are opposed to regulating the RTDs and want a total ban on AS,¹⁸² while the Liberals and the Social Democrats favour more permissive regulation on AS.¹⁸³ This active confrontation of religious and secular party ideologies in the Swiss parliamentary arena, combined with the current 'liberal' policy on AS, seems to be a context that is rather hostile (unlike the religious cleavage in the Netherlands) to forming any consensus on policy change concerning either AS or VAE.

(c) *'Right to die' Organizations*

Weyers maintains that 'values influence the political process only when interest groups arise that champion an issue as to which the new values are relevant.'¹⁸⁴ As far as societal interest groups championing assisted dying are concerned, the largest are present in the Netherlands and Switzerland. The Dutch Association for Voluntary Euthanasia (NVVE),¹⁸⁵ founded in 1973, has a current membership of 161,000 members.¹⁸⁶ This organisation played a key role, particularly in the 1980s, in both developing societal acceptance of VAE and in bringing about legal change.¹⁸⁷ It faced (and indeed still faces) mobilized opposition in the form of the Dutch Patients Organization (NPV) – a Christian pro-life group with approximately 60,000 members. This opposition, however, was (and still is) a runner-up to the

¹⁸² See Parliamentary initiatives 07.480 and 08.3300, demanding 'no trade with death' and 'stop death tourism', respectively; See also: Position sent by the Christian Democrats to the consultation procedure on the regulation of euthanasia led in 2010 by the Federal Office of Justice.

¹⁸³ See the press release on 29 June 2011, available at <www.news.admin.ch/message/index.html?lang=fr&msg-id=39905>.

¹⁸⁴ Griffiths, Weyers and Adams (n 65) 524.

¹⁸⁵ *Nederlandse Vereniging voor Vrijwillige Euthanasie*.

¹⁸⁶ Note should also be made of the Foundation for Voluntary Euthanasia (SVE) – a small but vocal discussion group that closed down in 1985, and the Foundation for Voluntary Life (SVL) – a break away group of NVVE with approximately 2,500 donors.

¹⁸⁷ See H. Weyers, 'Dutch Social Groups on "Euthanasia" – The Political Spectrum on Ending Life on Request' in S.J. Youngner and G.K. Kimsma (eds) *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (Cambridge University Press, 2012) 82-99.

force of the NVVE. 'As far as political influence is concerned, the NVVE is not only big enough to be a major political actor, it has also cultivated good relations with political parties and governmental bodies (especially the Minister of Health in the 'Purple'-coalitions of the 1990s).'¹⁸⁸ In Switzerland, the largest social interest groups championing assisted dying are the leading right-to-die organisations that offer AS: Exit (current membership of 22,000 plus in the French speaking sub-body, and 80,000 plus in the German speaking sub-body) and Dignitas (current membership of 7,100 plus). The 'radicalization' of these advocacy groups have been said to be one of the 'main triggers' in placing the issue on the Swiss political agenda over the past three decades.¹⁸⁹ Unsurprisingly, it has resulted in the active mobilization of pro-life advocacy groups – who successfully brought a case before the Federal Court in 2009 to invalidate an agreement between officials in the Canton of Zurich and the RTD Exit to establish minimum rules relating to AS.¹⁹⁰ The Swiss Federal Council's stance against regulating RTDs¹⁹¹ and the Federal Parliament's failure to reach a compromise on the matter means that the RTDs interests (i.e. the largest advocacy groups in favour of AS) are, inadvertently or not, still being served – sidestepping greater demands for transparency and accountability in their practices.

Advocacy groups on assisted dying do exist of course in England and France, but they have failed to cultivate strong relations with existing political parties and government bodies. Note in contrast to today, that prior to World War II and the negative connotations subsequently attached to the term 'euthanasia', the English right to die society known as the Voluntary Euthanasia Society (now known as Dignity in Dying) 'enjoyed the support of many of Britain's most distinguished doctors, public figures and clergy men' and had proposed a bill for legislation before the House of Lords in 1936.¹⁹² Today, the leading right-to-die associations in England (Dignity in Dying) and in France (*l'association pour le Droit de Mourir dans la Dignité*) have approximately 25,000 and 50,000 members respectively.

¹⁸⁸ Griffiths, Weyers and Adams (n 65) 524.

¹⁸⁹ Engeli and Varone (n 179) 107,108.

¹⁹⁰ BGE 136 II 415. See Section 6.3., above.

¹⁹¹ As shown in Section 6.4, above this stance is in order to avoid legitimizing the provision of AS (by giving the State's stamp of approval).

¹⁹² M.F.A. Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press, 1998) 169.

These numbers may be contrasted with those in the Netherlands and Switzerland. Indeed it is true that relative to their general population size, a 100,000 strong advocacy group will have more effect on the political agenda in the Netherlands or Switzerland than the equivalent number in England or France. But if we introduce this argument of equivalence, then it is worth noting the comparative size of these groups per capita: in the Netherlands, the advocacy groups represent 0.6% of the total population, if this percentage is applied to the English and French populations, then the size of the leading advocacy groups would increase to 330,000 and 412,000, respectively. However, it is still arguable whether or not a group this size could cultivate enough political support in England and France, particularly in light of the lack of religious cleavage in the party system and the lack of formal support from the medical profession in pushing for legal reform.

(iv) The specificities of the (functional) separation of powers structure cannot be underestimated. As outlined above, the legal vacuum created by the slow pace of political decision-making in the Netherlands was filled in by the highest Dutch Courts and the willingness of the prosecutorial authorities (albeit over the course of two decades). The Supreme Court rulings determined the minimum content of the law, in effect seizing the constitutional power offered by the parliamentarians. In contrast, both the English and French courts have made it clear that lawfully permitting assisted dying is a matter for parliament only. They are resigned to pass any power to effect legal change into the hands of the respective parliamentarians. In return, parliamentary inaction on the issue has left the prosecution authorities and members of the judiciary to deal with criminal accusations of assisted dying and individual (human rights based) challenges to the blanket ban.¹⁹³ To avoid punishing benevolent physicians and usurping the parliament's role, the prosecutors and judiciary subsequently rely upon problematic techniques not to impose the full, if any, force of the law (see **CHAPTER FIVE**, above). This creates a regulatory paradox: the law is unlikely to be consistently enforced and unlikely to be adequately reviewed.¹⁹⁴ The same may be said for the Swiss situation. Unlike 'direct democracy' in

¹⁹³ See Section 4.2.1 and 4.2.2, above.

¹⁹⁴ Although it must be said that the recent English Supreme Court decision in *Nicklinson* [2014] UKSC 38 is a peculiar example of a highest national court giving a type of 'heads up' to the elected official's to debate the impugned law on assisted dying or face judicial intervention in the future. The fact of the matter still

the US, 'interventions by courts are seen as a violation of the (quasi-)sacred people's will.'¹⁹⁵ The lack of federal level legislation, coupled with the judicial reluctance to step in, has left local prosecutors with little room to tackle misuse of the rules by RTDs.¹⁹⁶

Tying the above observations in - from point (i) to (iv) - with the law and governance claims made in **CHAPTER TWO**, it may be said that we can see the over-politicization of the law on assisted dying in England, France and Switzerland. The democratic institutions and political representatives turn from the legitimate *gate-keepers* of the law on this morality policy into the legitimate *gate-closers* of the law on this morality policy. Directly elected officials remain, in effect, entirely responsible for reform yet indifferent (at least when presented with concrete bills on the matter) towards the problems inherent in maintaining the status quo. Meanwhile, judicial reluctance to become quasi-legislators and to formulate specific regulations means that the legal framework (however unintentionally) facilitates, at worst, abuse of the rules and, at best, covert acts of compassionate assisted dying. As far as the creation or reform of legal policy is concerned, a change in the relationship between law and politics is necessary in these nations – a turn from public governance *through* the law to public-private governance *in* the law is potentially the solution. The governance mechanism at play in the Netherlands - meaningful public-private actor interaction not just in the application and enforcement of the law but in its creation/reform – is, as argued and evidenced here, something that warrants greater attention in England, France and Switzerland.

The prosecution authorities, the State Commission on Euthanasia, the 'Rommelink' Committee and the national medical association provided politically neutral and objective solutions which the Court accepted – having been presented with somewhat of a legal vacuum.¹⁹⁷ As Weyers states: when the Dutch Parliament voted in favour of a Bill to allow conditional assisted dying, many outside the Netherlands found it shocking, '[i]n the Netherlands, however, almost everybody knew that the only thing that really happened

remains that the English Supreme Court, for all its doubts about the compatibility of the current law, refused the relatively mild legal effects of declaring the law as incompatible with the HRA – which, does not result in the law becoming null and void, but merely formally requires the Parliament to review the issue in a timely manner.

¹⁹⁵ Kresi and Trechsel (n 177) 67.

¹⁹⁶ The Canton most affected by the activities of RTDs, Zurich, has made clear that it requires Federal level controls on the provision of AS – the public prosecutor of the region is on the record claiming that the current legal framework prevents proper investigation of misconduct.

¹⁹⁷ Arguably, due to the deliberately slow pace of political decision-making.

was codification of a situation that had existed since the end of the 1980s.¹⁹⁸ The Dutch approach alludes to the value in political avoidance of legal reform on assisted dying, but it is, arguably, only of value provided a number of other factors are at play: namely, the presence of formal support from the leading professional medical organization, the acquirement of reliable empirical data on all MBSL (thus contextualizing the debate, as mentioned in point (i) above), some form of religious cleavage in the political party system; and the willingness (or institutional capacity) of the judiciary and the prosecution service to step in and fill the void.

¹⁹⁸ Weyers (n 126) 34.

PART THREE

LAW AND GOVERNANCE ON THE EUROPEAN LEVEL

LAW AND GOVERNANCE ON THE EUROPEAN LEVEL

The previous chapters in Part II looked at national actors and institutional structures involved in the creation, application and enforcement of the law on assisted dying. This part moves beyond state borders. It looks at what role actors and institutional structures at the supra-national level (namely, in the Council of Europe and the European Union) have, or may have. Just as on the national level, one may identify two abstract types of relationship between law and governance on the European level. On the one hand, we have public governance *through* the law – where the focus is on supra-national central institutions or political actors. On the other hand, we have public-private governance *in* the law – where the focus is on the interdependence between supra-national central institutions or political actors and private actors (in the form of expert groups, civil society, etc.). Any mention of law and governance on assisted dying beyond the state (at the European-level or otherwise) is likely to raise substantial scepticism. And perhaps for good reasons too. As observed in **CHAPTER TWO**, the national democratic process offers indispensable benefits when it comes to legal policies on highly sensitive social or moral issues. It offers a robust political space to mediate between conflicting first principles. This political self-determination not only legitimizes the policy output and allows for constant renegotiation, but it also legitimizes the coercive authority required to secure the moral choices that thereby arise. However valid these reasons may be, they do not excuse the lack of scholarly attention paid to whether the Council of Europe or the European Union may positively benefit the relationship between law and governance on assisted dying.

First, as conceptualized in **CHAPTER TWO** and identified in practice in **CHAPTER 5** and **CHAPTER 6**, the over-politicization of the law on this manifest-morality policy reveals inherent incapacities at the nation-state level. Second, the same debate on assisted dying has been reappearing in the public domain periodically across Europe for the past

decade.¹ Advancements in medical science and life-prolonging techniques raise unavoidable questions, such as what is, if any, the distinction between ‘biological life’ and ‘being alive’ or when is it correct, if ever, to help a patient to die. Leaving aside the debate on whether we can or should seek universal answers to such questions, one can hardly deny the universal nature of the very questions. All modern societies are acutely facing these challenges. Third, assisted suicide *de facto* transcends national borders via what is popularly termed ‘suicide tourism.’ The term ‘suicide *tourism*’ is unfortunate but it is unlikely to be dropped from common usage.² It is defined here as an act whereby an individual travels to another jurisdiction (‘host state’) with more permissible assisted suicide laws than his or her country of origin or residence (‘home state’), in order to receive assistance in committing suicide.³ It is often claimed that Switzerland is the only jurisdiction in Europe that is legally open to such ‘tourism’. This, however, is a misreading of the substantive requirements of the law in the Benelux nations. As explained in Part II, in the Netherlands, there is no explicit legal requirement that the patient who receives assistance in dying (be it VAE or AS) must be a citizen or be domiciled in that jurisdiction. Nor is it legally required that the doctor who performs the assistance (be it VAE or AS) is the patient’s attending doctor. It is ‘only’ required that there is a sufficient proof of a relationship between the doctor and the patient so as to permit the doctor to make a judgment in accordance with the due care criteria.⁴ The same is true regarding the law in Belgium and Luxembourg.

Nonetheless in practice, the jurisdiction that is more commonly associated with the issue of ‘suicide tourism’ is Switzerland. And one organisation in particular, *Dignitas*, is greatly responsible for publicising this so-called ‘Swiss option’. Between 1998 and (December) 2014, *Dignitas* has assisted in 1,905 suicides. It has received patients from 43 different

¹ Media and public discourse is most often initiated by high profile judgments: from the ECtHR’s decisions in *Pretty v UK* (2002), *Haas v Switzerland* (2009), *Gross v Switzerland* (2013) to various national decisions (such as the 2003 ‘*Humbert case*’ in France, the 2006 ‘*Welby case*’ in Italy; the 2007 ‘*Echevarria case*’ in Spain; the 2009 ‘*Purdy case*’ in England, the 2014 ‘*Fleming case*’ in Ireland, and so on).

² Agreement is had with Pennings, who observes that the association with recreational travel indirectly devalues the desire motivating the journey. See G. Pennings, ‘Reproductive tourism as moral pluralism in motion’ (2002) 28 *Journal of Medical Ethics* 337–341.

³ See R. Huxtable, ‘The Suicide Tourist Trap: Compromise Across Borders’ (2009) 6 *Bioethical Inquiry* 328.

⁴ This ‘doctor-patient relationship’ requirement in the Netherlands, has been clearly stated by the Regional Review Committees. In Belgium this requirement is implied from Article 3 of the ‘Law on Euthanasia’ – which provides that the doctor must have a number of conversations with the patient, over a reasonable period of time, in order to be certain of the durability of the euthanasia request. In Luxembourg, this requirement is made clear in a publication by the Ministry of Health, see ‘*L’euthanasie et l’assistance au suicide* – Loi du 16 mars 2009: 25 questions -25 responses.’

countries of residence.⁵ Since 2005, it has also been operating a branch based in Hannover to provide information to its German members.⁶ It is an organisation that has gained wide-spread media attention. *Le Monde* coined the headline ‘*En Suisse, rendez-vous avec la mort*’ after an interview with its controversial founder Ludwig Minelli.⁷ It was described by *Die Zeit* as a ‘*diktatorischer Verein*’.⁸ It has also been the subject of numerous mainstream documentaries, such as the BBC’s ‘*A Short Stay in Switzerland*’ and PBS Frontlines’ ‘*Right to Die?*’. Leaving aside arguments by its critics and its supporters,⁹ Dignitas have made ‘suicide tourism’ a less than discrete trans-national issue.

Fourth, with the large majority of the suicide tourists travelling to Dignitas (1,754 of 1,905) coming from 24 different European nations, we may also ask if we are watching another dimension of what Kurzer terms the ‘Europeanization of norms’ in sin tourism.¹⁰ On the one hand - this is a subtle process of cultural assimilation in which ethics cross European boundaries to bring people together. On the other hand, it is an assimilation bolstered by the demands of regional integration (such as political agreements on human rights protection and/or European free movement), which may undermine political agreements to protect national values. Indeed, retrospective institutional analysis shows that the political promises to protect national values ‘failed to reckon with the cumulative consequences’ of agreements to promote the free circulation of people in Europe.¹¹ Weyers points out that the broad effect of ‘suicide tourism’ in particular, is two-fold: (i)

⁵ The country of residence (the number of patients): Switzerland (156), Germany (920), Great Britain (273), France (194), Austria (39), Italy (79), Australia (20), Bahamas (1), Belgium (4), Brazil (1), Denmark (5), Finland (3), Greece (3), Hong Kong (1), India (2), Ireland (8), Iceland (1), Israel (24), Canada (36), Croatia (2), Lebanon (1), Luxembourg (1), Malaysia (1), Monaco (1), Morocco (2), Mexico (1), New Zealand (1), Netherlands (10), Peru (1), Poland (1), Portugal (4), Russia (2), Sweden (17), Zimbabwe (1), Singapore (1), Slovenia (1), Spain (24), South Africa (4), Thailand (1), Czech Republic (5), Hungary (1), Uruguay (1), USA (51).

⁶ Note: to avail of the service German patients must still travel to the clinic in Switzerland.

⁷ ‘*En Suisse, rendez-vous avec la mort*’, *Le Monde*, 24.05.2008. See: <www.lemonde.fr/europe/article/2008/05/24/en-suisse-rendez-vous-avec-la-mort_1049148_3214.html>.

⁸ ‘*Dignitas ist ein diktatorischer Verein*’, *Die Zeit*, 27.08.2005. See <www.zeit.de/2005/44/Dignitas>.

⁹ See CHAPTER 5 of this book for a discussion on this.

¹⁰ P. Kurzer, *Markets and Moral Regulation. Cultural Change in the European Union* (Cambridge: CUP, 2001). Kurzer used the term ‘sin tourism’ and focused exclusively on abortion, alcohol tourism, and drug tourism.

¹¹ Agreement such as those laid out in Article 3(2) of the Treaty on European Union (TEU); Article 21 of the Treaty on the Functioning of the European Union (TFEU); Titles IV and V TFEU; the Agreement on the European Economic Area; and the Agreement on the Free Movement of Persons between Switzerland and the EU. See Kurzer (n 10) 175; P. Pierson, ‘The Path to European Integration: A Historical Institutionalist Analysis’ (1996) 29 *Comparative Political Studies* 123-163; A. Stone-Sweet and W. Sandholtz, ‘Integration, Supranational Governance, and the Institutionalization of the European Polity’ in W. Sandholtz and A. Stone-Sweet (eds) *European Integration and Supranational Governance* (New York: OUP, 1998) 14-20.

national prohibitions on assisted suicide cannot stop people from realising their values regarding bodily self-determination, and (ii) by going to Switzerland, individuals challenge (or at least highlight) the national norms and policy on assisted suicide in their home country. In short, 'suicide tourism' exposes the cultural narrative and institutionalised norms on the national level to European cross-border realities.¹² For these reasons, this study provides a novel but necessary European-level analysis.

¹² Moreover, said tourism, for Kurzer, 'prompts fresh scrutiny of widely held beliefs and attitudes and inures people to the idea that a debate on these topics is no longer taboo.' See Kurzer (n 10).

7

THE COUNCIL OF EUROPE AND ASSISTED DYING

7.1. INTRODUCTION

Founded in 1949, the Council of Europe ('the CoE') set out 'to develop co-operation'¹ between governments² and to provide a means through which 'the aspirations of the European peoples will be formulated and expressed'.³ In 1950, the CoE created the first legally binding instrument guaranteeing the protection of human rights (the European Convention on Human Rights)⁴ and set out the requirement of an international Court (the European Court of Human Rights)⁵ to guard and interpret these rights.

Arguably the international community's post-war preoccupation with how individuals are treated *vis à vis* national governments was not inspired by altruistic ideals of human rights, but rather by the need to deliver soft security inspired by the palpable threats of totalitarianism and communism.⁶ This may be true. But this realist interpretation of international relations does not suffice as an explanation for the contemporary importance of the Council of Europe. Today, the CoE has become the embodiment and the symbol of standard setting activities in the pursuit of individual and constitutionalist

¹ See: 'Statement issued by the signatories of the Statute of the Council of Europe', 5th May 1949.

² *Via* the Committee of Ministers.

³ *Via* the Consultative Assembly, now known as the Parliamentary Assembly.

⁴ Which has, to date, been supplemented/amended by 14 Protocols.

⁵ Article 19 of the Convention set out the obligation to establish a Court, but it was not until 1959 that the Court became operational.

⁶ See for example: R. Roty, 'Human Rights, Rationality, and Sentimentality' in S. Shute and S. Hurley (eds) *On Human Rights: the Oxford Amnesty Lectures* (Basic Books, 1993) 111.

justice.⁷ More specifically, it has provided ‘the world’s most successful experiment in the trans-national judicial protection of human rights.’⁸

In light of shifting societal values and scientific advancements, it may be said that the CoE’s re-active judicial and pro-active political institutions have provided a platform to promote positions (permissive or non-permissive moral standpoints) on controversial issues – such as abortion,⁹ embryo donation,¹⁰ home-birth,¹¹ sexual orientation,¹² surrogacy,¹³ and of fundamental relevance here, assisted dying.¹⁴ In this sense, the CoE’s aspirations to achieve high standards of respect for human rights and the rule of law have made it an appealing contemporary legal and political regime. Policy outputs by its various institutions offer (i) a means for individuals to affect (instigate or prevent) national legal reform¹⁵ on emerging morality policies, and (ii) a source for those in the midst of the political debate on morality policies to be publically (and, more often, positively) associated with.¹⁶ Over the past 15 years, five claims based on Convention rights challenging substantive and procedural national rules on assisted dying have come before the ECtHR. In that same time, a number of Recommendations, Resolutions, Reports, and Opinions on assisted dying have also been produced by other institutions and agencies of the CoE.

⁷ For example, the ‘constitutionalist justice’ model is evident in efforts of Pan-European standard setting (e.g. The Oviedo Convention on Bioethics), while ‘individual justice’ is evident in the review of national acts and the provision of remedies for particular individual violations brought before the Court.

⁸ S. Greer and A. Williams, ‘Human Rights in the Council of Europe and the EU: Towards “Individual”, “Constitutional”, or “Institutional Justice”?’ (2006) 15 *European Law Journal* 462-481.

⁹ For example – (i) on the judicial level: see: *Tysiac v Poland* (181) ECHR Chamber Judgment 20.3.2007; *A., B., and C. v Ireland* (App no. 25579/05) ECHR Grand Chamber, 16 December 2010; *R.R. v Poland* (App no. 27617/04); and (ii) on the political level: see Parliamentary Assembly Resolution 1607 (2008) ‘Access to safe and legal abortion in Europe.’

¹⁰ See for example: (i) on the judicial level: see *Parillo v Italy* (App no. 46470/11) ECHR Grand Chamber 18 June 2014; (ii) on the political level: Parliamentary Assembly Recommendation 1100 (1989) ‘on the use of human embryos and fetuses in scientific research.’

¹¹ See for example: (i) on the judicial level: *Ternovsky v. Hungary* (App no. 67545/09) ECHR 14 December 2010; (ii) on the political level: as of yet there has been no political response.

¹² See for example: (i) on the judicial level: *M.C. and C.A. v. Romania* (App no. 12060/12) ECHR 30 January 2013; *E.B. v. France* (App no. 43546) ECHR Grand Chamber 22 January 2008; *Vallianatos and others v. Greece* (App nos. 29381/09 and 32684/09) ECHR Grand Chamber 7 November 2011; (ii) on the political level: see Parliamentary Assembly Recommendation 1915 (2010) ‘Discrimination on the basis of sexual orientation and gender identity.’

¹³ See for example: (i) on the judicial level: *Mennesson and others v. France* (App no. 65192/11) and *Labassee v. France* (App no. 65941/11) ECHR 26 June 2014; (ii) on the political level: Parliamentary Assembly Written Declaration Doc. 12934: Surrogate Motherhood. Note the only signatories of this Written Declaration were parliamentarians from the Christian Democrat Group.

¹⁴ See Sections 7.2.3 to 7.3.4 in this Chapter.

¹⁵ *Via* a favourable decision by the ECtHR.

¹⁶ *Via* a favourable Recommendation by the Parliamentary Assembly and/or the Committee of Ministers.

An attempt to explain in detail the governance dimensions in the CoE is far beyond the scope and purpose of this book. Attention here is limited to its institutions and policy outputs that are of relevance to the creation, application and/or enforcement of the law on assisted dying. The first focus is on governance through the law, which is sub-divided into three parts, providing: **(7.2.1)** a brief overview of judicial governance by the ECtHR; **(7.2.2)** a descriptive evaluation of the ECtHR's five high profile decisions on assisted dying; **(7.2.3)** a critique of these assisted dying decisions in light of the Court's governance function, and **(7.2.4)** a brief conclusion. The focus then moves to governance *within and beyond* the state, which is also sub-divided into three parts: **(7.3.1)** a brief overview of multi-level governance by the relevant institutional pillars of the CoE; **(7.3.2)** a descriptive evaluation of the non-binding policies (in the form of recommendations, reports, resolutions and opinions) on the legality of assisted dying made by the Parliamentary Assembly, the Committee of Ministers, the Steering Committee on Bioethics, the (former) Social, Health and Family Affairs Committee, the Committee on Legal Affairs and Human Rights, and certain INGOs of the CoE; **(7.3.3)** a critique of these policies in light of CoE's more multi-level governance function; and **(7.3.4)** brief conclusions.

7.2. GOVERNANCE THROUGH THE LAW

7.2.1 JUDICIAL GOVERNANCE FROM STRASBOURG¹⁷

Keller and Stone Sweet claim the most important governance feature of the European Court of Human Rights is its case law.¹⁸ Its precedential approach as the final authority on interpreting and applying the Convention¹⁹ has resulted in a rich and impressive jurisprudence. This type of governance – structural European judicial supremacy – is built on a type of functional legitimacy.²⁰ This is explainable by considering contemporary delegation theory. Here, ‘the Principals’ (the High Contracting Parties to the Convention), those in power at the *ex ante* constitutive moment, delegate political rights to the trustee (the ECtHR), on the basis of some rationale.²¹ In general, the rationale behind delegation of such rights will vary depending on the needs of the principals. There may be a need to resolve commitment problems and/or to simply avoid taking the blame for unpopular

¹⁷ A brief note on the internal structure of the ECtHR: it consists of one judge from each State in the Council of Europe. The selection procedure is two-fold. First, on the national-level: each State party chooses a list of three qualified candidates. Then, there is a voting procedure in the Parliamentary Assembly to select one of the candidates from the three shortlisted candidates. Prior to voting in the Assembly, a special sub-committee of parliamentarians with legal experience interview the shortlisted candidates, and scrutinize their qualifications etc. It cannot be denied that this procedure contains politically motivated elements, as it does at national constitutional court level, especially the first stage at the national level. Erik Voeten demonstrates that partisan politics shape the ECtHR judicial selection process, yet there is no evidence (from existing quantitative empirical data) that the selected judges pursue the national interest of their own States. See E. Voeten, ‘Politics, Judicial Behaviour, and Institutional design’ in J. Christoffersen and M.R. Madsen, *The European Court of Human Rights: Between Law and Politics* (Oxford University Press, 2014) 62. There are four types of Court sittings: (i) Single Judge (makes admissibility decision only); (ii) Committee of 3 Judges (makes decision on the admissibility and the merits); (iii) Chamber of 7 judges (makes decision on the admissibility and the merits); and (iv) Grand Chamber of 17 judges (receives a case based on an referral made by the parties or relinquishment by a Chamber – both occur exceptionally. This Court, of course, makes a decision on both the admissibility of the case and its merits).

¹⁸ A. Stone Sweet and H. Keller, ‘The Reception of the ECHR in National Legal Orders’ in A. Stone Sweet and H. Keller (eds) *A Europe of Rights: The Impact of the ECHR on National Legal Systems* (Oxford University Press, 2008) 14.

¹⁹ The coming into effect of Protocol no. 11 revolutionized the role of the Court: (i) the pre-existing part time institutions of the European Commission of Human Rights and the European court of Human Rights are now superseded by a single full time European Court of Human Rights, (ii) all applications under the Convention now go directly to the Court, and (iii) the right of individual petition becomes mandatory for all member states. See for an insight on the issue of ‘judicial trusteeship’: G. Majone, ‘Two Logics of Delegation Theory: Agency and Fiduciary Relations in EU Governance’ (2002) 2 *European Union Politics* 103; T. Moe, ‘Political Institutions: The Neglected Side of the Story’ (1990) 6(1) *Journal of Law, Economics, and Organisation* 213; A. Stone Sweet, ‘Constitutional Courts and Parliamentary Democracy’ (2002) 25 *Western European Politics* 77; and Stone Sweet and Keller (n 18) 9. For more general reading on delegation theory in the Council of Europe, see: A. Moravcsik, ‘The Origins of Human Rights Regimes: Democratic Delegation in Post-war Europe’, *International Organisation* 54(2) (2000) 217-252;

²⁰ See Stone Sweet and Keller (n 18) 8; T. Barkhuysen and M. van Emmerik, ‘Legitimacy of the European Court of Human Rights Judgments: Procedural Aspects’, in N. Huls, M. Adams and J. Bomhoff, *The Legitimacy of the Highest Courts’ Rulings; Judicial Deliberations and Beyond* (TMC Asser: The Hague, 2009) 437-451.

²¹ K.J. Alter, ‘Agents or Trustees? International Courts in their Political Context’ (2008) 14(1) *European Journal of International Relations* 33-63.

policy choices. Arguably, the rationale behind delegating power to the ECtHR is for Contracting Parties to acquire a means to enhance pan-European commitment to the Convention and its norms, thereby also enhancing the legitimacy of the national political regime (and thus, it's public image both domestically and internationally). This means the Contracting Parties accept, however reluctantly, that such a means may occasionally interfere with national political decisions on fundamental issues.²² The Court has the legal authority to determine the scope and the content of human rights protection under the Convention, and the Contracting Parties have (as a result of the legal commitments they have agreed to) a reduced means of overruling the determinations they find objectionable. To do otherwise would require revising Convention norms – an almost impossible prospect in practice, requiring unanimity of all the members. In short, the Court exercises 'extensive fiduciary' authority over the Convention, but the States designed the system for their own express purposes, and they make it effective on a continuous basis.

This last point on effectiveness is important in understanding judicial governance in the Council of Europe. Formally speaking, the Court's decision is limited to the specific individual applicant.²³ But determinations by the Court on the scope of Convention rights may, in practice, go beyond the specific case before it.²⁴ On the one hand, agreement is

²² As touched upon in the introduction, this rationale behind delegating power to the ECtHR – i.e. to enhance Pan-European commitment to the Convention - does not necessarily mean the Contracting Parties shared ideals of altruism or the desire to protect individualism. Certain commentators argue that the original objectives of the Council of Europe (and hence the rationale behind it's, and thus the Court's, *raison d'être*) was to freeze the minimum level of protection by the Contracting States as a means to prevent the populations of Europe from slipping into the hands of fascist or communist politicians. In the Court's formative years, the sovereign-conscious Contracting Parties were not overly welcoming to the idea of a Court, preferring instead the more State-centric Commission on Human Rights and the Committee of Ministers. See E. Bates, 'The Birth of the European Convention on Human Rights—and the European Court of Human Rights' in J. Christoffersen and M.R. Madsen, *The European Court of Human Rights: Between Law and Politics* (Oxford University Press, 2014) 17-42.

²³ Each judgment is only legally binding for the Contracting State that is a party to the case. A Contracting State that breaches the ECHR has a duty under Article 46 ECHR to abide by the final judgment of the Court and to award just compensation to the victim. The Committee of Ministers, the political organ that supervises the execution of judgments (explained in more detail below in **Section 7.3.1**), may expel, under Article 8 of the Statute of the Council of Europe, Contracting States that seriously violate their obligation to accept the principle of the rule of law and human rights and to collaborate sincerely in the realization of the aims of the Council.

²⁴ J. Gerards, 'Judicial Deliberations in the European Court of Human Rights', in: N. Huls, M. Adams and J. Bomhoff, *The Legitimacy of the Highest Courts' Rulings; Judicial Deliberations and Beyond* (TMC Asser: The Hague, 2009) 409.

had here with Harmsen that the debate between ‘constitutionalist’²⁵ and ‘individual’²⁶ visions of the role of the Court should not be overstated. ‘[T]he Court, by its nature, will continue to perform both functions – ‘that of constitutional standard-setting’ and ‘that of providing individual remedies’ – the nature of this performance will depend on the case at hand.²⁷ The wider focus ought to be on the question of how to balance these two functions. On the other hand, the Court’s limited ability to provide ‘systematic individual justice’ should not be underestimated:

- First, the Court is capable of judging less than 3-5% of the applications it receives, similar to the highest national courts.²⁸
- Second, the Court has a haphazard method of adjudication. On many occasions it fails to clearly distinguish between the definition of the scope of fundamental rights and the test of justification.²⁹
- Third, the Court’s command-and-control capacities beyond the specific case remain limited. The larger impact of the Court’s decisions depends on if, and how, national officials recognize and enforce the authority of the Court. To

²⁵ The ‘constitutionalist’ argument claims: the core function of the Court is to set pan-European standards, using individual cases as a vehicle to signal problems and establish principles. This argument has notable supporters, such as the current UK Judge of the ECtHR and the former President of the ECtHR. See respectively: P. Mahoney, ‘An Insider’s View of the Reform Debate (How to Maintain the Effectiveness of the European Court of Human Rights)’, *NJCM-Bulletin* 29 (2004) 175; and L. Widhaber, ‘A Constitutional Future for the European Court of Human Rights?’ (2002) 23 *Human Rights Law Journal* 161. Note, that the term ‘constitutional function’ is distinct from the technical question of the extent to which the ECtHR acts in an analogous manner to a national constitutional court. See on this J. F. Flauss, ‘La Cour européenne est-elle une Cour constitutionnelle?’ in J. F. Flauss and M. de Salvia (eds) *La Convention européenne des droits de l’homme: Développements récents et nouveaux défis* (Brussels: Bruylant, 1997).

²⁶ The ‘individual justice’ argument claims: the core function of the Court is the provision of remedies for individual-level violations, stressing the vast diversity of the Convention’s community. See: T. Barkhuysen and M. L. van Emmerick, ‘De Toekomst van het EHRM: Meer middelen voor effectievere rechtsbescherming’ (2003) 28 *NJCM-Bulletin* 298.

²⁷ See R. Harmsen, ‘The Reform of the convention System: Institutional Restructuring and the (Geo-) Politics of Human Rights’ in J. Christoffersen and M.R. Madsen, *The European Court of Human Rights: Between Law and Politics* (Oxford University Press, 2014) 132. The Court have admitted as much, see *Pretty v the UK* (App. No. 2346/02) ECHR 29 April, para 75: ‘judgments issued in individual cases establish precedents, albeit to a greater or lesser degree’ and in certain cases ‘could not in theory or practice, be framed in such a way as to prevent application in later cases.’

²⁸ See the ‘European Court of Human Rights: In Facts & Figures - 2014’, Public Relations Unit of the Court European Court of Human Rights, February 2015. See also: S. Greer, *The European Convention on Human Rights: Achievements, Problems and Prospects* (Cambridge University Press, 2006) 39.

²⁹ See for a convincing analysis on this J. Gerards and H. Senden, ‘The structure of fundamental rights and the European Court of Human rights’ (2009) 7(4) *International Journal of Constitutional Law* 652. This blurred approach to the first and second stage of review results, according to the aforementioned authors, in problems with the clarity of the Court’s case-law, but also with the division of the burden of proof in fundamental rights cases, and the application of the margin of appreciation doctrine. The need for a clear bifurcated approach is focused on in more detail in Section 7.2.2, below.

a large extent this depends on how the convention is incorporated into the national legal orders.³⁰ Keller and Stone Sweet, after extensive examination of eighteen Member States, conclude that the Court's authority is most effective where Convention rights, *de jure* and *de facto*: (1) bind all national officials in the exercise of public authority; (2) possess at least supra-legislative status, and (3) can be pleaded directly by individuals before judges who may directly enforce them, while disapplying conflicting norms.³¹

- And fourth, judicial governance in the CoE is restrained from providing systematic individual justice due to the complex 'constitutional relationship' between the ECtHR and the national authorities. Although for some the Court may be seen as 'the conscience of free Europe',³² it must remain measured and somewhat modest. It has to set a balance between progressive human rights protection and maintaining respect with national sensitivities.³³

³⁰ Take for example, the former mechanism of reception in France as compared to the mechanism of reception in the Netherlands. In France, up until the 1980s (this is no longer the case today) the Convention had basically no legal status in the internal legal order – in other words there was no obligation on the French authorities to change a particular law found by the Court to be in breach of the Convention, it would merely discharge its duty by compensating the affected claimant. While in the Netherlands, the national Constitution explicitly provided for the supremacy of the Convention rights as determined by the Court. Moreover, the Dutch Supreme Court has chosen to directly enforce the Convention without express Constitutional competence for the judicial review of statute. See E. Lambert Abdelgawad and A. Weber, 'The Reception Process in France and Germany' in: A. Stone Sweet and H. Keller (eds) *A Europe of Rights: The Impact of the ECHR on National Legal Systems* (Oxford University Press, 2008) 107-164; E. de Wet, 'The Reception Process in the Netherlands and Belgium' in A. Stone Sweet and H. Keller (eds) *A Europe of Rights: The Impact of the ECHR on National Legal Systems* (Oxford University Press, 2008) 229-310; G.F. Rees, 'The Effect of Decisions and Judgments of the European Court of Human Rights in the Domestic Legal Orders' (2005) 40 *Texas International Law Journal* 359, 374.

³¹ Today, the Convention acts a type of surrogate Constitution in some Members States (e.g. Belgium, France, the Netherlands, Switzerland, and the UK), while in other States the reception of the Convention is more structural (e.g. the Scandinavian countries) or supplementary to the national Constitution (e.g. Germany, Ireland, Spain, and certain Central European States). Stone Sweet and Keller (n 18) 683.

³² See P. H. Teitgen, 'The European Guarantee of Human Rights: A Political Assessment', in Council of Europe (ed), *Proceedings of the Fourth International Colloquy about the European Convention on Human Rights*, Rome 1975 (Strasbourg: Council of Europe, 1976), 29.

³³ See Bates (n 22). This is a challenge that the Court has faced since its inception. It is a challenge that has presented itself in various but unrelenting ways during what Christoffersen and Madsen identify as the Court's four main phases of life: (i) in the late 1950's, the Court began to cautiously develop its institutional autonomy and jurisprudence, trying to diplomatically induce the Contracting Parties to accept the then optional right to individual petition; (ii) in the 1970s, when the Court commenced on a more progressive course of jurisprudence, invoking notions such as 'living instrument', 'margin of appreciation' and 'practical and effective'; (iii) in the post-Cold war period, when the Court had to aid the transition of democracy and rule of law in Eastern Europe; and (iv) the current era, in which the Court faces more new Member States and an incredibly large case-load. See J. Christoffersen and M.R. Madsen, 'Introduction' in J. Christoffersen

It is therefore not unreasonable for the Court to take the implicit principle in Article 1 of the Convention very seriously - that it is the national authorities who have the *primary* responsibility to protect human rights.³⁴ The Court has a subsidiary governance role and must only intervene when a case before them presents an obvious failure by the national authorities. It must respect, as much as possible, national majoritarian values inherent in democratic legislative measures. In this sense, the application of the well-known concept of 'margin of appreciation' is a corollary to the principle of subsidiarity. Since the Court (as opposed to the former Commission) first recognised this concept in 1976,³⁵ it has been 'at the heart of virtually all major cases that have come before it whether the judgments refer to it explicitly or not.'³⁶ And its application has received a fair share of attention³⁷ and criticism.³⁸ In short, the Court uses the margin of appreciation: (i) in a substantive way, to address the relationship between individual freedoms and collective goals, and (ii) in a structural way, to determine the limits of intensity of review in light of how it views its status as an 'international tribunal'. According to Letsas, ambiguity and confusion arise because the Court fails to distinguish between the substantive and structural ways of applying the doctrine. In other words, the Court uses the same term (margin of appreciation) both for saying that the applicant did not have the human right she claimed, and for saying that it will not substantively review the decision of national authorities as to whether there has been a violation of a human right.³⁹ This is a result of not adopting a more formal bifurcated approach to reviewing the structure of fundamental rights. In

and M.R. Madsen (eds) *The European Court of Human Rights: Between Law and Politics* (Oxford University Press, 2014).

³⁴ Unlike the EU Treaties, the principle of subsidiarity is not expressly mentioned in the Convention or its Protocols, but it has been long deemed implicit in the wording of Article 1 of the Convention: 'The High Contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms in Section 1 of [the] Convention.' This was recognised by the Court as far back as 1968 in the *Belgian language case*, ECHR 23 July 1968, Series A, No. 6. For more recent judicial reconfirmations of the principle of subsidiarity, see (amongst many others): *Scordino v. Italy* (no. 1) (App no. 36813/97) ECHR Grand Chamber 2006-V, 26 March 2006, para 140; and also *Varnava and Others v. Turkey* (App no. 16064/90 et al.) ECHR Grand Chamber, 18 September 2009, para 164.

³⁵ *Handyside v UK* (App no. 5493/72) ECHR 7 December 1976, para 47.

³⁶ R. St. MacDonald, 'The margin of appreciation in the jurisprudence of the ECHR' in *International Law at the time of codification, Essays in honour of Judge Roberto Ago* (Giuffrè: Milan 1987) 187, 208.

³⁷ H. Yourow, *The Margin of Appreciation Doctrine in the Dynamics of European Human Rights Jurisprudence* (Kluwer, 1996); Y. Arai-Takahashi, *The Margin of Appreciation Doctrine and the Principle of Proportionality in the Jurisprudence of the ECHR* (Hart, 2002); J.H. Gerards, 'Pluralism, deference and the margin of appreciation doctrine', (2011) 17 *European Law Journal* 80.

³⁸ R. MacDonald, 'The Margin of Appreciation' in J. MacDonald, F. Matscher and H. Petzold (eds), *The European System for the Protection of Human Rights* (1993) 85; G. Letsas, 'Two Concepts of the Margin of Appreciation' *Oxford Journal of Legal Studies* 26(4) (2006) 705-732; P. Mahoney, 'Marvellous Richness of Diversity or Invidious Cultural Relativism' *Human Rights Law Journal* 19(1) (1998).

³⁹ Letsas, *ibid*, 705, 706.

short, one may argue that the margin of appreciation ought to only be applied when justifying the limitation of a particular fundamental right, not when defining the actual existence or scope of a fundamental right. This point is explained in more detail below (see section 7.2.3).

Moreover, the Court has frequently declared (and quite understandably so in light of its complex relationship with national authorities), that the ‘margin of appreciation’ may vary depending on the context. On occasion it has recognised that where a particularly important facet of an individual’s existence or identity arises, the margin allowed to the State will normally be restricted.⁴⁰ Where there is no consensus within the Contracting States of the Council of Europe however, either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises moral or ethical issues, the margin will be wider.⁴¹ However, as Gallagher alludes to, it is not clear how the Court measures consensus or what qualifies as sufficient evidence of consensus.⁴² Arguably, the ambiguity and vagueness surrounding the margin of appreciation in the Court’s jurisprudence undermines its effectiveness against both an over-expansive and under-expansive interpretation of the Convention.

This short introduction to the ECtHR highlights the ambitious aims and serious challenges inherent in judicial governance beyond the State, particularly when it concerns sensitive legal policies. In sum, judicial governance in the Council of Europe has (i) the potential to override domestic political processes and remedy defects in the domestic protection of human rights; (ii) has struggled to provide an authoritative and consistent method of adjudication; and (iii) has clear institutional limitations dependant on geo-politics, the moral sensitivity of the issue at hand, and contextual factors such as the social and economic climate specific to each member state. In light of these observations, the proceeding sections focus in-depth on the position taken by the Court regarding individual rights-based claims to assisted dying that have come before it.

⁴⁰ *Dudgeon v the UK*, para 52; *A.D.T. v the UK*, no. 35765/97, para 37, ECHR 2000-IX.

⁴¹ *A, B & C v Ireland* Application No. 25579/05 16th September 2010

⁴² P. Gallagher, ‘The European Convention of Human Rights and the Margin of Appreciation’, *UCD Working Papers in Law, Criminology & Socio-Legal Studies*, Research Paper No. 52/2011. See in support of Gallagher’s argument the Court’s reasoning in *Goodwin v the UK* (App no 28957/95) ECHR Grand Chamber 11 July 2002. See also *A, B & C v. Ireland* (n X) para 229-238, for a pertinent example of how unpredictable the Court’s application of this concept may be.

7.2.2. THE JURISPRUDENCE ON ASSISTED DYING

1. *Pretty v the UK (2002)*⁴³

The applicant suffered from motor neuron disease - a progressive neuro-degenerative disease of motor cells within the central nervous system. Death usually occurs due to the weakening of breathing muscles and muscles controlling speech and swallowing, leading to respiratory failure (suffocation) and pneumonia. There was, and sadly still is,⁴⁴ no treatment to cure or prevent the progression of the disease. At the time of trial, the applicant's condition was at an advanced stage – she was paralyzed from the neck down, had no decipherable speech, and was fed through a tube. Her life expectancy was measured in weeks or months. Both the House of Lords and the ECtHR accepted upon medical evidence that her disease meant she faced 'the prospect of a humiliating and distressing death.' Crucially for her legal claim, her mental capacity was deemed to be unimpaired. She desired to take control of her death and therefore commit a dignified suicide. But due to her physical disabilities, an independent suicide was no longer an option.

As a result of these circumstances, her husband of twenty-five years had agreed to assist her in committing suicide. However, before doing so he sought assurance off the UK Director of Public Prosecutions ('the DPP') that he would not be prosecuted in accordance with the English criminal ban on assisted suicide - the decision not to prosecute may be taken by the DPP if it justified 'in the public interest', but may only be made *ex-post* an act of assisted suicide.⁴⁵ The DPP refused to give the requested *ex ante* assurance. The applicant then applied for judicial review, claiming that the DPP was required to give such an assurance and that the criminal ban on assisted suicide is incompatible with Article 2 (the right to life), Article 3 (the prohibition of torture, inhuman and degrading treatment), Article 8 (the right to respect for private life), Article 9 (the freedom of thought, conscience, and religion) and Article 14 (the prohibition of discrimination) of Schedule 1 of the Act incorporating the ECHR into domestic UK law - the 'Human Rights Act 1998'.

⁴³ Case of *Pretty v. the UK*, (App no. 2346/02) ECHR, 29 April 2002.

⁴⁴ See the British NHS overview on "motor-neuron disease" - available at <www.nhs.uk/conditions/Motor-neurone-disease/pages/treatment.aspx>. Last accessed 28.01.2016.

⁴⁵ For more details of the law on assisted suicide in England, see CHAPTER 4 and 5 of this book.

The Court's Assessment:

Article 2: Right to Life = No Violation

The Court interpreted the right to life in an instrumental manner. In other words, it stated that without properly safeguarding this right, the enjoyment of any other rights and freedoms in the convention 'is rendered nugatory.'⁴⁶ The Court relied on previous case-law⁴⁷ to reason that the right to life not only imposes a negative obligation on the State, but may even (albeit in limited circumstances) impose a positive obligation to take preventative measures in order to protect life.⁴⁸ Essentially, the consistent emphasis in the Court's jurisprudence on Article 2 has been the protection of life. The Court held that said Article, in light of the relevant case law and its very definition, is 'unconcerned with the quality of living or what a person chooses to do with his or her life.'⁴⁹ It reasoned that the right to life could not be interpreted to confer a right to die (at the hands of a third party or with assistance from a public authority) or to confer a right to self-determination to choose death rather than life.⁵⁰ This sentiment was supported with a reference to Recommendation 1418 (1999) issued by the Parliamentary Assembly of the Council of Europe.⁵¹ The Court, in response to the applicant's arguments, concluded that this finding does not necessarily entail that Member States which permit assisted suicide (such as the Benelux nations and Switzerland) are therefore in breach of Article 2.⁵² The Court believed this to be a distinct and unrelated question to the one at hand (i.e. as to whether the UK is in breach of its obligations under Article 2) and need not be assessed in this case.

Article 3: Prohibition of Torture – No Violation

⁴⁶ Para 37.

⁴⁷ Such as *L.C.B. v. the U.K.* (App no 23413/94) ECHR 1998-III, para 36.

⁴⁸ See the case of *Osman v. UK* (App no 23452/94) ECHR 1998-VIII 3124, para 115 and the case of *Kilic v. Turkey* (App no 22492/93) ECHR 2000-III, para 62 and 76: whereby the State was held to have an obligation to take operational measures to protect an individual whose life was at risk from the criminal acts of another individual. See also the case of *Keenan v the UK* (App no. 27229/95) ECHR 3 April 2001: whereby the State was obliged, under Article 2, to take active measures in order to protect a mentally ill prisoner who disclosed clear signs of being suicidal.

⁴⁹ Para 39.

⁵⁰ *Ibid.*

⁵¹ Para 40. This Recommendation rejected any change the law to permit assisted dying. See below for more on this Section 7.3.2.

⁵² Para 41.

In contrast to other provisions, Article 3 is cast in absolute terms, without exception or proviso. It principally imposes a negative obligation on the States to refrain from inflicting torture or inhuman and degrading treatment on persons within their jurisdiction.⁵³ Given the fundamental importance of Article 3, and in light of Article 1,⁵⁴ the Court restated its jurisprudence requiring States to take positive measures in ensuring persons within their jurisdiction are not subject to torture or inhuman and degrading treatment.⁵⁵ Treatment that ‘attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering’⁵⁶ is deemed to fall within the scope of Article 3. Also, the suffering which flows naturally from illness, physical or mental, may be covered by Article 3, ‘where it is, or risks being, exacerbated by treatment flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible.’⁵⁷ The applicant claimed that by refusing to give any undertaking that her husband will not be prosecuted for assisting in her suicide, the State is responsible for exacerbating the inhuman and degrading treatment she suffers from. The Court rejected this claim. It acknowledged its own obligation to interpret the Convention as a ‘living instrument’, but to only do so within the remits of ‘the fundamental objectives of the Treaty and its coherence as a system of human rights protection.’⁵⁸ In this respect, focus was put on the harmony between Article 3 and Article 2. It recalled its assessment that the right to life (i) prohibits the use of lethal force that leads to death and (ii) does not confer any right on an individual to require a State to permit or facilitate his or her death. To accept the applicant’s claim would, according to the Court, require a ‘new and extended construction on the concept of treatment [...] which goes beyond the ordinary meaning of the word.’⁵⁹ Essentially, the Court was unwilling to interpret Article 3 so that it would require the State ‘to sanction actions intended to terminate life’

Article 8: Right to Respect for Private Life – No violation

⁵³ Para 50. See *Ireland v. the UK* (App no 5310/71) 18 January 1978, Series A no. 25.

⁵⁴ Article 1 reads: ‘The High contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms defined in Section 1 of this Convention.’

⁵⁵ Para 51.

⁵⁶ Para 52. See *Ireland v. the UK* (cited above).

⁵⁷ Para 52. See *D. v. the UK* (App no 30240/96) 2 May 1997, Reports 1997-III, para 49; *Bensaid v. the UK* (App no. 44599/98) ECHR 2000-I.

⁵⁸ Para 54.

⁵⁹ Para 55.

The Court reiterated its previous case law, stating the concept of “private life” is a broad term not susceptible to exhaustive definition.⁶⁰ It covers “the physical and psychological integrity of a person.”⁶¹ The Court then established, for the first time in its jurisprudence, a right to self-determination as contained in Art 8.⁶² Attention then turned to the acute issue of whether the right to private life can or cannot encapsulate a right to die with assistance.

The Court embarked on this question by citing two well-known decisions, albeit dealing with substantially different circumstances,⁶³ whereby compulsory and criminal measures designed to deter potentially life-threatening conduct were deemed to fall within the ambit of Article 8, and thus require justification. Closer attention was paid to one of these types of decisions – the autonomous right to refuse medical treatment that may lead to a fatal outcome. Two references were made to the domestic law of the responding state. The first was the recognition of a ‘right to exercise a choice to die by declining to consent’ to life-prolonging treatment as laid down in English case law.⁶⁴ And the second was a reference to Lord Hope’s judgment in the House of Lords *Pretty* decision: ‘the way she [the applicant] chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask that this too must be respected.’ The Court agreed, at least indirectly. It concluded that as the applicant was prevented by law from exercising her choice to avoid what she considers to be an undignified and distressing death, it could not be excluded that an interference with her right to private life had been established.⁶⁵

⁶⁰ Para 61.

⁶¹ *Ibid.*

⁶² The Court had on previous occasions established that various aspects of an individual’s personal sphere fell within Article 8 – such as gender identification, name and sexual orientation and sexual life. See for example: *B. v. France*, judgment of 25 March 1992, Series A no. 232-C, para 63; *Burghartz v. Switzerland*, judgment of 22 February 1994, Series A no. 280-B, para 24; *Dudgeon v. the United Kingdom*, judgment of 22 October 1981, Series A no. 45, para 41.

⁶³ One case involved the freedom to partake in sado-masochistic activities – see *Laskey, Jaggard and Brown v. the UK* (App nos. 21627/93; 21628/93; 21974/93) ECHR 19 February 1997, and the other involved a decision to refuse medical treatment – *Acmanne and Others v. Belgium* (App no. 10435) Commission decision 10 December 1984. It is interesting to note that the Court did not choose to cite its own decisions on the right to refuse life-prolonging treatment, such as *Jehova’s Witnesses of Moscow and Others v. Russia*, (App no. 302/02) ECHR, paras 135-138.

⁶⁴ Para 64. The English case referred to was: *Airedale NHS Trust v. Bland* [1993] AC 789, at 864, per Lord Goff.

⁶⁵ Para 67, the precise wording by the Court was: “[t]he applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8 § 1 of the Convention.”

The Court then moved on to the next stage of its review: the assessment of whether this interference is justified in light of the second paragraph of Article 8. Given the nature and legitimate aim of the measure clearly set out by national law (to protect the lives of weak and vulnerable persons), there was understandably little hesitation in granting a wide margin of appreciation to the national authorities.⁶⁶ Agreeing with the House of Lords, the Court found that Member States are entitled to place criminal prohibitions on activities that are detrimental to the life and safety of other individuals. The more serious the harm to others, the more weight is given to considerations of public health and safety against the countervailing principle of personal autonomy. It concluded that despite potential safeguards and protective procedures, if the general prohibition was relaxed then clear risks of abuse would still remain. Moreover, the assessment of this risk is the responsibility of the State.⁶⁷ The Court explicitly referred to the likelihood of its decision going beyond the case at hand. Its reluctance to set a general precedent for abrogating the criminal bans on assisted suicide present in the vast majority of Member States was then made clear.⁶⁸

As the blanket ban in question reflects in a non-arbitrary manner the importance of the right to life and it allows for due regard to be given to each particular case,⁶⁹ it was not, according to the Court, a disproportionate measure. Furthermore, it recognised that any decision requiring the DPP, part of the executive branch of government, to give an undertaking that no prosecution would be brought raises concerns regarding the separation of powers and the rule of law. In light of all of the above reasons, the Court found no violation of Article 8.

Article 9: Freedom of Thought, Conscience and Religion – no violation

The Court rejected that firm beliefs concerning assisted suicide constitute beliefs in the sense protected by Art 9. Instead, the applicant's strong commitment to the principle of

⁶⁶ Paras 69-71.

⁶⁷ Para 74.

⁶⁸ Para 76.

⁶⁹ Ibid. According to the Court, sufficient flexibility was provided via the requirement of consent from the DPP to initiate proceedings, which is a decision made in consideration of the 'public interest' to do so or not.

autonomy in ending life was deemed a 'restatement of the complaint under Article 8 of the Convention'.⁷⁰

Article 14: Prohibition of Discrimination – no violation

As the applicant's rights under Article 8 were engaged, the Court was obliged to consider the complaint of discrimination under Article 14.⁷¹ The Court declared that a wide margin of appreciation ought to be enjoyed by national authorities in deciding differences in treatment in such circumstances.⁷² Moreover, the Court repeated its previous finding in relation to Article 8 that there is an objective and reasonable justification for not distinguishing in law between those who are and those who are not physically capable of committing suicide.⁷³ The risks of abuse and the fundamental importance of protecting the life of vulnerable persons were deemed as sound reasons (as in the case of Article 8) to find no violation of Article 14.

2. *Haas v Switzerland (2011)*⁷⁴

The applicant was suffering from bipolar affective disorder for about two decades. He failed in two attempts at suicide and stayed in psychiatric hospitals on numerous occasions. Having become a member of Dignitas⁷⁵ to receive assistance in committing suicide, he sought a prescription, as required by Swiss law, for the necessary lethal substance. However, no psychiatrist he approached would provide him with such a prescription. As a result, the applicant made a request to various official bodies⁷⁶ to grant him permission to obtain the required substance from a pharmacy without a prescription. This request was unanimously rejected, resulting in an appeal being lodged before the Swiss Federal Supreme Court. His main claim was that Article 8(1) of the ECHR guaranteed the right to choose the time and manner of one's own death and that any State interference with this right must be justified in light of Article 8(2). In his view, the Swiss

⁷⁰ Para 82.

⁷¹ Para 86.

⁷² Para 87.

⁷³ Ibid.

⁷⁴ *Haas v Switzerland* (App no. 31322/07) 20 January 2011.

⁷⁵ Right-to-die organization based in Switzerland, which assist persons in committing suicide within the limits of Swiss law. For more information on Dignitas see CHAPTERS 3 and 4 of this book.

⁷⁶The Federal Office of Justice (which stated that it did not have jurisdiction to grant his request), the Federal department of Public Health, the Health Department of the Canton of Zurich, the Federal Department of the Interior, and the Administrative Court of the Canton Zurich

law requiring a medical prescription in order to obtain the substance necessary for a dignified suicide is a disproportionate interference with his right to die *vis a vis* his right to respect for private life. All the Swiss courts he brought his case before, including the Federal Supreme Court, rejected his claim. Having exhausted all domestic remedies, he brought his claim before the ECtHR.

The Court's Assessment:

Article 8: Right to Respect for Private Life – No Violation

The Court commenced its assessment by stating that an individual's right to decide by what means and at what point his or her life will end is, in light of its case-law, one of the aspects of the right to respect for private life under Article 8.⁷⁷ It was also stated that this right is conditional on whether the individual 'is capable of freely reaching a decision on this question and acting in consequence'.⁷⁸ Leaving aside the second condition and its ambiguous meaning for now, the first condition is implied from the *Pretty* decision.⁷⁹ The facts of the case at hand were then distinguished from those in *Pretty*. According to the Court, the applicant was not just claiming a disproportionate interference with his right to determine the manner and time of his death, but moreover that the State must ensure that he can obtain a specific substance without a medical prescription in order to commit a painless and risk-free suicide. It was deemed to be a claim that would require a positive obligation on the Swiss authorities to take affirmative action to ensure the applicant had the means for a dignified suicide.⁸⁰

Immediately, the Court recognised the need for States to enjoy a wide margin of appreciation in such cases.⁸¹ It then proceeded to read the Convention 'as a whole', stating that any violation of Article 8 as claimed by the applicant requires Article 2 to be taken into account - the duty for authorities to protect vulnerable persons, even against actions by which they endanger their own lives.⁸² Moreover, the Court understood the right to life

⁷⁷ Para 51.

⁷⁸ *Ibid.*

⁷⁹ See paras 61-67 of the *Pretty* decision, where the Court set out its reasoning for finding the impugned ban on assisted suicide as an interference with the applicant's rights under Article 8(1) – namely the choice to avoid an undignified and distressing end to her life.

⁸⁰ Para 52-53.

⁸¹ *Ibid.*

⁸² Para 54.

under the Convention to 'oblige the authorities to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved.'⁸³ Noting that there was no consensus among the members of the Council of Europe with regard to an individual's right to decide the time and manner of his or her death, the Court did observe that the 'vast majority of member States seem to attach more weight to the protection of the individual's life than his or her right to terminate it'.⁸⁴ This was deemed to further support the need to grant a 'considerable margin of appreciation' to the national authorities.

The Court, in considering the balancing of interests before it, held that the impugned Swiss regulation (the requirement to obtain a medical prescription) pursues a legitimate aim of protecting persons from hasty decisions and preventing abuse. Essentially, it is designed to prevent a patient 'lacking discernment' from obtaining a lethal substance.⁸⁵ It then stated that such regulations 'are all the more necessary' in a jurisdiction (such as Switzerland) that facilitates access to assisted suicide. It stressed that the inherent risks of abuse in any system that facilitates assisted suicide must not be underestimated.⁸⁶ In this respect, the Court returned to Article 2 and followed the reasoning of the Swiss Federal Supreme Court. It stated that the right to life guaranteed by Article 2 'obliges States to establish a procedure capable of ensuring that a decision to end one's life does indeed correspond to the free will of the individual concerned.'⁸⁷ This positive procedural obligation appears to apply only to those States where domestic legislation allows 'relatively easy access' to assisted suicide. In this case, the requirement for a medical prescription as laid down by Swiss law was deemed to satisfy this positive obligation.⁸⁸ The Court concluded that 'even assuming' a positive obligation also exists under Article 8 to ensure that the applicant has the means for a dignified suicide, the Swiss authorities, particularly in light of the wide margin of appreciation enjoyed, have also not failed to comply with this duty.⁸⁹ Thus no violation of Article 8 was deemed to have occurred.

⁸³ Ibid.

⁸⁴ Para 55.

⁸⁵ Para 56.

⁸⁶ Paras 57-58.

⁸⁷ Para 58.

⁸⁸ Ibid.

⁸⁹ Paras 59-61.

3. *Koch v Germany (2012)*⁹⁰

Mrs. Koch was a quadriplegic woman who was almost completely paralyzed; she needed artificial ventilation and constant care. She also suffered from spasms. She wished to end what was, in her view, an undignified life by committing suicide with her husband's help. The Federal Institute for Drugs and Medical Devices ("the Federal Institute") refused to grant authorization for a lethal substance that would enable her to commit suicide in her home. The couple lodged an administrative appeal against this decision before the Federal Institute, but before a decision was granted, Mrs. Koch (in the company of her husband) had travelled to Switzerland to commit suicide with the assistance of Dignitas. The Federal Institute confirmed its previous decision one month later on the merits of the decision and informed Mr Koch that he had no standing to lodge an administrative appeal on behalf of his now deceased wife. Mr Koch appealed this finding before the Cologne Administrative Court, the North-Rhine Westphalia Administrative Court of Appeal, and the Federal Constitutional Court, all of whom dismissed his claim. While the Cologne Administrative Court addressed the substantive merits of his claim in *obiter dictum*, neither the Administrative Court of Appeal nor the Constitutional Court examined the merits at all. The main reason for this being that Mr Koch had failed to satisfy the procedural requirements on admissibility. In short, the German courts held that he could not rely on the posthumous rights of his wife. Mr Koch then submitted a complaint before the ECtHR that due to the refusal by the domestic courts to examine the merits of his complaint, that his right to private life under Article 8 (and his wife's right to private life) and his right to an effective remedy under Article 13 had been infringed.

Article 8 – violation of the applicant's procedural rights established

The Court had to first identify (i) whether there had been an interference with the applicant's own rights under Article 8, and if so (ii) if this interference is justified in light of Article 8(2). Then the Court had to address (iii) whether the applicant's complaint of a violation of the rights of his late wife was admissible.

In regard to (i), the Court commenced by distinguishing the claim at hand from previous similar cases before the Court. The question *in casu* was whether a relative could claim a violation of *his own* rights under Article 8, not whether a relative or heir can bring an

⁹⁰ *Koch v. Germany* (App no 497/09) ECHR 19 July 2012.

action before the Court on the deceased person's behalf.⁹¹ Nonetheless, the criteria developed in previous case law regarding the latter question were deemed worthy of relevance to help answer the former. First, the Court decided it must examine if sufficiently close family ties existed. It was satisfied that 25 years of marriage left no doubt the applicant shared a very close relationship with his late wife.⁹² Second, the Court decided it must examine if the applicant had sufficient personal or legal interest in the outcome of the proceedings. It was satisfied that this was the case as the applicant had accompanied his late wife throughout her suffering, and had accepted and supported her wish to end her life.⁹³ Third, the Court decided it must examine if the applicant had previously expressed an interest in the case. It was satisfied that was also the case as the applicant had lodged the administrative appeal jointly with his wife and pursued the domestic proceedings in his own name after her death.⁹⁴ Given the 'exceptional circumstances', it was held that Mr Koch had demonstrated a 'strong and persisting interest in the adjudication of the merits of the original motion.' According to the Court, this provided sufficient basis to support his own claim to have been 'directly affected' by the refusal to ensure his wife had access to a lethal substance.

The Court then repeated the broad notion of 'private life' regarding the individual's personal autonomy in deciding the time and manner of his or her own death,⁹⁵ as implied in *Pretty*⁹⁶ and explicitated in *Haas*.⁹⁷ It also repeated its previous finding that Article 8 encompasses a right to judicial review even in a case where the substantive right in question had yet to be established.⁹⁸ In light of all these considerations, the Court held that the Federal Institute's original decision and the proceeding domestic courts' refusal to examine the merits of the applicant's motion interfered with *his* rights under Article 8.⁹⁹ The next question was if the Federal Institute's decision and the proceeding domestic decisions were compliant with Article 8(2). The Court set out its assessment in two parts: (i) the procedural aspects of Article 8, and (ii) the substantive aspects of Article 8. Regarding the former, the Court held that the refusal by the domestic courts to examine

⁹¹ Para 43.

⁹² Para 45.

⁹³ *Ibid.*

⁹⁴ *Ibid.*

⁹⁵ Paras 51-52.

⁹⁶ See *Pretty* (n 43), para 67.

⁹⁷ See *Haas* (n 74) para 51.

⁹⁸ Para 53. See *Schneider v. Germany* (App no. 17080/07) 15 September 2011.

⁹⁹ Para 54.

the merits of the applicant's case did not serve any of the legitimate interests under paragraph 2 of said Article.¹⁰⁰ It followed that the applicant's right had been violated. Regarding the latter aspect, the Court reiterated the principle of subsidiarity and insisted that it is 'primarily up to the domestic courts to examine the merits of the applicant's claim.'¹⁰¹ As a result, the Court limited itself to only addressing the procedural aspect of Article 8 in the instant complaint.

Article 8 – Applicant's complaint of a violation of the rights of his late wife is inadmissible by virtue of Art 35(4).

The Court held that there was insufficient reasons to depart from its established case-law, whereby Article 8 was held to be "of a non-transferrable nature and could thus not be pursued by a close relative or other successor of the immediate victim."¹⁰² It thereby held that the applicant does not have legal standing to rely on his wife's rights under Article 8. In accordance with Article 34 and Article 35(4), the Court then rejected the claim of any violation of Mrs. Koch's rights under Article 8 as being inadmissible.

Article 13: right of access to a Court – not necessary to examine

In light of the Court's finding on the applicant's procedural rights under Article 8, it was deemed unnecessary to examine if there was also a violation of his rights under Article 13 or under Article 6(1).

4. *Gross v Switzerland (2014)*¹⁰³

It must be stated from the outset that the application in this case was ultimately deemed inadmissible by a majority of the Grand Chamber. This was because the applicant's conduct was deemed to constitute an abuse of the right of application within the meaning of Article 35(3)(a). In short, the applicant had committed suicide (by availing of

¹⁰⁰ Paras 65-68.

¹⁰¹ Paras 69-72.

¹⁰² Para 81.

¹⁰³ *Gross v Switzerland* (App no 67810/10) 14 May 2013 (Second Section); *Gross v Switzerland* (App no 67810/10) 30 September 2014 ECHR (Grand Chamber).

assistance) in November 2011, and this information was withheld in her application before the ECtHR. This meant that when the Second Section of the Court made its decision in 2013, it was made whilst unaware of the applicant's death. When the case and notification of the applicant's death came before the Grand Chamber, it was held that the applicant's counsel had failed to disclose information that concerned the very core of the claim at hand and there was sufficient evidence to infer that the applicant had intended to mislead the Court. Although this means that the decision handed down by the Second Section of the Court no longer stands, it is still of value to note the reasoning and decision of the Court. This analysis will only focus on this (Section of the Court) decision, as the appeal decision did not deal with the merits of the claim but exclusively with issues regarding admissibility.

The applicant was an elderly Swiss woman who had wished to end her life for many years. She was experiencing a decline in her physical and, to an extent, mental faculties. She believed that her quality of life had diminished to an unbearable degree and sought an assisted death with EXIT (a right to die organization).¹⁰⁴ However, she was unable to obtain a medical prescription for the required lethal substance as she was not deemed to be suffering from a terminal clinical illness. She submitted a request before the Health Board of the Canton of Zurich to be provided with the substance without a medical prescription. Her claim was rejected, as were her subsequent appeals before the Administrative Court of the Canton of Zurich and the Swiss Federal Supreme Court. The domestic courts held that Swiss case law had established that a doctor who provides a patient suffering from a *terminal* illness with the means to commit suicide, will not be subject to criminal liability. As the applicant did not suffer from a terminal illness, she had failed to fulfil this condition. Moreover, according to the national authorities, the prerequisite of a medical prescription for obtaining a lethal substance in order to commit suicide was deemed a measure compatible with Article 8 of the ECHR and the Swiss Constitution – it served a legitimate aim, and was proportionate in doing so. The applicant then lodged proceedings before the ECtHR that her rights under Article 8 were violated as the State had failed to provide her with the only means for a dignified and pain-free method of suicide.

¹⁰⁴ See Section 3.3., above, for more details on EXIT.

Article 8 – violation found

The Court repeated its findings in *Haas* and *Koch*: Article 8 encompasses the right for an individual to decide the time and manner of his death, provided he or she was in a position to freely form his or her own judgment and to act in consequence.¹⁰⁵ This meant according to the Court, that the applicant's wish to be provided with a lethal substance for the purpose of committing suicide fell within her rights under Article 8.¹⁰⁶ The Court then emphasized that Article 8 may also require positive obligations on the State that 'involve the adoption of measures designed to secure respect for private life in the sphere of relations between individual, including both the framework of adjudicatory and enforcement machinery protecting individuals' rights.'¹⁰⁷ The Court then distinguished the case at hand from the facts in *Haas*. Here the issue was not whether it was appropriate for the State to require a medical prescription to obtain a lethal substance, but rather if the State had failed to provide sufficiently clear guidelines defining the circumstances in which a medical practitioner *may* prescribe a lethal substance to a person in the applicant's condition (i.e. a person not suffering from a terminal illness and seeking a lethal substance to commit suicide). The question was one of procedural clarity surrounding a substantive right, not the content of the substantive right itself. In short, the Court held that as Swiss law provides for the right to obtain a lethal substance for the purposes of suicide, but does not provide sufficiently clear guidelines as to the extent of this right, it has violated the applicant's rights under Article 8.¹⁰⁸

The Court's reasoning hinged on the fact that the Swiss Criminal Code does not limit a doctor's assistance in a suicide to persons suffering from a terminal condition. It merely states that the assistor must not act out of 'selfish motives'. However, the Swiss Federal Supreme Court did limit the permissibility of a doctor's role in assisted suicide by relying on medical ethics guidelines. The fact these guidelines were provided by a non-governmental body and had not been State approved (i.e. by 'the necessary political consensus'), meant that they could not, according to the Court, have the "formal quality of law."¹⁰⁹ Thus, as the applicant faced uncertainty regarding the extent of her right, it was

¹⁰⁵ Para 59.

¹⁰⁶ Para 60.

¹⁰⁷ Para 62.

¹⁰⁸ Para 67.

¹⁰⁹ Paras 65-66.

held that her rights under Article 8 were violated. The Court then made clear that this violation was solely a result of the absence of clear and comprehensive guidelines, and by no means was the Court 'taking up a stance on the substantive content of such guidelines.'¹¹⁰

It is worth noticing that this decision was not unanimous, it was reached by a majority of four to three. The three dissenting judges considered the Federal Supreme Court's case-law to 'sufficiently and clearly' define the circumstances under which a doctor may prescribe a lethal substance to a person in the applicant's condition.¹¹¹ The medical ethics guidelines and the Federal Supreme Court's interpretation of these guidelines clearly limited the right to obtain such a prescription to persons who are, according to medical expertise, facing death 'within a matter of days or a few weeks.' Moreover, as the impugned measure is in pursuit of a legitimate aim and the national authorities enjoy a wide margin of appreciation in achieving this aim, it may be said, according to the dissenting judges, that the subsequent infringement of the applicant's rights under Article 8 is in accordance with the law and justified.

5. *Nicklinson and Lamb v the UK (2015)*¹¹²

It must be noted from the outset that the applicants' claims in this case were deemed inadmissible by the Court (Fourth Section). The first applicant was the widow of Tony Nicklinson - the applicant in the various trials unsuccessfully brought before the English courts between 2011 and 2012, seeking to strike down the ban on assisted dying (see section 4.2.1. above). His widow now claimed before the Strasbourg Court that 'the domestic courts violated her Article 8 rights and the Article 8 rights of Mr Nicklinson by refusing to determine the compatibility of section 2(1) of the Suicide Act 1961 with their right to respect for private life.'¹¹³ The second applicant was also a co-applicant with Mr Nicklinson in the cases before the English courts. As a result of his condition, he was unable to commit suicide, even with assistance. He complained that his rights under Articles 6, 8, 13 and 14 were infringed by the failure to confer on him, and others in a

¹¹⁰ Para 69.

¹¹¹ See joint Dissenting Opinion of Judges Raimondi, Jociene and Karakas. Paras 1-7.

¹¹² *Nicklinson and Lamb v the UK* (App no. 2478/15 and 1787/15) 23 June 2015.

¹¹³ *Ibid*, para 76.

similar situation, the opportunity of seeking the authority of the court (a judicial procedure) to permit a volunteer to administer lethal drugs to him, with his consent.¹¹⁴

The first applicant's claim:

The Court was satisfied that the majority of the Supreme Court in *Nicklinson* did deal with the substance of the first applicant's claim. It noted that: with the exception of Baroness Hale and Lord Kerr, the Supreme Court judges decided that developments since *Pretty* meant that the ban could no longer be considered a proportionate interference with Article 8 rights.¹¹⁵ Simply because the majority of the Supreme Court attached great significance or "very considerable weight" (see paragraph 52 above) to the views of Parliament does not mean that they failed to carry out any balancing exercise.¹¹⁶ Thus, the Court here – quite rightly – held that the English judges very much determined the compatibility of the statutory ban on AS with Article 8. Moreover, the Court rejected the argument that even had the Supreme Court *not* determined the merits of the complaint before it then the applicant's Article 8 (procedural) rights would have been violated. It held that it would be 'odd to deny domestic courts [...] the possibility of concluding that Parliament is best placed to take a decision' on assisted dying, particularly in light of its 'ethical, philosophical and social' nature.¹¹⁷ Contracting states are, according to the Court, free to determine which of the three branches of government are to be responsible for policy decisions that fall within their margin of appreciation.

The second applicant

The Court noted that Mr Lamb had only pursued his complaint about the ban on AS and not his argument that there should be a judicial procedure to authorise VAE in certain circumstances. It could not be assumed that the Supreme Court would have disposed of the argument concerning VAE in the same way as it disposed of the claim in respect of the prohibition of AS. Recalling that those who wish to complain to the ECtHR against a State

¹¹⁴ Para 77.

¹¹⁵ See *R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent); R (on the application of AM) (AP) (Respondent) v Director of Public Prosecutors (Appellant); R (on the application of AM) (AP) (Appellant) v Director of Public Prosecutors (Respondent)* [2014] UKSC 38, per Lord Neuberger at para 38 above; Lord Mance at para 40 above; Lord Wilson at para 43 above; and Lord Reed at para 52.

¹¹⁶ Para 84.

¹¹⁷ Para 84.

first have to use remedies provided for by the national legal system, the Court dismissed Mr Lamb's application as inadmissible for non-exhaustion of domestic remedies.¹¹⁸

7.2.3. A CRITIQUE OF THE ASSISTED DYING JURISPRUDENCE

(i) A Formal Theory on the Structure of a Human Right to Assisted Death

This critique follows the reasoning that it is useful to distinguish between two stages of review when trying to understand the structure of any fundamental right.¹¹⁹ In the first stage, it must be determined whether a *prima facie* right actually exists, and if so, what constitutes an interference with that right.¹²⁰ In the second stage, the validity of any justification(s) for an identifiable interference must be assessed in light of other conflicting general interests or individual interests. This is not just a useful method of judicial review but also a suitable method to evaluate the ECtHR's jurisprudence, and the structure of a right to assisted dying.¹²¹ This bifurcated approach is akin to the classic constitutional rights doctrine evident in the Netherlands,¹²² Germany¹²³ and the United States,¹²⁴ and there are a number of reasons behind its application:

- First, as Gerards and Senden argue: defining the scope of a right *per se* assists the application of general conclusions and interpretations to individual cases.¹²⁵ Faigman demonstrates this, by identifying how a bifurcated approach is simply pragmatic in understanding and weighing competing values.¹²⁶ In the first stage, the values laid down in a constitution or convention and the rights inherent are

¹¹⁸ Para 94.

¹¹⁹ A number of legal scholars and judges have endorsed this two-stage approach: see J. Gerards and H. Senden (n 29) 622; D.L. Faigman, 'Reconciling Individual Rights and Governmental Interests: Madisonian Principles versus Supreme Court Practices' 78 *Va. L. Rev.* 1521, 1552-1523; G. van der Schyff, 'Interpreting the protection guaranteed by two-stage rights in the European Convention on Human Rights' in E. Brems and J. Gerards (eds) *The Role of the European Court of Human Rights in Determining the Scope of Human Rights* (Cambridge University Press, 2014) 65-83; See also the dissenting opinion of Judge Fitzmaurice in *Marckx v. Belgium* (App no. 6833/74) 31 Eur. Ct. H.R. (ser. A).

¹²⁰ Strictly speaking, this stage involves two distinct steps itself: it first requires defining the scope of a right and then identifying an interference of that right.

¹²¹ Moreover, the bifurcated nature of fundamental rights is clearly reflected in the only Convention right (the right to respect for private life) deemed applicable by the Court in the above jurisprudence on assisted dying.

¹²² Gerards and Senden (n 29) 624.

¹²³ R. Alexy, *A Theory of Constitutional Rights* (Oxford University Press, 2002) 84-86, 180 and 199.

¹²⁴ Faigman (n 112) 1529.

¹²⁵ Gerards and Senden (n 29) 639.

¹²⁶ Faigman (n 119) 1529.

beyond the reach of majoritarian forces, such as the legislator. While in the second stage, when applying fundamental rights to a concrete case and assessing the justification of an interference, greater weight may be attached to general interests and the values emanating from majoritarian forces.

- Second, according to Alexy: a bifurcated approach allows clearer consideration to be given to both the ‘rule-like element’ of fundamental rights (such as: everyone has the right to freedom of expression), and the ‘principle-like element’ of such rights (such as: consideration must be had to any competing interests that may justify limiting one’s freedom of expression).¹²⁷ In turn, a fairer distribution of the burden of proof arises. In the ECtHR context, this is more of ‘a burden of persuasion’,¹²⁸ which should be placed on the applicant in the first stage, and then shifted to the State’s counsel in the second stage.
- Third, Lavrysen convincingly reasons that this bifurcated approach to Convention rights is also useful for determining negative and positive obligations in a ‘symmetrical’ manner.¹²⁹ This is in line with the opinion given by Judge Wildhaber (the former president of the ECtHR) in *Stjerna*.¹³⁰ In short, the first stage places the focus on the perspective of the *victim* of a human rights violation, not on the question of who is responsible for the ‘interference’ (private actors by their actions or state authorities by their actions or omissions). The perspective of those responsible and the manner of the interference should only be important in the second stage.

¹²⁷ Alexy (n 123) 84-85.

¹²⁸ See: R. Wolfrum, ‘The Taking and Assessment of Evidence by the European Court of Human Rights’ in S. Breitenmoser and others (eds) *Human Rights, Democracy and the Rule of Law* (Zurich: Dike, 2007); T. Thienel, ‘The Burden and Standard of Proof in the European Court of Human Rights’, 50 *German Yearbook of International Law* 533-54.

¹²⁹ L. Lavrysen, ‘The Scope of rights and the scope of obligations: Positive obligations’ in E. Brems and J. Gerards (eds) *The Role of the European Court of Human Rights in Determining the Scope of Human Rights* (Cambridge University Press, 2014).

¹³⁰ *Stjerna v. Finland* (App no. 18131/91) ECHR 25 November 1994. This approach to merging negative and positive obligations under the notion of interference has attracted academic support: See P. Van Dijk, ‘“Positive Obligations” Implied in the European Convention on Human Rights: Are the States Still the “Masters” of the Convention?’ in M. Castermans-Holleman and others (eds), *The Role of the Nation-State in the 21st Century Essays in Honour of Peter Baehr* (The Hague: Kluwer Law International, 1998) 25; F. Sudre, ‘Les “Obligations Positives” dans la Jurisprudence Européenne des Droits de l’Homme’ in P. Mahoney and others (eds) *Protecting Human Rights: The European Perspective: Studies in Memory of Rolv Ryssdal* (Koln: Carl Heymanns Verlag, 2000) 1359-1376.

- Fourth and continuing on from the above argument, the line between negative and positive rights is somewhat blurred when specifically seeking to define a *human right to assisted dying*. This statement requires a brief description of traditional typologies of rights (as seminally set out by Hohfeld)¹³¹ and traditional typologies of rights explicitly in relation to assisted suicide (as seminally set out by Battin).¹³² As suicide is neither criminally or civilly sanctioned in the member states of the Council of Europe, individuals across Europe may be said to have what Hohfeld would term a ‘privilege’ to commit suicide, or according to Battin a ‘liberty right’ to commit suicide. In other words, there is no law with respect to which the holder of the privilege is required *not* to commit suicide.¹³³ However, the kind of right the applicants argued for in the above cases is what Hohfeld would describe as a ‘claim right’. This may be either a *negative* claim right or a *positive* claim right. Which one of these two the applicants argued for above is less clear. From Battin’s perspective, the latter (positive claim) right may be termed as a ‘welfare right’ to assisted suicide. This type of right places a duty on the part of others to assist an individual to commit suicide. The former (negative claim) right is what Battin labels a ‘non-interference’ right to assisted suicide. This is traditionally understood to place a duty on others not to interfere with an act of assisted suicide. Arguably, a more holistic understanding of the issue requires an appreciation of both ‘negative’ and ‘positive’ aspects of the *prima facie* right to assisted suicide. In other words, once the argument made by many proponents for the ‘non-interference right’ are broken down, it appears they are, in effect, advocating for a more mixed-type of right: the individual must be free to choose assistance in dying (negative claim right under Article 8) but in order to ensure this choice is free and to make this free choice effective, certain affirmative measures and safeguards must be

¹³¹ W. Hohfeld, ‘Some Fundamental Legal Conceptions as Applied in Judicial Reasoning’ *Yale Law Journal* 16(1913). See P. Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007) 17, whereby attention is had to other typologies that exist. It is deemed unnecessary to focus on these here: I. Berlin, ‘Two Concepts of Liberty’ in *Four Essays on Liberty* (Oxford University Press, 1969) 118, 121-122 (distinguishing between positive and negative rights); H.L.A. Hart, ‘Are There Are Natural Rights?’ (1995) 64 *Phil. Rev.* 175 (distinguishing between general and special rights).

¹³² M. Battin, *Ethical Issues in Suicide* (Englewood Cliffs, N.J.: Prentice-Hall, 1995) 184-185. See Lewis (n 131) 17, whereby attention is had to other typologies that exist.

¹³³ See for a brief mention of the type of assisted suicide right made before the Irish Supreme Court, also with reference to Hohfeld: D. Clarke, ‘Assisted Suicide after Fleming’, *Irish Law Times* (2013).

implemented (the latter is a type of positive claim right: it may be defined as a self-standing substantive one under Article 2 or as a necessary procedural one under Article 8).

In light of all the reasons above, a bifurcated formal theory concerning the structure of fundamental rights in favour of a symmetrical approach (at least at the first-stage of review) to negative and positive obligations is favoured herein. Moreover, such an approach demands an answer to the following preliminary, seemingly straightforward, question: did the ECtHR actually recognize any *prima facie* right to assisted dying under the Convention?

(ii) A Prima Facie Right to Assisted Dying Under the Convention?

In *Pretty*, the Court correctly avoided making the question of justifying a measure part of the determination of the scope of a right. However, it was also reluctant to out-and-out recognize a *prima facie* Convention right to assisted dying. As the applicant was ‘prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end her to her life’, the Court was ‘not prepared to exclude’ that this ‘constitutes an interference with her right to respect for private life as guaranteed under Article 8(1).’ There is one issue that has not been given sufficient attention in the critique of this judgment and must be clarified. The Court’s statement ‘not prepared to exclude’ is logically equivalent (by means of double negation) to stating it is *prepared to include*. This was, at best, merely a semantic tactic by the Court to disguise its finding, which is quite simply that exercising the choice to avoid an undignified and distressing death was deemed to fall within the scope of Article 8(1). The Court’s language suggested that it had a *prima facie* negative right in mind, but this does not necessarily rule out that a positive procedural right was implied therein to make this free choice effective. Leaving this ambiguity aside for now, attention must be paid to how the Court interpreted the choice to avoid a subjectively undignified and distressing end to life as a choice protected by the right to respect for private life.

Central to the Court’s decision was its interpretation of the basic aim of the Convention: stating, its ‘very essence [...] is respect for human dignity and human freedom.’ Perhaps

anticipating criticism from the majority of national authorities and vocal pro-life supporters, the Court attempted to depict a compromising stance. First, it declared that the principle of the 'sanctity of life' is protected under Article 2 of the Convention, but without any attempt to clarify what it meant by the word 'sanctity', it preceded to state that making 'quality of life' considerations under Article 8 does not negate this principle. This reasoning was supported by referring to the growing age of medicalization, fears of advanced physical and mental 'decrepitude' and the undermining of 'strongly held views of self and personal identity.' The Court's notion of *the sanctity of life* here seems to accord with Leenen's understanding of *respect for life*, meaning: 'respect for humanness in all its aspects, thus also for the autonomy of the person and human dignity.'¹³⁴ Moreover, the Court exercised some cosmopolitan flare by referring to a majority opinion of the Canadian Supreme Court to add further support to its finding. The prohibition on assisted suicide under Canadian law was deemed to deprive the concerned individual of her autonomy protected under the Canadian Charter, and thereby required justification.

In following their Canadian Supreme Court colleagues, the ECtHR's wide interpretation of conduct *prima facie* protected under the substantive notion of 'private life' should not be taken for granted. It was a brave move considering the anti-assisted suicide sentiment evident in the criminal policies in the majority of Council of Europe states. Although the Court's method of interpretation here was evolutive and teleological, it was not strictly autonomous. On the one hand, it focused on the need to consider 'notions of quality of life' and the spirit of the Convention to protect human dignity and human freedom in light of present day realities: 'an era of growing medial sophistication combined with longer life expectancies.' On the other hand, it took inspiration from the recognition of a right 'to exercise a choice to die' under English case law. And it followed its own case-law by restating that the right to respect for private life includes a right to engage in potentially fatal self-harm. This interpretative approach avoided any 'pre-mature balancing.'¹³⁵ In other words, (and as evident from the remainder of the Court's judgment) this wide finding of a *prima facie* right under the first paragraph of Article 8 did not result in

¹³⁴ H. Leenen, *Handboekgezondheidsrecht. Deel I; Rechten van mensen in de gezondheidszorg [Handbook of Health Law. Volume I: Individual Rights in the Context of Medical Care]*, (3rd edn, Alphen aid Rijn: Samsom H.D. Tjeenk Willink) 261.

¹³⁵ Lavrysen (n 129) 168.

prejudging the *definitive* protection of such a right. The latter was always dependent on the next stage of the Court's analysis in light of the second paragraph of Article 8.

Puppnick and de la Hogue describe what the court recognised in *Pretty* not as a 'right' to assisted suicide but rather as a specific 'quality of personal freedom', a choice to avail of assisted suicide.¹³⁶ This description is both theoretically and practically unnecessary. If it is not a right but merely a personal freedom, in Hohfeld's language a 'privilege', in Battin's language a 'liberty', this means that the applicant has no claim under Article 8 (positive or negative) against the State. Although the Court did not directly assert that Article 8 encompasses a right to assisted suicide in the first stage of review, it did explicitly refuse to exclude that said Article encompassed the right claimed *in casu* – the right to choose to avoid an undignified and distressing end to life. The Court then continued with the second stage of review, explicitly subjecting the English criminal ban on assisted suicide to a legitimacy test as it interfered 'with the exercise of an Article 8 *right*' (emphasis added). There is no benefit to claiming that this is merely a 'personal freedom' to choose assisted suicide. In effect, *Pretty* sets out (admittedly, in a less than obvious manner) that Article 8 encapsulates a *prima facie* legal right to choose to avoid an undignified and distressing end to life. Moreover, and quite importantly, the Court's language did not specifically limit the general protective scope of Article 8 in this respect to decisions of assisted suicide. The scope of Article 8(1) identified in *Pretty* is broad enough to include other means to exercise the right to choose to avoid an undignified and distressing end to life – such as voluntary active euthanasia.

As for this second stage of review in *Pretty*, the Court recognised that there was no qualms about the legitimacy of the aim (to safeguard life and protect the rights of others) pursued by the interference with the applicant's right. Quite rightly, the Court recognised the issue at hand was the *necessity* of the measure in pursuit of that legitimate aim. Given the wide margin of appreciation, the serious risks involved in relaxing the general prohibition on assisted suicide, and the inevitability of the Court's judgment setting a precedent beyond the case at hand, it was concluded that no violation of Article 8(2) could be declared. This finding is hard to criticize. The Court was aware of the potential Pandora's box it would open if it found a criminal blanket ban on assisted suicide to be in violation of the

¹³⁶ G. Puppnick and C. de la Hogue, 'The "Right" to Assisted Suicide in the case law of the European Court of Human Rights' (2014) 18(7-8) *The International Journal of Human Rights* 735-755.

Convention. It would, in effect, be a finding capable of invocation by individuals to challenge the necessity of criminal bans on assisted suicide in 38 of the 42 Council's Member States. Given the complexity of devising a control framework to replace the criminal bans and the disparity among the Member States in terms of their ability to put such a framework into action, the Court quite reasonably could not risk declaring the ban *in casu* to be a violation of Article 8.

Nonetheless, in reaching this position it arguably did not need to rubberstamp the compatibility of the impugned English measure with the Convention's norms. As evident from the comparative analysis in **CHAPTER 5**, one may well question the conclusion that the English ban on assisted suicide is, as the Court concluded, 'fair' or 'proper' in the interests of retribution and deterrence. The Court could have concluded that no violation was found due to the pressing need to grant a wide margin of appreciation, without making any statement on the merits (favourable or not) of the English ban on assisted suicide. Indeed, to do so would have been more consistent with its insistence on institutional appropriateness. Despite this and the unwillingness to explicitly identify what it included under Article 8 - a *prima facie* right to choose to avoid an undignified and distressing end to life - the Court's decision in *Pretty* is somewhat commendable.

Less praise may be given to the next case before the Court involving a claim right to assisted suicide. In *Haas*, the Court did not take a bifurcated approach and added more confusion than clarity regarding what type of right to assisted dying is protected under the Convention. It confirmed what was implied and logically discernible in *Pretty*: an individual has 'a right' under Article 8 'to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question.' But then it added a condition to this right. The individual must also be 'capable of [...] acting in consequence' - a phrase taken directly from the Swiss Federal Supreme Court's judgment against the applicant. It is not clear (in either the English or French versions) as to what the ECtHR or the Swiss Court meant by this. It may have meant that the individual has a right to decide the means and point his or her life will end conditional upon his or her *physical* capability to take the final act alone, i.e. excluding any right to decide to avail of voluntary active euthanasia. However, the wording: a right to decide by what means and at what point one's own life will end, 'provided he or she is capable of freely reaching a decision on this question *and acting in consequence*' (emphasis added)

does not lend itself to that meaning exclusively and without any further clarification by the Court, one may be reluctant to accept this meaning.¹³⁷ This is especially in light of its discriminatory nature. Such an interpretation would mean the very existence of a *prima facie* human right to freely decide the time and manner of one's own death is dependent on one's physical capability.

Satisfied with this summary of its own case-law, the Court focused on the specifics of the case before it. It clarified that the applicant's legal claim at hand is distinct from the one raised in *Pretty*. According to the Court, Mr Haas's complaint 'does not concern the freedom to die'. It stated that the applicant sought a positive claim right *via* Article 8 that the State is obliged to help him commit a pain-free, dignified suicide. In order to determine the existence of such a right, the Court did not recognize the distinction between defining the scope of a right under the first paragraph of Article 8 and examining the justification under the second paragraph. Instead, it merged elements typical of the second stage of review: (a) the margin of appreciation afforded to national authorities and (b) the fair balance test, with elements typical of the first stage of review: (c) methods of interpreting the protective scope of Convention rights. Moreover, in its final reasoning, the Court was unwilling to definitely state what type of right the applicant *in casu* actually had under the Convention.

Closer attention must be paid to this mixed approach by the Court. In relation to (a), it reasoned that given the nature of the issue, the interests at stake, and the lack of consensus among the Member States on how to balance these interests,¹³⁸ a wide margin of appreciation should be enjoyed by the national authorities. In relation to (c), the Court reiterated the need to 'read the convention as a whole', which means taking due account of Article 2 and the duty therein to protect vulnerable persons, even against actions by which they endanger their own lives. This led the Court to reason that Article 2 requires

¹³⁷ For example, one may conclude that words: a right to decide by what means and at what point one's own life will end, 'provided he or she is capable of freely reaching a decision on this question and *acting in consequence*' means that one has a right provided he or she is capable of freely deciding to end one's own life and capable of acting without *any* assistance. This would mean that the Court in *Haas* has merely recognised a liberty right to commit suicide and no more, thus limiting the *prima facie* right recognised in *Pretty* and contradicting its reliance on that decision. This interpretation is only unlikely as the remainder of the judgment implies no such intention to limit the Court's decision in *Pretty*. But it is an interpretation that alludes to how open-ended and ambiguous the condition laid down by the Court is.

¹³⁸ This conclusion is questionable given the same approach to balancing these interests is taken by the overwhelming majority of member States to the Convention, i.e. the protection of the right to life outweighs the patient's self-determination.

national authorities to take affirmative measures to prevent an individual committing suicide *if* the decision was not a wholly autonomous one. In relation to (b) the Court stated it was sympathetic to the applicant's claim for a safe and dignified suicide, however, as the impugned Swiss measure was aimed at preventing patients who lack 'discernment' from obtaining the means to commit suicide, it was clearly in pursuit of a legitimate aim. The Court then turned to the specifics of the case at hand and the 'liberal' Swiss regime that allows for 'relatively easy access to assisted suicide.' In respect of such regimes, the Court insisted that the State was obliged under Article 2 to 'establish a procedure' that ensures a decision to commit suicide is an act of individual free will. This is arguably a departure from the Court's staunch reasoning in *Pretty* regard the scope of Article 2, which it stated is 'unconcerned [...] with what a person does 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.'

Having nebulously combined considerations traditionally from the first and second stage of review, the Court concluded that 'even assuming that the States have a positive obligation to adopt measures to facilitate the act of suicide with dignity, the Swiss authorities have not failed to comply with the obligation'. There are a number of consequences that result from the Court's approach here. It must be said that however problematic these consequences are in themselves, they do not necessarily mean that the ultimate decision by the Court in not finding a violation of Article 8 is incorrect. The Swiss law had (and indeed still has) a legitimate aim and given the interests at stake, a wide margin of appreciation was to be reasonably expected - albeit expected preferably at the justificatory stage of review, not at the definition stage.

This however cannot take away from the unsoundness of the Court's reasoning on a deeper level. First, the Court developed the right to decide for assisted dying under Article 8 so as to explicitly include (i) the self-evident condition in *Pretty* that such a decision is an autonomous one *and* (ii) the ambiguous condition that the individual 'is capable of [...] acting in consequence'. This latter condition, as explained above, without any further explanation as to its meaning only adds uncertainty to the scope of the right. This uncertainty should not be downplayed. It calls into question the very authority of the Court's development of the right to assisted dying for future adjudicatory purposes and policy making by national authorities. Second, the Court failed to take the opportunity to

explicitly develop positive obligations inherent in the negative obligation implicitly recognised in *Pretty*.¹³⁹ The applicant's claim in *Haas*, according to the Court, 'did not concern the freedom to die.' This reasoning may be questioned. It may be argued that the applicant's claim did concern the freedom to die; it was a variation of the 'freedom to die'. Third, having attempted to answer the question of a positive obligation by mixing the elements of the first and second stages of review, the Court failed to give a concrete answer. It ultimately assessed the impugned Swiss measure on the 'assumption' that some form of positive obligation exists. Such indecisiveness again results in a lack of guidance for national courts as to the general scope and meaning of Article 8 in such cases. This is inexcusable for a Court that claims to be the final authority of human rights protection in Europe.

Arguably the decision in *Haas* could have been clearer if the Court had adopted Lavrysen's model for determining the scope of rights and obligations under the Convention. This model, as laid out below,¹⁴⁰ takes the bifurcated nature of human rights seriously and treats the examination of positive and negative obligations as symmetrical, at least at the first stage of review.¹⁴¹ It is purported here that by applying this model the Court could have delivered a more generally applicable, structured decision, whilst still reaching the same outcome in the concrete case at hand. Such an approach would have required the following two stages of review to be taken:

Stage One: Does the applicant have a protected interest and, if so, what is the scope of the infringement? To answer this, the Court could have **(i)** clarified the *Pretty* decision: repeat (as it did) that the respect for private life under Article 8 includes a right to choose to avoid an undignified and distressing end to life. It did not need to create any extra ambiguous conditions, such as 'capability of acting in consequence'; **(ii)** restated its own established jurisprudence that there may not only be negative obligations but also certain

¹³⁹ Based on the principle of effectiveness, and Article 1 of the Convention: The Court could have recognized that the State must take some procedural measures to ensure the individual's decision to die *is* an autonomous one, and on this basis not to be further interfered with.

¹⁴⁰ It is important to point out, as indeed Lavrysen does, that this model is not based on a normative theory concerning the necessary level of human rights protection, but a formal theory concerning the structure of human rights.

¹⁴¹ In the second stage of review, more weight may be given to the State's arguments to justify an inaction (justify the failure to fulfil a positive obligation) than their arguments to justify an action (failure to fulfil a negative obligation).

positive obligations inherent in an effective 'respect' for private life;¹⁴² **(iii)** recognised that the choice to use a particular lethal substance constitutes part of the right to decide the manner of one's own death, and therefore constitutes protected conduct under the right to private life;¹⁴³ and **(iv)** determined if there was first a factual disturbance or interference¹⁴⁴ with the protected conduct, and then determined the nature of the interference.¹⁴⁵

Clearly Swiss rules requiring a medical prescription to obtain the desired lethal substance and the subsequent refusal by Swiss authorities to make an exception in the applicant's case interfered with the applicant's protected conduct. His choice to obtain a particular substance for a pain-free suicide was nullified. Moreover, it may be said that the interference in this case is first caused by an action (the formulation of rules preventing access to a lethal substance without a medical prescription) and then by an inaction (the refusal to make an exception for persons in the applicant's condition, 'by way of derogation' to said rules). Having considered these steps, the Court could have therefore concluded: that (i) a *prima facie* negative obligation is incumbent on the State to rectify the initial interference. In other words: the Swiss authorities must justify, in the second stage of review, the active interference with the applicant's rights (an interference brought about by the formulation of rules that limit access to a lethal substance); and that (ii) a *prima facie* positive obligation may be incumbent on the State, if the *prima facie* negative obligation does not become a *definitive* one. In other words, if the Swiss arguments in favour of the rule requiring medical prescriptions to obtain a lethal

¹⁴² These obligations may involve the adoption of a regulatory framework or adjudicatory and enforcement machinery to secure respect for private life in the sphere of relations between individuals. See among other authorities, *X and Y v. The Netherlands*, 26 March 1985, 23, Series A, no. 91; and *Tysiack v. Poland* (App no. 5410/03) 110 ECHR 2007-I.

¹⁴³ As the Court in *Pretty* (para 67) had already provided a wide interpretation of 'protected conduct' under Article 8 (i.e. it protects the choice to avoid what an individual considers will be an undignified and distressing death) – it would not be inconsistent with this interpretation to conclude that the choice to obtain a lethal substance for a pain-free suicide is therefore protected conduct under Article 8.

¹⁴⁴ Interference here is understood as: 'a state of affairs, be it occasioned by an action or an inaction which causes the exercise of the protected conduct and interests of a right to be impaired or hindered.' See G. Van der Schyff, *Limitation of Rights* (Nijmegen: Wolf Legal Publishers, 2005) 31.

¹⁴⁵ In other words, the Court did not need, as it did from the outset, 'to consider it appropriate to examine the applicant's request [...] from the perspective of a positive obligation on the state to take the necessary measures to permit a dignified suicide.' Instead, it could have merely identified if there was an interference with the applicant's protected conduct, and then identify if it was an action and/or an inaction by the state that was the cause of this interference. See Lavrysen in his critique of the *Botta v Italy* decision: in the first stage of review, 'the Court should focus on the relationship between the situation and an applicant's private life, rather than on the relationship between the requested measures and his or her private life.' (n 129) 176.

substance succeed, it still has to justify its passive interference with the applicant's rights (an interference brought about by not granting an exemption to persons in his condition).

Stage Two: Here, two main questions arise. Is the State's action justifiable? And if so, is the State's inaction also justifiable? To answer both these questions, the Court could have applied three traditional evaluative steps of justification. This means applying **(i)** 'the legality test': here, it may be said that the decision by the Swiss authorities to limit the ability to obtain a lethal substance (action) and the decision to refuse to make an exception to this in the applicant's case (inaction) are both in accordance with accessible and precise law;¹⁴⁶ **(ii)** 'the legitimacy test': it is also clear that both the Swiss authorities actions and inactions are based on manifestly legitimate aims in accordance with Article 8(2);¹⁴⁷ and **(iii)** 'the proportionality/fair balance test': generally, the application of this test in cases involving State inactions is more lenient than in cases involving State actions. This is because finding a violation by a particular inaction involves not only the balancing of competing substantive principles, but also competing formal principles to discharge the *definite* positive obligation. As for the 'proportionality test' in *Haas*, both the Swiss authorities action¹⁴⁸ and inaction¹⁴⁹ are straightforward to justify as 'necessary in a democratic society.' Given the sensitivity of the conflicting principles and in light of the wide margin of appreciation national authorities enjoy in resolving such a conflict, the Court could readily have found no violation of either the *prima facie* negative obligation or the *prima facie* positive obligation that arise under Article 8.

This approach would have allowed the Court in *Haas* to clarify the scope of Article 8. Moreover, we can see that applying a bifurcated approach to positive obligations that may arise from a right to assisted dying avoids the pitfalls of distorting the burden of proof, of premature balancing and of introducing counter-majoritarian values in determining the

¹⁴⁶ Section 24 and 26 of the Therapeutic Products Act, in conjunction with the Federal Drugs Act, further defined by the Swiss Academy of Medical Sciences and the Federal Supreme Court's case-law.

¹⁴⁷ The requirement of a medical justification is to protect persons from making hasty decisions, to prevent abuse and to ensure that a person lacking the ability to understand the consequences of his or her action does not obtain a lethal substance to commit suicide.

¹⁴⁸ The requirement of a medical prescription before obtaining a lethal substance is proportionate to maintain public health and safety, and to prevent crime. As the Swiss Federal Court stated: '[a] substance which, when ingested, leads to death, cannot simply be dispensed by a pharmacist without any knowledge of the circumstances of the case: in the patient's best interests, provision of such a substance must be subject to the presentation of a medical prescription.'

¹⁴⁹ The refusal to grant a case-by-case exemption for patients (non-terminally ill, psychiatric or otherwise) to obtain a lethal substance without a prescription may also be readily seen as proportionate to maintain public health and safety, and to prevent crime.

very existence of that right. These are pitfalls that the Court in *Haas*, by taking a mix and match form of review, arguably, did not avoid. Moreover, accusations that the bifurcated approach to positive obligations would have resulted in an open-ended variety of obligations incumbent on the state to assist in a person's death must be put into context. This is only true as far as *prima facie* obligations are concerned,¹⁵⁰ the second stage of review (taking into account all things considered) could have substantially filtered out - as evident from above - the recognition of any *definitive* positive obligation to assisted dying.

The next two decisions made by the Court, in *Koch v Germany* and *Gross v Switzerland*, are also of limited value in clarifying the type of right to assisted dying protected under the Convention. In *Koch*, the Court refused to examine the merits of the German ban on assisted suicide and focused only on the admissibility of the applicant's claim to be fully heard by the German Courts. In considering if the applicant's procedural rights under Article 8 were interfered with by the refusal to examine the merits of his motion, the Court made reference, among other things,¹⁵¹ to the findings in *Pretty*¹⁵² and *Haas*¹⁵³ as to what choices fall within the protection of Article 8. Essentially, the Court restated the current jurisprudence on the substantive aspect of Article 8. In *Gross*, the decision by the Second

¹⁵⁰ Again, this is not *per se* a bad thing. As Alexy points out a narrow interpretation of *prima facie* obligations (positive or negative) results in premature balancing that do not respect the necessary structure of reason and counter-reason, and render the relevant limiting reasons superfluous. See Alexy (n 123) 206. Of course, this does not necessarily mean that the applicant can claim that any conduct whatsoever falls within the protective scope of a right. For example, an applicant who argues that 'jumping in front of a train' is defined as conduct protected by 'the right to choose the time and manner of his/her death' may fail at the first stage of review. In other words, the Court could apply traditional methods of constitutional interpretation (textual, historical, teleological or purposive, structural or systematic) to readily find that such conduct has nothing to do with the kind of rights that are protected by the European Convention on Human Rights. As Gerards and Senden state '[no] actual balancing exercise is required if notions such as "expression" or "private life" are defined with reference to the text of the Convention or with reference to its underlying principles and guiding values.' See Gerards and Senden (n 29).

¹⁵¹ Namely how the criteria developed in previous case-law for allowing a relative to bring an action on the deceased person's behalf are of relevance to a relative bringing an action that a violation of his own rights under Article 8 has occurred.

¹⁵² See para 51: where it stated, that the court in *Pretty* was "not prepared to exclude" that preventing the applicant by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life constituted an interference with her right to respect for private life as guaranteed under Article 8(1) of the Convention.

¹⁵³ See para 52: where it stated, that the Court in *Haas* (para 51) developed the decision in *Pretty* by "acknowledging that an individual's right to decide in which way and at which time his or her life should end provided that he or she was in a position freely to form her own will and to act accordingly, was one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention." The Court in *Koch* also reiterated para 61 of the *Haas* judgment: "Even assuming that the State was under an obligation to adopt measures facilitating a dignified suicide, the Court considered, however, that the Swiss authorities had not violated this obligation in the circumstances of that specific case".

Section of the Court is of no formal authority, but is certainly of interest. The Court, like in *Haas*, did not distinguish between the first stage of review and the second stage of review. From its reading of *Pretty*, *Haas* and *Koch*, the Court considered that the applicant's choice to be provided with a particular substance in order to commit suicide fell within the scope of her right to respect for her private life under Article 8. In addition, it observed that 'positive obligations' to adopt a 'regulatory framework' may be 'inherent in an effective respect for private life'. The Court then turned its attention to what it deemed the primary question in the case at hand: did the State fail to provide sufficiently clear guidelines defining if, and under what circumstances, a doctor may prescribe a lethal substance for the suicide of non-terminally ill patients? It insisted that the issue was not about the substantive content of the guidelines. By a majority of four to three, it was decided that the Swiss guidelines were not 'comprehensive' and 'clear' enough. This was due to the fact that said guidelines did not stem from a legislative decision. As they were issued by the Swiss Academy of Medical Science (SAMS), the Court concluded they did 'not have the formal quality of law.'

There is a number of problems here. First, the majority's decision seems to run counter to the Court's own case-law whereby a norm can be regarded as having the formal quality of law provided it is adequately accessible and formulated with sufficient precision.¹⁵⁴ Agreement is had here with the three dissenting judges that the medical professional guidelines were sufficiently accessible and foreseeable to enable patients and physicians to regulate their conduct, and do therefore possess the formal quality of law – (i) they clearly define that the presence of a terminal illness is a pre-condition for obtaining the lethal substance, and moreover (ii) they were State-approved by the highest judicial body. Second, the Court failed to clear up the ambiguity about the general scope of *prima facie* positive obligations on Member States to ensure individuals can efficiently exercise the choice to a dignified death. Instead, it appeared to place a positive obligation (to have a clear "regulatory framework" in place) only on States that do not entirely ban access (at least not formerly speaking and in an *ex post* manner) to assisted suicide.¹⁵⁵ In any case,

¹⁵⁴ See for example *Leander v. Sweden* (App no. 9248/81) ECHR 26 March 1987, para 51; *Hertel v. Switzerland* (App no. 25181/94) ECHR 25 August 1998, para 35; *Rotaru v. Romania* (App no. 28341/95) 4 May 2000, para 55.

¹⁵⁵ This is a similar approach taken by the Court in the abortion cases involving Ireland and Poland, whereby positive procedural obligations were found without making any judgment on the substantive merits of the right in question.

it must be restated that this decision is not binding since the Grand Chamber of the Court found the entire claim inadmissible on the basis of an abuse of individual application.

7.2.4. CONCLUSIONS

The ECtHR is open to criticism for the lack of clarity that its jurisprudence on assisted dying demonstrates. *Pretty, Haas, Koch* and *Gross*¹⁵⁶ are innovative decisions but stop short of being convincing because of what the Court seems to be suggesting, but not clearly saying. The acceptance that Article 8 protects the right to make subjective end of life decisions, was followed by statements and decisions that posed more questions than they solved. This uncertainty has left commentators¹⁵⁷ and national authorities¹⁵⁸ to interpret this important jurisprudence in different ways. In short, if the Court, as Stone Sweet and Keller suggest is ‘the unrivalled master of the Convention, a posture it uses to construct the European fundamental rights in a prospective and progressive way’¹⁵⁹ then it has fallen somewhat short of these standards in the assisted dying cases.

The greatest point of confusion created by the case law is the existence and scope of a positive obligation on states. If one agrees with Shue that ‘taking rights seriously means taking duties seriously’,¹⁶⁰ then the confusion demonstrated by the Court should not be taken lightly. The Court, particularly in *Haas*, was directly confronted with this issue and presented with the chance to take the question of duties in the context of assisted dying seriously. It followed the traditional approach to determine the existence of a positive obligation by a ‘fair balance test’. As Forder, Xenos and Levrysen, amongst others, have noted: this approach leads to general uncertainty and unpredictability.¹⁶¹ The Court’s

¹⁵⁶ At least the Second Section judgment of May 2013 that never became final, not the Grand Chamber judgment of September 2014.

¹⁵⁷ Compare for example the different conclusions on the right to assisted suicide as set out in the above jurisprudence by Puppincck and de la Hougue (n 136) and J. Dorscheidt, ‘Euthanasia and Physician Assisted Suicide from a Human Rights Perspective’ in B. Toebes, M. Hartlev, A. Hendriks and J. Rothmar Hermann (eds.), *Health and Human Rights in Europe* (Intersentia, 2012) 177-209.

¹⁵⁸ Compare for example the English High Court’s interpretation of this case-law in *Purdy* with the House of Lords interpretation upon hearing the appeal of said decision. Also, see the German government’s declared uncertainty of the Court’s decision in *Pretty* and *Haas*, as set out in their response to the claimant in the *Koch* decision (para 33).

¹⁵⁹ Stone Sweet and Keller (n 18) 7.

¹⁶⁰ H. Shue, *Basic Rights: Subsistence, Affluence and the U.S. Foreign Policy* (2nd edn, Princeton University Press, 1996) 167.

¹⁶¹ See C. Forder, ‘Legal Protection under Article 8 ECHR: Marckx and Beyond’ (1990) 37(2) *NILR* 162-181, 179; D. Xenos, *The Positive Obligations of the state under the European Convention of Human Rights* (Routledge, 2012) 60; L. Lavrysen, ‘The scope of rights and the scope of obligations: Positive obligations’ in

approach failed to concretely determine the existence of a positive obligation to assisted dying – it would, in the end, only ‘assume’ one to exist.

The consequences are unfortunate. Although the court’s power to give binding judgments is, strictly speaking, limited to the concrete circumstance of the case, the reality in practice is that the Court’s case law - not just its application of fundamental rights but its argumentative strategies and procedural methods - reaches beyond the case at hand. Part of the Court’s supervisory position requires it to provide guidance to national authorities in an authoritative manner. As stated in Section 7.2.1., the Courts primary mode of governance – its body of case-law – depends on this type of functional legitimacy. The failure to provide a clear decision in the cases above and definitively state the *prima facie* scope of a right to assisted dying under the Convention increases the likelihood of repetitive individual applications finding their way to Strasbourg on the issue. This means that individuals are likely to get entangled in long legal disputes at high costs (financial and psychological) and that the Court’s already enormous caseload will be further increased.

On the particular point of methodology in judicial review, by taking into account ‘public interests’ at the stage of *defining* the very scope of a right to assisted dying is unjustly detrimental to the individual applicant. As Faigman points out,¹⁶² failing to clearly divide the burden of persuasion means the applicant must refute the public interests to merely render his or her human rights under the Convention applicable. Given the strength and sensitivity of the public interests to limit acts of assisted dying, the burden on the individual applicants is acutely high. This means the margin of appreciation, which is classically a fundamental part of the second stage proportionality test, is arbitrarily elevated to autonomous status and operates independently from the purpose for which it was devised.¹⁶³ Furthermore, it is reasonable that the Court places some weight on the existence of consensus (or lack thereof) on legal policies related to assisted dying. But it is less reasonable to argue that the very existence of a *prima facie* right to assisted dying is dependent on the consensus (or lack thereof) within the Council of Europe. The

E. Brems and J. Gerards, *Shaping Rights in the ECHR: The Role of the European court of Human Rights in Determining the Scope of Human Rights* (Cambridge University Press, 2014) 166.

¹⁶² The applicant bears burden of persuasion in the first stage of review to show the applicability of a fundamental right, and the state bears the burden in the second stage of review to show that its interests justify an interference with this right. For more on this, see Section 4.1.4 above.

¹⁶³ See Xenos (n 154).

definition of the right under the Convention is either universal or not. In this respect, there is no reason as to why national authorities are better placed to define the very scope of a fundamental right and absolve the Court of its final authority to interpret the Convention.

All things considered, it is nonetheless possible to make some *tentative* assertions on what type of right to assisted dying exists under the Convention. First, Article 8 of the Convention appears to encapsulate the right for each individual to exercise his or her choice (leaving aside the unclear condition of capability 'to act in consequence' of that choice) in the manner and time of his or her death. This protected choice includes the choice to avail of assistance in ending one's life. Second, national authorities will enjoy a wide margin of appreciation in justifying limitations on that right. And third, however problematic in light of the formal theory of the structure of human rights argued above, only Member States that permit access to assisted dying appear to have a positive obligation stemming from Article 2 to ensure that the procedural guidelines in place are sufficiently clear and that a decision to seek assistance in ending one's life is an autonomous one.

As for broader conclusions on judicial governance *vis à vis* the ECtHR, it is clear that the moral and political sensitivity of the issue at hand played a key role in the above jurisprudence. This is not unexpected, nor is it necessarily a point of criticism. The complexity in balancing the substantive and procedural principles surrounding an act of assisted dying (once a *prima facie* right has been established) demands that national authorities enjoy a suitable margin of appreciation. In this sense, European judicial governance through human rights law encounters its political limitations. However, this cannot amount to a defence for the confusing argumentative methods set out by the Court (particularly in the *Haas* decision). In short, the ECtHR could have followed the classic constitutional rights doctrine visible in Germany, the Netherlands, and the U.S. – i.e. apply a clear bifurcated approach treating positive and negative obligations symmetrically. This would have allowed it to explicitly and clearly state what it appeared to be suggesting – that there is a wide *prima facie* (negative and positive) right to decide for assisted dying capable of restriction in light of a legality, legitimacy and a fair balance test.

7.3. GOVERNANCE IN THE LAW

7.3.1. MULTI-LEVEL GOVERNANCE IN STRASBOURG

This section looks at the multi-level governance dimensions of the Council of Europe. It moves away from the role played by the ECtHR on the issue of assisted dying and focuses on the role played by political actors, experts and civil society in the CoE. There are a number of relevant institutions and bodies: the Committee of Ministers ('CoM' or 'the Committee'), the Parliamentary Assembly ('the Assembly'), the Steering Committee on Bioethics ('the CDBI')¹⁶⁴, the (former) Social, Health and Family Affairs Committee (AS/Soc), the Committee on Legal Affairs and Human Rights (AS/Jur), and certain International non-governmental organizations (INGOs).¹⁶⁵

Judicial governance and multi-level governance in the CoE are related, but also distinct, in two major respects. First, judicial governance is inherently reactive, in other words, the ECtHR must await for disputes to come before it. This means that even the Court's best efforts cannot be representative of all the human rights violations occurring in its jurisdiction. Multi-level governance in the CoE is proactive regardless of an active dispute/claim. It also, of course, cannot prevent or deter all human rights violations, but it does provide the unique institutional capacity to address human rights violations in an *ex ante* manner. This unique institutional capacity may be either highly political¹⁶⁶ or less political in nature.¹⁶⁷ Either way, multi-level governance in the Council is intended to complement the judicial governance exercised by the ECtHR.

Second, the full force of judicial governance may be readily restricted to the specific circumstances before it. As outlined above, the ECtHR faces real challenges in making systematic decisions. Multi-level governance in the Council is precisely to facilitate systematic solutions to human rights violations. In theory, the interdependence of political actors, experts, and civil society provides a more robust framework to devise

¹⁶⁴ 'CDBI' stands for Comité Directeur pour La Bioéthique. Since 2012, it the Committee on Bioethics (DH-BIO) has taken over the responsibilities of the Steering Committee on Bioethics (CDBI).

¹⁶⁵ The fourth pillar of the Council – The Congress of Local and Regional Authorities in Europe – is not of concern here, as it has played no role in the legal or political debate on assisted dying.

¹⁶⁶ Such as the capacity to debate and adopt a Parliamentary Assembly Recommendation. See M. Bond, *The Council of Europe: Structure, history and issues in European politics* (Routledge, 2012) 4-21.

¹⁶⁷ Such as the capacity to carry out an expert legal and factual evaluation, for example an evaluation by the Advisory Committee on the Framework Convention for the Protection of National Minorities. See Bond, *ibid.*

decisions and policies beyond a case-by-case basis. For example, a committee of experts after a careful and scientific investigation can give superior recommendations, and then receive the required political support from the Committee to increase the chances of having those recommendations realized. There is of course a potential downside to the interdependence of political actors and experts.¹⁶⁸ For example, the involvement of actors from the Committee may influence the independence of a working group or politicise the 'expert' debate – resulting in less than satisfactory systematic policies.

Third, multi-level governance in the CoE does not result in binding policies. This is, arguably, its Achilles' heel. It faces the risk of being ineffective in the protection and promotion of its aims. Negotiating conventions, recommendations or resolutions that develop common political and social standards in keeping with the political climate of Europe, and encouraging members to accept regimes of mutual monitoring to realize these standards is a colossal endeavour.¹⁶⁹ Even if a particular recommendation is devised by a fruitful interdependency of experts, stakeholders and political representatives, the power to put that recommendation into action is, in essence, a 'soft' one. But it does not necessarily follow that this 'soft' power is an 'insignificant' power. One must step back and look at the broader function of multi-level governance in the Council. In a sense, multi-level governance is dependent on a carrot-and-stick-style approach. The stick is in the form of exposure to criticism, initially *in camera* by peers in the Committee, and subsequently by the threat of public exposure and media criticism. For example, the threat of damaging publicity arising from reports by the CPT¹⁷⁰ is, in practice, more effective than the publicity itself.¹⁷¹ Kickers highlights how States tend to eventually co-operate once informed there is a procedure opened against them.¹⁷² The carrot is in the form of constructive monitoring and capacity building. Quiet diplomacy may readily lead

¹⁶⁸ G. de Beco, 'Introduction: The Role of European Human Rights Monitoring Mechanisms', in: G. de Beco (ed) *Human Rights Monitoring Mechanisms of the Council of Europe* (Routledge, 2012) 5.

¹⁶⁹ See M. Bond (n 166) 4.

¹⁷⁰ CPT = the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

¹⁷¹ Although sometimes it is deemed necessary to follow through with certain threats, as was the case with Turkey (in 1992 and 1996) and Russia (in 2001, 2003 and 2006) when reports from the CPT were made public due to persistent failures to co-operate.

¹⁷² See R. Kicker, 'The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment'; in G. de Beco (ed) *Human Rights Monitoring Mechanisms of the Council of Europe* (Routledge, 2012).

to acknowledgement of human rights failures and subsequent responses.¹⁷³ This is a pragmatic approach often preferred over a blame game (public or discrete). In addition, the CoE devises hands-on ways to help improve national legal and administrative processes. This occurs through the Secretariat's wealth of trans-national experiences, frameworks of co-operation with the EU,¹⁷⁴ and networks of experts sharing knowledge.¹⁷⁵

Before moving on to the policies on assisted dying made by various institutions and bodies situated in the CoE's multi-level governance structure, attention must be paid to the specific characteristics of these institutions and bodies. This attention is brief, but sufficient enough to shed some light on the relevant processes.

The Committee of Ministers is the main political policy and decision-making organ of the Council. It is the Council's 'supreme intergovernmental body' - the voice of national governments so to speak. It comprises of the Foreign Affairs Ministers¹⁷⁶ of all the member states, and the minister's deputies¹⁷⁷ or ambassadors. Its structure is laid out in Chapter IV of the Statute of the Council of Europe, where Article 15 therein mandates its general function: 'to further the aim' of the Council.¹⁷⁸ It is the ultimate authority for legislative decisions, and is also responsible for supervising the execution of judgments

¹⁷³ For example, via *in camera* discussions by the Committee of Ministers on particular monitoring reports. See Benoit-Rohmer and Klebes F. Benoit-Rohmer and H. Klebes, *Council of Europe law – Towards a pan-European legal area* (Council of Europe Publishing, 2005) 124.

¹⁷⁴ To date, nearly 200 joint programmes have provided funding and technical assistance involving co-operation with Albania (since 1993), Armenia (since 1999), Azerbaijan (since 1999), Bosnia and Herzegovina (since 2003), Bulgaria, Croatia, Estonia, the Former Yugoslav Republic of Macedonia, Georgia (since 1999), Latvia, Lithuania, Moldova (since 1997), Montenegro (since 2001), the Russian Federation (since 1996), Serbia (since 2001), Turkey (since 2001), and Ukraine (since 1995). See Bond (n 166) 154.

¹⁷⁵ For example, public authorities can learn from practices in other Member States via the expert reports, and judges can benefit from the exchanges of experience encouraged by the European Commission for the Efficiency of Justice (CEPEJ). Ibid.

¹⁷⁶ Thus unlike the EU Council, the Committee does not vary its membership depending on the issues being discussed. However, in practice, foreign ministers are often replaced by other members of government (ministers for European affairs, specialised secretaries of state) or experienced diplomats. See F. Benoit-Rohmer and H. Klebes (n 173) 49.

¹⁷⁷ The Deputies have the same powers as the Ministers, and their decisions have the same force. See Benoit-Rohmer and Klebes, *ibid.*

¹⁷⁸ See 'Statute of the Council of Europe' (London 5.V.1949). Aside from this general aim, the Committee has various other responsibilities, such as: settling internal matters (see Article 15 of the Statute), voting on the budget (Article 38 of the Statute), organizing administrative affairs (Article 37b of the Statute), adopting its own rules of procedure (Article 18 of the Statute), adopting final texts of conventions or agreements, making recommendations to other states (Article 15 b of the Statute), and adopting new member states and monitoring compliance with obligations.

delivered by the ECtHR.¹⁷⁹ Meetings by the Committee are held *in camera* and the minutes generally remain confidential. To carry out its tasks, it works through some 20 steering committees and several other sub-committees of experts.¹⁸⁰

One of the more relevant steering committees for the purpose of this study is the Steering Committee for Human Rights ('CDDH').¹⁸¹ It consists of representatives of each member state government and aims to help the Council define policy and co-operation with regard to human rights. The CDDH operates through smaller sub-committees of experts, which it supervises and directs. Every national government has the voluntary right to appoint one expert.¹⁸² Formally speaking, the experts act independently of their national governments. Despite having been appointed by them, they are to remain impartial and not receive any instructions from them. The work of committees of experts is regulated by Resolution (76)3 on the structures, terms of reference and working methods of committees.¹⁸³

In 1985, the Ad Hoc Committee of experts on Bioethics (CAHBI), set up under the direct authority of the Committee of Ministers, was responsible for the activities of the Council in the field of bioethics. It later became the Steering Committee on Bioethics (CDBI). The work of CAHBI, and then of the CDBI, led to the adoption of Recommendations of the Committee of Ministers and to the preparation of the well-known Convention on Human Rights and Biomedicine.¹⁸⁴ In 2012, following the reorganisation of intergovernmental

¹⁷⁹ If a State fails to execute a particular judgment against it, the Committee takes action in a number of ways: it may enter into discussion with peers to encourage States to honour their commitment; grant more time to improve their performance; or in cases of persistent negligence, it may sanction the State by name and shaming and bring an action before the ECtHR. Bond (n 166) 13.

¹⁸⁰ For further details on the CM, see Benoit-Rohmer and Klebes (n 173) 48-55.

¹⁸¹ The acronym 'CDDH' is French – *Comite directeur des Droits de l'Homme*,

¹⁸² For example, the composition of the expert sub-committee on Bioethics (DH-BIO): 'Governments of the member states are invited to designate one or more representatives of the highest possible rank, with appropriate expertise in the various aspects of bioethics and able to consider these from a human rights perspective.' *Information document concerning the DH-BIO*, Secretariat memorandum prepared by the Bioethics Department, Directorate of Human Rights, Committee on Bioethics (DH-BIO), Strasbourg, 5 March 2013 DH-BIO/INF (2013) 3.

¹⁸³ This 1976 Resolution of the Committee of Ministers applies in general to committees whose members are appointed by member States, and which are established by the Committee of Ministers or with its authority.

¹⁸⁴ This was the first international treaty on Biomedicine (adopted by the Committee of Ministers on 19 November 1996; entry into force on 1 December 1999). The work of the CDBI also led to the adoption of: the additional Protocol on the Prohibition of Cloning Human Beings (adopted by the Committee of Ministers on 6 November 1997, entry into force on 1 March 2001); the additional Protocol concerning Transplantation of Organs and Tissues of Human Origin (adopted by the Committee of Ministers on 8 November 2001, came into force on 1 May 2006); the additional Protocol on Biomedical Research (adopted

bodies at the Council of Europe, the CDBI became the Committee on Bioethics (DH-BIO). One of the first tasks ahead of the DH-BIO was to draft a report on decision making process regarding medical treatment in end-of-life situations.

As for the role of nationally elected representatives in the CoE, one must turn to the Parliamentary Assembly. This is the indirectly democratic organ of the Council. It consists of 318 representatives and 318 substitutes appointed by national parliaments. The manner of how each national parliament selects their representative is determined at the national-level alone. The only rule is that delegations must, in their political make-up, reflect with reasonable accuracy the balance of political parties or groups in their home parliaments.¹⁸⁵ The Assembly consists of a President,¹⁸⁶ a Bureau,¹⁸⁷ a Standing Committee,¹⁸⁸ political groups,¹⁸⁹ specialist committees,¹⁹⁰ and an Assembly Secretariat.¹⁹¹

The primary mode of governance exercised by the Parliamentary Assembly is via its function as a forum for discussion. Although it shook off the formal title of 'Consultative

by the Committee of Ministers on 30 June 2004, entered into force on 1 September 2007); and the Protocol concerning Genetic Testing for Health Purposes (adopted by the Committee of Ministers on 7 May 2008, opened for signature on 27 November 2008).

¹⁸⁵ Note also, in accordance with Resolution 1348 (2003), the selected delegations must also include a percentage of members of the under-represented sex at least equal to that in the home parliament – and at least one member of each sex in any case.

¹⁸⁶ The President directs the Assembly's work, but does not speak in debates or vote, leaving this to his or her substitute. Benoit-Rohmer and Klebes (n 173) 62.

¹⁸⁷ The Bureau co-ordinates the work of the Assembly and its committees. It consists of the President of the Assembly, the nineteen Vice-Presidents, and the chairs of the political groups or their substitutes. See Benoit-Rohmer and Klebes, *ibid*.

¹⁸⁸ The Standing Committee fixes dates for the opening and resumption of ordinary sessions and prepares the Assembly's work. It comprises of the Bureau, the chairs of national delegations and the chairs of committees. See Benoit-Rohmer and Klebes, *ibid*.

¹⁸⁹ At the time of writing, there are five political groups: the Socialist Group (SOC), the Group of the European People's Party (EPP/CD), the European Democratic Group (EDG), the Liberal, Democratic and Reformers Group (LDR) and the Group of the Unified European Left (UEL). See the Parliamentary Assembly's official website: <http://website-pace.net/en_GB/web/apce/political-groups>. Last accessed on 23/01/2016.

¹⁹⁰ Article 24 of the Statute authorises the Assembly to establish 'committees or commissions to consider any matter which falls within its competence.' There are currently 9 'general committees': (1) Committee on Political Affairs and Democracy (AS/Pol); (2) Committee on Legal Affairs and Human Rights (AS/Jur); (3) Committee on Social Affairs, Health and Sustainable Development (AS/Soc); (4) Committee on Migration, Refugees and Displaced Persons (AS/Mig); (5) Committee on Culture, Science, Education and Media (AS/Cult); (6) Committee on Equality and Non-Discrimination (AS/Ega); (7) Monitoring Committee (AS/Mon); (8) Committee on Rules of Procedure, Immunities and Institutional Affairs (AS/Pro); and (9) Committee on the Election of Judges to the European Court of Human Rights (AS/Cdh). See the Parliamentary Assembly's official website: <http://website-pace.net/en_GB/web/apce/committees>. Last accessed on 23/01/2016. Last accessed 28.01.2016.

¹⁹¹ This is the Assembly's administrative body, which is headed by the Secretary General of the Parliamentary Assembly. See. Benoit-Rohmer and Klebes (n 173) 64.

Assembly', it is an institution that remains essentially advisory in character.¹⁹² If a majority can be obtained, it may attempt to sway or influence the Committee of Ministers via Recommendations¹⁹³ or Resolutions,¹⁹⁴ but the Committee is not obliged to follow such instruments. It may ignore the Assembly's efforts, which according to Benoit-Rohner and Klebes, it often does.¹⁹⁵ The Amended Article 23 of the Statute on the Council of Europe broadly allows the Assembly to discuss "any matter within the aim and scope of the Council of Europe."

Within the Assembly, two committees are of particular relevance here: (i) the Committee on Legal Affairs and Human Rights (SA/Jur), and (ii) the Committee on Social Affairs, Health and Sustainable Development (SA/Soc).¹⁹⁶ Both consist of 84 parliamentarians appointed by the national delegations to the Assembly, and their composition represents the relative strengths of the political groups in the Assembly.¹⁹⁷ The former works through three sub-committees: on Human Rights; on Crime problems and the fight against terrorism; and on the Rule of Law. In this sense, it is the Assembly's *de facto* legal adviser. The latter works through four sub-committees: on the European Social Charter, on Environment and Energy, on Public Health, and on the Europe Prize. The agenda and reports of both parliamentary committees are public, but the meetings are usually held in private. Through personal and party networks, the Committee on Legal Affairs and Human Rights has proven relatively effective. For example, it was responsible for ironing out issues regarding the Russian opposition to Protocol 14,¹⁹⁸ and in 2006 it produced the first report unveiling the scandal of CIA rendition flights and secret detention centers for

¹⁹² However, it should be noted that the Assembly does have important election functions: in short, it votes in the Secretary General of the Council of Europe, the Deputy Secretary General, the Secretary General of the Assembly, judges to the ECtHR, and the Commissioner of Human Rights. Benoit-Rohner and Klebes (n 173) 64.

¹⁹³ As defined in Rule 23 of its Rules of Procedure, a recommendation is 'a proposal by the Assembly addressed to the Committee of Ministers, the implementation of which is beyond the competence of the Assembly, but within that of governments.'

¹⁹⁴ As defined in Rule 23, a resolution: 'embodies a decision by the Assembly on a question of substance which it is empowered to put into effect, or an expression of a view for which it alone is responsible.'

¹⁹⁵ Benoit-Rohner and Klebes (n 173) 65.

¹⁹⁶ This Committee replaces the (former) Social, Health and Family Affairs Committee.

¹⁹⁷ The largest represented group being the European People's Party (EPP), followed by the Group of Socialists (SOC), the Alliance of Liberals and Democrats for Europe (ALDE), the European Democratic Group (EDG), and finally the Group of the United European Left (UEL). See the Parliamentary Assembly's official website: <http://website-pace.net/en_GB/web/apce/political-groups>. Last accessed on 23/01/2016.

¹⁹⁸ A Protocol that changes the admissibility criterion, the treatment of repetitive cases or clearly inadmissible cases, and assists the Committee of Ministers in its task of supervising the execution of ECtHR judgments.

terrorist suspects within Europe.¹⁹⁹ The Committee on Social Affairs, Health and Sustainable Development has also had relative success with over 40 of its reports being adopted by the Assembly from 2012 to 2014 alone.

In terms of interaction between the Assembly and the Committee, there is (i) a liaison body known as the Joint Committee:²⁰⁰ It consists of members from both institutions, and has very limited independent powers. Although it may decide to set up joint working parties on a specific issue, it is more commonly used 'as a platform for the exchange of information, and occasionally bringing pressure to bear on the Committee of Ministers;'²⁰¹ and there is also (ii) a number of ways in which they interact, via: follow-up actions on Assembly Recommendations, Assembly Opinions for the Committee (namely, on the prospect of new members, draft treaties, the budget, and implementation of the Social Charter), admission rights and the Committee's right to address the Assembly, oral and written questions to the Representatives, and the Activity Report by the Committee of the Assembly.²⁰²

In 2003, the Council upgraded the Conference of International Non-government Organisations (INGOS) from a 'participatory body' to a 'consultative body.' The conference represents over 400 INGOs that focus on bringing the voice of civil society to the European political table. Its upgrade has a dual function: one, to tighten up the conditions for acquiring status at all. And two, to further encourage active INGO participation in policy-making. The type of INGOs varies in membership and focus from large sized movements on European issues (such as the 'European Movement') and global issues (such as Amnesty International), to smaller movements focused on specific issues (such as the 'Quaker Council for European Affairs').²⁰³

Although the Conference may be seen as the fourth pillar of the Council of Europe (alongside the Committee of Ministers, the Assembly, and the Congress of Local and Regional Authorities), it plays a minor role compared to the other three. In what it adds via its expertise and ability to deliberate on societal concerns in a manner that escapes

¹⁹⁹ See 'Alleged secret detentions and unlawful inter-state transfers involving Council of Europe member states', Draft Report – Part II (explanatory memorandum), Rapporteur: Mr Dick Marty (Switzerland, ALDE) 7 June 2006.

²⁰⁰ See Rule 55 of the Assembly's Rules of Procedure and the rather obsolete Statutory Resolution 51 (30).

²⁰¹ Benoit-Rohmer and Klebes (n 173) 70

²⁰² Ibid.

²⁰³ Bond (n 166) 18.

elected representatives, it loses in other respects. Bond recognises three main factors detrimental to the Conference's effectiveness: INGOs volunteer themselves to it; the self-selected nature of its composition; and its heterogeneous nature without any elected mandate.²⁰⁴ Moreover, the majority of INGOs find it hard to generate broad media coverage required to trigger public support.

In light of this brief introduction to the institutional structure of the Council of Europe, the proceeding section looks in descriptive detail at the policies on assisted dying created by these institutions.

7.3.2. ASSISTED DYING ON THE COUNCIL'S AGENDA

The first sign of end of life decisions making an appearance on the Council's agenda was in 1976. Here the Assembly issued a Resolution declaring 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.'²⁰⁵ In the same year, it also issued a Recommendation declaring 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.'²⁰⁶ However, it also stated in this Recommendation that although the doctor must 'make every effort to alleviate suffering', he or she has 'no right, even in cases which appear to him to be desperate, intentionally to hasten the natural course of death.'²⁰⁷ Since this Recommendation, the issue of assisted dying did not arise before the Assembly (or the Council in general) again for over two decades.

(i) Recommendation 1418 (1999).

In May 1999, the (former) Social, Health, and Family Affairs Committee (AS/Soc)²⁰⁸ issued a report entitled 'Protection of the human rights and dignity of the terminally ill and the dying' ('the 1999 AS/Soc report').²⁰⁹ This Report firmly rejected voluntary active

²⁰⁴ Bond (n 1666) 18.

²⁰⁵ Resolution 613 on the rights of the sick and the dying, (1976), para 2.

²⁰⁶ Recommendation 779 on the rights of the sick and the dying (1976), para 5.

²⁰⁷ Ibid, para 6.

²⁰⁸ Which, as stated above, is now part of the Committee on Social Affairs, Health and Sustainable Development.

²⁰⁹ Doc. 8421, 21 May 1999: 'Protection of the human rights and dignity of the terminally ill and the dying', Report of the Social, Health and Family Affairs Committee. Rapporteur: Mrs Edeltraud Gatterer (Austria), Group of the European People's Party.

euthanasia and assisted suicide.²¹⁰ It referred to the World Medical Association Marbella Declaration of 1992, which maintained: ‘Physician-assisted suicide [...] is unethical and must be condemned by the medical profession.’ As for VAE, the Report referred to Article 2 of the ECHR and stated that although a ‘terminally ill or dying person has the right to self-determination as to the course of the process of dying’, he or she, however, ‘has no right to be killed [...] even if the killing is wished for by the individual.’²¹¹ AS/Soc justified this stance on the reasoning that: ‘[i]nvariably, individual or societal pressure on a terminally ill or dying person would mount, given that he or she is under the impression of being a burden while society offers the option of having oneself killed.’ Moreover, it then continued to rely on ‘experiences in societies that have a lenient approach towards the prohibition against taking life’.²¹² They showed, according to the report, that ‘in due consequence human beings are killed without their consent.’ The ‘general thrust’ of the Report was supported by the Committee on Legal Affairs and Human Rights (AS/Joc).²¹³ It described it as a ‘compassionate and considered attitude to the problems affecting the terminally ill and dying’.²¹⁴

Later that same year and after some amendments, the Assembly adopted the Report and its rejection of assisted dying. It did so in the form of a Recommendation.²¹⁵ The final text regarding assisted dying stated: the Assembly recommends that the Committee of Ministers encourage the member states to respect and protect the dignity of terminally ill or dying persons “by upholding the prohibition against intentionally taking the life of terminally ill or dying persons” and to recognise “(i) that the right to life is guaranteed by Article 2 [...]; (ii) that a terminally ill or dying person’s wish to die never constitutes any

²¹⁰ Ibid, para 46. See Section C; entitled ‘To uphold the prohibition against intentionally taking life also with regard to terminally ill or dying persons.’ Note the term ‘voluntary active euthanasia’ was not used in the report, instead the term ‘mercy killing’ was preferred. In the SA/Soc, there were 19 votes in favour of the report, 4 against and 4 abstentions.

²¹¹ Ibid, paras 54-55.

²¹² Presumably at the time, this was a reference to the Netherlands (which had since 1985 allowed for a limited exception in the criminal code for VAE and AS) and Switzerland (which has allowed AS since 1942, provided it is not performed with selfish motives).

²¹³ Doc. 8454, 22 June 1999, ‘Protection of the human rights and dignity of the terminally ill and dying’, Opinion by the Committee on Legal Affairs and Human Rights. Rapporteur: Mr Kevin McNamara (United Kingdom) Socialist Group.

²¹⁴ Ibid.

²¹⁵ Recommendation 1418 (1999): ‘Protection of the human rights and dignity of the terminally ill and the dying.’ Extract from the Official Gazette of the Council of Europe, available at: <<http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta99/EREC1418.htm>>.

legal claim to die at the hand of another person [...]; and (iii) 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."²¹⁶

It is worthwhile recalling the debate leading up to the vote on the final text.²¹⁷ The Recommendation, like the Report underlying it, did not actually refer to the term 'euthanasia' and did not have as its sole focus the issue of assisted dying. However the debate immediately prior to the vote in the Assembly paid considerable attention to the issue. Of the twenty six officially listed speakers, only two, Mr Hancock (UK; *ALDE*) and Mr Flynn (UK; *SOC*), argued against the Report's condemnation of assisted dying. The majority of the speakers supported the Report on this. The Rapporteur of the Report, Mrs Gatterer (Austria, *EPP*), clarified in her introduction that allowing assisted dying would 'inevitably mean pressure being exerted on the patient by family and friends' and no parliament should ever pass a law that 'even suggests death as a possibly desirable alternative to life.'²¹⁸ The speaker on behalf of his national's Democratic People's Party, Mr Surjan (Hungary, *EPP*), claimed that terminally ill persons requesting assistance in dying are 'in fact crying out for more medical and personal care';²¹⁹ Mrs Smereczynska (Poland, *EPP*) stated that 'legislation of euthanasia will destroy the sense of communal life [...] it will also destroy that trust [between doctor and patient] irrevocably because a patient will never know why a doctor is at his bed';²²⁰ Mr Wodarg (German, *SOC*) warned against laws that allow the ending of life on the grounds of relieving 'suffering' by referring to the Nuremburg trials, stating 'as a German, I know what I am talking about'; Mr Wojick (Poland, *EPP*) asserted that if a patient requests death, 'it is an appeal for love', if the family requests it (in cases of unconscious patients) 'that means impatience, lack of resources and laziness', and concluded that 'making euthanasia lawful would mean the demise of Europe'; Mr Pinggera (Italy, *EPP*) reasoned that 'as no legal system can give life [...] the law cannot empower anyone to destroy a person's existence'; and for his

²¹⁶ *Ibid.*, para 9(c).

²¹⁷ See: Official Report of Debates, 1999 Ordinary Session (Third Part) 21-25 June 1999, 24th Sitting, 808

²¹⁸ *Ibid.*, 809.

²¹⁹ *Ibid.*, 810.

²²⁰ This particular speaker, at a later point in the debate stated: 'According to the latest information from the Netherlands, some Dutch people carry cards that say "Don't kill me" and we read reports that say the practice is out of control. Nine per cent of deaths on the Netherlands are due to euthanasia and 50% of instances of euthanasia are carried out without the patient's consent.' See *ibid.*, 828. For an overview of the empirical data in the Netherlands, see Sections 4.1.4 and 4.2.4, above.

compatriot Mr Diana (Italy, *EPP*) ‘euthanasia and assisted suicide pervert the law of nature [and] must be forbidden to everyone, especially the medical profession’.

Despite this clear sentiment against self-determination to choose assisted dying (especially medically assisted), the Recommendation adopted wholly recognized that patients have a right to be informed, or not to be informed if they so wish, to consult other doctors and to refuse treatment, provided that no outside influence or pressure has been exerted. It also recognized patients’ right to leave advance directives or living wills refusing specific types of treatment: such directives, the agreed Recommendation says, are valid and must be complied with even when patients are incapacitated, provided their wishes are clearly expressed and they have not been swayed by any outside influence. Moreover, the Recommendation definitively advocates the use of pain-relief “even if this treatment as a side-effect may contribute to the shortening of the individual’s life.”²²¹

The Committee of Ministers replied to the Assembly on Recommendation 1418 in two stages. The first was an interim reply in October 2000,²²² where it was keen to stress caution in making any statements on the ‘advanced refusal of certain treatments and on euthanasia.’ It noted the divergent legal positions on such behaviour in member States, and instructed the Steering Committee on Bioethics (CBDI) to gather information on the relevant laws and practices in the member States. It also instructed the Steering Committee for Human Rights (CDDH) to formulate an opinion on the Recommendation.²²³

Both Steering Committees duly responded. The CDDH released its opinion in November 2001.²²⁴ In expressly limiting its consideration of Recommendation 1418 in light of the ECHR and the non-existent case law of the ECtHR (at the time), this opinion was largely speculative. It drew attention to the scope of Article 1, Article 2 (emphasizing that there

²²¹ Ibid, para 9.

²²² Doc. 8888 – (7 November 2000) Reply from the Council of Europe Committee of Ministers to Recommendation 1418 (1999 - adopted on 30 October 2000, at the 728th meeting of the Ministers’ Deputies. Available at <www.coe.int/t/dghl/standardsetting/cddh/Meeting%20reports%20committee/52nd_en.pdf>, see pp. 33-36 in particular.

²²³ The Committee made reference to the work ongoing at the time by the European Health Committee (CDSP). This study resulted in a detailed report on the development and status of palliative care in Europe – see Doc CM(2003) 130 Addendum. The report refused to take a stand on euthanasia and physician assisted suicide as they ‘are not included in any definition of palliative care’ (para 50).

²²⁴ See: Opinion concerning Recommendation 1418 (1999) of the Parliamentary Assembly on the protection of the human rights and dignity of the terminally ill and the dying – adopted by the CDDH during its 52nd meeting (6-9 November 2001).

'can be no derogations to the right to life other than those mentioned' under said Article) and Article 3 (emphasizing that the State is obliged to protect vulnerable individuals against 'serious breaches of personal integrity'). It paid less attention to Article 8, stating that '[t]here could also be instances where the right to respect for private life [...] would become relevant.' It endorsed the Assembly's Recommendation, but also concluded that from the perspective of human rights protected under the Convention, a number of 'very complex' questions arise. These questions regarded: (i) the interplay between conflicting rights and the margin of appreciation of the States in reconciling these rights; and (ii) the nature and scope of positive or negative obligations incumbent upon the States to effectively protect rights provided for by the Convention.

The CDBI provided a purely descriptive analysis of responses by member States²²⁵ to a questionnaire concerning aspects of their law and practice relating to VAE and other end of life decisions²²⁶. A number of conclusions on assisted dying followed from this analysis: (i) there was no consensus on the definition or consistency in the use of the terms: euthanasia, active euthanasia, passive euthanasia, assisted suicide and assisted dying;²²⁷ (ii) there was a divergence in the existence of legislation and professional codes of conduct that explicitly dealt with assisted dying,²²⁸ although in the vast majority of Member States there existed criminal sanctions that would apply to an act of assisted dying;²²⁹ and (iii) in only a small minority of the States did some form of a national commission on euthanasia exist in the past (note prior to 2003).²³⁰

On the basis of the above reports, the Committee of Ministers released its second reply to the Assembly. It reiterated the CDDH's view that 'very complex' questions nonetheless remain to be answered. But it did not refuse to take a normative stance this time, and instead opted to support the Recommendation. It explicitly endorsed the Assembly's position about 'upholding the prohibition against intentionally taking the life of terminally

²²⁵ Not all the Member States replied, only 35.

²²⁶ 'Replies to the questionnaire for member states relating to euthanasia', Steering Committee on Bioethics (CDBI) Strasbourg, 20 January 2003, CDBI/INF 8 (2003)

²²⁷ Ibid, 3.

²²⁸ Ibid, 16 and 24

²²⁹ In relation to VAE see *ibid.*, 26. In relation to AS, see *ibid.*, 30. Only two of the responding States (Albania and Finland) answered 'no' to the question (8a) 'Do criminal sanctions exist [for acts of VAE]?' Unfortunately, there was no further information provided in the report to elaborate on these answers. While only four of the responding States (Albania, Estonia, Finland and Georgia) answered 'no' to the question (10a) 'Do criminal sanctions exist [for acts of AS]?'

²³⁰ Ibid, 33. These three States were Italy, the Netherlands and the United Kingdom.

ill or dying persons' and the principle 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.'

(ii) The 'Marty Reports' (2004 and 2005)

In 2004 and 2005, the issue of assisted dying reappeared on the Parliamentary Assembly's agenda. Once again, it was instigated by the (former) AS/Soc. This time, said parliamentary committee concluded two reports (the 'Marty reports').²³¹ These Reports were radically different from the previous one in 1999. The initial Marty report (Doc. 9898) was merely entitled 'Euthanasia'.²³² It requested that governments of the member states '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.'²³³ It received public criticism from the International Federation of Catholic Medical Associations and the Scottish Council on Human Bioethics. The former organisation feared 'the resolution, if approved, will constitute a tremendous element of pressure on national parliaments, medical doctors and public opinion', and it would 'provide an unethical and unnecessary medical solution to a problem that is basically of a social nature: [the] solitude of the elderly and poor care at the end of life.'²³⁴ The latter organisation considered the report to lack objectivity and to be of little added value considering the position already taken by the Assembly in its Recommendation 1418.²³⁵ In any case, the Assembly voted in April 2004 to send the report back to the Committee for revision. This resulted in the drafting of a second Marty report (Doc. 10455) entitled 'Assistance to patients at end of life'.²³⁶

²³¹ They were both commonly referred to as the 'Marty report' as they were written by the Committee's rapporteur, Mr Dick Marty (Switzerland, *ALDE*).

²³² Doc. 9898 10 September 2003, 'Euthanasia', Report by Social, Health and Family Affairs Committee. Available at < <http://assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewHTML.asp?FileID=10255&lang=EN>>.

²³³ Ibid, 'Summary'.

²³⁴ Statement of Catholic Doctors Opposed to Report on Euthanasia. Available at: <www.zenit.org/en/articles/statement-of-catholic-doctors-opposed-to-report-on-euthanasia>.

²³⁵ Scottish Council on Human Bioethics, 'Briefing to UK Parliamentary Assembly Members of the Council of Europe': Mr Dick Marty's Euthanasia Proposals (Doc. 9898) for the Parliamentary Assembly of the Council of Europe - 27 April 2004.

²³⁶ Doc. 10455, 9 February 2005, 'Assistance to patients at end of life', Report by Social, Health and Family Affairs Committee, Rapporteur: Mr Dick Marty.

This Report was broader in its scope, covering all end of life decisions. But it was also seemingly narrower in its ambition. It no longer advocated for Member States to consider legalising VAE²³⁷ (or even the need to collect empirical data on such behaviour) but rather that the Assembly ‘does not bury its head in the sand’. It advocated the need to foster informed public debate on assisted dying. Despite this change of stance in the main body of the Report, the accompanying Explanatory Memorandum contained largely the same arguments as the first Marty report. In short, it argued in favour of removing the secrecy surrounding VAE: it condemned the mismatch between the reality in medical practice (based on empirical evidence) and the legal systems in place;²³⁸ it questioned the ethical difference between other (permissible) end of life decisions, such as the refusal of life-saving treatment, and an act of VAE;²³⁹ and it alluded to the changing public opinion and attitudes towards VAE.²⁴⁰

The Committee on Legal Affairs and Human Rights (AS/Joc) refused to support this Report, advocating instead that the Assembly should reaffirm its previous Recommendation 1418. It criticized the Report for its treatment of evidence from the Netherlands²⁴¹ and for failing to see the ‘huge moral difference’ between VAE and withholding/withdrawing medical treatment.²⁴² Again, it is deemed a worthy endeavour to pay attention to the political discourse in the Assembly’s debate preceding the vote.²⁴³ As there were forty five names on the list of speakers (and seventy proposed amendments), it is not reasonable to reflect here on each view expressed. However, some general reflections may be made and certain examples will be given to provide an insight into the tone of the debate.

²³⁷ In fact, in paragraph 1 of the Report, it stated its ‘unwavering belief [...] that it is forbidden to cause someone’s death deliberately.’

²³⁸ Ibid, paras 25-35.

²³⁹ Ibid, para 46.

²⁴⁰ Ibid, para 12.

²⁴¹ It stated: ‘The Dutch situation demonstrates that legalizing euthanasia and assisted suicide, far from introducing greater control, simply introduces more euthanasia and more assisted suicide’ (para 17) and also that ‘[e]mpirical 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.’ See *ibid.*, para 21. Contrast this with the findings in Section 4.1.4. and 4.2.4., above.

²⁴² In support of this statement, the Committee relied entirely on the position of the Catholic Church, stating: ‘the Catholic Church obviously only accepts the latter.’ See *ibid*, para 30.

²⁴³ See Official Report of Debates, Parliamentary Assembly Council of Europe: 2005 ordinary session (second part), 25-29 April, 448.

First, considerably more speakers²⁴⁴ voiced support for assisted dying (9 out of the 23 present) as compared to the first Marty report and the report leading up to Recommendation 1814. Ms Err (Luxembourg, *SOC*) speaking on behalf of the Socialist group, praised the Report's 'practical approach' and its focus on patients' rights and transparency.²⁴⁵ Mr Dees (Netherlands, *ALDE*), on behalf of the Liberal, Democratic and Reformers' Group, stated it is "unacceptable to prosecute a doctor for assisting the patient, at his request, in the process of dying when there is unbearable suffering and humiliation"; Mr Kox (Netherlands, *UEL*), speaking on behalf of the Group of the United Left, felt the need to 'assure everybody here that the Netherlands has not lost its civilisation due to this law [permitting euthanasia]' and invited the speakers who implied this 'to come and see' and 'not base [their] views on strange statements in newspapers'; Mr Jurgens (Netherlands, *SOC*), stated from the outset that he is a Catholic from the Netherlands who agrees with (and indeed voted for in the national parliament) the Dutch law on assisted dying, he argued that this particular Report is 'reasonable' as it 'asks that public debate be fostered. How can anybody be against an open and robust debate on an important matter such as the right and ability of a person to decide to die in dignity?'

Second, the predominant arguments opposing the Report were analogous with those opposing assisted dying in the debate preceding the vote on the first Marty report and Recommendation 1814. They ranged from concerns over slippery slopes, to concerns of paving the way for a duty to kill, to purely moral objections to VAE itself. Baroness Knight (UK, *EDG*²⁴⁶), speaking on behalf of the European Democratic Group, stated that if the Report was accepted, one should 'fear for sick people, young people, Muslim or Christian medical staff and for society as a whole'²⁴⁷ and concluded by stating that '1,000 patients are killed every year following the passage of [euthanasia] legislation in the Netherlands, but without the patient's consent'; Mr Wodarg (Germany, *SOC*) claimed that 'being killed' by a doctor is 'taking the easy way out'; Mr Davern (Ireland, *ALDE*) declared 'I have been a member of parliament for more than thirty-six years, but I have never seen a law yet

²⁴⁴ At least of those speakers actually present to deliver their speeches before the voting. Almost half of the parliamentarians on the list of 'speakers' submitted their speeches in text form, and therefore they were unavailable to the Assembly before the debate. See Official Report of Debates, Parliamentary Assembly Council of Europe: 2005 ordinary session (second part), 25-29 April, 461.

²⁴⁵ Ibid, 450.

²⁴⁶ Note that the EDG (European Democratic Group) is now known as the European Conservative Group (EC).

²⁴⁷ Ibid, 453

that was introduced and not expanded within a very short time'; Mr Federov (Russia, *EDG*) argued that 'many patients were deeply depressed when they asked doctors to end their life and were not in a position to take a clear view. The Assembly must uphold the right to life until the very end'; Mr Czinege (Hungary, *SOC*) asserted that 'everybody can make a decision about his or her death. If a doctor helps to end a patient's life, the situation is completely different. That is not a part of the patient's right to self-determination.'

The net result was quite conclusive. The report was rejected by 138 votes against to 25 votes in favour. Mr Marty's efforts had failed and the majority in the Assembly did not want to go beyond the Recommendation it made in 1999.

(iii) Resolution 1859 (2012).

In 2012, the Parliamentary Assembly was again faced with the issue of end of life decisions as a result of a Report by the Committee on Social Affairs, Health and Sustainable Development (AS/Soc).²⁴⁸ This Report (Doc. 12804) was entitled 'Protecting human rights and dignity by taking into account previously expressed wishes of patients'.²⁴⁹ Based on the European Convention on Human Rights (the 'ECHR') and the Convention on Human Rights and Biomedicine (the 'Oviedo Convention'), the Report urged Member States to put into place and implement legislation to protect the wishes of patients who refuse treatment in the form of an advanced directive, a living will, or via continuing powers of attorney. It did not take any normative stance on assisted dying. It did assert that 'associations made between advanced directives and euthanasia are unfortunate', and that the former 'helps to ensure that no form of euthanasia is practised on one's self against one's will'.²⁵⁰

The text adopted by the Assembly in the form of Resolution 1859 was based on this Report, but with the addition of one highly relevant amendment (Amendment 4) explicitly relating to the legality of assisted dying. In short, it was a 'last minute'²⁵¹ amendment that

²⁴⁸ This replaced the Social, Health and Family Affairs Committee (also known as 'AS/Soc').

²⁴⁹ Doc. 12804, 12 December 2011, 'Protecting human rights and dignity by taking into account previously expressed wishes of patients', (Former) Social, Health and Family Affairs Committee, Rapporteur: Mr Jordi Xucla (Spain, ALDE).

²⁵⁰ Ibid, para 6.2

²⁵¹ Even those who supported the Amendment recognised that it was 'last-minute' and 'contradicted' the report. See the speech by Mr Machoux (Belgium).

resulted in the final text of the Resolution taking an unequivocal normative stance on assisted dying. A stance that the original Report had not taken. The adopted Resolution states that it is 'not intended to deal with issues of euthanasia', but is instead limited 'to the question of advance directives, living wills and continuing powers of attorney.' Nonetheless, it then affirmed that: '[e]uthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited.' For a Resolution that supposedly did not intend to deal with assisted dying, this statement is quite remarkable. Once again, it is of value to look into the Assembly debate that preceded the vote adopting the Resolution.

Of particular relevance is the debate surrounding Amendment 4, which read: "*This resolution is not intended to deal with the issues of euthanasia or assisted suicide. Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, should always be prohibited. This resolution thus limits itself to the question of advance directives, living wills and continuing powers of attorney.*"

Mr Xucla (Spain, *ALDE*), the Rapporteur of the Committee on Social Affairs, Health and Sustainable Development, insisted that the report was about advanced directives and 'did not seek to introduce anything that was against the law such as euthanasia.' Lord Boswell (UK, *EDG*) and Mr Marquet (Monaco, *ALDE*) welcomed that 'euthanasia and assisted suicide had no place' in the Report, without making any mention of Amendment 4. Mr Mahoux (Belgium, *SOC*) understood that 'the last minute' Amendment clearly addressed euthanasia and assisted suicide, and thus 'contradicted the approach of the Report.' He, nonetheless, supported the Amendment. Mr Leigh (UK, *EDG*) urged the acceptance of Amendment 4, stating that the Report was about euthanasia, as living wills to refrain from life saving treatment in the case of a suicide are no different, and both should be 'appalled.'²⁵² Mr Flynn (UK, *SOC*) claimed the 'report is absolutely right insofar as it goes, but it would be outrageous to allow an amendment to change the entire nature of the report.'

Immediately prior to the vote on Amendment 4, Mr Volonte (Italy, *EPP/CD*) proposed an oral sub-amendment: to replace 'Euthanasia [...] *should* always be prohibited' with 'Euthanasia [...] *must* always be prohibited'. In response, Mr Mahoux proposed a second

²⁵² Moreover, he claimed that 'for decades, proponents of euthanasia in Europe have been waging a campaign that they themselves have admitted is underground and secretive'.

oral sub-amendment: to remove the sentence in question entirely, as the Report had claimed not to deal with the issue. Mr Volonte, claimed that the second sub-amendment was inadmissible and in any case, ‘the Assembly and the European Convention both agreed that euthanasia was not a right and should be banned.’ The President of the Assembly accepted both oral sub-amendments within the rules, and put them to a democratic vote. The first one was agreed to,²⁵³ while the second one was rejected.²⁵⁴ The revised Amendment 4 was then put to the vote, whereby 38 voted in favour, 14 voted against and 5 abstained from voting. This meant that the Parliamentary Assembly, in adopting this change to the text of the Resolution on advanced directives, had set its formal face firmly against assisted dying.

***(iv) ‘Guide on the decision-making process regarding medical treatment’
(2013)***

In 2010, the CDBI hosted a symposium to help further its work in implementing the principles enshrined in the Oviedo Convention – namely Article 9 and the protection of advanced directives laid out therein. Two reports were produced for the purpose of this symposium: the first was a (partly normative) report on ‘Medical decisions in end-of-life situations and the ethical implications of the available options’,²⁵⁵ the second was a descriptive report on ‘the previously expressed wishes relating to health care, common principles and differing rules in national legal systems.’²⁵⁶ In regard to the first report, it explicitly decided ‘not go into the debate on euthanasia.’²⁵⁷ However, it did state that the ethical doctrine of double effect in bio-medicine (used to justify treatment intended to provide relief but concomitantly risks bringing the time of death nearer) cannot be used to justify euthanasia, as the latter has by definition the ‘intention to hasten another

²⁵³ 34 votes in favour, 20 votes against and 2 abstentions.

²⁵⁴ 24 votes in favour, 30 votes against, and 0 abstentions.

²⁵⁵ CDBI, ‘Medical decisions in end-of-life situations and the ethical implications of the available options’ (December 2008). Available at <www.coe.int/t/dg3/healthbioethic/Activities/09_End%20of%20Life/CDBI_2008_30%20Hacpille%20e.pdf>. Last accessed 29.01.2016.

²⁵⁶ CDBI, ‘The previously expressed wishes relating to health care – Common principles and differing rules in national legal systems’ (December 2008). Available at <www.coe.int/t/dg3/healthbioethic/activities/09_end%20of%20life/CDBI_2008_29%20Andorno%20e.pdf>. Last accessed 29.01.2016.

²⁵⁷ CDBI (n 255) 23.

person's death.'²⁵⁸ Thus it supported the need to ethically distinguish between 'expectation' and 'intention'. As for the second report, it concluded that the legal norms relating to advanced directives of European countries 'adopt different approaches, based on their diverse legal, socio-cultural and philosophical traditions.'²⁵⁹ Some nations give greater legal weight to patient autonomy, while others 'which rely more on paternalistic decision-making structures are still reluctant to legislate in this field.'²⁶⁰

In 2013, based on these reports, after public consultation, the CDBI drew up a guide on 'the decision making process regarding medical treatment.' It explicitly stated that the report does not deal with VAE or AS. It outlined the ethical and legal frames of reference for the decision-making process for other end-of-life behaviour: emphasizing the principles of autonomy, beneficence, non-maleficence and justice. The guide is aimed primarily at health care professional but is also a potential source for information and a basis for discussion for patients and other persons involved in end-of-life situations.²⁶¹

7.3.3. A CRITIQUE OF THE COUNCIL'S MULTI-LEVEL GOVERNANCE OF ASSISTED DYING

One institution in particular, and its working committees, has played the dominant role in policy making on assisted dying in the Council of Europe – the Parliamentary Assembly. The Committee of Ministers did support the Assembly's Recommendation (1814) in 2003 but has remained quiet on the issue of assisted dying since. The Assembly on the other hand has not remained quiet, and rather recently, as explained above, took its most uncompromising stance on the issue. This critique is two-fold. On the one hand, concerns arise over the procedural manner of the process leading up to the adoption of policies in the Assembly. On the other hand, concerns arise regarding the substantive quality of the arguments supporting the Parliamentary sub-committee reports, the discourse in the Assembly debates, and the final recommendations adopted.

²⁵⁸ Ibid, 64

²⁵⁹ CDBI (n 256) 17.

²⁶⁰ Ibid.

²⁶¹ CDBI, 'Guide on the decision-making process regarding medical treatment in end-of-life situations' (Council of Europe, 2014). Available at: <www.coe.int/t/dg3/healthbioethic/conferences_and_symposia/Guide%20FDV%20E.pdf>. Last accessed 29.01.2016.

(i) Concerns about the parliamentary procedure:

First, the timings of the debates set by the Bureau of the Assembly were problematic. During deliberations on the second Marty report, there was also an on-going vote in process for electing judges to the ECtHR, and the President frequently reminded the parliamentarians during the speakers debate about this. Moreover, the President of the Assembly acknowledged that due to the 'very substantial amendments', the speeches thereon 'must be limited to 30 seconds.' As for the Assembly debate in 2009, a number of complaints were voiced regarding the day and hour selected (having been scheduled at the end of the day's agenda, often expected to run late into the evening – in this case after 8.30pm), and for the limited amount of time then allocated to the debate (a total of 45 minutes). The speakers had 3 minutes each, which in any case failed to ensure that each listed speaker was given the opportunity to deliver his or her speech.²⁶² The Rapporteur of the Report, Mr Xucla (Spain, *ALDE*) thanked 'delegates for remaining in the Chamber in spite of the late hour.' Mr Leigh (UK, *EDG*) - who wholly supported the report and the controversial amendments - expressed his 'disgust' at the time allocation. Ms Maury Pasquier (*Switzerland*) described the time-limit as 'deeply regrettable.' Mr Flynn (UK, *SOC*) took this complaint further, stating 'that the number of people present is not representative of the full membership of the Organisation [...] we all know what small groups can organise when many members have gone home'. This displeasure was equally supported by Mr Hancock (UK, *LDR*) who stated there was: 'barely enough time to do justice [...] to those who have stayed here this evening. Sooner or later, the Bureau of this Assembly is going to have to come to terms with the fact that important issues like this must be programmed in a much fairer way. It is totally irresponsible for the Bureau to tell us that we cannot have a proper debate.' The facts also shed some light on this concern regarding underrepresentation voiced by Mr Flynn: the most substantial Amendment (condemning assisted dying in a report otherwise unrelated to the issue) passed with only 38 votes to 16, which is one in six of the 318 members of the Assembly.

Second, the use of substantial last minute amendments deserves a mention in itself. Regarding the Assembly debate on the second Marty report, 71 amendments were tabled

²⁶² With the President of the Assembly stating: 'I am very sorry, but I must close the debate. The speeches of members on the speakers' list who have been present during the debate but have not been able to speak may be given, in typescript only, to the Table Office for publication in the official report.'

just before the deadline, despite having months to do so. Mr Err (Luxembourg, *SOC*) stated that an overwhelming majority were against the amendments tabled before the Socialist Group the day just before the debate, and one could question the ‘democratic nature’ of the time given to each group to discuss these amendments. Mr Kox²⁶³ (the Netherlands, *UEL*) labelled the amendments as purely ‘destructive’, Mr Dreyfus-Schmidt (France, *SOC*) accused them of causing ‘an obstruction unbecoming to our Assembly,’ Ms Vermont-Mangold (Switzerland, *SOC*) claimed that ‘it is shameful to see the intention of a small majority on the committee²⁶⁴ to destroy the many years work done by the committee’, she also added that the AS/Soc meeting the day before the debate was merely an ‘absurd power game’. While, Mr Jurgens (Netherlands, *SOC*) alluded to the fact that ‘there have been two and a half months in which to table amendments, but people waited until the very last moment. In all my years as a member of the Assembly, I have never seen the like.’ In the 2009 Assembly debate, history repeated itself and a large number of amendments were tabled one day before the debate, including one that strongly condemned assisted dying in all circumstances. Mr Flynn (the UK, *SOC*) claimed that the substance of the amendments coupled with the maximum delay in introducing them was ‘an attempt to hijack’ the Report. Moreover, one must question the motives of a last minute oral sub-amendment by Mr Volonte (Italy, *EPP*) to make the condemnation of assisted dying an absolutist one: changing assisted dying ‘should’ always be prohibited to ‘must’ always be prohibited. Given the timing of the oral sub-amendment there was no opportunity for any debate on the issue, meaning it went straight to a vote. Arguably, all of this is merely astute political manoeuvring, something engrained in the day-to-day workings of any parliamentary debate. But given the importance of the topic at hand, the inherent political challenges it already faces as a morality policy, and the fact that the main governance mode of the Assembly is its function as a forum of deliberation, such astute political manoeuvring is a concern. A number of media and public sources focused on the text adopted by the Assembly preceding the 2009 debate, paying no attention to the questionable democratic process behind it. For example, The European Centre for Law and Justice hailed a “Major Victory for Life in Europe”, the London *Daily Telegraph* stated “Euthanasia and assisted suicide should be banned in every country in the Continent, the Council of Europe has ruled.” The net result is true, that is what the Parliamentary

²⁶³ Who is now the current chairman of the UEL.

²⁶⁴ Referring to the Social, Health and Family Affairs Committee.

Assembly decided. But the final text must be stated with the proviso about how this decision on assisted dying was reached: by the insertion of a last minute oral sub-amendment unrelated to the detailed report, and passed by 11% of the Assembly parliamentarians.

Third, questions must be raised about the less than transparent role played by INGOs in the above policy-making on assisted dying. In the Assembly debate on Recommendation 1418, only one parliamentarian made reference to consultation with NGOs. Mr Briane (France, *EPP*) spoke on behalf of the INGOs in the Health Group, who he said 'have seen the document'²⁶⁵ and 'offer their full support'. In the 2004 and 2005 Assembly debates, again only sporadic references were made to INGOs. The European Association for Palliative Care (EAPC) claims, via its national associations, to have 'reacted strongly' to the first Marty report, and 'contacted its national representatives on the Council'.²⁶⁶ Mr Dees and Mr Marty stated that the European Organisation of Nurses supported the second report and draft resolution for an open public debate. Leaving aside casual references to the work of NGOs, the Conference of INGOs (its Standing Committee, Bureau or sub-committees) have adopted no official texts, publications or press releases on assisted dying. Thus, the 'fourth pillar' of the Council of Europe has so far remained largely inactive on the issue. This is not intended to downplay the Conference's capacity to mobilize interest groups on both sides of the debate. The 'pro-assisted dying' movement is represented in the Conference of INGOs by the 'right-to-die Europe'²⁶⁷ (which only acquired participatory status in 2013), alongside the International Humanist and Ethical Union. There is also a number of INGOs with participatory status likely to object to assisted dying – such as the European Association for Palliative Care, Disabled People's International: Region Europe,²⁶⁸ and numerous religion-based organisations. As for the means to increase direct engagement between these organisations and sub-

²⁶⁵ Referring to AS/Soc Doc. 8421 'Protection of the human rights and dignity of the terminally ill and the dying'.

²⁶⁶ See European Association of Palliative Care, 'Report on Euthanasia', , available at: http://www.eapcnet.eu/Themes/Policy/Europeaninstitutions/CouncilofEurope/COE_Marty.aspx

²⁶⁷ This is the European division of the World Federation of Right to Die Societies. Its only involvement since obtaining participatory status was to send a letter to the Committee on Bio-ethics [DH-BIO] concerning its 'Draft guide on the decision-making process regarding medical treatment in end-of-life situations' DH-BIO/INF (2013) 1. It stated its support for the 'main thrust of the document' but also stated its reservation over a caveat in Paragraph 11, which 'wrongly' asserts that euthanasia or assisted suicide 'do not involve medical treatment.'

²⁶⁸ This organisation has publically condemned assisted dying in a 2003 'Statement on Bioethics'. Available at: <www.biopolitics-berlin2003.org/docs.asp?id=144>.

committees/steering committees' some inspiration may be had from the 'Launching Conference' on medical treatment in end-of-life situations, excluding cases of assisted dying, as organised by the Committee on Bioethics (DH-BIO). Said Committee has the experience in bringing together experts and stakeholders for symposiums, research programmes and conferences. This may readily be done with a focus purely on assisted dying - a topic avoided by DH-BIO in its recent focus on end-of-life treatment. And moreover, it may invite representatives of concerned INGOs to formally present positions and form partnerships (joint positions) to increase awareness-raising efforts in the Contracting States.

(ii) Substantive concerns regarding the reports, debates and recommendations:

It is argued here that the '1999 report' (above) by the Parliamentary Committee on Social, Health and Family Affairs, which was endorsed by the Committee on Legal Affairs and Human Rights, was based on (i) questionable accounts on legal control, and (ii) a shaky slippery slope argument.

In relation to the first assertion, it stated that 'experiences in societies that have a lenient approach towards the prohibition against taking life show that in due consequence human beings are killed without their consent.' To test the validity of this statement, we need empirical results – a comparison of the frequency of non-voluntary termination of life before and after legislation on assisted dying. However, there are no empirical results to support or reject AS/Soc's assertion – either at the time of writing the report, or at the time of writing up this study. Griffiths, Weyers and Adams point out that legal-sociologists 'do not know how much non-voluntary termination of life there was in the Netherlands before the legislation of euthanasia and the only evidence afterwards suggests a modest decline.'²⁶⁹ The limited comparative data available since the report was made does cast doubt on the sureness of its assertion. Such data implies there is no substantial difference in the frequency of termination of life without a request in societies that permit assisted dying as compared to those that do not. But as this data is contestable for extrapolation purposes, like any data on the issue, it serves limited value on either side of the debate. It is equally problematic to make such assertions in regard to Switzerland. The AS/Soc report must be entitled to stress concerns about indirectly opening the door to an increase

²⁶⁹ J. Griffiths, M. Adams and H. Weyers, *Euthanasia and Law in Europe* (Hart, 2008) 515.

in non-voluntary termination of life, but it should not have authoritatively claimed there is evidence to prove this occurrence in other societies.

The second assertion states that legalising assisted dying will inevitably result in increasing individual and/or social pressure on terminally-ill persons, who are already 'under the impression of being a burden while society offers the option of having oneself killed.'²⁷⁰ Moreover, the report states that such 'annihilation of life'²⁷¹ without consent will eventually become socially accepted. On the one hand, this assertion implies a legitimate fear of insufficient legal control once assisted dying is permitted. It is only inevitable that some individuals will exercise undue influence over terminally ill persons to opt for assisted dying, and that in some cases it *will* go unnoticed. However fundamentally legitimate that fear is, it must still be contextualized in light of the grim fact that there is no legislation capable of ensuring that these cases do not occur and go unnoticed. This does not mean, as Keown points out, that it is suitable to state that because the law will be broken, we must relax the law. Instead, it is a method of contextualization. It places the inevitable risk of undue influence in cases of assisted dying in the same category as the inevitable risks of undue influence (over terminally ill persons or not) in almost all end-of-life decision making scenarios. For example, it is hard to ignore the financial costs/burdensome considerations a cancer patient may face when presented with the self-determination to refuse life-prolonging treatment. If, as the AC/Soc imply, there is a distinction between being a burden 'in a society which offers the option to have oneself killed' and being a burden in society which allows one to refuse costly life prolonging medical treatment, that distinction cannot be that only one and not the other poses a grave risk of abuse in terms of non-voluntary decision making due to external/societal factors. If the risks are comparable, so too must be the risk minimisation measures. However, AS/Soc consistently championed the right to refuse treatment and made no mention of its inherent risks. The reality is that there is no obvious legal control framework on any end-of-life decisions, not least one that suits the diversity of States in the Council of Europe. The least that was demanded by the AS/Soc here was a starting

²⁷⁰ Para 55.

²⁷¹ Arguably, this may be flagged as loaded language. The specific use of the noun 'annihilation' (meaning complete obliteration or destruction) in the context of ending 'life', appeals to a particularly negative emotional response. It implies a malicious motive. For example, one would not readily describe (however factually true it may be) lawful self-defence that causes death to be a lawful 'annihilation' of life.

point in context and based on a fair assessment of the different frameworks that exist. Unfortunately, it only expressed legal-control fears over assisted dying and justified its stance by relying on questionable conclusions of ‘experiences’ in the Netherlands and Switzerland.

On the other hand, the second assertion in the report is based on a concern over the weak moral standards of future generations. If we allow compassionately-motivated (voluntary) forms of assisted dying, it will inevitably facilitate an increase in selfishly-motivated (and thus non-voluntary) forms of assisted dying, which will eventually become acceptable behaviour. The crux of AS/Soc’s reasoning here reads as: we must not accept A, because if we do, *they will* accept B. This is a disputed basis for policy-making. There is good reason to be weary of policy making on the basis of an instrumentalist understanding of the relationship between law and its working in society.²⁷² In other words, the AS/Soc’s presumption that legal rules (strict or not) allowing assisted dying will have a direct cause (an increase) on a particular behaviour (non-voluntary assisted suicide) and the moral reaction to (societal acceptance of) such behaviour ignores the complexities of any casual mechanism between legal rules and subsequent social effects. As the Dutch experience shows, since the introduction of legal rules allowing a limited type of assisted dying, there has been an increase in control mechanisms (such as SCEN consultation, reporting and reviewing by the RRCs, and prosecution proceedings) designed to reduce instances of non-voluntary assisted dying.²⁷³ This is not to say that there is casual relation between the Dutch law and this increase in legal control, they may be directly related, indirectly related, or simply unrelated - but it is a quantitative fact that the Dutch legal policy allowing assisted dying has not become more accepting of non-voluntary assisted dying. Moreover, it is problematic for legal policies to be shaped on the presumption expressed by AS/Soc that future generations *will lack* the moral ability to make fundamental distinctions that present-day policy makers do not lack - in this case between the acceptability of a compassionate act of voluntary assisted dying and the abhorrence of pressurizing the ‘burdensome’ terminally ill into acts of non-voluntary assisted dying.

²⁷² The relationship between a rule and its social effects is conceived of in the instrumentalist paradigm as a straightforward causal one. See J. Griffiths, ‘The Social Working of Legal Rules’ *Journal of Legal Pluralism and Unofficial Law* 48 (2003).

²⁷³ See CHAPTER 5 of this book.

These criticisms of AS/Soc's report were not shared by the majority in the Assembly or in the Committee of Ministers. Instead, the report appeared to have caught the mood of the political elite in Europe – it received support and resulted in a Recommendation rejecting assisted dying and a response by the Committee of Ministers endorsing said Recommendation. This mood was patent in the defeat of the two Marty reports before the Assembly half a decade later, and the adoption of the 2012 Resolution stating that VAE 'must never be permitted'. From examining the Assembly debates in particular, one can see the relevance of Mucciaroni's take on the political effects of morality policy. Simply put, the outcome of the political debate was almost a given due to the framing (strategic or not) of the issue by adherence to 'principle above instrumental rationality.'²⁷⁴ This is not to say by any means, that principle has no place in the Assembly - but rather that principle alone must not come at the expense of coherent reasoning. The second Marty report merely asked to encourage member states to ensure that there was an informed public debate on assisted dying. There were, of course, some more questionable elements of the report. For example, in its assessment of the *Pretty* decision, it focused on the recognised scope of Article 2 and not on Article 8,²⁷⁵ and also some of the data overestimates the number of doctors involved in acts of assisted dying.²⁷⁶ However, its conclusions were neutral. It stated that there is no clear cut answer to the legal policy question on assisted dying, and that the '[c]ultural and religious differences in Europe are far too great for our Assembly [...] to envisage any single solution applicable to everyone.'²⁷⁷ The core message was that open, honest debate is 'vital', and moreover, that the focus must not be only on VAE but also on *all* end-of-life decisions. However, the report's call for instrumental rationality was largely met with principled arguments that assisted dying is abhorrent and that the report must therefore be rejected (which it was). The report - a call for open debate - was deemed in itself a threat with untold

²⁷⁴ G. Mucciaroni, 'Are debates about 'morality policy' really about morality? Framing opposition to gay and lesbian rights' (2011) 39(2) *The Policy Studies Journal* 187–215.

²⁷⁵ Marty report (n 232) para 24.

²⁷⁶ For example, the report pointed to a survey of UK doctors (see B.J. Ward and P.A. Tate, 'Attitudes among NHS doctors to requests for euthanasia', *BMJ* 1994. 308:1332–1334), in which almost 60% replied that they had been asked to hasten death, with 32% carrying out the request. However, this 60% includes 14% who were asked to let the patient die "through deliberate inaction", and the 32% who admitted taking active steps to end a patient's life represented only 9% of all the doctors who had been sent a questionnaire. Moreover, the report overlooked a relevant study in the UK which indicated a smaller involvement of doctors involved in assisted suicides (8% of respondents), see McLean S A M, Britton A. Sometimes a small victory. Glasgow: Institute of Law and Ethics in Medicine, University of Glasgow, 1996. 31–2 (appendix III, table 17).² (appendix III, table 17).

²⁷⁷ Marty report (n 232) para 49.

consequences on vulnerable persons. The Rapporteur of the report was perhaps entitled to reason, as he did: 'I have the impression that some of you have not read the report.'²⁷⁸

7.3.4 CONCLUSIONS

The effect of the Council of Europe's multi-level governance on national laws on assisted dying is open to criticism. In theory, multi-level governance in the Council of Europe has promising potential. It may introduce the issue of assisted dying to an inter-governmental forum for deliberation (the Assembly) and action (the Committee) with the participation of trans-national experts (sub-committees) and larger civil society (the Conference of INGOs). However, the evidently dubious procedural nature of the 'democratic' debates in the Assembly, the substantive shortcomings in the sub-committee reports and the ambiguous role of INGO involvement fall somewhat short of this offer. Arguably, this form of governance in the Council of Europe has increased the unwarranted politicization of the law on assisted dying. In other words, the legal policy debate on assisted dying was exposed, but this time on a well-respected European-level, to partisan and polarized ideologies. In a sense, the Parliamentary Assembly and the Committee of Ministers adopted policies drawn from causal beliefs of society and thus revalidated the national belief system and intellectualized its utility and effectiveness. The result was a public endorsement for policies advocating absolutism and status quo bias on assisted dying, which may in turn be authoritatively relied on by national political actors and institutions to further justify inaction. A case in point is the opportunity presented to elected officials to point to the 'democratic' rejection of the Marty report in the Assembly - Europe's 'democratic conscience' - to justify the avoidance of merely organising an open public debate on assisted dying.

²⁷⁸ Mr Marty also, quite correctly, picked up on statements by certain parliamentarians describing the report in the debate that simply contradicted the actual text of the report.

THE EUROPEAN UNION AND ASSISTED DYING

INTRODUCTION

The involvement of the EU in national laws on assisted dying is not a popular idea. The most obvious objection stems from the Treaty and the EU's catalogue of competencies therein. At the risk of stating the obvious, the Union's legislative bodies have no competence in the field of assisted dying.¹ The basic principle of subsidiarity applies: decisions on this issue must be made as closely as possible to the citizen. Article 4 TEU states:

“The Union shall respect the equality of Member States before the Treaties as well as their national identities, inherent in their fundamental structures, political and constitutional [...] It shall respect their essential State functions [...]”

In practice, the EU has, on more than one occasion, acquiesced to the Member State demands of self-determination over morality policies.² Leaving aside Treaty text and practice, there are obvious deeper objections to EU interference in national governance processes regarding morality policies. First and foremost, the determination of such policies and the ‘first principle’ questions that arise (i.e. the ‘ideal dimension of the law’) - such as: ‘is it ever right to assist a person in their own death?’ - do not easily lend themselves to the Union's transnational processes of rationalization. As de Witte points out: the EU cannot replicate the ‘institutional and normative preconditions required for it

¹ At the most, it may fall within the field of ‘supporting competences’ (Article 6 of the TFEU): the EU can only intervene to support, coordinate or complement the action of Member States.

² For example: the Netherlands succeeded in inserting a short paragraph in the Schengen Convention to guarantee that increased European-wide cooperation against international drug trafficking would not spill over into forced harmonization of national drug control strategies. Ireland insisted on a separate protocol to the Treaty of European Union (Maastricht Treaty) to the effect that future European Court of Justice decisions could not void and nullify the eighth (anti-abortion) amendment of the Irish Constitution. Swedish and Finnish negotiators extracted concessions from the Commission to protect the state-owned retail monopoly from outside competition.

to be a space of communal self-expression.’³ As touched upon in **CHAPTER 2**, these preconditions are vested in the State via a sophisticated political framework that mediates between conflicting norms on the permissibility of certain controversial behaviours. This type of majoritarian legitimacy in turn increases the normative obligation to voluntarily comply with decisions of authority – even if we happen to be in the minority and disagree with the decision.⁴ Aside from the institutional capacity to account for shared norms on first-principle questions, the State also provides strong legal and administrative compliance mechanisms to defend the polity’s moral choices.⁵ There is therefore a strong normative and institutional basis to the argument that the autonomy of the national ‘political forum through which such values are articulated and renegotiated’⁶ is respected. In short, the EU does not have a culturally entrenched and robust political structure of mediation, safeguarded by democratic ideals.⁷ Moreover, if we put the EU’s institutional inadequacies to one side for a moment, its underlying motives are popularly considered to be economic-driven, and thus far removed from any (if not abhorrent to) concerns about manifest morality policies. These deficiencies drastically highlight the default-like appeal to oppose any shift towards governance beyond the State on highly sensitive morality policy, particularly via the EU.

As a result, the words ‘assisted dying’ and ‘the EU’ are rarely used in the same sentence.⁸ This chapter argues that there is a connection between them, and one that deserves attention. This is particularly so in light of the underlying concerns and questions outlined in **CHAPTER 2** and **CHAPTER 6**,⁹ and in light of the EU’s ability to place normative limitations on national politics. This chapter challenges us to think beyond the contractarian reflex that equates the pursuit of morality policies (specifically assisted dying) with political

³ F. de Witte, ‘Sex, Drugs & EU law: The Recognition of Moral and Ethical Diversity in EU law’ (2013) 50(6) *Common Market Law Review* 1545-1578. See also D. Chalmers, ‘The European redistributive State and a European law of struggle’ (2012) 18 *European Law Journal* 667; Lisbon ruling of the BVerfG, 2 BvE 2/08 of 30 June 2009.

⁴ F.W. Scharpf, ‘Legitimacy in the multi-level European polity’ in M. Loughlin and P. Dobner (eds) *The Twilight of Constitutionalism?* (Oxford University Press, 2010).

⁵ D. Chalmers, ‘European restatements of sovereignty’ (2013) *LSE Law Working Paper* 10.

⁶ De Witte (n 3) 1545, 1546.

⁷ A.P. McCann, ‘The CJEU on Trial: Economic Mobility and Social Justice’ (2014) 22(5) *European Review of Private Law* 729-768.

⁸ See for an exception to this: S. Nic Shuibhne, ‘Margins of appreciation: National values, fundamental rights and EC free movement law’ (2009) 34 *EL Rev.* 230. Where Nic Shuibhne briefly raises the issues of free movement to receive euthanasia in the Netherlands or Belgium.

⁹ Such as the need for alternative governance mechanisms to mitigate the often unwarranted effects of political monopoly over the law on morality policies at the nation state level.

self-determination by a demos, and to observe the distinct normative objectives of certain EU governance mechanisms – namely that of (i) judicial governance and free movement rules,¹⁰ and (ii) network governance *vis à vis* epistemic communities.¹¹ The preceding section sets out a number of reasons why we should not discount the role of the EU in affecting national policies on assisted dying. Then a very brief governance overview of the Union is provided to situate the proposed mechanisms in their wider institutional context. Finally, these mechanisms are explored, unveiling the EU's capacities and limitations to effect national policies on assisted dying.

8.1. TAKING EU GOVERNANCE AND ASSISTED DYING SERIOUSLY

Here, four inter-linked arguments are set out regarding the EU's general potential to mitigate the externalities of national level public governance *through* the law. For EU lawyers, these arguments may seem banal, but in the broader governance context of this study they are warranted. They showcase how constraining national practises by way of the EU may benefit (but not offer, by any means, a panacea for) national decision-making on morality policies.

The first argument may be described as the *transnational effects of integration*. Joerges and Neyer aptly explain its underlying logic:

“The kernel of our argument is that the legitimacy of governance within constitutional states is flawed insofar as it remains inevitably one-sided and

¹⁰ On judicial governance and the EU see, amongst others: C.U. Schmid, 'Judicial Governance in the European Union' in E. Eriksen, C. Joerges and F. Rödl (eds) 'Law and Democracy in Europe's Postnational Polity' (ARENA report 1/2006) 197-233; A. Stone-Sweet, 'The European Court of Justice and the judicialization of EU governance' (2010) 5(2) *Living Review of European Governance*; A.L.B. Colomi Ciacchi, 'Judicial Governance in Private Law through the Application of Fundamental Rights' 1(1) *Austrian Law Journal* 120-134.

¹¹ P. Haas, 'Introduction: Epistemic Communities and International Policy Coordination' (1992) 46 *International Organization*, 1-35; See B. Kohler-Koch and R. Eising (eds), *The Transformation of European Governance* (London: Routledge, 1999).

parochial or selfish. The taming of the nation-state through democratic constitutions has its limits.”¹²

National democracies have a systemic defect – they are, according to Somek ‘burdened with a grave deficiency [...] predisposed to disregard the interests of those who, in spite of being affected by their operation, remain in a disenfranchised state.’¹³ Accordingly, Maduro evidences how this reasoning provides the basis for a certain legitimacy to free trade regimes or a common market. From this perspective, international guarantees of economic mobility, when correctly understood, turn out to be guarantees of political rights.¹⁴ EU economic mobility may boldly be understood as a means not only to extend democracy, but to enhance democracy.¹⁵ It demands that interests not represented in the democratic process, but which are nonetheless affected by the process, are taken into due consideration.

The second argument is that of *constrained democracy*. In its more historical form (and less relevant for our purposes) it purports that European integration may limit political self-determination on the national level in order to mitigate ‘extremely violent practices of internal exclusion and external antagonism’¹⁶ – and thus maintain peaceful relations.¹⁷ In its more modern form, this argument stresses that the national processes of political self-determination will almost inevitably lead to restricting the capacity of the individual to partake in the development of society (violence *of the sovereign*) and to under-protecting internal minorities or external others.¹⁸ The argument of constrained democracy demands a shift in policy-influence towards judicial governance (e.g.

¹² See C. Joerges and J. Neyer, ‘From Intergovernmental Bargaining to Deliberative Processes: The Constitutionalisation of Comitology’, (1997) 3 *European Law Journal* 273–299 at 293.

¹³ A. Somek, ‘The Argument from Transnational Effects 1: Representing Outsiders through Freedom of Movement’ (2010) 16(3) *ELJ* 320.

¹⁴ M.P. Maduro, *We The Court: The European Court of Justice and the European Economic Constitution* (Hart Publishing, 1998).

¹⁵ Not only is democracy pushed beyond its traditional limits, but it can have a correcting effect. Nation states can be forced to take the interests of foreign democratic constituencies into account on the basis of international arrangements that require them to heed how their choices affect outsiders, even if only retrospectively. See Somek (n 13) 321.

¹⁶ E. Balibar, *We, the People of Europe?* (Princeton University Press, 2004) 184.

¹⁷ Müller, ‘Beyond militant democracy’ (2012) 73 *New Left Review* 43; J.W. Müller, *Contesting Democracy* (Yale University Press, 2011), 128 et seq.

¹⁸ O. Parker, *Cosmopolitan Government in Europe* (Routledge, 2013) 28 et seq; J. Kristeva, *Nations without Nationalism* (Cambridge University Press, 1993) 51.

constitutional or transnational courts), expert governance (e.g. independent non-political agencies), and market governance (e.g. through the expression of individual preferences).

The third argument is premised on the *entry and exit options*. In short, EU law allows individuals to not only escape the normative limitations imposed by their own Member State but also to challenge normative limitations imposed in the host Member State. For Weiler and Lockhart, the Union's very ethos 'is achieved through the inability of Member States, practical and legal, to screen off different social choices, legally sanctioned in other Member States.'¹⁹ On the one hand, the 'escaping' of domestic limitations is what Kremier would describe as the 'exit option' protected by federalism.²⁰ In a similar vein, Kochenov aptly states 'if the moral choices made by the member state of your residence (or nationality) do not suit you, the obvious option open to all EU citizens²¹ [...] is to choose a different state of residence, where the laws are less restrictive'.²² The phenomenon of cross-border reproductive healthcare - whereby women travel abroad to receive fertility treatment - is an example of this pragmatic 'exit option' in the context of a manifest morality policy.²³ On the other hand, the 'challenging' of foreign normative limitations may be described as the 'entry option' - obliging states (the host state) to recognise different social choices made in another state (the home state). This ties in with what Azouli describes as the re-contextualizing effects of free movement on the national decision making process, whereby the normative standards are 'denationalized.'²⁴ Excluding its *de facto* application in ideologically charged domains, the entry option 'is already a day to day reality in the EU.'²⁵

¹⁹ J.H.H. Weiler and J.S. Lockhart, "'Taking rights seriously" seriously: The European Court of Justice and its fundamental rights jurisprudence' (1995) 32 *CML Rev* 604.

²⁰ S.F. Kreimer, 'Federalism and Freedom' (2001) 66 (574) *American Academy of Political and Social* 72-73. See also, the seminal work of A.O. Hirschman, *Exit, Voice, and Loyalty* (1970) (discussing the exit option concept).

²¹ On the concept of European Union ("EU" or "Union") citizenship, see, inter alia, D. Kochenov, 'Ius Tractum of Many Faces: European Citizenship and a Difficult Relationship Between Status and Rights' (2009) 15 *Colum.J. Eur. L.* 169, and the literature cited therein.

²² D. Kochenov, 'On options of citizens and moral choices of states: Gays and European federalism' (2009) 33 *Fordham International Law Journal* 191. See also T. Kingreen, 'Fundamental freedoms' in Von Bogdandy and Bast (eds) *Principles of European Constitutional Law* (Hart, 2008) 561.

²³ *R v Human Fertilisation and Embryology Authority, ex parte Blood* [1997] 2 All ER 687 Attorney General's Reference (No. 3 of 1994) [1998] AC 245.

²⁴ L. Azouli, 'The Court of Justice and the social market economy: The emergence of an ideal and the conditions for its realisation' (2008) 45 *CML Rev.* 1342-1343.

²⁵ Kochenov provides the example of the 'home-country rule' in the law on free movement of services, Kochenov (n 22) 157.

The fourth argument (which is considerably less explored yet perhaps most applicable to the study at hand) is based on Kukovec's *freedom/limitation* dichotomy. To better explain this argument, brief attention may be paid first to Micklitz's concept of 'access justice/*Zugangsgerechtigkeit*'. This is justice through market access, *not* access to justice.²⁶ It purports that the EU model of justice does not aim for redistributive social protection,²⁷ or for allocative libertarian concepts of justice.²⁸ Instead, the concept of access justice is more akin to that of 'equity' in Common Law,²⁹ realizing regulatory law to counterbalance the market freedoms. From such a perspective, this EU model of justice essentially contains two elements: (i) breaking down the barriers which limit market participation/access, and (ii) strengthening the position of consumers and workers with a view to enforcing their rights. It is the second element that must be emphasised here, and Micklitz's sentiment that: '[r]ights are useless if they cannot be enforced.' In this sense, the EU's capacity to turn theoretical choices into realistic opportunities through the effective judicial protection of 'economic' legal rights is commendable. A number of cases exemplify this, whereby market-based Treaty rights³⁰ provided the means to *de facto* achieve fundamental human entitlements (regardless of preferred classification of first, second or third generation rights) – such as access to crucial health care, the continuation of one's education, integration into society, and the protection of fair employment opportunities.³¹ The Former Advocate General Ruiz-Jarabo Colomer stated that stepping back from singular decisions, the Court's judgments collectively:

²⁶ See H.W. Micklitz, 'Social Justice and Access Justice in Private Law', EUI Working Papers Law 2011/02.

²⁷ In the sense that the addresses of EU labour law, anti-discrimination and consumer law are hardly the vulnerable members of society. The normative *leitbild* for the completion of the internal market is the 'omnipresent market citizen'.

²⁸ In the sense that EU labour law, anti-discrimination and consumer law all contain certain normative concepts (such as the vulnerable consumer in Directive 2005/29 on unfair commercial practices or in the field of services of general economic interests) that run counter to the *leitbild* of the internal market – the 'omnipresent market citizen.'

²⁹ 'Equity was meant to compensate for the deficiencies which resulted from the narrow and formalised rules on writs which restricted access to common law.' Micklitz (n 26).

³⁰ In such cases, the legal ambit of the fundamental freedoms was interpreted broadly: extending to all types of contracts, all types of parties and players (Member States, Community, private law subjects), and all types of obstacles, explicit or not, direct or indirect. See S. Grundmann, W. Kerber and S. Weatherill, *Party Autonomy and Role of Information in the Internal Market- An overview* (Berlin: de Gruyter, 2001); P. Müller-Graff, 'Private Law Society in the Constitution of the European Union' in M. Faure, J. Smits and H. Schneider (eds), *Towards a European Ius Commune in Legal Education and Research* (Antwerp: Intersentia, 2002) 57–70. This broad understanding fits neatly into Micklitz's concept of *access justice*.

³¹ D. Chalmers, *European Union Law – Text and Materials* (1st edn, Cambridge University Press, 2006) 543; and also E. Spaventa, 'From Gebhard to Carpenter: Towards A (Non)-Economic European Constitution' (2004) 41 *CMLRev.* 743-773; A. McCann, 'Economic Mobility, Social Justice and the CJEU on Trial' (2014) 22(5) *European Review of Private Law* 729-767.

‘demonstrate a tendency towards protecting individuals, a concern with the personal situation of those who exercise a right under the Treaties which in the past was much less evident. Thus, the free movement of persons acquires its own identity, imbued with an essential nature that is more constitutional than statutory, transforming it into a freedom akin to the dynamics of the fundamental rights.’³²

This provides a strong basis to support Kukovec’s theory. The simplified ‘economic v. social’ dichotomy in popular legal discourse ignores the more wholesome conceptualization of a type of access justice.³³ In short, the EU’s legal system is better understood as a system of *freedoms* and *limitations*. What is ‘social’ and what is ‘economic’ depends entirely on your perspective, rather like Wittgenstein’s duck/rabbit portrait. As Kukovec acknowledges ‘what from one perspective looks like a protection against harm, from another perspective looks like a claim for autonomy’. There is sufficient evidence that ‘economic’ mobility is not treated as an end in itself but rather a pragmatic functional means – largely, at the Court’s disposal – to protect individual freedom from disproportionate limitations and the follies of state politics.

This section has evidenced that the EU’s potential to mitigate the externalities³⁴ of *governance by the state* should be taken seriously. The next sections take a closer look at the various governance dimensions in the EU itself. It is well beyond the scope and purpose of this book to give a general account of EU governance - or as Hix puts it: a general account of ‘*how the EU works today*’.³⁵ However, a number of points must be made to very briefly explain where any *relevant* governance dimensions (for our purposes) conceptually fit within the broader framework of the Union.

³² Opinion of AG Ruiz-Jarabo Colomer in Case C-228/07 *Petersen v Arbeitsmarktservice Niederösterreich* [2008] ECR I-6989, paras. 17- 18.

³³ On this point Kaupa also shows how the economic/non-economic doctrine is not only susceptible to ideological biases, but also dysfunctional in the practical sense that it is actually unable to explain the decisions made by the CJEU. C. Kaupa, ‘Internal market law and the crisis: contested economic knowledge, democratic governance and the limits of the Treaty freedoms.’ (on file with the author - acquired as reading material for the ‘International Conference on the Moral Limits of the Internal Market’ at University of Amsterdam).

³⁴ Externalities acutely present in the case of manifest morality policies – see **CHAPTER TWO**.

³⁵ S. Hix, *The Political System of the European Union* (Basingstoke and London: MacMillan, 1999).

8.2. BROADER ASPECTS OF EU GOVERNANCE – A BRIEF OVERVIEW

It is not uncommon to reason that the EU does not represent one particular type of governance, but features different combinations of market, network and hierarchy.³⁶ To explain these different combinations, we may take as a point of departure the abstract relationships between law and governance set out in **CHAPTER TWO**.

(i) PUBLIC GOVERNANCE THROUGH THE LAW AT THE EUROPEAN UNION-LEVEL

‘Supranational’ public governance through the law³⁷ involves decision and policy making by central institutions and actors (the European Commission, the Council of Ministers, the European Parliament, and the European Court of Justice) in the creation and interpretation of binding EU law. There are two techniques of supranational public governance *through* the law: (i) positive integration and (ii) negative integration.³⁸ The former approach requires some form of harmonization of national rules via formal European legal norms, such as a regulation or a directive. These binding norms usually emanate from the notional ideal-method of EU centralized law-making, known as ‘the Ordinary Legislative Procedure.’³⁹ Scott and Trubek identified this⁴⁰ as the benchmark which new forms of governance can be measured against. This ideal-method involves the exercise of legislative power by the EU following the Commission’s initiative, leading to the adoption of legislation by the Council and Parliament and resulting in a binding uniform rule that is subject to the jurisdiction of the Court.⁴¹ The latter approach – negative integration - occurs when the national court via a ruling from the European Court

³⁶ See T.A. Borzel, ‘The European Union – A unique governance mix?’ in D. Levi-Faur (ed), *The Oxford Handbook of Governance* (New York, 2012) 613-627. Majone explains that the institutional architecture of the EU reveals striking similarities to a much older model of governance known as *mixed government* - a system characterized by the presence in the legislature of the territorial rulers and of the ‘estates’ representing the main social and political interests in the polity. See G. Majone, ‘The Community Method’ in G. Majone (ed) *The Dilemmas of European Integration* (Oxford University Press, 2005) 6.

³⁷ Note that this is distinct from another form of governance *through* the law at the Union-level: intergovernmental governance through the law. Here, central *state* actors/institutions and *state* sovereignty are privileged in policy-making more than central EU actors/institutions. The policy output that results is often less detailed or prescriptive. Although under the Common Foreign and Security Policy, intergovernmental governance results in the adoption of binding measures which are obligatory for the Member States.

³⁸ G. Majone, ‘Positive and Negative Integration’, in: G. Majone (ed), *Dilemmas of European Integration* (Oxford University Press, 2005) 14.

³⁹ As set out in Article 294 TFEU.

⁴⁰ J. Scott and D. Trubek, ‘Mind the Gap: Law and New Approaches to Governance in the European Union’, (2002) 8 *ELJ* 1. At the time said article was written, the method was known as the ‘Classic Community Method’ and not the ‘Ordinary Legislative Procedure.’ In any case, both reflect most of the same procedural elements.

⁴¹ See Craig and de Burca, *EU Law: Text, Cases and Materials* (Oxford University Press, 2011) 160.

of Justice declares a national rule inapplicable because it unjustly restricts free movement. As observed by Majone, 'negative integration is not only about removing restrictions on the free movement of the factors of production, but also about [...] monitoring closely the behaviour of national regulators to make sure they do not abuse their autonomy for protectionist purposes or violate rights guaranteed by EU law.'⁴²

The rationale for Member State's delegating (both positive and negative harmonization) power to central EU actors and institutions is explained by a number of political scientists as 'new institutionalism.' First, new institutionalists argue, and indeed evidence, how institutions matter⁴³ in understanding EU policy-making.⁴⁴ Second, of the variations within this school of thought, particular weight is given here to 'rational choice institutionalism'⁴⁵ and elements of 'sociological institutionalism.'⁴⁶ Rational choice institutionalists, such as Pollack, Stone-Sweet and Majone, seek to explain why supranational EU actors have a certain autonomy from national governments in the first place. They do so by focusing on contemporary 'delegation' or 'principal-agent' theory.⁴⁷ Simply put, Member States (the Principal) have handed some authority – or 'political property rights' – to make binding decisions over to EU institutions (the Agent). The Member States also have the on-going power to 'constitute themselves as a collective body for the purposes of revising the treaty law that constitutes the regime.'⁴⁸ Since they are willing to pay the costs of delegation, it may be assumed that Member States expect the benefits of delegation to outweigh costs, over time. In this sense, delegation to

⁴² G. Majone, 'Positive and Negative Integration' in G. Majone (ed), *Dilemmas of European Integration* (Oxford University Press, 2005) 14.

⁴³ Matter, in the sense, that they are more relevant than behaviouralists suggested. See I. Bache, S. George and S. Bulmer, *Politics in the European Union* (3rd edn, Oxford University Press, 2011) 23.

⁴⁴ J.G. March and J. Olsen, 'Institutional Perspectives on Political Institutions' (1996) 9 *Governance* 247-264; S. Bulmer, 'The Governance of the European Union: A New Institutional Approach' (1993) 13 *Journal of Public Policy* 351-380; S. Bulmer, 'New Institutionalism and the Governance of the Single European Market' (1998) 5 *Journal of European Public Policy* 365-386.

⁴⁵ The former stresses the importance of looking at formal institutional structures (and constraints therein) in order to understand the behaviour of policy makers. In this sense, it lends conceptual support to the arguments (outlined above) for *transnational effects of integration* and *constrained democracy*. For example, from the perspective of rational choice institutionalism: market actors that are "outside" the sphere of influence in national decision-making or democratic processes are likely to turn to the supranational institutions to get their voices heard.

⁴⁶ P. Hall and R. Taylor, 'Political Science and Three and the Three New Institutionalisms' (1996) 44 *Political Studies* 936-957.

⁴⁷ M. Pollack, *The Engines of European Integration: Delegation, Agency and Agenda Setting in the EU* (Oxford University Press, 2003).

⁴⁸ A. Stone Sweet, 'The European Court of Justice and the Judicialization of EU Governance' (2010) 5(2) *Living Reviews in European Governance* 10.

supranational public governance *through* the law takes place in so far as it is functional for (i.e., “in the interest of”) the Member States in the long run.⁴⁹

Majone, Pollack, Talberg, Thatcher and Stone-Sweet have set out a number of general functional reasons for why it is in the Member States’ interest to ensure supra-national governance through the law.⁵⁰ In sum: central EU institutions and actors (especially, the Commission and the Court) can help Member States, *inter alia*, to find solutions to commitment problems;⁵¹ mitigate information asymmetries in technical areas of governance;⁵² increase the efficiency of rule making;⁵³ and evade taking blame for unpopular policies.⁵⁴ To explain the rationale behind delegating power to the European Parliament, we may turn more to the logic of appropriate behaviour identified by sociological institutionalists. In other words, the Parliament’s increasing power is to contribute to social legitimacy rather than efficiency. Indeed, the rationalist ‘logic of instrumentality’ (efficiency) may, once manifested in certain policy domains, clash with the sociological ‘logic of appropriateness’ (input legitimacy).

Returning to the issue at hand and as stated from the outset of this sub-chapter, the possibility of the EU to *positively* integrate national laws or reach binding measures on assisted dying is non-existent. In the parlance of the above delegation theory - there is a very ‘weak rationale’, namely from the perspective of sociological institutionalists, in delegating any law-making power on assisted dying to the EU. However as Kurzer points

⁴⁹ As we will see below, the Court’s ‘activism’ (e.g. in *Viking* and *Laval*) has left a number of national policy makers and commentators questioning whether EU law is actually in their interest any more. Such judicial governance creates tensions with the ‘Principle-Agent’ theory. This will be addressed below in more detail.

⁵⁰ M. Thatcher and A. Stone Sweet ‘Theory and Practice of Delegation to NonMajoritarian Institutions’, (2002) 25(1) *West European Politics* 1–22; G. Majone, *Dilemmas of European Integration: The Ambiguities and Pitfalls of Integration by Stealth* (Oxford University Press, 2005); M.A. Pollack, *The Engines of Integration: Delegation, Agency, and Agenda Setting in the European Union* (Oxford University Press, 2003); J. Tallberg, ‘The Anatomy of Autonomy: An Institutional Account of Variation in Supranational Influence’ (2000) 38(5) *Journal of Common Market Studies* 843–864.

⁵¹ i.e. the Union’s institutions are expected to enhance the credibility of promises made either between Member States, or between Member States and their constituents, given underlying collective action problems.

⁵² i.e. the Unions’s institutions are expected to possess, develop, and employ expertise in the resolution of disputes and the formation of policy in a given domain of governance.

⁵³ i.e. the Union’s institutions are expected to adapt law to situations (e.g., to complete incomplete contracts), while Member States maintain the authority to update policy in light of the EU’s efforts.

⁵⁴ i.e. by commanding the Union’s institutions to maximize specific policy goals, which Member States know may be unwelcomed with important societal actors and groups.

out, morality policies are not alien to the classic process of *negative* integration.⁵⁵ Thus in terms of examining supranational public governance *through* the law at the EU-level, the remainder of this study will focus only on the negative integration side (**Section 8.4**, entitled: '*The Free Movement of Suicide Tourists*'). In short it highlights the CJEU's capacity and limitations to second guess national rules that hinder 'suicide tourism.' For this reason, some brief points must be made regarding the particular structure of EU judicial governance.

Matti and Shapiro apply the above-mentioned 'logic of instrumentality' – simply put, the Union requires an effective Court to achieve its aims.⁵⁶ The CJEU's role is to overcome the various collective action problems associated with market and political integration.⁵⁷ By removing barriers to exchange within the Union (negative integration), pressure is put on national governments to consider Union-level action (positive integration). However, on a closer examination, serious questions arise over the default 'Principle-Agent' framework applied to explain EU judicial governance. Indeed, as Stone Sweet, Carposo and Majone attest, it may be more a case of 'Trusteeship'.⁵⁸ In other words, the Court has more power than a mere Agent:⁵⁹ it can annul acts taken by the EU institutions and the member states within the scope of EU law; it has compulsory jurisdiction; it is almost

⁵⁵ As seen in cases involving Swedish alcohol control policies, Dutch soft drug policies and prostitution control policies, Irish abortion control policies, and Italian gambling control policies, to name a few. See P. Kurzer, *Markets and Moral Regulation. Cultural Change in the European Union* (Cambridge: CUP, 2001).

⁵⁶ W. Mattli, *The Logic of Regional Integration: Europe and Beyond* (Cambridge University Press, 1999); M. Shapiro, "The European Court of Justice" in P. Craig and G. de Burca (eds) *The Evolution of EU Law* (Oxford University Press, 1999) 321–348; M. Shapiro, 'The US Supreme Court and the European Court of Justice Compared' in A. Menon and M.A. Schain (eds) *Comparative Federalism: The European Union and the United States in Comparative Perspective* (Oxford University Press, 2006) 195–220.

⁵⁷ The Court's jurisdiction to do so is laid out in four main Treaty articles: Article 258 TFEU ('enforcement actions' brought by the Commission); Article 263 TFEU ('annulment actions' brought by any Member State, the Parliament, the Council of Ministers, and the Commission); Article 267 TFEU ('preliminary reference procedure' whereby national judges send question on the interpretation of European law); and Article 259 TFEU ('infringement action' brought by one Member State against another).

⁵⁸ A. Stone Sweet and J.A. Caporaso, 'From Free Trade to Supranational Polity: The European Court and Integration' in W. Sandholtz and A. Stone Sweet (eds) *European Integration and Supranational Governance* (Oxford University Press, 1998) 92–134; G. Majone, 'Two Logics of Delegation: Agency and Fiduciary Relations in EU Governance' (2001) 2(1) *European Union Politics* 103–122

⁵⁹ As Pollicino puts it: 'Ever since the creation of the European Community, the Court of Justice has not simply been a group of judges with expertise in European law, but has represented one of the real driving forces of European integration. In other words, if today there exists something called E.C. law, with its own particular features, characteristics, and issues, all this is due to the Court's work. As, in a well known piece, Stein wrote of it, "tucked away in the fairyland Duchy of Luxemburg and blessed, until recently, with the benign neglect by the powers that be and the mass media, the Court of Justice of the European Communities has fashioned a constitutional framework for a federal-type structure in Europe.' O. Pollicino, 'Legal Reasoning of the Court of Justice in the Context of the Principle of Equality Between Judicial Activism and Self-restraint', 5(3) *German Law Journal* 284.

impossible for the Member States to restrict the Court's jurisprudence or reverse its decision. In this sense, the CJEU is a 'Trustee' of the aims of the Union and the general principles of EU law, its fiduciary responsibility (review authority) is discharged in the name of the aspirational entity set out in Article 1 TEU: 'The Peoples of Europe.'⁶⁰ The Treaties and general secondary legislation provide a breeding ground for judicial creativity. The Court has the capacity, within the programmatic nature of the law it must interpret, to determine its own zone of discretion and scope of its powers.⁶¹ There are certain seminal demonstrations of this judicial 'creativity'; certain constitutional-type decisions that are quite simply the bread and butter for first year EU law students. The Treaty of Rome made no mention of supremacy and the Member States did not provide for direct effect of Treaty provisions or secondary legislation. These are the product of the Court's broad interpretative freedom. This expansion of the scope of EU law via judicial governance has reached a new peak in recent years. The spill-over effect of the internal market rules has not stopped at national policies on tax, social security, education, immigration, or criminal procedures. Indeed, a more political constitutionalist view would see the Court's 'creativity' in 'filling in' the integration process *vis à vis* individual rights as a case of judicial activism, a usurpation of power, subverting the preferences of national governments and political communities. Indeed, there is a vast debate on the degree of scrutiny the Court in Luxembourg should place on the political autonomy of the Member States.⁶²

⁶⁰ A. Stone Sweet, 'The European Court of Justice and the Judicialization of EU Governance' (2010) 5(2) *Living Reviews in European Governance* 14.

⁶¹ This zone of discretion is quite extensive for explainable reasons. As the Former President of the ECJ, Kutscher points out: the nature of the Treaties encourages creative law making. Firstly, because they are the products of a compromise between States which may share ultimate goals but still represent different economic, social, political, and legislative backgrounds and may hold strongly divergent views on specific policy areas. In the second place, the Treaties are by nature programmatic, outlining policy in general terms without giving precise definitions. The CJEU has the role of filling the void left by the legislative branch. The inactivity of the legislature compels the Courts to decide questions and solve problems which should be dealt with by the legislature, i.e. the Council and the Commission, and to a lesser degree also the European Parliament. The Court refers to the aims of the Community and to general principles of EC law, and Community judges sometimes find themselves compelled to interpret from the standpoint of the existential necessities of the Communities and ensure the maintenance of their capacity to function. See H. Kutscher, President of Chamber at the Court of Justice: 'Methods of interpretation as seen by a judge at the Court of Justice' *Judicial and Academic Conference* sect 6(a).2 (ECJ, Luxembourg 1976).

⁶² For some fine examples see the contributions in D. Kochenov, G. De Burca and A. Williams, *Europe's Justice Deficit?* (Hart, 2015); H.W. Micklitz and B. de Witte, *The European Court of Justice and the Autonomy of the Member States* (Hart, 2012); M. Dawson, B. de Witte and E. Muir, *Judicial Activism at the European Court of Justice* (Edward Elgar, 2013).

Regardless of whether one views the Court's jurisprudence of 'filling in' the integration process or 'undermining the political community',⁶³ it is a fact that it has not acted autonomously. It has a complicit and indispensable relationship with national courts via Article 267 TFEU.⁶⁴ Explanations behind this vertical relationship, and indeed the true nature of the very relationship itself, are contested in EU political and legal discourse. Having said this, Weiler's seminal 'judicial empowerment' thesis remains undeniably popular.⁶⁵ In short, the 'incentive structures' in place for national judges and the CJEU's constitutional jurisprudence both pushed in the same pro-integration direction.⁶⁶ First, national judges are empowered to second-guess parliamentary and executive decisions. Second, Article 267 provides a degree of legal protection from political externalities for both EU and national judges – the CJEU responds to the national courts as required by the Treaty but does not apply EU law, while the national courts provide the case-load but only implement the CJEU's interpretation. As Stone-Sweet puts it:

'at critical moments, each court can claim to be responding to the requirements of the law, and the demands of the other court, thereby obscuring their own political role and empowerment.'

However, there is a darker side to this relationship too. Kumm correctly points out the more deep-rooted (and on-going) conflicts between the CJEU and national constitutional courts. This is what he describes as the 'the jurisprudence of constitutional conflict'.⁶⁷ National judges may resist developments that threaten to weaken national rights protection, undermine their own case-law, autonomy or close relations with other actors in the national government. As we will see, these are tensions that cannot be taken for

⁶³ G. Garrett, 'International Cooperation and Institutional Choice: The European Community's Internal Market' (1992) 46(2) *International Organization* 533–560; K.J. Alter, *The European Court's Political Power: Selected Essays* (Oxford University Press, 2009).

⁶⁴ The bifurcated system of justice established by the Treaty requires close co-operation between the ECJ and the national courts. See T. Tridimas, 'Bifurcated Justice: The Dual Character of Judicial Protection in EU Law' in *The Court of Justice and the Construction of Europe: Analyses and Perspectives on Sixty Years of Case-law - La Cour de Justice et la Construction de l'Europe: Analyses et Perspectives de Soixante Ans de Jurisprudence* (TMC Asser Press, 2013) 367-379.

⁶⁵ J.H.H. Weiler, 'The Transformation of Europe' 100(8)(1991) *Yale Law Journal* 2403–2483; J.H.H. Weiler, 'A Quiet Revolution: The European Court of Justice and its Interlocutors' (1994) 26(4) *Comparative Political Studies* 510–534.

⁶⁶ A. Stone Sweet (n 60) 29.

⁶⁷ M. Kumm, 'The Jurisprudence of Constitutional Conflict: Constitutional Supremacy in Europe before and after the Constitutional Treaty' (2005) 11(3) *European Law Journal* 262–307.

granted when looking at any involvement of EU judicial governance and national restrictions on 'suicide tourism.' Before this however, a brief attempt must be made to broadly contextualize another type of governance at the EU-level.

(II) PUBLIC-PRIVATE GOVERNANCE IN THE LAW AT THE EUROPEAN UNION-LEVEL

Regarding EU public-private governance *in the law*, the central EU supranational actors/institutions are still involved in policy making, but 'they share that space more obviously with other stakeholders, [such as] states, regional actors, private actors, non-governmental organizations, or others'.⁶⁸ The interdependent relationship between central actors/institutions of government at various territorial levels (supranational, national, sub-national) and non-state actors is complex and may fluctuate substantially. A useful starting point to explain policy-making⁶⁹ *vis à vis* EU governance *in the law* is to take two broad concepts from the study of comparative and domestic politics: 'policy networks' and 'epistemic communities.'⁷⁰ The former, according to the seminal 'Rhodes model', may be described as a set of resource-dependant organisations,⁷¹ ranging from highly integrated policy communities to loosely integrated issue networks.⁷² In the EU context, Peterson and Bomber describe the different resource dependencies and structural characteristics of policy networks as setting 'the chessboard where private and public interests manoeuvre for advantage.'⁷³ While policy networks are bound by a certain resource dependence, epistemic communities consist of knowledge-based groups. Such communities are defined by Haas as: 'a network of professionals with recognised expertise and competence in a particular domain and an authoritative claim to policy-

⁶⁸ Craig and de Burca (n 41) 161.

⁶⁹ As opposed to a predicative theory of policy making.

⁷⁰ J. Richardson, 'Actor-Based Models of National and EU Policy Making' in H. Kassim and A. Menon (eds) *The European Union and National Industrial Policy* (Routledge, 1996) 26-51.

⁷¹ Resource-dependent means that each of the groups needs something that the others have in order to fulfill its own objective. Types of resource that organizations may exchange in a policy network include: constitutional/legal, organizational, financial, political, and information services.

⁷² R.A.W. Rhodes, *Control and Power in Central-Local Relations* (Aldershot: Gower, 1981); R.A.W. Rhodes, *Beyond Westminster and Whitehall: The Sub-Central Governments of Britain* (London, Unwin Hyman, 1988).

⁷³ J. Peterson and E. Bomberg, 'Decision making in the European Union: A Policy Networks Approach', Paper prepared for the presentation to the annual conference of the UK political Studies Association, Leicester 20-22 April 1993. In another article, Peterson sets out three pragmatic arguments to explain the important use of policy networks: (i) there is considerable variation in how different EU policy sectors operate; (ii) much of the EU's policy making is highly technical; and (iii) EU policy-making is based on a complex maze of committees that shape before they are 'set' by the political decision makers such as the Commission, the Council or the European Parliament.

relevant knowledge within that domain.’⁷⁴ Bache, George and Bulmer contend that epistemic communities are more likely to influence policy makers, when the later face conditions of uncertainty about the likely consequences of policy choice.⁷⁵ In similar vein, Haas purports that such communities not only inform but increase the likelihood of international policy co-ordination by illuminating salient dimensions of an issue to decision makers.⁷⁶

There are a multitude of examples of policy networks and epistemic communities in EU governance, three noteworthy examples being: the ‘new’ technical harmonization and standardization approach to the internal market, which came about in the 1980s;⁷⁷ (ii) the Lisbon Agenda and the Open Method of Co-ordination;⁷⁸ and (iii) general EU governance reform initiatives such as the ‘culture of subsidiarity’⁷⁹ and ‘better regulation’.⁸⁰ The normative verdict in popular legal and political discourse on these forms of governance is far from unequivocal. First, concerns are often raised over the impact, influence and effectiveness of the policy outcomes.⁸¹ This is due in no small part

⁷⁴ P. Haas, ‘Introduction: Epistemic Communities and International Policy Coordination’ (1992) 42 *International Organization* 3.

⁷⁵ I. Bache, S. George and S. Bulmer, *Politics in the European Union* (3rd edn, Oxford University Press) 32.

⁷⁶ See Haas (n 74) 4.

⁷⁷ See Technical Harmonisation and Standardization: A New Approach, COM (1985) 19; Council Resolution on a new approach to technical harmonization and standards [1985] OJ C136/1; Efficiency and Accountability in Standardization under the New Approach, COM (1998) 291; Council Conclusions of March 2002 on Standardisation [2002] OJ C66/01.

⁷⁸ See for a snippet of the literature on this issue: J. Zeitlin, ‘Introduction: The Open Method of Coordination in Question’ in J. Zeitlin, P. Pochet, L. Magnusson (eds), *The Open Method of Coordination in Action: The European Employment and Social Inclusion Strategies* (PIE-Peter Land, 2005); K. Armstrong, ‘Tackling Social Exclusion Through OMC: Reshaping the Boundaries of EU Governance’ in T. Borzel and R. Cichowski (eds) *The State of the Union: Law, Politics and Society* (Oxford University Press, 2003) 170; M. Citi and M. Rhodes, ‘New Modes of Governance in the EU: Common Objectives versus National Preferences’, *European Governance Papers* No 07/01 (2007); M. Heidenreich and G. Bischoff, ‘The Open Method of Coordination: A Way to the Europeanization of Social and Employment Policies?’ (2008) 46 *JCMS* 497.

⁷⁹ G. de Burca, ‘Reappraising Subsidiarity’s Significance after Amsterdam’, Jean Monnet Working Paper 7/1999; Protocol (No 2) on the application of the principles of subsidiarity and proportionality, [2008] OJ L115/206; Report from the Commission on Subsidiarity and Proportionality, COM (2010) 547.

⁸⁰ See for example: Simplifying and Improving the Regulatory Environment, COM (2002) 278; European Parliament, Council and Commission Interinstitutional Agreement on Better Law-making [2003] OJ C321/01; First Progress Report on the Strategy for Simplification of the Regulatory Environment, COM (2006) 689; Strategic Review, COM (2006) 689; Implementing the Community Lisbon Programme: A strategy for the simplification of the regulatory environment, COM (2005) 535; Impact Assessment SEC (2007) 84; for a critical take on many of these initiatives, see G. Van Calster, ‘An Overview of Regulatory Innovation in the European Union’ (2009) 11 *CYELS* 289.

⁸¹ See Citi and Rhodes (n 78); J. Zeitlin, ‘The Open Method of Coordination in Action: Theoretical Promise, Empirical Realities, Reform Strategy’ in Zeitlin, Pochet and Magnusson (n 78); M. Heidenreich and G. Bischoff, ‘The Open Method of Co-ordination: A Way to the Europeanization of Social and Employment Policies?’ (2008) 46 *JCMS* 497.

to the predominantly ‘soft’ nature of the instruments that arise. One response to this concern is to situate policy outcomes in the broader objectives of this form of EU governance – in other words, the process of knowledge creation, greater participation, experimentation, and reflexivity are, to a certain extent, virtues in themselves.⁸² The second major critique focuses on the relationship between EU governance *in* the law and constitutional norms and values⁸³ – namely institutional balance, the rule of law and fundamental rights. In short, concerns range from democratic deficit to legitimacy and accountability deficit. It has been argued in response that alternative modes of governance – often labelled as ‘new governance’ in the EU context - necessitate a re-conceptualization of entrenched understandings of said constitutional values and norms.⁸⁴ Returning to the issues at hand, this study (**Section 8.5**) looks at what potential forms of ‘new governance’ may benefit national legal policies on assisted dying. First however, the issue of EU judicial governance and suicide tourism will be addressed.

8.3. THE FREE MOVEMENT OF SUICIDE TOURISTS

First and foremost, there is, largely due to the ‘Swiss option’ outlined above, a *de facto* occurrence of suicide tourism in Europe. This section, perhaps provocatively to some, looks at this tourism from the perspective of ‘economic’ EU free movement rules. **Section 8.1**, above, has laid out why this particular legal route is not as abhorrent as it may initially seem. To better explain this potential claim (and to understand that it is not as far-fetched as one may think), the facts of three real and well-known English decisions are first set

⁸² Craig and de Burca (n 41) 177.

⁸³ C. Joerges, ‘Integration through de-legislation?’ (2008) 33 *ELRev* 291; See N. Walker, ‘EU and New Governance’ in G. de Burca and J. Scott (eds) *Law and New Governance in the EU and the US* (Hart, 2006) 15-36.

⁸⁴ See C. Sabel and W. Simon, ‘Epilogue’ in G. de Burca and J. Scott (eds), *Law and New Governance in the EU and the US* (Hart, 2006) 395, where it is quite eloquently stated that: “Modern jurisprudence casts an enormous shadow of doubt over the stronger claims of traditional legality, and history gives no reason to think that traditional legal institutions could perform the tasks of insuring accountability and protecting rights in a world of rapid technological and organisational change, and cross-border transactions, migration and externalities.” See also the contribution by N. Walker in the same edited volume, where he calls for constitutionalism to be reconceived as a ‘responsible discourse of transformation’ which both recalls the general aspiration of collective self-government and political responsibility, but which also provides a set of ideas and norms which can be applied to the new and more differentiated world of reflexive and experimental regulation.

out.⁸⁵ Then the novel argument based on EU law, which the applicants in said cases *could* have invoked, is set out.

Ms Dianne Pretty and Ms Debbie Purdy both suffered from incurable progressive degenerative illnesses, and both faced the real prospect of a painful and distressing death. Both had reached the autonomous decision to end their lives, in a non-clandestine and safe manner, before the severe degenerative effects of their respective illnesses could take effect. However, neither of the women were physically capable of taking their own lives autonomously - they needed assistance. Aware that it is a criminal offence in the UK to encourage or assist in another person's suicide or an attempted suicide (under Section 2 of the Suicide Act),⁸⁶ the two women understood that to carry out their wish, they would have to travel to a country where assisted suicide is lawful.

Ms Dianne Pretty claimed that Section 2 of the Suicide Act and the DPP's failure to provide an exception so as not to prosecute her husband should he assist in her suicide violated her rights under the European Convention on Human Rights.⁸⁷ Although it was accepted by the English Supreme Court⁸⁸ that the right to private life under the Human Rights Act was engaged, her claim was ultimately rejected. It was held that the interference with that right was justified and proportionate. The ECtHR upheld this decision.⁸⁹ Some years later, Ms Debbie Purdy tried a different legal approach. She built upon the *Pretty* decision and argued that the *uncertainty* surrounding the DPP's discretion whether to press charges for acts of assisted suicide, not the ban or the DPP's discretion itself, violated her right to private life under Article 8(2).⁹⁰ Her claim succeeded and the English Supreme Court

⁸⁵ Namely the cases involving Dianne Pretty, Daniel James and Debby Purdy.

⁸⁶ Section 2(1) of the 1961 Suicide Act reads as: a person commits an offence if he/she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and his/her act was intended to encourage or assist suicide or an attempt at suicide. Section 2(4) states that any proceedings under section 2(1) can only be brought by or with the consent of the Director of Public Prosecutions (DPP).

⁸⁷ In short, she argued that (i) the right to life under Article 2 protected a right to self-determination, entitling her to commit suicide with assistance; (ii) failure to alleviate her suffering by refusal of the undertaking amounted to inhuman and degrading treatment proscribed by Article 3; (iii) her rights to privacy and freedom of conscience under Articles 8 and 9 were being infringed without justification; and (iv) she had suffered discrimination in breach of Article 14, since an able-bodied person might exercise the right to suicide whereas her incapacities prevented her doing so without assistance.

⁸⁸ Which was then the Judicial Committee of the House of Lords.

⁸⁹ See the previous Chapter for a detailed examination of her claim before the ECtHR.

⁹⁰ In the sense that her right under Article 8(1) was engaged and could only be infringed in accordance with the law. To satisfy this condition, it was claimed the DPP's prosecution policy must be more accessible and foreseeable.

ordered the DPP to draft up a general policy of factors for and against prosecution in cases of assisted suicide.

It is also worth noting that in between these two decisions, the DPP published the full reasoning behind a decision not to initiate criminal charges in a *de facto* case of assisted suicide.⁹¹ The case involved a 23-year, Daniel James, who was diagnosed with permanent paralysis from the neck down due to a rugby accident. Over a year and half after the accident, he ended his life with the assistance of a doctor at the Dignitas clinic in Switzerland. His parents had assisted him in sending documentation to Dignitas, made payments to Dignitas from their joint bank account, made the travel arrangements and accompanied him on the flight. After a criminal investigation, the DPP announced that there was sufficient evidence for a realistic prospect of convicting the parents (and the family friend who assisted with travel arrangements). However, due to its case-by-case discretion, the DPP deemed that such a prosecution was not in the public interest and that no further action should be taken against them.

Although these decisions raise an abundance of issues, for the sake of the study at hand, there is one pertinent point that must be highlighted: in the view of English Supreme Court, and the Crown Prosecution Services, the English ban on assisted suicide has 'extraterritorial' jurisdiction. In other words, an English citizen who assists in another person's suicide (or attempted suicide) *abroad* may still face investigation and charges under English criminal law.⁹² The *Pretty* and *Purdy* decisions also provide evidence that applicants are willing to try various legal techniques (to varying degrees of success) in order to challenge both the territorial and extraterritorial effect of said English law.

It appears, however, that counsel for Ms *Pretty* and Ms *Purdy* did not quite exhaust the available legal claims before them. They could have also claimed that the extraterritorial nature of the English law is a restriction on their client's freedom to receive the 'service' of assisted suicide either in the Benelux nations (under primary EU law) or in Switzerland (under the EU-Swiss Free Movement of Persons Agreement). Furthermore, had the parents and friends of Daniel James been prosecuted by the DPP, as they were liable to,

⁹¹ In fact, this publication sparked the *Purdy* litigation.

⁹² To quote Lord Hope in the *Purdy* decision: "All that having been said it is plain, to put the point at its lowest, that there is a substantial risk that the acts which Ms Purdy wishes her husband to perform to help her to travel to Switzerland will give rise to a prosecution in this country." Para 17.

they too could have challenged the charge on the grounds that it was a restriction on their freedom to receive a service under the EU-Swiss Agreement. The corollary of this is that physicians working in the Benelux nations or in Switzerland could claim that the UK Suicide Act is a restriction on their freedom *to provide* the service of assisted suicide. Given the complexities of the legal connection between a criminal ban on assisted suicide and substantive EU free movement law, the hypothetical claim will be broken down in the form of a preliminary ruling. The facts are as follows: an English citizen seeks to travel from her residence in England to Dignitas in Switzerland in order to receive assistance in suicide, with the required and willing assistance of her family and loved ones. The motivation behind choosing Switzerland as the destination in this hypothetical claim is three-fold – (i) the occurrence of such instances, specifically involving Dignitas, is a real phenomenon; (ii) the legal conditions are more difficult to satisfy in order to receive assisted suicide in the Benelux nations; and (iii) there is no recorded occurrence of suicide tourism in the Benelux nations. Nonetheless, the last three sub-questions set out below addressing the ‘Swiss Option’ are also relevant to a claim involving the Benelux nations.

(1) DISSECTING THE ‘SWISS OPTION’ UNDER EU LAW

The EU and its Member States signed seven agreements with the Swiss Confederation on 21 June 1999,⁹³ including the Agreement on the free movement of persons (the ‘FMP Agreement’).⁹⁴ This Agreement is not akin to other agreements between the EU and other third-countries – it is a ‘mixed agreement’ that requires each individual Member State to be a party and, thus to take ratification measures before it may enter force.⁹⁵ The objective of the FMP Agreement according to Article 1(a) and (b) is, *inter alia*, for the benefit of nationals of the Member States and the Swiss Confederation, to accord a right of entry, residence, access to work as employed persons, establishment on a self-employed basis and the right to stay in the territory of the contracting parties and to facilitate the provision of services in the territory of the contracting parties, in particular those of brief duration.⁹⁶

⁹³ They were approved on behalf of the Community by Decision 2002/309/EC, Euratom of the Council and of the Commission of 4 April 2002 (OJ 2002) L 114, p. 1 and entered into force on 1 June 2002.

⁹⁴ COM (1999) 229, 4 May 1999. The other Agreements concern: civil aviation; public procurement; agricultural trade; overland transport; technical barriers to trade; and research.

⁹⁵ For a recent detailed discussion of such agreements see the work of former judge of the ECJ: C.W.A. Timmermans, ‘The Court of Justice and Mixed Agreements’ in *The Court of Justice and the Construction of Europe: Analyses and perspectives on sixty years of case-law* (Asser, 2013) 659.

⁹⁶ See F. Weiss and C. Kaupa, *European Union Internal Market Law* (Cambridge University Press, 2014) 25.

As Peers notes,⁹⁷ it is quite a remarkable agreement in that it extends full free movement of persons⁹⁸ between the Union Member States and a third country - an extension the Union was only willing to make as part of the European Economic Area Agreement ('EEA Agreement').⁹⁹ Turning to the issue at hand, there are a number of provisions in the FMP Agreement and Annex I of that Agreement that are of relevance:

Article 5 entitled, 'Persons providing services', states:

"1. Without prejudice to other specific agreements between the Contracting Parties specifically concerning the provision of services [...] persons providing services [...] shall have the right to provide a service in the territory of the other Contracting Party for a period not exceeding 90 days' of actual work in a calendar year.

[...]

3. Nationals of a Member State of the European Community or Switzerland entering the territory of a Contracting Party solely to receive services shall have the right of entry and residence"

Article 16, entitled 'Reference to Community law', states:

"1. In order to attain the objectives pursued by this Agreement, the Contracting Parties shall take all measures necessary to ensure that rights and obligations equivalent to those contained in the legal acts of the European Community to which reference is made are applied in relations between them.

2. Insofar as the application of this Agreement involves concepts of Community law, account shall be taken of the relevant case-law of the Court of Justice of the European Communities prior to the date of its signature. Case-law after that date shall be brought to Switzerland's attention. To ensure that the Agreement works properly, the Joint Committee shall, at the request of either Contracting Party, determine the implications of such case-law."

⁹⁷ S. Peers, 'The EC-Switzerland Agreement on Free Movement of Persons: Overview and Analysis' (2000) 2 *European Journal of Migration and Law* 127-142.

⁹⁸ With minor variations from EU rules and excluding the concept of citizenship of the Union.

⁹⁹ An agreement between the Union and Iceland, Lichtenstein and Norway. Note that the Swiss public rejected membership of the EEA in a 1992 referendum, but voted in favour of the new agreements in a 2000 referendum. See Peers (n 97). All other Union agreements with third states either ignore the issue of movement of persons altogether, or leave to the Member States the decision on whether to admit such persons initially. For example, the EC-Turkey association agreement, and the EC agreements with North African states.

Article 17 of Annex I, entitled 'Provision of services', states:

"With regard to the provision of services, the following shall be prohibited under Article 5 of this Agreement:

- (a) any restriction on the cross-frontier provision of services in the territory of a Contracting Party not exceeding 90 days of actual work per calendar year;
- (b) any restriction on the right of entry and residence in the cases covered by Article 5(2) of this Agreement concerning:
 - (i) persons providing services who are nationals of the Member States of the European Community or Switzerland and are established in the territory of a Contracting Party other than that of the person receiving services; [...]"

Article 23 of Annex I, entitled 'Persons receiving services', states:

"1. A person receiving services within the meaning of Article 5(3) of this Agreement shall not require a residence permit for a period of residence of three months or less. For a period exceeding three months, a person receiving services shall be issued with a residence permit equal in duration to the service. He may be excluded from social security schemes during his period of residence."

The Agreement is distinguishable from the EEA Agreement in a number of respects. First, it restructures the rights in the Treaty in its own way¹⁰⁰ and second it does not contain the clear institutional structure that the EEA contains.¹⁰¹ For these reasons, we must be cautious in approaching the scope of the agreement, and take a number of questions in turn in order to answer the general question (the hypothetical preliminary reference), which way may now be read as:

Does Article 5 of the Agreement, read in conjunction with Article 16 of the Agreement and Article 17 and 23 of Annex I of the Agreement preclude the English criminal ban on acts of assisted suicide that occur abroad and thus hinder the provision of a service lawfully provided in Switzerland?

¹⁰⁰ It does not, as the EEA Agreement does, merely copy the EC Treaty rights to free movement of persons (excepting citizenship) and then include all relevant secondary legislation in Annexes.

¹⁰¹ It does not provide any distinct Court or Surveillance Authority, but contains more limited rules on legal integration with EU case law and legislation.

1. Does the Court have jurisdiction to reply?

Despite a number of CJEU decisions in relation to the FMP Agreement, the question whether the Court has jurisdiction to reply to a preliminary reference arising out of the FMP Agreement was only explicitly addressed by an Advocate General ('AG') opinion once.¹⁰² In the other cases, the Court (and the respective AGs) instantly embarked on a type of substantive law interpretation of the relevant provisions, which not only implied that the provisions in the EU-Swiss agreement may have direct effect,¹⁰³ but that the Court must therefore have jurisdiction on the matter.¹⁰⁴ Nonetheless, as the jurisdictional question is important in its own right,¹⁰⁵ the specific jurisdictional arguments provided by the former AG Ruiz-Jarabo Colomer in relation to the FMP agreement and the general jurisdictional arguments provided in other decisions concerning 'pure Union' third-country agreements are worthy of attention.

Regarding the latter arguments, as early as 1974, the Court in *Haegeman* held that it has the jurisdiction to give a preliminary reference regarding an Association Agreement with Greece.¹⁰⁶ The seminal *Kupferberg* judgment some years later (involving a free trade agreement with Portugal),¹⁰⁷ elaborated on this and set out the Court's cumulative reasoning for accepting jurisdiction: (i) the EU Treaty has established treaty-making capacity (or more formally speaking agreement-making capacity)¹⁰⁸ for the Union; and (ii) agreements concluded on the basis of this capacity are binding on the Community

¹⁰² Case C-339/05 Opinion of Advocate General Ruiz-Jarabo Colomer delivered on 6 June 2006.

¹⁰³ Direct effect here means the capacity of a provision of the agreement to be invoked before national courts. See Craig and De Burca (n 41) 182. This understanding does not in any way determine *the scope* of a directly effective provision in the 'substantive law interpretation' stage. Here, the applicant may still fail to prove that the provision actually covers his/her situation. See Jacobs (n X) 17, where the two stages are treated separately, and for justifiable reasons.

¹⁰⁴ Cases C-351/08 *Grimme*, 2009 ECR, I-10777; C-541/08 *Fokus Invest AG*, [2010] ECR, I-1025; C-70/09 *Hengartner and Gasser*, [2010] ECR, I-7233; C-425/11 *Ettwein* [2013] ECR.

¹⁰⁵ Timmermans aptly sums up the important consequences of accepting the jurisdiction of the Court: 'it entails the availability, without prejudice to the applicable conditions of admissibility, of all Treaty procedures granting the Court jurisdiction to interpret the relevant rules of a mixed agreement uniformly for the whole of the Union, more particularly within the framework of the preliminary reference procedure, and allowing legal protection for those who may invoke these rules. See Timmermans (n 95) 667.

¹⁰⁶ Case 181/73 *Haegeman v Belgium* [1974] ECR 449

¹⁰⁷ Case 104/81, *Kupferberg* [1982] ECR 3659.

¹⁰⁸ See on this formal distinction, F. Jacobs, 'Direct effect and interpretation of international agreements in the recent case-law of the European Court of Justice' in A. Dashwood and M. Maresceau (eds) *Law and Practice of EU External Relations. Salient features of a changing landscape* (Cambridge University Press, 2008) 14.

institutions and on Member States via what was then Article 228(2) EEC Treaty, now Article 216(2) TFEU. Consequently, 'it is incumbent upon the Community institutions, as well as upon the Member States, to ensure compliance with the obligations arising from such agreements.'¹⁰⁹ The Court then stated that it was 'within the framework of its jurisdiction in interpreting the provisions of agreements, to ensure their uniform application throughout the Community.'¹¹⁰

Specifically in relation to the FMP Agreement, the Advocate General put forward a number of similar arguments to justify the Court's jurisdiction. First, the judgment in *Demirel*¹¹¹ was invoked, whereby the Court held that it had jurisdiction to interpret the provisions of mixed agreements relating to powers under primary law since such powers form an integral part of the Union's legal system.¹¹² Second, in the absence of a specific statement,¹¹³ its jurisdiction is discernible from Article 220 EC (now Article 19 TFEU), which provides that the Court is charged with ensuring that Union law is observed.¹¹⁴ Thus, if the agreement is in relation to free movement, a clear 'commitment' in the Union's field, then the Court has jurisdiction to carry out an interpretation.¹¹⁵ Swiss commentators have also endorsed this position, with Kaddous stating 'if the ECJ were to decide on its jurisdiction with regard to the FMP Agreement or to [...], it should no doubt adopt the same position as in the *Demirel* and *Herme* judgments.'¹¹⁶

¹⁰⁹ *Kupferberg*, para 11.

¹¹⁰ *Ibid*, paras 13-14. Moreover, in *Kupferberg*, the Court rejected the arguments invoked *against* direct effect, one by one. They related to the division of powers regarding the external relations of the Union, the possible lack of reciprocity governing the application of the free-trade agreements, the institutional structures and in particular the role of the "Joint Committee", dispute settlement mechanisms and safeguard clauses set up by such agreements. Former Advocate General Francis Jacobs has questioned this interpretation 'in terms of law, but arguably desirable in the interest of maintaining the rule of law and in the development of a coherent system of law.' See Jacobs (n 108).

¹¹¹ Case 12/86 [1987] ECR 3719, paragraphs 6 to 12.

¹¹² Para 29. See also C-53/96 *Hermes* [1998] ECR I-3603; and Former Advocate General Jacobs (n 108) 14.

¹¹³ For academic support on this point, the AG referred to: Macleod, 1., Hendry, I.D., Hyett, S, *The External Relations of the European Communities* (Clarendon Press, Oxford, 1996) 156; Louis, J.V., *El ordenamiento jurídico comunitario*, (5th edn, Office of Official Publications of the European Communities, Luxembourg, 1995) 127.

¹¹⁴ Para 29. For academic support on this point, the AG referred to: D. Petrovič, *L'effet direct des accords internationaux de la Communauté européenne: à la recherche d'un concept*, (Presses Universitaires de France, Paris, 2000) 155 et seq.

¹¹⁵ Para 30.

¹¹⁶ C. Kaddous, 'The Relations Between the EU and Switzerland' in A. Dashwood and M. Maresceau (eds) *Law and Practice of EU External Relations: Salient Features of a Changing Landscape* (Cambridge University Press, 2008) 257.

A rich amount of case-law since these two seminal decisions prove that the Court will not shy away from taking the lead role in interpreting¹¹⁷ third-country agreements - mixed or otherwise. And as already stated, it has not refused jurisdiction to answer the small number of preliminary references involving the FMP that came before it. Thus, it may be said quite confidently that the Court would be required to reply to our hypothetical preliminary reference presented above. The next issue to be addressed is the interaction between the direct effect of the specific provisions and the subsequent substantive law interpretation of the said provisions.

2. Do the relevant Articles on the provision of services in the FMP Agreement have direct effect? And if so, is the Court required to interpret said provisions in the same way as the corresponding provisions in EU primary law?

Having identified the Court's jurisdictional basis, we must now (i) identify whether the right to provide or receive services, as laid down under Article 5 of the Agreement and Article 17 of the Annex to the Agreement, may be invoked before the English courts, and if so (ii) whether the case law of the Court concerning the scope of Article 56 TFEU may be applied by analogy in order to interpret the scope of Article 5.

2.1 Do the relevant provisions of the FMP Agreement have direct effect?

Unfortunately, in the judgments relating to the FMP Agreement, the Court skipped the question of direct effect of the specific provisions under the Agreement, and immediately embarked on a substantive law interpretation (i.e. the second issue raised above). Thus, just like the Court's jurisdiction, it may be implied from this that the Court considered the provisions to have direct effect.¹¹⁸ Given the nature of the claim at hand, it seems appropriate to follow the Advocate General Ruiz-Jarabo Colomer's approach to this question. Moreover, it is an approach the Court has on numerous occasions considered part of 'consistent case-law' in examining the direct effect of specific provisions in other

¹¹⁷ This is a distinct stage in the methodology of review and will be discussed under the next heading.

¹¹⁸ As we will see, until the most recent judgment, how the Court dealt with the second question of substantive homogeneity between the Agreement and the Treaty meant that the question of direct effect was irrelevant to the claimant.

EU third-country agreements, particularly in complex cases.¹¹⁹ In short, it involves a ‘two-step methodology’, whereby regard must be had to (i) whether the wording of the provision is clear, precise and unconditional,¹²⁰ and (ii) the broad nature and purpose of the overall Agreement.¹²¹ Former Advocate General Jacobs contends (extra-judicially) that the Court stands to be criticized for not always distinguishing between the two and when it does so, it addresses them in the wrong order.¹²² Here, the two steps will be distinguished but notwithstanding this last point of criticism, the general order of the Court’s methodology will be followed. This means we will start with an analysis of the specifically relevant provisions – namely, those concerning the free movement of services.

In his careful assessment of the EU-Swiss FMP Agreement, Peers concludes¹²³ that the Chapter on ‘services’ is a mix of provisions (i) based on the EU Treaty,¹²⁴ (ii) based on Directive 73/148¹²⁵ referring explicitly to Directive 96/71 on posted workers,¹²⁶ and (iii) based on no specific EC law provision.¹²⁷ At this stage, we are interested particularly in Article 5(1) and 5(3), in light of Article 17 in Annex I, which states, *inter alia*: with regard to the provision of services, any restriction on the cross-frontier provision of services in the territory of a Contracting Party not exceeding 90 days of actual work per calendar year shall be prohibited under Article 5 of this Agreement. This may be compared with Article 56 TFEU, which has of course been given direct effect:¹²⁸ ‘restrictions on freedom to provide services within the Union shall be prohibited in respect of nationals of Member States who are established in a Member State other than that of the person for whom the services are intended.’ Clearly there are some differences between the precise wording of said provisions and Article 56 TFEU,¹²⁹ but the fundamental aim is the same. Moreover,

¹¹⁹ See Case C-485/07, *Akdas*.

¹²⁰ Case 12/86, *Demirel* [1987] ECR 37, para 19.

¹²¹ *Ibid.*, para 14.

¹²² ‘[It] seems that it would make little sense to analyse the provision and conclude that it is apt to have direct effect, but then to negate that conclusion on the ground that the agreement as a whole is not apt to have such effect. Jacobs (n 108) 32.

¹²³ Peers (n 97) 24

¹²⁴ He compares Art. 17(b)(i) to Art. 49 EC; Art. 18 to Art. 48 EC; Art. 19 to the end of Art. 50 EC; and Art. 22(1) to Art. 45 EC, extended to services by Art. 55 EC.

¹²⁵ He compares Art. 20 of the FMP Agreement with Arts. 4(2), 5 and 6 of said Directive.

¹²⁶ See Art. 22(2) of the FMP Agreement.

¹²⁷ See Art. 22(3) and 22(4) of the FMP Agreement.

¹²⁸ Case 33/74 *Van Binsbergen v. Bestuur van de Bedrijfsvereniging voor de Metaalnijverheid* [1974] ECR 1299 para. 27.

¹²⁹ Art. 56 TFEU does not apply to a fixed time period, but rather applies for a period limited by the nature of activity in question (Case C-55/94 *Gebhard* [1995] ECR I-4165). Moreover, Reg. 1408/71 refers to posting workers for far longer than three months. Also as for the exceptions to permit restrictions, the Agreement accepts under Article 22(3): laws, regulations and administrative provisions in respect of the

as Article 56 has long since been considered to contain a clear and unconditional obligation,¹³⁰ then it may be hard to reason that Article 5 of the Agreement does not also contain such an obligation.

As for the aim and objective of the Agreement itself, a number of observations may be made. First, in the short preamble, the parties state their resolve to bring about the free movement of persons between them 'on the basis of the rules applying in the European Community'. Second, Article 1 explicitly sets out the objectives of the Agreement, which is 'for the benefit of nationals' of the EU Member States and Switzerland to '*facilitate the provision of services* in the territory of the Contracting Parties, and in particular to *liberalise the provision of services of brief duration*'¹³¹ (see Article 1(b) in particular). Third, Article 16 of the Agreement contains a condition, only present in one other EU-Swiss Agreement. It states that: 'in order to obtain the objectives of the Agreement, the Contracting Parties *must take all measures necessary* to ensure that *rights and obligations equivalent to those contained in the legal acts of the European Community* [...] are applied.'¹³² When the application of the Agreement 'involves concepts of Community law', the Contracting Parties are required to take account 'of the relevant case-law of the Court of Justice.' Advocate General Ruiz-Jarabo Colomer argued that this provision 'must be read in conjunction with the joint declaration on the application of the Agreement, contained in the final act, which provides that the Contracting Parties must ensure that Swiss nationals may rely on the *acquis communautaire* in accordance with the terms of the Agreement.'¹³³

Thus, it is submitted here that in light of the clear and unconditional wording of Article 5 and Article 17 of Annex I, and the similar nature of the general objective of the Agreement

activities of temporary and interim employment agencies and certain financial services; and under Article 22(4): laws, regulations and administrative provisions required by imperative requirements in the public interest. In comparison Article 56 TFEU accepts express exceptions for public policy, security and health contained in Article 52 TFEU, which are made applicable by Article 62 TFEU. Moreover, the ECJ has developed a justificatory test in relation to the free movement of persons, akin to the '*Cassis de Dijon*' 'rule of reason' in the free movement of goods context, often termed 'imperative requirements.' Clearly this wider Court-made exception lays the basis for the 'imperative requirement' exception to the provision of services in Article 22(4) of the FMP Agreement.

¹³⁰ Case 33/74 *Van Binsbergen*. As Craig and de Burca point out: the conditions for direct effect have broadened somewhat over the course of the Court's jurisprudence. Note, however that even under the Court's earlier test, direct effect could apply regardless of Member State discretion (such as to place restrictions on the grounds of Treaty derogations). Craig and de Burca (n 41) 186.

¹³¹ Emphasis added by author.

¹³² Emphasis added by author.

¹³³ See Opinion of Ruiz-Jarabo Colomer (n 102).

with the Treaty, the right to provide and receive a service under the Agreement may have direct effect.

2.2 Is there substantive homogeneity between the Treaty provisions on services and the FMP Agreement provisions on services?

In the CJEU's case-law on the FMP Agreement this was the question immediately embarked upon.¹³⁴ In the present hypothetical case, it is a question that turns our attention to the interpretation of the substantive scope of Article 5 of said Agreement and Article 17 of Annex 1, and whether the Court's case-law on the substantive scope of Article 56 TFEU may be applied by analogy.

In its three earlier judgments on the FMP Agreement, the Court authoritatively stated in regard to the substantive law interpretation that:

“[...] the Swiss Confederation did not join the internal market of the European Union and that, consequently, the interpretation given to the provisions of Union law concerning that market cannot be *automatically applied* by analogy to the interpretation of the Agreement, *unless there are express provisions to that effect* laid down by the Agreement itself.”¹³⁵

The Court relied on, and in effect narrowed, the tentative approach to assume substantive homogeneity adopted in its early case-law regarding a Free Trade Agreement with Portugal,¹³⁶ whereby: ‘the mere similarity of the wording of a provision of one of the Treaties establishing the Communities and of an international agreement between the Community and a non-member Country [was] not sufficient to give to the wording of that agreement the same meaning as it has in the Treaties.’ The Court in *Grimme*, *Fokus* and *Hengartner* demanded the provisions in the FMP Agreement explicitly provide for

¹³⁴ Taking the above questions on its general jurisdiction and the direct effect of particular provisions for granted. This is in contrast to the approach taken by Former AG Ruiz-Jarabo Colomer.

¹³⁵ Case C-351/08, *Grimme* [2009] ECR I-10777, para 29; Case C-541/08, para 29; *Fokus Invest* [2010] ECR I-1025, para 28; Case C-70/09, *Hengartner* [2010] ECR I-07233, para 42. Emphasis added by author.

¹³⁶ Case 270/80 i [1982] ECR 329.

'automatic' substantive homogeneity with the Treaty – otherwise they fall outside the basic internal market logic of the Court.¹³⁷

In 2013, however, the Court's judgment in *Ettwein*, cast serious doubt over the authority of these decisions when it struck down a German tax rule as incompatible with the FMP Agreement. Tax lawyers considered it a 'landmark' judgment.¹³⁸ It is argued here that it is a landmark judgment not just in the domain of tax law, but also in understanding the substantive scope of the FMP Agreement. Essentially, the Court did not hesitate to interpret the relevant provisions of the Agreement in light of internal market jurisprudence on the freedom of establishment and the free movement of workers as laid down in the Treaty.¹³⁹ It did so without so much referring to Article 16 of the Agreement¹⁴⁰ (the duty to take into account 'concepts' of Union law and relevant decisions by the Court) but by referring solely to the *objective* expressed in article 1(a) of the Agreement and its preamble to bring about the free movement of people on the basis of EU law.¹⁴¹ In doing so, it ignored the opinion of the Advocate General that the *Grimme*, *Fokus* and *Hengartner* judgments must be followed.¹⁴² In fact the Court made no reference to these previous decisions or the narrow rationale endorsed therein to determine substantive homogeneity between the Agreement's provisions and the Court's internal market jurisprudence. It may be said that the Court followed (albeit implicitly) the *Metalsa* judgment, as previously advocated by the Former AG Ruiz-Jarabo Colomer in relation to the FMP Agreement. In short, the Court extended the substantive law

¹³⁷ Baudenbacher suggests that approach and certain statements by the Court in these decisions indicate that it took offence that Switzerland rejected the EEA agreement, which would have been open for the same interpretation. See Baudenbacher, 'The EFTA Court and the Court of Justice of the European Union' in: *The Court of Justice and the Construction of Europe: Analyses and perspectives on sixty years of case-law*, (Asser: Den Haag, 2013) 191.

¹³⁸ See T. O'Shea, 'ECJ Determines Applicability of German Tax Advantages for Swiss Residents' (2013) 72(3) *Tax Notes International*, 257; Opinion Statement ECJ-TF 4/2013 of the CFE on the decision of the European Court of Justice in case C-425/11 *Ettwein*, concerning personal tax benefits in Germany for Swiss residents, prepared by the ECJ Task Force of the CFE and submitted to the European Institutions in December 2013. Furthermore, as O'Shea highlighted, the Court in *Ettwein* also made it clear that nationals of the origin member state may claim the rights granted under the FMP agreement against its own state of origin.

¹³⁹ Case C-279/93 *Schumacker* [1995] ECR I-225, and Case C-107/94 *Asscher* [1996] ECR I-3089.

¹⁴⁰ Although it did of course identify it as relevant in the legal context at the start of its judgment. See C-425/11, para 8.

¹⁴¹ *Ibid*, para 50 and 51.

¹⁴² See Case C-425/11 *Ettwein*, Opinion of Advocate General Nillo Jaaskinen delivered on 18 October 2012. The Court also ignored AG's opinion that the FMP Agreement is 'different in spirit and purpose from the freedoms of movement laid down in the treaties.'

interpretation of a provision in the Treaty to similarly worded provisions in said Agreement due to the similarity of their objectives.

Therefore the answer as to whether the Court may interpret the scope of a particular provision in the FMP Agreement in the same way as corresponding provisions of the Treaty itself is not entirely obvious or indisputable. However, it may be said *in casu* that Article 56 TFEU on the one hand, and Article 5 of the Agreement and Article 17 of Annex I on the other hand *do* share the same fundamental aims (especially in light of the Preamble, Article 1(b), and Article 16 of the Agreement). That same aim is: the abolition of any restrictions on the cross-border provision of services. Moreover and as already identified above, there is a notable comparison between the objectives and context of the Agreement in general, and those of the Treaty itself. In light of this and the most recent standard set out by the Court in *Ettwein*, there is arguably no reason why the case-law of the Court on Article 56 should not be extended to substantively interpret Article 5 of said Agreement and Article 17 of its Annex.

3. May it be said that assisted suicide constitutes 'a service' within the meaning of Article 5 of the EU-Swiss FMP Agreement and Article 17 of its Annex?

In light of the above interpretation, the answer to this question depends on whether assisted suicide constitutes a service within the meaning of Article 56 TFEU. According to the first paragraph of Article 57 TFEU, services shall be considered to be "services" within the meaning of the Treaty where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to the free movement of goods, capital or persons. Indent (d) of the second paragraph of Article 57 expressly states that activities of the professions fall within the definition of services. In *Luisi and Carbone*,¹⁴³ the Court made clear that medical treatment constitutes a 'service' within the meaning of EU law.¹⁴⁴ It is also relevant to point out that this judgment laid down the now-established rule that

¹⁴³ Joined Cases C-286/82 and 26/83 *Luisi and Carbone*.

¹⁴⁴ Furthermore, as recognised by Advocate General van Gerven, the Treaty provisions on free movement expressly [Article 52(3)] mention the medical and allied professions. See Opinion of AG Van Gerven in Case C-159/90 *SPUC v Grogan*, at para 9.

Article 56 TFEU although explicitly referring to the freedom to ‘provide services’ contains the necessary corollary of that freedom – the freedom to ‘receive services.’¹⁴⁵

The next judgment to be addressed in answering the above question is the highly controversial decision in *SPUC v Grogan*.¹⁴⁶ Although the reasoning and final decision of the Court has fallen subject to substantial academic criticism,¹⁴⁷ certain preliminary deductions can be made regarding the concept of a ‘service’. The first question referred to the Court asked whether the organized activity or process of carrying out an abortion or the medical termination of pregnancy come within the definition of ‘services’ provided for in the Treaty.¹⁴⁸ In response, the Court reiterated the well-known characteristics of a service within the meaning of EU law, before stating that the termination of pregnancy, as lawfully practiced in several Member States, is a medical activity, which is normally provided for remuneration and may be carried out as part of a professional activity. SPUC (Society for the Protection of Unborn Children) refuted this understanding of abortion on the grounds that such an activity, in their view, involved the destruction of life of a human being, namely the unborn child and therefore it must be regarded as ‘grossly immoral.’¹⁴⁹ In response the Court stated:

‘Whatever the merits of those arguments on the moral plane, they cannot influence the answer to the national court’s first question (i.e. that abortion is a service). It is not for the Court to substitute its assessment for that of the legislature in those Member States where the activities in question are practiced legally.’¹⁵⁰

This rationale was reinforced by the Court in cases where the subject matter of the service involved gambling¹⁵¹ and prostitution.¹⁵² In *Schindler*¹⁵³, the German government argued

¹⁴⁵ Ibid, para 16. See for further confirmation of this understanding of the freedom to receive a service: Case C-17/00 *De Coster v College des Bourgmestre et echevins de Watermael-Boitsford* [2001] ECR I-9445; Case C-294/97 *Eurowings Luftverkehrs*; Case C-158/96 *Kohll v Union de Caisses de Maladie* [1998] ECR I-1931.

¹⁴⁶ Case C-159/90 *SPUC v Grogan*.

¹⁴⁷ Most criticism was directed at the fact the Court’s reasoning turned on the absence of an economic link between the Irish information provider (Grogan) and the English service provider (the abortion clinics). Had the abortion clinics paid Grogan – even a small sum – the case would have fell within the material scope of EU law. See S. O’Leary, ‘The Court of Justice as a reluctant constitutional adjudicator: An examination of the abortion information case’ (1992) 17 *ELRev.* 138, 146.

¹⁴⁸ Case C-159/90 *SPUC v Grogan*, para 9.

¹⁴⁹ Ibid, at para 19

¹⁵⁰ Ibid, at para 20.

¹⁵¹ For example, Case C-67/98 *Zenatti* [1999] ECR I-7298; Case C-243/01 *Gambelli* [2003] ECR I-13031.

¹⁵² Case C-268/99 *Jany* [2001] ECR I-8615.

¹⁵³ Case C-275/92 *Schindler* [1994] ECR I-01039.

that lotteries could not be considered an ‘economic activity’ within the meaning of the Treaty, since they were traditionally prohibited or operated by public authorities in the public interest. This argument was rejected on the grounds that lotteries constituted a service provided for remuneration and although the ‘morality’ of such services is questionable, they could not be considered as ‘activities whose harmful nature causes them to be prohibited in all the Member States.’¹⁵⁴ Then in *Jany*¹⁵⁵, the Court held that prostitution, ‘pursued in a self-employed capacity, can be regarded as a service provided for remuneration’.¹⁵⁶ In reaction to complaints regarding the immoral nature of prostitution, the Court cited its rulings in *Grogan* and *Schindler*, and stated that ‘far from being prohibited in all Member States, prostitution is tolerated, even regulated by most of those Member States.’¹⁵⁷ According to Craig and de Burca, the result of these rulings appears to be that provided it is lawful in some Member States and perhaps even in just one state, a remunerated activity will constitute a service within the meaning of EU law.¹⁵⁸

Although many people indeed view any form of assisting suicide as grossly immoral, the Court has stipulated that it will not substitute its assessment of what is moral or not, once it is lawfully provided in other Member States. This stance, according to NicShuibhne ‘reflects the dominant approach in free movement law: definitions tend to be applied in a neutral way without an express accommodation of associated value debates, however sensitive.’¹⁵⁹ The Court tackles the moral complexities at the justification and proportionality stages of review. Thus, just like abortion, gambling activities and prostitution, assisted suicide would not fall outside the scope of the economic free movement provisions *per se*.

According to Article 115 of the Swiss Penal Code, assisted suicide is not a crime provided it is performed without any self-interest. It is not necessary, according to the criminal code, that the recipient of assistance is a Swiss national or has a medical precondition. Nor is it necessary that the assistor is a physician. Almost all cases of assisted suicide in

¹⁵⁴ Ibid, at para 32.

¹⁵⁵ Case C-268/99 *Jany* [2001] ECR I-8615.

¹⁵⁶ Ibid, at para 57. On this see U. Belavusau, ‘EU Sexual citizenship: sex beyond the internal market’ in D. Kochenov (ed) *EU Citizenship and Federalism: The Role of Rights* (Cambridge University Press, forthcoming 2016)

¹⁵⁷ Ibid.

¹⁵⁸ Craig and de Burca (n 41) 798.

¹⁵⁹ NicShuibhne (n 8) 72.

Switzerland occur in 'right-to-die' organizations.¹⁶⁰ As a result of the internal guidelines of these organizations,¹⁶¹ physicians *de facto* play a pivotal role in the provision of assisted suicide. The behaviour of the physicians in providing this assistance has been approved by the Swiss Federal Supreme Court, and is set out Federal Narcotic laws and medical professional guidelines. As the co-operation of a physician is now crucial in obtaining the required drug for assistance in suicide, and he or she is paid for the consultation,¹⁶² it may be said that assisted suicide is a medical activity in Switzerland normally provided for remuneration and may be carried out as a professional activity. The fact that the physician assisting in the suicide may be employed or associated with Dignitas, a non-profit making enterprise, or the fact that the remuneration is directly provided to Dignitas (who then pay the doctor) does not change, according to the Court's case-law, the economic nature of the service.¹⁶³ As specified in *Bond van Adverteerders*: remuneration does not need to come from the recipient of the services, so long as there is remuneration from some party.¹⁶⁴ This criterion is easily satisfied as patients pay Dignitas anything from £4,500 to £14,000 (approx.) in order to receive assistance in suicide.¹⁶⁵

Having accepted that the Court's case law on the provision of services under the Treaty shall be applied to interpret the scope of the provision of services under the FMP

¹⁶⁰ See **CHAPTERS THREE** and **FOUR**. These are non-profit organisations consisting of volunteers who are mostly clergymen, social workers or nurses. There are four main 'right to die' (RTD) organizations that provide (almost all instances of) assisted suicide in Switzerland. Each is subject to their own 'internal guidelines'. *Exit Deutsche Schweiz* and *Exit ADMD* require a person seeking assistance to be of legal majority with either permanent residence in Switzerland or Swiss citizenship. *Dignitas* and *Exit International* offer assistance to persons not resident and persons without Swiss citizenship. See S. Ziegler and G. Bosshard, 'Role of Non-governmental Organisations in Physician Assisted Suicide', *BMJ* 334(7588) (2007) 295-298; See S.J. Ziegler, 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process' *Journal of Medical Ethics* 37(2) (2009) 318-330.

¹⁶¹ All four organizations place greater conditions – what they refer to as 'self-imposed restrictions' – than that set out in Art.115 of the Penal Code. The person seeking assistance must be 'suffering from a disease with hopeless prognoses, or with unbearable symptoms, or with unacceptable disabilities'. A number of procedural steps/diligence rules must be satisfied (submission of medical diagnosis, personal interview, discussion about alternatives, the role of the assistant in preparing the drug, notifying police services, 'legal inspection'). See the homepage of Dignitas (available at: <www.dignitas.ch>), Exit Deutsche (available at: <www.exit.ch>), and Exit ADMD (available at: <www.exit-geneve.ch>); See Ziegler (n 159).

¹⁶² This is clear from 'The Information Brochure of Dignitas', which states: "(2) Doctor's consultation: Further costs will be incurred because a Swiss medical doctor who co-operates with DIGNITAS must be involved to meet a member and subsequently write the prescription for the drug. Two extended consultations with the physician cost an additional contribution of 1'000.- Swiss Francs (approx. GBP £ 800 / US \$ 1'200)."

¹⁶³ Case C-70/95 *Sodemare*; Case 352/85 *Bond van Adverteerders v Netherlands* [1988] Case C-159/90 *SPUC v Grogan* [1991] ECR I-4685.

¹⁶⁴ *Ibid.*

¹⁶⁵ See 'The Information Brochure of Dignitas', available at <www.dignitas.ch/index.php?option=com_content&view=article&id=22&lang=en>.

Agreement, it may be said that assisted suicide is a ‘service’ within the meaning of the Agreement. And moreover, the situation in our hypothetical¹⁶⁶ case is that: an English citizen and resident travelling to Dignitas and providing payment for the purpose of receiving assistance in suicide is covered by the material scope of Article 5 of the FMP Agreement and Article 17 of its Annex.

4. Is the English criminal ban on assisted suicide a restriction on the freedom to receive and/or provide a service under the FMP Agreement?

In its seminal judgment in *Säger*, the Court stated that Article 59 [now Article 56 TFEU]:

“requires not only the elimination of all discrimination against a person providing services on the ground of his nationality but also the abolition of any restriction, even if it applies without distinction to national providers of services and to those of other Member States, *when it is liable to prohibit or otherwise impede* the activities of a provider of services established in another Member State where he lawfully provides similar services.”¹⁶⁷

The Court has since repeated this understanding of Article 56 TFEU on numerous occasions.¹⁶⁸ It is also apparent from the Court’s jurisprudence that the ascertainment of a ‘restriction’ to the free flow of trade is entirely independent from the area of state regulatory competence upon which the measure in question has been adopted. As regards national areas of criminal justice, the Court held in *Cowan and Calfa*:

‘that although in principle criminal legislation is a matter for which the Member States are responsible, Community law sets certain limits to their power, and *such*

¹⁶⁶ Reminder: as stated before, only the legal claim here is hypothetical – the underlying facts are far from hypothetical. 273 patients travelled from Great Britain to Dignitas during the period of 1998 to 2014.

¹⁶⁷ Case C-76/90, *Säger v Dennemeyer* [1991] ECR I-4221. Emphasis added.

¹⁶⁸ Case C-369 and 376/96 *Arblade* [1999] ECR I-8453; Case C-384/93 *Alpine Investment Alpine* [1995] ECR I-1141; Case C-108/96 *Mac Queen* [2001] ECR I-837, para 26 and 27; Case C-212/97 *Centros* [1999] ECR I-1459, para 34; Case C-289/02 *AMOK Verlags GmbH* [2003] ECR I-15059, para 36; Case C-8/02 *Leichtle* [2004] ECR I-2641, para 32; Case C-346/04 *Conjin* [2006] ECR I-6137; Case C-433/04 *Commission v Belgium* [2006] ECR I-10653.

*legislation may not restrict the fundamental freedoms guaranteed by Community law.*¹⁶⁹

Returning to the issue at hand, can it be said that under the substantive scope of EU law, Section 2 of the English Suicide Act 1961 is a restriction on a patient's freedom to receive assisted suicide in a country where it is lawfully provided? The English Supreme Court¹⁷⁰ and the Director of Public Prosecutions¹⁷¹ have affirmed that it is still formally an offence under English law for any person to assist (or even act in a manner capable of assisting) another to travel abroad for the purpose of committing suicide. It is irrelevant if it is legal in that other country. As stated already, English law claims what is known as 'prescriptive' extraterritorial jurisdiction¹⁷² over acts of assisted suicide.¹⁷³ This means that the assister(s), upon returning to England, may face criminal liability (for an offence that carries a maximum penalty of 14 years imprisonment). Regardless of DPP discretion to initiate proceedings *ex post* any assistance, there can be little doubt that such a measure is 'liable to hinder or make less attractive' the desire to help another person travel from England to Dignitas, and therefore in a very real sense, it is liable to hinder the patient's ability to travel to Dignitas in order to receive the service in question.

In light of the Court's jurisprudence on Article 56 TFEU, it is reasoned here that Section 2 of the 1961 Suicide Act is a restriction on both the service recipient's rights and the service provider's rights. As we have already established that there is no reason not to extend the substantive interpretation of Article 56 TFEU to the substantive interpretation of the FMP Agreement, it is submitted here that Section 2 of the English 1961 Suicide Act is also a restriction on the provision of services under said Agreement.

¹⁶⁹ Case C-186/87 *Cowan v Tesor Public* [1989] ECR 195, para 15 and Case C-3048/96 *Calfa* [1999] ECR I-11, para 17. Emphasis added.

¹⁷⁰ *R (on the application of AM) (AP) (Appellant) v Director of Public Prosecutors (Respondent)* [2014] UKSC 38.

¹⁷¹ CPS press release, No charges following death by suicide of Daniel James, 9 December 2008 8 CPS/DPP, Decision On Prosecution - The Death By Suicide Of Daniel James, 9 December 2008

¹⁷² This type of jurisdiction is in contrast to 'enforcement jurisdiction': the ability for English enforcement officers to violate Swiss sovereignty and march into the Dignitas and arrest the English citizen who assisting the suicide on the basis of English criminal law.

¹⁷³ See G. Cohen, 'Medical Tourism and Ending Life: Travel for Assisted Suicide and Abortion' in G. Cohen (ed) *Patients with Passports: Medical Tourism, Law and Ethics* (Oxford University Press 2014).

5. In Light of Article 22(4) of the EU-Swiss FMP Agreement, may it be said that the English ban on assisted suicide is a lawful restriction on the provision of services under the EU-Swiss FMP Agreement?

Article 22(4), which sets out exceptions to the provision of services in the FMP Agreement ('imperative requirements in the public interest') is terminologically identical to the Court-made exceptions¹⁷⁴ for non-discriminatory restrictions on the free movement of persons within the scope of the Treaty.¹⁷⁵ There is a substantial amount of case law on the latter type of exceptions.¹⁷⁶ In short, the Court has provided an open-ended category of justifications, meant to reflect the social, moral and cultural diversity which still exists between the Member States, and which, at least in the absence of further harmonization, may come into conflict with fundamental freedoms guaranteed by the EC [now EU] Treaty.¹⁷⁷ It requires, in principle, that in order to find indistinctly applicable measures that restrict free movement as justifiable, such measures must comply with the requirements of proportionality.

In the case at hand, we need to first identify the aim behind the impugned English measure. This is not a difficult endeavour. Leaving aside the more contentious religious arguments, criminal bans on assisted suicide aim to uphold the public interest in

¹⁷⁴ As opposed to the Treaty-based derogations on grounds of public policy, public security and public health.

¹⁷⁵ See Case C-288/89 *Gouda* [1991] ECR I-4007, para 12-13; Case C-76/90 *Sager* [1991] ECR I-4221, para 15. The had, however, previously recognised a number of overriding reasons relating to the public interest prior to these judgments: professional rules intended to protect recipients of the service (Joined Cases 110/78 and 111/78 *Van Wesemael* [1979] ECR 35, paragraph 28); protection of intellectual property (Case 62/79 *Coditel* [1980] ECR 881); the protection of workers (Case 279/80 *Webb* [1981] ECR 3305, paragraph 19; Joined Cases 62/81 and 63/81 *Seco v EVI* [1982] ECR 223, paragraph 14; Case C-113/89 *Rush Portuguesa* [1990] ECR I-1417, paragraph 18); consumer protection (Case 220/83 *Commission v France* [1986] ECR 3663, paragraph 20; Case 252/83 *Commission v Denmark* [1986] ECR 3713, paragraph 20; Case 205/84 *Commission v Germany* [1986] ECR 3755, paragraph 30; Case 206/84 *Commission v Ireland* [1986] ECR 3817, paragraph 20; *Commission v Italy*, [1991] ECR I-709, paragraph 20; and *Commission v Greece*, cited above, paragraph 21), the conservation of the national historic and artistic heritage (*Commission v Italy*, [1991] ECR I-709, paragraph 20); turning to account the archaeological, historical and artistic heritage of a country and the widest possible dissemination of knowledge of the artistic and cultural heritage of a country (*Commission v France*, [1991] ECR I-659, paragraph 17, and *Commission v Greece*, ECR I-727, paragraph 21). Note, the 'imperative requirements' are to free movement of persons, what the 'mandatory requirements' are to the free movement of goods. For a detailed discussion on this see L.W Gormley, *EU Law of Free Movement of Goods and Customs Union* (Oxford University Press, 2009).

¹⁷⁶ For an overview in the areas of services, see C. Barnard, *The Substantive Law of the EU: The Four Freedoms* (Oxford University Press, 2013) 389-404.

¹⁷⁷ S. O'Leary and J.M. Fernandez-Martin, 'Judicial exceptions to the free provision of services' in M. Andenas and W.H. Roth (eds) *Services and Free Movement in EU Law* (Oxford Press University, 2002).

discouraging suicide and to protect vulnerable members of society from abuse. Such a measure quite clearly seeks to uphold a highly legitimate public interest. The extraterritorial nature of the ban is simply the geographical extension of this objective. It cannot be seen as less of a legitimate public interest to protect vulnerable citizens or residents merely because the threat comes from or is exercised abroad. Moreover, the Court has recognised that justifications based on the protection of fundamental rights may well constitute an overriding reason of public interest. In this sense, the English ban and its extraterritorial nature, is a means to carry out a duty on the State to protect the right to life of persons within its jurisdiction, as enshrined in Article 2 ECHR and Article 3 of the CFEU. But this is just a point of departure in the rationale of EU internal market law - the legitimacy of the aim, however clear or fundamental, says nothing about how the measure chosen to achieve that aim is applied.

It is widely accepted that the Court's proportionality test contains three elements.¹⁷⁸ It must be satisfied that: (i) there is a causal connection between the national measure and the aim pursued; (ii) there is no alternative measure available, which is less restrictive of trade or free movement generally; and (iii) there is a relationship of proportionality between the obstacle introduced and the actual attainment of the objectives. This last element is sometimes referred to as 'proportionality *stricto sensu*' and is rarely applied by the Court. Craig and de Burca have alluded to the emergence of a fourth element in the Court's case law – the need for any restrictive measure to respect fundamental rights.¹⁷⁹

The degree to which the Court will 'intrude' on national regulatory choices via the requirements of proportionality (and its constitutive elements) depends on a number of factors. Its methodology here is variable. It does not, however, vary to the extent that there is any serious dispute about the Court's general reluctance to rigorously apply a substantive proportionality test when faced with a manifest or latent morality policy.¹⁸⁰

¹⁷⁸ See S.A. de Vries, 'The protection of fundamental rights within Europe's internal market after Lisbon' in S.A. de Vries, X. Groussot, G.T. Petursson (eds) *Balancing Fundamental Rights with the EU Treaty Freedoms: The European Court of Justice as 'tightrope' walker* (Eleven International, Utrecht, 2011) 26; J.H. Jans, 'Proportionality Revisited' (2000) 27 LIEI 239; Harbo, "The function of the proportionality principle in EU law", 16 *ELJ* (2010), 165. See also Opinion of A.G. Maduro in Case C-434/04 *Ahokainen*, [2006] ECR I-9171, paras. 24–26.

¹⁷⁹ Craig and de Burca (n 41) 802. See for example, Case C-60/00 *Carpenter v Home Secretary* [2002] ECR I-6279; Case C-260/89; *ERT v DEP* [1991] ECR I-2925, para 42. See also NicShuibhne (n 8).

¹⁸⁰ See L. Azoulai, 'The ECJ and the duty to respect sensitive national interests' in M. Dawson, B. de Witte and E. Muir, *Judicial Activism at the European Court of Justice* (Edward Elgar, 2013) 181. The Court itself has made it clear that in cases touching upon particularly sensitive socio-cultural issues, it will afford 'a

Given the tensions that emerge when such national policies are exposed to the dynamics of European integration, the Court (in our hypothetical preliminary reference and at this stage of adjudication) has, in a sense, reached a three-pronged fork in the road.¹⁸¹ It may (i) avoid the application of any meaningful proportionality review (substantive or procedural) and insulate the English legal policy choice¹⁸² on assisted suicide – which it probably would do; (ii) apply a substantive proportionality test and potentially stage a direct and normative ‘Europeanization’-type intervention¹⁸³ on the English policy choice on assisted suicide – which it probably would not do; or (iii) distinguish between the substantive and procedural versions of proportionality, and focus mainly on the internal coherence and consistency of the English policy choice on assisted suicide – which it, arguably, should do.

In regard to the first option, agreement is had here with O’Leary and Fernandez-Martin. By ignoring the proportionality principle, the Court ‘undermines the role which it and national courts must play in policing respect for EU fundamental freedoms.’¹⁸⁴ Azoulai equally discourages such an approach as ‘moralization can easily be extended to specific legal regimes and to any system of regulation.’ Moreover, the Court risks not only inflating value-claims, but it runs the real risk of doing it to inconsistent degrees in regard to comparably sensitive policies.¹⁸⁵ By washing its hands of the issue *in casu* entirely – both

considerable margin of appreciation.’ Case C—67/98 *Zenatti* [1999] ECR I-7289, paras 15 and 33; Case C-112/00 *Eugen Schmidberger* [2003] ECR I-5659, para 82.

¹⁸¹ This reasoning borrows elements fleshed out by de Witte of the three alternatives facing the EU in the more general context of respecting moral diversity and market integration. See F. de Witte, ‘Sex, Drugs & EU law: The Recognition of Moral and Ethical Diversity in EU law’ (2013) 50(6) *Common Market Law Review* 1545-1578.

¹⁸² For examples of national authorities being granted an unfettered degree of autonomy in certain morality policies, see the Court decision in Case C-275/92 *Schindler* [1994] ECR I-1039 (regarding the free movement of goods, services and lotteries); and more recently, Case C-137/09 *Josemans* [2010] ECR I-13019 (regarding the free movement of goods, services and soft drugs). It is also worth noting the Court’s approach in *SPUC v Grogan* (regarding the free movement of services and abortion), where it avoided any question of proportionality via highly questionable exclusionary reasons.

¹⁸³ For a rare example of a direct normative intervention, albeit not via a rigorous proportionality test, see the Opinion of Attorney General Bot in in Case C-137/09 *Josemans* [2010] ECR I-13019 – who even went so far as to claim that the Netherlands has a positive obligation to change its drug policy. For an example of this away from free movement justifications, see the decision in C-34/10 *Brustle* [2011] ECR I-09821. For an insight to the critique of this decision, see: K.T. Vrtovec and C.T. Scott, ‘The European Court of Justice ruling in *Brustle v Greenpeace*: The impacts on patenting of human induced pluripotent stem cells in Europe’ (2011) 9 *Cell Stem Cell* 502; S.H.E. Harmon and G. Laurie, ‘Dignity, plurality and patentability: The unfinished story of *Brustle v Greenpeace*’ (2013) 38 *EL Rev.* 95

¹⁸⁴ J.M. Fernandez-Martin and S. O’Leary, ‘Judicial exceptions to the free provision of services’ in M. Andenas and W.H. Roth (eds) *Services and Free Movement in EU Law* (Oxford: OUP, 2002) 187.

¹⁸⁵ See G.C. Rodriguez Iglesias, ‘Drinks in Luxembourg. Alcoholic Beverages and the Case Law of the European Court of Justice’, in D. O’Keefe (ed) *Judicial Review in European Union Law. Liber Amicorum in Honour of Lord Slynn of Hadley* (Kluwer, 2000) 523-539.

in the substantive and procedural review sense - the Court would undermine a core objective of European free movement: the normative 'trampoline'/'exit option' to politically disenchanted individuals and the limitation of sovereign 'violence' by the nation state.

In the second instance and at the very other end of the extreme, there are two main inter-related problems. First, according to the substantive proportionality test, the legality of the national policy on assisted suicide hinges on the absence of policy alternatives that are the 'least restrictive' to the rights of mobile actors/services. In the context of such a manifest morality policy (as opposed to a more technical policy issue), the Court in Luxembourg is simply not in a position to assess this outright. This is not an objection based on support for democratic sovereignty in determining first principles; it is an objection against underestimating the substantive complexity surrounding a safe and workable legal policy on assisted dying, and the practical inability for a transnational court to sufficiently assess these complexities. Second, a decision by a transnational Court whereby a national ban on assisted suicide is deemed to be precluded by EU law, especially 'economic' EU law, is too politically confrontational. The *Laval* and *Viking* decisions¹⁸⁶ (limiting the right to strike in light of 'economic' rules) created an unprecedented wave of public and political backlash, attacking the Court's very legitimacy and *raison d'être*. A similar finding concerning national policy choices on end-of-life determinations would undoubtedly amplify this public and political backlash. This is further evident, albeit not in a case involving a limitation on free movement, from the reaction to the Court's judgment and the Advocate General's opinion in *Brustle*.¹⁸⁷ This case concerned the interpretation of Article 6 of the Biotech Directive and the patentability of biotech inventions related to human embryos. Essentially, the Court imposed an autonomous European answer to the question of when life begins – an answer that was severely criticized (and perhaps correctly so) from scientific, legal, moral and commercial angles.¹⁸⁸

In the third instance, some middle-way is sought. The Court may simply adopt a procedural proportionality test over a direct substantive test. The latter test seeks 'to

¹⁸⁶ C-341/05 *Laval* [2007] ECR I-11767; C-438/05 *Viking* [2007] ECR I-10779.

¹⁸⁷ C-34/10 *Brustle* [2011] ECR I-09821.

¹⁸⁸ See Harman and Laurie (n 182); Vrtovec and Scott (n 182).

rationalize the *content* of national legislation,¹⁸⁹ and if applied rigorously, leaves little normative leeway for Member States. The former, in contrast, seeks to ‘rationalize the *process* of national legislation’,¹⁹⁰ and in doing so shows a certain respect for the normative policy aims of the Member States.¹⁹¹ It is purported here that when faced with the task of adjudicating on latent or manifest morality policies, this type of proportionality test is better suited. De Witte advocates explicitly dissecting the procedural proportionality test in two parts. To determine if the actual measure is coherent and consistent, it (i) must have general regulatory equivalence and (ii) must be legally and administratively transparent. For our purposes attention is paid to the latter one only,¹⁹² but in a broader proportionality context of what Barnard, Prechal and de Vries refer to as requirements of ‘good governance.’¹⁹³ The procedural requirements of ‘good governance’ advocated here is not strictly a contemporary method of judicial review,¹⁹⁴ but it is a method more often applied in an implicit manner. Moreover, it is also a method the Court has used in more sensitive cases – judgments on gambling,¹⁹⁵ on medical services¹⁹⁶ and on Japanese Anime.¹⁹⁷ In the *Watts* case, the Court held that a system of prior authorization for medical treatment in another member state is not a disproportionate

¹⁸⁹ De Witte (n 180) 1566.

¹⁹⁰ Ibid.

¹⁹¹ Ibid.

¹⁹² Essentially, de Witte’s call for general regulatory equivalence is a call for the principle of non-discrimination, be it direct or indirect. According to de Witte, if domestic and foreign actors are not treated the same, then the moral policy is disproportionate: ‘A difference *in application* between domestic and foreign actors, [...] makes a national moral or ethical policy incoherent, inconsistent and thus disproportionate.’ This is supported with the example of the soft drugs policy in Maastricht - if the Dutch moral/public policy claims that it is permissible to buy and consume cannabis, then it is incoherent and illogical to only permit Dutch residents from buying and consuming cannabis. Arguably, this example is too easy. Take a different example: granting patient’s the autonomous wish to receive VAE or AS is a moral policy by the Dutch state. One of the regulatory conditions that allows for a person to receive VAE or AS is the existence of a close doctor-patient relationship. This is in order to ensure that the due care criteria may be fully satisfied – i.e. to ensure as much as possible the patient’s decision is autonomous. This rule is, in effect, indirectly discriminatory. It is a condition laid down irrespective of nationality, but it is also one that Dutch nationals are more likely to satisfy than foreign nationals. Thus as the domestic and foreign actors are not treated the same, does the regulatory condition for a close doctor-patient relationship (i.e. the need to take steps to ensure the patient’s decision is autonomous) make the Dutch moral policy incoherent, inconsistent and thus disproportionate? The answer here must be an emphatic no.

¹⁹³ S. de Vries (n 172) 42; S. Prechal, ‘Topic One: National Applications of the Proportionality Principle – Free Movement and Procedural Requirements: Proportionality Reconsidered’ (2008) *LIEI* 35.

¹⁹⁴ Prechal recognizes the emergence of certain elements of this version of proportionality in the 1980s (namely the requirement of administrative and judicial procedures)– see Case 304/84 *Muller* [1986] ECR 1511; Case 178/84 *Commission v. Germany* [1987] ECR 1227.

¹⁹⁵ Case C-243/01 *Gambelli* [2003] ECR I-13031; Joined Cases C-338/04, C-359/04 & C-360/04 *Placanica* [2007] ECR I-1891; Case C-67/98 *Zenatti* [1999] ECR I-7289; Case C-124/97 *Läärä* [1999] ECR I-6067.

¹⁹⁶ Case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473, para. 90; Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, para. 85 and C-372/04 *Watts* [2006] ECR I-4325, para. 116

¹⁹⁷ Case C-244/06 *Dynamic Medien* [2008] ECR I-505.

restriction, provided the procedural system is, *inter alia*, 'easily accessible.' In the *Dynamic Medien* case, the Court held that a classification decision from a regional or national authority on the permissibility of importing Japanese cartoon to be sold to minors is not a disproportionate restriction on the free movement of goods – provided that the examination procedure is, *inter alia*, readily accessible, can be completed in a reasonable time and may be challenged if it leads to a negative decision. Moreover, the Court recently explicated that rules restricting free movement must be legally certain, i.e. the rules of law must be clear, precise, and predictable as regards their legal effects. Should they fail this test then they cannot be 'considered proportionate to the objectives pursued.'¹⁹⁸

Returning to the case at hand, the Court could make clear from the outset of its proportionality test that its objective and application is not to challenge or re-orient the content of the national policy on assisted suicide. To do so, it could simply repeat the methodology it has used in a number of previous judgments. First, it could recall how the objective of the restriction – the protection of the right to life - is recognised by the ECHR, the CFEU and various Member State constitutions, and moreover that the conception of what is 'the right to life' may vary from one Member State to another on the basis of moral or cultural views.¹⁹⁹ Then it could repeat its stance in *Laara* and, more recently in *Omega*, that:

“it is for [national] authorities to assess whether it is necessary, in the context of the aim pursued, totally or partially to prohibit activities of that kind or merely to restrict them and, to that end, to establish control mechanisms, which may be more or less strict. In those circumstances, the mere fact that a Member State has opted for a system of protection which differs from that adopted by another Member State cannot affect the assessment of the need for, and proportionality of, the provisions enacted to that end. Those provisions must be assessed solely by reference to the objectives pursued by the national authorities of the Member State concerned and the level of protection which they are intended to provide”²⁰⁰

¹⁹⁸ Case C-318/10 *SIAT v Etat Belge* [2012] ECR, paras 58-59.

¹⁹⁹ *Schindler*, para 60.

²⁰⁰ Case C-124/97 *Läärä*, [1999] ECR I-6067, paras. 35–36; *Liga Portuguesa*, cited supra note 77, para 59; and *Omega*, cited supra note 111, para 38.

The last sentence sets the Court up to embark on rationalizing the implementation of the national policy on assisted dying. Here the Court could resort to procedural principles of good governance and, arguably, reason the following:²⁰¹

In this present case, the national court is required to appraise the national extra-territorial ban on assisted suicide under Sec 2 of the 1961 Suicide Act, taking into account the actual means²⁰² to discourage suicide and protect vulnerable persons from going abroad for assisted suicide and to assess whether the impugned provisions are based on objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities' discretion so that it is not used arbitrarily. Such a system must furthermore be based on a procedural system which is easily accessible²⁰³ and meet the requirements of the principle of legal certainty, in accordance with which rules of law must be clear, precise and predictable as regards their effects, in particular where they may have unfavourable consequences for individuals and undertakings.²⁰⁴

On the one hand, this approach respects the capacity of the political community in England to express its moral preferences on the extra-territorial nature of the ban on assisted suicide. On the other hand, it presents the English national court with the adjudicatory capacity to closely review the actual implementation of that moral choice in light of procedural principles of good governance.²⁰⁵ The focus of the proportionality review therefore becomes less political and more legal and procedural. Given the objectives of the extra-territorial ban (to discourage suicide/protect the right to life and protect vulnerable persons), the English court could note the considerable discrepancies between the law on AS 'in the books' and the law on AS 'in action' (see **Chapter 5**, above). There have been a number of criminal investigations for cases of assisted suicide abroad (*ex post* the suicide) but not a single prosecution, and there is, according to empirical

²⁰¹ The italics in the preceding paragraph represent the exact wording of either Advocate Generals or the Court in different judgments, whereby different principles of 'good governance' were applied in the procedural proportionality test.

²⁰² The italic words by Advocate General La Pergola (at point 34 of his Opinion in *Läärä*), who stated: In the present case, the national court is therefore required to appraise the Finnish Law on Gaming taking into account the actual means of organising and operating the monopoly held by the RAY and to assess whether the provisions introduced for that purpose, as they operate in practice, are consistent with and appropriate to the reasons relied upon by the national authorities to justify them

²⁰³ Case C-372/04 *Watts* [2006] ECR I-4325, para 116.

²⁰⁴ Case 318/10 *SIAT v Etat Belge* [2012] ECR para 58-59.

²⁰⁵ See G.H. Addink, 'Governance and Norms: An Interdisciplinary Approach of Good Governance' in A.L.B. Colombi Ciacchi and others (eds) *Law and Governance: Beyond the Public-Private Law Divide?* (Eleven International, 2013) 243-274.

evidence, a considerable number of patients who are not deterred by the criminal law and continue to travel from England to Switzerland for assisted suicide every year. Arguably, the only legal certainty is that the law will be undermined by those who can pay and travel to Switzerland, and also by the prosecution authorities who rely on the 'public interest' criterion to make that investigation nothing but a paper tiger. It will be up to the English court to decide if this is the legal certainty the legislator has in mind, particularly in light of the fundamental objectives pursued by the measure and the level of protection for vulnerable persons it is intended to provide.

(II) CONCLUSIONS ON THE 'SWISS OPTION'

From the perspective of EU law, 'suicide tourism' is another form of free mobility, another form of the 'exit option' in practice. In turn, national measures of an extra-territorial nature that prohibit assisted suicide run the risk of being seen as an unjustifiable obstacle to free movement rules. The above analysis has shown how the scope of EU law and the scope of the EU-Swiss FMP Agreement may extend to place the ECJ in an unenviable position. The question of the free movement of assisted suicide services brings the well-known tensions between the market orientated foundations of the Union and the contemporary essence of its constitutional system into sharp focus. As we have seen, the rationale behind EU judicial governance is one of instrumental rationality. It acts as a 'Trustee' to interpret the Treaty rights (and rights that emanate from secondary legislation and third-country agreements) on behalf of the 'peoples of Europe'. However as we have also seen, this does not mean that it is a Court with the unhindered capacity to protect individual rights and disregard the autonomy of democratic political processes. Despite the challenge the Court may face if a preliminary reference such as the one laid out in this study was made, it would appear nonetheless to have the normative capacity to re-politicize the national law on assisted dying by bringing principles of procedural good governance to the fore. This may not seem like a satisfactory result to the prospective applicant invoking his or her rights under EU free movement law – ultimately the discretion is passed back to the national court. But this discretion should not be exaggerated; if the Court would impose a procedural proportionality test, it becomes incumbent upon the national court to ensure that the impugned measure provides sufficient legal certainty in light of its objectives. As we have seen in Part II of this study -

the law and governance of assisted suicide on the national level - the question of legal certainty specifically in light of the objective of an extra-territorial blanket ban on assisted suicide is a substantial one, and may not be so easy for national authorities to simply deflect. This is particularly true for national measures which impose an extra-territorial ban on assisted suicide but upon implementation allow that ban to be entirely undermined. In this sense, EU free movement law and judicial governance has real potential to benefit the relationship between law and politics on assisted suicide on the national level.

8.4 'NEW GOVERNANCE' AND ASSISTED DYING

This section briefly looks into another underexplored domain involving national laws on assisted dying and governance beyond the state. In particular it looks at 'new governance' mechanisms and frameworks that EU institutions and Member States have introduced in the domain of health-care.²⁰⁶ As an initial point of departure, this presupposes that assisted dying is located in the context of health care policies, or more specifically in the context of other medical behaviour that potentially shortens life (MBPSL). The reason for this is quite simple. All countries in the EU are facing dilemmas brought about by the triumphs of modern medicine over previously untreatable medical conditions. However, no national health care system in the Union has the sole objective of postponing death at all costs.²⁰⁷ Another purpose is to offer patients a death free from pain and distress. In all EU countries subject to analysis, there is evidence of medical behaviour that shortens or potentially shortens the patient's life – such as the withholding/withdrawing of life-prolonging treatment or the administration of pain relief with life-shortening effect.²⁰⁸ Agreement is had here with Griffiths, Adams and Weyers, that these behaviours 'cannot always easily be distinguished, either analytically or in practice.'²⁰⁹ From this point of

²⁰⁶ For essential reading on 'new governance' in the EU, see: K.A. Armstrong, *Governing Social Inclusion – The Law and Politics of EU Co-ordination* (Oxford University Press, 2010); I. Bache, *Europeanization and Multilevel Governance: Cohesion Policy in the European Union and Britain* (Rowman & Littlefield, 2008); F. Cafaggi (ed), *Reframing Self-Regulation in European Private Law*, Private Law in European Context Series (Kluwer Law International, 2006); G. De Burca and J. Scott (eds), *Law and New Governance in the EU and the US* (Hart, 2006); O. De Schutter and J. Lenoble (eds), *Reflexive Governance: Redefining the Public Interest in a Pluralistic World* (Hart, 2010).

²⁰⁷ 'Replies to the questionnaire for member states relating to euthanasia', Steering Committee on Bioethics (CDBI) Strasbourg, 20 January 2003, CDBI/INF 8 (2003).

²⁰⁸ See *ibid.* See also H. Weyers, 'Physician-Assisted Death in Western Europe: The Legal and Empirical Situation' in T.E. Quill and F.G. Miller (eds) *Palliative Care and Ethics* (Oxford University Press, 2014).

²⁰⁹ J. Griffiths, M. Adams and H. Weyers, *Euthanasia and Law in Europe* (Hart, 2008) 8.

view, to avoid making any normative assertions regarding the different behaviours from the outset, any ‘new governance’ mechanism on the Union-level would arguably be better served by not treating the behaviours in isolation. They all present not dissimilar challenges to medical professionals throughout the Union and they all have inherent risks with potentially fatal consequences.

Any ‘new governance’ mechanism focusing on MBPSL must fall within a particular category of ‘new governance’ in the EU. Senden identifies three broad categories:²¹⁰ (i) preparatory and informative instruments – a way to prepare further EU law or policy action, which may be seen as fulfilling a ‘pre-law’ type function; (ii) interpretative and decisional instruments – a way to guide the interpretation and application of existing EU law, which may be seen as fulfilling a type of ‘post-law’ function; and (iii) steering instruments – a way to establish or give further effect to the objectives and policies of the Union or related policy areas, which may be seen as fulfilling a type of ‘para-law’ function. This last category of mechanisms is the main one at work in the EU health policy sector, and is therefore the most relevant for the purpose of this analysis. In light of these observations, a number of questions may now be asked. First, why would Member States develop EU-level ‘steering instruments’ in regard to MBPSL? Second, which type of ‘steering instrument’? And third, what are the potential benefits and pitfalls?

Regarding the first question, it is necessary to understand why health-care emerged on the EU ‘new governance’ agenda in the first place. It may be said that health-care was ‘framed’ as an EU issue due to three main factors: (i) there was, and indeed still is, no Treaty basis for formal supranational coordination of health care across Member States. However, there does exist a Treaty basis for horizontal member state initiatives in improving public health;²¹¹ (ii) in the 1990s increasing pressure was applied by finance ministers (via the Economic and Financial Affairs Council (ECOFIN) and its main advisory body, the Economic Policy Committee (EPC)) over concerns of health-care spending and welfare budgets,²¹² and (iii) concerns were raised over case-law by the European Court of

²¹⁰ L. Senden, ‘Soft law, self-regulation and co-regulation in European law: where do they meet?’ (2005) 9 *Electronic Journal of Comparative Law* 18

²¹¹ Introduced to the Treaty by the Single European Act, see Article 168 TFEU (formerly 152 TEC).

²¹² See S.L. Greer and B. Vanhercke, ‘The hard politics of soft law: the case of health’ in E. Mossialos and others (eds) *Health Systems Governance in Europe* (Cambridge University Press, 2010) 198-202.

Justice in the *Kohll*²¹³ and *Geraets-Smits* rulings,²¹⁴ whereby medical treatment financed by the public purse was deemed to fall within the ambit of the Treaty's free movement provisions. In short, member states took an interest in their ability to forge new governance mechanisms *vis a vis* more 'social actors', once it became clear that the Union's 'economic' actors (ECJ, DG MARKT, and ECOFIN) were beginning to influence national health-care practices.

The same 'framing' logic may be applied to our case. First, as we have seen in Part II, the free movement of persons from various EU member states to Dignitas in Switzerland (leaving aside for now any issue of the applicability of EU law) is a *de facto* common concern for the governments of the concerned EU member states. Moreover, the challenge in dealing with modern medicine and regulating all medical behaviour that potentially shortens life is also a common concern for all Member States. Arguably, this makes the Treaty base implying new governance in the field of Public Health somewhat relevant. Article 168(2) TEFU *requires* Member States, in liaison with the Commission, 'to coordinate amongst themselves their policies and programmes' in 'improving public health, obviating sources of danger to physical and mental health [...] and combating serious cross-border threats to health.' Second, a key factor in encouraging Member States to develop an EU level 'steering instrument' would be a decision by the ECJ involving the free movement of services.²¹⁵ In other words, 'new governance' may become more appealing should the Court (if faced with a claim such as the hypothetical one outlined in Section 8.4., above) decide that the patient's home State is free 'to determine the content and the scope of' an extra-territorial ban on assisted suicide, but the means to achieve the objectives must nonetheless satisfy the procedural proportionality test. It is purported here that such a decision would inspire a potential win-win outcome. National authorities are likely to strategically accept new governance to prevent any further surrender of formal national competences, while at the same time creating learning processes and epistemic communities would be created to help achieve the requirements of procedural good governance. Leaving aside any ECJ decision, it is still not difficult to argue why Member States should be interested in a non-intrusive objective exchange of ideas and

²¹³ C-158/96 and C-120/95 *Kohll and Decker* [1998] ECR I-1931.

²¹⁴ C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473.

²¹⁵ Such as the hypothetical one above – which incidentally follows a similar approach to the ECJ decisions (*Kohll* and *Geraets-Smits*) that opened the subject of new governance and European health care to remarkable academic and political attention in the first place.

experiences on regulating MBPSL, neither intended to harmonize national rules or to interpret national rules in light of market-based assumptions. The real challenge, however, is highlighted in answering the second question set out above: what shape could a 'steering instrument' on MBPSL – on such manifest morality issues - realistically take?

First, we have the Open Method of Co-ordination (the 'OMC'), the most well-known EU 'steering instrument.'²¹⁶ It was introduced in 1997 to facilitate the development of the European Employment Strategy, but has since been extended into various policy areas, including health care in 2004. Although the detailed application of the OMC varies in different policy areas, it is possible to discern a basic design. In short, it is a recursive system of policy development, facilitated by the European Commission, in which very general policy objectives are agreed upon at the EU level. Then the more specific goals and indicators, articulated in a formal Council resolution, are established by the Ministerial Council in the policy area involved. Each Member State then develops a set of national reports both explaining the current situation of the state *vis a vis* the policy area (including challenges and best practices) and outlining the specific strategies to best achieve the general goals set out at the European level. These strategies are unique to each country, but are developed under the rubric of a coherent overarching policy.

The OMC-option is not likely to be of real use in our case. One, it has been subject to extensive negative critiques. Some commentators have described it as a way to reinforce the position of the DG SANCO or DG Social Affairs within the Commission,²¹⁷ and thus more of an 'open method of centralization.'²¹⁸ Two, others have accused the OMC process of being too broad and ambiguous – accepting a vagueness to satisfy everyone but equally deterring the real arguments.²¹⁹ Three, the OMC has been superseded by newer instruments that retain informal processes of multi-level governance, but which are

²¹⁶ J. Rodrigues, 'The Open Method of Coordination as a New Governance Tool' in M. Telo (ed) *L'evoluzione della governance europea*, Special Issue of *Europa/Europe*, Rome, No 2-3, 2001, 96; C. De la Porte and P. Pochet, 'Why and how (still) study the Open Method of Co-ordination (OMC)?' (2012) 22(3) *Journal of European Social Policy* 336-349.

²¹⁷ See Greer and Vanhercke (n 210) 213.

²¹⁸ S. Smismans, 'EU employment policy: decentralisation or centralisation through the open method of coordination?', European University Institute Working Paper LAW No. 2004/1, 15. For a critical discussion of the role of civil society in the OMC process, see K. Armstrong, 'Tackling Social Exclusion Through OMC: Reshaping the Boundaries of EU Governance' in T. Borzel and R. Cichowski (eds), *The State of the Union: Law, Politics and Society* (Oxford University Press, 2003).

²¹⁹ See M. Dawson, 'The Ambiguity of Social Europe in the Open Method of coordination', (2009) 34 *ELRev* 55; P. Copelnd and B. Ter Haar, *A Toothless Bite? The (in)effectiveness of the European employment Strategy as a Governance Tool* (2010) 23(1) *Journal of European Social Policy* 21-36.

defined by tighter parameters and expectations. It must also be noted that the OMC was not explicitly articulated in Europe 2020, the EU's current long term planning strategy. Four, given the nature of the first principle end-of-life questions surrounding MBSPL, it is unlikely that a general policy objective will be agreed upon at the EU level. Arguably, agreement could be had based on the objectives of the Oviedo Convention (which most EU member states²²⁰ have signed and ratified), i.e. the objective to respect the autonomy of the patient in refusing treatment (by advanced directive or otherwise), but this policy objective says nothing about a host of other MBPSL – such as VAE, AS or the administration of pain relief that shortens life.

This takes us on to a more relevant form of EU 'new governance' in health care policy: 'joint action strategies.'²²¹ These strategies are very precise policy initiatives that are funded jointly by the European Commission and by participating Member States. Key NGOs (such as the WHO, OECD, and EMCDDA) are also welcome to participate. Joint Actions are generally funded on a 50/50 basis, although the Commission will shoulder up to 80% of the costs in 'exceptional' cases. The focus of Joint Action strategies is generally quite precise (health indicators, rare diseases, nanomaterials, congenital anomalies, organ donation, e-health governance, HIV, pharmacovigilance, alcohol use), and the topics are by their very nature more complex (chronic disease, cancer, health inequalities, health human resources, mental health and well-being). The stated objective of the Joint Action strategy is to identify common priorities between states, and to facilitate communication and coordination between them. Capacity gaps and best practices are noted, potential strategies of cooperation are discussed, and modes of operationalisation are developed. Unlike OMCs, the attempt is, as one interviewee noted, to see that the EU's money is "well spent". The funding period is clearly limited (up to 36 months) and potential deliverables must be identified *ex ante*.

Any potential participant is free to submit a proposal for Joint Action funding, though many of the programmes have been initiatives led by a current Council's presidency (such as Spain's support for the health inequalities programme). Specific countries normally act

²²⁰ The exceptions being: Austria, Germany, Belgium, Ireland, Malta and the UK.

²²¹ Note: that instruments of 'new governance' are not exhaustive in European Health policy, instruments such as the 'EU Health Forum', 'reference networks', the 'High Level Process of Reflection' and 'Social Dialogue' could also be mentioned here, but are not due to a decision based both on space and core relevance to the issue.

as “leads” on issues in which they are particularly interested (France and the UK have been the most active in coordinating Joint Actions), and states are free to join if they believe that a particular focus is especially relevant to their jurisdiction. The focus of the Joint Actions is more on implementing existing knowledge than producing new ideas. Rather than isolated pilot projects, Joint Actions are attempts at executing best practices across jurisdictions. Effort is made to achieve economies of scale, promotion of best practices, facilitating networks, and establishing benchmarks. The results are to be quite concrete, and are expected to be permanently institutionalized.²²²

It is contested here that periodical ‘Joint Action Programmes’ are exactly what national legal-policy makers require concerning MBPSL. It may begin with a relatively manageable European research network, involving a small number of Member States. In any case, it must involve (medical, legal and sociological) experts in qualitative and quantitative research, offering a functional descriptive analysis on the practice and regulation of MBPSL using a trans-national comparative methodology. Any empirical data could also be supplemented by publishing national reports involving the professional medical associations; patient rights groups and outcomes/votes at public meetings. Greater details on this recommendation are set out in *Finding 7* in the proceeding section on conclusions.

²²² See K. Fierlbeck, ‘The changing contours of experimental governance in European health care’ (2014) 108 *Social Science and Medicine* 89-96.

PART FOUR

CONCLUSIONS

CONCLUSIONS

This study commenced with one over-arching ambition: to improve, however fractionally, the legal and political debates on assisted dying.²²³ It concludes with seven main, inter-related findings. Moreover, the seventh finding sets out a relatively detailed proposal for a future research agenda. Within these main findings, a number of sub-findings are made. Before setting these out however, a reminder is warranted on how the analytical framework used here - '*a comparative law and governance analysis*' - complements and merges existing discourses from various disciplines. For this a quick and succinct methodological summary shall suffice.

First, a normative ethical analysis was carried out to evaluate the ideal dimension²²⁴ of the law on assisted dying. To do this, Sections 2.1. and 2.2. built upon existing discourses in *moral-philosophy*.²²⁵ Attention then turned in Section 2.3. to the real dimension of the law on assisted dying (i.e. to the positive rules and mechanisms required to achieve the ideal dimension). It was illustrated from the outset that in order to better inform policy-makers on this dimension, a holistic method of inquiry was needed. In other words, one would need to take a step beyond the boundaries of *legal science* and into the realms of *political and social science*. Policy-makers would need to know of: (i) the different policy outputs concerning assisted dying (i.e. the content of different legal rules, prosecution guidelines, judicial verdicts, etc. in other jurisdictions); (ii) the different policy effects (i.e. how these different legal rules, prosecution guidelines, judicial verdicts, etc., succeed or

²²³ See CHAPTER ONE, Section 1: 'Outline of this Study'.

²²⁴ Alexy's theory on the 'dual nature' of law was followed here. See: R. Alexy, 'The Dual Nature of Law' (2010) 23(2) *Ratio Juris* 167-182.

²²⁵ In sum, to fix the moral content of the legal policy on assisted dying, von der Pfordten's 'general theory of normative individualism' and a Rawlsian-type though experiments were combined and applied. See D. von der Pfordten, 'Five Elements of Normative Ethics – A General Theory of Normative Individualism' (2012) 15 *Ethical Theory and Moral Practice* 449-471; See J. Rawls, *A Theory of Justice* (Revised Edition, Belknap Press: Harvard University, 1999) 133.

fail to achieve their stated objectives); and (iii) the different experiences surrounding policy change (what has been done by policy-makers, if anything, to alter or reform these different legal rules, prosecution guidelines, judicial verdicts, etc., in light of their effects).

To help in this endeavour, a ‘comparative law and governance’ analysis was fleshed out.²²⁶ This, in sum, provides for a descriptive, critical, and prescriptive comparative analysis of the actors and institutional architecture (formal and informal) involved in the creation, application and enforcement of formally binding rules. In our case, the rules on assisted dying. In light of this proposed general methodology, a conceptual framework was presented. In short, to highlight the importance of looking at particular governance dimensions of the law on assisted dying (and morality policies, in general) certain steps were followed:

(i) Two abstract relations between law and governance were presented - both of which may manifest themselves on the national or supranational level.²²⁷ On the one hand, there is ‘public governance *through* the law’; here the creation, application and enforcement of the law is predominately in the hands of public actors - central political institutions (parliaments, executives and bureaucracies), central political actors (parties and unions), and the judicial branch. As far as the public policy on assisted dying is concerned, this relation on the national level has an intuitive appeal.²²⁸ On the other hand, there is ‘public-private governance in the law’; here the creation, application and enforcement of the law is the result of positive interaction between public and private actors. This more ‘consensual style’ of governance in the law, is not readily equated with morality policies, especially a ‘life and death’ one such as assisted dying.

(ii) A number of observations were presented from political scientists on the pronounced effects morality policies have not only on the political dimension²²⁹ of legal policy

²²⁶ See Section 2.3: ‘A Comparative Law and Governance Analysis.’

²²⁷ See Section 2.3.2. ‘A Law and Governance Taxonomy’.

²²⁸ The democratic political process at the nation-state level provides: (i) a means to internalize dissent and mediate between different fundamental values within a polity; (ii) an equal voice for every citizen, albeit abstracted through the development of political parties, (iii) input legitimacy to sensitive policy formulation and the justification for its constant renegotiation, and (iv) the voluntary and coercive authority to ensure or increase compliance and enforcement of that policy.

²²⁹ I. Engeli, C. Green-Pedersen and L. Thorup Larsen, *Morality Politics in Western Europe: Parties, Agendas and Policy Choices*, (Palgrave, Macmillan, 2012).

change,²³⁰ but also on legal policy content, implementation, and evaluation.²³¹ These observations challenged us to conceptualize, from the outset, alternative modes of creating and enforcing morality policies more suitably distanced from the inadequacies of central political institutions and actors. Moreover, these observations challenged us to consider whether potential, less orthodox, governance mechanisms (within and beyond the state), could or should have a greater influence on how we approach the law not just on assisted dying, but all morality policies.

In short, the six Chapters proceeding section 2.3. suggest that we take these challenges seriously. It evidences the benefits of a move away from ‘public governance through the law’ on assisted dying, and that governance processes on the European-level may indeed be of value. These assertions will be addressed in detail below. A more principled finding on the ideal dimension of the law must be addressed first.

Finding 1:

A suitable balance between the principle of autonomy, the principle of beneficence and the principle of respect for life requires that voluntary active euthanasia and assisted suicide should be permitted – but only on the condition that assistance is performed by a doctor, the patient’s request is evaluated, and that the patient is suffering unbearably and hopelessly according to relatively objective medical standards.

This is, by no means, a novel principled standpoint, particularly to any reader vaguely familiar with the law in the Netherlands, Belgium, or Luxembourg. Nonetheless, it is a standpoint that is evaluated and justified in this study by a novel normative framework²³²

²³⁰ S. Heichel, C. Knill, and S. Schmitt, ‘Public policy meets morality: conceptual and theoretical challenges in the analysis of morality policy change’ (2013) 20(3) *Journal of European Public Policy* 319.

²³¹ C. Knill, and J. Tosun, *Public Policy: A New Introduction* (Palgrave Macmillan, 2012).

²³² This broad normative framework states that: (i) an adequate moral decision on the provision of assisted dying must consider individuals as the ultimate point of reference (the ‘principle of individuality’); (ii) due account must be taken of all individuals that are probably or logically affected by that decision (the ‘all-principle’); (iii) any restriction on the individual’s control over the manner of his/her death in the name of communal concerns must face the burden of justification; (iv) in order to decide *if* the restriction is justified, an impartial ‘original position’ is of benefit; (v) all individuals in the original position know that any individual is potentially susceptible to unbearable and incurable suffering, and that any individual may be susceptible to undue influence; (vi) in order to balance the competing individual and communal interests a heuristic device in the form of the maximin rule may be used.

– a framework which combined a specific theory of normative ethics and a specific theory of rational choice.²³³ It is, moreover, equally important to note that this principled standpoint is insufficient in itself for defining the legal policy on assisted dying. It is an ‘ideal dimension’ of the law. Regardless of how suitable the normative framework that identifies this dimension happens to be (or not to be), it fails to tell us anything about the actual achievement or enforcement of this ideal. It may well be the case that it is an ideal which is simply unachievable in the realities of a particular jurisdiction. In the wider context of morality policy studies, this conceptualization of the ‘dual nature’ of law is in itself fundamental. It allows the focus to be purposefully and distinctly shifted away from ideological concerns (read: pitfalls) to more pragmatic concerns - without neglecting or underestimating the former.

Before moving on to the remaining findings, mention must be made of some limitations. The national analysis here is limited to four nation states in Western Europe only and the supranational analysis is limited to the EU and the ECHR legal systems only, thus caution must be had on attempting to directly ‘transplant’ these findings to other national and supranational legal or political systems. Equally, this caution applies to directly ‘transplanting’ the findings from within the group of states studied here – for example: what might work in the Netherlands, may not necessarily work in France, or of course, vice versa. Instead, Kohn’s typology of approaches to cross-national comparisons²³⁴ is adopted: each selected system may be treated as ‘an object of analysis’ in idiographic way,²³⁵ as ‘a context of study’ for examining some general hypotheses,²³⁶ and as a ‘unit of analysis.’²³⁷

Finding 2:

Problematic policy effects arise (particularly in light of Finding 1):

²³³ See von der Pfordten (n 3); Rawls (n 3).

²³⁴ M.L. Kohn, *Cross-national research in sociology* (Sage Publications, 1989).

²³⁵ To understand what is distinctive (or not) about how policy outputs on assisted dying are created, subjected to reforms, applied and enforced in each system.

²³⁶ To understand if certain actors and institutional architectures have a positive or negative impact on the creation, reform, application and enforcement of the policy outputs on assisted dying, particularly in light of their objectives.

²³⁷ To explain why certain Western European liberal democratic nations²³⁷ design, reform, apply or enforce policy outputs on assisted dying in a different or similar way.

- (i) *when exclusively relying on judges, public prosecutors, and law enforcement officers to apply and enforce the law on voluntary active euthanasia - as is the case in England, France and Switzerland;*
- (ii) *when exclusively relying on judges, public prosecutors and law enforcement officers to apply and enforce the law on assisted suicide - as is the case in England and France; and,*
- (iii) *when relying on judges, public prosecutors and law enforcement officers to scrutinize the fragmented delegation of responsibility handed to private, non-medical actors in the day-to-day provision of assisted suicide - as is the case in Switzerland.*

In relation to point (i) above, when certain cases of VAE have come before the courts in all three of the aforementioned nations, the accepted criminal law norms on murder have been overlooked in order to avoid punishing benevolent medics or family members.²³⁸ Moreover, these decisions do not represent the recognition of a new, judicially developed defence to VAE in said jurisdictions, but rather sporadic manifestations of actively defying the law in the interests of justice in the case at hand. The result is that medics and loved ones may face months, or even years of litigation, only to be overwhelmingly excused by a judge or a jury. Moreover, beyond the case at hand, it means that the prohibition on VAE remains in place, but its disregard goes unsanctioned. On the one hand, this is a fundamental problem from a procedural rule of law perspective. On the other hand, it is a problem from a control-framework perspective – it means acts of VAE may occur without any *ex-ante* safeguards pertaining to the patient’s request or degree of suffering.

In relation to point (ii) above, criminal prosecutions for AS in England and France are very unlikely to occur. This is not, in itself, a criticism. However, this gradual adoption of

²³⁸ See **CHAPTERS THREE, FOUR, and FIVE**. For an example in Switzerland, see the ‘Bern case’, Le Tribunal de police, Canton de Neuchâtel, ‘Distinction entre assistance au suicide et meurtre sur demande de la victime. Circonstances justificatives’; For an example in France, *Humbert/Chaussoy*, Tribunal de Boulogne sur Mer, 27 February 2006, *Le Monde* (1 March 2006). For an example in England, see *R v Adams* (unreported). See H. Palmer, ‘Dr. Adams trial for murder’ (1957) *CrimLRev* 365; and the *Dr Ludwig* case (unreported) *The Times* (16 March 1990). Moreover, in England the Courts have, on occasion, directed the jury not to find a doctor guilty of murder if he administered a lethal dose of painkillers (with or without the patient’s consent) to a terminally ill patient, knowing that it is virtually certain that the drug will bring about the death of the patient. Such a direction is entirely inconsistent with the generally accepted meaning of (indirect) intent for an act of murder in criminal law. On this, see A. Arlidge, ‘The trial of Dr David Moor’ (2000) *Crim LR* 31.

permissive policy implementation rather than a direct modification of the formal rules creates similar risks to those just mentioned in point (i) above. Namely, there are no *ex-ante* checks and balances. Also, both legal systems seem to favor lay assistance.²³⁹ Moreover, neither legal policy in England or France makes any reference to a requirement that the patient is suffering whatsoever.

In relation to point (iii) above, the main concern that arises is the motives of the right-to-die organisations (RTDs) and the (non)application of the Swiss Penal Code on what is considered 'selfish.' Article 115 of said Code, makes the act of AS a crime in Switzerland if accompanied by 'selfish motives'. This is generally understood²⁴⁰ to mean that a person who materially benefits from another's suicide should fall foul of the criminal law. Yet, at the time of writing, there have been no prosecutions for this offence despite the most well known RTD (Dignitas) charging extortionate prices - two consultations with doctors is billed at over €1,000 - and, moreover, there is a direct fee to be 'paid to the person acting as an escort/helper', which accompanied with the costs of renting the apartment, comes to €2,600. In light of the costs, one must seriously suspect that some helpers at Dignitas are materially benefiting from the provision of AS.

Finding 3:

Third, when voluntary active euthanasia and assisted suicide are conditionally lawful, removing the immediate threat of criminal prosecution and placing a 'buffer' (e.g. the Regional Review Committees) between the physician and the medical inspectorate/prosecution services, appears to have positive results on the reporting rate – as is the case in the Netherlands.²⁴¹

Taking assisted dying out of the general criminal law and subjecting it to an issue-specific framework reduces the role of law enforcement officers and invites increased use of specialized agencies. Convictions are not deemed as a sign of efficient control in the Dutch system. In this respect, members of the judiciary and prosecution services do not need to overlook fundamental principles of the criminal law system to avoid punishing

²³⁹ For the English law on this, see Section 3.1.(ii); For the French law on this, see Section 3.2.(ii).

²⁴⁰ See Section 5.1., above and (n) 17 therein. Note the total costs of an AS with Dignitas may be over €10,000.

²⁴¹ See Section 5.1.

benevolent doctors or loved ones (contrast this with Finding 2). The primary forms of control are before-the-act communications with networks of experts (SCEN) or independent consultants, and prospective investigation – the physician knows he may face questioning (non-criminal questioning, at least initially) over the nature of his/her report submitted to the Regional Review Committee.

Finding 4:

In the four national systems and in the two supranational systems studied here, relying exclusively on central political institutions and actors to determine or evaluate the legal policy on assisted dying is problematic.

First, the majority of political actors in England (from both the House of Commons and the House of Lords), in France (from both the National Assembly and the Senate), in Switzerland (from both the Federal Council and the National Council),²⁴² and in the Parliamentary Assembly of the Council of Europe²⁴³ failed to recognise problems in the content and the effects of blanket bans on assisted dying. This failure was more often of a dual nature – on the one hand, the difficulties in not enforcing the formal ban but still maintaining it went unnoticed, while on the other hand, fears over slippery slopes (empirical, speculative and conceptual) on the basis of the Dutch experience were frequently invoked. Moreover, there was marked (moral and legal) acceptance of other end of life behaviors (such as withholding/withdrawing life-prolonging treatment and the hastening of death by administering pain killers). This was so, despite the potential empirical slippery slopes these behaviours present if not regulated properly, and also despite the moral insignificance between them and assisted dying.²⁴⁴ It must also be said that the Parliamentary Assembly in the Council of Europe fell particularly foul to the rhetoric of ideological argumentation and misreading of the motion(s) actually up for debate.²⁴⁵

²⁴² See Sections 6.1 to 6.5. for a detailed examination of the political debates on assisted dying in each of these nations.

²⁴³ See Section 7.3.3. for a detailed critique of the Parliamentary Assembly debates on assisted dying.

²⁴⁴ On this last argument, see Section 2.2.2, specifically point (iii) therein, and also Section 2.2.3.

²⁴⁵ See Section 7.3.3.

Second, politicians in each of the four nations, and also those indirectly elected to Parliamentary Assembly in the CoE, are keen to avoiding either pushing the issue onto the political agenda or supporting concrete legal reform, even if public support is in their favour. This, arguably, only remains the case –until and unless – certain factors, external but nonetheless linked to the issue, exist that may effect their re-election chances.²⁴⁶ These factors are namely the existence of: (a) a strong religious-secular divide in the party system, (b) a well-respected medical association that supports legal change and is willing to take responsibility, and (c) a well-mobilized powerful right-to-die interest group. Without the presence of these factors, the issue of assisted dying is likely to remain at the periphery of the political agenda or susceptible to a weaker compromise (as was almost the case in France in 2015).²⁴⁷

Finding 5:

Strategic interaction between the judicial and legislative or executive branches has an enormous relevance in not only triggering/stagnating legal policy change on assisted dying but also in determining the nature of how that policy is reviewed.

In England, France, and Switzerland, the courts are reluctant to usurp the role of the legislator in reforming the law on assisted dying. It is an issue considered to be jealously guarded by democratically elected representatives. This institutional sensitivity is in marked contrast to that in the Netherlands, where the Dutch government and parliament for over two decades refrained from formally intervening, and hence left the issue to the judges to determine. In light of findings above – namely, the evident reluctance of political actors to meaningfully place the issue on the political agenda (subject to a number of contextual factors) – the capacity and willingness of the Dutch courts to intervene was a welcomed form of judicial activism. However, the recent Arnhem-Leeuwarden Court of Appeal decision in *Heringa*²⁴⁸ is a sign of this activism perhaps going too far. This was the first decision in which the defence of necessity was extended to justify the performance of assisted dying by a lay person and not a medic. This marks a substantial move away

²⁴⁶ See Section 6.5.(iii).

²⁴⁷ See the discussion of the ‘Leonetti-Claeys’ Bill in Section 6.5.(iii).

²⁴⁸ ECLI: NL: GHARL: 2015: 3444; The full judgment is available (in Dutch) at: <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:GHARL:2015:3444&keyword=euthanasie>. Last accessed 28.01.2016. Note that this decision is subject to an upcoming appeal before the Dutch Supreme Court.

from the established legal doctrine and the statutory law – which provides that assisted dying is only lawful if performed by a physician. This condition, which was present throughout the development of the prosecution guidelines on assisted dying (in the 1980s and 1990s), and was considered crucial in the Parliamentary debates leading up to the 2002 ratification of the law, is a condition that is included for well-considered reasons.²⁴⁹

The relevance of the strategic interaction between the judicial and legislative or executive branches when dealing with assisted dying is even more pronounced on the supra-national level. The European Court of Human Rights (ECtHR) is undoubtedly aware of its duty to strike a balance between progressive human rights protection and maintaining respect with national sensitivities.²⁵⁰ Where there is no consensus within the Contracting States of the Council of Europe as to the relative importance of the interest at stake or as to the best means of protecting it, or if the case raises moral or ethical issues, the margin of appreciation will be wider (and thus the intensity of judicial review will be weaker). For these reasons, which are indeed valid reasons given the potential for individual decisions to reach beyond the case at hand, the ECtHR²⁵¹ unsurprisingly resisted not only striking down the impugned national laws on assisted dying that came before it, but also resisted subjecting them to any real degree of scrutiny. As valid as this may be given the Court's 'constitutional relationship' with national authorities, it cannot excuse the poor methodology used by the courts to avoid explicitly identifying the existence of a *prima facie* human right to assisted dying.²⁵² In this sense, the Court failed to provide any authoritative guidance to national courts if (or rather when) faced with the matter themselves. An important channel of international judicial influence on morality policymaking was overlooked at the expense of institutional over-sensitivities.

Finding 6:

²⁴⁹ Namely – the advantage for medical assistance over lay person assistance is that it reduces the likelihood of botched suicides or botch assistance (and thus unnecessary suffering), it increases the likelihood of identifying unknown psychiatric disorders, and also increases the likelihood that all reasonable alternatives to treat the suffering have been properly evaluated.

²⁵⁰ See Section 7.2.1. for an overview of the various challenges facing the ECtHR.

²⁵¹ For a detailed analysis of the ECtHR's jurisprudence on assisted dying, see Section 7.2.2.

²⁵² See Section 7.2.4.

Judicial governance in the European Union offers a surprisingly positive means to improve national judicial review processes of legal policies on assisted dying.

In **CHAPTER 8**, the unlikely role for judicial actors at the EU-level to influence member state laws on assisted dying was set out. In short, a hypothetical free movement claim was developed in light of the very real phenomena of suicide tourism, i.e. the occurrence of a person travelling to another jurisdiction ('host state') – namely Switzerland - with more permissible assisted suicide laws than his or her country of origin or residence ('home state'), in order to receive assistance in committing suicide. This claim reached the conclusion that: in light of European Court of Justice (CJEU) case-law, the extra-territorial (criminal) ban on assisted suicide in English law is a restriction on the provision of services under the EU-Swiss FMP Agreement. It was then presupposed that the CJEU would almost certainly not apply a substantive proportionality test and risk finding the impugned English ban as an unlawful restriction to 'economic' free movement rules. However, an alternative option for the CJEU was presented.

The CJEU could adopt a procedural proportionality test over a direct substantive test. Indeed, it is the former procedural test which the Court more often adopts in sensitive free movement cases – for example in its judgments on gambling,²⁵³ medical services²⁵⁴ and Japanese Anime.²⁵⁵ Unlike an attempt to rationalize the *content* of a particular national legal policy (i.e. a substantive proportionality test), this form of proportionality review merely seeks to rationalize the *process or effects* of that national legal policy.²⁵⁶ In our hypothetical case, this would mean the CJEU could grant a margin of appreciation to the English authorities in deciding to impose an extraterritorial ban on AS. However, it would also present the (referring) English national court with the adjudicatory capacity to closely review the actual implementation of that ban in light of its objectives and the requirements of both the rule of law and good governance. The focus of the proportionality review therefore becomes less political and more procedural (legal) in nature. If an English court was to look at the actual workings of the extra-territorial ban

²⁵³ Case C-243/01 *Gambelli* [2003] ECR I-13031; Joined Cases C-338/04, C-359/04 & C-360/04 *Placanica* [2007] ECR I-1891; Case C-67/98 *Zenatti* [1999] ECR I-7289; Case C-124/97 *Läärä* [1999] ECR I-6067.

²⁵⁴ Case C-157/99, *Smits and Peerbooms* [2001] ECR I-5473, para. 90; Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, para. 85 and C-372/04 *Watts* [2006] ECR I-4325, para. 116

²⁵⁵ Case C-244/06 *Dynamic Medien* [2008] ECR I-505.

²⁵⁶ *Ibid.*

on AS it may find itself looking at nothing but a 'paper tiger.'²⁵⁷ Arguably, the only legal certainty provided by the current application of impugned ban is it will be undermined by those who can pay and travel to Switzerland, and that certain individuals will face criminal investigation only to be notified by the prosecution authorities that no charges will be brought in the 'public interest.' As stated in **CHAPTER 8**: it will be up to the English court to decide if this is the 'legal certainty' the policy-makers in Westminster had in mind, particularly in light of the fundamental objectives pursued by the measure and the level of protection for vulnerable persons it is intended to provide. In any case, it is arguable that the CJEU, through the operation of 'economic' free movement rules within the EU (and with certain third countries, such as Switzerland), has the capacity to re-politicize the national law on assisted dying by bringing principles of procedural good governance to the fore.

Finding 7:

Periodical EU-level 'Joint Action Programmes' on not just assisted dying, but on all medical behaviour that shortens life, could better inform legal-policy makers across Europe.

In light of the above findings, it may be stated we must seriously consider alternative modes of evaluating and enforcing the legal policy on assisted dying that are suitably distanced from the inadequacies of central political institutions and actors on the national and supra-national level. One small but pragmatic step in this endeavour would be to focus on EU 'new governance' mechanisms in the area of health care policy. This study concludes by strongly recommending the establishment and funding of a specific 'Joint Action Strategy.'²⁵⁸

The objective of this strategy would be to identify common priorities between EU Member States on how to properly regulate all medical behaviour that shortens life (MBSL), and to facilitate communication and coordination between them in doing so. This would involve the funding and creation of a European research network (however small initially, with perhaps only six to eight Member State participants). Moreover, the network must

²⁵⁷ See **CHAPTER FIVE** and Section 8.4.

²⁵⁸ On the specifics of a 'Joint Action Strategy', see Section 8.5.

involve state actors (officials from the State Health Departments) and non-state actors (representatives of the professional medical associations, and a select number of legal and medical sociologists from each nation, with particular experience on qualitative and quantitative research). This network should have a time-limited mandate:

- (i) to complete a comparative descriptive study on the regulation of MBPSL in a select number of Member States;
- (ii) to establish up-to-date national frequencies of MBPSL and to comparatively track the impact of various factors on such behavior (such as the regulation or guidelines, health care setting, patient characteristics, and general medical culture); and
- (iii) to provide a European-wide basis for policy dialogue and facilitate better-informed decision-making on current or future regulation (best practices) with the aid of quantitative data. Especially in Member States where the debate is not as open as the Member States already subjected to analysis.

In terms of the scope and methodology of the programme, this study recommends that it is divided into two forms of analysis:

1. A descriptive legal/policy analysis

Here the national legal experts should provide a functional descriptive analysis of the rules in place regarding the following behavior:²⁵⁹

- when a patient refuses life-prolonging treatment (be it contemporaneous or in advanced directive)
- when a doctor withholds/withdraws life-prolonging treatment based on medical futility
- when a doctor administers pain relief which hastens the patient's death
- when a doctor induces a patient into terminal sedation
- when a doctor administers a substance to instantly terminate a patient's life upon that patient's request
- when a doctor provides assistance in a patient's suicide

²⁵⁹ Note 'rules' here refers namely to statute, case-law and professional medical standards.

2. A quantitative medical-sociological analysis

There are three main methods of acquiring quantitative data in this area of study: (i) interviews with a sample of physicians (the 'interview method'); (ii) a written questionnaire sent to the responsible doctors in a sample of registered deaths (the 'death-certificate study'); and (iii) a study of the most recent death in the practice of a national sample of doctors.

The 'joint action' programme recommended here should adopt the 'death certificate study' approach. This methodology is used in all the EURELD studies²⁶⁰ and is considered the most reliable methodology for the purposes at hand. Traditionally, it produces basic data on the frequencies of various MBSL – generally speaking, what did the doctor do? What was his/her intention? Was there a request from the patient? In this programme, the second question regarding the doctors' subjective intention may be disregarded. Instead, any intention will be inferred objectively from what the doctor actually did and whether it was indicated to hasten death according to professional medical standards.

The frequency of MBSL will be expressed as a percentage *of all deaths*, not as a percentage *of all non-sudden deaths*. Also, the focus should only be *the most important (causative) end-of-life decision* in a particular case, and not *all end-of-life decisions* made throughout the course of treatment.

To sum up the recommended methodology: the medical sociologists involved in the programme must obtain a sample of death certificates registered within a certain period in each of participant Member States, substantially large enough in size for analysis. A questionnaire would then be sent to the attending physician for each death sampled. All deaths reported during the sampling period must be stratified for the likelihood that an end-of-life decision had preceded the death involved. Based on the relevant causes of death in the country, the sample deaths may be assigned more or less strata. Sampling

²⁶⁰ See **CHAPTER FOUR** above on empirical data. These studies were entitled: 'Physicians' experiences with End of Life Decision Making: Survey in 6 European Countries and Australia' [2007]; 'End of Life Decision Making in 6 European Countries: Descriptive Study' [2005]; 'Forgoing Treatment at the End of Life in 6 European Countries' [2005].

fractions ought to be higher for strata in which the cause of death made an end-of-life decision more likely – e.g. cancer versus sudden death in a car accident. Stratification is applied to enhance the efficiency of the sampling procedure and to yield smaller confidence intervals around estimates. Stratification may not be possible in Member States that have delays in registering causes of deaths. Results *representative* for all deaths during the studied period ought to be given an additional weight in all cases, which is calculated by dividing the sampled number and the response number for all cases with a specific combination (if available) of gender, age, place and cause of death.

Country-specific versions of the findings should be made, with a common English version, which is to be translated into the languages of the studied countries and translated back into English to search for any inconsistencies. All country-specific databases ought to be combined into one common file, to ensure identical coding and analysis procedures. If applicable, results ought to be corrected for stratification by giving all cases a weight that is the reverse of the sampling fraction within the stratum they were assigned to.

The *types* of MBSL must be defined and clearly distinguished from each other. Essentially, the frequency of the following behavior must be obtained from the period sample: the refusal of life-prolonging treatment and advanced directives; the withholding/withdrawing of life-prolonging treatment based on medical futility; the administration of pain relief with life shortening effects; the inducement of terminal sedation; the administration of a substance to instantly terminate the life of another person upon that person's request; the assistance in suicide; and the total number of MBSL.

Furthermore, certain characteristics of the patients who dies as a result of MBSL should be requested, including but not limited to: the age of the patient (0-30 yrs; 30-65 yrs; 65-80 yrs; 80yrs or older); the gender of the patient; the patient's ethnicity; the patient's medical condition (cancer; cardiovascular disease; nervous system issues; other/unknown); the location of death (home; hospital; nursing home; old age home; other); the estimated life-shortening effect of the MBSL (less than 1 week; 1 week to 1 month; more than 1 month; unknown); the type of attending physician (specialist; consultant; general practitioner; other); if attainable or relevant, any religious affiliations

of the patient and the attending doctor; any available information regarding economic factors or the patient's economic status (was he or she below the poverty line/underprivileged member of society; the relevant costs of alternative treatments).

A final word:

The aim of this study was to improve, however fractionally, the legal and political debates on assisted dying. Thus, the above findings and the proceeding eight Chapters are not intended to be merely of some academic value. They demand that we question the existing actors and institutional structures that are entrusted to create, evaluate, and enforce the law on assisted dying. Moreover, they evidence that relying on central political institutions and actors – *public governance through the law* - to do this, is not to be taken for granted. For now, progressive steps are needed to move away from uncompromising first-principle debates which too easily overshadow the important governance dimensions at play. One practical way to do this is by embarking on more systematic empirical research on all medical behaviour that shortens life. This may, as outlined in the final recommendation above, come in the form of a European transnational independent network of experts who report directly to national policy makers (namely State ministers and representatives of the professional medical associations). In this sense, a small but tangible type of *European public-private governance in the law* could mitigate the problems of *national public governance through the law*.

As for the question of how effective this can be, the answer depends largely on how one defines its purpose. Notwithstanding the real potential for no agreed solutions on the matter, this form of governance has the potential at the very least to inject some overdue instrumental rationality into national debates on assisted dying and to contextualize this manifest morality policy in the wider context of all MBSL. Moreover, in some Member States it may represent a catalyst for the first public or political debates on the content, evaluation and enforcement of the law on assisted dying. The political or judicial willingness (or indeed, the willingness of the stakeholders themselves to conclusively respond) to any findings on best practices cannot be foreseen. As we learnt from processes in the Netherlands - whereby experts, stakeholders and national authorities were mutually involved – there is no simple recipe for de-politicizing (or re-politicizing) the debate on assisted dying. It may take decades in order for it to be done correctly. National-level parliamentary sub-committees may be set up and more empirical research

agendas may be established, indeed, politicians may well 'kick the can down the road', but sooner or later a large volume of comparative data will find its use in this legal policy debate.