The Right to Life – A Duty to Live?: A Comparative Analysis of the Regulation of Active Assisted Dying in England, Germany and under the ECHR

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Abstract

This thesis addresses the question whether there is a basis for active assisted dying to fall within the protection of the European Convention on Human Rights (ECHR). With desperate individuals addressing the European Court of Human Rights (ECtHR) in order to be granted a right to die, but being denied it, the right to life is turned into a *de facto* duty to live.

An evaluation of the concepts of dignity and autonomy will highlight the need for a right to die, to counterbalance the right to life. Seeing dignity as a subjective element means that a dignified life can only be evaluated by the person living it. If therefore a dignified death is believed to be one brought about with assistance before natural death would occur, this should not be dismissed based on a general idea of how and when people should best die. Believing in a right to a dignified life asks for a right to die in dignity. Seeing autonomy as a relational concept, meaning that for a truly autonomous life we are dependent on others and society as a whole, stresses the need for a legalisation of assisted dying.

The thesis analyses the ECtHR's approach towards assisted dying and what factors prevent it from adopting a more forthright approach towards a right to die. Based on a lack of consensus among the Member States, the Court relies on the margin of appreciation and shies away from taking a stand. While seeing that dying is a part of life and consequently falls within the ambit of Article 8, the protection of private and family life, Article 2, the right to life, acts as a barrier to any claim for a right to die, which arguably turns the right to life in a duty to live.

Looking at the legal situation in England and Germany highlights the difficulty in reaching a European consensus on assisted dying. Actively assisting someone in dying, who is unable to commit suicide unaided, is a criminal offence in both countries. However, there are significant differences between the two jurisdictions. In England, assisting someone in committing suicide is prohibited under Section 2 of the Suicide Act 1961, whereas in Germany it is in theory legally possible. Yet, in England assistants can hope to avoid prosecution based on the Director of Public Prosecution's guidelines of 2009, whilst in Germany assistants face prosecution based on other legal provisions like the Narcotics Act. While Germany moves towards a criminalisation of assistance in suicide offered for a fee (commercial assisted suicide), in England, debates on Bills focus on attempts to legalise some categories of assisted dying. The comparison

suggests that a European consensus is not likely to be achieved in the near future.

The thesis concludes that based on dignity and autonomy the national approaches towards assisted dying should be revised and legalisation should be considered. This is necessary so that the ECtHR can counterbalance the right to life with a right to die.

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Abbreviations

AMWG .... *Arbeitsgemeinschaft Medizinisch-Wissenschaftlicher Gesellschaften* – ..... Association of the Scientific Medical Societies in Germany

BGH ..... *Bundesgerichtshof* – Federal Supreme Court

BtMG ..... *Betäubungsmittelgesetz* – German Narcotics Act

BVerfG .....*Bundesverfassungsgericht* – Federal Constitutional Court

BVerfGG .....*Gesetz über das Bundesverfassungsgericht* – Law for the BVerfG

CRPD ..... Convention on the Rights of Persons with Disabilities

DGHS ..... *Deutsche Gesellschaft für Humanes Sterben* - ..... German Society for Dying with Dignity

DPP .....Director of Public Prosecutions

ECHR ..... European Convention on Human Rights

ECtHR ..... European Court of Human Rights

GG .....*Grundgesetz* – German Basic Law

GP ..... General Practicioner

ICU ..... Intensive Care Unit

MND .....Motor Neurone Disease

SOG .....*Sicherheits- und Ordnungsgesetz* – Safety and Order Regulations

StGB ..... *Strafgesetzbuch* – German Penal Code

1. Introduction

Assisted dying is a current and controversial topic. It regularly features on the news, either because someone wishes to be granted a right to die – see for example the most recent English case of Tony Nicklinson et al[1] – or because someone is accused of having assisted another in dying, as happened in 2014 to former Senator Kusch in Hamburg, Germany.[2] News reports also feature the other aspect involved, the ongoing struggle for legal change, be that concerning attempts for legalisation as in England,[3] or attempts at further restrictions as in Germany.[4]

The wish for assistance in dying does not concern the majority of people – but it does affect a number of desperate individuals. The European Convention on Human Rights (ECHR) grants individuals a right to life under Article 2, but is silent on the opposite, a right to die. What that means is that individuals are in theory protected from arbitrary takings of life by State agents. The right is not absolute as Article 2.2 lists three exceptions and the death penalty is only abolished by signatory States to Protocols 6 and 13 to the Convention.

While some argue that a right to die should be entailed in Article 8 ECHR, the right to respect for private life, Article 2 is applied to stop such claims, which – it can be argued – turns the right to life into a duty to live for those unable to commit suicide unaided. This is discriminatory in that those capable of committing suicide without help can legally end their lives, while those requiring help are left without a chance to end their life before dying naturally. This thesis will look at the need for a right to die and the legalisation of assisted dying from the perspective of the European Court of Human Rights (ECtHR), as well as carrying out a comparison of two national approaches, namely those of England and Germany.

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[1] See for example 'Assisted suicide campaigners fail to get supreme sourt to overturn ban' The Guardian, 25 June 2014, http://www.theguardian.com/society/2014/jun/25/assisted-suicide-ban-doctors-supreme-court accessed 13 November 2014 at 1:25pm. *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38.

[2] See for example 'Ehemaliger Hamburger Senator Kusch wegen Totschlags angeklagt' Süddeutsche Zeitung, 12 Mai 2014, http://www.sueddeutsche.de/panorama/umstrittene-sterbehilfe-ehemaliger-hamburger-senator-kusch-wegen-totschlags-angeklagt-1.1959692 accessed 13 November 2014 at 1:22pm.

[3] See for example 'Assisted dying will be made legal in UK 'within two years'' The Guardian, 8 November 2014, http://www.theguardian.com/society/2014/nov/08/assisted-dying-will-be-legal-within-two-years-bma-deputy accessed 13 November 2014 at 1:48pm.

[4] See for example 'Sterben ist das Letzte' Süddeutsche Zeitung, 12 November 2014, http://www.sueddeutsche.de/politik/bundestagsdebatte-zur-sterbehilfe-sterben-ist-das-letzte-1.2215657 accessed 13 November 2014 at 1:46pm.

1.1. Terminology

Euthanasia, deriving from Greek and meaning 'good death', is a term used for the practice of bringing about the death of another person, in order to end suffering. It can be divided into voluntary, non-voluntary and involuntary euthanasia. Non-voluntary euthanasia means that there is no knowledge of a request, for example because the individual in question is in a coma, and involuntary euthanasia stands for an act which is carried out against the wish of the individual. Assisted suicide has the requirement that the final act has to be carried out by the person wishing to die, the assistance in advance can be provided by a physician, a nurse, or other non-medical helpers.

Assisted dying as a general term can be taken to apply only to dying patients, hastening or relieving the already started dying process. However, it can – and in this thesis will – be used as a general term depicting all forms of assistance to hasten death. Assisted dying can further be divided into active or passive, active meaning the deliberate shortening of life, passive relating to the withdrawal or withholding of treatment. A further distinction is made between indirect and direct assisted dying, direct assisted dying being an act with the sole aim of bringing about death and indirect assisted dying being used to depict a medical act – usually to relieve pain and suffering – which has the accepted side-effect of hastening the dying process.

Due to the German concerns regarding the term euthanasia, based on the historic atrocities carried out under said term, it will not be used in this thesis. Even though it can be argued that the term was misused in Nazi-Germany – euthanasia after all meaning 'good death' in Greek – it will not be used out of respect for those who feel it is inappropriate terminology. Instead, the terms to be used are assisted dying as the general practice and physician assisted dying and assisted suicide more specifically.

1.2. Limit of Scope

While the questions of this thesis relate to assisted dying generally, the focus of the thesis is solely on active assisted dying. It is furthermore limited to voluntary assisted dying of a competent adult. Cases of individuals in persistent vegetative states or involuntary assisted dying will not be further engaged with. Indirect assisted dying and passive assisted dying will only be mentioned in reference to active assisted dying. While part of the assisted dying debate focuses on the differentiation between

actively ending life and merely letting die and the moral difference between an act and an omission, this will only be a minor matter in this thesis since the general focus is on active assistance. The restriction scope-wise is not based on a specific belief but is solely due to time and word-limit constraints.

The national comparison, in order to evaluate the approach of the ECtHR, will be limited to Germany and England. An analysis of a greater number of European countries would not have been feasible given the parameters of this doctoral research. England and Germany, however, do serve as very insightful examples. They can be argued to share the same moral and ethical ideas about life and death. While England has its own official state church, it is very close to Germany's Protestantism, and while in both countries religion is nowadays given a side-role, it features in both countries' debates on ethically sensitive issues. However, while they share the same ideas about philosophy, ethics and morals, the countries' approaches towards assisted dying are quite different. Consequently, a comparison of England and Germany serves well to demonstrate the difficulty of the ECtHR to discover a European consensus in end-of-life questions.

1.3. Literature Overview[5]

What makes the approach of this thesis unique is the combination of different focusses. Existing literature tends to focus on one aspect: the rights and wrongs of assisted dying, the legal situation concerning assisted dying either of one country or as a comparison, or problems arising in connection to the human right to life. This thesis combines all these approaches in order to answer the research questions set out below.

Some researchers did attempt a multi-facetted approach towards a right to die. While Groenhuijsen for example mentioned the major aspects – dignity, autonomy, the right to life – and compared various national approaches, he did not come up with any sort of conclusion, much to the contrary: "The debate will never stop. The truth will never be found, because it does not exist".[6] Wernstedt looked at the philosophical foundations of assisted dying across Europe, focussing on deontology and

[5] This section serves the purpose of giving a short overview concerning the existing literature on assisted dying. It is by no means complete, which would be impossible given the amount of already existing literature combined with the restraints of this research, but a brief exemplary sketch of the different kinds of research existing on assisted dying.

[6] Marc Groenhuijsen, 'Euthanasia and the Criminal Justice System. General Report on the State of the Art in 14 Jurisdictions' in Marc Groenhuijsen, Floris van Laanen (eds) *Euthanasia in International and Comparative Perspective* (Wolf Legal Publishers 2006), 26.

utilitarianism, claiming that in both England and Germany it seemed important to hold on to specific principles even if in reality they were already being ignored.[7] Ferreira attempted a comparison of various jurisdictions' approaches towards assisted dying,[8] however, being a rather short piece of work, it has a number of shortcomings, like not engaging with the "dying in dignity" aspect of its title. Sumner compared 11 jurisdictions, three in which assisted dying was a criminal offence (UK, Canada and the majority of the United States of America) and eight in which it had already been legalised to some degree (the Netherlands, Belgium, Luxembourg, Switzerland, Oregon, Washington, Montana, and Colombia).[9] Pointing out that it was possible to either decriminalise or legalise assisted dying, he argued in favour of legalisation.[10] While this shows that there is a small amount of research engaging with the same varied aspects that will be addressed in this thesis, the bulk of research is focussing on only one of the aspects involved, the general arguments in favour of or against assisted dying or an analysis of national law on assisted dying.

1.3.1. General Rights and Wrongs of Assisted Dying

Some authors focus on the general rights and wrongs of assisted dying, like Frieβ, who engaged with the different varieties of assisted dying and then heavily focuses on German law, not clearly stating an opinion apart from the fact that suicide and assisted dying should be treated the same by law.[11] Battin wrote about the fundamental issues of assisted dying and suicide, claiming that a self-determined death was a matter of fundamental human rights,[12] and that assisted dying rested on mercy, autonomy and justice.[13] Harries argued against a legalisation, based on the danger of the possibility of the old and vulnerable being coerced into requesting a death they do not truly want, the fear that doctor-patient relationships could be negatively influenced, the fact that legalisation of assisted dying would take the attention away from the need to expand the area of palliative care

[7] See Thela Wernstedt, *Sterbehilfe in Europa* (Peter Lang 2004), 161.
[8] Nuno Ferreira, *Revisiting Euthanasia: A Comparative Analysis of a Right to Die in Dignity* (ZERP 2005).
[9] See LW Sumner, *Assisted Death: A Study in Ethics and Law* (OUP 2011), 131.
[10] See ibid, 166.
[11] See Michael Frieβ, *"Komm süβer Tod" – Europa auf dem Weg zur Euthanasie? Zur Theologischen Akzeptanz von Assistiertem Suizid und Aktiver Sterbehilfe* (Kohlhammer 2008), 79.
[12] See Margaret Battin, *The Least Worst Death* (OUP 1994), 165.
[13] See ibid, 101.

and that it could open up a slippery slope.[14] Baumann gave an overview on the history of the perception of suicide, from Plato over Hume and Kant to Nietzsche, concluding that a prohibition of voluntary assisted dying could only be based on religious arguments.[15] Biggs argued for a change in law based on the needed possibility to die in dignity and the freedom to have a choice and have that choice respected. While stressing the need for adequate safeguards, she saw autonomy and a right to self-determination as asking for people to be able to have their choices respected and stay in control over their lives until death;[16] Dworkin looked at the value of life and its meaning in the assisted dying debate, differentiating between intrinsic and personal value.[17] Beauchamp collected a number of essays on the moral difference between killing and letting die, arguing that both intention and causality were not sufficient in determining the rightfulness or wrongness of active assisted dying and letting die;[18] Harris dealt with questions relating to the value of life, for example when life begins, the duty of physicians to treat, the rights and wrongs of abortion and whether killing can ever be justified.[19] His approach was less useful than Dworkin's in that he defined a person as someone having the capacity to value their existence. So before and after having that capacity one was not a person.[20] Keown published a collection of papers on the general rightness (or wrongness) of assisted dying,[21] the first third consisting of three essays each by John Harris and John Finnis, Harris arguing in favour of assisted dying on the basis that if someone did not value his or her own life anymore he or she could not be wronged by being killed,[22] while for Finnis human life always retained intrinsic value and dignity.[23] Singer proposed that our traditional ethics approach to questions relating to the beginning and end of life had to be reconsidered and modernised. He looked at the classic sanctity-of-life-argument as a stop to claims relating to abortion,

[14] Richard Harries, *Questions of Life and Death. Christian Faith and Medical Intervention* (Society for Promoting Christian Knowledge 2010).
[15] See Ursula Baumann, *Vom Recht auf den Eignen Tod. Die Geschichte des Suizids vom 18. bis zum 20. Jahrhundert in Deutschland* (H. Böhlaus Nachfolger 2001), 322.
[16] Hazel Biggs, *Euthanasia, Death with Dignity and the Law* (Hart 2001).
[17] Ronald Dworkin, *Life's Dominion. An Argument about Abortion and Euthanasia* (HarperCollins 1993).
[18] See Tom Beauchamp, *Intending Death: The Ethics of Assisted Suicide and Euthanasia* (Prentice-Hall 1995).
[19] John Harris, *The Value of Life. An Introduction to Medical Ethics* (Routledge 1985).
[20] See ibid, 25-26.
[21] John Keown (ed), *Euthanasia Examined. Ethical, Clinical and Legal Perspectives* (CUP 1995).
[22] See John Harris, 'Euthanasia and the Value of Life' in John Keown (ed), *Euthanasia Examined. Ethical, Clinical and Legal Perspectives,* (CUP 1995), 9.
[23] See John Finnis, 'A Philosophical Case against Euthanasia' in John Keown (ed), *Euthanasia Examined. Ethical, Clinical and Legal Perspectives* (CUP 1995), 34.

suicide and various forms of assisted dying and suggested that a more liberating approach was needed.[24] Keown and Jackson wrote a two-sided argument, Jackson arguing in favour of the legalisation of assisted dying, based on dignity and autonomy, and Keown arguing against it based on palliative care arguments and a different view on autonomy.[25] What this small set of examples shows is that the research on assisted dying is as diverse as the general debate, engaging with either one or both sides of the debate.

1.3.2. Nationally Restricted Approach towards Assisted Dying

When looking at the legal situation concerning assisted dying, authors mainly focus on a single jurisdiction. For England there is for example Wicks, arguing that while religious beliefs of course shape arguments, a law has to stand for the whole society, regardless of religious beliefs.[26] Ost argued that assisted dying should be removed from the medical context to a more personal one (where assistance is rendered by relatives or friends) in order to make it a more personal act.[27] Coggon tried arguing towards a right to die in dignity under English law in general and medical law in particular.[28] Grubb believed a legal change concerning assisted dying to be rather unlikely.[29] Shaw reviewed cases and assisted dying bills, claiming that the House of Lords failed to see that it was not simply a contest of assisted dying versus palliative care.[30] McLean addressed the general rights and wrongs of assisted dying, looked at the current legal situation and proposed changes to it, engaging with all the classical arguments: autonomy, dignity, sanctity of life, palliative care, consent and the patient-doctor relationship.[31] Freeman focussed on the case of Mrs Pretty to analyse the English legal situation,[32] and Greasley approached her analysis of the English law on assisted dying from the judgment concerning Ms

[24] See Peter Singer, *Rethinking Life and Death. The Collapse of Our Traditional Ethics* (OUP 1995).
[25] Emily Jackson and John Keown, *Debating Euthanasia* (Hart 2012).
[26] Elizabeth Wicks, 'Religion, Law and Medicine: Legislating on Birth and Death in a Christian State' (2009) 17 *Medical Law Review* 410.
[27] Susanne Ost, 'Euthanasia and the Defence of Necessity: Advocating a More Appropriate Legal Response' [2005] *Criminal Law Review* 355; 'The De-medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward?' (2010) 18 *Medical Law Review* 497.
[28] John Coggon, 'Could the Right to Die with Dignity Represent a New Right to Die in English Law' (2006) 14 *Medical Law Review* 219; 'Assisted Dying and the Context of Debate: "Medical Law" versus "End-of-Life" Law' (2010) 18 *Medical Law Review* 541.
[29] Andrew Grubb, 'Euthanasia in England: A Law Lacking Compassion?' (2001) 8 *European Journal of Health Law* 89.
[30] See Julia Shaw, 'Recent Developments in the Reform of English Law on Assisted Suicide' (2009) 16 *European Journal of Health Law* 333, 346.
[31] Sheila McLean *Assisted Dying: Reflections on the Need for Law Reform* (Routledge 2007).
[32] See Michael Freeman, 'Denying Death its Dominion: Thoughts on the Dianne Pretty Case' (2002) 10 *Medical Law Review* 245.

Purdy, taking into account other cases like that of Mrs Pretty and Mr James.[33]

Authors writing on Germany are for example Antoine, who claimed that the German right to life also included a right to determine the circumstances of one's own death[34] and that an absolute prohibition of active assisted dying violated the rights of the patient.[35] Groβe-Vehne gave an overview of the history of assisted dying regulation in Germany.[36] Wittler et al looked at assisted dying in Germany from a medical, ethical, legal and philosophical point of view, arguing that while there is a case for assistance in dying, a legal basis for active assisted dying was rather problematic,[37] and that turning the right to commit suicide into a claim right would have to include for the State to enable everyone to commit a risk and pain free suicide.[38] Lindner claimed that turning assisted dying into a taboo could not stop the debate[39] and that creating a legal vacuum might be a solution for assisted dying.[40] Scheffler dealt with the question whether the German Federal Court was consistent in its approach towards assisted dying cases, coming to the conclusion that indeed it was.[41] Kreß looked at the religious approach towards suicide to shed some light on the difficulty of regulating physician assisted suicide in Germany[42] and Hoerster argued in favour of a legalisation of assisted dying, claiming that a prohibition based on the sanctity of life did not find support in the constitution and was ethically unfounded.[43]

Some researchers look at assisted dying under the ECHR, like Morris, who stated that Article 2 is used to protect life and therefore against claims of assisted dying and that equally Articles 3 and 8 do not encompass a

[33] See Kate Greasley, 'R. (Purdy) v DPP and the Case for Wilful Blindness' (2010) 30 *Oxford Journal of Legal Studies* 301.
[34] See Jörg Antoine, *Aktive Sterbehilfe in der Grundrechtsordnung* (Duncker u. Humblot 2004), 270.
[35] See ibid*,* 394.
[36] Vera Groβe-Vehne, *Tötung auf Verlangen (§216 StGB), "Euthanasie" und Sterbehilfe, Reformdiskussion und Gesetzgebung seit 1870* (Berliner Wissenschaftsverlag 2005).
[37] Hector Wittwer et al (eds) *Sterben und Tod. Geschichte – Theorie – Ethik* (Metzler 2010).
[38] See Dagmar Fenner, 'Selbsttötung – Philosophisch' in Hector Wittwer et al (eds) *Sterben und Tod. Geschichte – Theorie – Ethik* (Metzler 2010), 330.
[39] See Joseph Franz Lindner, 'Grundrechtsfragen Aktiver Sterbehilfe' (2006) 8 *Juristen Zeitung* 373, 373.
[40] See ibid*,* 382.
[41] Uwe Scheffler, 'Die Rechtsprechung des Bundesgerichtshofs zur Strafbarkeit der Mitwirkung am Suizid – Besser als ihr Ruf? Rechtsprechung zur Strafbarkeit der Mitwirkung am Suizid' (1999) 7 *Jahrbuch für Recht und Ethik,* 341.
[42] Hartmut Kreß, *Ärztlich Assistierter Suizid. Das Grundrecht von Patienten auf Selbstbestimmung und die Sicht von Religionen und Kirchen – ein Unaufhebbarer Gegensatz?* (Zentrum für Medizinische Ethik 2012).
[43] Norbert Hoerster, *Sterbehilfe im Säkularen Staat* (Suhrkamp 1998), 12.

right to an assisted death;[44] Wicks, who engaged with the issues that arguably made human life special, personhood, sanctity of life and autonomy, and recalled that according to the ECtHR there is no obligation on the State to permit or provide help in suicides;[45] and Humphry and Wickett who gave a general history of suicide and assisted dying perception, claiming that the current assisted dying movement had developed in tandem with the emergence of the modern hospice movement.[46]

1.3.3. Purely Legal Analysis

Additionally, there are legal analyses which do not engage with the philosophical foundations too much but focus on one specific aspect of the debate, like Roggendorf, who wrote about indirect assisted dying from medical, ethical and legal perspectives, claiming that such a thing as indirect assisted dying did not exist;[47] and authors writing on the suggested legal changes, like Brassington, who argued that the conditions set in Lord Joffe's Bill were neither useful for those suffering nor for those needing protection;[48] Warnock and Macdonald who examined the various arguments brought forward in connection to Lord Joffe's Bills[49] – the main arguments being autonomy, sanctity of life and the slippery slope –[50] and Williams who analysed the Code for Crown Prosecutors which was amended to take account of the *Purdy* decision, arguing that it was not the Director of Public Prosecutions' (DPP) task to give guidelines before a crime was committed.[51] Furthermore, there are specific case comments like those by Herzberg,[52] De Cruz,[53] Stephen,[54] and Mason,[55] to name just a few, which engage with a single case of one of the jurisdictions.

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[44] See Dan Morris, 'Assisted Suicide under the European Convention on Human Rights: A Critique' (2003) 1 *European Human Rights Law Review* 65, 91.
[45] See Elizabeth Wicks, *The Right to Life and Conflicting Interests* (OUP 2010), 197.
[46] Derek Humphry and Ann Wickett, *The Right to Die. Understanding Euthanasia* (The Bodley Head 1986), 187.
[47] Sophie Roggendorf, *Indirekte Sterbehilfe. Medizinische, Rechtliche und Ethische Perspektiven* (Centaurus 2011).
[48] Iain Brassington, 'Five Words for Assisted Dying', (2008) 27 *Law and Philosophy* 415.
[49] Lord Joffe is a lawyer and member of the House of Lords. In 2003, 2004 and 2005 he introduced Assisted Dying Bills in the House of Lords. These Bills and the ensuing debates will be discussed below in chapter 4.4.
[50] Mary Warnock and Elisabeth Macdonald, *Easeful death. Is There a Case for Assisted Dying?* (OUP 2008).
[51] Glenys Williams, 'Assisted Suicide, the Code for Crown Prosecutors and the DPP's Discretion' (2010) 39 *Common law World Review* 181.
[52] Rolf Dietrich Herzberg, 'Der Fall Hackethal: Strafbare Tötung auf Verlangen?' [1986] *NJW* 1635.
[53] Peter De Cruz, 'Case Comment. The Terminally Ill Adult Seeking Assisted Suicide Abroad: The Extent of the Duty Owed by a Local Authority' (2005) 13 *Medical Law Review* 257.
[54] Christopher Gordon Stephen, 'From Pretty to Purdy: Suicide and Assistance from Across the Border - R (on

As this brief overview – which is far from exhaustive but gives an impression of the overall pool of research – shows, there is a great amount of literature on issues connected to assisted dying. However, there is none yet comparing different legal approaches under the ECHR and the designated national jurisdictions based on a philosophical foundation, which is what this thesis will do.

1.4. Research Questions

The main aim of this thesis is to demonstrate the need for a right to die as a human right. A further aim is to discover to what extent a European human right to die has already been realised. Following from that it is to be seen whether the current situation concerning a right to die and the regulation of assisted dying in England and Germany is satisfactory or whether there is need for enhancement in the legal systems examined. To answer those questions the thesis is divided into four chapters: Initially, the philosophical foundations of the assisted dying debate will be discussed, followed by an analysis of the approach of the European Court of Human Rights and lastly a comparative analysis of the legal situation concerning assisted dying in first England and then Germany.

The philosophical first chapter will address the arguments that are generally brought forward concerning both the rejection as well as the support of assisted dying claims. Furthermore, it will take a look at how the concepts of dignity and autonomy can strengthen claims for assisted dying and a right to die. In the following legal chapters a common question will be how these philosophical arguments feature in the actual case law and legal and political debates.

The ECHR chapter will analyse how the ECtHR approaches assisted dying cases and what the influences are on its decision making. A comparison of England and Germany will help shed further light on the approach of the ECtHR. In comparing the approaches of the ECHR and the two nations, the need for a right to die and the legalisation of active assisted dying will become clear. It will demonstrate how difficult it is to reach a consensus within Europe, since even two arguably similar countries have very different attitudes towards the issue of assisted dying. Questions addressed in the chapters on England and Germany are to what extent the

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the application of Purdy) v Director of Public Prosecutions' (2008) 39 *Scots Law Times* 267.
[55] J. K. Mason, 'Case Comment. Unalike as Two Peas? R (on the Application of Purdy) v DPP' (2009*) Edinburgh Law Review* 298.

law in question is dominated by the judges or the legislature, what effect the current law has on suffering individuals, and what the attempts towards change are. Furthermore, they will address the question of adequate legal safeguards regarding assisted dying and whether the current legal situation is discriminatory.

2. The Theoretical Foundation of Active Assisted Dying

A right to die does not exist yet, neither as a European human right, nor on national level in either England or Germany. It is much needed though, to offer suffering individuals who cannot end their lives unaided a base for their claim for needed assistance. Without a right to die, those wishing to set an end to their lives but lacking the physical means to do so have no basis to claim assistance, since suicide has been decriminalised but is not a right. The following chapters will analyse the legal situation in England, Germany and under the ECHR in order to demonstrate how hard a right to die is to achieve. What complicates the endeavour to establish a right to die is the emotional nature of the debates surrounding the attempts at legalising forms of assisted dying, which is due to the topic being one almost everybody has an opinion on or at least a feeling towards, if not some strongly held beliefs. Active assisted dying has vehement supporters and as strongly feeling objectors. The problem of any debate on the subject is the nature of most of the arguments. In debates, whether they are taking place in the general public (e.g. in the form of news reports)[56] or in specialised forums,[57] the arguments most commonly used are emotional in character and make an objective debate near to impossible. What is needed in order to approach active assisted dying from a less subjective and emotional stance is a solid theoretical base to build the argument on. This chapter will establish such a theoretical foundation for claims in favour of assisted dying. First, the common arguments both in favour and against active assisted dying will be introduced. Next, autonomy and dignity will be proposed and elaborated upon as a basis for a call for a right to die and the legalisation of active assisted dying.

2.1. The Rights and Wrongs of Active Assisted Dying

In debates around active assisted dying, the same sets of arguments are usually being used, whether in Germany or England, in academic literature or political debates. As a background for the debates in England and Germany, which will be dealt with in chapter 4 and 5 of the thesis, it is vital to look at those arguments in turn. Arguments used in favour of active assisted dying usually emphasise the need for a dignified death, an autonomous end and non-discrimination. Arguments against active assisted dying are frequently grounded in the moral difference between

[56] See for example Fergus Walsh, 'Tanni Grey-Thompson: Assisted Dying 'A Dangerous Path'', http://www.bbc.co.uk/news/health-28360534, accessed 30 March 2015, 9.55am.
[57] See for example the House of Lords Debates analysed below at 4.4.

killing and letting die, the threat it would pose to vulnerable individuals, the sufficiency of palliative care and the sanctity of life.

2.1.1. Arguments Against Active Assisted Dying

2.1.1.1. Killing vs Letting Die

One possible argument against active assisted dying is that killing is morally wrong under all circumstances and that the only legal option is letting someone die.[58] A patient may refuse treatment upon which the physician has to cease all medical help and let him or her die (also referred to as passive assisted dying).[59] A physician's task is seen to be the restoration of health, with the onus on saving life, not the taking of it. Letting die is only an option if the patient demands it, based on respect for the autonomous choice of the patient. The supporting argument is that letting die by withdrawing or withholding treatment is favourable over assisted dying since it means allowing nature to take its course. However, as Beauchamp rightly stated, letting someone die by permitting them to starve – which is part of stopping all treatment – is not a natural death either.[60]

While there is a clear difference in action between actively ending someone's life and ceasing treatment, the stress of said difference is often criticised. According to McLean this distinction between killing and letting die is not useful,[61] and the views among physicians varied as to the acceptability.[62] De Ridder furthermore claimed that a physician's task was not mainly curative but also palliative.[63] To Warnock and MacDonald, the distinction between killing and letting die was not only blurred but also not morally relevant.[64] Doctors should not only refrain from imposing their own values on the patient, they should also be aware that care does not necessarily mean the maximal treatment possible.[65] Pace also stated that the differentiation was in practice not always possible.[66] Furthermore, and

[58] Though even in that distinction there is a differentiation based on who is the one letting someone die. In most debates this is the physician. However, this can also count as denial of assistance.
[59] Though even 'just' letting die is often viewed as a failure of the physician. See for example E Jackson and Keown, *Debating Euthanasia* (n 25), 51, or Nicholas Pace, 'Law and Ethics at the End of Life: The Practitioner's View' in Sheila McLean (ed) *Death, Dying and the Law* (Dartmouth 1996), 6.
[60] See Beauchamp (n 18), 5.
[61] See McLean (n 31), 81.
[62] See ibid, 92.
[63] See Michael de Ridder, 'Jenseits der Palliativmedizin?' in Heinrich Böll Stiftung (eds) *Selbstbestimmung am Lebensende. Nachdenken über Assistierten Suizid und Aktive Sterbehilfe* (Heinrich Böll Stiftung 2012), 57.
[64] See Warnock and Macdonald (n 50), 92.
[65] See ibid, 98-99.
[66] Pace (n 59), 13.

most importantly, while the actions in question are different, they serve the same purpose, letting an individual who does not want to live anymore die. While for some the discontinuing of medical care might be enough to be able to die according to their wishes, others might need active help. Both letting die and actively assisting someone in dying should be permissible.

A way to overcome the differentiation would be to change the focus on intention and outcome of an act, not the act itself. Since in both, active and passive assisted dying, the intention is ending a life according to the person's wishes, and the outcome is their death, there should accordingly be no legal difference. However, this idea is problematic to some. According to Frey, for example, causality is what really matters since intention is not only hard to prove but also because one is even responsible for outcomes one does not intend but causes nevertheless.[67] When briefly looking at issues concerning assisted dying, Harris also engaged with the act/omission distinction. "What matters […] is how our decisions and actions affect the world, not whether that effect is direct or indirect".[68] So it was the result that was of importance, not whether it was brought about as a direct act, a mere side-effect like in indirect assisted dying, or even an omission as in passive assisted dying. It is the result based on the voluntary and autonomous wish to have that result brought about that matters, not the distinction between active or passive actions.

2.1.1.2. Threat to the Vulnerable

The most widely used argument against the legalisation of active assisted dying is the threat it would pose to the vulnerable, especially the old and sick.[69] It is argued that once active assisted dying was a legal option, people would be coerced into requesting it without truly wanting it themselves. The fear is that greedy family members, or those burdened with the duty to care – whether in a private setting or State health agencies facing growing demand and declining budgets – would take the option of active assisted dying as an easy way out of their responsibility,

[67] See Raymond Frey, 'Intention, Foresight, and Killing' in Beauchamp (n 18), 67-68. However, Carse in the same collection stated that causality alone was also not a useful determining factor, since one was not automatically answerable for every outcome one causes. See Alisa Carse, 'Causal Responsibility and Moral Culpability' in Beauchamp (n 18), 88. Ost also favoured looking at the circumstances of each case instead of focussing merely on intention, see Ost, 'Euthanasia and the Defence of Necessity' (n 28), 359-360.
[68] See Harris, *The Value of Life. An Introduction to Medical Ethics* (n 19), 44-45.
[69] This view is for example held by John Keown. To him the wish of the majority to continue living and be protected from threats should trump the wish of a minority to have the freedom to ask for death. See E Jackson and Keown (n 25), 97.

and by persuading the old or sick person into asking for death could get rid of the unwanted obligation.

It would be too easy to simply dismiss this concern. Liberties always carry the danger of being used against someone by a stronger party hoping to profit from that in some way. It is not only imaginable but also likely that someone will try to coerce someone else into requesting assisted dying, or that an individual feels to be a burden and therefore requests assistance in dying without desiring to be dead. However, a prohibition of active assisted dying is not the solution to draw from this fear. It should be possible to introduce safeguards that will make sure that most deaths are truly voluntary. All abuse can never be prevented, but that should not stop a much needed right to die.

Also an argument, to counter the fear of a slippery slope which would then pose a danger to the vulnerable, is that we still retain our moral values. It is not evident why the possibility of an assisted death for someone willing to die should lead to society tolerating people being killed who do not wish to die.[70] Legal dangers do not automatically lead to moral acceptance.

2.1.1.3. Palliative Care

Another argument often brought against the legalisation of active assisted dying is the claim that palliative care is sufficient in easing the suffering of the dying and that furthering the offers of palliative care and hospices would therefore be more desirable than authorising active assisted dying. The claim is that once the pain and other physical suffering was dealt with adequately, nobody would have the desire to hasten death. However, this is short-sighted. Not every instance of suffering can be medically prevented or dealt with. Suffering can be more than pain or physical unease. Also, dying in a hospice or being heavily medicated might not be the death an individual is looking for. If one is not willing to be a burden to anyone or has a specific view on how one wants to die, then palliative care and hospices are not the solution. As Jackson claimed, palliative care might help some but it is for the person suffering to decide whether they want to avail themselves of it.[71]

Harries tried to refute the argument that palliative care and assisted dying opportunities could coexist by claiming that "in a world governed by

[70] See for example Brassington (n 48), 430.
[71] See E Jackson and Keown (n 25), 10.

scarce resources and where everything is a matter of priorities, there would be more than a danger, there would be a high likelihood that palliative care would suddenly begin to seem less important".[72] While this would be non-desirable, the fear that palliative care might lose its financial means and perish is not strong enough to counter the need for assisted dying. Funds must be made available to both since neither option is a solution for everyone, therefore both opportunities have to be available.[73]

A pain-free death is not a complete solution. Palliative care is alleviation of suffering at the end of a terminal illness but is not necessarily synonymous with a dignified and autonomous death.[74] To some dying in a hospice might be seen as undignified and troublesome.[75] If one has lived an active, autonomous life then one might not want to end that life highly sedated waiting for death. Furthermore, there are illnesses that bring about symptoms of suffering that cannot be dealt with by sedation alone (see for example Mrs Pretty and Mr Nicklinson in Chapter 4). Of course hospices are needed and they offer valuable care to many dying individuals. But they cannot be seen as the solution for everyone.

2.1.1.4. Sanctity of Life

The sanctity of life is usually used as an argument against active assisted dying – or any other life-shortening measure for that matter. The claim is that life is sacred – either due to religious reasoning, i.e. because it is given by God, or because of its intrinsic value. According to Dworkin, "a premature death is bad in itself, even when it is not bad for any particular person".[76] It is true that life is something special, with a worth above other things. But we cannot condemn people to suffer because we view their life as being sacred, if they themselves do not wish to live that life anymore. There should be a way to wave one's right to life, even if it is seen as something special or indeed sacred. A way to accommodate both the idea that life is sacred but also the idea that one can want to give it up would be to approach the value of life the way Dworkin does in *Life's*

[72] Harries (n 14), 90. The claim that legalising assisted dying would take finances and attention away from palliative care was of course also brought forward by others, for example John Keown in E Jackson and Keown (n 25), 103.
[73] A sometimes made point is that euthanasia will save the State money. This is because a considerable proportion of medical costs occur in our final stages of life, mostly in the final weeks and days. (On this note see for example Battin (n 12), 115.) A slightly earlier death would therefore save the State considerable sums of money (given that there is general health insurance).
[74] As McLean claimed, assisted dying is about more than pain, (n 31), 43.
[75] On the limits of palliative care see for example de Ridder (n 63).
[76] R Dworkin (n 17), 69. Prematurity of course depends on the viewpoint, the person wishing to die would probably not see their death as being premature.

Dominion. He differentiates between intrinsic value and personal value. While the intrinsic value applies to every human life – regardless of age, health, personal situation, etc, – personal value gets attributed by the person living the life in question. This view entails that intrinsic value cannot be done away with, it is part of being human and seems to be linked to dignity. Personal value, however, is highly subjective and can change. It grows with the development of personality and can diminish due to personal losses and tragedies, illnesses or just age. While the intrinsic value therefore remains, the personal one varies and can even be completely lost. While accepting the intrinsic value, the loss of the personal value should then allow for the person to seek death. The intrinsic value should consequently not weigh more heavily than the personal one.

The sanctity of life claim – when based on religious views – implies that life is given by God and can therefore only be taken away by God.[77] While living one's life, one always 'belonged' to God;[78] one was only the custodian but not the owner of one's life.[79] To Harries, the gift of life remained precious even in suffering, according to him a Christian should not seek an earlier than naturally caused death.[80] Any religious person may hold a view on life and death based on their religion. Therefore, if a God prohibits a certain way of dying, it must be avoided by that individual (if possible and not harming anyone else). However, a religious view must not be used to form a law in a secular society so that a religious belief can prevent an individual from acting on their informed wish to die.[81] So while MPs are of course influenced by their own personal beliefs, the decisions they make must be applicable to society as a whole.[82] As Jackson claimed, the sanctity of life argument preventing any form of suicide should only apply to religious people.[83] According to him, the monopoly on life and death now was with the medical profession, not God.[84] Furthermore, what seemed tolerable for one individual might not be tolerable to another,[85] so there should not be one prohibition valid for everyone, no matter their individual belief. According to Hoerster, the religious rejection of assisted dying was illogical in that it would mean that God approved of (legal) death

[77] See for example Harries (n 14), 99.
[78] See for example Kreß (n 42), 6.
[79] See ibid, 9.
[80] See Harries (n 14), 119.
[81] This view is for example held by McLean (n 31), 30.
[82] See Wicks, 'Religion, Law and Medicine' (n 26), 431. Of course this claim has some difficulties to it when it comes to religious peers in the House of Lords, appointed for their status as bishop or chief rabbi.
[83] See E Jackson and Keown (n 25), 37.
[84] See ibid, 38.
[85] See ibid, 41.

penalty or killings in war, but not of assisted dying –[86] a religious rejection could only be a weak one in a modern, secular society.[87]

What can be argued based on the intrinsic value of life is that active assisted dying is wrong – like any kind of taking life. However, just like abortion – which would following this argumentation also be morally wrong due to the intrinsic value of the developing life, – assisted dying would have justifications. Instead of being a morally right thing to do, it is a wrong thing which can be justified. Even if some people might want to argue that, if justifiable, a prima facie 'wrong' thing is not 'wrong' anymore, as it is merely the adoption of the lesser of two evils; a morally wrong deed stays wrong even if justified.

What serves as a justification is the consent of the person in question, the voluntariness of the death. The loss of personal value justifies the extinction of the intrinsic value through death.

2.1.2. Arguments in Favour of Active Assisted Dying

2.1.2.1. Dignity

One of the strongest arguments in favour of active assisted dying is the right to a dignified life. If taken seriously, this should also include a dignified dying process, since dying is part of life. While it can be argued that death is the antithesis to life, it should really be seen as being part of it. As will become apparent in the later section of this chapter on dignity, it is a very difficult concept to grasp and translate into everyday life. But what it should translate to is a respect for life not in the abstract but connected to the individual personality. Consequently, dignity should not be used as a prohibition of practices leading to death. The dignity of the individual asks for their choice to be respected. What a person understands under a dignified death is as individual as a dignified life. The argument of dignity is therefore tightly linked to that of autonomy.[88]

Dignity can be seen as looming large in the dying-debate since it is a powerful foundation to the general idea of human rights. If it is seen as being part of being human and the basis for human rights then it can be taken to condemn assisted dying – because dignity is a foundation for the right to life and the protection of each person's life – and at the same time as favouring assisted dying to help end a dignified life in a dignified way.

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[86] Hoerster (n 43), 20.
[87] ibid.
[88] See for example Biggs, *Euthanasia, Death with Dignity and the Law* (n 16) who claimed that autonomy and self-determination were "key factors in conflating euthanasia and dignity", 149.

At this stage it cannot be discounted that dignity is a problematic concept in that it is difficult to define.[89] However, as it looms large in human rights and the assisted dying debate, especially as an argument in favour of active assisted dying, the concept will be analysed in greater detail in a separate part at 2.3.

2.1.2.2. Autonomy

Another strong argument in favour of active assisted dying is that of autonomy. We seem to aspire to live our lives as autonomously as possible. We see it as part of our human nature to be able to decide freely how to live our lives. Being limited by duties and obligations seems frustrating, especially when young, and only becomes acceptable with maturing. However, being fully dependent on others is something most of us would despise. And yet, it can happen to all of us. Illnesses and disabilities are something nobody is safe from. But even when dependent on others, we want to be in control of ourselves as much as possible. This can lead to the wish to also be in control of how and when to die. Most of us probably wish for a natural death of old age after a long and fulfilled life. And most people do not want to actively end their lives even when severely ill or suffering. But for some the wish exists to decide freely when and how to end their life.

If we accept the idea of the human being as autonomous and free, then he or she should also be free to make decisions about his or her own life, even if they are detrimental to health and even life. This idea has been accepted in so far as patients are allowed to refuse treatment even if that is endangering or ending their lives. The logical next step would, therefore, have to be to accept a voluntary death wish and help people who are unable to do so unaided to end their lives in the way they desire. In theory autonomous choices should be respected so active assisted dying could serve to maintain independence until death.[90] Since in reality the right to make autonomous choices about one's own medical care is not absolute, "[m]ultiple reforms are required if autonomy at the end of life is to be effectively promoted, but this may need to be achieved incrementally".[91]

[89] This finds mentioning by many authors, among them McLean (n 31), 71, Sebastian Unger, 'Human Dignity Shall Be Inviolable – Dealing With a Constitutional Taboo' in Katja Ziegler Peter Huber (eds), *Current Problems in the Protection of Human Rights* (Hart 2013), 197 and Christopher McCrudden, 'In Pursuit of Human Dignity: An Introduction to Current Debates' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 10.
[90] See Biggs, *Euthanasia, Death with Dignity and the Law* (n 16), 105.
[91] ibid*,* 113.

According to Jackson, autonomy should trump sanctity of life claims.[92] This view was shared by Antoine who claimed that under German law autonomy ranked higher than the right to life.[93]

What is problematic with the autonomy argument in the assisted dying debate is, that, if taken seriously, it would have to mean that assisted dying had to be available to everyone who is wishing to die but being unable to kill themselves, regardless of whether they were terminally ill or not.[94] Limiting the offer to those terminally ill is meant to refute slippery slope claims. However, based on autonomy (and likewise dignity and equality), assisted dying would have to be available to everyone incapable of committing suicide unaided.[95]

Very rarely is autonomy used in opposition to assisted dying. The claim then would be that acknowledging the free will of a free individual cannot lead to its extinction.[96] A more logical view of autonomy would allow for the free individual to will his/her own extinction. According to Antoine, asking for assistance in dying did not mean giving up ones autonomy but was an act of self-determination.[97] After all, an individual is allowed to make decisions even if they harm that individual. The harm should be accepted to go as far as death. Since autonomy is such a vital argument in the debate around active assisted dying, it will further be dealt with at 2.2.

2.1.2.3. Equality

Another argument in favour of active assisted dying is to stop the discrimination brought about by the current legal situation. It can be seen as discrimination that able-bodied individuals can commit suicide freely without facing sanctions if failing, while those unable to commit suicide unaided cannot legally end their lives. This brings about legal problems for those willing to assist, be it doctors, family members, friends, or other assistants. According to Nietzsche for example, we have the freedom to want to die at the right time.[98] Suicide therefore is an option of human autonomy.[99] Taking that thought further, if autonomy meant we were

[92] See E Jackson and Keown (n 25), 22.
[93] See Antoine (n 34), 217.
[94] See for example David Price, 'What Shape to Euthanasia after Bland? Historical, Contemporary and Futuristic Paradigms' (2009) 125 *Law Quarterly Review* 142, 163.
[95] It could even be argued that it should then be available to everyone, whether able to commit suicide unaided or not, in order to provide everyone with the same option of a dignified death.
[96] See for example Hans Lilie, 'Sterbehilfe. Medizinethisch' in Hector Wittwer et al (eds) *Sterben und Tod. Geschichte – Theorie – Ethik* (Metzler 2010), 231.
[97] See Antoine (n 34), 262.
[98] See Freidrich Nietzsche, *Vom Vernünftigen Tode,* referred to by Baumann (n 15), 293-4.
[99] See Baumann (n 15), 294.

allowed to commit suicide, then for equality reasons it should also be available to those requiring assistance. As Battin put it, "control of one's own death as far as possible is a matter of fundamental human rights".[100]

Often held against the discrimination-claim is that there is no express right to commit suicide, it is only no longer criminal. Since there is no right to commit suicide,[101] there is no discrimination in not making assistance available to those unable to do it without help. This is the reason why a right to die is needed. The actual discrimination would then have a legal basis for claims to be brought forward.[102]

At the same time, this approach poses difficulties. If there is a right to die, then any competent adult would have to be enabled to act upon it. The question would be whether the right could be limited. Would the State have the right to limit the right to die, for example, of a suicidal prisoner or would the right to die be a right that cannot be limited, meaning that if a prisoner wanted to commit suicide, the State would have to help the individual? With the duty to protect life, a right to die appears difficult to accommodate.

However, waiving one's right to life does not seem to be a basis strong enough for people needing assistance to base their claim on. Waiving a right has different implications. If one, for example, waives one's right to vote or right to assemble, then that is a passive procedure which does not require any form of activity by anyone. However, if someone wants to waive their right to life, without being able to commit suicide unaided, then they do need active assistance. This means that a stronger basis for the claim is needed. Consequently, in order to achieve equality and enable everyone to die the death they wish for, a right to die is needed.

2.1.3. Concluding Remarks

As was briefly demonstrated, there are strong arguments both in favour of assisted dying as well as against it. The arguments are of a nature that makes each and every one of them hard to dismiss. The threat to the vulnerable has to be taken seriously, palliative care is indeed needed and deserves financial and political support, and it has to be accepted that life is seen to be sacred by many religious individuals. However, dignity,

[100] Battin (n 12), 165.
[101] An argument as to why there is no express right to commit suicide can be seen to be that it is damaging to family and friends. It therefore ceases to be a liberty right. See Battin (n 12), 278.
[102] Article 5.3 of the Convention on the Rights of Persons with Disabilities (CRPD) for example puts an obligation on States to tackle discrimination by making reasonable accommodations.

autonomy and equality are of such importance to each individual life that they cannot be dismissed either. Keeping the objecting factors in mind and engaging with them is an important facet of the process of legalising active assisted dying. Dignity and autonomy with the overarching aim of achieving equality are lending themselves to be quite a powerful basis for claims for change and will therefore be elaborated upon in the following sections.

2.2. Autonomy and Assisted Dying

Autonomy is a value we all wish to possess and assert in our daily bearings. Under a non-religious world-view we believe that we can freely choose our path through life. This freedom to live conforming to our wishes, ideas and desires is what we believe to be autonomy.[103] The most basic idea of autonomy can be found in the meaning of the term: autos = self, nomos = rule. Consequently, autonomy is a form of self-determination. "Autonomy means that a good life is a life which is a free creation".[104] Gerald Dworkin claimed that autonomy was a term of art that could be used to denote a variety of ideas: liberty, self-rule, integrity and individuality, to name just a few.[105] The question is how autonomy manifests itself and how it can work for the individual within society.

In human rights law, autonomy can be seen to be protected by Article 8 ECHR, the right to respect for private and family life. This was for example stressed in *Pretty v the United Kingdom,* an assisted dying case which will be dealt with in chapter 3.[106] In medical ethics and law, autonomy plays a major role in strengthening the patients' rights. Autonomy in that context finds protection (at least partly) through the principle of informed consent.[107] However, according to Foster, courts are not clear about which idea of autonomy they apply, Mill's self-determination, Kant's deontology or some form of relational autonomy.[108]

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[103] See for example Iain Law referring to Gerald Dworkin's hierarchical model of autonomy: "[A]utonomy is freedom not only to act as we will, but to choose the ends for the sake of which we act. As such, autonomy can be thought of as the ability to scrutinise the things for the sake of which we act – our projects, goals and desires – and decide whether or not they are ends we really want to have". Iain Law, 'Autonomy, Sanity and Moral Theory' (2003) 9 *Res Publica* 39, 40.
[104] Joseph Raz, *The Morality of Freedom* (OUP 1986), 412.
[105] See Gerald Dworkin, *The Theory and Practice of Autonomy* (CUP 1988), 6.
[106] Application no. 2346/02. On autonomy and the ECHR see for example Bulak Begum and Alain Zusset, '"Personal Autonomy" and "Democratic Society" at the ECtHR: Friends or Foes?' (2013) 2 *UCL Journal of Law and Jurisprudence* 230, who criticised autonomy for being too indeterminate for being a human rights norm. See ibid 253.
[107] See John Coggon and Jose Miola, 'Autonomy, Liberty and Medical Decision-Making' (2011) 70 *Cambridge Law Journal* 523, 532.
[108] See Charles Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2014) 22 *Medical Law Review* 48, 48.

Still, when it was used by courts it usually functioned as a trump.[109] Foster nevertheless argued that autonomy could not function on its own in the courtroom but usually also needed other principles for back-up,[110] for example dignity.[111]

Whereas dignity seems to be tied to the physical existence, autonomy is more strongly tied to the mind. As will be seen below in chapter 2.3., dignity applies to the unborn as well as to a corpse. We therefore connect it to our physical existence. Autonomy, on the other hand, additionally has a strong link to our mental capacities which dignity does not have. In order to lead an autonomous life, a certain degree of mental capacity is needed. Autonomy is developed and can be lost. Someone in a persistent vegetative state is not autonomous anymore, while a newly born child is not autonomous yet. It is arguable to what extent someone who is demented or someone who is seriously mentally impaired is autonomous. What this shows though, is that the source of autonomy lies in the brain, while leading an autonomous life also involves physical capacities. This can be demonstrated with the case of conjoined twins. While being two autonomous individuals, they share (to varying degrees) one body, are not able to live their autonomy to a full degree. But having separate brains makes them two autonomous individuals.[112] The importance of individuality was dealt with for example by Oshana[113] and then taken up by Westlund,[114] who looked at the autonomy of fundamentalist Muslim women living in patriarchal societies. According to Westlund, such a life could still be autonomous, if it was lived in that specific way voluntarily, with full awareness of the choices made.[115] According to Oshana, while it is possible to autonomously choose non-autonomy, this means forfeiting some degree of autonomy.[116] The problem with these thoughts is that it is hard to assert how aware individuals are of their level of autonomy. However, for the question of availability of assisted dying it does not play too big a role, since the focus is on competent individuals making requests for assistance, without taking into account individuals who are unable of making a request due to their cultural (or other) constraints.

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[109] See ibid.
[110] See ibid, 49.
[111] See ibid, 62.
[112] At least in legal theory. The constant presence of the one diminishes the possibilities of the other regarding autonomous action.
[113] See Marina Oshana, 'Personal Autonomy and Society' (1998) 29 *Journal of Social Philosophy* 81.
[114] See Andrea Westlund, 'Rethinking Relational Autonomy' (2009) 24 *Hypatia* 26.
[115] See ibid, 29-30.
[116] See Oshana, 'Personal Autonomy and Society' (n 113), 88 and 91.

Autonomy is composed of two constituents, an internal and an external one. It can be illustrated by the French terms for 'to be able to do': *pouvoir faire* and *savoir faire*. Whereas *savoir fair* means having the knowledge to do something, *pouvoir faire* translates to having the means and capacity to do it. Similarly, autonomy requires the mental capacity as well as the physical one. According to Westlund this two-folded character of autonomy means that "an autonomous person is one who has the capacities that are exercised in autonomous choice and action, and an autonomous life is one led by an agent who successfully exercises these capacities to a significant extent".[117] First of all, autonomy is a freedom of choice. It is the capacity to make decisions in order to lead a self-determined life. But autonomy also needs the second component, a society in which one can live according to one's autonomous choices.[118] This again is made up of two parts, the metaphysical liberty to act and the physical possibility to act upon those choices.[119] This second part is the most relevant aspect for the debate of assisted dying. In our Western societies we have reached the understanding that people wishing to die are free to commit suicide. There might not be a right to die (yet) but there is the freedom to commit suicide. However, not everyone can autonomously act on the free (and legal) choices they have made. In those instances, to transfer the internal autonomy into a wholly autonomous life, assistance is needed. In societies which take pride in being liberal and supportive of equality, those unable to act upon their choices need support in order to live an autonomous life. This is why vulnerability and relational autonomy are important features of an assisted dying debate and will be dealt with further down at 2.2.2. and 2.2.3. Referring to Carter and Christman, Marshall stated that autonomy is a close cousin or even twin of freedom.[120] This freedom did not just mean to be 'free from' but also to be 'free to'.[121] This is where the connection between freedom and autonomy matters for assisted dying. While

[117] Westlund (n 114), 28.
[118] As Oshana stated: "Autonomy, more than positive and negative freedom, calls for the presence of certain social, political, and economic arrangements". Marina Oshana, 'Autonomy and Free Agency' in James Stacey Taylor (ed), *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy* (CUP 2005), 196. See also Raz, who claimed that "[a] person is autonomous only if he has a variety of acceptable options available to choose from, and his life became as it is through his choice of some of these options". Raz (n 104), 204.
[119] "If having an autonomous life is an ultimate value, then having a sufficient range of acceptable options is of intrinsic value, for it is constitutive of an autonomous life that it is lived in circumstances where acceptable alternatives are present". Raz (n 104), 205.
[120] Jill Marshall, *International Studies in Human Rights: Personal Freedom through Human Rights Law?: Autonomy, Identity and Integrity under the European Convention on Human Rights* (Martinus Nijhoff 2008), 14.
[121] ibid, 16.

autonomy is often referred to in order to stress the freedom from interference, in assisted dying it functions as a freedom to end one's life autonomously with as much assistance as needed.

2.2.1. The Development of Autonomy as a Philosophical Concept

Autonomy as a philosophical concept found different interpretation over the centuries. It started out being applied to the Greek city state, denoting its independence.[122] Like the term dignity (see below at 2.3.1.), its scope was then extended, initially by religious thinkers, to also cover humans.[123]

For Kant, being autonomous mainly meant acting completely rationally,[124] and in accordance with universal moral law.[125] For Hume, autonomy meant being free to pursue choices even if they were based on non-rational preferences.[126] And according to Mill, autonomy was a combination of Kant's and Hume's view. Rationality required that one ensured that the beliefs on which one acted were not false.[127] "Mill's version of autonomy within a naturalistic setting sees individuals not merely as choosing to implement whatever desires they happen to have at a given moment, but as taking charge of those desires, as reflecting on and selecting among them in distinctive ways".[128] This is often referred to as one of the capacities that makes humans unique, not just having a desire but having the second order capacity to desire to want something to be one's will or desire.[129] "A person's will is free only if he is free to have the will he wants".[130] So while autonomy requires the capacity to reflect on desires,[131] one is only morally responsible for actions if there has been a choice to act otherwise.[132]

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[122] See G Dworkin (n 105), 12.
[123] See ibid, 13.
[124] See Immanuel Kant, *Groundwork to the Metaphysic of Morals*, referred to in Richard Lindley, *Autonomy*, (Macmillan 1986), chapter 2.
[125] See Charles Foster, *Choosing Life, Choosing Death. The Tyranny of Autonomy in Medical Ethics and Law* (Hart 2009), 7. According to Foster, there are four ways in which the label autonomy is being used: In the Kantian sense, as the ideal of living a self-determined life, as a reason for constraint, as an evaluation which determines whether respect is required. See ibid 7-9.
[126] See David Hume, *A Treatise of Human Nature,* and *Enquiry into the Human Understanding,* as well as *Enquiry Concerning the Principle of Morals* referred to in chapter 3 of Lindley (n 124).
[127] See John Stuart Mill, *On Liberty,* and *Utilitarianism* referred to in chapter 4 of Lindley (n 124).
[128] Onora O'Neill, *Autonomy and Trust in Bioethics* (CUP 2002), 31.
[129] See Harry Frankfurt, 'Freedom of the Will and the Concept of a Person' (1971) 68 *Journal of Philosophy* 5, 10.
[130] See ibid, 18.
[131] See James Stacey Taylor, 'Introduction' in James Stacey Taylor (ed), *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy* (CUP 2005), 1-2.
[132] See ibid, 17. This idea of moral responsibility depending on the availability of choice is called the 'principle of alternative possibilities'. See Ishtiyaque Haji, 'Alternative Possibilities,

While Kant saw an autonomous agent to be a completely rational one, Hume and Mill had the more realistic view that even rational agents were influenced by desires and personal preferences.

> Too great a concern for rationality essentially debars many people from having the power of choice and narrows further the available options from amongst which to choose. Too great a concern with liberty, by contrast, leaves everyone hostage to unwisdom. The trick in political philosophy, and in its practical instantiations such as medical jurisprudence, is to mediate between these competing ideals.[133]

According to the libertarian view on autonomy postulated by for example Mill and Singer, autonomy is the right to have own choices in life respected, and the duty not to interfere with those of others.[134]

Autonomy is an important concept in the field of bioethics, the significance of this notion being strongly influenced by Beauchamp and Childress' *Principles of Biomedical Ethics.*[135] In their seminal work, autonomy is one of four principles deemed to be underlying biomedical ethics, the others being nonmaleficence – the idea to refrain from inflicting harm - beneficence – the idea to act with mercy, kindness and humanity – and justice.[136] According to Brownsword, bioethics is a 'bridge' connecting the abstract moral beliefs of a community to practical guidance required by biopractitioners.[137] In medical ethics we have moved away from blind trust in doctors towards a more equal doctor-patient relationship.[138]

> In this more sophisticated approach to trust, autonomy is seen as a precondition of genuine trust. […] the patient has heard a full explanation and is being offered a consent form; he is deciding whether to give his fully informed consent. Trust is properly combined with patient autonomy.[139]

Personal Autonomy, and Moral Responsibility' in James Stacey Taylor (ed), *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy* (CUP 2005), 235.

[133] Coggon and Miola (n 107), 528.

[134] See Foster, *Choosing Life, Choosing Death* (n 125), 3.

[135] See O'Neill (n 128), 34, referring to Thomas L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (OUP 1984).

[136] All four of these principles can be seen to strengthen a claim for active assisted dying. Autonomy as discussed below, justice as in the non-discrimination claims made when asking for a right to die and nonmaleficence and beneficence in strengthening the position of the individual wishing to die towards their medical practitioner.

[137] See Roger Brownsword, 'Bioethics: Bridging from Morality to Law?' in Michael Freeman (ed) *Law and Bioethics. Current Legal Issues 2008, Volume 11* (Oxford: OUP, 2008), 18.

[138] See O'Neill (n 128), 18.

[139] See ibid*,* 19.

2.2.2. Relational Autonomy

Originating as a feminist concept, relational autonomy might be the key to finding support for assistance in dying. The basic idea behind relational autonomy is that the human being is a social creature and needs other humans in order to thrive.

> The term 'relational autonomy,' as we understand it, does not refer to a single unified conception of autonomy but is rather an umbrella term, designating a range of related perspectives. These perspectives are premised on a shared conviction, the conviction that persons are socially embedded and that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity.[140]

Instead of seeing society and its influences as having a negative impact on our autonomy, it should be seen as enhancing our capacities.[141] Barclay rightly stated that "our capacity for autonomy is acquired in contexts where we are dependent on others".[142] While society shapes us, autonomy is needed "[t]o consider which particular attachments we should reshape, which to reject, which to choose, and which to promote".[143] But autonomy does not mean that a person's personality, his/her desires and values have developed uninfluenced.

> More to the point, autonomy does not entail that the individual be an island of independence, distanced in a radical way from the company of others. Indeed, the opposite is the case. Insofar as the freedom to make oneself is definitive of agent autonomy, it is a freedom that transpires within the social milieu.[144]

For Christman, being autonomous meant having developed procedurally independent.[145] It did not matter with which values and believes one grew up, as long as one "adopts traits in the proper manner or if [one] reflectively identifies with the characteristic".[146] After all, we are all shaped by a complex and diverse social life.[147]

According to Christman,

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[140] Catriona MacKenzie and Natalie Stoljar, 'Introduction' in Catriona MacKenzie and Natalie Stoljar (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Self* (OUP 2000), 4.
[141] See Westlund (n 114), 27.
[142] Linda Barclay, 'Autonomy and the Social Self' in Catriona MacKenzie and Natalie Stoljar (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Self* (OUP 2000), 57.
[143] ibid, 68.
[144] Oshana, 'Autonomy and Free Agency' (n 118), 198.
[145] See John Christman, 'Procedural Autonomy and Liberal Legitimacy' in James Stacey Taylor (ed), *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy* (CUP 2005), 281.
[146] ibid.
[147] See ibid, 291.

> the model of the autonomous agent upon which liberal principles are built assumes a conception of human identity, value, and commitment which is blind to the embeddedness of our self-conceptions, the fundamentally relational nature of our motivations, and the overall social character of our being.[148]

However, life in all its aspects has to be seen to be open to changes. While we might be embedded in social constructs, we, and the constructs, undergo constant changes.[149] Whatever the changes are, and to whatever degree we rely on social connections to others, "many life patterns […] crucially involve intertwined personalities, close relations of care and dependence, embedded cultural identities, and values, and the like".[150] While being autonomous means being self-governing and dependet on psychological conditions,[151] for a person to be truly autonomous the external circumstances matter as well.[152]

It could of course be argued that only the external aspect of autonomy is relational, that the internal aspect – the individual, autonomous self – is not. However, to some extent, even the internal aspect is relational. Not only since, as Westlund claimed, "self-governance of choice and action requires a form of reflectiveness that is irreducibly dialogical in form".[153] Furthermore, in order to develop an autonomous self, some form of society is needed. It is highly doubtable that an adult who grew up without contact to any human society can lead an autonomous life in such a society. We need relationships and bonds to others in order to be able to fully develop our capacities.

2.2.3. Vulnerability

The idea of relational autonomy can find further support in the concept of vulnerability. A pertinent idea in Western democratic societies is the notion of equality of all citizens.[154] Non-discrimination is an important aspect of national laws[155] as well as human rights law.[156] The problem with equality is that it is often taken as equality of treatment, not as equality of outcome. "This sameness-of-treatment version of equality ignores contexts, as well as differences in circumstances and abilities on the part of

[148] John Christman, 'Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves' (2004) 117 *Philosophical Studies* 143, 143.
[149] See ibid*,* 145.
[150] Ibid*,* 155.
[151] See Oshana, 'Personal Autonomy and Society' (n 113), 81.
[152] See ibid*,* 96.
[153] See Westlund (n 114), 36.
[154] The rights of the ECHR not even being limited to citizens.
[155] See for example the UK Equal Pay Act 1970, or the German *Allgemeines Gleichbehandlungsgesetz* 2006.
[156] ECHR Protocol 12.

those whose treatment is compared".[157] True equality would ask of the State to ensure equal opportunities for all.[158] This would mean more assistance for some than for others. According to Fineman, equality should come before autonomy, since a focus on pure liberty and autonomy of agents led to factual un-equality within society.[159] However, autonomy brought with it the idea that the State had to stay in the background.[160] This does not have to be the case. If we accept that autonomy is a relational construct, as argued above, then the State 'interfering' can actually be a good thing, furthering the autonomy of vulnerable individuals. What should not be inferred from the vulnerability-aspect of our existence is that it means being a weaker human or a less autonomous one for that matter. As Fineman stated, "[vulnerability] define[s] the very meaning of what it means to be human".[161]

Anyone may become (or be) vulnerable at any given time. "[A]s desirable as autonomy is as an aspiration, it cannot be attained without an underlying provision of substantial assistance, subsidy, and support from society and its institutions, which give individuals the resources they need to create options and make choices".[162] According to Misztal, there were three kinds of vulnerability, the first being our dependency on others,[163] the second form arising out of the uncertainty about our future,[164] and the third out of the irreversibility of past actions.

While each life is one of individual vulnerability, we are all united by the fact that we are prone to it and do experience it – to varying degrees, at varying stages of our lives.[165] Vulnerability should not be seen as a stigmatising label but as "a universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility".[166] According to Misztal, we were all vulnerable and therefore in need of legal protection.[167] However, we do not just need protection but also help and assistance. Misztal rather looked at the

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[157] Martha Albertson Fineman, 'The Vulnerable Subject and the Responsive State' (2010) 60 *Emory Law Journal* 251, 251.
[158] See ibid, 256.
[159] See ibid, 258.
[160] ibid, 259.
[161] ibid, 266.
[162] ibid, 260.
[163] See Barbara Misztal, *The Challenges of Vulnerability: In Search of Strategies for a Less Vulnerable Social Life* (Palgrave Macmillan 2011), 51.
[164] See ibid, 75.
[165] See Fineman, 'The Vulnerable Subject and the Responsive State' (n 157), 269, and Martha Albertson Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 *Yale Journal of Law and Feminism* 1.
[166] Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (n 165), 8.
[167] See Misztal (n 163), 32.

protection side of vulnerability, claiming that social policies were in place in order to prevent risk which can increase vulnerability,[168] and that it could be seen as the starting point of human rights.[169] This can yet again be taken further to imply that while human rights are in place to protect vulnerability, people need different levels of support in order to fully enjoy their rights. Misztal claimed that vulnerability stemmed from "our existence in the public as sensuous, bodily, gendered, emotional beings".[170] The stress should be on the public, as society should not only function as the saviour in situations of vulnerability but could also be the cause of it. It causes vulnerability in establishing class structures, exposes us to threats and norms and expectations we are required to live up to. Vulnerability "forces us to acknowledge that we are not always autonomous and potentially equal".[171]

Most of the individuals asking for assistance in dying have lost – or are about to lose – the ability to autonomously perform the act of suicide. While still having the mental aspect of autonomy, being able to reach that decision, they are physically unable to act on it. This means they have reached a stage of vulnerability where they require assistance in order to act upon their autonomous choice.

2.2.4. Concluding Remarks

Autonomy is an important argument in medical law and ethics, however, on its own it is not enough to decisively sway a claim for assisted dying. While we might want to live and die autonomously, relational autonomy and vulnerability show that a truly autonomous life is hard to fulfil at the best of times in life, and near to impossible when we come to the stage of dying. Nevertheless, aiming at an as autonomous life as possible and accepting that this means support by others, does function as one supporting argument in favour of assisted dying. While autonomy establishes the claim for assistance, dignity establishes a right to die, which is why the following subsection of the chapter will engage with dignity in more detail. Even once an individual is stripped of all autonomy, dignity prevails.

[168] See ibid, 37.
[169] See ibid, 42.
[170] See ibid, 46.
[171] See ibid, 47.

2.3. Dignity

Dignity is a key aspect in the support of assisted dying and a right to die. As 'human dignity' implies, dignity is often believed to be a trait only humans, but all humans, possess. Attempts at justifying why only humans have dignity demonstrate how problematic the concept is. It gets accredited to the human being based on specific human traits, such as being aware of past and future, being rational, and other mental capacities. Such an attribution is difficult, as it makes it hard to accredit dignity for example to new-borns or individuals in a persistent vegetative state. However, if it is applied based on the *potential* of rationality, etc, then finding a starting point for dignity is difficult, as even an egg or sperm has the potential of turning into a human, yet one would not speak of the human dignity of a sperm cell. "The idea of human dignity must coexist with the knowledge that human beings have never lived up to their moral and existential standards".[172]

According to Birnbacher, dignity grants humans some basic rights, like minimal liberty, the guarantee of necessary means of existence, freedom from strong pain and minimal self-respect.[173] While this is a useful starting point to define what dignity is, the question remains why humans, and only humans, have it. Dignity could be seen as a metaphysical spark which makes us humans acknowledge another human as being part of the same species. That way even an embryo, someone in a coma, someone with severe physical deformities, would have dignity, even without fulfilling all the traits often used to define a possessor of dignity. "Human dignity […] is the freedom of choice of human beings and the autonomy of their will. It is their human identity. It is the freedom of each individual to write the story of his or her life".[174]

Further problems with dignity, apart from accreditation, can be seen in its wide, somewhat undefined, meaning which to some renders it a useless concept. Macklin for example claimed that autonomy was a far more useful idea than dignity,[175] and even that in medical ethics dignity could be done away with, without any content being lost.[176] Rosen stated that dignity was merely a façade covering up emptiness – "when everybody's somebody,

[172] Georg Kateb, *Human Dignity* (HUP 2011), 119.
[173] See Dieter Birnbacher, 'Ambiguities in the Concept of Menschenwürde' in Kurt Bayertz (ed), *Sanctity of Life and Human Dignity* (Kluwer 1996), 110.
[174] Aharon Barak, 'The Constitutional Value and the Constitutional Right' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 363.
[175] See Ruth Macklin, 'Dignity is a Useless Concept' (2003) 327 *BMJ* 1419.
[176] See ibid, 1420.

nobody's anybody" –[177] and referred to Schopenhauer who had claimed that dignity was a "shibboleth of all perplexed empty-headed moralists".[178] Acknowledging that dignity was about who we are,[179] Gearty nevertheless claimed that it was too vague on its own to be effective.[180] Others, according to Hollenbach, see it too closely connected to religious claims.[181] However, Hollenbach disagreed in that dignity had a clear function as a normative declaration.[182] It is this normative declaration which is of importance in the debate around assisted dying, as this debate involves the question how humans should be treated once they wish to die. Dignity cannot be fulfilled or achieved in isolation, it asks for solidarity and collaboration.[183] Those asking for assistance in dying in order to die a dignified death illustrate exactly that. In order to live and die in dignity some need more assistance than others. Dignity can in many scenarios only be fulfilled through respect and positive actions of others.

Regardless of the problems posed by defining dignity, it is a strong feature in bioethics, human rights law, and thereby assisted dying. According to Ashcroft, there are four groups regarding the evaluation of dignity. The first one sees it as incoherent, the second believes it can mainly be reduced to autonomy, the third claims it belongs to other concepts such as capabilities and social interactions, and the fourth group believes it to be a property possessed by all humans on which moral philosophy and human rights are founded.[184] Whichever view one shares, dignity is a mere theory, a concept one has to believe in, as it cannot be proven, examined or be directly pointed out; we can only examine its role and importance. When it comes to assisted dying, dignity can be used by both sides of the argument, as having a right to die in dignity and as assisted dying violating the dignity of the old, vulnerable and sick.

[177] See Michael Rosen, 'Dignity: The Case Against' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 145.
[178] See Arthur Schopenhauer*, The Basis of Morality* (Dover Publications 2005), 51.
[179] See Connor Gearty, 'Socio-Economic Rights, Basic Needs and Human Dignity' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 171.
[180] See ibid*,* 155.
[181] See David Hollenbach, 'Dignity: Experience and History, Practical Reason and Faith' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 124.
[182] See ibid*,* 127.
[183] See ibid*,* 136.
[184] See Richard Ashcroft, 'Making Sense of Dignity' (2005) 31 *Journal of Medical Ethics* 679, 679.

2.3.1. The Development of Dignity as a Philosophical Concept

Going back to at least Cicero,[185] dignity started off as denoting rank, which thereby was not possessed by everyone but which was limited to a few State-officials. Socrates was one of the first to move towards a notion of equal status for every individual, though that was only in a very limited setting of Athenian democracy.[186] Dignity being used to denote status continued into Christian times.[187] During the Renaissance, this very exclusive view on dignity was replaced by the concept encompassing every human being, based on human capacities, like self-determination.[188] A widely postulated idea was (and still is, as will be seen in the debates in England on assisted dying in chapter 4) the religious view that man was created in the image of God, which gave man a special value – dignity – but also required of man specific behaviour, for example not to throw the gift given by God (i.e. life) away.[189] The next major step in the development of dignity was Kant, who based the special worth of human life on man being an end in himself instead of a means to an end.[190] This meant a step away from dignity coming from a transcendental world towards dignity being rooted in humanity itself.[191] The individual was not a mere image of God anymore but rather a God in himself.[192] Since Kant, most attempts of defining dignity use him as a starting point.[193] Furthermore, "[a]fter Kant, dignity joined the political mainstream".[194] According to McCrudden, Kant's dignity concept is probably the most cited non-religious view on dignity.[195] Interestingly, when analysing the way

[185] See Marcus Tullius Cicero, *De Officiis*, referred to in Michael Rosen*, Dignity. Its History and Meaning* (HUP 2012), 11.
[186] See Kateb (n 172), 8, referring to Plato's *Apology*.
[187] See Rosen*, Dignity. Its History and Meaning* (n 185), 13.
[188] See ibid*,* 15.
[189] Of course there are also arguments that can be held against this still existing claim. For example that God also created worms and viruses, which we do kill and try to get rid of. And that usually gifts can be rejected or given back, so why not the gift of life. See Wolfgang Lenzen, 'Value of Life vs Sanctity of Life – Outlines of a Bioethics that Does Without the Concept of Menschenwürde' in Kurt Bayertz (ed), *Sanctity of Life and Human Dignity* (Kluwer 1996).
[190] According to Kant everything fell into one of two categories, either having a price or having dignity, dignity being an unconditional, incomparable value. See Immanuel Kant, *Groundwork to the Metaphysics of Morals,* referred to in Rosen, *Dignity Its History and Meaning* (n 185), 20 ff.
[191] See Kurt Bayertz, 'Human Dignity: Philosophical Origin and Scientific Erosion of an Idea' in Kurt Bayertz (ed), *Sanctity of Life and Human Dignity* (Kluwer 1996), 74.
[192] See ibid*,* 77.
[193] Of course the debate on dignity did neither end with Kant, nor did everyone following him agree with his conception. Nietzsche for example disagreed in claiming that existence alone had no value. See Nietzsche, 'The Greek State', referred to in Rosen, *Dignity. Its History and Meaning* (n 185), 44.
[194] See Charles Foster, *Human Dignity in Bioethics and Biolaw* (Hart 2011), 39.
[195] See Christopher McCrudden, 'Human Dignity and Judicial Interpretation of Human Rights' (2008) 19 *European Journal of International Law* 655, 659.

Kant used dignity in his famous works, Sensen found that Kant only rarely used dignity denoting worth but more often in an aristocratic sense.[196]

> What makes the one-and-a-half pages on dignity in the Groundwork so complicated is that they tie together four concepts ('autonomy', 'morality', 'dignity', 'worth') that are each expressed differently. Unfolding this complicated structure yields a picture that fits perfectly well with the traditional paradigm of thought.[197]

What this underlines is the difficulty in defining dignity. While the 'Kantian' concept of dignity seems well established, even that one is prone to misunderstandings and vagueness.

Dignity functioning as an international legal concept has its official starting point in the Universal Declaration of Human Rights, however, its origins as a legal concept can be said to go back to 1789 (at the domestic (French) constitutional level).[198] After the Second World War it began to appear in the newly emerging international human rights documents (and national constitutions, like that of Germany) as a reaction to the atrocities of the war.[199] While the lack of definition of dignity leads to plenty of criticism concerning its use,[200] according to Chapman and McCrudden, said lack helped in that everyone could agree to it and then fill it with own meaning.[201]

2.3.2. Dignity as a Value

According to Rosen, the most fitting idea of dignity was seeing it as value.[202] This could then explain why we also attribute dignity to embryos and corpses.[203] Even in death dignity remains. This is so since dignity is derived from being human and we are human even when dead.[204]

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[196] See Oliver Sensen, *Kant on Human Dignity* (Walter de Gruyter 2011), 177.
[197] Ibid*,* 188.
[198] See Catherin Dupre, 'Constructing the Meaning of Human Dignity: Four Questions' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 117.
[199] See Audrey R Chapman, 'Human Dignity, Bioethics and Human Rights' (2011) 3 *Amsterdam Law Forum*, 3, 5.
[200] See for example Christopher McCrudden, who claimed that "the use of 'dignity', beyond a basic minimum core, does not provide a universalistic, principled basis for judicial decision-making in the human rights context, in the sense that there is little common understanding of what dignity requires substantively within or across jurisdictions." See Mc Crudden 'Human Dignity and Judicial Interpretation of Human Rights' (n 195), 655. See also Kuhse, stating that "[dignity] is a slippery and inherently speciesist notion, it has a tendency to stifle argument and debate and encourages the drawing of moral boundaries in the wrong places", Helga Kuhse, 'Is There a Tension Between Autonomy and Dignity?' in Peter Kemp et al (eds), *Bioethics and Biolaw. Vol II. Four Ethical Principles* (Rhodos 2000), 74.
[201] Chapman (n 199), 5 and McCrudden 'Human Dignity and Judicial Interpretation of Human Rights' (n 196), 678.
[202] See Rosen*, Dignity. Its History and Meaning* (n 185), 55.
[203] See ibid*,* chapter 3.
[204] See Yechiel Michael Barilan, *Human Dignity, Human Rights and Responsibility: The New Language of Global Ethics and Biolaw* (MIT Press 2012), 98.

> We begin thinking about the human dignity of individuals, their equal status, when we impute to every person this thought: I have a life to live; it is my life and no one else's; it is my only life, let me live it. I exist and no one can take my place; I exist and though I do not owe my existence to fate, or other superhuman necessity, I am not nothing. My birth may have been planned, but I was not intended as the specific person I eventually became. [...] I am not nothing, even if or even though I go to nothing at the end. I am not nothing, even if in my life I amount to nothing out of the ordinary.[205]

Seeing dignity as a value demonstrates why it is not sufficient to talk of autonomy, as Macklin suggested,[206] but why we need dignity as a further element of our human existence. Autonomy can be impaired and completely lost. But dignity cannot be lost. It can be violated, but not cease completely like autonomy. As Dupre stated, only very few individuals are autonomous in dying.[207] At that stage dignity comes into play. According to Andorno, dignity was close to respect, but neither just another term for it,[208] nor simply another slogan for autonomy.[209] While dignity and autonomy are related in that they assure a self-determined life, they are not the same in that dignity is more fundamental and autonomy more nuanced – as was seen above at 2.2.

Dignity as such is not completely void of meaning. If seen as a value, it denotes the basic value of human life which then leads to the possession of specific rights. As human beings we see ourselves as having a special worth. We are the top of the evolutionary chain, feel like the most advanced species. Seeing the human race as special, and being part of it, together with our mental attributes of valuing past and future, hoping, dreaming and planning, means subjectively seeing the own life, as lived and experienced daily, in a special light. Somehow this perceived specialness needs further justification. Dignity fulfils that function: its possession can – and does – justify rights and duties. Human dignity gives life a special value which serves to lift it above common goods and commodities. It is the most basic value since one can be stripped of every right and possession but not of one's dignity. Barilan saw life as the only fundamental value since without it there would be no one to hold rights.[210]

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[205] Kateb (n 172), 18-19.
[206] See Macklin (n 175).
[207] See Catherine Dupre, 'Unlocking Human Dignity: Towards a Theory for the 21st Century' (2009) 2 *European Human Rights Law Review* 190, 194.
[208] See Roberto Andorno, 'Human Dignity and Human Rights as a Common Ground for a Global Bioethics' (2009) 34 *Journal of Medicine and Philosophy* 223, 230.
[209] See ibid*,* 229.
[210] See Barilan (n 204), 154.

However, it was life itself, not its continuity, which was of value, so no one should be forced to continue with an unwanted life.[211]

Dignity can not only be seen as a value but also as a right. However, it is not a right to dignity, but the right to have one's dignity respected. As Feldman stated, dignity is the foundation for rights, but there is no right to dignity.[212] The rights approach would imply that based on being human we have the right to be treated in a specific way, and a corresponding duty in the way we treat others. As Knoepffler argued, the duty idea can also be used the other way around, as not just implying a duty towards others but also a duty towards oneself.[213] For assisted dying this view can be especially important. It could be taken to signify that we should not end our lives prematurely. But this would imply having to remain alive even after one's own sense of dignity has seriously been impaired by suffering. Since this is not desirable, the duty to protect dignity actually functions as a claim for assisted dying. Due to our duty to protect dignity, we have to help those to a dignified end who request it.

The value approach brings with it the more fundamental view that human life has a specific worth. This worth must be seen as two-fold, for one the value a life has in itself and also the value oneself or others attach to it. This can either be the differentiation of intrinsic value and personal value – see Dworkin –[214] or intrinsic value and realised value – see Sensen.[215] What both mean is that while life has value in itself, there is a second layer which can vary from one individual to another. In the assisted dying debate it would imply that once the personal value was lost, life could be meaningless, even if there was still intrinsic value to it, qua being human. Human dignity can be seen as a moral standing based on our fundamental moral law.[216] According to Brownsword, "humans express their dignity precisely by acting on their moral judgments and doing what they judge to be the right thing for the right reason".[217] As Chapman claimed: "For human rights theorists, human dignity refers to the intrinsic

[211] See ibid. 187.
[212] See David Feldman, 'Human Dignity as a Legal Value. Part I' [1999] *Public Law* 682, 689.
[213] See Nikolaus Knoepffler, 'Menschenwürde Heute – ein Wirkmächtiges Prinzip und eine Echte Innovation' in Nikolaus Knoepffler et al (eds), *Facetten der Menschenwürde* (Verlag Karl Alber 2011), 26.
[214] R Dworkin (n 17).
[215] Sensen claimed that the traditional view on dignity consisted of four elements: Dignity not being a value but a status in creation; dignity existing in two levels, intrinsic and realised; dignity not yielding rights but duties; and the need to realise/perfect one's own dignity. See Sensen (n 196), 162-64.
[216] See Thomas Hill, 'In Defence of Human Dignity: Comments on Rosen and Kant' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 316.
[217] Roger Brownsword, 'Human Dignity, Human Rights, and Simply Trying to do the Right Thing' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 345.

worth of all human beings and the requirement that all human beings should be treated with appropriate respect".[218]

2.3.3. Dignity as Constraint

Dignity can be used as both, empowerment and constraint.[219] However, the claim that the legalisation of assisted dying would violate the dignity of the dying, the old, and generally the sick and vulnerable – which would mean using dignity as a constraint – is not tenable. It is similar to the claim that allowing for abortion in cases of severe disability is a statement about the unworthiness of disabled life. Concerning assisted dying it is claimed that if it were available for the sick and dying, then people in similar situations would feel pressured to request euthanasia. In order to protect their life – and dignity – it must therefore not be permitted.

> Dignity became a legal value in the context of broadly liberal human-rights instruments in international law, so one would expect it to be entirely compatible with liberal values. Curiously, dignity has been used in some jurisdictions in ways which both advance social rights and permit paternalistic restrictions on individual autonomy.[220]

A restriction of individual autonomy could be seen as important in order to save the dignity of society.[221] However, this is a questionable view. A society stressing individual autonomy and self-determination will not be undermined by allowing for assisted dying according to the individual's wish to die in dignity.

A second way in which dignity could function as a constraint would be the view that the dignity attached to life should not be violated by a premature death. For Kant, ending life prematurely was wrong since we had to respect ourselves.[222] However, there does not have to be a contradiction in respecting oneself, yet wanting to die. The respect for oneself could imply the wish to end life before it got undignified. As Beyleveld and Brownsword stated, we have to respect the person, not their life per se. So respecting an individual would mean respecting their choices.[223]

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[218] Chapman (n 199), 3.
[219] See Deryck Beyleveld and Roger Brownsword, *Human Dignity in Bioethics and Biolaw* (OUP 2001). Dignity being able to function as both can lead to tensions. Dignity stressing an individual's autonomy means it is functioning as empowerment, while dignity stressing social values means using it as constraint. Both are possible at the same time. See ibid, 11. It can even be seen as a struggle around autonomy, individual autonomy versus the control of society over autonomy. See ibid, 44.
[220] Feldman (n 212), 699.
[221] See ibid, 702.
[222] See Rosen, *Dignity. Its History and Meaning* (n 185), 147.
[223] See Beyleveld and Brownsword (n 219), 238.

As Jones claimed, "killing contradicts the intrinsic dignity of the human existence in all its aspects: both life itself and what life makes possible for the person and for other people".[224] This argumentation uses dignity as a constraint in that it tries to limit available options in order to save someone's dignity. This is a very short-sighted argument. Just because something is possible and legally available does not automatically lead to it being the norm. It seems farfetched that the legalisation of assisted dying would attack the dignity of those sick and dying who do not want to avail themselves of an earlier death.

2.3.4. Dignity as Empowerment

The German term for dignity, *Würde,* also exists as verb: *würdigen*. This actually helps in defining dignity. *Würdigen* translates to 'treat with dignity, acknowledge, respect'. So someone having dignity asks for everyone else to treat them with dignity. Saying someone has human dignity means respecting him or her as a fellow human.[225] This view can also avoid specicism, since animals can and should also be treated with respect.[226] Dignity then acts as empowerment, giving the individual a core that may not be violated, a minimum of rights that may not be infringed. It also gives the power to voice claims, like that for a dignified life or a dignified death. Based on dignity one is entitled to make basic decisions about how to live and die.

Dignity has two aspects, one being ontological, giving humans an equal worth, the other being normative, requiring of others to respect said worth.[227] It is the second aspect which builds the foundation for the empowerment (and arguably also the constraint, but as was argued above, in assisted dying dignity should not function as constraint). As Carozza argued, many jurisdictions base the right to self-determination of patients in medical scenarios on the individual's dignity.[228] Schlink stated that

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[224] David A Jones, 'Is Dignity Language Useful in Bioethical Discussion of Assisted Suicide and Abortion?' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 529.
[225] On this see for example Peter Kunzmann, 'Die »Menschheit in deiner Person« und die Sprachspiele der Menschenwürde' in Nikolaus Knoepffler et al (eds), *Facetten der Menschenwürde,* (Verlag Karl Alber 2011), 31.
[226] However, it does not have to avoid specicism. In speaking of human dignity there is still the connotation that the human being stands out among species. Of course this is not wrong *per se*, as the human species does dominate this planet (see for example the coining of the term anthropocene to depict a new genealogical epoch of the human dominating and shaping the planet. Jan Zalasiewicz et al 'The New World of the Anthropocene' (2010) 44 *Environmental Science and Technology* 2228). However, it gets difficult when used as justification for exploitation, etc of animals.
[227] See for example Paolo G. Carozza, 'Human Rights, Human Dignity, and Human Experience' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 616.
[228] See ibid*,* 618.

"[h]uman dignity is further used as a last resort, insisted upon when every other claim fails".[229] This seems to be very true for the case of assisted dying, the wish for a dignified death can be seen as an ultimate request. According to Schlink, one of three reasons to hold on to dignity in debates around human rights is it being a "*Sehnsuchtsbegriff,* a concept that encompasses our longing for a better and fairer world where the recognition and protection of humans is not up for grabs and cannot be overpowered or outmanoeuvred or argued down".[230] This fits with McCrudden's view that dignity has the role to supply a value other approaches don't.[231] According to Reaume, dignity was about choice since it was strongly connected to autonomy.[232] While it is sometimes claimed that a right to die in dignity does not entail a right to assisted dying,[233] it would have to follow. Since dignity is an equal value in every human being, it must mean that a dignified dying process should be available to everyone, based on the right to a dignified life.

2.3.5. Relational Dignity

As was seen above in chapter 2.2.2., autonomy is most useful when seen as a relational concept, meaning that in order to be autonomous we need the assistance of other individuals and society as a whole. Dignity can also be seen as a relational concept, though to another degree than autonomy. While autonomy is strengthened through relations, dignity is safest when there is no interference by others, yet at the same time requires some specific forms of actions by those around us. We do not need others to fulfil our own dignity to the same extent that we need assistance in being autonomous; instead, others can threaten and violate our dignity. Yet, it is a relational concept as dignity is attributed by others. Without society which defines what dignity and a dignified life are, it would not exist. "Human Dignity is not automatically inherent in humans, […] it is imparted by others by speaking and acting".[234] Depending on society, dignity can connote different ways of living. What is undignified behaviour in some societies can be dignified in others. Society is also the source for

[229] Bernhard Schlink, 'The Concept of Human Dignity: Current Usages, Future Discourses' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 631.
[230] ibid*,* 634, italics in original.
[231] See McCrudden, 'In Pursuit of Human Dignity' (n 89), 2.
[232] See Denise Reaume, 'Dignity, Choice, and Circumstances' in Christopher McCrudden (ed), *Understanding Human Dignity* (OUP 2013), 539.
[233] See for example Etienne Montero, 'The Socio-Political Stakes of Euthanasia', in Bernard Ars and Etienne Monero (eds), *Suffering and Dignity in the Twilight of Life* (Kugler 2004), 168.
[234] Dietrich Ritschl, 'Can Ethical Maxims be Derived from Theological Concepts of Human Dignity?' in David Kretzmer and Eckart Klein (eds), *The Concept of Human Dignity in Human Rights Discourse* (Kluwer Law International 2002), 98.

dignity applying to embryos and corpses. It is not the formerly alive individual who attaches dignity to its own corpse but the still alive individuals connected to it. Without society and others around us we might not even need dignity. A hermit growing up without society which teaches him how to live, which behaviour is acceptable and which is not, or leaving all those societal structures behind him later on in life, does not have to worry about his dignity.

Dignity not only serves as a restraint on certain relational interaction, it also is relational in requiring specific behaviour of society and other individuals. With dignity being an integral part of our society and definition of what makes us human, there is a need for positive action in order to secure dignity. Having ideas regarding what a dignified life and death are can require specific action from others, just like relational autonomy. Wishing to die a dignified death is very strongly connected to the need for assistance of those incapable of committing suicide unaided. In that scenario, a dignified death is so strongly linked to an autonomous death that the relational aspect can be claimed to attach to both. Dignity serves as a guarantee for minimal rights and as protection against some forms of interference by others. It therefore can be seen to be a relational concept.

2.3.6. Concluding Remarks

Dignity is a controversial philosophical concept, which can only be one facet of a multi-layered debate, yet it still fulfils a function, namely that of a philosophical common property – everyone has a feeling about what dignity is, or could be, and that it should not be violated. It is the last element remaining in dying – once autonomy ceases – and therefore vital in the assisted dying debate. While we might not be able to agree on exactly why we possess human dignity, and all the parameters that define it, we can agree on human life having a specific value – which is what I want to call dignity. Autonomy alone does not suffice to build a definitive argument in the assisted dying debate, as autonomy can be lost and is hard to assert (see chapter 2.2.). Respect for the individual is very similar to the idea of dignity, yet it does not carry the authority that dignity has. Therefore, a claim for the need for a legalisation of active assisted dying under strict parameters can and should be based on the individual's right to a dignified death.

2.4. Overall Conclusion

Various arguments are brought forward regarding the support or rejection of the legalisation of active assisted dying. Many of them are emotional and have valid aspects to them which makes it hard to reject the counterarguments concerning a legalisation of active assisted dying. However, while the threat to the vulnerable, the need for palliative care and the objective worth of human life (classified often as sanctity of life) are solid arguments and do need to be considered, the arguments in favour of assisted dying weigh more strongly. Still, palliative care and the protection of the vulnerable do need to find consideration in drafting laws on assisted dying. While safeguards need to be tightly drawn in order to prevent an often invoked slippery slope which would threaten the old and ill who do not wish to hasten their death, those wishing to set an end to their life and needing assistance in doing so require a right to die so they can then demand assistance.

In order to strengthen the claim for a right to die and the legalisation of active assisted dying, a solid theoretical basis is needed. Autonomy is a good starting point. Aspiring to be autonomous and enabling autonomous lives of others serves as a basis for the claim of needing assistance to fulfil a death-wish. However, realizing that it is a relational concept and problematic to achieve fully even in the most beneficial circumstances, it cannot stand alone. Dignity is a viable second basis for these claims. Even once someone has lost their autonomy, dignity remains. While dignity can also be seen to have a relational aspect, it cannot be lost like autonomy. Together they form a strong foundation, dignity as a right to a dignified death and relational autonomy as a claim for assistance in dying. Combined they strengthen the claim for a much needed right to die and legalisation of active assisted dying.

3. The Right to Die under the ECHR

When discussing the legality of issues surrounding the right to life one would assume that the ECtHR offered some guidance for Member States, especially in connection to the crucial question how death relates to the right to life and whether individuals have the right to a self-determined death. While Article 2 ECHR grants a right to life, this has never been interpreted as being an absolute right. Even though it is the precondition for the enjoyment of all other rights, the Article itself lists exceptions, namely the loss of life through use of force "a. in defence of any person from unlawful violence; b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; c. in action lawfully taken for the purpose of quelling a riot or insurrection". Yet, Article 2 seems to be an insurmountable hurdle regarding claims for assisted dying. To help with such claims, Article 8 is of importance, granting a right to respect for private life. Seeing dying and death as part of private life, assisted dying should be encapsulated in said right. However, this does not help claimants, since Article 2 can be evoked to stop any such claim.

As was seen in chapter 2, the notions of dignity and autonomy provide a potent conceptual basis for a strong argument in favour of assisted dying. Both ideas are important concepts for the interpretation of the ECHR. Dignity itself finds no mentioning in the ECHR,

> however, interpretations of the European Commission and Court of Human Rights, particularly of the Article 3 ECHR prohibition of torture and inhuman and degrading treatment and punishment, have drawn extensively on the concept of human dignity as a basis for their decisions.[235]

So, albeit without being explicitly mentioned, dignity is read into the Convention. The status of autonomy is similar; "the ECtHR has focused on the notion of 'personal autonomy' to adjust its margin of appreciation under Articles 8-9. The more personal autonomy is endangered, the more it reinforces the scrutiny in the assessment of reasons for an interference".[236] Autonomy therefore is seen as a qualifying attribute which limits the States' freedom to interfere with rights. One question to be addressed in this chapter is how much the ECtHR takes autonomy and dignity into account when considering assisted dying cases.

[235] McCrudden, 'Human Dignity and Judicial Interpretation of Human Rights' (n 195), 683.
[236] Begum, Zusset (n 106), 230.

Assisted dying and the right to die have so far only occurred in five cases of the ECtHR: *Zoon v the Netherlands* in 2000,[237] *Pretty v the United Kingdom* in 2002,[238] *Haas v Switzerland* in 2011,[239] *Koch v Germany* in 2012[240] and *Gross v Switzerland* in 2013.[241] The first case, *Zoon*, though involving the issue of assisted dying, did not reach the ECtHR due to the matter of a right to die but because of an alleged violation of Article 6, the right to a fair trial, and will therefore not be considered in this analysis.

The chapter will start with an analysis of the four relevant cases which will be followed by a commentary section and a discourse on the margin of appreciation. Looking at the margin of appreciation is vital for the analysis of the right to die under the ECHR, as it features in all of the assisted dying cases. Consequently, the major questions approached in this chapter are to what extent a right to die already exists under the ECHR and how the Court approaches assisted dying cases.

3.1. Cases

3.1.1. *Pretty v the United Kingdom*

The first time the ECtHR had to engage with the question whether a right to die existed and where the limits of the right to life as guaranteed under Article 2 ECHR are was *Pretty*[242] in 2002. Mrs Pretty was suffering from a motor neurone disease (MND), a terminal illness of progressive muscle weakness. "Death usually occurs as a result of weakness of the breathing muscles, in association with weakness of the muscles controlling speaking and swallowing, leading to respiratory failure and pneumonia. No treatment can prevent the progression of the disease".[243] To avoid a distressing and undignified death by suffocation, Mrs Pretty had sought a guarantee from the DPP that he would not prosecute her husband under Article 2.1 of the Suicide Act 1961,[244] prohibiting assistance in suicide, if he assisted her in ending her life. Since the DPP refused to grant immunity from prosecution, Mrs Pretty took the case to the ECtHR, claiming violations of Articles 2, 3, 8, 9 and 14 ECHR. According to Mrs Pretty,

[237] Application no. 29202/95, 7 December 2000.
[238] Application no. 2346/02, 29 April 2002.
[239] Application no. 31322/07, 20 January 2011.
[240] Application no. 497/09, 19 July 2012.
[241] Application no. 67810/10, 14 May 2013, Grand Chamber judgment 30 September 2014.
[242] Application no. 2346/02.
[243] ibid. [7].
[244] The Suicide Act 1961 decriminalises suicide while stressing the illegality of assisting someone in committing suicide. The Act will be dealt with in more detail in chapter 4, dealing with the legal situation in England.

Article 2 protected the right to life but not life itself.[245] Therefore, everyone should be free to decide what to do with his or her life.

Concerning the domestic case law, the ECtHR drew on cases that demonstrated that passive assisted suicide is legal in England.[246] This means that physicians must end life-prolonging or life-preserving treatment when an individual makes the informed choice to refuse it. As is stated in Article 5 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine: "An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it". Concerning active assisted dying, the ECtHR referred to a report of 1994 issued by the House of Lords Select Committee on Medical Ethics. The report came to the conclusion that the existing law should not be changed since it concerned only a very small number of individual cases which was not a sufficient base for changes.[247] It further stated: "The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole".[248] A further argument made by the Committee quoted in the case was the safety of vulnerable elderly and sick people. The fear uttered by some assisted dying opponents is that decriminalisation would lead to the felt pressure to request assisted dying in order not to be a burden on society or friends and family.[249]

The next argument considered by the ECtHR was that of the Voluntary Euthanasia Society[250] which had been given third-party status by the Court. The submission of the society stated that palliative care is in some cases not the right approach to suffering; for some, death is the only acceptable treatment. According to the society, English law on assisted dying was amongst the most restrictive in Europe, which made it inappropriate. Yet, even though it was illegal, this did not mean that assisted dying did not take place. Furthermore, the numbers in countries

[245] See application no. 2346/02, [14.4].
[246] See ibid, [17]-[18].
[247] See ibid, [22.237].
[248] See ibid.
[249] See ibid, [22.239].
[250] An English organisation campaigning for the legalisation of assisted dying. In 2006 it changed to 'Dignity in Dying'.

where assisted dying can legally be practiced did not indicate that legalisation led to an increase in requests from the elderly and sick.[251]

Opposed to that approach was the submission by the Catholic Bishops' Conference of England and Wales, another third-party for the case. One fundamental belief in Christianity is that life is sacred, since it is a gift made by God.[252] Furthermore, they argued that many wishes for death originated in depression. If this depression was treated, the wish would vanish, there was therefore no need for assisted dying but instead for better treatment of mental conditions.[253]

Even though the Government had submitted that the case should be dismissed because none of the articles of the ECHR had been violated (as found by Lord Bingham in the House of Lords, see below at 4.2.1.), the ECtHR declared it admissible since the application raised serious matters of law that required an examination of the merits of the case.[254] The Court reaffirmed that Article 2 was one of the most fundamental rights in the Convention since the right to life was a precondition to the enjoyment of the other rights.[255] However, it came to the conclusion that Article 2 was not concerned with the quality of life or individual choices of individuals concerning their lives. It could not be interpreted to include the opposing right, namely a right to die.[256] Article 3 likewise had not been violated according to the ECtHR since it had not been the State that had imposed ill-treatment on the applicant and instead tried its best in providing her with all medical care available.[257] Concerning Article 8, the Court reaffirmed that it concerned the person's physical and social identity. Though no case had clearly established the extent of the right to personal self-determination to be covered by Article 8, the ECtHR stated that autonomy was an important feature of Article 8.[258] Furthermore, the quality of life had to be taken into account under Article 8 since the Convention was in general concerned with human dignity and freedom.[259] Therefore, the ECtHR did not exclude the possibility that Article 8 was of concern in this case. However, according to Article 8.2, States have the right to limit the freedoms guaranteed under Article 8. Since the ban on assisted suicide is grounded in national law in order to safeguard life, the

[251] See application no. 2346/02 [25]-[27].
[252] See ibid, [29].
[253] See ibid, [31].
[254] See ibid, [33].
[255] See ibid, [37].
[256] See ibid, [39]-[40].
[257] See ibid, [53].
[258] See ibid, [61].
[259] See ibid, [65].

Court found the ban on assisted suicide appropriate and an interference with the freedoms under Article 8 therefore justified as necessary in a democratic society.[260] Since it had found Article 8 to be involved it also had to consider a violation of Article 14. However, it held that there was justifiable reason for a State to differentiate in law between people who can commit suicide without help and those who cannot, therefore there had not been a violation of Article 14.[261]

As was demonstrated above in chapter 2, the most pertinent arguments behind the legalisation of assisted dying are grounded in the concepts of dignity and autonomy. Dignity, the strongest basis for an argument in favour of assisted dying, was mentioned a total of 15 times in the judgment – including the term indignity. Only twice though was it used by the Court itself. The first occasion was in connection with the alleged violation of Article 3, restating that if "treatment humiliates or debases an individual, showing a lack of respect for, or diminishing his or her human dignity […] it may be characterised as degrading and also fall within the prohibition of Article 3".[262] However, the Court did not find the State to be violating its obligations under Article 3, since Mrs Pretty's suffering was not brought about by the State. This is a rather limited view on dignity, especially since the undignified existence in this case was prolonged by the State's laws prohibiting what was believed to be a dignified end. If an existence becomes undignified, the State should enable a change of that situation, even if that implied making assistance in dying available. This view was backed up by the Court's second use of dignity when it claimed: "The very essence of the Convention is respect for human dignity and freedom".[263] With this statement the Court introduced its finding that Article 8.1 was involved in assisted dying cases. However, if the essence of the Convention truly is the protection of human dignity, then the leeway of States under Article 8.2 should be considerably reduced in areas which threaten dignity – such as the prohibition of assisted dying.

Autonomy was mentioned thirteen times, five of which by the Court itself. Concerning Article 8, it stated that "personal autonomy is an important principle underlying the interpretation of its guarantees".[264] The Court further referred to the Canadian case *Rodriguez v the Attorney*

[260] See ibid, [74]-[78].
[261] See ibid, [87]-[90].
[262] ibid, [52].
[263] ibid, [65].
[264] ibid, [61].

General of Canada[265] in which it had been held that the absence of assisted dying infringed the applicant's autonomy – something the Court found to be an issue under Article 8.[266] However, the Court then claimed that States were entitled to restrict personal autonomy in the name of public health and safety.[267] While this is to some extent a valid and vital aspect – personal autonomy cannot be absolute but has to be limited by the State for the protection of others, as well as society as a whole, – autonomy should weigh more heavily in the considerations of assisted dying than it did in this case. Criminalising assisted dying, thereby limiting the autonomy of the individual wishing to die but requiring assistance, also seriously threatens the dignity of the suffering individual as has been discussed above.

The Court was right in *Pretty* in stressing the fundamental importance of Article 2. Having one's life protected is a prerequisite for the enjoyment of any other right. However, not acknowledging that a person may wish to end their life can turn the right to life into an obligation to live, which is something human rights should not do. The duty of the State to safeguard life, as mentioned by the Court to be part of Article 2,[268] should not be taken to apply against the individual's wishes. Even if one accepts the claim that the right to life cannot be interpreted to include the diametrically opposed right, a right to die, the right to life should not be used to prevent a self-determined death-wish. However, the Court stated that suicide regulations were for the individual States to determine since they had to weigh individual liberties against conflicting public interests.[269] While this is right to some degree – it should be left to States to resolve such conflicts, – it would still be desirable for the Court to have a stronger say on issues so fundamental to human life and dignity as assisted dying. Why this is currently not possible will be seen in the elaborations on the margin of appreciation below.

Regarding Article 3, while of course it is not the State inflicting the illness per se, it could and should be seen to be the State which is prolonging the suffering by not making an end to the suffering possible. Acknowledging that Article 8 can be interpreted to also include the quality of life and therefore claims for assistance in dying, the Court saw the interference by the State with Mrs Pretty's wish to die as justified under

[265] [1994] 2 Law Reports of Canada 136.
[266] Application no. 2346/02 [66].
[267] ibid, [74].
[268] See ibid, [38].
[269] See ibid, [41].

Article 8.2. This is rather unfortunate. Instead of seeing the Suicide Act as a justification for the State's ban, the Court should have questioned the State's ban on assisted dying. Yet again, the discussion of the margin of appreciation below will highlight why this was not possible. Sadly, Mrs Pretty's right to dignity and autonomy did not outweigh the State's interests in the eyes of the Court.

3.1.2. *Haas v Switzerland*

Mr Haas claimed that the right to die when and how one wishes to do so is guaranteed under Article 8 ECHR[270] and had been violated by Switzerland when he could not obtain lethal medication from his pharmacy, in order to commit suicide, without a medical prescription. He had attempted to commit suicide twice before, had become a member of Dignitas,[271] and now sought a medication that would enable him to commit suicide without pain, suffering or fear of failing. Switzerland claimed that no obligation could arise from Article 8 on the State to enable a suicide without pain, distress or the like.[272] The Swiss Supreme Court stressed that even though Article 8.1 could be interpreted as including a right to die when and how one wishes this did not induce a duty on the State or a third party to assist in and facilitate suicides.[273] Similarly, Article 2 could not be interpreted as implying a duty on the State or a third party to assist in suicide, as it does not include a right to die.[274] The question the Supreme Court saw open to still be addressed was whether Article 8 could be interpreted as to include a duty on the State to enable suicides without risk of pain or failure. The case of Mr Haas was complicated by the fact that he did not seek death because of a physical illness but because of a mental disorder. The Supreme Court accepted that the suffering caused by a mental illness can be as grave as from a physical one. However, though maybe untreatable, it lacked the fatal element that will lead to a painful and undignified death (as for example in *Pretty*). The Supreme Court held that Article 8 ECHR could not be interpreted as to oblige a State to make

[270] See application no. 31322/07 [3].
[271] Dignitas is a non-commercial Swiss organisation concerned with dignified dying. It provides counselling concerning general questions around dying and suicide and also specific advice and support regarding assisted suicide in cases of unbearable suffering, terminal illnesses and serious impairment.
[272] See application no. 31322/07 [10].
[273] See ibid, [16.6.2.1].
[274] See ibid, [16.6.2.2].

lethal medication available to individuals without a prescription by a doctor.[275]

According to Mr Haas, obtaining the medication he had asked for was the only way to commit suicide in a dignified, secure, fast and painless way.[276] He had written to 170 physicians asking them to take him on as a patient to then be able to attest that he was capable of making a confirmed and rational choice concerning his wish to die, but all of them had refused to do so, for various reasons (e.g. lack of time and ethical reasons).[277] Without finding a doctor he was unable to get a prescription and therefore could not commit suicide in his favoured way.

The ECtHR started by restating that 'private life' was a very broad term that covered various aspects of life. Most importantly in light of a right to die, the ECtHR stated that the right to decide when and how to die fell within the ambit of private life protected by Article 8 ECHR.[278] But in this case the question was not whether someone had the right to assistance in dying but whether the State was obliged to make lethal medication available without medical prescription. Even though in Switzerland assisted suicide is exempt from punishment, the majority of Member States value protection of life over a right to die, which is why the ECtHR grants a margin of appreciation in this matter.[279] Additionally, it stressed the reasoning of the State which saw an importance in requiring patients to obtain a medical prescription in order to be able to commit suicide via medication, as a means to prevent abuse.[280] This derived from Article 2 ECHR which requires States to protect the lives of individuals and have in place safeguards against a violation of Article 2.[281] Consequently, due to the right to life as guaranteed by Article 2 ECHR and the obligation on the State to safeguard the lives of its people, lethal medication could not be obtained without medical prescription, even though Article 8 ECHR could be interpreted to guarantee a right to choose when and how to die. With that reasoning, and even though it acknowledged the obligation on States to enable a dignified suicide, the ECtHR found no violation of Article 8 in said case.[282]

[275] See ibid, [16.6.3.6].
[276] See ibid, [33].
[277] See ibid, [17]-[18].
[278] See ibid, [51].
[279] See ibid, [55].
[280] See ibid, [56].
[281] See ibid, [58].
[282] See ibid, [61].

In *Haas*, dignity was mentioned four times, twice by the Court itself. However, the first of those only was a summary of what Mr Haas had claimed, i.e. that he would not be able to commit a dignified suicide without the legal medication he had requested but had been denied. The second mention was the assumption that "the States have a positive obligation to adopt measures to facilitate the act of suicide with dignity",[283] finding that Switzerland had not violated that obligation. The Court was rather hesitant in determining that claim, only 'assuming' there to be such an obligation. Based on the accounts of dignity and autonomy given in chapter 2, the Court arguably should have stressed more forcefully that States are under an obligation to facilitate a death in dignity.

Autonomy was referred to only once by the Federal Court, recalling the case *Pretty.*[284] It would have been desirable had the Strasbourg Court engaged with the idea of autonomy in this judgment. While Mr Haas was not physically incapable of committing suicide, he wished for help in committing a dignified form of suicide. Acknowledging ideas of relational autonomy (see above chapter 2.2.2), even an individual not suffering of a terminal illness or too handicapped to commit suicide unaided should be able to receive assistance.

The Court was right in stating that "an individual's right to decide by what means and at what point his or her life will end […] is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention".[285] With that it restated its hesitant finding in *Pretty*. However, the Court then found a difference in that *Haas* not only wanted the assertion of a right to die but also a specific deed by the State. The Court bringing into play Article 2 and the obligation it creates on States to protect vulnerable adults is understandable, yet has the unfortunate side-effect of using Article 2 as a knock-out argument. It would have been favourable had the Court instead limited Article 8 solely by referring to Article 8.2 and the freedom of the State to limit liberties granted by Article 8, instead of bringing into play the right to life, which yet again turned said right into a form of obligation, instead of a liberty. Stating that Article 2 "obliges the national 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"[286] seems to imply that Mr Haas is seen

[283] See ibid.
[284] See ibid*,* [16.6.2.2.].
[285] See ibid*,* [51].
[286] See ibid*,* [54].

to not be capable of making the decision in question, an interpretation the Court should refrain from making without clear evidence to support it. Merely stating that the Court is sympathetic with Mr Haas' desire does not help for future interpretation of Articles 2 and 8 in the light of a right to die. While the Court was right in arguing that Switzerland has sufficient regulation in place in order to facilitate assisted dying for suffering individuals, the approach and use of Article 2 and 8 could have been more clearly oriented towards a right to die, instead of using Article 2 against any such request.

3.1.3. *Koch v Germany*

The case *Koch*[287] concerned an application by Mr Koch who claimed that his wife's rights under the Convention had been violated when her request for a lethal dose of medication to enable her to commit suicide at home was refused. Mrs Koch "had been suffering from total sensorimotor quadriplegia after falling in front of her doorstep. She was almost completely paralysed and needed artificial ventilation and constant care and assistance from nursing staff".[288] She had a life expectancy of another 15 years but wished to end what to her was an undignified life.

The *Bundesinstitut für Arzneimittel und Medizinprodukte* (German Federal Institute for Drugs and Medical Devices) had found that enabling someone to commit suicide was contrary to the Narcotics Act. Following that decision, Mrs Koch travelled to Switzerland and committed suicide with the help of Dignitas. The Institute for Drugs and Medical Devices confirmed its decision by stating that Article 8 could not be interpreted as obliging a State to facilitate suicides by providing narcotics. That would run contrary to Article 2.2 of the German Basic Law which obliged the State to protect life.[289] Furthermore, even if a right to die existed, this could not extend to the husband's right being violated under Article 6.1 of the German basic law – protection of marriage and family life – and Article 8.1 of the ECHR by the refusal of assistance since rights of one spouse were not automatically rights of the other spouse as well.[290]

Under German law suicide is legal while killing someone on their request is illegal.[291] Additionally, the professional rules for doctors include

[287] Application no. 497/09, 19 July 2012.
[288] ibid, [8].
[289] See ibid, [13].
[290] See ibid, [16].
[291] See §216 Criminal Code. For a more detailed description of the German legal situation concerning assisted dying see below at 5.1.

that doctors may refrain from life-prolonging measures but may not actively curtail a patient's life.[292] In 2009 the German Medical Assembly had stated that although doctors should assist patients in the process of dying, they may not actually help someone to die. This means that passive assisted dying (sometimes called 'letting die', as it means discontinuing or not commencing life-prolonging treatments) is permitted in cases where the patient is capable of voicing informed consent. Also, indirect assisted dying is permitted, meaning that a dying person can and should be administered enough painkillers to die at ease, accepting that the painkillers might hasten the process of dying. However, administering medication with the aim of bringing about death, which would be active assisted dying, is illegal.[293]

> In Germany, committing suicide autonomously or assisting an autonomous suicide is exempt from punishment. Discontinuation of a life-prolonging treatment of a terminally ill patient with the patient's consent does not engage criminal responsibility as well. Assisted suicide *per se*, or euthanasia, is not legal in Germany.[294]

Concerning Mr Koch's claim that his wife's Article 8 ECHR had been violated, the Government replied that since he was not the victim of the alleged violation he could not bring a claim and that the right of his wife could not be transferred to him.[295] The State furthermore claimed that Article 8 did not apply in this case, as in contrast to *Pretty* Mrs Koch had not sought protection from State intervention but instead had sought facilitation of her suicide by the State.[296] If the State had acted according to her wishes that would have contravened Article 2 ECHR. Also, the State invoked its margin of appreciation in delicate moral areas such as this and brought up the history of Germany as a reason why Germany should refuse to practice assisted dying.[297] Lastly, Mrs Koch could have chosen other ways to end her life, like passive assisted dying in connection with palliative care.[298]

Mr Koch on the contrary claimed that under Article 34 ECHR he, as a close family member, could count as a victim of a violation of Article 8

[292] See Section 16 of the Model Professional Code for German Doctors.
[293] For a detailed differentiation of the different concepts of assisted dying see for example Roggendorf (n 47), 22-24.
[294] Gregor Puppinck and Andrea Popescu, 'Koch v Germany: The ECHR Called Again to Decide on Assisted Suicide' Press Release, European Centre for Law and Justice, 08 September 2011, italics in original.
[295] See application no. 497/09, [28].
[296] See ibid, [32].
[297] See ibid, [57].
[298] See ibid, [58].

ECHR.[299] According to him, Article 8 should grant individuals the right to end their lives and this did not conflict with Article 2.[300] While Dignitas (a third-party to the case) submitted that Article 8 should be interpreted as to grant a right to self-determination which implies the right to decide when to end one's life,[301] the organisation 'Aktion Lebensrecht für Alle e.V.'[302] submitted that no legal document which includes a right to life grants persons a right to die.[303]

The ECtHR declared the application admissible since the claim of the Government that Mr Koch did not qualify as a victim had to be examined on the merits. Concerning his own victim status, Mr Koch claimed that his right to private and family life had also been violated when his wife had to travel to Switzerland to be able to commit suicide instead of receiving lethal medication in Germany to be able to commit suicide at home. Even though the Government opposed that claim, the ECtHR did not see his claim as manifestly ill-founded under Article 35.3 and declared his application admissible. Considering the relationship between Mr and Mrs Koch, the Court acknowledged that Mr Koch could claim to be directly affected by the decision of the Federal Institute's refusal.[304] The Court recalled *Haas*,

> 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.[305]

Therefore, the Court found a violation of Mr Koch's right to respect for private life, based on the rejection of Mrs Koch's request by the Federal Institute and the Administrative Courts' refusal to examine the case on its merits.[306] The Court further examined whether the violation of Article 8 was justified under Article 8.2 but could not "find that the interference with the applicant's right served any of the legitimate aims enumerated in that paragraph".[307] Due to the margin of appreciation, granted in cases on issues that lack European consensus and due to the principle of

[299] See ibid, [35]-[36].
[300] See ibid, [39].
[301] See ibid, [40].
[302] Aktion Lebensrecht für Alle e.V. is a German non-profit organisation, concerned with an absolute right to life, rejecting inter alia assisted dying.
[303] See application no. 497/09, [42].
[304] See ibid, [50].
[305] ibid, [52].
[306] See ibid, [54].
[307] ibid, [67].

subsidiarity,[308] the Court saw the merits of the case as a matter to be decided by national courts. It therefore only decided on a violation of the procedural aspects of Article 8.[309] Additionally, the Court reaffirmed that Article 8 is non-transferable and that Mr Koch therefore "does not have the legal standing to rely on his wife's rights under Article 8 of the Convention".[310] Concluding, the Court declared the complaint of a violation of Mrs Koch's rights under the ECHR inadmissible, held that Mr Koch's Article 8 rights had been violated by the German courts' refusal to examine the case under its merits and saw it unnecessary to examine an alleged violation of Article 6 ECHR.

In *Koch*, dignity was mentioned a total of twelve times, however, none of those featured in the assessment by the Court itself. Autonomy was mentioned twice, once by the Court recalling *Pretty* and the claim made there that autonomy was a vital element of Article 8.[311] While it is commendable that the Court found at least a procedural violation, a stronger expression regarding autonomy and dignity would yet again have been favourable. However, seeing that it did not make a judgment on the merits of the applicant's substantive complaint, it is no surprise that the Court did not elaborate on the relevance of autonomy or dignity here.

While the Court restated that matters of assisted dying are within a country's margin of appreciation, due to subsidiarity and a lack of European consensus (on those issues see below at 3.3.) it did take a vital step in finding a violation of Mr Koch's rights under Article 8 in the national courts' refusal to examine the merits of the case. Of course it can be seen as unfortunate that the Court still did not get involved in the topic at hand, but it is a vital step forward for it to declare that States have to face the issue of assisted dying.

3.1.4. *Gross v Switzerland*

Gross concerned a suicidal woman in her seventies who requested specific medication in order to be able to commit suicide.[312] Her claim towards the ECtHR was "that her right to decide how and when to end her

[308] On the margin of appreciation see 3.3. below.
[309] See application no. 497/09, [71]-[72].
[310] ibid, [81].
[311] See ibid, [51].
[312] Application no. 67810/10, 14 May 2013.

life had been breached".[313] The applicant was not suffering from a mental or physical illness but was unwilling to wait for a natural death while watching herself decline through age.[314] After a failed suicide attempt and a six month stay in a psychiatric hospital she got in touch with EXIT, an assisted dying organisation in Switzerland, in order to receive support for her wish to die with the help of sodium pentobarbital.[315] She was examined twice by a psychiatrist who found her to be of sound mind and her death-wish to be well-considered.[316] However, he did not offer her a prescription since "he did not want to confuse the roles of medical expert and treating physician".[317] The applicant submitted a request for medication to three physicians who all refused her the prescription, for reasons such as her not suffering from any illness and there not being a guarantee that the physician would not suffer legal consequences.[318] Ms Gross thereupon contacted the Health Board of the Canton of Zurich requesting 15 grams of sodium pentobarbital but had the request rejected on the grounds that neither the Swiss Constitution nor the ECHR obliged the State to provide her with the means to commit suicide.[319] The Administrative Court to which the case was taken considered the legal situation of Switzerland and the psychiatrist's expert opinion and found that a "wish to die taken on its own, even if it was well-considered, was not sufficient to justify the issuing of a medical prescription".[320] Ms Gross appealed against the decision on the basis that it rendered her right to choose when and how to die (as she saw guaranteed by Articles 2, 3 and 8 ECHR) illusionary.[321] However, the Federal Supreme Court upheld the previous judgment, since "[i]t was up to the democratically elected legislature to decide if and under which circumstances the purchase, transport and storage of sodium pentobarbital should be allowed".[322]

The applicant therefore turned to the ECtHR, complaining of a violation of her Article 8 rights by having been refused the right to choose the time and means of her death.[323] The Government submitted that their interference with her Article 8 rights was justified as it was "up to the State to assess the risk and the likely consequences of possible abuse in the

[313] ibid, [3].
[314] See ibid, [7].
[315] See ibid, [8].
[316] See ibid, [9].
[317] See ibid, [10].
[318] See ibid, [11].
[319] See ibid, [12]-[13].
[320] See ibid, [15].
[321] See ibid, [18].
[322] See ibid, [20].
[323] See ibid, [38].

context of assisted suicide".[324] The restrictions on the availability of lethal drugs like sodium pentobarbital "served the aims of protecting life, health and public safety and of preventing crime".[325]

While stressing that the sanctity of life was a principle underlying the Convention, the ECtHR recalled that it had pointed out in *Pretty* that preventing the measures needed to avoid an undignified and distressing death could be an interference with Article 8 ECHR.[326] It recalled having stated in *Haas* and *Koch* that choosing means and time to die was part of private life which found protection under Article 8 ECHR.[327]

> [T]he Court considers that the instant case primarily raises the question whether the State had failed to provide sufficient guidelines defining if and, in the case of the affirmative, under which circumstances medical practitioners were authorised to issue a medical prescription to a person in the applicant's condition.[328]

The Court found that the uncertainty of the extent of the right to end one's life was undesirable. While it was clear that it was difficult for a State to find a consensus on such a profoundly ethical and moral question, "these difficulties are inherent in any democratic process and cannot absolve the authorities from fulfilling their task therein".[329] The ECtHR found a violation of the applicant's Article 8 rights, in that Switzerland did not provide clear enough guidelines for individuals in her situation (individuals not terminally ill wishing to receive a lethal dose of medication in order to be able to commit suicide).[330] Yet, it did not point towards any directions such guidelines should take.[331]

However, on 30 September 2014 the application was declared inadmissible by the Grand Chamber. As the Court had been informed by the Government on 7 January 2014, Ms Gross had been able to obtain a prescription of sodium pentobarbital in October 2011 and had committed suicide on 10 November 2011. "Accordingly, the Court upholds the Government's preliminary objection that the applicant's conduct constituted an abuse of the right of application within the meaning of Article 35 § 3 (a) of the Convention".[332]

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[324] See ibid, [46]- [47].
[325] See ibid, [48].
[326] See ibid, [58].
[327] See ibid, [59]
[328] See ibid, [63].
[329] See ibid, [66].
[330] See ibid, [67].
[331] See ibid, [69]
[332] See application no. 67810/10, 30 September 2014, [37].

Astonishingly, in its most recent case, dignity only was mentioned once, in the facts of the case in connection to the assisted dying organisation Dignitas. This is somewhat astounding in that *Gross* was the first assisted dying case in which a violation had been found – before the case was declared inadmissible by the Grand Chamber. Out of three uses of autonomy, the one by the Court referred to *Pretty* and the fact that a right to personal autonomy is a part of Article 8.[333] Without elaborating on this any further, it is a vital element in finding a violation of Article 8. The Grand Chamber, when declaring the case inadmissible, naturally did not mention autonomy again since it declared the application inadmissible on its facts and therefore did not have to look at the underlying issues again.

In its latest case, before overturning the judgment by declaring it inadmissible, the Court again stressed sympathy for suffering and the wish to not be forced to continue with an unwanted life. Yet, it still could not do so without stressing the sanctity of life.[334] At the same time, it is commendable that the Court declared that States should have clear guidelines in place as to the limits of a right to die, even if it is difficult for individual countries to find political consensus on the matter. So while not expressing an opinion as to the direction legislation should take, at least the Court urged States to have clear legislation in place, which is a vital start for the debate on assisted dying and a right to die.

3.2. General Commentary

The four cases concerning assisted dying which the ECtHR has had to deal with so far are very diverse and reflect a variety of assisted dying scenarios. While Mrs Pretty and Mrs Koch needed assistance due to a physical incapacity to commit suicide unaided, Mr Haas wanted assistance for a suicide based on mental illness and Ms Gross' reason for committing suicide was old age. These are very different starting points, which require different approaches. Even countries which permit assisted dying, like the Netherlands, do have restrictions in place, for example limiting assistance to those suffering unbearably from a physical ailment. While in its first decision the Court very clearly stated that a right to die could not be seen to be part of the right to life, it also tentatively acknowledged dying to be part of private life under Article 8. However, the effect of that is rather illusionary since it can be limited for various reasons under Article 8.2, as

[333] See application no. 67810/10, [58].
[334] See ibid.

was done in *Pretty*. Restating this aspect of Article 8, the Court in *Haas* then moved on to the specific circumstances, claiming that while dying is part of Article 8, there is no duty upon any State to facilitate a particular kind of suicide. Again not inferring a right to die, the Court did find a procedural violation in *Koch* in the State's refusal to address the issues. In *Gross*, before the Grand Chamber declared the case inadmissible, the Second Section had found a violation of the applicant's rights in that the State's guidelines on assisted dying were found to be not clear enough. So the general stance of the ECtHR is that while there is no right to die, the right to respect for private life does include a freedom to choose how and when to die. However, it is for the individual State to legalise assisted dying, as that has to be done in accordance with national laws and morals.

As will be seen under 3.3., the reasons behind applying a margin of appreciation are significant for understanding why the Court does not rule in favour of a right to die, or the legalisation of assisted dying. Still, a stronger stance by the Court would be desirable. At the same time, it will become clear from an analysis of the margin of the appreciation that the Court is not in the position to rule in favour of a right to die as long as there is no (emerging) consensus among the Member States.

3.2.1. Right to Die under Article 2 ECHR

Article 2, while granting a right to life, does not mention the opposite, a right to die. According to Morris the mere fact that 3 courts and a total of 15 judges have ruled against Mrs Pretty's claim for a right to die might be regarded as a "coup de grace for arguments about the right to assistance in death under European human rights law".[335] However, stating that a right to die would be diametrically opposed to the right to life[336] is only true under one of various possible viewpoints. While it can of course be seen that death is the opposite of life and that every being can only be alive or dead, it also has to be acknowledged that dying is a part of life. So while it can be accepted that a right to die cannot be part of the right to life, the right to life should at the same time not work as a prevention of assisted dying.

According to the ECtHR, cases engaging Article 2 emphasise the obligation of States to protect life but are not concerned with the quality of

[335] Morris (n 44), 65.
[336] See application no. 2346/02, [39].

life.[337] Morris claimed that according to many commentators Article 2 is more likely to be used as an argument against assisted suicide since it is "the most important right of all, the pre-requisite to all other human rights, […] [and therefore] must be construed strictly".[338] Concluding, Morris saw the ruling of the ECtHR concerning Article 2 as no surprise. "The restrained interpretation of Mrs Pretty's rights under Articles 2, 3 and 9, though perhaps not to everyone's taste, is it seems perfectly justifiable given current Strasbourg jurisprudence".[339] However, while it is no surprise, this should not be taken to justify a lack of change in the Court's approach. While Article 2 is a pre-requisite for the enjoyment of other rights, the Court should take into consideration the individual's view on their own life.

According to Puppinck and Popescu, *Koch* should not have been considered on its merits by the ECtHR.

> In the present case, as to the late wife's rights under the Convention, it is to be noted that the applicant cannot be considered to be a victim. Even if he took part in the internal proceedings, they had no impact on his legal situation, as the Court considered in the above mentioned cases.[340]

Recalling the judgement of *Pretty,*[341] the authors of the press release restated that there is no right to die to be derived from the right to life "but that there is a right to personal autonomy deriving from the right to respect for private life".[342] Still, the ECHR does not include a right to die or a right to assisted suicide.

> The subsidiary reasons are the following: the strong ethical dimension of this issue, the lack of consensus among member States on the matter, the strong defence of the human dignity by the German legal system due to historical reasons, the interest of the society in preserving health, public safety and the prevention of crime and of abuses.[343]

While these are all valid points, they do not justify the use of Article 2 as a knock-out argument. Based on autonomy and dignity, as seen above in chapter 2, the right to life should include the possibility of being waived.

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[337] See Morris (n 44), 69.
[338] ibid.
[339] ibid, 75.
[340] Puppinck and Popescu (n 294).
[341] Application no. 2346/02.
[342] Puppinck and Popescu (n 294).
[343] ibid.

3.2.2. Right to Die under Article 8 ECHR

Article 8 seems to be a more promising basis for assisted dying claims than Article 2 in that the Court is willing to include dying in the concept of private life. "If dying is part of living, then there is nothing in principle to exclude it from the protection guaranteed by Art.8(1)".[344] However, the ECtHR asserted that the interference with Mrs Pretty's Article 8 right to respect for private life was necessary to protect the elderly and vulnerable.[345] This is a general argument in assisted dying claims – the prohibition is seen as vital in safeguarding the lives of vulnerable individuals. However, dignity and autonomy of the suffering individual are clear and strong arguments that should outweigh the preventive arguments under Article 8.2.

While the House of Lords found no violation of any of the allegedly implied rights in *Pretty*, the ECtHR went further in its analysis of Article 8.

> The European Court reiterated the principle that the concept of 'private life' is a broad term not susceptible of exhaustive definition. It went on to provide an example of the extent to which the Convention is a living instrument that can respond to social change when it acknowledged the significance of considerations of 'quality of life' for the sick and dying.[346]

The difference in finding a violation of Article 8.1 (whether justified under 8.2 or not) is vital as this makes Article 14 applicable. While there are instances in which the Court finds a breach of Article 14 with no link to a violation of another right,[347] the Article has the limitation "that it does not contain an independent prohibition of discrimination".[348] A general prohibition of discrimination is guaranteed by Protocol 12 to the ECHR, whereas Article 14 is concerned with the prohibition of discrimination in the context of the other rights encompassed by the ECHR. The discrimination claim concerns Section 2 of the Suicide Act 1961 which prevents disabled people from committing suicide in prohibiting assisted suicide. However, as

[344] Morris (n 44), 78.
[345] See application no. 2346/02, [74]-[78].
[346] 'Case Comment. Health Care: Refusal of DPP to Undertake not to Prosecute Applicant's Husband if he Assisted Applicant's Suicide' (2002) 5 *European Human Rights Law Review* 686, 688.
[347] See Alastair Mowbray, *Cases, Materials, and Commentary on the European Convention on Human Rights* (3rd end, OUP 2012), 815-18. Article 14 furthermore is open-ended in that any discrimination ground can be considered under it by the Court. See Oddný Mjöll Arnardóttir, 'The Differences that Make a Difference: Recent Developments on the Discrimination Grounds and the Margin of Appreciation under Article 14 of the European Convention on Human Rights' (2014) 14 *Human Rights Law Review* 647: "It follows that the Court has traditionally exhibited a certain openness and indifference towards the 'precise [sic] definition of protected discrimination grounds". ibid, 665-66. However, "'equality before the law' situations are often simply related to arbitrary miscarriages of justice and not to any pre-identifiable personal characteristics or group memberships". ibid, 666.
[348] Mowbray, *Cases, Materials, and Commentary* (n 347), 839.

long as the restriction of Article 8.1 is seen as justified under 8.2, the discrimination claim cannot be evoked and is therefore of no use for the applicant.

In *Koch*, the Court did find a procedural violation of Article 8. While it can be claimed that this was an "incremental progression in the law of assisted suicide",[349] it is also a "hollow victory"[350] in that the Court rejected the claim to a right to access of deadly medication. "With Strasbourg deferring to Member States and domestic courts deferring to the legislature, the developments of this area of law may inevitably have to come from parliamentarians, not the courts".[351]

Before having been declared inadmissible, *Gross* was the first and so far only case to find a violation of Article 8 in a State's regulation of assisted dying in that Switzerland's law was found to not be clear enough. According to Black, this was not a very convincing finding in that the law was clear in reacting with prosecution to incidents of physician assisted suicide if the individual was neither terminally ill nor suffering of a mental disorder.[352] With bringing the case, Ms Gross jeopardised her access to physician assisted suicide. "Thus, in gaining clarity, Ms Gross may have given up a somewhat nebulous, yet exercisable, right to PAS [physician assisted suicide]".[353] While there might be some truth in Black's claim, what he suggested – leaving the law vague in order for people to have access to physician assisted suicide in a nebulous legal void – cannot be the ideal situation. In order to achieve a general right to die, the legal situation has to be as clear as possible. As was stated in another case comment, while the ECtHR did not directly rule on whether Ms Gross should have had access to medication ending her life, "in expressing the view that this was 'primarily' a matter for the domestic authorities, the majority clearly do not exclude the possibility of the Court ruling on the issue at some point in the future".[354]

On the right to assist, which according to Livings is a corollary of the right to die, there is hardly any jurisprudence so far, the issues being for

[349] 'Case Comment. Assisted suicide: Paralysis – Decision to Commit Suicide', (2012) 6 *European Human Rights Law Review* 701, 703.
[350] ibid.
[351] ibid, 704.
[352] See Isra Black, 'Existential Suffering and the Extent of the Right to Physician-Assisted Suicide in Switzerland' (2014) 22 *Medical Law Review* 109, 116.
[353] ibid, 117.
[354] 'Case Comment. Assisted suicide: Applicant Not Suffering From a Serious Illness', (2013) 5 *European Human Rights Law Review* 549, 551.

the first time considered in depth in the case of *Pretty*.[355] Yet, *Pretty* does not resolve all the issues around assisted suicide. "The legality of the blanket ban on assisted suicide is therefore still open to question, and quality of life now falls squarely within the protection of Article 8 even though the interference with that right was found to be justified on the present facts",[356] which remained to be the Court's approach in all following assisted dying cases.

3.2.3. Discrimination

Discrimination can either occur in treating alike things differently or treating different things alike. Law can be discriminatory in that "applying the same law to all amounts to failing to treat differently persons whose situations are significantly different".[357] By not differentiating between those who can and those who cannot commit suicide, the State discriminates against people who are impaired in a way that prevents them from committing suicide without assistance. Suicide is exempt from punishment across Europe today.[358] Since assisted suicide and assisted dying remain prohibited in most countries, without a right to die people unable to commit suicide are forced to continue with their lives. This can be argued to turn the right to life into a duty to live for those severely impaired. However, the question is whether it really can be argued that the absence of a right (here: to die) automatically turns into the duty concerning the opposite (here: to live). It seems logical in this scenario but cannot be a generalised statement about law. If there was no expressed right to marry it would not mean that everyone had a duty to stay unmarried, but simply that one could not make a legal claim if refused the marriage they wanted. Still, the absence of a right to die creates a *de facto* duty to live for those unable to end their lives without help. While evaluating criteria as to whom should be eligible for assistance in dying is one of the harder tasks in drafting legislation, the current situation is unfavourable in that the absence of a right to die and the illegality of assisted dying discriminate against individuals unable to commit suicide unaided.

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[355] See Ben Livings, 'A Right to Assist: Assisted Dying and the Interim Policy' (2010) 74 *Journal of Criminal Law* 31, 34.
[356] Claire de Than, 'No Convention Right to Die' (2002) 66 *The Journal of Criminal Law* 320, 324.
[357] Antje Pedain, 'The Human Rights Dimension of the Dianne Pretty Case' (2003) 62 *Criminal Law Journal* 181, 198.
[358] The country taking longest to change its laws was Great Britain. See Lieven Vanderkerckhove, 'The Decriminalization of Suicide in 18th-Century Europe' (1998) 6 *European Journal of Crime, Criminal Law and Criminal Justice* 252, 266.

Even though human rights clearly encompass all human beings, people with impairments need special protection by the law, which has, for example, been recognised in the form of the United Nations Convention on the Rights of Persons with Disabilities of 2006 (CRPD). While it reaffirms the inherent dignity and equality of persons[359] it also stresses that equality can ask for special measures in order to enable the equal enjoyment of rights.[360] One could argue that for the equal enjoyment of rights the accessibility of death should also be guaranteed. Since able-bodied persons are free to commit suicide, impaired persons should receive special measures to have the same freedom. Article 9 CRPD means to ensure for "persons with disabilities to live independently and participate fully in all aspects of life". Dying clearly is a part of life. Therefore, based on this Article, impaired persons could argue that they should have a right to gain access to suicide. Should the ECtHR ever rule that Article 2 ECHR includes a right to die, that would automatically give a right to die to persons with an impairment. This would be reinforced by Article 10 CRPD, which reaffirms an equal right to life of everyone.

Also of interest is Article 15 CRPD which guarantees freedom from cruel, inhuman or degrading treatment. In *R.R. v Poland* the ECtHR ruled that an absence of treatment can lead to suffering which reaches the minimum threshold of Article 3.[361] If the absence of treatment can be cruel treatment to be condemned, then the absence of a way to die in dignity should be seen as equally cruel, which asks for accessibility of death. In conjunction with Article 17, which protects physical and mental integrity, these Articles can be taken as an argument for a right to assistance for people who are unable to commit suicide.

The discrimination concerning help in dying not only takes place between the able-bodied and the physically impaired but also in connection with mental suffering opposed to physical suffering, as can be seen in *Haas.* The impossibility of people to get assistance in committing suicide when suffering mentally is a problematic aspect of assisted suicide. While Dignitas in Switzerland provides help for those suffering of an incurable physical illness, it does not help people with mental illnesses.[362] Generally,

[359] See CRPD 2006, Article 3 and 5.
[360] See ibid, Article 5.4.
[361] See application no. 27617/04, 26 May 2011 [161].
[362] As it says on the webpage: 'Anyone suffering from an illness which will lead inevitably to death, or anyone with an unendurable disability, who wants voluntarily to put an end to their life and suffering can, as a member of DIGNITAS, request the association to help them with accompanied suicide'.
http://www.dignitas.ch/index.php?option=com_content&view=article&id=22&Itemid=5&lang

opponents to assisted suicide claim that the wish to die is often based on mental suffering, for example depression, and that if that mental disorder was treated properly, no one would wish to die.

In a case comment, the obligation of States concerning the possibility and maybe even facilitation of suicides was highlighted.

> Both *Pretty* and *Purdy* are couched in terms of the negative obligation not to interfere with the right to self-determination. In *Haas v Switzerland* the Court confirmed this negative obligation, but left open the question of whether States have a positive obligation under art.8 to adopt measures facilitating a dignified suicide.[363]

Yet, since there is no European consensus on the issues surrounding a dignified death "any such positive obligation is far from being affirmed".[364] According to Black's case comment, *Haas* gave clarity in respect of assisted suicide in cases of mental illnesses. "However, greater legal certainty for physicians may come at a cost to individuals seeking suicide assistance".[365] Furthermore,

> the procedure developed in *Haas* is problematic insofar as mentally disordered individuals are subject to measures not imposed on individuals with somatic conditions. Individuals with somatic illness are not required to demonstrate that the wish to die is authentic--no distinction is made between the individual and the condition.[366]

One problem of the wish to die of someone with a mental illness is that the illness is not itself lethal and might be curable, if not now then maybe in the foreseeable future. So if assistance would be granted to people wishing to commit suicide due to a mental illness, it could easily lead to an increase of suicides of depressed people who might be able to be cured at some later stage or at least might find some joy in their lives again.

The question is how competent a mentally ill person is to decide to end his or her life, how much mental illness takes away from the capacity to make such a choice.[367] The term 'mental illness' covers a broad range of

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=en, accessed 19 April 2012 at 11.55am and further in the FAQ section: '**Q**: I suffer from a mental illness and/or psychological problems. Can Dignitas arrange an accompanied suicide for me?
A: No. The Swiss law and Swiss psychiatrists are not yet sufficiently positive on this', http://www.dignitas.ch/index.php?option=com_content&view=article&id=69&Itemid=136&lang=en, accessed 19 April 2012 at 12.15pm.

[363] 'Case Comment. Assisted suicide: Suicide Drugs Available only on Prescription - Sufferer from Bipolar Affective Disorder' (2011) 3 *European Human Rights Law Review* 348, 350.

[364] ibid.

[365] Isra Black, 'Case Comment. Suicide Assistance for Mentally Disordered Individuals in Switzerland and the State's Positive Obligation to Facilitate Dignified Suicide' (2012) 20 *Medical Law Review* 157, 164.

[366] ibid.

[367] The CRPD provides under Article 12.2 that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life". For an

conditions, which may be more or less severe, and not all of which will entail a lack of capacity. In particular, while it is often argued that a wish to commit suicide is to some extent connected to a depressive mind-set,[368] this claim should not function as devaluing the wish to die, especially keeping in mind the arguments concerning dignity and autonomy presented in chapter 2 which stress that assistance in dying should be available to every individual, based on the idea of relational autonomy and a dignified death. If an individual with a mental illness wanted assistance in committing suicide, the safeguards would be an even more problematic issue than with physical illness, as the question would be how much the illness influenced the capacity in reaching the decision. Yet, assisted dying should generally be available as well to such a person if he or she has been able to make an informed decision.

3.2.4. Rights vs. Liberties

Even if there is no right to commit suicide for anyone, able-bodied persons do have the liberty to commit suicide.[369] Pedain did see it as being unfortunate that Mrs Pretty's counsel referred to a right instead of a liberty. "Nevertheless, what matters is that most of us can in reality exercise our liberty to commit suicide while those who lack a sufficient degree of physical mobility to kill themselves unaided cannot".[370] Pedain introduced a further thought on *Pretty* by stating that a naturalist approach[371] towards the case would be that it was fate that restricted Mrs Pretty's liberty.[372] However, it is not fate that diminished her liberty but law.

> It is the law which makes what would otherwise be a private interaction between responsible individuals a matter for public authorities to interfere with. It is the law which, by restraining others

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analysis of capacity under the URPD see for example Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 *The Modern Law Review* 752, who points out that having one's capacity acknowledged is an aspect of keeping one's autonomy. See ibid, 765.

[368] See for example the submission of the Catholic Bishops' Conference of England and Wales in *Pretty*, application no. 2346/02 [31].

[369] See Pedain, 'The Human Rights Dimension of the Dianne Pretty Case' (n 357), 196-97.

[370] ibid, 197.

[371] Natural law, as opposed to positive law claims that laws originate in our human nature. Based on this idea each and every human being should have the same rights. According to Finnis, human rights are a synonym for natural rights (see John Finnis, *Natural Law and Natural Rights* (2nd edn, OUP 2011), 198. Finnis referred to Hohfeld's distinction between liberties and duties, according to which a liberty of A does not impose a duty upon B, while a claim-right of A would correlate with a duty of B (see ibid, 200). Since there is no right to commit suicide under English law (or European human rights law for that matter), but only a liberty, this would mean that Mrs Pretty had no valid claim to make that would have resulted in a duty to assist her in committing suicide.

[372] See Pedain, 'The Human Rights Dimension of the Dianne Pretty Case' (n 357), 183.

> from acting at her behest, constrains her freedom to carry out the choice she has made.[373]

Pedain then went on to consider the Hohfeldian differentiation between a right and a liberty: "[W]hat Mrs. Pretty wants to have is not a right to commit suicide (which would impose a corresponding duty upon others to refrain from saving her from death), what she wants is to be at liberty (in the Hohfeldian sense) to commit that act".[374] According to Pedain, the absence of a right to die did not validate the right to life but instead imposed a duty to die naturally.[375] "Neither the right to life, nor the right to be free from inhuman and degrading treatment, nor the right to freedom of conscience, at present appear to have the sort of scope within which could be brought a right to assisted death".[376] As long as there is no right to commit suicide but only the liberty to do so, it is a death that remains restricted to those who are physically able to commit suicide without assistance.

3.2.5. 'Slippery Slope' Argument

In *Pretty*, the discrimination between able-bodied and impaired individuals was seen as being justified based on a 'slippery slope' argument.[377] In a case comment regarding *Pretty,* Keown claimed that the decision by the Court was correct since granting Mrs Pretty a right to die would easily lead towards too liberal approaches regarding assisted dying.[378] In order to prevent cases of involuntary assisted dying, all sorts of active assistance in dying were to be prevented. The danger in permitting assisted suicide was also stressed by Pedain who claimed that "the prohibition [of assisted suicide] is meant to protect vulnerable persons from acting upon a death wish which might be merely transitory in nature, induced by third parties, or related to personal conditions affecting the validity of individual judgments".[379] Allowing for assisted suicide would weaken the protection of vulnerable persons. However, Pedain further stated that allowing for competent but physically impaired persons to receive assistance in committing suicide might not run contrary to the sanctity of life principle. "The reason why we ought to respect [Mrs

[373] ibid*,* 184.
[374] ibid*,* 187.
[375] ibid*,* 204.
[376] See Morris (n 44), 91.
[377] See Pedain, 'The Human Rights Dimension of the Dianne Pretty Case' (n 357), 200.
[378] John Keown, 'Case Comment. No right to assisted suicide' (2002) 61 *Cambridge Law Journal* 8, 10.
[379] Antje Pedain, 'Case Comment. Assisted suicide and Personal Autonomy' (2002) 61 *Cambridge Law Journal* 511, 512.

Pretty's] choice is the same reason that makes us respect the choice of able-bodied persons to commit suicide: not that it is *the right* choice, but that it is *her* choice".[380] Slippery slope arguments like this one are not totally unjustified, as legalisation can always lead to abuse. However, the argument should not be used to prevent desirable and progressive change but to make sure relevant safeguards are in place to prevent abuse.

3.2.6. Changing National Legislation

While in Switzerland, responding State of the cases *Haas* and *Gross*, assisted dying has been legalised to some extent, this is not the case for the two other responding States, England and Germany. Therefore, arguments can be brought forward that the cases show that national law needs changing.

According to Freeman, the Court in *Pretty* came to the only conclusion possible by following the current law.[381] "Were the Law Lords to have held in Mrs Pretty's favour (or the European Court to have done so), there would have had to have been legislation".[382] Freeman saw the danger in legalising assisted suicide in the possibility of abuse. "Whether there would be abuse cannot be determined: that there is a concern that there would be abuse is clear".[383] Instead of ending all discussion at this point, as a slippery slope claim often does, he suggested a 'Death with Dignity Act' that would have to lay down in detail what has to be fulfilled before someone was granted assistance in committing suicide. For example, it should be restricted to competent individuals over 18, who are suffering from a terminal, unbearable and irreversible physical illness. The request should be done in writing and witnessed by two independent witnesses who are neither family members nor the doctors involved in the treatment of the patient.[384] With requirements like this Freeman claimed most abuse could be avoided while being realistic: "These safeguards would eliminate most abuse. No safeguards could eliminate all".[385]

While this is a valid point, it must be seen that in England various attempts have been made over the previous years to change the law. As will be highlighted in chapter 4.4. below, a number of Assisted Dying Bills have been introduced into the House of Lords. What also is considered by

[380] ibid, 514.
[381] See Freeman (n 32), 270.
[382] ibid, 264.
[383] ibid, 268.
[384] See ibid, 268-69.
[385] ibid, 269.

academics in connection to *Pretty* is the appropriateness of the Suicide Act 1961. According to Morris, Section 2 of the Suicide Act, which prohibits assisted suicide and thereby limits the scope of Article 8 ECHR, is disproportionate, *inter alia* because of the importance of the rights at stake and the lack of evidence that there would be any threat to vulnerable groups if the law were to be changed.[386] According to Livings, the exact scope of that Section was unclear.[387]

Section 2 of the Suicide Act was also criticised by Tur who claimed that

> the blanket prohibition in subsection 2(1) taken on its own is indeed much too wide, 'over-broad' or 'disproportionate' and subsection 2(4) [which states that 'no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions'] which might otherwise cure the defect of subsection 2(1) by qualifying it, is too vague, inaccessible, incomplete, or imprecise.[388]

While stating that the underlying principle of the Suicide Act is neither clearly autonomy and self-determination nor sanctity of life,[389] Tur stated that "in the *Pretty* appeal all the judges […] applied section 2(1) so rigidly as to deny justice".[390] In general, Tur claimed that

> section 2 of the Suicide Act should be reformed in the interests of transparency and fairness, or at the very least, the Director [of Public Prosecutions] should promulgate a criterial policy in order to give citizens fair and reasonable notice of the legal consequences of their conscientiously chosen conduct.[391]

What this demonstrates is that not just the ECtHR's approach towards assisted dying needs changing. As will be seen below, with ideas of subsidiarity and the thereupon applied margin of appreciation, it is vital that national law changes first in order for the ECtHR to then be able to adopt a more positive approach towards active assisted dying.

3.2.7. Concluding Remarks

As was seen, neither Article 2 nor Article 8 ECHR are being interpreted by the ECtHR as to include a right to die. This leads to the discriminatory situation of those capable of committing suicide unaided being able to end their lives, while those needing assistance are required to continue living.

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[386] See Morris (n 44), 90.
[387] See Livings (n 355), 34.
[388] Richard Tur, 'Legislative Technique and Human Rights: The Sad Case of Assisted Suicide' [2003] *Criminal Law Review* 3, 4.
[389] ibid*,* 5.
[390] ibid*,* 7.
[391] Ibid*,* 12.

Even though it can be claimed that no one has the right to kill themselves but only the liberty to do so, the absence of a right to die causes a *de facto* discriminatory situation. While there is a fear of a slippery slope once assisted dying became a legal possibility, proper safeguards should be able to prevent this. A change in national legislations is needed for the Court to be able to take a more favourable stance concerning assisted dying and a right to die.

3.3. Margin of Appreciation

Anyone turning to the ECtHR for answers about a possible right to die will be disappointed. That disappointment is largely brought about due to a concept the Court tends to apply in cases concerning such highly sensitive questions: the margin of appreciation. A brief analysis of said concept therefore seems apt, to find out whether the use of the margin in assisted dying cases is justified.

The margin of appreciation is a recurring element in the judgments of the ECtHR.

> The justification of the doctrine has a sound basis and the margin of appreciation has a role in the decision making of an international tribunal. Even within the framework of human rights there is room for manoeuvre for governments and national courts […] However, the current inflation of the use of the margin only diffuses the concept and undermines its rationale. […] Yet, it must be admitted that with the surreal amount of cases that the Court processes it is probably too much to expect absolute consistency.[392]

When applying the margin, the Court refrains from making a judgment on the matter involved and instead leaves it to the State to resolve the issue. The margin is by some commentators seen as a useful and justified tool, by others it is seen as doing more harm than good.

The margin of appreciation finds no mention in the ECHR itself, instead "[t]he role played by the margin has developed over a period of at least twentyfive years".[393] Its first use dates back to *Lawless v Ireland* in 1960,[394] while its origin is often seen to be *Handyside v United Kingdom*[395] 16 years later.[396] "The doctrine started as a doctrine of deference to

[392] Jan Kratochvil, 'The Inflation of the Margin of Appreciation by the European Court of Human Rights' (2011) 29 *Netherlands Quarterly of Human Rights* 324, 357.
[393] James Sweeney, 'Margins of Appreciation: Cultural Relativity and the European Court of Human Rights in the Post-Cold War Era' (2005) 54 *International and Comparative Law Quarterly* 459, 467.
[394] Application no. 332/57, 1 July 1961.
[395] Application no. 5493/72, 7 December 1976.
[396] See Michael Hutchinson, 'The margin of Appreciation Doctrine in the European Court of Human Rights' (1999) 48 *International and Comparative Law Quarterly* 638, 639.

national authorities in evaluating whether concrete factual circumstances fitted a definition in the Convention".[397] Mowbray referred to Mahoney who was of the opinion that "the origins of the concept are found in the basic philosophical values embodied in the Convention system",[398] those being evolutive interpretation, subsidiarity, democracy and cultural diversity.[399]

Traditionally, the margin of appreciation was applied in respect of Article 15, out of which the doctrine originated, but over the years the application got extended to further articles. "The case-law shows examples particularly with respect to the condition 'necessary in a democratic society' contained in paragraph 2 of Articles 8-11".[400] It can be seen as coming from classical French martial law and the jurisprudence of the Conseil d'Etat.[401] While Article 15 generally receives the widest margin of appreciation, Articles 5 and 6, to which an application of the margin has extended by now, receive a narrower margin, which can be seen in the fact that they are drafted in much more detail than Article 15.[402] As can be seen in the analysis of cases concerning assisted dying, the Court today even applies the margin in relation to issues under Article 2.

"The doctrine of margin of appreciation illustrates the general approach of the European Court of Human Rights to the delicate task of balancing the sovereignty of Contracting Parties with their obligations under the Convention".[403] The ECHR has the purpose of granting a set of basic rights to all the individuals of the Member States. "On any reading of the text of the Convention it is plain that its underlying object and purpose is to protect human beings - their existence, their integrity, their dignity, their liberty and their autonomy".[404] According to Costa, "[e]ffectiveness is the golden thread running through the fabric of the Strasbourg case-law".[405] The effectiveness in protecting human beings does ask for some element of flexibility in the application of rights. The Court does not see its role as

[397] Kratochvil (n 392), 329.
[398] Mowbray*, Cases, Materials, and Commentary* (n 347), 635-36.
[399] See ibid*,* 636.
[400] Anne Marie von Luttichau, 'What Is the Meaning and Effect of the Principle of "Margin of Appreciation" within the Jurisprudence of the European Convention on Human Rights? Is this Principle Compatible with the Concept of Effective Protection of Rights?' (1994) 26 *Bracton Law Journal* 99, 99.
[401] See Jeffrey Brauch, 'The margin of appreciation and the jurisprudence of the European Court of Human Rights: threat to the rule of law' (2004) 11 *Columbia Journal of European Law* 113, 116.
[402] See ibid*,* 120.
[403] R. Macdonald, 'The Margin of Appreciation' in R. Macdonald et al (eds) *The European System for the Protection of Human Rights* (Martinus Nijhoff Publishers 1993) 83, 83.
[404] Jean-Paul Costa, 'On the Legitimacy of the European Court of Human Rights' Judgments' (2011) 7 *European Constitutional Law Review* 173, 177.
[405] ibid.

legislator[406] but rather as a guardian over the application of the rights laid down in the ECHR. To enable the needed flexibility the margin of appreciation functions in setting the relationship between the individual State and the Convention rights.[407]

According to Sweeney, a further element of the margin is that it "expresses that Contracting Parties have some space in which they can balance for themselves conflicting public goods".[408] Therefore, the margin is mainly applied in cases concerning Articles 8-11 which involve the task of "balancing the need to protect a Convention right against some legitimate reason for restricting it, such as the need to protect morals".[409] However, Sweeney saw a problem in not setting a standard for the margin, as that can run counter to the idea of universality of human rights.[410] According to Hutchinson, the margin was causing some weakness in the functioning of the Court: "Reliance on the margin of appreciation is an announcement of deference, and not coherent jurisprudential principle".[411] Still, if it functions in well-defined limits, it can be "a valuable tool for recognising and accommodating limited local variations within a nevertheless universal model of human rights".[412]

Letsas saw two different uses of the margin of appreciation. First, in answering

> whether a particular interference with a Convention freedom is justified […] [and second] in cases where the Court refrains explicitly from employing a substantive test of human rights review on the basis that there is no consensus among Contracting States.[413]

The controversies around the margin were due to the "Court's failure to distinguish between those two ideas in its case law".[414] In dividing the structural and the substantive use of the margin, Letsas claimed that "the structural concept of the margin of appreciation should be completely abandoned".[415]

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[406] See Kanstantsin Dzehtsiarou 'Does Consensus Matter? Legitimacy of European Consensus in the Case Law of the European Court of Human Rights' (2011) July *Public Law* 534, 543, referring to *Johnston v Ireland* (application no. 9697/82).
[407] See Costa (n 404), 180.
[408] Sweeney (n 393), 462.
[409] Hutchinson (n 396), 640.
[410] See Sweeney (n 393), 462.
[411] Hutchinson (n 396), 649.
[412] Sweeney (n 393), 474.
[413] George Letsas, 'Two Concepts of the Margin of Appreciation' (2006) 26 *Oxford Journal of Legal Studies* 705, 705.
[414] ibid*,* 706.
[415] See ibid*,* 732.

According to Brauch, the margin of appreciation threatened the rule of law, which it is the Council of Europe's task to protect.[416] Feingold did not go that far in her evaluation of the margin but saw it as a threat to the effectiveness of the ECHR.[417] An explanation she came up with for the use of the margin was the Court's "natural reluctance […] to find a Member State in breach of the Convention".[418]

Arguments in favour of the use of the margin are the principle of subsidiarity, which implies that the ECtHR is not a fourth instance, and the pluralism among Member States to the ECHR. Arguments against the margin are its vagueness and the universality of human rights. To Macdonald, the scope of the margin cannot be clearly defined, as it is dependent on the context and therefore changing from case to case.[419] However, the margin finds justification in the lack of a European consensus regarding certain issues.

3.3.1. Subsidiarity

The major argument in favour of the application of the margin of appreciation is that of subsidiarity.[420] "The principle of subsidiarity is generally understood to mean that in a community of societal 'pluralism' the larger social unit should assume responsibility for functions only insofar as the smaller social unit is unable to do so".[421] The principle serves to ensure a working relationship between the ECtHR and the Member States.

> The margin of appreciation gives the flexibility needed to avoid damaging confrontations between the Court and Contracting States over their respective spheres of authority and enables the Court to balance the sovereignty of Contracting Parties with their obligations und the Convention.[422]

The ECtHR is not a court of appeal for the Member States, it does not function as a fourth instance above national Courts. "The ECtHR has argued in case law that it must *defer* to the national authorities whenever they are *'better placed'* than an international judge to decide on human

[416] See Brauch (n 401), 115.
[417] See Cora Feingold, 'The Doctrine of Margin of Appreciation and the European Court of Human Rights' (1977) 53 *Notre Dame Lawyer* 90, 91.
[418] ibid*,* 105-106.
[419] See Macdonald (n 403), 85.
[420] For an analysis of the principle of subsidiarity see Alastair Mowbray, 'Subsidiarity and the European Convention on Human Rights' (2015) 0 *Human Rights Law Review,* 1.
[421] Herbert Petzold, 'The Convention and the Principle of Subsidiarity' in R. Macdonald et al (eds) *The European System for the Protection of Human Rights* (Martinus Nijhoff Publishers 1993), 41.
[422] Macdonald (n 403), 123.

rights issues raised by the applicant's complaint".[423] Also, the main actors in guaranteeing the enjoyment of human rights are the States, therefore, the States' courts are the main fora to deal with violations. This aspect can be found in Article 35 which demands the exhaustion of domestic remedies before a case can be brought before the ECtHR.[424] "The task of the European Court of Human Rights is to ensure observance by the states parties - governments, parliaments, courts - of their engagements under the Convention and the Protocols".[425] Under the heading of subsidiarity, "[t]he margin of appreciation then is more a matter of who takes the decisions, rather than what those decisions might be".[426] This is not merely an expression of unwillingness of the Court to get involved but, according to von Luttichau, has both practical reasons and is founded in the wish of the Member States.[427]

Just like the margin of appreciation itself, subsidiarity finds no mention in the original text of the ECHR. "Although the principle of subsidiarity does not expressly appear in the text of the Convention, it underpins the whole treaty".[428] For Petzold, the principle can be seen in Article 53 ECHR (which until Protocol 11 of 1998 was Article 60) which states that "[n]othing in this Convention shall be construed as limiting or derogating from any of the human rights and fundamental freedoms which may be ensured under the laws of any High Contracting Party or under any other agreement to which it is a Party".[429] Furthermore, the principle will be added to the preamble once all the Contracting Parties have ratified Protocol 15.[430] The margin of appreciation often finds application in cases where the Court has carried out a comparative study and comes to the conclusion that no consensus exists. This "comparative exercise protects the Court from charges of overreaching political activism. It thus helps maintain the viability of the system".[431] The subsidiarity of the Convention system is based on three factors, according to Petzold:

> the Convention is not exhaustive […,] the national authorities […] are generally in a better position than the supervisory European bodies to strike the balance between the interests of the community and the

[423] Letsas (n 413), 721, italics in original.
[424] See Costa (n 404), 179.
[425] ibid, 175.
[426] Hutchinson (n 396), 640.
[427] See von Luttichau (n 400), 99.
[428] Costa (n 404), 179.
[429] See Petzold (n 421), 43.
[430] CETS No 213, Strasbourg 24th June 2013.
[431] Paolo Carozza, 'Uses and Misuses of Comparative Law in International Human Rights: Some Reflections on the Jurisprudence of the European Court of Human Rights' (1998) 73 *Notre Dame Law Review* 1217, 1228.

> protection of the individual's fundamental rights […] [and] uniformity is not at all the concern of the Convention.[432]

This leads to the second argument in favour of the margin of appreciation, the pluralism of cultures and societies protected by the Convention.

3.3.2. Pluralism

As is apparent in its title, the ECHR is designed to protect human rights across the State Parties of the Council of Europe. "It is a very broad jurisdiction, potentially covering a population of 800 million".[433] The Court is not trying to press them all into one fixed set of rules. "The margin of appreciation is a clear expression of the fact that the Convention does not command or even aspire to strict uniformity throughout Europe in the protection of human rights".[434] The ECtHR is very aware of the differences present among the State Parties to the Council of Europe and accepts the present diversity. "States have nonetheless been required on many occasions to make certain adjustments to their systems, modifying rules or practices that were long deemed unproblematic until they were subject to the external scrutiny of the European Court".[435] But as Kratochvil claimed, democratic States can be given some discretion by international courts on the basis of them being democratic.[436]

This pluralism is not always seen as beneficial for the protection of human rights:

> Cultural relativists have argued that the concept of human rights is a western liberal idea and has no (or a different) value outside of the western context. They contend that universalists fail to understand their own enculturation and the resulting unconscious bias of their position.[437]

A general application of one set of rights among different societies is problematic. "It is unjustifiable to impose upon one society a system of social justice deriving from another".[438] Yourow not only saw a huge diversity among European States which enriches the landscape. "The long history of national rivalry and warfare – and of a multitude of North/South and other regional centrifugal pulls within nations – emphasizes a non-

[432] Petzold (n 421), 60.
[433] Costa (n 404), 175.
[434] ibid, 180.
[435] ibid.
[436] See Kratochvil (n 392), 327.
[437] Sweeney (n 393), 460.
[438] ibid.

integrated Europe".[439] This multitude makes the margin of appreciation doctrine necessary.[440]

Due to the difficulties posed by the pluralism of States, the margin of appreciation can be seen as a helpful tool in accommodating the different cultures and backgrounds in granting the States some leeway in the realisation of their obligations under the ECHR. "Human rights are *generally universal,* but in becoming embedded in society some local particularities affect the substantiation of human rights and result in *specific qualifications*".[441] The differences among States are on many diverse levels, one level which often leads to the application of the margin of appreciation is that of the national concept of morals. "The margin of appreciation doctrine is a structured, meaningful, but ultimately conditional recognition of Contracting Parties' complex thickly constituted morality".[442] In this respect, national judges are seen to be in a better position to evaluate the situation than the international judges of the ECtHR.[443] This idea was for example evoked by the State in *Koch v Germany*, where Germany claimed that the ECtHR had no power to determine Koch's wife's right to die since limiting the freedoms under Article 8 was up to the State's perception of what is necessary in a democratic society. In this case the State claimed that it is a highly ethical issue which, due to the history of Germany, should lead to a broad margin of appreciation.[444] Concluding, a multitude of differences among European States make a margin of appreciation necessary: cultural and historical differences, different ideas of morals, but also general differences in legal systems.[445]

3.3.3. Vagueness

A major problem with the margin of appreciation is its vagueness. As it has not been laid down in the Convention yet (though it will be added to the Preamble in due course by Protocol 15), its application seems to appear on an at times arbitrary level. In addition, the width of the margin varies from case to case. Due to these two factors, Hutchinson claimed there was incoherence in the judgments of the ECtHR.[446] Hutchinson further argued that in cases where the Court applied a margin of

[439] Howard Charles Yourow, *The Margin of Appreciation Doctrine in the Dynamics of European Human Rights Jurisprudence* (Martinus Nijhoff Publishers 1996), 4.
[440] ibid*,* 6.
[441] Sweeney (n 393), 471, italics in original.
[442] ibid*,* 474.
[443] See von Luttichau (n 400), 101.
[444] See application no. 497/09, 19 July 2012.
[445] See Petzold (n 421), 58.
[446] See Hutchinson (n 396), 641.

appreciation the general norm that was at stake remained unarticulated because otherwise "the Court would find itself in the position of having to say that the 'best' interpretation was one particular approach, but that the margin was wide enough to cover also the different approach taken by the State".[447] However, by not articulating its reasoning, "[t]he margin of appreciation obscures this important distinction between an unreviewable decision and a justifiable one by preventing the articulation of the court's reasons for not intervening in the decision".[448]

According to Lavender, "[t]he principal objection to the 'margin of appreciation' is that it introduces an unwarranted subjective element into the interpretation of various provisions of the European Convention on Human Rights".[449] The variable width of the margin according to von Luttichau was inevitable since cases involving the same right have different backgrounds, therefore, the reaction of the Court can also be different.[450] Still, the lack of definition of width and of circumstances for the application of the margin pose a problem. "We have no prior theory of what falls within the States' margin of appreciation, which we can use to find out what State acts (or omissions) amount to a violation".[451]

3.3.4. Universality of Human Rights

Another problem of the margin is its opposition to the universality of human rights. "The judicial output of the ECHR and the other international bodies carries the promise of setting universal standards for the protection and promotion of human rights".[452]

No matter the variety of States and the pluralism of cultures and societies in Europe, "the clearly articulated consensus among European States is to ensure and sustain the effectiveness of the Convention system".[453] According to Sweeney, the presence of diversity could not be the justification for any interpretation, as that would mean deriving an 'ought' from an 'is'.[454] "A normative proposition such as 'we ought to tolerate diverse cultures' can not be inferred from a purely factual

[447] ibid, 645.
[448] Rabinder Singh, 'Is There a Role for the "Margin of Appreciation" in National Law After the Human Rights Act?' (1999) 1 *European Human Rights Law Review* 15, 21.
[449] Nicholas Lavender, 'The Problem of the Margin of Appreciation' (1997) 4 *European Human Rights Law Review* 380, 380.
[450] See von Luttichau (n 400), 101.
[451] Letsas (n 413), 713.
[452] Eyal Benvenisti, 'Margin of Appreciation, Consensus and Universal Standards' (1998) 31 *New York University Journal of International Law and Politics* 843, 843.
[453] Costa (n 404), 175.
[454] See Sweeney (n 393), 461.

statement such as 'there are diverse cultures'".[455] If every difference was to be accepted as an argument for diversion from the rights, culture would be "a state's untouchable 'trump card' reason for failing to comply (fully) with human rights standards".[456]

Brauch claimed that the Court's application of the margin of appreciation in respect of Articles 8-11 threatened the rule of law. This is interesting, as, while the margin serves to protect diversity, "[t]he rule of law is universally loved".[457] Thereby, if the rule of law finds general acceptance among Member States, it is questionable how the margin could threaten it. One should rather assume that both concepts can function together. The rule of law, together with democracy, serves to form Europe's appearance as a collective of free nations. "With the fall of communism in Eastern Europe in 1989, the world has turned to the rule of law – along with democracy and judicial independence – as the primary tools for rebuilding and reshaping the nations of the former eastern block".[458] According to Brauch, the threat the margin of appreciation poses towards the rule of law lies in the ECtHR's failure to uphold some basic elements – predictability, equality and non-arbitrarily – of the rule of law in the creation and application of the margin.[459]

> Margin of appreciation, with its principled recognition of moral relativism, is at odds with the concept of the universality of human rights. If applied liberally, this doctrine can undermine seriously the promise of international enforcement of human rights that overcomes national policies.[460]

3.3.5 Consensus

A further concept closely connected to the margin of appreciation is that of consensus. However, while regularly applying it, the Court has never defined what it understands under 'European consensus'.[461] "Consistent and coherent application of any legal concept is problematic if its scope remains unclear. Moreover, the court has not used a unified terminology".[462] According to Dzehtsiarou, consensus "is a legitimising tool,

[455] ibid.
[456] ibid.
[457] Brauch (n 401), 121.
[458] ibid, 122.
[459] ibid, 125.
[460] Benvenisti (n 452), 844.
[461] See Dzehtsiarou (n 406), 534.
[462] ibid, 541.

but […] its potential can be unlocked only if the court clearly states its meaning and application".[463]

On the surface, the application of consensus seems only logical. Since the ECHR intends to cover all of Europe, its provisions gain strength when all, or at least a clear majority, of the States agree on them. The argument can also be phrased the other way around.

> The approach of the European Court has been that the less consensus there is among Contracting States on whether something counts as a human rights violation, the better placed national authorities are to decide on the matter and the more deferential the European Court has to be in its review.[464]

However, "[t]he necessity for the consent has been increasingly questioned".[465]

The criticism of the use of European consensus can according to Dzehtsiarou be divided into two categories, procedural and substantive.[466] The procedural criticism concerns the way data is collected, claiming that the Court sometimes only collects favourable data.[467] However, the Court does have its own division, the Research and Library Division, that – if asked to do so by the Judge Rapporteur – carries out comparative studies which are said to be objective and competent.[468] "The impact of the Research Division can be clearly identified in the text of the judgments of the ECtHR. In recent judgments, the court has begun to include sections dealing with comparative law which cite relevant provisions of law of the Member States".[469] The substantive criticism claims that the presence or absence of consensus cannot legitimize a decision of the Court. "The critiques of the European consensus argument also emphasise that it undermines the aspirational role of the European Court".[470]

It should not be forgotten that consensus is only one tool in coming to a decision, and by no means the first one that finds application. According to Judge Rozakis, the Court applies a hierarchy of norms in finding a judgment, first of all the Convention itself, followed by existent case law, and only if these are not sufficient to form a judgment does the Court fall back onto European consensus.[471]

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[463] ibid, 534.
[464] Letsas (n 413), 722.
[465] Dzehtsiarou (n 406), 536.
[466] See ibid, 539.
[467] See ibid.
[468] See ibid, 549.
[469] ibid.
[470] ibid, 540.
[471] See ibid, 544.

The lack of consensus leads to a wide margin of appreciation. As mentioned earlier, the width of the margin is not defined. However, von Luttichau identified four areas that call for a wide margin: it is wider for establishing the facts of a case, in cases where economic and social issues are involved, when it comes to the positive obligations of the States and in areas that do not find consensus among Europe.[472] This was for example the case in *Vo v France* where the Court claimed that since there was no European consensus on the starting point of life, it would grant France a margin in determining that question.[473] Consensus was used in an opposed way in *Haas v Switzerland* where the margin was applied because the consensus within Europe contradicted the decision of one State, namely Switzerland. "It should be noted that 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. It follows that the States enjoy a considerable margin of appreciation in this area".[474] This is a rather unusual approach towards the margin since usually a consensus leads to the Court sticking to that – generally accepted – approach and does not usually apply a margin to let a State derive from that consensus.

According to Brauch, the imprecise, unpredictable and arbitrary application of consensus was very visible in the 16 years of cases concerning transsexuality in the UK.[475] "Unfortunately, […] a European consensus standard does not render the margin of appreciation doctrine more consistent with the rule of law. It, too, offers little analytical precision. It is not an effective predictor of how the court will resolve any particular case".[476]

Consensus can be seen as undermining the very idea of the universality of human rights. "Linking their [human rights'] requirements to the results of some comparison between states' national laws seems to deprive them of exactly the supranational status that they have achieved though [sic] international treaty".[477] Additionally, if one takes into consideration that the very norms of the Convention come from common traditions and are based on consensus, it becomes questionable why consensus again has to be taken into consideration in the judgments of the Court.[478] Still, the use

[472] See von Luttichau (n 400), 101-04.
[473] See application no. 53924/00, 8 July 2004, [82].
[474] Application no. 31322/07, [55].
[475] See Brauch (n 401), 139.
[476] ibid, 138.
[477] Carozza, 'Uses and Misuses of Comparative Law in International Human Rights' (n 431), 1218.
[478] See ibid, 1226.

of consensus can be grounded in the idea of subsidiarity of the ECtHR. "Since virtually all of the details of actual implementation of the Convention norms will thus be effected through national legal systems, the only way to adequately assess the compliance of any one domestic order is by reference to other domestic legal systems".[479]

The problem with consensus can again be linked to the pluralism within Europe. With the inclusion of Eastern European countries in the Council of Europe, finding a consensus on, for example, morally sensitive issues can be even more problematic than it was before their inclusion.[480] Notwithstanding the problems surrounding the idea of European consensus, "[t]he Court appears to be incorporating consensus as the law of the Convention".[481]

3.3.6 Concluding Remarks

The margin of appreciation finds application by the Court for various reasons and concerning a range of Articles. It finds its justification in the plurality of societies in Europe, the subsidiary role of the ECtHR and the lack of European consensus. However, the vagueness of the concept and the idea of universality of human rights make the use of it questionable. Especially a wide margin of appreciation has been criticised. "There certainly is the risk that too wide a margin of appreciation may cause an ineffective protection of the Convention's rights and freedoms and at the same time discourage the individual from making use of the system under the Convention".[482] Maybe the concept does not have to be eliminated completely since it does make sense in some areas. "But it ought to be possible for the Court to settle upon a reasonably workable framework which identifies the proper place of the "margin of appreciation", wide or narrow, in its reasoning".[483]

Carozza claimed that the misuse of the comparative approaches by the ECtHR can have serious consequences for the advance and respect of human rights, especially in areas concerning human dignity.[484] Furthermore, "[s]ome judges on the Court have themselves recognized

[479] ibid, 1227.
[480] See ibid, 1231.
[481] Yourow (n 439) 194.
[482] Von Luttichau (n 400), 106.
[483] Lavender (n 449), 390.
[484] See Carozza, 'Uses and Misuses of Comparative Law in International Human Rights' (n 431), 1233.

that making policy – not legal – decisions threatens the legitimacy of the court".[485]

A further criticism concerns the application to minor issues of the case. "The Court often invokes the margin unnecessarily because it decides the case on an issue unrelated to the doctrine".[486] This is problematic since "by invoking the margin, the Court avoids giving clear arguments as to why it interpreted the obligation in a certain way".[487] Especially in areas around the right to life one would wish for a more determined approach by the Court. After all, it is the human dignity that asks for the liberty to be master of one's own life.

"There are two ways for the Court to move forward from the current situation. It will either make the doctrine of the margin of appreciation history or it will develop it further and make good use of it".[488] How the Court can make good use of it remains to be seen, as it applies the margin in areas such as morals, where it is hard to find a more precise approach or more precise definitions. "But perhaps the Convention system is now sufficiently mature to be able to move beyond the margin of appreciation and grapple more openly with the questions of appropriateness which that device obscures".[489] Still, under Protocol 15, the margin will be positioned in the ECHR. As was stated in the Brighton Declaration[490] under B12: "[The Conference] [w]elcomes the development by the Court in its case law of principles such as subsidiarity and the margin of appreciation, and encourages the Court to give great prominence to and apply consistently these principles in its judgments".

3.4. Overall Conclusion

The cases so far considered by the ECtHR concerning a right to die show that no such right exists in the view of the Court. As was stated in *Pretty*, Article 2 is not concerned with the quality of life or individual choices concerning one's life. And while Article 8 does, at least to some extent, cover the quality of life, it can be limited by States, which is often seen as justified when it comes to death. While individuals have the liberty to commit suicide and in some jurisdictions have the possibility to request

[485] Brauch (n 401), 148.
[486] Kratochvil (n 392), 336.
[487] ibid, 336-337.
[488] ibid, 354.
[489] Macdonald (n 403), 124.
[490] http://www.echr.coe.int/Documents/2012_Brighton_FinalDeclaration_ENG.pdf.

passive and indirect assisted dying, there is no way to lawfully claim assistance in committing suicide under the Convention. This very clearly demonstrates a discriminatory aspect in law. While able-bodied persons can end their lives without facing punishment if failing, disabled individuals unable to commit suicide unaided have to wait for a natural death or travel to jurisdictions that permit assisted suicide. This can, as was the case for Mrs Pretty, lead to a prolonged and painful dying which prompts the conclusion that rights like those to privacy (Article 8) and to freedom from inhuman and degrading treatment (Article 3) should taken together lead to a right to die.

The ECtHR has been unwilling to interpret Article 2 so as to include a right to die as the Member States do not agree on the issue. As was seen under 3.3. above, the Court relies on the margin of appreciation in areas where there is no consensus among Member States. It refuses to set a precedent in formulating a right to die. What the Court still could do, however, is review its approach towards discrimination. If an able-bodied person can lawfully perform an action, a disabled person should receive lawful assistance in performing the same action. Additionally, the approach towards mental illnesses should be reconsidered. In a case like *Haas*, the impossibility to receive assistance because the suffering is mental and not physical can also be seen as discriminatory. Though mental illness might lack the terminal element, this does not mean that the suffering is not severe enough to lead to a wish to die, especially if there is no improvement of the condition in sight. However, since a mental illness can make the assessment of the capacity to give informed consent difficult, it is comprehensible why jurisdictions allowing for assisted suicide refuse to make assisted suicide available to persons suffering from mental illnesses.

As was demonstrated in chapter 2, dignity and autonomy are vital factors in considering the need for a right to die. Yet, as shown in this chapter, the Court does not truly engage with these concepts. This might be due to the fact that dignity is a very difficult notion to pin down (see above 2.3). With the Court's aim for consensus and uniformity it is comprehensible, though not desirable, that the Court does not stress these ideas more strongly in considering claims for assistance in dying. Still, it would be especially beneficial since the Court does take autonomy and dignity to be important concepts underlying the Convention, which would make a more rigorous approach legitimate.

While suicide has been decriminalised in Western societies, there is no express legal right to commit suicide. There only is the liberty to commit suicide without having to face sanctions if failing. Therefore, no one can bring a complaint towards a State if one does not have the means or capacity to perform the action, which makes a discrimination claim impossible, as no one has the right to commit suicide. This should be reconsidered by the ECtHR since human dignity asks for a dignified death. A right to life and a right to privacy should lead to a right to self-determination that includes a right to die, thereby making a right to assistance in committing suicide necessary. Seeing how a lack of consensus prompts the application of the margin of appreciation in assisted dying cases, the following two chapters will analyse assisted dying laws in England and Germany to shed some light on the difficulty in reaching a European consensus.

4. Assisted Dying in England

In England, assisting someone to die according to their own wishes is a criminal offence. It is covered by the Suicide Act 1961 which decriminalised suicide while keeping assisting someone else illegal. A variety of cases have been considered by the courts, challenging the compatibility of the Suicide Act with the provisions of the ECHR – arguing for a right to die, the legalisation of assisted dying, or even just a clarification of the current legal situation. Following a brief introduction to the Suicide Act, the five main cases[491] will be discussed – to demonstrate what the problem posed by the current legal situation is. This will then be followed by an analysis of the attempts to change the *status quo*. In 2003, 2004 and 2005 Lord Joffe[492] presented Assisted Dying for the Terminally Ill Bills in the House of Lords. However, none of the Bills was passed. This was followed by the Falconer Report and most recently an Assisted Dying Bill by Lord Falconer.[493] Looking at the arguments brought forward in the debates on the Bills in the House of Lords will demonstrate the difficulty in legalising assisted dying. The chapter will furthermore investigate whether it is the courts or Parliament trying to bring about change and what the attempts at safeguarding the old and vulnerable are.

4.1. Suicide Act 1961

"English law has always, and continues to, see no difference in principle between euthanasia and any other deliberate killing".[494] Under English law,[495] assisted dying is generally regulated by the Suicide Act 1961 which prohibits assistance in committing suicide. In the late 1950s, England saw a rise in debates surrounding suicide and assisted dying. Kenneth Robinson[496] campaigned in the House of Commons for a change of law concerning suicide, wanting it to cease to be a criminal offence. In 1958, 150 MPs signed his motion which led to the Suicide Act 1961. "The

[491] More than five cases concerning assisted dying have been dealt with by the English courts. The five to be dealt with are the ones most fitting to the topic of this research, concerning the wish for active assisted dying by a capable adult.
[492] Lord Joffe, member of the Labour party, joined the House of Lords in 2000. In an interview of 2008 he stated: "Well one does what one believes is right, and I see it as a matter of human rights as well that people should be able to make decisions on how to end their lives, just as they make decisions during their lives". Having been a member of the Voluntary Euthanasia Society since the age of 35, he was approached by the Society when they needed someone to introduce a Bill into Parliament.
http://www.swindonweb.com/?m=2&s=625&ss=632&c=3384&t=lord%20joffe%20interview, accessed 11 December 2012 at 11.25am.
[493] Lord Falconer, member of the Labour party, joined the House of Lords in 1997.
[494] Grubb (n 29) 89.
[495] The Suicide Act 1961 only covers England and Wales, as the Scotland Act 1998 established Scotland's own Parliament.
[496] Robinson was a Labour politician and served as Minister of Health from 1964 to 1968.

legalisation of suicide in 1961 provided the first formal recognition of an individual's right to determine his own criterion of when life was no longer worthwhile".[497]

However, the decriminalisation of suicide is only a very limited freedom when it comes to dying an autonomous, dignified death. "In English law, being allowed to do something is not always equivalent to having a right to do it".[498] While suicide has been decriminalized under the Suicide Act 1961, assisted suicide remains a criminal offence under Section 2 of said Act. It states: "1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years". The Act was amended by the Coroners and Justice Act 2009, reducing the offence from "aiding, abetting, counselling and procuring" to "encouraging or assisting" another's suicide.[499] Section 2 can be criticised for various reasons. It can be argued that refusing to help someone die, who cannot bring about his own death, violates his or her right to autonomy[500] and a dignified death.[501] What is needed is a change of the current legal situation. "If what is taking place in medical practice [as for example assisted dying] is acceptable to society, it is argued that the law should be changed to set out clearly the parameters within which they [i.e. doctors] should be acting".[502]

4.2. Case Law Assisted Dying

4.2.1. *Pretty*

In 2001, Dianne Pretty sought judicial review of a decision by the DPP.[503] Mrs Pretty was suffering from Motor Neurone Disease, which

> is a progressive incurable disorder characterised by degeneration of nerve cells in the brain and spinal cord. It causes progressive weakening and wasting of the muscles. Death eventually occurs when the diaphragm of the muscles that facilitate breathing are paralysed with the result that there is a respiratory failure.[504]

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[497] Nick Kemp*, Merciful Release: The History of the British Euthanasia Movement* (MUP 2002), 178.
[498] Coggon, 'Could the Right to Die with Dignity Represent a New Right to Die in English Law' (n 28), 219.
[499] Coroners and Justice Act 2009, s.59 (2)(1)(a).
[500] See J.K. Mason and G.T. Laurie, *Mason and McCall Smith's Law and Medical Ethics* (9th edn, OUP 2013), 628, referring to the *Linsell* case, concerning a woman with motor neurone disease asking for indirect assisted dying.
[501] See chapter 2 above for an analysis of autonomy and dignity.
[502] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (5th edn, Penguin 2011), 582.
[503] [2001] EWHC Admin 705, 31 August 2001.
[504] ibid*,* [2].

Mrs Pretty wanted to be able to choose the time and manner of her death to avoid the distressing and undignified death her illness would bring about. Due to her illness, she was not able to commit suicide unaided and would have had to rely on assistance. She had therefore asked the DPP "to give an undertaking not to prosecute Mr Pretty under the Suicide Act 1961, should he assist the claimant in taking her own life".[505] The DPP, however, refused to grant immunity from prosecution, a decision which Mrs Pretty brought to the courts since she saw in it a violation of her rights under Articles 2, 3, 8 and 14 ECHR.[506] The High Court granted Mrs Pretty permission for judicial review since her claim reached the required threshold and it "appeare[d] desirable that this matter should come on a full hearing as soon as possible".[507]

Following that, the merits of the case were considered by the High Court.[508] The statement in question, made by the DPP, was "that they [successive DPPs and Attorneys General] will not grant immunities that condone, require or purport to authorise or permit future commission of any criminal offence, no matter how exceptional the circumstances".[509] Being governed by the Prosecution of Offences Act 1985, the DPP is required to provide Crown Prosecutors with a Code which offers guidance concerning prosecutions. "A fundamental feature of the statutory scheme and the Code for Crown Prosecutors is that a decision to prosecute is only made after consideration of the evidence and the public interest against known facts relating to the offence committed".[510] Therefore, the Court had to agree with the DPP in that he could not grant immunity from prosecution to Mr Pretty.[511] The Counsel of Mrs Pretty had submitted that the prohibition of assisted suicide under the Suicide Act 1961 violated her rights under the ECHR.[512] "The short answer, in our view, is that section 2(1) of the 1961 Act is not incompatible with her Convention rights as it stands; there is therefore no need to interpret it in a different way; and no power to grant a declaration that it is incompatible".[513]

Nevertheless, the Court went on to consider the human rights arguments, starting with Article 2 ECHR, agreeing that it "does not *require*

[505] ibid, [6].
[506] See ibid, [10], those being the right to life, the prohibition of torture, the right to respect for private and family life and the prohibition of discrimination.
[507] ibid, [15].
[508] [2001] EWHC Admin 788, 18 October 2001.
[509] ibid, [7].
[510] ibid, [21].
[511] ibid, [23].
[512] See ibid, [35].
[513] ibid, [36].

the State to take positive steps to force life upon the unwilling".[514] What the Court disagreed with, however, was the Counsel's claim that the right to life included a right to die.[515] "In our view the right to human dignity which is enshrined in Article 3 is not the right to *die* with dignity, but the right to *live* with as much dignity as can possibly be afforded".[516] The Court furthermore held that Section 2(1) of the Suicide Act 1961, which states the illegality of assisted suicide, had a legitimate aim under Article 8.2 ECHR, namely the protection of the vulnerable.[517] Therefore, an interference with Article 8.1 ECHR was legitimate when it came to assisted suicide which meant that Mrs Pretty's rights under Article 8 ECHR had not been violated.[518] Concluding, the Court stated that Section 2(1) of the Suicide Act 1961 did not violate any rights under the ECHR.[519] "For the reasons given in this judgment Mrs Pretty's claim for judicial review must be dismissed. Before the Convention became part of English law there is no doubt that her claim would have failed. We do not think the position has changed since its incorporation".[520]

The case moved on to the House of Lords.[521] After summarising the facts of the case, Lord Bingham of Cornhill started by looking at the Convention rights supposedly violated. "On behalf of Mrs Pretty it is submitted that article 2 protects not life itself but the rights to life. […] The right to die is not the antithesis of the right to life but the corollary of it, and the state has a positive obligation to protect both".[522] Lord Bingham claimed that this would be going too far since if Article 2 ECHR included a right to die, it would mean that a person unable to commit suicide had a right to be killed by a third party without the State being able to interfere.[523] While there may be benefits attached to the different forms of assisted dying, "these are not benefits which derive protection from an article framed to protect the sanctity of life".[524]

The claim concerning Article 3 was that by preventing Mrs Pretty from committing suicide with assistance, she was subjected to inhuman or degrading treatment, as prohibited by Article 3 ECHR which would make

[514] ibid, [41], italics in original.
[515] See Ibid, [42].
[516] ibid, [48], italics in original.
[517] See [2001] EWHC Admin 788, [54].
[518] See ibid, [62].
[519] ibid, [66].
[520] ibid, [67].
[521] [2001] UKHL 61, 29 November 2001.
[522] ibid, [4].
[523] See ibid, [5].
[524] ibid, [6].

Section 2(1) of the Suicide Act 1961 incompatible with the ECHR.[525] Again, Lord Bingham disagreed with that submission. "Article 3 is, as I think, complementary to article 2. As article 2 requires states to respect and safeguard the lives of individuals within their jurisdiction, so article 3 obliges them to respect the physical and human integrity of such individuals".[526] And further: "It cannot, in my opinion, be plausibly suggested that the Director or any other agent of the United Kingdom is inflicting the proscribed treatment on Mrs Pretty, whose suffering derives from her cruel disease".[527] Lord Bingham did not see a justification under Articles 2 and 3 ECHR that would require the UK to legalize assisted suicide.[528]

Mrs Pretty's counsel had further submitted that Article 8 included a right to choose when and how to die,[529] which was refuted by the Secretary of State for the Home Department, claiming that Article 8 related to how one lived one's life but not how one ended it.[530] Lord Bingham shared the opinion of the Secretary of State and concluded "that the present legislative and practical regime do not offend the convention".[531] Article 14 ECHR had to be dismissed since no other violation of the ECHR had been found.[532] "The criminal law cannot in any event be criticised as objectionably discriminatory because it applies to all".[533] Since there was no right to commit suicide, there was no basis to request the right for assistance in committing suicide.[534] Consequently, according to Lord Bingham, Mrs Pretty could not claim any breach of a right under the ECHR[535] and dismissed the appeal.[536]

Lord Steyn started by stating that it would not be enough for Mrs Pretty to show that assisted suicide is allowed under the ECHR, she basically would have to "persuade the House [of Lords] that the European Convention compels member states of the Council of Europe to legalise assisted suicide".[537] However, as Lord Steyn mentioned,

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[525] See ibid, [11].
[526] ibid, [13].
[527] ibid, [13].
[528] See ibid, [15].
[529] See ibid, [17].
[530] See ibid, [18].
[531] ibid, [30].
[532] See ibid, [34].
[533] ibid, [36].
[534] See ibid, [35].
[535] See ibid, [37].
[536] See ibid, [40].
[537] ibid, [41].

> the European Court of Human Rights does not readily adopt a creative role contrary to a European consensus, or virtual consensus. The fact is that among the 41 member states, […] there are deep cultural and religious differences in regard to euthanasia and assisted suicide.[538]

Therefore, it seemed unrealistic that the ECHR would or could require Member States to legalise assisted suicide.[539]

As Lord Bingham before, Lord Steyn did not see how any article of the ECHR could be used to underpin Mrs Pretty's claim.[540] Article 2 ECHR "enunciates the principle of the sanctity of life"[541] and could not be used to achieve the opposite. Article 3 ECHR could not be evoked because the case lacked the element of 'treatment' covered by Article 3 ECHR.[542] Even if Article 8 had been engaged, Lord Steyn claimed the interference with that right would have been justified under Article 8.2.[543] Like Lord Bingham, Lord Steyn stated that believing in assisted suicide did not provide an entitlement to perform an unlawful action.[544] Concerning Article 14 ECHR, Lord Steyn added that even if it was engaged in this case, the violation would have been justified for the protection of the vulnerable.[545] The refusal of the DPP to make the statement requested by Mrs Pretty was once again stressed by Lord Steyn to be the right decision since "he may only exercise his discretion, for or against prosecution, in relation to the circumstances of a specific prosecution"[546] and not in advance of an offence committed. Agreeing with Lord Bingham, he dismissed the appeal.

Lord Hope added that "it does not create a right to life. The right to life is assumed to be inherent in the human condition which we all share. […] It does not say that every person has the right to choose how or when to die. […] [T]he protection of human life is its sole object".[547] Therefore, the refusal of the DPP had been very much in line with Article 2 ECHR. "[The DPP's] act in declining to give the undertaking to enable Mr Pretty to assist in his wife's suicide is compatible with the opening words of the second sentence of the article".[548] That start of the sentence reads as: "No one

[538] ibid, [56].
[539] See also chapter 3.3.5. on the margin of appreciation and consensus in the judgments of the ECtHR.
[540] See [2001] UKHL 61, [58].
[541] ibid, [59].
[542] See ibid, [60].
[543] See ibid, [62].
[544] See ibid, [63]
[545] See ibid, [64].
[546] ibid, [65].
[547] ibid, [87].
[548] ibid, [88].

shall be deprived of his life intentionally".[549] What he criticised in Mrs Pretty's request was the lack of precision and detail as to how the suicide would be carried out and claimed that also justified the DPP's refusal.[550] "[T]he margin between assisting suicide and euthanasia is so slender in Mrs Pretty's case as to be impossible to determine in the absence of a detailed account of the proposed act".[551] In general, he saw the prohibition of assisted suicide as highly justified. "Great weight must be attached to the state's interest in protecting the lives of its citizens. It was a proportionate response for Parliament to conclude that that interest could only be met by a complete prohibition on assisted suicide".[552] And while he could see that the way of dying was part of living and therefore was covered by the right to self-determination under Article 8 ECHR, he could not see a positive obligation arising from that in the form of making assisted suicide available.[553] Mrs Pretty's discrimination claim had to be dismissed since Article 14 ECHR can only be evoked in respect to other rights' violations, but there is no right to commit suicide.[554] Since no rights of Mrs Pretty had been violated Lord Hope also dismissed the appeal.[555]

Lord Hobhouse began by stating that "[t]he sanctity of human life is probably the most fundamental of the human social values".[556] He put it quite bluntly: "Assisted suicide and voluntary euthanasia have the same criminality as murder notwithstanding the consent of the deceased".[557] Concerning the alleged human rights violations he agreed with the other Lords that no such right had been violated.[558] He also agreed that it was not the DPP's task to grant immunities before something has happened.[559] He added that should the Suicide Act be amended, it would be the task for Parliament.[560] As all the other Lords he dismissed the appeal.[561] Without further explanations so did Lord Scott.[562]

Following that, Mrs Pretty took the case to the ECtHR, see chapter 3.1.1., where her claims failed as well. She died in a hospice in 2002.

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[549] Article 2 ECHR.
[550] [2001] UKHL 61, [95]. This lack of information had also been mentioned by Lord Steyn at [44].
[551] [2001] UKHL 61, [95].
[552] ibid, [97].
[553] See ibid, [100].
[554] See ibid, [106].
[555] See ibid, [108].
[556] ibid, [109].
[557] ibid, [110].
[558] ibid, [112].
[559] ibid, [114].
[560] ibid, [120].
[561] See ibid, [112].
[562] See ibid, [124].

As this was the first assisted dying case in England, the hesitant approach by the courts is reasonable. With focussing on the limits of the law, especially the implications of Article 2 ECHR, whether a right to life implies positive obligations and whether it could include a right to die, Mrs Pretty stood no chance of having immunity granted to her husband. However, a focus on the autonomy and dignity of the individual could in this case also not have led to a different outcome. While those two ideas stress the need for assistance to be made available, asking for immunity from prosecution is not the way forward. What is needed is a change in the law, to make assistance legally available to suffering individuals like Mrs Pretty.

Concerning dignity, what is of importance is the High Court's refusal to acknowledge a right to die in dignity. "In our view the right to human dignity which is enshrined in Article 3 is not the right to *die* with dignity, but the right to *live* with as much dignity as can possibly be afforded, until that life reaches its natural end".[563] While the House of Lords did pick up on aspects of dignity, it then did not comment on the question of whether dignity should have an impact on the law concerning assisted dying. With regard to autonomy, the courts stressed that it was connected to life and not death or dying, "article 8 is expressed in terms directed to protection of personal autonomy while individuals are living their lives, and there is nothing to suggest that the article has reference to the choice to live no longer".[564] Or as expressed by the High Court: "English law curtails a person's right to bodily autonomy in the interests of protecting that person's life even against her own wishes".[565] Ultimately, in *Pretty*, the courts were not prepared to acknowledge the right to an autonomous, dignified death.

4.2.2. *Ms B*

In 2002, *Ms B v An NHS Hospital Trust*[566] was decided in the High Court of Justice, Family Division. Ms B's claim was that the artificial ventilation administered to her was an invasive and unlawful treatment. The main issue was whether Ms B was competent and her decision not to be kept alive artificially therefore had to be accepted and acted upon by the doctors. In 1999, Ms B had suffered a haemorrhage of the spinal column,

[563] [2001] EWHC Admin 788, [48], italics in original.
[564] [2001] UKHL 61, [23].
[565] [2001] EWHC Admin 788, [37].
[566] [2002] EWHC 429 (Fam), 22 March 2002. For the facts of the case see [1]-[11].

after which she wrote a Living Will stating that "she wished for treatment to be withdrawn if she was suffering from a life-threatening condition, permanent mental impairment or permanent unconsciousness".[567] In 2001, she had an intramedullary cervical spine cavernoma upon which she became tetraplegic. She was then informed that her Living Will was not specific enough, however, after an operation that only succeeded in giving her the ability to move her head, Ms B asked for the first time for the ventilation to be switched off. After she had given instructions concerning the ending of the ventilation via a solicitor, "[a] case conference followed and it was arranged that two independent psychiatric assessments would be conducted before any further steps were taken".[568]

The two consultant psychiatrists first confirmed her capacity but later changed their opinion. Following this she was prescribed antidepressants and she "said that she was relieved the ventilator had not been switched off".[569] Instead of focussing on ending her life, she agreed to plans of rehabilitation "with a view to eventually returning home with 24-hour care, or alternatively a residential nursing home".[570] Some months later her capacity was assessed again with the conclusion that she had the capacity to make her own decisions. Upon that assessment she made a new Living Will.[571] With her doctors it was arranged that Ms B would start a one-way weaning process. The idea of a weaning process is that the support by the ventilator is reduced to stimulate the lung working on its own. If that is not happening, the artificial ventilation gets increased again. In one-way weaning the ventilation is gradually decreased which eventually leads to death. The doctors treating Ms B were reluctant to turn off the ventilator but agreed to the one-way weaning programme as a compromise. However, Ms B refused both suggested alternatives, the transferral to a weaning centre as well as undergoing the programme in the Intensive Care Unit (ICU) of the Hospital. She also rejected a transferral to a spinal rehabilitation unit and moving to a hospice. The case before the Court was "not about the best interest of the patient but about her mental capacity",[572] and therewith whether her wish to have the artificial ventilation removed had to be acted upon.[573] Additionally, Ms B sought nominal damages, provided the Court found she had had capacity from

[567] ibid, [4].
[568] ibid, [7].
[569] ibid, [9].
[570] ibid, [9].
[571] ibid, [10].
[572] ibid, [12].
[573] See ibid, [12].

August 2001 onwards, as in that case the hospital would have been treating her unlawfully.[574]

The Court started by stating that the principles of the law on mental capacity had been stated in a series of cases in the 1990s.[575] The major principle was that of autonomy,[576] another one the sanctity of life. "The interface between the two principles of autonomy and sanctity of life is of great concern to the treating clinicians in the present case".[577] However, the Court recalled the judgments of *Airdale NHS Trust v Bland* [1993] AC 789[578] and *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95,[579] where the Lords had stated that self-determination of the patient ranked higher than the sanctity of life, i.e. that a patient had to be allowed to refuse treatment.[580]

An important aspect for the Court to consider in judging Ms B's capacity was her ambivalence in statements. Ms B claimed that she had never changed her mind about wishing for the ventilation to be switched off. She had only given in to trying rehabilitation once she was assessed as not having capacity, but as soon as that assessment was changed felt she could state her wish again which was for the ventilation to be switched off.[581] Concerning her refusal to go to a weaning specialist clinic, she claimed that they were designed to help people recover and not to end ventilation. The suggested one-way weaning would have been painful, undignified and lasting for several weeks.[582] What she was asking for was a sedated quicker way of dying than the one-way weaning would offer. She refused rehabilitation as that offered her no recovery and because she believed that once she had tried it, it would be even harder to have her request for a withdrawal of treatment heard.[583] After considering all of Ms B's statements, Dame Butler-Sloss, the presiding judge, came to the conclusion that "[s]he is, in my judgment, an exceptionally impressive witness. Subject to the crucial evidence of the consultant psychiatrists, she appears to me to demonstrate a very high standard of mental competence, intelligence and ability".[584]

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[574] See ibid, [13].
[575] See ibid, [15].
[576] See ibid, [16]-[21].
[577] ibid, [22].
[578] Concerning the treating physicians' wish to end the artificial feeding of a patient in a persistent vegetative state.
[579] Concerning a pregnant woman refusing blood transfusions after an accident.
[580] See ibid, [22]-[27].
[581] See ibid, [40]-[44].
[582] See ibid, [45]-[46].
[583] See ibid, [49].
[584] ibid, [53].

The Court went on to consider the different doctors' statements concerning Ms B's capacity and wish to die. The two treating doctors had both found her capable of making her own decisions but also found they were in a distressing dilemma over the life of a person they respected and liked.[585] The external consultant, Dr G, also found her to be capable but was concerned that Ms B was not giving informed consent, as she had not yet experienced her life outside of the ICU so she was unable to say whether that life would be unbearable. In his experience, patients who left hospital, for example moved to a rehabilitation centre, learned to value life again but that could take up to two years.[586] However, Dame Butler-Sloss could not agree with that view. "Even in issues of the utmost significance and gravity people, including patients, have to make decisions without experience of the consequences and his requirement is unrealistic".[587] The second independent consultant also found Ms B to be capable. Dr I shared Dr G's view that her decision might have been negatively influenced by her current situation and not be a determined wish to die. However, since he found no justification to challenge her capacity, her wish had to be accepted.[588] Another consultant psychiatrist, Dr Sensky, also found her to be capable of making her own decisions. What Dr Sensky pointed out was his observation of the clinicians not starting their assessment form the point of Ms B's capacity but from her decision, which they did not want to accept.[589] What he suggested for future cases was to first of all acknowledge the problem and the clash of values and to get a mediator from the outside.[590]

> The circumstances of Ms B illustrate the conundrum and how difficult ethically and personally it is for doctors serving people who only remain alive with the help of medical technology. […] The principle is to have appropriate respect for values and recognise the patient's equal right to autonomy.[591]

Dame Butler-Sloss stated she had to "reject any suggestion that Ms B's capacity has been impaired by the advent of psychological regression".[592] She could not see a sign of incapacity in Ms B's behaviour of accepting to try rehabilitation when considered to lack capacity and changing her mind

[585] See ibid, [55]-[58].
[586] See ibid, [59]-63].
[587] ibid, [63].
[588] See ibid, [64]-[71].
[589] See ibid, [78].
[590] See ibid, [79].
[591] ibid, [80].
[592] ibid, [92].

as soon as her capacity was established.[593] While accepting that the view of Dr G as to the necessity of experiencing rehabilitation to know of the benefits of it might be of value to some patients, "[h]is view that not to have experienced rehabilitation means that the patient lacks informed consent cannot be the basis for the legal concept of mental capacity".[594]

The concept of autonomy should not be discarded too lightly. "There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient".[595] Dame Butler-Sloss came to the conclusion that Ms B did not lack capacity, had never lacked capacity, and would not lose it in the foreseeable future, so she had to be allowed to make her own decisions regarding her medical treatment.[596] Consequentially, she had been treated unlawfully by the NHS Hospital Trust which would have had to deal with the issue.[597] The case concluded with a set of guidelines. Most importantly they stressed the need for respect for autonomous choices of the patient. "The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who is mentally competent has the same right to personal autonomy and to make decisions as any other person with mental capacity".[598] Ms B refused all further treatment and reportedly died on 29 April 2002.[599]

Ms B v An NHS Hospital Trust is an important case in the development of the evaluation of assisted dying by the courts. While Ms B did not ask for the same kind of assistance as, for example, Mrs Pretty, but 'just' needed the machines that kept her alive to be switched off, the judgment stresses two vital elements in assisted dying: capacity and autonomy. As was seen above in chapter 2, autonomy is elementary in arguing for the need for legalisation of assistance in dying. Stressing that physical ability is not a prerequisite for personal autonomy is an integral element in reaching a more favourable legal situation regarding a right to die and assistance in dying. It is a meaningful case in establishing that a person with capacity has the right to autonomy and therefore the right to make the decision to want to die. Since this case was primarily concerned with autonomy, the Court did not engage with questions of a dignified death. The dignified

[593] See ibid.
[594] ibid, [93].
[595] ibid, [94].
[596] See ibid, [95].
[597] See ibid, [96]-[99].
[598] ibid, [100.x].
[599] See Anne Slowther, 'The Case of Ms B and the "Right to Die"' (2002) 28 *Journal of Medical Ethics* 243.

death would have been the following issue once it was established that her right to autonomy was not diminished by her physical incapacities.

4.2.3. *Z*

In 2004, the High Court dealt with *Local Authority v Z*.[600] "The critical issue in this case is the extent of the duty owed by a local authority when the welfare of a vulnerable person in their area is threatened by the criminal (or other wrongful) act of another".[601] In 1998, Mrs Z had been diagnosed with cerebella ataxia, an incurable and irreversible "condition which attacks that part of the brain that controls the body's motor functions".[602] In addition, in 2003 she had developed signs of Parkinson's which pointed to a multi-system atrophy. In 2000, she had been admitted to hospital after having overdosed on paracetamol. Though she had left a suicide note it was not until 2003 that she had voiced her wish for assisted suicide. After initial opposition to the plan, her husband had agreed on helping her to commit suicide in Switzerland with the help of Dignitas. Throughout the planning process the husband had kept the authorities informed about the plans. His assistance in her act of committing suicide would have been a criminal offence, and "[t]he local authority therefore sought to invoke the inherent jurisdiction of the High Court".[603] In November 2004, the Court had granted an injunction to keep Mr Z from assisting his wife in travelling to Switzerland. A consultant psychiatrist was ordered to assess Mrs Z's legal capacity which he confirmed she had and furthermore found "that the decision was hers alone entirely uninfluenced by outside consideration".[604] Since the travel arrangements had been made for December 1st, the public hearing took place on November 30th.[605]

The Court started with looking at the standpoint of the local authorities who "were obliged to treat Mrs Z as a vulnerable adult. […] The term only has meaningful context in a specific context. In this case that context is physical and mental deficit".[606] The problem for the authorities was how to evaluate the duty this posed on them as they could not ignore the situation once having been informed by Mr Z.[607] However, while recalling that there was no right to commit suicide, the Court stated that due to general

[600] [2004] EWHC 2817 (Fam), 3 December 2004. For the facts of the case see [1]-[7].
[601] ibid, [1].
[602] ibid, [2].
[603] ibid, [7].
[604] ibid, [8].
[605] See ibid, [9].
[606] ibid, [10].
[607] See Ibid.

human freedom, individuals had to be free to make what seems to be an unwise or bad decision in relation to their own life. "It follows that the court has no basis in law for exercising the jurisdiction so as to prohibit Mrs Z from taking her own life. The right and responsibility for such a decision belongs to Mrs Z alone".[608] However, to carry out her freedom she had to rely on the help of someone, in this case her husband. Helping her would be a criminal conduct, under Section 2(1) of the Suicide Act 1961.[609] So the question for the Court was "whether the local authority are under a duty to apply for the continuation of the injunction […] and secondly, whether the court should grant any such injunction in any event".[610]

The Court stated "that in the context of a person of full capacity, whilst the right to life is engaged, it does not assume primacy (at the hands of another especially) over rights of autonomy and self-determination".[611] Concerning Mrs Z, the judge stated that "although they [the local authorities] have the power to do so under Section 222 of the 1972 Act, in my judgment they have no obligation to seek the continuation of the injunction".[612] This was due to the fact "that the criminal justice agencies have all the necessary powers. Moreover, Parliament has committed to the DPP the discretion as to whether to permit a prosecution".[613] So the Court did not justify Mrs and Mr Z's actions but saw no need for an injunction as a civil remedy.[614] What could be interpreted as a glimmer of hope for someone in Mrs Z's situation was the Court's statement that it did not need to continue the injunction "where the effect of the injunction is to deny a right to a seriously disabled but competent person that cannot be exercised herself by reason only of her physical disability".[615] Still, the Court was very careful.

> This case affords no basis for trying to ascertain the court's views about the rights or wrongs of suicide, assisted or otherwise. This case simply illustrates that a competent person is entitled to take their own decisions on these matters and that that person alone bears responsibility for any decision so taken.[616]

[608] ibid, [12].
[609] ibid, [14].
[610] ibid, [15].
[611] ibid, [18].
[612] ibid, [19].
[613] ibid.
[614] ibid.
[615] ibid, [20].
[616] ibid, [21].

What is of significance in this judgment is foremost the Court's claim that the right to life does not supersede the right to autonomy. This is one of the major claims in arguing for a right to die. The right to life should not be used as a trump over the autonomous choice of wishing to die. So while not making any claims as to a needed legality of assisted dying, the Court at least valued the autonomous choice. Like the case of Mrs B, this case was concerned with the limits of autonomy, a step before considering the implications of dignity. A dignified death would be the issue arising after autonomy has been confirmed and secured.

4.2.4. *Purdy*

In 2009, the House of Lords decided the case *R (on the application of Purdy) v Director of Public Prosecutions*.[617] The case had originated in a claim in the Divisional Court.[618] Ms Purdy was suffering from primary progressive multiple sclerosis. While still wanting to live, she believed that due to the degenerative nature of her illness there would come a day when she would want to end her life. However, by then she would be unable to commit suicide unaided and would therefore want to rely on the help of her husband. Her claim differed from that of Mrs Pretty in that she did not ask for immunity from prosecution by the DPP but instead claimed that "the Director of Public Prosecutions (DPP) has acted unlawfully in failing to publish detailed guidance as to the circumstances in which individuals will or will not be prosecuted for assisting another person to commit suicide".[619]

For Ms Purdy's claim that the DPP had acted in a way breaching Article 8 ECHR, the questions that needed answering by the Divisional Court were, whether Section 2 of the Suicide Act engaged Article 8 ECHR and if so, whether the interference with Article 8.1 was justified under Article 8.2.[620] In *Pretty,* the House of Lords had determined that Article 8 was not engaged,[621] the ECtHR, however, had found the contrary,[622] a finding on which Ms Purdy now based her claim. For the Divisional Court the question therefore was which court to follow in this case. In the light of the ruling in *Kay v Lambeth LBC*,[623] "the lower courts should follow the decision of the

[617] [2009] UKHL 45, 30 July 2009.
[618] [2008] EWHC 2565 (Admin), 29 October 2008.
[619] ibid*,* [1].
[620] See [2008] EWHC 2565, [11].
[621] See ibid*,* [27].
[622] See ibid*,* [33] and above at 3.1.1.
[623] [2006] UKHL 10, a case concerning property and tort law.

House of Lords".[624] Finding that the House of Lords had not departed from its views on Article 8 following *Pretty*, the Divisional Court reached the conclusion that Article 8.1 was not engaged in *Purdy*.[625]

The Divisional Court further stated that a more detailed policy would not be possible since

> it is going to be difficult to frame a law which covers the almost infinite variety of circumstances in which the offences might occur. Thus a more closely worded form of definition of the offence [of aiding and abetting, counselling or procuring suicide] is not possible.[626]

Furthermore, the Court did not see the need for a more detailed policy, since

> if the guidance in the Code of Practice is followed reasonably and rationally by the DPP and his delegates and only relevant factors are taken into account in making a decision on whether to prosecute an offence under s.2(1) of the [Suicide] Act, it cannot be said that the exercise of the discretion on whether to prosecute constitutes an arbitrary or unfettered power of the executive.[627]

For all these reasons, the Divisional Court dismissed the claim.

Ms Purdy appealed and the case was decided by the Court of Appeal in early 2009.[628] Restating that assisted suicide was a crime and that law was made by Parliament and could only be changed by Parliament,[629] the Court of Appeal phrased the question at stake as whether the DPP could be required to formulate a detailed policy regarding the facts and circumstances that will be taken into account in determining whether it was not in the public interest to prosecute, even if there was enough evidence for a prosecution under Section 2 of the Suicide Act.[630] As the Divisional Court before, the Court of Appeal started by looking at Article 8 ECHR and following the House of Lords and its approach in *Pretty*, stated "that we must find that Ms Purdy's art.8(1) rights are not engaged".[631]

Next, the Court of Appeal declared that the DPP could not be required to publish further policy documents, as "there was ample material to enable Ms Purdy's legal advisers to address the likelihood of a prosecution if her husband assisted her suicide. And in truth, that is all that can be

[624] [2008] EWHC 2565, [45].
[625] ibid, [58].
[626] ibid, [71].
[627] ibid, [75].
[628] [2009] EWCA Civ 92, 19 February 2009.
[629] See ibid, [2].
[630] See ibid, [3].
[631] ibid, [62].

done".[632] Consequently, the Court of Appeal dismissed the appeal unanimously.[633]

As a last step the case went to the House of Lords.[634] According to Lord Hope, the provision of the Suicide Act was clear enough, including that "acts which help another person to make a journey to another country, in the knowledge that its purpose is to enable the person to end her own life there, are within its reach".[635] While the Suicide Act applied only in England and Wales, Lord Hope called it absurd to interpret this to mean one could evade liability by travelling to another country.[636] "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".[637] He stressed again that what Ms Purdy sought was not immunity for her husband, the way Mrs Pretty had, but merely information as to whether her husband would be prosecuted.[638]

When it came to the involvement of Article 8 ECHR in this case, Lord Hope again saw a difference to the case of Mrs Pretty. Unlike Mrs Pretty, Ms Purdy wanted to travel abroad to commit suicide with the help of the Swiss organisation Dignitas. If she could not rely on her husband's assistance she would have to travel and then commit suicide at an earlier stage of her illness while she was still capable of doing it alone which to Lord Hope implied an involvement of Article 8.1 ECHR. According to him, the decision on how to spend the last moments of life belonged into the category of private life. Since Ms Purdy would have to end her life earlier if she could not rely on assistance, the statement she had asked for would have an effect on her private life, her claim therefore fell under Article 8.1 ECHR.[639]

The next point to be considered was the DPP's discretion in prosecuting. "It has long been recognised that a prosecution does not follow automatically whenever an offence is believed to have been committed".[640] In connection to the Suicide Act, Lord Hope claimed that "Parliament did not intend that all those who might be guilty of an offence under section 2(1) should be punished or even prosecuted for the

[632] [2009] EWCA Civ 92, [78].
[633] See ibid, [81].
[634] [2009] UKHL 45, 30 July 2009.
[635] ibid, [18].
[636] See ibid, [24].
[637] ibid, [25].
[638] See ibid, [30].
[639] See ibid, [36]-[39].
[640] ibid, [44].

offence".[641] The Code for Crown Prosecutors published in November 2004 "states that a prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour".[642] In the case of Daniel James,[643] the DPP "decided that a prosecution [of his parents, who had helped him] was not needed in the public interest".[644] Lord Hope came to the conclusion that while the Code was normally sufficient in indicating what would lead to prosecution, it was not clear enough for cases concerning assisted suicide. He

> would therefore allow the appeal and require the Director to promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding […] whether or not to consent to a prosecution under section 2(1) of the 1961 Act.[645]

According to Baroness Hale, "there would appear to be a general feeling that, while there are cases in which a prosecution would not be appropriate, it is necessary to retain the offence [of assisted suicide]".[646] The need for protecting autonomy and valuing someone's life, even if that person did not value his own life, lead Baroness Hale to favouring the appeal.[647] Lord Brown added that "there will on occasion be situations where, contrary to the assumptions underlying the Code, it would be possible to regard the conduct of the aider and abettor as altruistic rather than criminal".[648] Since the Code was not sufficient in his view to clarify the nature of Section 2(1) of the Suicide Act, he too allowed the appeal.[649]

Lord Neuberger added that after the case of Daniel James it should be clear to relatives accompanying someone abroad to commit assisted suicide in a country where that is lawful, how the DPP approached such cases.[650] Still, he would ask the DPP to publish a policy clarifying his prosecution practice.[651] Therefore, all judges agreed on allowing the appeal.

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[641] ibid, [45].
[642] ibid, [49].
[643] Daniel James was a young man who was left paralysed following a Rugby accident. Not wanting to continue with his life, he travelled to Switzerland in 2008 and committed suicide with the help of Dignitas.
[644] [2009] UKHL 45, [51].
[645] ibid, [56].
[646] ibid, [59].
[647] See ibid, [66]-[69].
[648] ibid, [83].
[649] See ibid, [87].
[650] See ibid, [97].
[651] See ibid, [101].

Following this judgment, the DPP published the 'interim policy for prosecutors in respect of cases of assisted suicide' at the end of September 2009. While Ms Purdy's wish for legal clarity can be understood, it is debatable whether a policy concerning the likelihood of prosecution really is the way forward. Each case will be different, so a broad list of factors can only ever be a rough guide but does not serve to bring certainty to the law. Instead of focussing on prosecution guidelines, the aim should be legalisation. However, as the courts repeatedly stress, it is for Parliament to change the law. So ordering the DPP to publish guidelines seems to be the only thing they logically could do.

Ms Purdy died on 23 December 2014 in a hospice, where she had spent the last year of her life, unable to afford a journey to Switzerland to commit suicide with the help of Dignitas.[652] This serves to show how little the guidelines changed the actual suffering of Ms Purdy. What she would have needed was the legalisation of assisted dying, in order to be able to die autonomously and in dignity, without having to travel abroad, and without having to starve herself to death, which is claimed she did.

Autonomy was recalled by the Court of Appeal as an important feature of Article 8 ECHR.[653] However, the Court did not further engage with the question what this finding entailed for Ms Purdy's rights. Concerning dignity, it only recalled that it was the essence of the Convention.[654] In the House of Lords an important claim about autonomy was made by Baroness Hale: "If we are serious about protecting autonomy we have to accept that autonomous individuals have different views about what makes their lives worth living".[655] Dignity was not specifically engaged with by the Courts.

4.2.5. *Nicklinson, Martin, Lamb*

The most recent case concerning assisted suicide was *R. (on the application of Nicklinson) v Ministry of Justice*.[656] Mr Nicklinson was a man of 58 years, who, after a stroke in 2005, was left paralyzed below the neck and unable to speak. The High Court considered whether to grant permission for judicial review in early 2012 and delivered its judgment in March 2012.[657] Nicklinson sought three declarations, namely that it would

[652] See for example The Independent, http://www.independent.co.uk/news/people/news/debbie-purdy-dead-righttodie-campaigner-dies-aged-51-9948768.html, accessed 21 January 2015 at 5.30pm.
[653] See [2009] EWCA Civ 92, [47].
[654] See ibid.
[655] See [2009] UKHL 45, [66].
[656] [2012] EWHC 2381, 16 August 2012.
[657] [2012] EWHC 304 (QB), 12 March 2012.

not be unlawful for a doctor to assist him in dying, that the current law regarding assisted suicide was incompatible with his rights under Article 8 of the ECHR implemented by the Human Rights Act 1998, and "that existing domestic law and practice fail adequately to regulate the practice of active euthanasia (both voluntary and involuntary) in breach of Article 2 [ECHR]".[658] The case was seen to be a conflict "between the sanctity of life and the individual's right of self-determination".[659] The Court accepted the first two claims for judicial review.

> [W]hilst in general it may be preferable for issues of broad social and moral policy to be determined by Parliament, the fact that they are hotly contested can be a factor in favour of the court intervening particularly if, as here, the suggested solution involves the participation of the courts on a case by case basis.[660]

The third declaration sought was not granted permission.[661] Judge Charles claimed he had "not identified any part of the general arguments advanced by the Claimant under this head, and thus by reference to Article 2, that arguably add value or force to his argument in support of the first two declarations he seeks".[662]

The case went on to be considered by the High Court. The case also concerned a second man, called 'Martin' to preserve his anonymity, who had suffered a brain stem stroke in 2008 which had also left him paralyzed and unable to speak. While Nicklinson requested a right to voluntary assisted dying, Martin, who was still capable of assisted suicide, wanted the DPP to clarify his policy as to whether someone helping Martin in travelling to Switzerland to commit suicide with the help of Dignitas faced prosecution. Both wanted help in dying to end what to them was an undignified and intolerable life.

The High Court started by looking at the issues in Martin's case. The main questions were whether voluntary assisted dying was a possible defence to murder and whether the DPP was "under a legal duty to provide further clarification of his policy".[663] The High Court recalled a statement made in *Purdy*[664] asking the DPP to clarify his policy about what will be taken into consideration when deciding to prosecute under Section 2(1) of

[658] ibid, [5].
[659] ibid, [16].
[660] ibid, [32.vii]
[661] See ibid, [51].
[662] ibid, [48].
[663] [2012] EWHC 2381, [26].
[664] [2009] UKHL 45.

the Suicide Act.[665] In 2009, the DPP had issued an interim policy in which he had declared that "one of the factors against prosecution was that the victim had 'a terminal illness; or a severe and incurable physical disability; or a severe degenerative physical condition; from which there was no possibility of recovery'".[666] While this factor would have granted Martin's assistant freedom from prosecution, the point did not make it into the final policy statement.[667] Still, the remaining factors of the statement could be interpreted to give the assistant of Martin enough security in assisting Martin to commit suicide without fearing prosecution. These factors are that the decision to end one's life has been reached voluntarily, the assistant acts out of compassion, the action is only a minor assistance, the assistant sought to dissuade the 'victim' before providing assistance, the act is "a reluctant encouragement or assistance in the face of a determined wish on the part of the victim", and the assistant reports his actions to the police and cooperates fully with them in their inquiry into the suicide.[668]

Lord Justice Toulson started his approach towards voluntary assisted dying by stating that "the time has come when the common law should give respect to [Mr Nicklinson's] autonomy and dignity by recognising that voluntary euthanasia can provide a defence to murder by way of the defence of necessity".[669] However, the Law Commission had in its report on murder, manslaughter and infanticide considered the present state of the law to classify all mercy killings as unlawful homicides.[670] In *Inglis,*[671] at paragraph 37, Lord Chief Justice of England and Wales had stated even more straightforwardly that mercy killing was murder.[672]

The next part of the analysis in the case focussed on the distinction between omission of treatment (i.e. passive assisted dying), which was legal, and the administering of lethal drugs (active assisted dying) which was illegal, if done with the intention to shorten life.[673] After looking at diverse cases regarding the medical profession's approach towards ending life, the House of Lords had reached the conclusion that "[t]he reasons given in *Bland*[674] and *Inglis*[675] for saying that it is for Parliament to

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[665] See [2012] EWHC 2381, [36].
[666] ibid*,* [38].
[667] See ibid*,* [39].
[668] See ibid*,* [42].
[669] ibid*,* [50].
[670] (2006) Law Com 304. See [2012] EWHC 2381, [54].
[671] [2010] EWCA Crim 2637. In *Inglis* a mother tried killing her son with an overdose of heroin to relieve his suffering after he had suffered catastrophic head injuries.
[672] See [2012] EWHC 2381, [55].
[673] See ibid*,* [60]-[62].
[674] [1993] AC 789.
[675] [2010] EWCA Crim 2637

decide whether to change the law on euthanasia are compelling and should be followed by this court".[676] Generally speaking, "major changes involving matters of controversial social policy are for Parliament".[677] When it came to the parliamentary change that can be argued to be needed, the Court was conscious of the care with which it would have to be brought about. "As to control of the consequences, it is hard to imagine that Parliament would legalise any form of euthanasia without a surrounding framework regarding end of life care and without procedural safeguards".[678] For this separation of duties, "it would be wrong for the court to depart from the long established position that voluntary euthanasia is murder".[679]

Then followed an analysis of the implication Article 8 ECHR has on cases concerning the right to die. If Article 8 is read to protect personal autonomy and a right to dignity, it can be taken to ask for a right to assistance in committing suicide. As Nicklinson's counsel had submitted: "For Tony [Nicklinson], autonomy and dignity, humanity and justice require that he should be permitted to end his life; and it is submitted that article 8 gives him the right to do so".[680] The Court recalled *Pretty*[681] and *Purdy*[682] which had concerned similar fates as those of Martin and Mr Nicklinson, and *Haas*'[683] proceedings before the ECtHR. Since the ECtHR had so far not ruled that a blanket ban on assisted suicide and voluntary assisted dying violated Article 8 ECHR, Toulson concluded "that it would be wrong for this court to hold that article 8 requires voluntary euthanasia to afford a possible defence to murder".[684]

Concerning the clarification of the DPP's policy regarding prosecution, Toulson claimed that it had been done in a sufficient manner and that making the DPP formulate his policy in even more detail would be impractical, or even impossible and would make him "cross a constitutional boundary which he should not cross".[685] With that conclusion Martin's claim was rejected.[686]

Regarding the compatibility of Section 2 of the Suicide Act and Article 8 ECHR, Toulson rejected the claim as the State had been given a wide margin of appreciation by the ECtHR, and within the UK it was for

[676] [2012] EWHC 2381, [75].
[677] ibid, [79].
[678] ibid, [85].
[679] ibid, [87].
[680] ibid, [88].
[681] [2001] UKHL 61, [2002] 1 AC 800, (2002) 35 EHRR 1.
[682] [2009] UKHL 45, [2010] 1 AC 345.
[683] (2011) 53 EHRR 33. On Haas see Chapter 3.1.2.
[684] [2012] EWHC 2381, [122].
[685] ibid, [143].
[686] ibid, [145].

Parliament to decide and not the courts.[687] Both claims, of Martin and of Mr Nicklinson, were consequentially refused for judicial review.[688] The other two judges agreed with Toulson, Royce adding that "[s]ome will say the Judges must step in to change the law. Some may be sorely tempted to do so. But the short answer is that to do so here would be to usurp the function of Parliament in this classically sensitive area".[689]

Mr Nicklinson died a few days later, after having been on a hunger strike for a couple of days and refusing treatment for his pneumonia. His wife, joined by Mr Lamb, who was completely immobile after a car-crash and sought the same relief that Nicklinson had, appealed, together with Martin. The Court of Appeal delivered its judgment on 31 July 2013. It noted that "these appeals raise complex and highly controversial moral and ethical issues concerning the sanctity of life and the limits of autonomous self-determination".[690] All three submissions were "to the effect that the right to die at the time of one's choosing engages fundamental common law rights as well as the right to private life protected by article 8 of the Convention".[691] Mr Lamb, like Mr Nicklinson before, pleaded for a defence to murder if the killing was in the form of voluntary assisted dying concerning individuals in a situation like his.[692] Necessity should serve as defence to assisted dying in cases of unbearable suffering with no other means of relief, following an informed and voluntary death-wish, carried out by a medical doctor.[693]

According to the Court, dignity was not a right as such but rather a value underlying rights such as those to bodily integrity and privacy.[694] A defence of necessity applying to cases of assisted dying was seen to be unsustainable due to the sanctity of life being a fundamental principle in common law, the absence of a right to die, and the matter being for Parliament, not the Courts, to decide.[695] Furthermore, a blanket ban on assisted dying was seen to be proportionate under Article 8.2 ECHR, following *Purdy, Pretty* and the Strasbourg cases.[696] While claiming that the DPP could not be required to name categories of cases which she would

[687] ibid, [148].
[688] ibid, [150].
[689] ibid, [151].
[690] [2013] EWCA Civ 961, [3].
[691] ibid, [16].
[692] ibid, [38].
[693] ibid.
[694] ibid, [50].
[695] ibid, [54]-[56].
[696] ibid, [105].

not prosecute,[697] the current list of factors in the guidelines following *Purdy* were seen to be insufficient.[698] Consequently, while Mrs Nicklinson's and Mr Lamb's appeals were dismissed, that of Martin was upheld.[699]

Mrs Nicklinson and Mr Lamb appealed to the Supreme Court which delivered its judgment on 25 June 2014. Furthermore, the DPP had appealed the earlier decision, to which Martin cross-appealed. Mrs Nicklinson and Mr Lamb continued to claim that Section 2(1) of the Suicide Act 1961 was an unjustifiable interference with the rights guaranteed by Article 8 ECHR. Martin's appeal was based on the claim that the DPP's policy regarding prosecution of individuals who have assisted another in committing suicide needed clarification.[700] Lord Neuberger of Abbotsbury, President of the Supreme Court, however, stated:

> I do not consider that the Strasbourg jurisprudence suggests that a blanket ban on assisted dying is outside the margin of appreciation afforded to member states and, even if it is, then, in any event, the provisions of section 2(4) prevent the ban in this jurisdiction being a 'blanket ban'.[701]

Consequently, it was for national courts to decide on the matter.[702] The arguments he then looked at in detail were the need for a ban, based on the protection of the vulnerable, moral reasons and Parliament being in a better position to regulate assisted dying.[703] While coming to the conclusion that the Court could in theory rule on the issue at stake,[704] he found that no declaration of incompatibility should be made at this point, as Parliament should first be given the opportunity to amend the Suicide Act accordingly.[705]

> In any event, at least on the basis of the arguments and evidence which have been put before the court, there would have been too many uncertainties to justify our making a declaration of incompatibility. Of course, it is for Parliament to decide how to respond to a declaration of incompatibility, and in particular how to change the law.[706]

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[697] ibid, [114]
[698] ibid, [138].
[699] ibid, [149].
[700] [2014] UKSC 38, [55]-[61].
[701] ibid. On the margin of appreciation and its use by the Strasbourg Court see above at 3.3.
[702] See ibid, [76].
[703] See ibid, [85]-[110].
[704] See ibid, [112].
[705] See ibid, [113].
[706] ibid, [127].

Concerning Martin's appeal, Lord Neuberger was of the opinion that it was not for the Court to dictate the DPP's policies.[707] He therefore stated that the DPP's appeal should be upheld and all others dismissed.

While Lord Mance stressed the importance of autonomy, he claimed that in assisted suicide other factors, like the effect on third parties, came into play.[708] To him, the discrimination between those able to commit suicide unaided and those incapable to do so was justified.[709] He also upheld the DPP's appeal and dismissed the other three. Lord Wilson stressed the importance of Parliament deciding on assisted dying, stating that Parliament would be able to sufficiently protect the weak and vulnerable with installing safeguards,[710] thereby upholding the DPP's appeal. Lord Sumption agreed that the legal differentiation between suicide and assisted suicide was legitimate,[711] and that any possible change was up for Parliament to decide.[712] Like the other Supreme Court judges he did not see it as being appropriate to order the DPP to change the policy.[713] Lord Hughes agreed that "change, whether desirable or not, must be for Parliament to make. That is especially so since a change would be likely to call for an infrastructure of safeguards which a court decision could not create",[714] and that Martin's appeal could not stand,[715] which was similarly upheld by Lord Clarke.[716]

Baroness Hale also saw it as being Parliament's task to review and change the law,[717] however, she stressed a need for change because she saw the current law as being incompatible with human rights due to not allowing for any exceptions.[718] She also stressed that a right to choose when and how to die did not automatically entail a right to receive assistance.[719] Still, while she saw a general ban of assisted suicide to be justified, she stated there was need for room for exceptions in cases like those of Mr Nicklinson, Mr Lamb and Martin.[720] She saw the current law to be

[707] See ibid, [141].
[708] See ibid, [160].
[709] See ibid, [161].
[710] See ibid, [197].
[711] See ibid, [215].
[712] See ibid, [230]-[232].
[713] See ibid, [251].
[714] ibid, [267].
[715] See ibid, [287].
[716] See ibid, [290].
[717] See ibid, [300].
[718] See ibid, [301].
[719] See ibid, [307].
[720] See ibid, [312]-[314].

> a disproportionate interference with their right to choose the time and manner of their deaths. It goes further than is necessary to fulfil its stated aim of protecting the vulnerable. If fails to strike a fair balance between the rights of those who have freely chosen to commit suicide but are unable to do so without some assistance and the interests of the community as a whole.[721]

Baroness Hale therefore would have allowed the first appeal.[722] While thinking that the DPP should review the policy concerning assisted suicide, she saw no need to order her to do so, therefore agreed with dismissing Martin's cross-appeal.[723]

According to Lord Kerr, "Section 2(1) does not strike a fair balance between, on the one hand, the rights of those who wish to, but who are physically incapable of, bringing their lives to an end and, on the other, the interests of the community as a whole".[724] However, seeing that it was for Parliament to change the law, not the Court,[725] he then voted to allow the DPP's appeal.[726] Consequently, the Supreme Court dismissed the appeals of Mrs Nicklinson, Mr Lamb and Martin and allowed the DPP's appeal.

This most recent case engaged with the vital elements of arguing for a right to die and the legalisation of assisted dying: dignity, autonomy, and the task being one for Parliament instead of the courts. As stated in the High Court, autonomy and dignity should at least function as a defence to murder.[727] While this is not the ideal outcome, it would be a start. The finding that the DPP's guidelines are clear enough is acceptable since it is debatable whether guidelines as such are of much use.[728] As stated before, what is needed instead is legalisation.

A main issue this case brought up was the suggestion of introducing a defence of necessity to murder in cases of assisted dying. A defence of necessity would leave the law rendering assistance illegal in place but provide for exceptions regarding prosecution. "Justifications suggest that the defendant's action was morally tolerable, thus recognising a valid reason to perform the action. Excuses affirm the wrongfulness of the defendant's conduct, but hold that the circumstances render blame

[721] ibid, [317].
[722] See ibid, [321].
[723] See ibid, [323]-[324].
[724] ibid, [357].
[725] See ibid, [363].
[726] ibid, [366].
[727] [2012] EWHC 2382, [50].
[728] Concerning the DPP's guideline, see below the commentary at 4.3.

inappropriate".[729] However, "any common law defence was bound to fail because there is no fundamental right to commit suicide".[730] According to Foster, the Court of Appeal "felt that the sanctity of life was a fundamental principle of common law, as reflected in article 2 of the European Convention, which should not give way to values of dignity and autonomy",[731] thereby refusing a defence of necessity. Without acknowledging a right to die and the supremacy of autonomy and dignity over the sanctity of life, there seems to be little ground for such a defence.

The Supreme Court engaged with autonomy and dignity in a way that shows how closely connected those two principles are.

> Autonomy's basis is the moral instinct, which is broadly accepted by English law subject to well-defined exceptions, that individuals are entitled to be the masters of their own fate. Others are bound to respect their autonomy because it is an essential part of their dignity as human beings.[732]

Even more importantly, the Court did not see the sanctity of life to be an argument more powerful than autonomy or dignity. "Our belief in the sanctity of life is not consistent with our belief in the dignity and autonomy of the individual in a case where the individual, being of sound mind and full capacity, has taken a rational decision to kill himself".[733]

Finally, the courts have arrived at this conclusion which makes a change in law pertinent. As the Supreme Court stressed, it is for Parliament to change the law.[734] "It would, therefore, appear that the limits of the common law in this area have been reached and that any future development would be the responsibility of Parliament".[735] After a brief discussion of the academic commentary regarding the above cases, the chapter will therefore examine proposed legislative reforms.

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[729] Findlay Stark, 'Case Comment. Necessity and Policy in R (Nicklinson and Others) v Ministry of Justice' (2014) 18 *Edinburgh Law Review* 104, 105.
[730] Adam Jackson, 'Case Comment. "Thou Shalt Not Kill; But Needst Not Strive Officiously to Keep Alive": Further Clarification of the Law Regarding Mercy Killing, Euthanasia and Assisted Suicide' (2013) 77 *Journal of Criminal La*w 468, 472.
[731] Steve Foster, 'Case Comment. Human Rights – Assisted Suicide – Right to Die – Declaration of Incompatibility – Separation of Powers' (2014) 19 *Coventry Law Journal* 73, 73.
[732] [2014] UKSC 38, [208].
[733] ibid*,* [209].
[734] As Foster put it: "the supreme law maker is Parliament and the courts should not, via the development of the common law or the Human Rights Act, directly challenge that supremacy". S Foster (n 731), 76.
[735] A Jackson (n 730), 472.

4.3. Case Analysis

An argument used to refute the claim for a right to die is that it would contradict the right to life. Coggon argued instead that the opposite to life is not dying, but death. So while a right to death could contradict a right to life, a right to die does not have to.[736] Additionally, dying can be seen as part of life, since "most people will be both living and dying at the same time before they are legally dead. While you can be living *and* dying, you cannot be alive *and* dead (legally)".[737] It is debatable whether what is needed is a right to die or a right to waive one's right to life. The important point, however, is that dying is a part of life and therefore does fit in with ideas regarding the right to life, guaranteed by Article 2 ECHR, and the right to private life, guaranteed by Article 8 ECHR.

The legalisation of assisted dying involves a number of different concepts and philosophical issues. It is a question of acknowledging, and to some extent merging, autonomy, vulnerability, capacity and the sanctity of human life. In the cases dealt with by the English courts concerning assisted dying, a number of themes surface. Major ones are capacity and autonomy; other aspects are discrimination and the need to respect a voluntary death wish.

The discrimination aspect includes the problem of physical incapacity to commit suicide unaided and issues surrounding travelling abroad in order to receive assistance. Also, the question is if the policy published by the DPP in 2009 concerning prosecution in cases of assisted dying is offering useful guidance to those pondering assisted suicide. What is not engaged with in much detail is the idea of human dignity. While the claimants ask for a right to die in dignity, or a way to escape a life in indignity, the courts do not engage with the idea of dignity. A key to that might be a statement by Lord Justice Toulson in the High Court in *Nicklinson,* who recalled a claim by the Advocate General in a German case that "the concept of human dignity is a generic concept, for which there is not a traditional legal definition, but that respect for human dignity is an integral part of the general legal tenets of Community law".[738] From this, one could assume that dignity is not defined and precise enough to function as a distinctive argument in front of the courts.[739]

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[736] See Coggon, 'Could the Right to Die with Dignity Represent a New Right to Die in English Law' (n 28), 224-25.
[737] ibid, 225, italics in original.
[738] [2012] EWHC 2381 (Admin), [88].
[739] On the problematic nature of dignity see above chapter 2.3.

4.3.1. Autonomy

In *Z,* Article 2 ECHR was not used to argue for a right to die but to support the opposing view, that suicide should be prevented.[740] However, as stated by the High Court, if a person has full capacity, the right to life does not supersede autonomy.[741] With that judgment, the Court strengthened the role of the autonomy of the patient and thereby seemed to accept assistance to some degree.

> In situations involving chronically ill patients, *Re Z* suggests that the decision to prosecute persons willing to aid and abet in the death of those patients will not be made as a matter of course, particularly if the Court considers it is not 'in the public interest' to do so.[742]

Under the heading of equality, the State is kept from interfering with the life of the individual, based on liberty and autonomy.[743] However, some individuals might need interference to enable them to live a life of what we call autonomy. According to Fineman, a vulnerability approach would mean an active role of the State in ensuring equality.[744] If we see autonomy as an ideal human trait, it stigmatises those needing help or assistance as being weak and failures.[745] Fineman claimed that for real equality of opportunities we need a more active and responsive State.[746] As was seen above in chapter 2, when analysing autonomy, relational autonomy and vulnerability, in order for everyone to live an autonomous life, some need more assistance than others. "Autonomy is not an inherent human characteristic, but must be cultivated by a society that pays attention to the needs of its members".[747] Accordingly, vulnerability would be the natural status of the human being who, with assistance by the State, could be encouraged to live an autonomous life. Of course, it is not only the State that is to assist the individual, but, as parts of a society, we also have to assist each other.[748] "The vulnerable subject approach […] embodies the fact that human reality encompasses a wide range of differing and interdependent abilities over the span of a lifetime".[749]

In the case of Mrs Z, the concept of capacity was conflated with that of vulnerability. Vulnerability is a problematizing feature in cases of assisted

[740] See De Cruz (n 53), 264.
[741] [2004] E.W.H.C. 2817 (Fam), [18].
[742] De Cruz (n 53), 266.
[743] See Fineman, 'The Vulnerable Subject and the Responsive State' (n 157), 252.
[744] See ibid*,* 256.
[745] See ibid*,* 259.
[746] See ibid*,* 260.
[747] ibid*,* 260.
[748] See ibid*,* 261.
[749] Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (n 165), 12. On vulnerability, see also above chapter 2.2.3.

dying. It can be used to argue both for judicial interventions to enable autonomy to be achieved by a vulnerable person and as a means to disregard autonomous choices. While the Mental Capacity Act 2005 does establish a need to respect autonomous choices, the reality looks different. "Strikingly, it now appears that a decision made by a person judged able to make that decision for him/herself need no longer be respected by the court, if he/she is deemed to be 'vulnerable'".[750]

The key to solving the autonomy vs. vulnerability problem might be relational autonomy, as was seen in chapter 2.2.2. above. Relational autonomy, being an originally feminist approach, claims that the human can only function autonomously due to his relations to others and due to being part of a functioning society. "[H]umans are socially embedded, intimately related to other people, groups, institutions, and histories, […] they are motivated by interests and reasons that can only be fully defined with reference to other people and things".[751] Accepting the relational aspect of our lives could lead to a stronger acceptance of requests for assistance. As Fineman put it: "It is not beyond our current ability to imagine a new concept of autonomy, one that recognizes that the individual lives within a variety of contexts and is dependent upon them".[752] In all five cases summarized above, the individuals wishing to die had lost some of their autonomy due to being physically impaired. However, a true understanding of autonomy, seen as relational autonomy, gives strength to the claims for assistance.

4.3.2. Capacity

The determination of capacity is one of the most important factors in allowing someone to seek death. One cannot be too careful in assessing the nature of a request for death. However, once the capacity has been established, a person should be entitled to go through with a plan to commit suicide in Switzerland or refuse medical treatment. As the Mental Capacity Act 2005 Code of Practice states:

> The starting assumption must always be that a person has the capacity to make a decision, unless it can be established that they lack capacity […] A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it

[750] Michael C Dunn et al, 'To Empower or to Protect? Constructing the 'Vulnerable Adult' in English Law and Public Policy' (2008) 28 *Legal Studies* 234, 236.
[751] Christman, 'Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves' (n 148), 144.
[752] Martha Albertson Fineman, *The Autonomy Myth. A Theory of Dependence* (The New Press 2004), 28.

> needs to be made […] A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour.[753]

It follows that the mental capacity of someone uttering a death wish has to be analysed in that context and cannot be judged simply by their status of being ill or handicapped.

In *Z*, the question was whether Mrs Z had the capacity to make the decision to end her life, or whether, as a vulnerable adult, she had to stay under supervision from the local authorities. What became apparent was the difficult situation of doctors who do not have to treat someone who refuses treatment, while at the same time not being allowed to help someone who requires help to end their life. "A person may not wish to undergo a lingering and undignified death, kept 'alive' by medical science but enjoying absolutely no quality of life. In theory, he or she should have the same right to refuse treatment when incapacitated as when in full capacity".[754] If full capacity was to be proven, Mrs Z would have the same right as anyone else to travel abroad, even if that is to commit suicide with the help of Dignitas.

However, the case cannot be understood to challenge the existing law on assisted suicide. "There was no suggestion that the injunction was lifted because the Court was prepared openly to sanction suicide under current English law".[755] The same was stressed by Mahendra who stated that "the general law remains unaltered, and will apply in all its rigour".[756] The injunction set in place had after all not been issued to analyse the rights and wrongs of assisted dying but only to assess her capacity.[757]

Also a case on capacity was that of Ms B.[758] While the Court did not make a value statement about her life or her wish to die, it did rule in her favour in stating that she had the capacity to make her own decisions and that the hospital "had acted unlawfully by failing to resolve the dispute over Ms B's predicament expeditiously".[759] An interesting aspect of her case was the incapacity of the hospital personnel to deal with a death-wish objectively. Dr C, for example, "felt she was being asked to kill Ms B".[760] Both clinicians treating Ms B found themselves unable to comply with her

[753] Mental Capacity Act 2005 Code of Practice, 40.
[754] Alec Samuels, 'Complicity in Suicide' (2005) 69 *Journal of Criminal Law* 535, 539.
[755] De Cruz (n 53), 261.
[756] B Mahendra, 'Assisted Suicide: The Law Upheld' (2004) 154 *New Law Journal* 1848, 1848.
[757] See ibid, 1849.
[758] [2002] EWHC 429 (Fam).
[759] Kenneth Veitch, 'Medical Law and the Power of Life and Death' (2006) 2 *International Journal of Law in Context* 137, 150.
[760] [2002] EWHC 429 (Fam), [57].

wish. "They knew her well and respected and liked her. They considered her to be competent to make decisions about her medical treatment. They could not, however, bring themselves to contemplate that they should be part of bringing Ms B's life to an end".[761] If her autonomy had been respected and her capacity proven, she should have been allowed to refuse treatment. The doctor's refusal to act on her wishes is maybe understandable on a personal level but lacked the respect of a person's right to self-determination. Ms B did not want the proposed treatment and should therefore not have received it. As Dame Butler-Sloss put it in her judgment: "I have to say, with some sadness, that the one-way weaning process appears to have been designed to help the treating clinicians and other carers and not in any way designed to help Ms B".[762] Ms B's request was different to those of Mrs Z, Mrs Pretty, Ms Purdy or Mr Nicklinson. She did not ask for assisted dying, but simply wanted to refuse treatment, which is legal and should be acted upon, even if it brings about death.

Dunn et al dealt with three capacity cases, two concerning decisions in respect of marriage and one concerning the contact of a girl with her father, all three leading to pre-emptive interventions. The authors stated that prior to those cases there were only two scenarios in which an autonomous choice concerning health or welfare could be overridden, those being "the compulsory assessment or treatment of an adult with a 'mental disorder' […] [and] the compulsory examination and/or detention of a person with an infectious and 'notifiable' disease".[763] Cases of assisted dying now bring a new dimension into play, the autonomous death wish. Once capacity has been ascertained, an autonomous death-wish should be accepted.

4.3.3. DPP's Policy

An important aspect arising from the case law is the attempt to clarify the legal situation with the help of a prosecution guideline. The case of Ms Purdy led to the DPP publishing the 'interim policy for prosecutors in respect of cases of assisted suicide' at the end of September 2009. A final revised version was published on 25 February 2010. In that policy, the DPP listed 16 factors in favour of prosecution, such as the victim not having

[761] ibid, [58].
[762] ibid, [98].
[763] Dunn et al (n 750), 237, footnote 23. It should be noted though, that those compulsory treatments are issued under different acts, the first under the Mental Health Act 1983, the second under the Public Health (Control of Disease) Act 1984, with the mental health law powers being far more intrusive than the general notification requirements addressed by public health law.

asked directly for help, the victim being younger than 18 or the suspect not being a spouse, family member or friend. He furthermore listed 6 factors against prosecution, such as the victim having been unable to commit suicide unaided and the suspect having tried to dissuade the victim.[764] The policy additionally highlighted which factors will generally weigh more heavily than others in each list.[765]

According to Livings, "the Interim Policy may mean that the offence outlined under s. 2 of the Suicide Act 1961 has undergone a process of *de facto* decriminalisation".[766] However, he criticised the fact that the weighing of factors for or against prosecution was left open[767] and that a policy like that was discriminatory because it enabled those who have the financial means to travel abroad for assisted suicide to kill themselves while not being of any help to those not having the financial means.[768] "In responding to the demands of the House of Lords in *Purdy,* the DPP has largely crystallised the prosecutorial policy that has in fact been in existence for some time […] the document is deliberately equivocal and shies away from giving any guarantees as to prosecutorial decisions".[769]

Greasley went further in her criticism in claiming that the policy was a step backwards and that the DPP's previous policy of turning a blind eye was more satisfactory.[770] According to Greasley, the approach of the DPP towards assisted suicide had always been consistent and was therefore not in need of clarification.[771] While understanding that Ms Purdy might be afraid of future inconsistency and therefore asked for clarification, Greasley stated that "the need for administrative consistency cannot shoulder much argumentative weight where there is nothing there to rectify".[772] The same was held by Samuels who stated that though the Suicide Act prohibits all sorts of assistance, in reality the DPP is reluctant to prosecute.[773]

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[764] See DPP, 'Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide', [19], [21]. The terminology used, speaking of 'vitims' and 'suspects', was criticised by Biggs since, "where a person is physically incapable of performing the final act herself, but has acted upon a settled and determined wish to die and has not been pressurised into fulfilling that desire, she is certainly not a victim in the usual sense". Hazel Biggs, 'Legitimate Compassion or Compassionate Legitimation? Reflections on the Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide' (2011) 19 *Feminist Legal Studies* 83, 85.
[765] See DPP (n 764), [20], [22].
[766] Livings (n 355), 32, italics in original. This was also claimed by Mullock. See Alexandra Mullock, 'Overlooking the Criminally Compassionate: What are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?' (2010) 18 *Medical Law Review* 442, 469.
[767] See Livings (n 355), 42.
[768] See ibid, 43.
[769] See ibid, 52.
[770] See Greasley (n 33), 301.
[771] See ibid, 310.
[772] ibid, 311.
[773] See Samuels (n 754), 536.

Further criticism was voiced by Rogers who stated "that offence-specific policies of the type that was mandated in *Purdy* are inherently objectionable, and no less so in this difficult and tragic case".[774] While claiming that the policy was not overly clear, "we can see that it is very difficult for prosecutorial 'public interest' guidelines to be clear *and* accessible, because clarity may tend to come at the price of concealing important nuances (thus undermining accessibility)".[775] Furthermore, the need for the policy was debatable since the fact that the DPP went public with his decision not to prosecute the assisted suicide of Daniel James can be interpreted as showing that he would never prosecute a case like that.[776] But as Powell highlighted, the judges in *Purdy* argued that the case concerning Daniel James demonstrated the unhelpfulness of the Code for Crown Prosecutors.[777] Still, he did not see the solution in a policy since a policy would either be too specific, thereby not covering all cases, or, as he saw being the case with this policy, too general, rendering it almost useless.[778] As was demonstrated by the latter case of Martin,[779] the policy was not perceived as too helpful by someone wishing for assistance in dying, however, the Supreme Court did not see a need for clarification.

According to Cartwright, the policy published by the DPP was not a step in the right direction since "the DPP's role is as prosecutor not legislator and it is improper for Parliament to stand back and leave him to resolve this controversial area of the law".[780] For Cartwright it was not a question of whether to allow assisted dying but, since it was already taking place, how to regulate it.[781] "We are already on the 'slippery slope' and Parliament should act to put in place their own safeguards, allowing for the ultimate act of compassion while safeguarding the interests of the vulnerable".[782] This was stressed in the recent judgment of the Supreme

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[774] Jonathan Rogers, 'Prosecutorial Policies, Prosecutorial Systems, and the Purdy Litigation' (2010) 7 *Criminal Law Review* 543, 545.
[775] ibid*,* 552, italics in original.
[776] See ibid*,* 554. The foreseeability of the DPP's behaviour as a reason against the need for a policy was also stressed by Mason, 'Case Comment' (n 55), 300.
[777] See Dave Powell, 'Case Comment. Assisting Suicide and the Discretion to Prosecute Revisited' (2009) 73 *Journal of Criminal Law* 475, 477.
[778] ibid*,* 479. Reidy also found the policy too vague. "Despite the fact that the court held that such a policy was needed to clarify and safeguard the existing law in the area, the policy which was issued has left the law in an even more vulnerable, dangerous and ambiguous position". Sheila Reidy, 'English Law on Assisted Suicide: A Dangerous Position' (2012) 18 *Medico-Legal Journal of Ireland* 68, 71.
[779] [2014] UKSC 38.
[780] Nick Cartwright, 'Case Comment. 48 Years on: Is the Suicide Act Fit for Purpose?' (2009) 17 *Medical Law Review* 467, 474. Furthermore, as Biggs stressed, it is not the role of the DPP to grant immunities of sorts, the decision to prosecute "can only ever be taken after the fact". Biggs, 'Legitimate Compassion or Compassionate Legitimation?' (n 764), 89.
[781] See Cartwright (n 780)*,* 475.
[782] ibid.

Court, which favoured action by Parliament over a further clarification of the DPP's policy.

> [O]nce Parliament has created an offence, only Parliament has the authority to redraw its boundaries so that it catches fewer people in its net. For any other organ of the State to attempt to do so is to infringe the first rule of the constitution, which is the supremacy of Parliament.[783]

The policy deriving from the *Purdy* judgment was challenged by Martin who asked for a clarification of it.[784] "The case of *Martin* exposes, but does not resolve, the tension between the principle of legality and the need to set out the public interest factors against prosecution. Probably it is necessary to over-rule *Purdy* in order to achieve that".[785] Finnis argued in a similar vein concerning the Supreme Court's judgment:

> Unfortunately, no party or intervener argued that *Purdy* was wrongly decided: Lord Hughes alone indicates (at [277]) that *Purdy* was incompatible with constitutional principles and finds (at [280]) that ordering the DPP to issue guidance was unjustified. It should indeed have been challenged and overruled.[786]

An important question is whether all variants of assisted dying should be legalised, or only either physician assisted suicide, or compassionate assisted suicide. The policy of the DPP solely engaged with compassionate assisted suicide by a family member or friend. However, people like Mr Nicklinson would want to rely on the professional help of a doctor. This not only guarantees a successful outcome of the suicide, it also does not put the pressure on a family member or friend to 'be responsible' or even just involved. Therefore, if assisted suicide was to be legalised, it should also cater for those seeking professional help and not only for the assistance of family or friends. The policy by the DPP concerning the prosecuting of those assisting the suicide of a loved one does not solve the problem of the current legal situation. What is needed is not a further clarification of the DPP's prosecution policies but a change of the legal situation.

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[783] JR Spencer, 'Case Comment. Assisted Suicide and the Discretion to Prosecute' (2009) 68 *Cambridge Law Journal* 493, 495.
[784] [2014] UKSC 38.
[785] Jonathan Rogers, 'Case Comment. Assisted Suicide Saga – the Nicklinson Episode' (2014) 7 *Archbold Review* 7, 9.
[786] John Finnis, 'Case Comment. A British "Convention Right" to Assistance in Suicide' (2015) 131 *Law Quarterly Review* 1, 7.

4.3.4. Discrimination

The current legal situation concerning assisted dying can be claimed to be discriminatory. Leaving aside the conspicuous discrimination seen in not legalising assisted dying while having decriminalised committing suicide,[787] the focus here is on the discrimination in the practice of the DPP. While the policy of the DPP shows the unlikelihood of prosecution of compassionate assisted suicide committed with the help of a spouse, family member or friend, Mr Nicklinson sought a declaration that his physician would not have to fear prosecution if helping him to die. However, the Court refused that claim since

> it would be wrong for the court to depart from the long established position that voluntary euthanasia was murder unless the court were required to do so by art.8 and that art.8 did not require voluntary euthanasia to afford a possible defence to murder.[788]

The Court also did not see a need for the DPP to clarify his position on assisted dying even further. Greater clarification "would go beyond the boundaries of the European Court of Human Rights jurisprudence; would be impractical and would be constitutionally inappropriate".[789] The discrimination behind this can be seen in the fact that compassionate assistance by family or friends has been declared by the DPP to be unlikely to be prosecuted, while the assistance by a healthcare professional is more likely to attract prosecution. This is rather unfortunate. "The fact is that medical expertise is needed if these suicides are to be performed properly--a general member of the public simply would not have the knowledge required to successfully, easily and properly aid another to die".[790]

Unless stated otherwise in the specific Act, English law only applies on a territorial basis.[791] Since it was not mentioned in the Suicide Act 1961 that it is to apply supra-nationally, it theoretically does not cover suicide committed abroad.[792] Hirst argued that since assisted suicide was a 'result crime', and the view of English law is that a crime is committed where the result occurs,[793] a husband who assisted his wife in travelling abroad to commit suicide in a country where assisted suicide was legal, as had been

[787] This can of course be argued to not be discrimination, due to the act/omission distinction. However, based on autonomy and dignity it leads to a *de facto* discrimination.
[788] See 'Human Rights' (2013) Jan *Public Law* 165, 168.
[789] 'Case Comment. Assisting Suicide: Whether Defence of Necessity Available' (2012) 9 *Archbold Review* 1, 1.
[790] Reidy (n 778), 73.
[791] See Michael Hirst, 'Suicide in Switzerland: Complicity in England?' (2009) 5 *Criminal Law Review* 335, 336.
[792] See ibid.
[793] See ibid.

the plan of Ms Purdy and Mrs Z, did not commit a crime under the Suicide Act 1961.[794] This is another aspect of discrimination, as it means that those being able to travel in order to commit suicide abroad are less likely to be prosecuted than those receiving assistance in England.

A claim against the law being discriminatory is the sanctity of life argument which can be interpreted to mean that we all have to live the life we have been given. Some of us are more fortunate in being healthy, others are less fortunate. According to that view, law does not discriminate, nature does. However, what this view leaves aside is the reality of medical development. "[H]uman beings' increasing ability to manipulate their biological functions has consequences for traditional notions of health and illness, and of life and death".[795] With medical developments we have mastered to cure many illnesses and keep persons alive who without the help of technology and medicine would die. Since the human being does intervene in prolonging life, it can be argued that we should also be allowed to shorten life – on a voluntary basis that is. "Without the assistance of the law, disabled and chronically ill persons incapable of exercising the choice to commit suicide are effectively consigned to an earthly limbo".[796] As Williams stated, the 'pro-life' lobby often uses disability as an argument against legalising assisted dying, as that could lead towards a slippery slope endangering the lives of the disabled.[797] However, the wish for assisted dying is coming from exactly that group of people, those too impaired to commit suicide unaided.

We could quite simply accept that a severely disabled person is generally capable of less than a healthy one.[798] However, when it comes to assisted dying, the matter is different. The impaired person does not ask for something that is only available to a limited group of persons due to specific abilities, he or she asks for help in something that an unimpaired person is capable of doing unaided. Of course it can be argued that no one has a right to die and that therefore an impaired person cannot request

[794] See ibid*,* 338. This was refuted by Chalmers who recalled Lord Hope of Craighead's assessment in *Purdy*, that "acts which help another person to make a journey to another country, in the knowledge that its purpose is to enable the person to end her own life there are within its [the Suicide Act's] reach". [2009] UKHL 45, [18]. Accordingly, assisting suicide is an offence in itself, no matter where the suicide takes place. See James Chalmers, 'Case Comment. Assisted Suicide: Jurisdiction and Prosecution' (2010) 14 *Edinburgh Law Review* 295, 296.
[795] Veitch (n 759), 139.
[796] Melanie L Williams, 'Death Rites: Assisted Suicide and Existential Rights' (2005) 1 *International Journal of Law in Context* 183, 188.
[797] See ibid.
[798] Legal provisions like the CRPD challenge such an over-simplifying approach. See for example Article 5, granting equality and non-discrimination.

help in dying. But exactly that is the reason why there is need for a right to die, so that those incapable of committing suicide unaided have a right to base their claim on.

4.3.5. Accepting a Voluntary Death Wish

The case of Ms B shows the difficulty in assessing a true and autonomous wish for death. Many opponents of assisted dying claim that a wish to die is a sign of depression and not a true, objective wish to cease living.[799] Their claim is that once the depression has been treated, or the person has gotten used to their situation, they will start to enjoy life again. But we do not have the means to tell whether a wish to die is influenced by a depression. Lord Hope of Craighead stated that even considering suicide shows a lack of judgement.[800] Accordingly, any request for assisted dying would mean a lack of capacity and would lead to the person not being allowed to pursue their wishes. Clearly, this is a very one-sided view. Just because we do not know what it feels like to not want to live anymore does not give us the right to discount that wish of others.

Ms B made the determination of the seriousness of her wish to die even more difficult by seemingly changing her opinion after receiving anti-depressants. Though she claimed that she had never changed her mind and only had acceded to giving rehabilitation a try when she was assessed as not having capacity,[801] it is hard to figure out what her motivation was and how serious her death wish was at different stages of her illness. One could argue that it does not matter what the motivation behind the death wish is, whether it is brought about by depression or is an objective, conscious choice since one cannot regret it, or change one's mind.[802] Unless there is an afterlife where individuals that have committed suicide are condemned and sent to hell, a 'wrongful suicide' cannot be regretted once it is committed. If that is perceived as a too easy way of dealing with a death wish, one could follow the argument of Ms B's doctor Mr G who

[799] See for example Baroness Symons of Vernham Dean who used the story of a man, suffering from leukaemia, who was close to giving up but became better and eventually enjoyed life again, as an example why the wish for death should not be acted upon. Hansard Vol 681, Friday 12 May 2006, col 1223. The view was picked up in the same debate by Baroness Morris of Bolton who stated that "patients are often not in the right frame of mind, and the information to patients may be wrong". Hansard Vol 681, Friday 12 May 2006, col 1271. The point was also made in the submission by the Catholic Bishops' Conference of England and Wales in *Pretty v UK*. See ECtHR Application no. 2346/02, [30].
[800] See [2001] UKHL 61, [71].
[801] See [2002] EWHC 429 (Fam), [40]-[44].
[802] See Brassington (n 48), 426, who claimed that making the wrong choice in picking a meal at a restaurant is worse than choosing death for a wrong reason because while being able to regret the former, one cannot regret the latter.

claimed that she could not choose death before having experienced all alternatives, in this case rehabilitation.[803] Dame Butler-Sloss rightly refused that claim by stating that one should be allowed to make decisions without having experienced the consequences.[804] The prerequisite of having experienced all alternatives of an action first, before settling for something, is illusionary. Of course there is a difference in deciding on a career path or a holiday destination and deciding to favour death over life. However, if we take the freedom to make choices regarding our own life seriously, we have to let people choose death over life, not based on autonomy but simply based on respect.

The case concerning Mrs Z demonstrated exactly the kind of respect required. While the case did not engage with the question whether assisted suicide is right or wrong and therefore offers no guidance in that matter, it acknowledged the freedom the individual – in this case Mrs Z – has in deciding for herself. "Human freedom, if it is to have real meaning, must involve the right to take what others may see as unwise or even bad decisions in respect of themselves; were that not so, freedom would be largely illusory".[805] That is the first step that needs to be taken in respect of assisted dying. People must be free to choose their own fate. Without that step the next one – receiving assistance in committing suicide – would be indefensible.

4.3.6. Concluding Remarks

Once the step has been taken to allow people to make their own choice regarding their life and death, the question is how to deal with those seeking assisted dying. The cases discussed above did develop domestic law concerning patient autonomy and assisted dying. While Mrs Pretty's quest for immunity from prosecution for her husband might have seemed unrealistic, because, as was stated by the Divisional Court and upheld by the House of Lords, the DPP cannot grant immunity before an action takes place, Ms Purdy followed up on that by asking for a clarification of the DPP's policy on prosecuting cases of assisted dying. However, the DPP's policy was seen to not clarify the law sufficiently, as was demonstrated by Martin asking for further clarification of the policy. Yet, the claim was refuted, which can be seen as the right step. What is needed is not a further elaboration of prosecution policies but a change of the criminal law

[803] See [2002] EWHC 429 (Fam), [63].
[804] See ibid.
[805] [2004] EWHC 2817 (Fam), [12].

concerning assisted dying. What *Nicklinson* demonstrated, however, is that there is no inclination by the English courts to interpret the law anew or to change existing law as to allow assisted suicide in England. The Supreme Court's judgment stressed the need for Parliament to address the issues.

4.4. Suggested Legislative Changes Concerning Assisted Dying

The case of Mrs Pretty can be seen as vital for the development of law concerning assisted suicide since "the first major reassessment of the law on assisted dying was prompted by the case of Diane Pretty in 2002".[806] While the law itself has not been changed yet, several attempts have been made. Three Bills were introduced into Parliament by Lord Joffe, in 2003, 2004 and 2005. None of those Bills gained parliamentary approval. In 2014, Lord Falconer introduced another Assisted Dying Bill, following the Falconer Report of the Commission on Assisted Dying in 2010. Currently, the Bill by Lord Falconer is at the committee stage of the House of Lords.[807]

4.4.1. Patient (Assisted Dying) Bill 2003

The first Bill introduced was the Patient (Assisted Dying) Bill by Lord Joffe in 2003. Its aim read as follows:

> A Bill to enable a competent adult who is suffering unbearably as a result of a terminal or a serious and progressive physical illness to receive medical help to die at his own considered and persistent request; and to make provision for a person suffering from such a condition to receive pain relief medication.[808]

The Bill, first of all, set out the conditions under which a patient may request assisted dying, such as him or her being competent[809] and suffering unbearably from an irremediable condition.[810] Following that came a list of requirements the doctor must fulfil, for example informing the patient of alternative treatments like palliative care[811] and making sure the request was formed voluntarily.[812] Only if all requirements under Sections 2(2) and 2(3) were satisfied could the physician proceed. Section

[806] Shaw (n 30), 336. For a summary of the case see above at 4.2.1. and for the analysis of the ECtHR's approach see chapter 3.1.1.
[807] After a first and second reading in the House of Lords, a Bill reaches the committee stage, followed by a report stage and a third reading. It then goes through the same procedure in the House of Commons, before amendments are incorporated. The final stage is royal assent.
[808] Patient (Assisted Dying) Bill. HL Bill 37. 53/2.
[809] ibid, S.2(2)(b).
[810] ibid, S.2(2)(d).
[811] ibid, S.2(3)(d).
[812] ibid, S.2(3)(e).

3 concerned the declaration that needed to be made by the patient and witnessed by a variety of persons, Section 4 listed further duties of the attending physician (like informing the patient of his right to revoke the declaration) and Section 5 concerned the revocation of the declaration. Section 6 gave physicians the right to conscientious objections, Section 7 was about the need to refer a patient to a psychiatrist if the competence was in doubt, Section 8 regulated the notification of the next of kin, Section 9 stated that a physician acting in accordance with the Bill would be free from prosecution and Section 10 was about possible offences under the Bill. Section 11 stated the validity of insurances made at least 12 months prior to the patient's death, Section 12 and 13 were about the need for reporting and monitoring the assisted dying, Section 14 declared the patient's entitlement to sufficient pain killers, and Section 15 was concerned with the power of the Secretary of State to make regulations concerned with the Bill. Section 16 gave the short title and stated that the Bill would not extend to Northern Ireland.

On 6 June 2003, the Bill received its second reading by the House of Lords. In the debate of seven hours nearly as many argued in favour of the Bill as argued against it. The arguments can generally be grouped under the headings of autonomy of the patient and a right to a dignified death versus the protection of the vulnerable, the sufficiency of palliative care and the sanctity of life. The Bill was rejected by the House of Lords. Since the debate in the House of Lords brought up the general arguments used in policy discussions surrounding assisted dying, it is valuable to briefly examine the parliamentary proceedings in a later part of this chapter.

4.4.2. Assisted Dying for the Terminally Ill Bill 2004

The following version of the Bill, introduced into Parliament in 2004, had an added clause on palliative care. 3(1) read: "The attending physician shall ensure that a specialist in palliative care who shall be a physician or nurse has attended the patient to discuss the option of palliative care".[813] Also, the precondition that the patient was suffering from an irremediable condition was changed to a terminal illness.[814] Concerning the patient's declaration, an additional requirement had been introduced in that it had to not only be witnessed by a solicitor but that the patient had to be known to the solicitor or must have proven his or her identity, must have

[813] Assisted Dying for the Terminally Ill Bill, HL Bill 17, 53/3.
[814] See ibid, S.2(2)(c).

appeared of sound mind to the solicitor, seem to be acting voluntarily and show that he or she understood the effects of the declaration.[815] The patient also had to prove his or her identity to the second witness and must again have seemed competent and acting voluntarily.[816] The Assisted Dying for the Terminally Ill Bill 2004 was discussed in less depth and length than the previous draft. This was not due to a lack of interest or controversy but due to the fact that the House of Lords had set up a Select Committee to deal with the Bill. In its second reading,[817] Lord Joffe introduced the Bill as being limited in scope compared to the previous version but including significant changes in response to the earlier debate. Those significant changes were first of all the limitation to terminally ill patients, the fact that active help by a physician was to be only allowed for those who were physically unable to perform suicide unaided and the need for a previous consultation with a specialist in palliative care.[818]

The Select Committee, which had been appointed in November 2004, published its report in April 2005.[819] In the report, the Committee dealt with the underlying ethical principles of the Bill, namely autonomy and the sanctity of life, and the practical issues concerning the Bill, such as for example the danger of a slippery slope, the already existing illegal practice of assisted dying and palliative care. The Committee had issued a call for written evidence to over 100 organisations, of which roughly 60 had replied and had furthermore received more than 14,000 individual letters and emails on the topic.[820] Both sides in the argument about whether or not to legalise assisted dying were found to value both principles at stake, autonomy and the sanctity of life, the question was which one should prevail.[821] After considering those details, the Committee had a look at three foreign jurisdictions, Oregon, the Netherlands, and Switzerland, where assisted dying had been legalised already; and analysed public opinion in England on the issue of a change of law concerning assisted dying. Due to the shortage of the remaining parliamentary time, the Committee found that the Bill could not be considered adequately in that session and concluded that it therefore could not proceed.[822] However, it

[815] See ibid, S.4(3).
[816] See ibid, S.4(4).
[817] See Hansard Vol 658, Wednesday 10 March 2004.
[818] See ibid, col 1316.
[819] HL Paper 86-I, 4 April 2005.
[820] See ibid, 10, [5].
[821] See ibid, 20, [39].
[822] See ibid, 81, [235].

"recommend[ed] that an early opportunity should be sought for our report to be debated by the House".[823]

4.4.3. Assisted Dying for the Terminally Ill Bill 2005

In changing the Bill to its later version of 2005, capacity was introduced. Subsequently, the Assisted Dying for the Terminally Ill Bill of 2005 had the purpose to "[e]nable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and for connected purposes".[824] Section 3 now was concerned with capacity and 3(2) stated that "[no] assistance to end the patient's life may be given unless the consultant psychiatrist or the psychologist has determined that the patient does not lack capacity". This version of the Bill provided for Section 2 of the Suicide Act 1961 to be amended by adding a Section 3(A):

> Subsection (1) does not apply where a person assists another person to die, or where a person helps another person to assist a third person to die, or where a person is present when another person ends his own life or attempts to do so, in accordance with sections 1 and 8 of the Assisted Dying for the Terminally Ill Act 2005.[825]

It received its second reading by the House of Lords on 12 May 2006. The debate lasted for seven hours, nearly 100 members of the House spoke for or against the Bill. In the end, the House voted with 148 to 100 in favour of an amendment by Lord Carlile that the Bill not be read 'now' but in six months' time, which in practice meant the end of the Bill.[826]

Lord Joffe explained in his introduction that the Bill followed the earlier versions of assisted dying Bills but following the Select Committee that had dealt with the issues of the Bill in 2005, this version now was modelled on the Oregon Death with Dignity Act.[827] "The Bill would allow a doctor, at the persistent and informed request of a terminally ill patient who has capacity and is suffering unbearably, to prescribe medication for self-administration by the patient in order to end his suffering by ending his life".[828] In drafting this version of the Bill, Lord Joffe had included all the recommendations made by the Select Committee, apart from two: the proposed change to 'unbearable suffering' and the prerequisite of having experienced palliative

[823] ibid, 81, [235].
[824] Assisted Dying for the Terminally Ill Bill, HL Bill 36. 54/1.
[825] ibid, [15].
[826] See Hansard Vol 681, Friday 12 May 2006, col 1189.
[827] See ibid, col 1184.
[828] ibid, col 1184.

care before making the decision for assisted dying.[829] This was not intended to devalue palliative care. "All the committee and all the supporters of the Bill strongly support the provision of more and better palliative care".[830] Still, palliative care could not be seen as the right solution for everyone and not as a substitute for assisted dying. One of the most prominent changes was that the Bill was now restricted to assisted suicide, excluding voluntary assisted dying.[831]

In this second lengthy debate on assisted dying the focus in argumentation had shifted to some degree. While the opponents still argued in favour of palliative care and the sanctity of life – often illustrated by personal anecdotes, – the supporters argued in relation to those objections and not on freestanding points. Therefore, it was more of an actual debate than the one on the original draft in 2003. As the previous versions of the Bill, this too was rejected.

4.4.4. Commission on Assisted Dying, Falconer Report

The following suggestion for legislative change was an amendment to the Coroner's and Justice Act 2009, introduced by Lord Falconer. In 2009, the Coroners and Justice Act had amended the Suicide Act. The offence was now reduced from aiding, abetting, counselling and procuring[832] to "encouraging or assisting the suicide or attempted suicide of another person".[833] In February 2010, the Commission on Assisted Dying, chaired by Lord Falconer, was established "to take a fresh look at how assisted dying is currently dealt with in English public policy and law, following the publication of the Director of Public Prosecutions' (DPP's) 'Policy for prosecutors in respect of cases of encouraging or assisting suicide'".[834]

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[829] See ibid, col 1187.
[830] ibid, col 1187.
[831] See ibid, col 1186.
[832] See Suicide Act 1961, 2(1).
[833] Coroners and Justice Act 2009, S. 59(2)(1)(a).
[834] The Commission on Assisted Dying, *"The Current Legal Status of Assisted Dying is Inadequate and Incoherent…"* (DEMOS 2011), 37. The Commission had been set up by Demos, an organisation that "is a think-tank focused on power and politics. Our unique approach challenges the traditional, 'ivory tower' model of policymaking by giving a voice to people and communities, and involving them closely in our research". http://www.demos.co.uk/ accessed 11 December 2012 at 12.55pm.
Demos saw the need for an independent inquiry into assisted dying and established a commission to analyse it. "The commission consists of individuals selected on the basis of their open mindedness and expertise. All commissioners are representative of their own beliefs and opinions, and not of any other organisation they may be affiliated to. Demos will be providing secretariat and administrative support". http://www.demos.co.uk/projects/commissiononassisteddying, accessed 11 December 2012 at 12.50pm. The Commission comprised 11 members, the Reverend Canon Dr Woodward, Dame Platt DBE, Ms Mordaunt MP, Dr Duckworth OBE, Dr Dacombe GP, Sir Catto, Professor

The report began by looking at the assisted dying debate in the UK, outlining the current legal situation, followed by the ethical basis of the debate and perspectives on the legal status of assisted dying. It then considered assisted dying in the context of health and social care services and in connection to vulnerable groups. The report next turned to the practical issues concerning a change of the assisted dying legislation, the determination of eligibility, proper safeguards and procedural issues. The third and last part concerned future steps, analysing evidence gathered by the Commission and working out core principles.

A general finding was the strength of argument on both sides of the debate.[835] Instead of focussing on whether assisted dying should be legalised, the Commission focussed on how the change might be brought about most successfully, should Parliament decide on a change.[836]

> It is clear from the evidence we have received that we need to raise standards of care and give the person and the patient a voice. The current gaps between theory and practice demonstrate a failure of imagination that limits the depth of compassion that we can communicate as individuals and as a society.[837]

The current situation in which the decision of whether or not to prosecute rested solely with the DPP was seen as intolerable.[838] Also intolerable was the effect on personal relationships.

> The particular prohibition on professional assistance also, by implication, favours amateur assistance, thereby putting unreasonable burdens on friends and family members, who could be involved in complex and emotive situations with loved ones who wish to have assistance to die.[839]

Another effect was that the threat of prosecution for some meant to choose a lone death to save others from prosecution and stigma.[840] The general view of the Commission was that assisted dying should be an option for terminally ill patients. "As well as relieving actual suffering, making this choice available could help to relieve the dread of suffering for those who live in fear of a very unpleasant death".[841]

Ahmedzai and members of the House of Lords: Baroness Murphy of Aldgate, Baroness Young of Old Scone, Lord Blair of Boughton and its Chair Lord Falconer.
For the lead up to the policy, see the analysis on Purdy at 4.2.4.
[835] The Commission on Assisted Dying, *"The Current Legal Status of Assisted Dying is Inadequate and Incoherent…"* (DEMOS 2011), 283.
[836] See ibid.
[837] ibid, 284.
[838] ibid, 285.
[839] ibid, 286.
[840] See ibid.
[841] ibid, 287.

One of the major concerns connected to assisted dying is the threat it could pose to the vulnerable. However, the Commission could find no evidence in Oregon, Belgium and the Netherlands (where it is a lawful practice) that the lives of vulnerable people were at risk.[842] In general, legislation might mean greater safety instead of a threat. "The evidence we have received in the Netherlands, Belgium and Oregon suggests that such a framework could be safer than the status quo, while also providing terminally ill people with more choice and control at the end of life".[843] The report ended with an elaboration of safeguards that were needed for a legalisation of assisted dying. "[T]he Commission considers that the most important safeguard in any assisted dying regime would lie in the relationship between the patient and their doctor"[844] since the general practicioner (GP) of a patient would be able to determine whether the patient had capacity and was acting voluntarily. While including the safeguard that the patient must be suffering a terminal illness,[845] the Commission chose not to include any classification of suffering (like 'unbearable') since that would be too subjective and hard to determine.[846]

While much of the debate around assisted dying centres around the issue of discrimination against those too handicapped to commit suicide unaided, the Commission could reach no consensus on whether to include those disabled like Mr Nicklinson but not suffering from a terminal illness, or whether to reserve the right to assisted suicide for terminal illnesses.[847] It chose to exclude the non-terminally ill in order to prevent a slippery slope and believed that "would send a clear message to the British public that disabled people's lives are equally valued and that if the 'opportunity' does not exist the 'obligation' cannot follow in the UK".[848] The Commission also stressed the importance of palliative care and that it did not see any evidence in jurisdictions that had decriminalised assisted suicide of palliative care losing its role and importance.[849] It was very clear on supporting only assisted suicide but not assisted dying as "assisted suicide, whereby the individual must take the medication that will end their own life, underlines the autonomy of the individual's act and thereby provides

[842] See ibid, 290.
[843] ibid, 299.
[844] ibid, 302.
[845] See ibid, 303.
[846] See ibid, 305.
[847] See ibid, 306.
[848] See ibid.
[849] See ibid, 314.

an additional safeguard regarding the voluntariness of the individual's choice".[850]

While the Commission did not have the role of proposing a change in the law, it came to the conclusion "that the current legal status of assisted suicide is inadequate and incoherent".[851] The report stated that compassionate assisted suicide did actually take place. However, there had been no prosecutions since the DPP had published his policy concerning assisted suicide in 2010, even though 40 cases had been reported since 2009. It was left open though what the reasons for non-prosecution were.

> The current policy on assisted suicide accepts the principle of compassionate assistance with suicide, but because assisting suicide remains a crime it does not allow for open discussion or professional assessment and support for people contemplating assisted suicide.[852]

The Commission saw a difficulty in the current situation in that there were no safeguards for those seeking assistance and in that the question of prosecution was at the discretion of the DPP and therefore dependent on the current DPP's opinion.[853] "The current situation, while being very distressing for families and unclear for health and social care staff, also lays a deeply challenging burden on police and prosecutors, which could be eased by a new statutory framework".[854] While being in favour of palliative care, the Commission saw the need for assisted dying to be legalised for the very small number of people who would actually seek it.[855]

The Commission introduced a number of core principles that should be included in a framework of assisted dying. Those core principles were: the promotion of open discussion about death and dying, core rights in end of life care, availability of end of life care in all settings, no discrimination in end of life care, and more choice concerning one's own death.[856] It did not seek a general legalisation of assisted suicide, it should only be lawful in very confined circumstances and remain criminal if those circumstances were not met.[857] The Commission further suggested safeguards and eligibility criteria, for example that a patient must be over 18 and suffering from a terminal illness, but also concerning the proper practical support

[850] ibid, 318.
[851] ibid, 20.
[852] ibid, 23.
[853] See ibid.
[854] ibid.
[855] See ibid, 24.
[856] See ibid, 24-25.
[857] See ibid, 25.

provided to the patient[858] and "bereavement support available to friends and relatives".[859]

> The Commission has not sought to resolve this ongoing ethical debate, which is a matter for Parliament to decide on behalf of the British public. Instead, the Commissioners have set out to understand the perspectives of all of those with a firm ethical position on assisted dying, across the spectrum of opinion, while focusing on collecting evidence that can provide insights into the practical issues that are at the heart of the debate.[860]

4.4.5. Assisted Dying Bill 2014

Lord Falconer introduced an Assisted Dying Bill in the House of Lords which received its second reading on 18 July 2014. The Bill aims at providing individuals with a chance for assistance in ending their lives if they are terminally ill and have a prognosis of dying within six months. The patient has to sign a declaration regarding his intention, together with a witness and two independent physicians. The declaration, attached in Section 3 of the Bill reads:

> I have [condition], a terminal condition from which I am expected to die within six months of the date of this declaration. The Attending Doctor and Independent Doctor identified below have each fully informed me about that diagnosis and prognosis and the treatments available to me, including pain control and palliative care. Having considered all this information, I have a clear and settled intention to end my own life and, in order to assist me to do so, I have asked my attending doctor to prescribe medicines for me for that purpose. I make this declaration voluntarily and in the full knowledge of its significance. I understand that I may revoke this declaration at any time.

The limitations imposed in the Bill are based on the need for safeguards, yet they do make the Bill problematic, as they do not solve the need for a dignified, autonomous death of everyone. After the second reading the Bill was passed to a committee which had its first sitting on 7 November 2014 and second sitting on 16 January 2015 where amendments to the Bill were discussed. For the Bill to become an Act it will still have to pass a report stage, and third reading in the House of Lords and then the same sequence (first and second reading, committee stage, report stage and third reading) in the House of Commons. While a change in legislation has become more foreseeable over the last years, culminating in the Supreme Court stressing in the latest judgment concerning assisted

[858] See ibid, 26-32.
[859] ibid, 31.
[860] ibid, 38.

dying that a change in law was desirable but up for Parliament,[861] there is still some way to go until at least a very limited number of individuals can avail themselves of assisted dying.

4.4.6. The Debates

To understand the difficulty in drafting legislation concerning assisted dying, it is pertinent to look at the main arguments brought forward in the debates in the House of Lords in 2003, 2006 – concerning the draft of 2005 – and 2014. They can be classified along the lines of the general arguments in favour of and against assisted dying as introduced in chapter 2 above. The debates in the House of Lords were each very long and repetitive. In the following subsections only the most important examples will be picked out from the debates to highlight the different sets of arguments.

4.4.6.1. Sanctity of Life

One of the two most common counter-arguments against assisted dying is that life is sacred.[862] This argument was first brought up in the debate of 2003 by Lord St John. In stating that the end of life is as important as its beginning,[863] he claimed that there was no need for assisted dying. "Dying people want more than anything else to avoid the sense of being written off. The final stage of an incurable illness can be a vital period of a person's life, reconciling him or her to life and death and giving an interior peace".[864]

Legalising assisted dying is specifically opposed by individuals holding strong religious beliefs. Baroness Masham, for example, uses the commandment "Thou shalt not kill" from the Bible as an argument against the Bill.[865] Likewise, Lord Ahmed relied on his religious believes in making his argument. "As Muslims, we believe that life is sacred and that only God, the creator of all, is the owner of life. Like all other Abrahamic faiths, we believe that only almighty God will decide about the life end of each one of us".[866] The Lord Bishop of St Albans, Herbert, also condemned the Bill due to his religiousness.

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[861] See Nicklinson, Lamb and Martin, [2014] UKSC 38.
[862] See chapter 2 above.
[863] See Hansard Vol 648, Friday 6 June 2003, col 1593.
[864] ibid, col 1594.
[865] See ibid, col 1634.
[866] ibid, col 1641.

> I believe, as a Christian, in the profound and inalienable sanctity of human life. I recognise that that is a view shared by some humanists and members of other faiths. I believe that our life is God-given and that the purpose of our lives is not terminated by death.[867]

Lord St John again used a highly religious argumentation in the debate of 2006. He claimed that "the end of life, the last period of life, is not a wasteland necessarily. It can be a wonderful period of renewal, reconciliation and acceptance".[868]

The sanctity of life argument is generally used as a counter-argument to that of personal autonomy. As Lord Alton stated: "'Autonomy' is one of the buzz words of the pro-euthanasia lobby and can clearly be seen in the wording of the Bill. However, autonomy is not an absolute right that each of us, as individuals, can exercise while living in our own little bubbles".[869] Lord Clarke formulated his fear quite bluntly: "We are talking about introducing legislation that would allow killing. It is no good trying to dress it up as something else. It is no good trying to present it as anything other than killing a fellow human being. It would literally be granting a licence to kill".[870]

In 2014, the Archbishop of York, Sentamu, claimed: "The Assisted Dying Bill would deprive some terminally ill individuals and their families of this very important time of shared love and wonder".[871] While sanctity of life arguments are understandably brought forward by individuals holding religious beliefs, as mentioned above,[872] religious argumentation should not be used to dictate law in a secular society.

4.4.6.2. Threat to the Vulnerable

The other most common counter-argument against assisted dying is the threat it would pose to vulnerable members of the society. In 2003, Lord Alton claimed that in Holland, where assisted dying was already legal, many cases of involuntary assisted dying occurred.[873] He concluded that "[w]e decriminalise; we move to voluntary euthanasia; we move on to involuntary euthanasia; and then, because it becomes so routine, we move

[867] ibid, col 1654.
[868] Hansard Vol 681, Friday 12 May 2006, col 1196.
[869] Hansard Vol 648, Friday 6 June 2003, col 1617.
[870] ibid, col 1630.
[871] Hansard Vol 755, Friday 18 July 2014, col 783.
[872] See chapter 2.1.1.4.
[873] See Hansard Vol 648, Friday 6 June 2003, col 1617.

on to non-reporting in some 50 per cent of cases".[874] Baroness Wilkins saw a general threat in the Bill towards disabled people.

> Its immediate provisions may not be but, once assisted suicide is legalised, severely disabled people know that their hold on the right to life would he [sic] weakened, that their lives would be too easily judged as not worth living and that there is no stopping place on that slippery slope.[875]

Lord Maginnis introduced a further thought in the argumentation against the Bill. "But, do we not all arrive in this world helpless and dependent? As there is no indignity in that, why should we imply that the state of being ill or elderly or both is different?"[876] By claiming that babies, like severely handicapped adults, are dependent on others – which takes nothing away from the value of their lives – he tried to make the point that no one should devalue his or her existence on the basis of dependency on others. Therefore, no one should feel the need to end their life just because of a lack of independence due to illness or disability.

In 2006, Lord Tombs claimed that "it would be all too easy for a right to opt for a deliberate death to become a duty to do so for the sake of others. The exception would then become normal, irrespective of the real wishes and welfare of the patient".[877] This point was also made by the Lord Bishop of Portsmouth, Stevenson, who claimed that a possibility quickly can become a duty.[878] In a similar vein were Baroness Finlay's claims:

> In letting this Bill proceed, we would be giving a message to the rest of the world that we will abandon the vulnerable and treat suffering by ending the sufferer's life. Let us get on with working for patients to live as well as possible until a natural dignified death and teaching others how to do it, not be taken up in becoming complicit in suicide.[879]

The risk of a slippery slope was claimed by Lord Hayhoe who stated: "The Netherlands experience is relevant here, and I recall […] how our abortion law gradually slipped, without change to the legislation, away from a restricted right into, effectively, abortion on demand".[880]

Lord Turnberg also saw the Bill as a threat to vulnerable people. "The probability of a risk to the aged, the disabled and the depressed, who will feel a burden to others despite the safeguards in the Bill, seem to me too

[874] ibid.
[875] ibid, col 1661.
[876] ibid, col 1645.
[877] Hansard Vol 681, Friday 12 May 2006, col 1212.
[878] See ibid, col 1227.
[879] ibid, col 1203.
[880] ibid, col 1246.

high. The finality of that risk, the termination of a person's life, is too severe".[881] Lord Elton's practical concern came from his experience as a former Minister of Health. Decisions on policies are always connected to money. Since palliative care is more expensive than assisted suicide he saw a danger in the Bill of becoming a threat to the vulnerable.[882]

In 2014, Baroness O'Cathain claimed that

> there is a grave danger that if the Bill were to be enacted, the vulnerable would be the most negatively affected. We are talking about the vulnerable as if they are the subject and object of the Bill, but we are not going through the effect on the individuals.[883]

While some fear of the old and vulnerable is understandable, a Bill introduced should have working safeguards in place that enable suffering individuals to receive help, while protecting those who wish to live.

4.4.6.3. Palliative Care

Another argument used against assisted dying, and therefore against the Bill, generally is that palliative care would be enough to relieve suffering and that bringing about death would not be necessary. Lord Turnberg claimed that "[t]he fact that there are failures in the current arrangements [regarding the care for terminally or incurably ill patients] is an argument in favour of looking at the causes of failure, not substituting another solution".[884] As Baroness Finlay put it: "One does not need to kill the patient to kill the pain".[885] In her view it would not be enough to inform a patient of palliative care, patients would have to experience it to see how much their quality of life could be improved.[886] Also, the wish to die could fluctuate if a patient was given the time to get used to his or her situation, if he or she was, for example, suffering of tetraplegia.[887] Lord Patten quoted from a letter by a nurse that the Bill would 'undermine caring' and from the letter of a medicine student that it would promote 'lazy medicine'.[888] Lord Patel relied on the experience of other (not further specified) countries when asking: "Should we therefore not press for better provision of care of such patients? Other countries where such services are

[881] ibid, col 1208.
[882] See ibid, col 1213-14.
[883] See Hansard Vol 755, Friday 18 July 2014, col 801.
[884] Hansard Vol 648, Friday 6 June 2003, col 1655.
[885] ibid, col 1598.
[886] See ibid, col 1598.
[887] See ibid, col 1599.
[888] See ibid, col 1612.

good have demonstrated less need for voluntary euthanasia".[889] This was also stressed by Lord Mowbray and Stourton. "Rather than introducing legislation of the type proposed by the noble Lord, Lord Joffe, our focus should be upon increased support of our marvellous hospice movement through greater funding and investment".[890] Likewise, Baroness Pitkeathley stated:

> I feel, as other noble Lords have said, that we would be better advised setting up more hospices at home to provide care and support and counselling than legislating to offer alternatives. We should concentrate on alleviating pain, distress and suffering as we approach the end of life, not on ending the life itself.[891]

In 2006, Lord Patten claimed: "First, grant the right to die and the right to live is lost. […] Secondly, I believe in killing the pain, not the patient".[892] As was repeatedly mentioned in the debate, palliative care is not the panacea for everyone. Still, many speakers tried selling it as that, for example Lord Wilson: "My view is that it is much better to put effort into palliative care, which is a very positive approach to the end of life, rather than bring forward death".[893] Baroness Cumberlege, in 2014, was in favour of palliative care by stating that "[hospices] show true humanity. They bring goodness to death, whereas this Bill brings only despair. In practical terms, would we prefer to die in the arms of one who cares for us, or be administered with venom by a licensed killer?".[894] While it surely is true that some people, after a serious injury that causes pain and maybe lifelong impairment, are able to regain joy in life and cease to wish to die, there are still cases where this is not true. The ones in need of the Bill are those whose suffering is not only pain-related but for whom death would, for example, come about through suffocation. Painrelief alone would therefore not be sufficient.

Some speakers did argue against palliative care. While generally being supportive of palliative care, Baroness Jay asked

> whether those who tend to see palliative care as a total panacea can recognise that for some people there are limitations to it, however widely spread and well practised. There are those, for example, who feel that pain control is not the answer to their situation.[895]

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[889] ibid, col 1619.
[890] ibid, col 1632.
[891] ibid, col 1637.
[892] Hansard Vol 681, Friday 12 May 2006, col 1199.
[893] ibid, col 1229.
[894] Hansard Vol 755, Friday 18 July 2014, col 829.
[895] ibid, col 1603.

This view was also held by Lord Goodhart. "I doubt if palliative care will ever be able to provide the best answer for everyone".[896] Furthermore he stated: "For those people [for whom life is a burden and of no value] the greatest kindness is to help them to die, and that withholding that help is unkind".[897] For Baroness Young, two reasons spoke against palliative care as a general solution.

> First, even with palliative care, many conditions can mean a horrible death for patients. The terror of death can be dreadful, particularly when there is severe respiratory distress. Aside from that, we are far from having easy access to high quality palliative care for all.[898]

4.4.6.4. Autonomy

Lord Lester stressed both the main arguments in favour of assisted dying, autonomy and dignity. "Patients have the right to life. They also have the right to personal autonomy and to live and die with dignity".[899] Supporting the Bill to him did not mean ignoring the sanctity of life. "This brave Bill does not deny the inevitability of death. It affirms the sanctity of life while acknowledging that there are other fundamental values that deserve our respect and compassion".[900] For Lord Plant of Highfield the individual should be free to decide on the time of death since "we do not have the moral or empirical certainty to make it reasonable to deny assistance with dying for those who clearly want to end their lives because of the level of unrelievable suffering they endure".[901] To him, the counter-argument of the intrinsic value and sanctity of life had little value since they would also have to forbid war and capital punishment.[902] But most importantly to him, the value of a specific life could only be determined by the individual living it.[903] "I think, therefore, that we do not have the moral certainty to deny this option [i.e. death] to people whose strong belief is that they need it".[904] His view was shared by Lord Alexander who stated that "an essential, fundamental issue in the Bill is the right to choice; or, as the noble Lord, Lord Joffe, put it so well in his opening address in words which I do not shrink to accept, the loss of personal autonomy".[905]

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[896] Hansard Vol 648, Friday 6 June 2003, col 1614.
[897] ibid.
[898] ibid, col 1646.
[899] Hansard Vol 648, Friday 6 June 2003, col 1596.
[900] ibid, col 1597.
[901] ibid, col 1619.
[902] See ibid, col 1619.
[903] See ibid, col 1620.
[904] ibid, col 1622.
[905] ibid, col 1622.

For Baroness Greengross, assisted dying did not devalue any form of life. Instead, letting someone choose on his own behalf, granting him autonomy over his life, meant valuing that life.[906] Furthermore, against Lady Howells' claim that assisted dying would lead to discrimination, Baroness Greengross stated the opposite, that not allowing assisted suicide was a way of discriminating against the disabled.[907]

In 2006, Lord Desai, who stated being an atheist, claimed:

> Religion relies on fear and the religious love suffering. I am an atheist and I have no fear, certainly no fear of God or the afterlife. I value my life, but I value it for the pleasure it gives me, and as soon as I cannot derive any pleasure, I want to be rid of it.[908]

This sort of freedom, which is an aspect of autonomy, was also mentioned by Lord Birt in 2014: "In a free, secular society, my Lords, the presumption should be that adults are free to do what they wish, subject only to not impinging on the rights of others".[909] In a similar vein spoke Lord Alli: "I believe that I am the guardian of my own life; I believe that my behaviour is my responsibility; and I believe that, in the end, I should have the right to decide whether I wish to bring my life to an early close".[910] When talking about the value of life, Baroness Warnock claimed that there was no universal value. "I do not think there is such a thing, such a stuff, as life that is abstract and common to everybody. Everybody has his own life and values, each for himself".[911] Baroness Young of Old Scone stated that "[t]he Bill is not about pity; it is about power – the power of being in control of one's own death".[912]

4.4.6.5. Dignity

The second most common argument in favour of assisted dying is the idea of human dignity, brought up, for example, by Lord Gray in his support for the Bill:

> Dignity in death is something to which everyone is entitled, but there is precious little dignity in having to continue to suffer the pain, mental agony and the indignity of the loss of control of one's bodily functions, sometimes for a period of months or even years.[913]

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[906] ibid, col 1650.
[907] ibid, col 1651.
[908] Hansard Vol 681, Friday 12 May 2006, col 1258.
[909] Hansard Vol 755, Friday 18 July 2014, col 803.
[910] ibid, col 808.
[911] ibid, col 831.
[912] ibid, col 870.
[913] Hansard Vol 648, Friday 6 June 2003, col 1649.

For Baroness Flather, the Bill of 2003 was about being able to choose a way of dying. "I do fear what is known as a bad death. I think that that is what we are talking about today. We are not talking about getting rid of vulnerable people".[914] She also brought up the need to rethink the current stance on assisted dying based on the fact that changes in medicine have prolonged the average lifespan. "In the past few years life has been prolonged enormously, but the quality of life and the control of some diseases has not improved with that".[915]

Lord Taverne claimed: "I support the Bill because, if it were passed, it would make this country a more compassionate and civilised society".[916] This can be seen as an argument based on dignity, as the compassion is needed to bring about a dignified death. Lord Russell-Johnston referred to *Pretty*[917] in arguing for a right to a dignified, autonomous end.

> I cannot understand the attitude of those who for ideological or theological reasons are prepared to deny people such as Diane Pretty the right to end their misery by their own choice. They should have that right. Those who oppose the Bill are also denying choice.[918]

Lord Laing would want that possibility of choice for everyone, including himself. "To deny me the legal benefit of a painless and dignified death, putting an end to terminal indignities would seem to me to be a high degree of bureaucratic arrogance and morally questionable".[919]

In 2014, Lord Brit stated that "[a] civilised society must offer, too, expert advice and support to ensure that the individuals who have made that choice can reach the last and gravest of life's milestones with dignity and certainty".[920] Or as Baroness Royall of Blaisdon put it: "For me, the goal must be to allow people who are suffering at the end of their life to choose to die. This, I believe, is a matter of compassion and human dignity".[921] What should be added here, is that people should be allowed to choose for themselves when that end of their life shall be.

[914] ibid, col 1663.
[915] ibid, col 1664.
[916] ibid, col 1624.
[917] See chapter 3.1.1. for the ECtHR judgment and 4.2.1. for the English judgment.
[918] Hansard Vol 648, Friday 6 June 2003, col 1633-4.
[919] ibid, col 1638.
[920] Hansard Vol 755, Friday 18 July 2014, col 803.
[921] ibid, col 833.

4.4.6.6. Equality

Baroness David claimed in 2006 that the Bill was about providing for an option.[922]

> As a 92 year-old, […] I think it is patronising for opponents of the Bill to suggest that elderly people are unable to make informed decisions about their lives. If I were terminally ill, I believe that I would be the only person with the right to decide how I died and whether I preferred palliative care to assisted dying.[923]

Baroness Hayman also claimed that the Bill would give terminally ill patients an option since "at the end of life we need to show people love and respect as well as giving them physical and medical care. For some people […] that love and respect would be given and devoted by the implementation of the Bill".[924] The Earl of Glasgow even claimed that having that option should be a human right.[925]

> The sincere and considered desire of a terminally ill patient to be allowed to die should be a human right. Surely, and I address this to the right reverend Prelates in particular, God gave us free will. Why does God deny us that free will when it comes to the approach of death?[926]

Lord Gilmour pointed out the discrimination caused by the illegality of assisted suicide.

> Suicide is legal and now the Bill's opponents have to explain why those who want to kill themselves because they are terminally ill and in agony, but are unable to do so because of their illness, should not be put in a position to do so, like all the rest of us. No amount of talk about palliative care will alter that position.[927]

This point was also stressed by Baroness Murphy, a psychiatrist and geriatrician.

> I know how diverse and sometimes contrary patients can be. I recognise the differences in how people approach death, and I respect those very few who would want to take advantage of this Bill's provisions. It should be their choice, not ours, and a matter of human rights.[928]

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[922] See Hansard Vol 681, Friday 12 May 2006, col 1203
[923] ibid.
[924] ibid, col 1213.
[925] The right to choose was also stressed by Baroness Flather in 2014 who told the House about her disabled husband who "says that disabled people should always have exactly the same rights as able-bodied people and it will be their choice". Hansard Vol 755, Friday 18 July 2014, col 899.
[926] Hansard Vol 681, Friday 12 May 2006, col 1240. On the right to die as a human right see the analysis by the ECtHR concerning Pretty, chapter 3.1.1.
[927] ibid, col 1204.
[928] ibid, col 1207.

This argument was further made by Baroness Warnock who stated that assisted dying was never intended to be or become a substitute for palliative care. However,

> the law should be changed in such a way that they [a small minority who wish for assisted suicide], in their extreme circumstances, should be allowed to follow the morality in which they do believe, not another which would compel them to live against their wish.[929]

This was also held by Baroness Greengross. "Most people do not suffer if they receive good, comprehensive palliative care. That is why I support it so strongly. However, we know that a minority do not. For them, this Bill, were it an Act, would bring a sense of security […] It is a form of insurance policy".[930]

4.4.6.7. Concluding Remarks

Depending on whether they were arguing in favour of or against the Bill, the members of the House of Lords seemed to be using different statistics. The lack of sources of those numbers used makes an objective analysis difficult. Lord Russell-Johnston, for example, claimed that "the Netherlands has not become a dangerous place for old people" since the legalisation of assisted dying.[931] Lord Alton of Liverpool on the other hand claimed that many cases of assisted dying in the Netherlands were involuntary.[932] Additionally, in different polls different questions have been asked, as was highlighted by Lord Gray. "Throughout the past decade a variety of ways have been employed to assess public opinion on this subject. The questions asked in different polls have not always been identical, so it is difficult to draw exact comparisons or conclusions".[933] The use of different sources and numbers illustrates the highly emotional and rarely objective way in which arguments are presented in the general debates concerning assisted suicide and assisted dying. It seems that since death awaits all of us, it is hard to approach that topic with an open mind. Instead, everyone enters the debate with a very strong opinion, based on personal believes. What renders the debates even more difficult is that one side of it is grounded in religious believes which is even harder to overcome than other sorts of opinions. The most reasonable approach seems to be the one expressed by Baroness Warnock who supported the

[929] ibid, col 1221.
[930] ibid, col 1240.
[931] Hansard Vol 648, Friday 6 June 2003, col 1633.
[932] See ibid, col 1617.
[933] ibid, col 1649.

Bill of 2003 for three reasons, the pure need for legislation in that field, the need to leave religion out of the debate, and the need for doctors to be able to help their patients, even if the only help left is a pain free, dignified death.[934] As Earl of Arran put it: "Most of us will need assistance to enter into this world, some of us may need assistance to depart from it".[935]

The main arguments summarised above are not the only ones featuring in the debates. Other arguments brought forward were the threat to the doctor-patient relationship ("doctors should not become killing machines")[936] and those addressing specific details of the Bills, for example claiming that the six months requirement in the 2014 Bill was too arbitrary.[937] While some claim that there are no safeguards,[938] or that they are "fundamentally flawed",[939] others state they are sufficiently tight.[940] Furthermore, the general fact that the law needed changing was stressed. For example by Lord Kerr, who stated: "The status quo […] is a mess",[941] and Lord Stevens: "What is certain is that there needs to be certainty in the law".[942] However, the main arguments, dignity, autonomy, equality, sanctity of life, palliative care, and the threat to the vulnerable, demonstrate how difficult it is to find a consensus. All arguments have the potential of being turned into highly emotional, subjective statements, which does not help the quest for a right to die.

At the heart of the various criticisms of the different attempts to change the law and legalise assisted dying is the conflict between the sanctity of life and the right to self-determination. The need to protect the vulnerable can be subsumed under the sanctity of life; and dignity and autonomy ask for a right to self-determination, giving one the right to choose death over life. Whether one is religious or not, the sanctity of life is something that should not simply be done away with in order to be able to support assisted dying. Life is valuable, and each life unique. Therefore, it needs to be protected as far as possible. However, if life is not valued by the one living it, the question is how far the protection should go. Once it has been established that the wish to cease living is an informed and voluntary choice, the principle of autonomy should supersede the sanctity of life. Based on the dignity one possesses due to being human, one should

[934] See ibid, cols 1607-9.
[935] ibid, col 1669.
[936] Baroness Masham of Ilton, Hansard Vol 755, Friday 18 July 2014, col 865.
[937] See Baroness Neuberger, Hansard Vol 755, Friday 18 July 2014, col 857.
[938] See Baroness Howe of Idlicote, Hansard Vol 755, Friday 18 July 2014, col 877.
[939] Lord Gold, Hansard Vol 755, Friday 18 July 2014, col 886.
[940] See Lord Haworth, Hansard Vol 755, Friday 18 July 2014, col 878.
[941] Hansard Vol 755, Friday 18 July 2014, col 881.
[942] ibid, col 889.

have the right to determine what to do with one's life, and if one reaches the conclusion that one wants to give it up that should be accepted. This acceptance shows itself in the decriminalisation of suicide. But the respect for every human being should lead to the legalisation of assisted suicide for those who cannot commit suicide unaided. Legalising assisted suicide would be a manifestation of respect for the autonomy of everyone.

4.4.7. Academics' Views on the Suggested Changes of Legislation

Many of the points that were brought up in the various debates also recur in academic literature on the topic. As Shaw criticised:

> Throughout the ensuing debate [in the House of Lords in 2006] it appeared that many House of Lords members failed to consider that the debate was not a contest between assisted dying and palliative care, rather about the provision of an additional end-of-life option.[943]

A common concern by opponents of assisted suicide is the fear that the patients might not be aware of alternatives, for example palliative care.[944] However, Section 2(2)(e)(iv) of the Bill of 2005 explicitly required the physician to inform the patient of "the alternatives to assisted dying, including, but not limited to, palliative care, care in a hospice and the control of pain".[945] As Biggs put it: "In this way the Bill actively promotes the exploration of palliative treatment options in opposition to assisted dying, and offers more than a simple choice between accepting or refusing treatment and opting for assisted dying".[946]

According to Keown, all the safeguards introduced in the 2005 Bill were illusionary and if the Bill were passed, it would pave the way for both voluntary and non-voluntary assisted dying.[947] The lack of safeguards could, for example, be seen in the failed implementation of some recommendations by the Select Committee.[948] For example, the recommendation that all patients requesting assistance in dying should be referred to psychiatric assessment was watered down to a referral of those where the capacity was in doubt.[949] This would mean a risk, since, according to the Royal College of Psychiatrists, only few doctors were

[943] Shaw (n 30), 346.
[944] See Hazel Biggs, 'The Assisted Dying for the Terminally Ill Bill 2004: Will English Law Soon Allow Patients the Choice to Die?' (2005) 12 *European Journal of Health Law* 43, 49.
[945] Assisted Dying for the Terminally Ill Bill 2005, HL Bill 36, 54/1, [2(2)(e)(iv)].
[946] Biggs, 'The Assisted Dying for the Terminally Ill Bill 2004: Will English Law Soon Allow Patients the Choice to Die?' (n 944), 49.
[947] See John Keown, 'Physician-Assisted Suicide: Lord Joffe's Slippery Bill' (2007) 15 *Medical Law Review* 126, 126.
[948] See ibid, 128.
[949] See Assisted Dying for the Terminally Ill Bill 2005, HL Bill 36, 54/1, [3(1)]

capable of determining capacity and many patients with a terminal illness suffered from undetected depression.[950]

Furthermore, the Bill might lead to involuntary assisted dying. "Although Lord Joffe placed autonomy centre stage, the principle of beneficence was lurking in the wings".[951] If beneficence means that the autonomous person requesting assisted dying is to be granted his/her wish, the option might get extended to those suffering who are incapable of uttering such a wish, thereby leading to assisted dying of the incompetent patient.[952]

Shaw saw the Bill in a quite favourable light. After stating that the Suicide Act was one of the harshest forms of suicide regulation in Europe,[953] she went on to call the safeguards of the 2005 Bill 'vigorous',[954] which clearly was more favourable than Keown's reading of the Bill. Also quite supportive was Biggs who stated that "[the 2004 Bill] proposes a carefully monitored legislative framework that includes stringent qualifying conditions and offers greater choice and more alternatives than the terminal care options currently available".[955] Furthermore, a Bill could solve the problems some doctor-patient relationships are facing due to the prohibition of assisted dying. Even though it was not legal, doctors were asked to assist in dying which could put a strain on their relationships with their patients. If the physician acted on the request, he or she not only acted against the law but also without any personal or professional support. Indirect assisted dying, receiving an amount of medication that not only reduces the suffering but also hastens death, might not be the death a terminally ill patient was hoping and asking for since the wish for assisted dying often was a desire to end a life in a pain-free, quick manner. A Bill could solve those problems between doctor and patient, as it would regulate the conduct, offering both sides safeguards.[956] Generally, Biggs found that "this is a comprehensive and well drafted Bill that would clearly secure an enhanced range of choice to terminally ill patients at the end of their lives".[957]

Ost suggested a further change in the law, the introduction of the defence of necessity for doctors, as the "legal recognition of the fact that

[950] See Keown, 'Physician-Assisted Suicide' (n 947), 128-29.
[951] ibid, 130.
[952] See ibid, 131.
[953] See Shaw (n 30), 336.
[954] See ibid, 339.
[955] Biggs, 'The Assisted Dying for the Terminally Ill Bill 2004: Will English Law Soon Allow Patients the Choice to Die?' (n 944), 47-48.
[956] See ibid, 51-52.
[957] ibid, 53-54.

the physician is faced with a situation of necessity would ensure a more effective and just response to this particular form of killing with compassion".[958] In the case of a compassionate killing by a spouse or relative, the defence of diminished responsibility was available but it was not available for a compassionate doctor.[959] So far, the only protection a doctor had was the doctrine of the double effect, which basically meant indirect assisted dying, administering pain killers that hastened death without having death as a primary goal.[960] The problem with that doctrine was, that it was not possible to determine what the intention behind the administration of the medicine was. "Undoubtedly, the physician is likely to know what his primary intent was in administering the drug in question, yet how can the jury truly know whether the intent was to relieve suffering rather than cause death"?[961] For Ost, a solution would be the defence of necessity, which in the Netherlands already justifies voluntary assisted dying.[962] It did not seem too far-fetched since the three main elements of necessity were present in cases of assisted dying: "First, the act is needed to avoid inevitable and irreparable evil. […] Secondly, no more should be done than is reasonably necessary for the purpose to be achieved. […] Finally, the evil inflicted must not be disproportionate to the evil avoided".[963] The only difficulty seemed to be to agree on whether death – the evil inflicted – was less severe than suffering – the evil avoided. This could be linked back to the issue of whether death was part of life that must be embraced in whatever way it presented itself, or whether we have the right to determine our own way of leaving life.

A very specific criticism came from Davey and Coggon who analysed the effect the 2005 Bill would have on life insurance,[964] claiming that Clause 10 – "No policy of insurance which has been in force for 12 months as at the date of the patient's death shall be invalidated by reason of a physician having assisted a qualifying patient to die in accordance with his Act" – would have only negative effects on the Bill overall.[965]

> Clause 10 is badly drafted […] What clause 10 appears to do is to remove the insurance industry's option to exclude liability for physician-assisted suicides. Piecemeal reform of this type often leads

[958] Ost, 'Euthanasia and the Defence of Necessity' (n 27), 355.
[959] See ibid, 355-56.
[960] See ibid, 356.
[961] ibid, 359.
[962] See ibid, 363.
[963] ibid, 366.
[964] James Davey and John Coggon, 'Life Assurance and Consensual Death: Law Making for the Rationally Suicidal' (2006) 65 *Cambridge Law Journal* 521.
[965] See ibid, 525.

> to inconsistent results. It is not clear why insurers would remain free to exclude liability for suicide but not physician-assisted suicide.[966]

Clause 10 had not been discussed in Parliament, as the focus in the debates had been the more general rights and wrongs of assisted dying and not the practical effects legislative reform would have on life insurance.

Brassington claimed that two criteria of the Bill, that of terminal illness and that of unbearable suffering, were not morally defensive if looked at separately but together made sense to protect the vulnerable.[967] "[T]his implies that the law might justifiably--and maybe even properly--aim to prevent a person from gaining access to that to which they have a serious moral right".[968] While accepting that the two criteria linked to physical suffering were a safeguard not only to protect the old and vulnerable from being pressured into seeking assisted dying but also to "stop […] people throwing away their lives lightly",[969] Brassingston criticised them as individual criteria. First of all they offered no perfect protection since, for example, the factor of unbearable suffering is highly subjective.[970] Also, what was unbearable at one point may with time become bearable.[971] The criterion of unbearable suffering could even be called inhuman because "it *promotes* not only suffering, but *unbearable* suffering […] Yet a law that will allow people to seek assistance to *end* suffering but will not allow them to seek assistance never to *begin* suffering is perplexing".[972] Even more importantly, the terminal illness criterion seemed arbitrary. An argument in favour of it was that in cases of terminal illness the assisted suicide only hastened the inevitable death. But countering that, it could be said that death is inevitable for all of us.[973] Still, Brassington accepted the combination of these criteria as a means to protect the vulnerable.[974]

In relying on the principle of autonomy, Brassington favoured the possibility of a self-determined death. "The simple recognition that someone either wants to die, or wants his suffering to end even though that will involve his death, is sufficient to give us a reason to assist".[975] This point was also made by Price. "A pure autonomy-based rationale

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[966] ibid, 538.
[967] Brassington (n 48), 415.
[968] ibid.
[969] ibid, 425.
[970] See ibid, 432.
[971] See ibid, 439.
[972] ibid, 440, italics in original.
[973] See ibid, 435-36.
[974] See ibid, 442.
[975] ibid, 422.

would however perceive no conceptual need for suffering at all to underpin the request [for assisted dying]".[976] Furthermore, if the criterion was terminal illness, this could be seen as discriminatory. "Indeed, to ignore suffering born of disability may be viewed as discrimination *against* persons with disability".[977] The concept of autonomy as a reason to allow for assisted dying would require it being available for more than just the terminally ill.

4.5. Overall Conclusion

What the analysis of the case law concerning a right to die shows, is the need for a change in the English law on assisted dying. While some steps were taken, namely the clarification of the DPP's prosecution policy, and the stress on respect for autonomous choices, not enough has been done in order to enable everyone to die a dignified death. The courts do not see it as their role to engage in said change and leave it to Parliament instead. The Bills proposed by Lord Joffe and Lord Falconer were a step in the right direction and started a much needed debate on the issues at hand. However, with both sides of the debate using highly emotional arguments and based on religious and philosophical claims that are hard to refute, no solution could yet be found. This means that people needing assistance in dying still have to travel abroad to find a legal way to end their lives. This is not only discriminatory but also puts a lot of strain on those close to the person seeking death. Whether we base the claim for a need to legalise assisted dying on the concepts of human dignity, autonomy, or vulnerability, something has to be done in order to help those who want to end their lives but cannot do it unaided.

When looking at numbers, for example from Oregon or the Netherlands, in order to strengthen a point, as was done by many speakers in the debates in Parliament, it becomes apparent how difficult it is to rely on any of them. Different studies lead to different results, as the angle, questions, groups consulted, etc, vary. This concerns both, studies about how many people avail themselves of help and studies concerning the public opinion on assisted dying. Both kinds of studies should not weigh too much in the legalisation of assisted dying. Based on the ideas of autonomy and dignity presented in chapter 2, assisted dying should be legalised to enable suffering individuals to die an autonomous, dignified

[976] Price (n 94), 163.
[977] ibid, 170, italics in original.

death in accordance with their wishes. While safeguards are needed, the claim that they are never sufficient seems to be unfounded.

The current situation is unacceptable as it leaves a small number of suffering individuals unable to find a way out of what they perceive to be an undignified life. Based on the need for autonomous and dignified ways to die, the law in England needs to undergo change. What the debates tend to do is draw a distorted picture of reality. What is asked for is not a form of routine-treatment that will endanger the lives of the old and dying. Instead, as the cases show, it is a very small number of individuals, for whom palliative care is not the solution, who would need a change in the law that would enable them to die a dignified death.

5. Assisted Dying in Germany

Assisted dying is a highly sensitive topic in Germany, both in the public sphere and on the political level. What makes it so delicate and difficult to regulate is the German past. While the crimes of the Nazi era happened more than 70 years ago, their ramifications are still being felt in some areas of life in Germany. One of them is assisted dying where the euthanasia program of the Nazis, killing off millions of Jews, disabled persons and other 'life unworthy of living' and their idea of eugenics[978] still have an impact on today's debates. For example, the term 'euthanasia' is a taboo that cannot be used without conjuring up emotional responses. Instead, the term *Sterbehilfe* (assisted dying) is used. However, that term is complicated in that it can be taken to mean *Hilfe im Sterben* (help in dying, i.e. forms of palliative care that facilitate the dying process which would be indirect assisted dying) or *Hilfe zum Sterben* (help to die, i.e. active assisted dying).

This chapter will start with an introduction of the current regulation of assisted dying, will move on to the case law to demonstrate how the laws affect those seeking assistance in dying and in a last step will introduce the proposed changes to the law. Questions are, whether the current legal situation allows for an autonomous, dignified death, or whether it is discriminatory, what the attempts at change are, and where the change is coming from, legislature or the courts.

5.1. The Legal Regulation of Assisted Dying

Assisted dying in Germany can be said to be controlled in a very normative way, based on the experience with assisted dying during the Nazi reign.[979] This can be opposed by the view that people should be given the freedom to make an autonomous choice about matters concerning their life and death, so that there is no powerful elite who dictates others how to live.[980] The regulation of offences concerning human life, being an aspect of criminal law, is a matter for the Federal Government, not the individual Länder. With the current regulation under the *Grundgesetz* (GG – German Basic Law/Constitution) and the *Strafgesetzbuch* (StGB – German Penal Code) the legal status of assisted dying remains unclear to

[978] Though the idea of eugenics was not a new concept introduced by the Nazis. In 1895 Alfred Ploetz had published his *Grundlinien einer Rassenhygiene* (Racial Hygiene Basics) which can be seen as the starting point of German eugenics. See Frieβ (n 11), 21.
[979] See for example Wolfgang Schluchter, 'Leben und Sterben als Widerspruch? Soziologische Aspekte zur Autonomie und Selbstbestimmung' in Lothar Knopp and Wolfgang Schluchter (eds) *Sterbehilfe – Tabuthema im Wandel?* (Springer 2004), 9.
[980] See ibid, 20.

some extent. While suicide is not a criminal offence, and assisting suicide consequently also is not (because the assistance of a non-criminal act cannot be criminal under German law),[981] this still requires the person committing suicide to be capable of performing the final act themselves. Since that is not the case for everyone who wishes to die, assisted dying would have to be legalised more generally to avoid discrimination against such persons.

Under German law, assisted dying is not regulated by a specific Act, as is the case in England, instead the regulation takes place via general paragraphs of the GG and the StGB.

5.1.1. Article 2 GG

The GG grants German citizens fundamental rights and recognises the protection of freedom and dignity as the main aim of law.[982] The right to life, as granted by Article 2 GG, was implemented as a reaction to the mass-killings committed under the Nazi regime.[983] Article 2.2 GG grants everyone the right to life and bodily integrity. It has been recognised by the *Bundesverfassungsgericht* (BVerfG – Federal Constitutional Court) to be one of the highest values to be protected,[984] and grants the same value and protection to every human life, from the moment of birth to the moment of death.[985]

A number of arguments exist which claim that the right to life inevitably means that assisted dying has to be illegal. For example, the basic rights can be seen to have a normative character, which can lead to the interpretation of the right to life including a duty of the State to protect all life.[986] However, since autonomy is very highly valued in a liberal society, Article 2 GG should not be interpreted as including a legal obligation to live, but is rather to be seen as one of the civil liberties,[987] thereby giving the rights holder the freedom to self-determinately also discard it. This is backed up by the fact that autonomy is seen as ranking higher than the right to life in what is to be protected by the constitution.[988] Thereby, since there is no constitutional prohibition to

[981] See §27 StGB which states that an assistant is to be punished if assisting in a criminal deed.
[982] See Kristian Kühl et al, *Einführung in die Rechtswissenschaft: ein Studienbuch* (Beck 2011), 285.
[983] See ibid, 295.
[984] See BverfGE 49, 24, (53), [72] - [73] and BverfGE 46, 160 (164), [14].
[985] See Ingo von Münch and Philip Kunig, *Grundgesetz-Kommentar* (6th edn, Beck 2012), 159.
[986] See Antoine (n 34), 197-8.
[987] See ibid, 217.
[988] See ibid.

commit suicide,[989] the autonomous choice has to be accepted and committing suicide is not illegal.[990]

Article 2.2 GG is generally a defence right of the citizen against the State (like Article 2 ECHR) and also entails the positive obligation for the State to protect its citizens.[991] What can be held against the need for the State to protect life in all cases and thereby prohibit assisted dying, is Article 1 GG which protects human dignity. It has for example been acknowledged by the *Bundesgerichtshof* (BGH - Federal Supreme Court) that Article 1 GG can be taken to guarantee dying under humane conditions.[992]

5.1.2. §216 StGB

Under German law, assisted dying is covered by the general regulation of bodily harm and homicide. In the StGB a series of paragraphs (§§211-222) regulate offences against life. 'Killing on request' is prohibited under §216 StGB which makes active assisted dying illegal. The custodial sentence is lower than that for homicide since the act of 'killing on request' involves elements of compassion and the urge to help. The first paragraph of §216 has remained unchanged since the entering into force of the StGB in 1871, however, in 1943 the Nazis added the culpability of the attempt,[993] an amendment that has been retained to date.

Suicide is not a criminal offence for a number of reasons; one of them being that for the different kinds of homicide regulated by the StGB the condition is that there is a perpetrator and a victim, a condition which is not met by suicides.[994] Also, generally speaking, a citizen is free to dispose of his own possessions; accordingly suicide is not an offence, since it is for the citizen to decide whether he wants his or her own life. This interpretation would entail that if someone asked to be killed, that killing should be exempt from punishment as well, since the person invited someone else to make use of their possession. However, the fact that §216 only entails a reduced sentence compared to murder (§211 StGB), but not impunity, is based on the need to protect the vulnerable and prevent

[989] See von Münch and Kunig (n 985), 161.
[990] As there is no law criminalising suicide and punishment can only follow a deed violating an existent law. §1 StGB.
[991] See Kühl et al (n 982), 295.
[992] See BGHSt 46, 279, [11]: "Dieser grundsätzliche Vorrang des Lebensschutzes ist zu beachten, wenn wie hier in eine Abwägung ein auch in Art. 1 Abs. 1 GG angelegtes Recht des Einzelnen auf ein Sterben unter 'menschenwürdigen' Bedingungen einzustellen ist".
[993] See Frieβ (n 11), 75-76.
[994] See Fritjof Haft, *Strafrecht. Besonderer Teil II. Delikte gegen die Person und die Allgemeinheit* (8th edn, Beck 2005), 117.

precipitousness.[995] Furthermore, due to the high rank of the legally protected interest (i.e. life), it is seen to be not disposable and protection is absolute, regardless of viability, life expectancy or interest in life.[996]

To fall within §216 StGB and not §211 StGB (murder) or §212 StGB (manslaughter), the request to be killed has to be formed voluntarily by a capable adult and the action has to be performed completely in accordance with the request and only by the person who has been addressed by the request.[997] The request has to be more than consent; the person wishing to die has to appeal to the other to do the deed. The request must furthermore be explicit and unambiguous.[998]

The legal situation has two main consequences. For one, like in England, those persons wishing to die but not being able to commit suicide unaided are not always able to get the assistance they wish to receive. And second, the medical profession is in part left in the unclear about what conduct is permitted and which is not and therefore also refrains from the permitted forms of assisted dying, namely indirect and passive assisted dying.[999] This can lead to painful and prolonged deaths and turns the right to life into a *de facto* duty to live.

5.2. Case Law[1000]

Since the focus of this thesis is on active assisted dying, following the express wish of a capable adult, most of the cases that have occurred in Germany will not be considered, as they deal with assisted dying of

[995] See Urs Kindhäuser, *Strafgesetzbuch. Lehr- und Praxiskommentar* (6th edn, Nomos 2015), 806.
[996] Haft (n 994), 116.
[997] See Kindhäuser (n 995), 807.
[998] See Haft (n 994), 123-24.
[999] Though in 2011 the German Medical Association has published guidelines concerning the proper medical conduct concerning assisted dying, stressing the permissibility of passive and indirect assisted dying.
[1000] The German process of prosecution is – like the legal system in general – quite different to the English one. The German procedural system is referred to as being "inquisitorial", where the prosecution is carried out by State services (either at Federal or Länder levels) with the courts then determining the guilt or innocence of the accused.
The whole prosecution process up until the pressing of the charge and presenting the charge in front of the criminal court lies with the prosecution. It is not a party to the proceedings but remains strictly neutral. By §§151-152 and 160 StPO (*Strafprozessordnung* – Criminal Procedural Code), the prosecutor is under an obligation to investigate as soon as there is a suspicion that an offence has been committed. Prosecutors do not have a margin of discretion as to whether to prosecute. Once there is enough evidence, the prosecution brings a charge against the defendant with the relevant court. The prosecution is the only agency that can press a charge. It is for the court to then decide in interlocutory proceedings whether it wants to open up a main hearing. The State prosecution service is an autonomous authority. It is independent from both executive and judiciary, being governed by the Ministry of Justice of the *Land* in question. Investigation of criminal offences by the police is based on the Federal Criminal Procedural Code, not the laws of the *Länder.* For an introduction to German law see for example Nigel Foster and Satish Sule, *German Legal System and Laws* (4th edn, OUP 2010) and Gerhard Robbers, *Einführung in das deutsche Recht* (4th edn, Nomos 2006).

unconscious patients. Apart from *Koch*, they do not focus on the patient requesting help in dying, but on the helper, either dealing with their actions before taking place, or after the death has occurred. While there is a second constitutional claim in addition to *Koch* (a physician asking for immunity if assisting a patient in dying), *Koch* is the only case of a patient asking for a right to die, challenging the existing legal reality; the other cases are applications of the legal provisions to deal with occurred cases of assisted dying or prevent future attempts.

5.2.1. *Wittig*[1001]

One of the most important cases in German assisted dying regulation is the case *Wittig*.[1002] While not being a case involving a claim for assistance, it did concern the right to die. Mrs Wittig was a 76 year old widow who did not see a purpose in her life anymore after the death of her husband. Her GP knew of her view on suicide and of a written declaration of will in which she stated her refusal to be admitted into a hospital or care home, the refusal of life-prolonging medication and the wish for a dignified death. When visiting her for an arranged house call one evening he found her unconscious with a suicide note in which she asked him not to admit her into a hospital. Seeing that she had taken an overdose of morphine and sleeping pills, but knowing of her wish to commit suicide and based on her note to him, he did nothing to save her life but only sat by her side until she died the next morning.

Following that, the doctor was charged and the subsequent question was whether it was a case of killing on request or of denial of assistance. After the District Court Krefeld had acquitted him, the public prosecution filed for revision. The District Court had based its acquittal on the fact that the inaction of the GP had not been the cause of the death. An attempted killing on request also had to be dismissed since that specific offence could not be committed through inaction. According to the District Court, killing on request could be dismissed based on the fact that letting a suicide happen, which had been committed by a capable adult, did not come under §216 StGB if the duty of care was seen as subordinate to the will of the patient committing suicide.[1003]

[1001] German cases do not have names *per se*. They are found and referred to by their reference number. In academic discussion some get a name to make a reference easier. Since this case was very important for how the role of the physician in assisted dying was viewed, it is referred to by the name of the patient, Wittig.
[1002] BGHSt 32, 367, 04 July 1984.
[1003] See ibid*,* [12].

The Federal Supreme Court upheld the claim that there was no basis for finding a killing through inaction.[1004] However, it also stressed that a physician can commit a homicide offence if not engaging in life-saving procedures after an attempted suicide of a patient.[1005] The Court recalled the generally accepted view in the literature that inaction in cases of suicide was a form of assistance in suicide and therefore legal.[1006] This view asserts that suicide is not an accident and therefore does not create a duty to help. The Court's view was that the general rule – that inactions by those holding a duty towards someone in a life-threatening situation (like spouses or doctors, called guarantors)[1007] could be interpreted as killing offences (the motive of the inactive person determining whether it was deliberate or negligent) – also had to apply if the life-threatening situation was brought about by the victim deliberately.[1008] Those holding a duty therefore had to interfere, regardless of the wish of the victim. This view was also based on recent insights from suicide-research which had revealed that the wish to die often vanished after the attempt, and that especially those suicide plans which left some time between the action and the actual death were not intended to actually kill oneself.[1009] Based on all those views, the Federal Supreme Court did not share the District Court's view that inactions by someone holding a duty towards the person committing suicide could never be killing on request but always had to be interpreted as assistance in suicide; instead inactions could also be interpreted as killings, depending on the circumstances.[1010]

However, based on the specific circumstances the Federal Supreme Court could not find a case of attempted killing on request. According to the Court, the GP had not violated his duty to care since he had concluded that saving her life would leave her with severe permanent impairment.[1011] Furthermore, acknowledging the autonomy of the patient was an important aspect of a physician's conduct.[1012] Whether the prohibition to treat a patient against his or her wish also had to be upheld in the case of a saveable person after a suicide attempt had not been decided yet by the

[1004] See ibid, [22].
[1005] See ibid, [23].
[1006] See ibid, [18].
[1007] The duty of guarantors (*Garantenpflicht*) is a duty under German criminal law (§13 StGB) to guarantee that a criminal act does not take place. This duty is imposed on people holding some form of responsibility towards the one carrying out a deed, like spouses and physicians. It is a necessity to be able to establish neglect as part of an offence.
[1008] See BGHSt 32, 367 [20]-[21].
[1009] See ibid, [25].
[1010] See ibid, [26].
[1011] See ibid, [28].
[1012] See ibid, [29].

Supreme Court.[1013] The Court was of the opinion that once the person committing suicide lost consciousness, a GP could not simply rely on the will of that person as voiced before the suicide, but had to make a decision on his own responsibility concerning possible measures to help.[1014] Ethical guidelines of a physician's conduct should not be seen as separate from legal provisions. Therefore, a physician should not ignore ethical concerns of society when it came to the legal provisions governing his conduct.[1015] At the same time there was no duty to save an already ending life at all costs.[1016] With today's technical possibilities it was vital to let human dignity and respect for life decide over the limits of the physician's duty to care. What was a vital point in this specific case was the GP's firm belief that due to the medication she had taken to bring about her death, he could have only kept her alive with the means of intensive care – which she had expressly refused – and with the strong likelihood of severe impairment.[1017] Seeing that the GP had found himself in a conflict situation of having to weigh the duty to protect and save life against the need to respect the patient's autonomy and having decided to respect the personality of the dying, the Court could not see that the decision was untenable.[1018] It therefore also decided to acquit the GP, not as a general ruling like the District Court before, but based on the specific details of the case.

This case – though not dealing with active assisted dying – is vital in that it is the first case where the Federal Supreme Court found that autonomy can under certain circumstances rank higher than the duty of physicians to preserve life. It acknowledged the will of an individual to die and released the physician from the duty to prevent death at all costs. This is the first step towards a right to die which could then be used for claims concerning needed assistance. Without the acknowledgment of autonomy even in connection to the decision of death over life, any claim towards wanting help in dying falls short. Therefore, this case, though not being one of assisted dying, is vital in the German case law, in that it lays the foundation of respecting a patient's autonomy when it comes to their wish to die.

[1013] See ibid.
[1014] See ibid, [30].
[1015] See ibid, [31].
[1016] See ibid, [33].
[1017] See ibid, [34].
[1018] See ibid, [35].

5.2.2. *BVerfGE 76, 248*[1019]

In 1987, the BVerfG for the first time had to address the issue of active assisted dying in a case which shows similarities to the one of Mrs Pretty in the UK (see chapter 4.2.1.) in that the future assistant asked for immunity before carrying out the deed. A 27 year old, left paralysed after a car-accident, wanted to end her life. Due to her inability to move anything apart from her head and mouth she needed assistance and asked her physician whether he could help her commit suicide with the remaining physical means she had. The physician (who had brought the constitutional claim) had come up with the idea to attach her to a drip which she could control with the help of her tongue. The drip would have two chambers, one filled with a sugary lotion and one with a deadly narcotic, giving her the possibility to decide which she would pick and therefore the chance to change her mind in the last moment.[1020] While being willing to assist her in that way, the physician saw the danger of a prosecution which could lead to him losing his medical licence. He therefore contacted the relevant prosecutors' office to see what measures they would be likely to take. To him, active assisted dying should be a possibility and indefeasible if §216 StGB – the prohibition of killing on request – was to be interpreted in conjunction with Articles 1 and 2 GG, the rights to dignity, personality and life.[1021] The prosecution handed the matter to the police authority which issued an order[1022] to prohibit him from creating a mechanism that would enable the patient to commit suicide. In that order the police authority stated that it was rather controversial whether the planned action would fall within the ambit of §216 StGB or would only amount to permitted assistance in suicide. The right to life was protected by Article 2.2 GG and no individual had a right of disposal concerning their own life. It fell within the police's duties to prevent suicides and keep third parties from assisting others in committing suicide. Consequently, the physician's planned actions had to be prohibited.[1023]

While lodging an objection against this order, the physician furthermore brought a constitutional claim against said ordinance based on it violating

[1019] *BVerfGE 76, 248*, 23 July 1987.
[1020] See ibid*,* [I.1].
[1021] See ibid*,* [I.2].
[1022] A police order (*Polizeiverfügung*) can be issued in order to prevent threats to public safety and order. Depending on the *Länder*, the police either have a general authorisation or only an authorisation for orders concerning specific threats. In general, a police order has to be reviewed and approved by an elected administrative body (like a local government).
[1023] See *BVerfGE 76, 248,* [I.3].

Articles 1, 2 and 12 GG (freedom of choice of vocation). While formally addressing the physician, the ordinance would touch upon the rights under Article 1 and 2 GG of the patient. He claimed she had a right to a dignified death which, based on her health, she could only receive with the help of a third party, an action that was now being prohibited. Since there were already on-going criminal proceedings against the physician (see the next case, *Hackethal,* which concerned the same physician and ran parallel to this case), he could not perform the actions without some form of guarantee that he would not evoke another criminal procedure by his actions.[1024]

However, the BVerfG declared the application inadmissible.[1025] Firstly, a constitutional claim can only be brought if all other remedies have been exhausted (§90.2 BVerfGG - *Gesetz über das Bundesverfassungsgericht* – Law for the BVerfG) which was not the case since the physician had lodged an objection against the order which was still being dealt with. And while the BVerfG could make exceptions and deal with cases that had not gone through all other avenues yet, if they were of general significance or if the claimant would be disadvantaged if having to go through all instances, this could not be seen as being an issue with the present case. While it could be argued that having to go through all instances would disadvantage the patient, since she wanted immediate help, he himself had brought the claim and would not be disadvantaged. While the claimant alleged that clarifying the legal issues surrounding active assisted dying in connection to §216 StGB was of general significance, the BVerfG did not feel obliged to engage with that question. The only point the BVerfG considered itself bound to deal with were the facts of the complaint. It recalled that it was a complaint against a police ordinance which had declared the attempted conduct of the claimant a disturbance of public order. Therefore, the BVerfG saw this as an issue of police law and not as an evaluation of the facts of the case under criminal law. The criminal status of active assisted dying was therefore not going to be addressed. The claimant was seen to request immunity before committing a possible offence which was not a task for the BVerfG. The patient would only have been justified to bring a constitutional claim against the police ordinance if that measure had prohibited her from doing a legal deed. However, since there was no right to receive active assistance in dying, and since the review of the ordinance

[1024] See ibid*,* [I.4].
[1025] See ibid*,* [II.1].

was not connected to shedding light on that issue, the BVerfG did not attempt to answer any question about assisted dying.

The request for immunity is what links this case to that of Mrs Pretty (see above chapters 3.1.1 and 4.2.1.). While not directly challenging the given legal status of assisted dying, the cases try to find a way around the illegality of the proposed conduct. The Court itself stated that it had some leeway in deciding whether to address an issue like assisted dying in the present case. Sadly, the only reason it gave for not wanting to address it was the claim that it was an issue of police law and that there was no need for a deeper analysis of the facts of the case. As it stated early on in its judgment, a reason why cases first have to go through all instances was that the Court wanted the chance to evaluate the opinion and analysis of the other courts, especially those of the Federal Court. Consequently, the Constitutional Court was not willing to make a ruling on the substance of the case before a lower court would.

5.2.3. *Hackethal*

A legal possibility in Germany is physician assisted suicide.[1026] An example case of this version of assisted dying was decided on 31 July 1987 by the Higher Regional Court München.[1027] The defendant was a physician who had provided a patient with deadly medication. He was accused of killing on request under §216 StGB. The initial proceedings had been brought to the District Court Traunstein which had refused to initiate a main trial. The proceedings were therefore taken to the Higher Regional Court München which could not find a killing on request under §126 StGB in the events that had led to the death of Mrs E. Mrs E was suffering of a serious case of facial cancer and wanted to set an end to her life. She contacted her physician, Dr Hackethal, and asked for his help in dying. He therefore obtained potassium cyanide for her and gave it to a friend of hers, who, in the clinic of Dr Hackethal but without him being present, put it in a glass of water and gave it Mrs E to drink.

Starting by stating that it was controversial where the line ran between legal assistance in committing suicide and illegal killing on request, the Court stated that the distinction had to be based on who was in control of

[1026] At least in theory. As was mentioned above (see footnote 999) there are ethical guidelines concerning the right conduct of a physician, assisting in suicide not being among them.
[1027] *1 WS 23/87*, 31 July 1987. Some cases are reported in the form of a continuous text without a numbering of paragraphs.

the action bringing about death. Since Mrs E had taken the poison provided by the defendant without the help of a third party, she did bring about her death herself. The only way that this could still be seen as an unlawful homicide carried out by the physician would be if she had acted against her own will when taking the poison. Seeing that she had called the clinic of the defendant repeatedly, reminding him of his promise to help her die and then came to the clinic autonomously, lead the Court to conclude that she had acted voluntarily. Since the defendant had only provided her with the poison, which she then took voluntarily and independently, he had only functioned as an assistant which was a legal action. The Court further stated that he had not violated his duty to help and had therefore not committed a crime by not engaging in any life-preserving measures after she had taken the poison. Referring to the *Wittig* judgment, the Court stated that as long as the person committing suicide was in control of their actions, the guarantor was under no duty to prevent the person from carrying out the action. At the same time the loss of control did not automatically lead to a duty to act on the side of the guarantor.

The Court also recalled the general opinion of courts and academia that the autonomy of the patient prohibited compulsory treatment. This autonomy furthermore included a right to a self-determined death. The autonomy of the patient was seen as ranking higher than the duty of the physician to intervene in his function as a guarantor of the patient. Even if the physician saw treatment as in some way justified or needed, there was no duty to treat that could override the patient's autonomy. The duty of the defendant towards Mrs E was the same as his general duty towards patients, regardless of the treatment in need. While he might have violated rules of professional conduct by helping her commit suicide, he did not break a law.

Furthermore, a breach of the duty to help could also not be found in that the circumstances of the suicide could not be defined as requiring a prevention of it. The circumstances included that she had acted voluntarily, was seriously and terminally ill, and suffered unbearable pain. The unavailability of life could not be absolute according to the Court. Mrs E had had the right to commit suicide and the assistance provided by the defendant had been within the legal boundaries.

As can be seen from this case, the courts had started to develop their approach towards assisted dying in that the guarantor's duty was not seen

as ranking higher than autonomy anymore, as had been the case in *Wittig*. This is a vital step forward concerning a self-determined death. As a development from *Wittig*, the Court in this case also stated that the control over the actions did not necessarily have to move over to the guarantor as soon as the dying person lost consciousness. This would only be the case if the help of the physician could prevent death. Since Mrs E could not have been saved (there was, according to an expert opinion, only a 66% chance of survival if the doctor would have intervened within the first five minutes) the control over the actions did not pass on to Dr Hackethal but remained with Mrs E. While the same point had led to the acquittal in *Wittig*, the difference in this case was that the Court stressed autonomy more than the guarantor's duty.

The Court referred both to academic literature and case law, and in so doing began to develop its own approach. While in *Wittig* autonomy was limited by the guarantor's duty, in this case it was the other way around: autonomy was now seen as limiting the guarantor's duty. A suicidal person was seen as requiring or deserving the same treatment as a non-suicidal patient, thereby being allowed to refuse any kind of treatment. The Court furthermore revoked the illogicality that had occurred in *Wittig* by acknowledging that it would make no sense to claim that while assistance in suicide was legal, a physician had to save the life upon unconsciousness. The Court also stated that any help for Mrs E would have turned into inhumane agony. So the Court did actually show compassion and looked at the law in relation to the specific circumstances. It did that whilst stating that the Federal Court's view – that it would be hard to evaluate the voluntary and informed nature of a suicide – could not be significant in this case since there was no doubt regarding the voluntary nature of Mrs E's decision. While recalling that the Federal Court saw a duty to save individuals after suicide attempts, it also was seen to state that the unavailability of life was not absolute. Since indirect assisted dying was an accepted legal option, the Higher Regional Court considered it to be illogical to then have a duty in place to keep suicidal individuals from dying. While Mrs E disposed of the value that her life constituted, the value of her redemption was seen to carry more weight. As a final statement, the Court concluded that any sort of help by the accused would have been infeasible. With this judgment the courts came closer to acknowledging a right to die an autonomous death. However, with stressing the vital criterion of who is in control over the final death-bringing actions, the

discriminatory element stayed in place, since there was still no legal possibility for someone to receive assistance who was incapable of committing the main act of suicide themselves.

5.2.4. *BGH 5 StR 474/00*

In 2001, the BGH reviewed a decision of the District Court Berlin concerning active assisted dying.[1028] The case concerned a Swiss national who had founded an assisted dying organisation in Switzerland and was himself active as a 'suicide-helper' (*Freitodbegleiter*). He claimed he had helped roughly 300 individuals commit suicide, not taking money for it but just asking for a reimbursement of his travel expenses. His means of help was natrium-pentobarbital, a sleeping-medication that is lethal in a high dosage, which he provided to those seeking assistance in dying. The case concerned a woman (Dr T) who had been suffering of multiple sclerosis and had tried committing suicide before unaided, which had failed due to preventive actions carried out by her husband. She contacted the organisation of the suicide helper, sent him a medical report about the incurability of her condition and asked that he provide her with medication to end her life. He thereupon travelled to Germany, visited Dr T and her husband and reassured himself that she was of sound mind and serious about her request. Once he had established that, he agreed to assist her. He assumed that – based on the German provision that assisted suicide is legal – his actions would be legal, not knowing that natrium-pentobarbital was subject to the German Narcotics Act (BtMG – *Betäubungsmittelgesetz*). Natrium-pentobarbital requires a prescription under the Narcotics Act which under §30.1.3 BtMG furthermore criminalises the supply of narcotics in order to bring about death. He purchased the medication in Switzerland and travelled back to Germany where he handed it to Dr T who took it in the presence of him and her husband and died within half an hour.

The Federal Court could find no mistake in the reasoning of the District Court. Neither human dignity nor the legality of assisted suicide could limit the provisions of the Narcotics Act which prohibited the defendant from importing the medicine and administering it to someone. While the deed itself – assisting Dr T in committing suicide – was not punishable, he had offended under the Narcotics Act. He was neither a physician nor a relative of the deceased; the Court could find no justification for the violation of

[1028] *BGH 5 StR 474/00*, 07 February 2001.

said Act. It further claimed that suicide was not lawful, since life ranked highest in the value order of German law, it only went unpunished since it was not a crime under the Penal Code. Also, §216 StGB, which criminalised killing on request, would show that the law condemned any involvement in somebody else's death.

Concluding, the Court could not find fault in the District Court's judgment. However, given that the accused had acted for altruistic reasons – assisting terminally ill persons in committing a voluntary suicide – and had not endangered any third parties, the Court only cautioned him and imposed a fine. The Court stressed that what was important was the autonomy of the person wanting to commit suicide. A further reason why his punishment could be lessened was that this was not a case that fell into the category of behaviour that the Act was meant to prohibit. While it was intended to act against the increase of deaths due to drug abuse, it did not have cases of voluntary and informed suicide in mind. Since this case did not fulfil the dimension of wrong the legislator had had in mind, the Court saw it as reasonable to only caution and not impose a custodial sentence. Under §59 StGB, courts are given the possibility to impose a fine or just issue an admonition if it is seen as unlikely that the accused will reoffend or if the specific circumstances of the case lead the Court to the conclusion that no further punishment is necessary. This paragraph gives courts some leeway in evaluating the specifics of a case. So while not giving room for proper interpretation, there is some room for an assessment of the circumstances.

The evaluation by the BGH in this case once again shows, just like *Hackethal* before, that the right to an autonomous death had gained in significance since *Wittig*. What this judgment furthermore highlights is the difficulty in regulating assisted dying. While there is a felt necessity for the prohibition of assisted dying in order to protect the weak and vulnerable, the Court accepted that assisting someone in dying out of purely altruistic reasons did not fully fall within the ambit of a criminal offence as for example §216 StGB, killing on request, would suggest. However, this is too ambiguous as a legal situation. While compassion on the part of the courts is naturally a good thing, it cannot be relied upon, especially since the courts tend to only apply the law without evaluating it. Therefore, change concerning the legal regulation of assisted dying is needed, so that the courts do not have to balance the law with compassion.

5.2.5. *BGH 5 StR 66/03*

An appeal concerning negligent homicide and the right to a dignified death reached the BGH in 2003.[1029] The case concerned Z, a conscientious objector performing civilian service,[1030] who had acted upon the wishes of the physically impaired S, by undertaking actions that had led to the death of S. The District Court of Hamburg had acquitted Z since he had not been aware that his actions would lead to S's death and that S had actually wanted to die. However, the prosecution filed for revision which led the Federal Court to annul the previous judgment and hand the case back to the District Court.

The case concerned a 20 year old who was in charge of looking after a 28 year old suffering of Duchenne muscular dystrophy. Due to his illness he was immobile and his capacity to breath was at only 10%. As early as 1999 he had written an email to a carer in which he had expressed a fantasy of being put into litter bags and be thrown away, to then be taken to a refuse incineration plant and be burned. In 2001 he asked the defendant to wrap him up in waste bags and position him in a refuse container. He claimed he had done that previously and that someone would come to rescue him during the afternoon. Aiming at helping the victim as much as possible, the defendant acted according to his wishes, without questioning them. The victim was found dead the next morning, having died of suffocation possibly in combination with hypothermia.

The BGH ruled that someone who – on the basis of a deception – provided active assistance in dying (without intent) did not simply take part in a legal act of self-endangerment. In general, self-endangerment does not turn into a case of bodily-harm or homicide if the harmful outcome that is being risked comes true. Someone who supports or enables an act of self-endangerment is consequently not guilty of an offence. Being guilty of an offence or just having been a supporter of a non-criminal act depends on the dividing line between perpetrator and participant. So the question for the Court was whether Z had been in control of the acts resulting in endangerment or whether he was a mere tool in S's suicide plan. The latter could only have been the case if S had misled Z about the actions and had made him participate based on a deception. However, the Federal Court did not see this as a case of

[1029] *BGH 5 StR 66/03*, 20 Mai 2003.
[1030] Up until 2011 there was a duty on male citizens to serve in the army for a few of months (the amount of months decreased over the years from 18 to 6 months). Based on a variety of reasons (like health or beliefs) one could object and instead do a civilian service, like working in a kindergarten or a nursing home.

deception. Even though S had claimed he had done the actions before, he did not mislead Z about the actual endangering element of the plan. Z therefore carried out the endangering actions in full knowledge about them and in contradiction to common medical knowledge. The belief that someone would come to S's rescue in the afternoon could not overrule the knowledge of the danger Z put S in.

Furthermore, judging this case as one of assisted suicide would not only be difficult – since the control over the action did not lie fully with S – but would also imply recognition of active assisted dying. However, this recognition would run counter the value system of the basic law which ranks the protection of human life highest. This was also seen to be the basis for the prohibition of killing on request under §216 StGB. A change of the values and rights to be protected by law could not be brought about by courts but had to be done by Parliament.

While acknowledging that under German law a completely immobile, severely disabled person of sound mind has no means to end his life which can turn his right to life into a duty to live, this could not be changed with reference to a right to a dignified death under Art 1.1 GG. A constitutional claim for active assisted dying which would bring with it impunity for the one killing another could not be accepted. Consequently, the acquittal by the District Court was not upheld by the Federal Court.

Interestingly, the acquittal by the District Court had happened on the basis of an evaluation of the circumstances surrounding the case and was not based on the mere facts of the case itself. While the Court had acknowledged that the actions of Z were not simply help in a self-endangering action but that he instead was in control over the actions, it found that the surrounding circumstances turned it into a case of voluntary self-endangerment. It is that assessment of the actions that the BGH could not agree with. For the BGH the facts outweighed any mitigating circumstances. The only circumstance mattering for the Federal Court was whether Z had been a mere tool of S, or whether he had been in control over the actions. The facts of the case therefore made an acquittal impossible. What the BGH did acknowledge in this case was that subsumed under Article 1.1 GG was a right to die in dignity. However, the availability of indirect assisted dying would be enough to fulfil that right; a constitutional claim to active assisted dying was not recognised.

Again, this is a case which is not directly concerned with active assisted dying in that the assistant claimed to have been unaware of what he was made to do. The *mens rea* provision of German law requires that for each case it has to be checked whether there has been intent or at least an act of negligence. Since the danger of what the accused did would be obvious to anyone of a sound mind, the act of neglect can indeed be found in the scenario in question. What this case shows though is the need for a change in regulating active assisted dying. Had there been a legal way to end his life, S might have died a more dignified death without legal consequences for Z. With the legal provisions the way they are, S's only option to die an autonomous death was by incriminating someone else.

5.2.6. *Koch*

In 2006 the judicial proceedings concerning Mrs Koch started,[1031] culminating in a hearing before the ECtHR in 2012 (see chapter 3.1.3.). After an accident in 2002, Mrs Koch had been left paraplegic and in need of artificial ventilation. She was in constant pain, could only move her head and swallow, even speaking was troublesome.[1032] She experienced life as agony and wanted to end it. Therefore she had contacted the *Bundesinstitut für Arzneimittel und Medizinprodukte* (Federal Institute for Drugs and Medical Devices) in order to obtain 15g natrium-pentobarbital. She wanted the natrium-pentobarbital to be handed by an apothecary to a representative of Dignitas who would be in charge of making sure that it was only used for that one purpose: to let her die in dignity.[1033] Based on Article 8 ECHR and the duty to protect human dignity under the GG, she claimed she had a right to commit suicide in the envisaged way. She was forced to contact the Institute since it was illegal for a physician to prescribe her with a lethal dose of medication.[1034] However, her request was refused as under the Narcotics Act designated medication could only be prescribed to secure necessary medical treatment[1035] which was held not to include suicide, as medical treatment was interpreted to mean only life-sustaining or life-promoting acts.[1036] Mrs Koch claimed that if she failed in obtaining the medication she had to travel to Switzerland with the help

[1031] *VG Köln Az. 7 K 2040/05*, 21 Feburary 2006.
[1032] See ibid*,* [6].
[1033] See ibid*,* [5].
[1034] See ibid*,* [6].
[1035] See §5.1.6 BtMG in connection to §3 BtMG.
[1036] See *VG Köln Az. 7 K 2040/05,* [7].

of her husband in order to be able to receive the needed assistance.[1037] However, she preferred committing suicide at home. She also objected to the view that medication had the purpose of sustaining and promoting life in that it were solely medical measures that kept her alive while there was at the same time no duty to continue living.[1038] However, the Federal Institute for Drugs and Medical Devices dismissed her appeal since there was no entitlement to receive the requested medication.[1039] Thereupon, she travelled to Switzerland and committed suicide with the help of Dignitas.

Mr Koch subsequently sued the Institute with the claim that their refusal to provide Mrs Koch with the medication, needed to commit suicide at home, had violated his right to private and family life.[1040] According to him, the Institute interpreted 'health' too narrowly; it would also need to include bringing about death in a risk- and pain-free way.[1041] The Institute claimed that Mr Koch could not bring a claim as a victim, since Mrs Koch had died already and the fact that she had had to travel to Switzerland in order to commit suicide could not be seen as sufficient as to violate his rights under Article 8 ECHR.[1042]

The Administrative Court dismissed Mr Koch's claim.[1043] The initial claim had centred around the wish to obtain natrium-pentobarbital. With Mrs Koch's death this request had ceased.[1044] Mr Koch could not bring a claim since he could not show that the refusal of the Institute had impacted on his own rights.[1045] The Court could not see that the impossibility of Mrs Koch to obtain medication to end her life had violated his rights concerning marriage and family life as guaranteed under Article 6.1 GG.[1046] While seeing that the decision had had an impact on him, it found that this impact was based on love and solidarity as occurring within a marriage but not on a legal reason.[1047] It could also not see a violation of Article 8 ECHR.[1048]

[1037] See ibid, [8].
[1038] See ibid, [9].
[1039] See ibid, [10].
[1040] See ibid, [12].
[1041] See ibid, [13].
[1042] See ibid, [19].
[1043] See ibid, [22].
[1044] See ibid, [23].
[1045] See ibid, [24].
[1046] See ibid, [30].
[1047] See ibid.
[1048] See ibid, [35].

Referring to the initial claims of Mrs Koch, the Court stressed that there was no right that she could base her claim on.[1049] The Narcotics Act clearly did not allow for actions that went counter the protection of life. Interpreting the Narcotics Act in any way separate from the intention underlying it could not be permissible.[1050] Receiving narcotics in order to commit suicide was diametrically opposed to the intention of easing and healing illnesses while preventing abuse and addiction.[1051] This intention was based on the duty of the State to protect life and physical integrity under Art 2.2 GG.[1052] Furthermore, there was no need to make a statement whether the provisions of the Narcotics Act violated Article 8 ECHR, since the ECtHR had not found yet that Article 8 ECHR included any rights regarding suicide and did not apply that article without any restrictions.[1053]

The Court considered human dignity – and the question whether the BtMG violated Art 1 GG – and came to the conclusion that it had not been violated by the facts of the case.[1054] As a basis for that interpretation it used the object-test as applied by the BVerfG. The object-test implies that dignity is violated once the being is degraded to an object by an action of the State.[1055] The question whether human dignity asks for a right to commit suicide in cases where the health of a person renders their life undignified in their own view, had so far not been decided by a German court.[1056] The Court did not see that the impossibility to receive the medication to commit suicide degraded the human being to an object. That provision was in place to protect from abuse and addiction and followed the State's duty to protect life and physical integrity.[1057] According to the Court, the line between active assisted dying and suicide was hard to draw in cases of ill persons who were nearly completely immobile. Seeing that everyone possesses the same kind of dignity it would be impossible to draw a line between people allowed to acquire medication in order to commit suicide and those not allowed. Therefore, it would be more sensible to not see a violation of human dignity in a general prohibition of acquiring

[1049] See ibid, [53].
[1050] See ibid, [56].
[1051] See ibid, [58].
[1052] See ibid.
[1053] See ibid, [59].
[1054] See ibid, [68].
[1055] See ibid, [66].
[1056] See ibid.
[1057] See ibid, [70].

lethal medication. Consequently, the Narcotics Act could not be seen to be unconstitutional.[1058]

The case was next taken to the Administrative Appeals Tribunal North Rhine-Westphalia which dismissed the appeal.[1059] The Appeals Tribunal did not have doubts as to the decision of the Administrative Court as it also could see no violation of Mr Koch's right to respect for his marriage and family life.[1060] As a final domestic appeal Mr Koch took the case to the BVerfG which declared the application inadmissible.[1061] The main claim was that the refusal to provide his wife with medication to commit suicide had violated her dignity which he could plead even after her death.[1062] However, the Court found that the admissibility conditions were not fulfilled.[1063] He had no authorisation to bring a complaint under §90.1 BverfGG[1064] which states that the person whose basic rights have been violated can bring a claim. According to the BVerfG, Mr Koch could not invoke a post mortal protection of his wife's dignity.[1065] Dignity cannot be invoked by someone else after one's death.[1066] Mr Koch then lodged an application with the ECtHR which did find an interference with his rights under Article 8: "It follows from the above that the domestic courts' refusal to examine the merits of the applicant's motion violated the applicant's right to respect for his private life under Article 8 in of the Convention".[1067]

The case demonstrates what impact the current legal situation has on suffering individuals. As in England, there is no way for those physically unable to commit suicide unaided, to die a dignified death at home with the help of friends or family. The Court's approach of applying an object-test to evaluate whether dignity was being violated was unfortunate. As was established above in chapter 2, dignity can also be violated by a lack of action, by for example forcing someone to continue what for them is an undignified life. Instead of coming to the conclusion that no one's dignity was violated by the futility to acquire lethal medication, the Court should have acknowledged that due to the impossibility of some to commit suicide

[1058] See ibid, [77].
[1059] *OVG Nordrhein-Westfalen Az. 13A 1504/06,* 22 June 2007.
[1060] See ibid, [9].
[1061] *BVerfG 1 BvR 1832/07*, 4 November 2008.
[1062] See ibid, [4].
[1063] See ibid, [5].
[1064] See ibid, [6].
[1065] See ibid, [7].
[1066] See ibid, [8].
[1067] See *Koch v Germany*, application no. 497/09, Judgment of 19 July 2012, [72]. For a further analysis of the ECtHR's approach see chapter 3.1.3.

unaided, they are not given the chance to die in dignity, which should then have led to the affirmation that a change in law was needed.

5.2.7. *VG Hamburg Az. 8 E 3301/08*

This case decided in early 2009[1068] concerned an individual offering assisted suicide for a fee of 8000 Euro. He petitioned for the repeal of a police order which prevented him from offering assisted suicide. His aim was to propagate the Dutch model of active assisted suicide in Germany and to add a new §217 to the German criminal code, legalising active assisted dying. Since he believed that change could only be brought about by active, personal engagement with the matter, he had started offering assistance in 2008.[1069]

The requirements for his assistance to be offered were that the recipient had to suffer of a terminal physical illness, be of sound mind, living in Germany and that the assistance would happen within the legal framework of assisting someone in committing suicide. The persons receiving help therefore had to be able to commit suicide themselves; he did not offer active assisted dying. While first assessing the situation himself, the petitioner would then refer the patient to a psychiatrist to determine the seriousness of the death-wish. The general fee was 8000 Euro, but depending on the financial situation of the person seeking help the fee could be lowered.[1070] In November 2008, the police received information through a journalist that an assisted suicide was about to happen.[1071] Based on the need to protect life, the prosecution started a judicial inquiry as there was suspicion that he was violating German drug law by distributing medication which required prescription,[1072] and the police issued an order prohibiting him from carrying out his service.[1073]

The petitioner thereupon entered an objection to said police order.[1074] The State authority resisting the petition claimed that the order prohibited all sorts of help in suicide, including the provision of substances leading to death and that the order had to be seen in connection with the on-going judicial inquiry concerning his violation of German drug law.[1075] The legal basis for the order was §3.1 SOG (*Sicherheits- und Ordnungsgesetz* –

[1068] *VG Hamburg Az. 8 E 3301/08*, 6 February 2009.
[1069] See ibid, [3]-[4].
[1070] See ibid, [4].
[1071] See ibid, [7].
[1072] See ibid, [8].
[1073] See ibid, [12].
[1074] See ibid, [13].
[1075] See ibid, [14].

safety and order regulations), stating that violations of the German drug law were a disturbance of public safety, the order being aimed at preventing further violations.[1076] While in general the *Behörde für Soziales, Familie und Gesundheit und Verbraucherschutz* (Agency for Social Affairs, Family, Health and Consumer Protection, since 2011 split into two different agencies) was responsible for issues concerning drug law, in this case the prevention of a criminal offence was on the forefront, and therefore fell within the power of disposition of the police.[1077] Even seeing that the provision of narcotics served the purpose of enabling an autonomous, uninfluenced suicide, it nevertheless went against the duty to protect which underlay the laws governing the prescription of certain medication and narcotics.[1078] The order preventing his actions served the protection of limb and life of others and was seen as more important than the interest of the petitioner to be able to continue with his business.[1079]

The petitioner claimed that the order was not lawful in that it was obscure and not clear about what sort of assisted dying it aimed at preventing.[1080] While life was a value the police had to protect he claimed that self-harm and endangerment were no threat to public safety. Instead, they could be based on the right to self-determination under Article 2.1 GG. He only helped in giving individuals the means to fulfil actions based on complete freedom of will. Only after ensuring that the choice was voluntary and based on free-will did he arrange for a psychiatric consultation and then organise the suicide. He furthermore claimed that it could not be said that he was turning death into a business transaction. After all, the person wanting to commit suicide had to acquire the needed medication themselves; he only assisted by giving advice and providing necessary information. He was also approaching the issue in a transparent way, recording all meetings and the suicide on video.[1081] Since at a house search no medication was found, and based on his transparent approach, the claim that the order was needed to prevent future criminal offences could not be seen as being valid. Also, his actions consisted only in offering advice, he never was in control of the actual actions.[1082]

However, his claims failed. The order was seen to be lawful with its aim of adhering to the German drug law and protecting life and limb of citizens.

[1076] See ibid, [15].
[1077] See ibid, [16].
[1078] See ibid, [18].
[1079] See ibid.
[1080] See ibid, [21].
[1081] See ibid, [22].
[1082] See ibid, [23]-[24].

The actions of the petitioner were seen to be independent work with the aim of making a profit. While it might be the case that his main aim was not that of making a profit, the fee he raised nevertheless took the 'altruistic' element out of his actions.[1083] Furthermore, his deeds could be viewed as going against commercial law. Under commercial law, not only illegal actions were prohibited, but also socially objectionable ones.[1084] Those are actions which are seen to run counter the generally accepted moral views of society. While the petitioner had claimed to not be involved in the actual acquisition of the medication, the Court had doubts as to the truth of that and assumed that he at least provided others with information as to where and how they could get that medication without a prescription.[1085] Therefore, the Court viewed his actions as commercial assisted suicide violating the German drug law and running counter the moral values enshrined in basic law by making a profit out of the misery and suffering of others.[1086] The Court furthermore saw dangers in offering commercial assisted suicide in that it could enable persons' suicides who would not commit suicide without that help.[1087] Also, it was seen as precarious in that it would mean the disregard of provisions of German drug law by a professional agency, provisions that were in place to prevent abuse of medication or even suicides with the help of medication.[1088] It did not matter to the Court that the help provided by the petitioner was – apart from the violation of German drug law – not (yet) illegal.[1089] According to the Court, the service offered by the petitioner (commercial assisted suicide) was a new line of business which therefore had only very recently started violating a taboo of society.[1090] If he was permitted to continue with his service, he would threaten public security, since public security included protection of life, health, freedom and property.[1091] Since the State had to protect life (under Article 2.2 GG), the police were under the duty to prevent suicides, while having to respect the right to self-determination leading to an autonomous suicide.[1092] The need to protect

[1083] See ibid, [48].
[1084] See ibid, [49].
[1085] See ibid, [51].
[1086] See ibid, [52].
[1087] See ibid, [53].
[1088] See ibid.
[1089] See ibid, [54].
[1090] See ibid.
[1091] See ibid, [63].
[1092] See ibid, [64].

could be seen as requiring the prohibition of actions as performed by the petitioner.[1093]

The commercial aspect was seen as especially crucial in this case. While Saarland, Thuringia and Hesse had introduced a Bill concerning commercial assisted suicide in 2006 already,[1094] the issue was taken up again by the *Bundesrat* (Federal Assembly) in 2008, which could be linked to this case. It was the first and so far only case which concerned the commercial aspect of assisted dying.[1095] The problem behind commercial assisted dying being that while assisting someone in committing suicide is legal (though problematic when it comes to for example the guarantor's duty as was seen in the previous cases), the commercial aspect – trading with death - is seen as morally offensive.

The Court's view that there was a danger in offering commercial assisted suicide in that it could enable individuals' suicides who would not commit suicide without that help seems odd in that this is actually an aim of active assisted suicide – enabling persons to end their lives who are unable (either physically or mentally) to do it unaided. However, the Court stressed that the State had to protect human life. While granting individuals the freedom to commit suicide, assistance as in this case should be prevented. This prohibition was seen as needed to protect a larger group of vulnerable people. While the protection of the vulnerable is of course an important aspiration of the law, it should at the same time enable individuals to die an autonomous death in dignity.

5.3. Case Analysis

German case law concerning assisted dying has so far had a different focus compared to English case law. While in England cases were brought by capable adults who sought help in dying and went to court to fight for a right to die (see chapter 4), in Germany only one case like that has emerged, that of Mrs Koch (which subsequently also went on to the ECtHR, see chapter 3.1.3.). Instead, German cases concern the prosecution of an assistant after the act of assistance has taken place.

As was stressed before, two main philosophical concepts can be taken to support the legalisation of active assisted dying: autonomy and dignity.

[1093] See ibid, [65].
[1094] See below at 5.4.5.
[1095] Though *BGH 5 StR 474/00* had happened before, this cannot really be counted as commercial assisted suicide since the accused only asked for reimbursement of his costs and did not aim at making a profit.

The current legal situation does not enable an autonomous death in dignity for everyone. This is demonstrated by the cases introduced above. If the law allowed for autonomous, dignified deaths of everyone, the cases would not have occurred. The suffering of the individual resulting in the prosecution of a helper who acts on the informed and autonomous wish to die should be taken as a trigger for a change in the law.

When it comes to commentaries regarding the cases analysed above, it is striking how few there are. While there are a number of comments on *Wittig*, the other cases are hardly mentioned in the academic literature. This might be due to two reasons. First of all, *Wittig* was seen to be a landmark case concerning the physician-patient relationship in situations of dying. Second, compared to England, German cases are shorter and are rather a statement of the legal provisions that apply and the consequences arising thereupon.[1096] The law is generally not being interpreted by the courts, which does not offer much to be commented upon. While in some cases courts are looking for a way to bring compassion into the application of the law, they do not evaluate the right to life or a needed right to die. While the courts are not always completely silent on those matters – see for example the statement in *BGH 5 StR 66/03* that the absence of a right to die turns the right to life in a duty to live – the courts then leave it at that, without making further suggestions or evaluations. Stating that Article 1.1 GG included a right to die in dignity, the Federal Court in *BGH 5 StR 66/03* did not draw any conclusions from such an important statement. In trying to find ways to lessen the sentence on grounds of compassion, the courts show that the right to life cannot be taken to be absolute, however, they do shy away from making any direct statements on this matter.

While the concept of autonomy has gained in acceptance after *Wittig*, it still is not as widely accepted as to guarantee help in dying if need be. Even though assisted suicide in theory is legal, in reality the assistant has to fear charges either based on the *Garantenpflicht* (guarantor's duty) or due to violations of other regulations like the Narcotics Act. This has the consequence that while in principle assisted suicide should be possible, in reality there are many obstacles in the way of an individual wishing to die with help.

[1096] This is largely based on the specifics of the German legal system. The courts' role is to apply written legal provisions to the case, but not to develop the law further. Only rarely do courts use previous cases to guide their decision making. On the different approaches by the courts see for example Basil Markesinis, 'Judicial Style and Judicial Reasoning in England and Germany' (2000) 59 *Cambridge Law Journal* 294.

What becomes apparent in the comments that do exist, is, that autonomy, dignity and the variations of different forms of assisted dying are playing important roles in the case law.

5.3.1. Capacity

As was seen in the previous chapters, capacity is vital in evaluating the rightfulness of a wish to die. While in cases like *Wittig* and *BVerfGE 76, 248* the capacity to make that decision was established or taken for granted, it always has to be evaluated with care. As the case *VG Hamburg Az. 8E 3301/08* showed, precautions can, and have to, be taken very seriously. In that case the assistant not only made assessments himself but also had the capacity assessed by a psychiatrist. However, that assessment by the psychiatrist in this case cannot be seen as the most favourable way to establish capacity, since he received payment for his service. If a financial gain can be made from establishing the capacity of someone, it can negatively impede on the outcome and should therefore be prevented. This, taken together with an argument concerning discrimination, is why commercial offers of assisted dying should be prohibited. Even though the assistant in *VG Hamburg Az. 8 E 3301/08* did offer his help for a lower price if someone could not afford the full payment, it nevertheless is a financial burden on some, like the need to travel to Switzerland to avail oneself of the help of Dignitas. The possibility to receive assistance in dying should be independent of financial means, based on the capacity to make the decision, following the claim for a dignified death and available to every consenting adult who wishes to receive it.

5.3.2. Autonomy

Autonomy is vital in the debate concerning active assisted dying, since varied levels of ability need different kinds of support to achieve equality. To be able to die an autonomous death some individuals need help, a help that is being denied them by the law. To value their autonomy, the law needs changing. An aforementioned issue concerning the autonomy of the patient is the *Garantenpflicht*.[1097] As the Court stated for example in *Wittig*, a physician can be found guilty of homicide if not engaging in life-preserving treatment of a patient who had tried committing suicide. This is the case because once the person committing suicide loses consciousness, he or she also loses control over the dying process and therefore the

[1097] For a brief explanation see footnote 1007.

control over the action moves over to the guarantor. This idea of the guarantor's duty poses two problems. First, it leads to arbitrary situations where a physician is allowed to help the person committing suicide but then has to save them in the last moment. Second, it runs counter the idea of a patient's autonomy. It seems almost cynical to accept a person's autonomous choice as long as they are conscious but then act against those wishes as soon as they lose consciousness.

Luckily, in *Wittig*, the Federal Court did not find that the guarantor's duty to prevent death had to be imposed at all costs. A way to interpret the judgment therefore could be, that while physicians hold a guarantor's duty towards their patients, they can determine arbitrarily how far that duty goes in cases of assisted dying. But this interpretation is unfortunate in that it offers no clear guidelines to physicians.[1098] And the argument that it was acceptable for the physician not to intervene since the patient would only have suffered severe brain damage also seems to be a weak one, since that can be assumed in many suicide-scenarios.[1099]

Furthermore, this stress of the guarantor's duty is disastrous for the patient's autonomy. With that devaluation of autonomy, the judgment contradicted the general approach towards passive assisted dying.[1100] It can be seen as surprising that the Court would ignore the general tendency in medical law which stressed the autonomy of patients, putting the whole decisive power in the hands of the physician.[1101] As Eser stated, the wish to die was being degraded to being just one factor within a physician's leeway in decision making.[1102] This negates the patient's autonomy.

With its judgment, the Federal Court made a contradictory value judgement in that active assistance in committing suicide continued to be with impunity, while a guarantor who did not get involved would have to face a charge of manslaughter.[1103] Furthermore, a physician may not engage in treatment the patient does not want. This makes it obscure to then impose a duty on him to administer treatment against the patient's wishes upon his unconsciousness.[1104] Still, it can also be seen in a more positive light in that the Court did not make an absolute statement of the guarantor's duty overriding patient autonomy and instead left it open to

[1098] See Dirk Stalinski, 'Gerichtlich Genehmigte Sterbehilfe' (1999) 2 *BtPrax* 43, 46.
[1099] See Rudolf Schmitt, 'Der Arzt und Sein Lebensmüder Patient' (1984) 39 *JZ* 866, 868.
[1100] See Scheffler (n 41), 361.
[1101] See for example Albin Eser, 'Sterbewille und Ärtliche Verantwortung. Zugleich Stellungnahme zum Urteil des BGH im Fall Dr. Wittig' (1985) 3 *Medizinrecht* 6, 11-12.
[1102] ibid, 13.
[1103] See Christoph Sowada, 'Strafbares Unterlassen des Behandelnden Arztes, der Seinen Patienten Nach einem Selbstmordversuch Bewußtlos Auffindet?' (1985) 2 *Jura* 75, 78.
[1104] See ibid, 83.

future courts to make a judgment based on the specific facts of the case.[1105]

With its decision, the Federal Court valued the duty of the physician to protect life somewhat higher than the wish to die of the patient.[1106] This can be seen to be problematic in that a duty to prevent suicides would furthermore conflict with the right of the patient to refuse medical treatment and not be the will of the legislator, since suicide was not criminalised itself.[1107]

The judgment in *Wittig* led to the question in which scenarios assistance in committing suicide would still be legal. Instead of leading to clarifications the judgment expanded the grey area in which physicians had to fear criminal punishment for assisted dying and therefore either refrained from it or only practiced it in secret.[1108] According to Gropp not much was left from the non-criminal act of assisting someone in committing suicide.[1109] Acquittals – if taking place – were not based on the impunity of assisted suicide anymore.[1110]

In the case of the carer helping his ward die, without being aware of the consequences of his action,[1111] the Court's assessment again meant that the protection of human life ranked higher than acknowledging active assisted dying.[1112] While the Court's view that the carer should have been aware of the consequences of his deeds seems justified, the view that the protection of life must rank higher than the wish of an individual to die does not. If there had been a means for the victim to die without having to trick someone into committing a criminal offence, this would not only have acknowledged his dignity but also his autonomy in being entitled to make valid choices about his life himself, regardless of the consequence. Even if his way of dying was his envisaged death, with a stronger recognition of autonomy he would not have had to trick the carer Z and put him in the danger of prosecution.

[1105] See Rolf Dietrich Herzberg, 'Beteiligung an einer Selbsttötung oder Tödlichen Selbstgefährdung als Tötungsdelikt. Teil 2' (1985) 4 *JA* 177, 184 and also See Schmitt, 'Der Arzt und Sein Lebensmüder Patient' (n 1099), 868.
[1106] See Schmitt, 'Der Arzt und Sein Lebensmüder Patient' (n 1099), 868 and also Rudolf Schmitt, 'Ärztliche Entscheidungen Zwischen Leben und Tod in Strafrechtlicher Sicht' (1985) 40 *JZ* 365, 367-68.
[1107] See Rudolf Schmitt, 'Das Recht auf den Eignenen Tod' [1986] *MDR* 617, 618.
[1108] See Oliver Brändel, 'Über das Recht, den Zeitpunkt des Eignen Todes Selbst zu Bestimmen' (1985) 3 *ZRP* 85, 86.
[1109] See Walter Gropp, 'Suizidbeteiligung und Sterbehilfe in der Rechtsprechung' [1985] *NStZ* 97, 98.
[1110] See ibid, 98.
[1111] *BGH 5 StR 66/03.*
[1112] See 'Problem: Fahrlässige Aktive Sterbehilfe' (2003) 8 *RA* 534, 537.

Since *Wittig,* the courts have moved on from the disrespect concerning the individual's right to self-determination towards a stronger stress on patient autonomy.[1113] What cases like *Hackethal* and *Koch* clearly demonstrate is the fact that different people need different levels of help to be able to die what they believe to be a death in dignity. As the case law demonstrates, there is no clear line by German courts as to how far autonomy goes in connection with wanting to die. The guarantor's duty rigidly limits the possibility of a self-determined assisted death. The early cases seem to imply that autonomy does not matter to the legislator and the courts. While courts are now willing to acknowledge the autonomy of patients more, the legislator still has to make more explicit changes to the current legal situation.

5.3.3. Dignity

Forcing someone to continue living by saving their life after a suicide attempt, as postulated by the Court in *Wittig*, violates human dignity instead of protecting it.[1114] The attempted 'help' actually turns the person wanting to die into an object which runs counter to the general idea of human dignity.[1115]

In *BGH 5 StR 474/00*, concerning a suicide helper who imported narcotics from Switzerland which were only available on prescription in Germany, neither claims concerning human dignity nor the legality of assisting a suicide could override the Narcotics Act.[1116] The protection of life, as guaranteed by said Act was seen as ranking higher than a right to a dignified death.[1117] The Narcotics Act serves the purpose of protecting public health, something that cannot be disposed of by an individual.[1118] However, the judgment shows some respect for the altruism and humane motives of the accused. After all, he had wanted to help people die with dignity. The judgment can be seen as a middle way, acknowledging the illegality of providing someone with the narcotics due to the provisions of the Narcotics Act while at the same time judging his actions as assistance in suicide.[1119]

[1113] See for example Gunnar Duttge, 'Überlassen eines Betäubungsmittels zum Freien Suizid an einen Unheilbar Schwerstkranken' [2001] NStZ 546, 547. This view was also expressed by Ernest Rigizahn in 'Entscheidungen' (2002) 10 *JR* 427, 428 in reference to *BGH 5 StR 474/00.*
[1114] This opinion was for example held by Eser (n 1101), 15.
[1115] See ibid, 17.
[1116] See 'Problem: Überlassen von Betäubungsmitteln zum Suizid' (2001) 6 *RA* 364, 366.
[1117] See ibid, 367.
[1118] See ibid. 364, 368.
[1119] This view is for example held by Duttge (n 1113), 546.

Commercial offers of assisted suicide, like in *VG Hamburg Az. 8 E 3301/08* do run counter to the idea of a dignified death. Firstly, having to pay for one's death seems appalling. We all have to die one day, so experiencing a pain-free death without suffering should not be some form of special treatment, available only against payment. Also, if a dignified death is seen as part of a dignified life, it should be available to everyone, not just those being able to afford it. More favourable under the heading of dignity would therefore be the service provided by the accused in *BGH 5 StR 474/00*, since he offered help while asking only for the reimbursement of his expenses.

In general, the cases show that the German provisions concerning assisted dying do not enable a dignified death for everyone who requests it. The right to life and the protection based on that right is seen as more important than a dignified death. While this is understandable regarding the aim of protecting the vulnerable, it should not lead to a general prohibition of assisted dying.

5.3.4. Differentiation between Varied Kinds of Assisted Dying

What proves to be one of the problems that has to be dealt with when deciding on the legality of assistance rendered, is the question of who was in control over the actions. This determines whether it was an act of legal assistance in committing suicide or an illegal deed under §216 StGB. The differentiation can be difficult in some cases, as it was for example in *Wittig*, in that the control can switch from one person to the other during the act. As was already mentioned under the heading 'autonomy' at 5.3.2., while being allowed to help tie the rope, as soon as the person using the rope lost consciousness the helper would have to cut them free again.[1120] So what seems to be a useful tool in coming to a distinction between something legal and something illegal, in reality is of little use.

When it comes to the differentiation between killing on request and assistance in suicide, the general legal deciding factor is who is in control over the actions bringing about the death. Therefore, the prosecution's question in *Hackethal* as to who had been in control over the final act of poisoning was justified.[1121] According to Herzberg, the prosecution came to a wrong conclusion in that it should have denied the physician's control

[1120] See for example Scheffler (n 41), 366.
[1121] See Herzberg, 'Der Fall Hackethal' (n 52), 1636.

over the actions and his guarantor's duty and should have instead realised the actions to be legal assistance in committing suicide.[1122]

As will be seen below at 5.4.6., Germany is currently trying to prohibit commercial assisted suicide, that is to say assistance in suicide offered for a fee. Leaving aside the question whether a fee covering just the expenses – as was the case in *BGH 5 StR 474/00* – would fall under such a prohibition, it should be noted that such a prohibition would actually be desirable. Commercial offers discriminate, like the need to travel to another country does. And nobody should make a profit from trading with death. However, it should be prohibited while making non-commercial offers available. This would not only solve the problem of people having to die an undignified, horrifying death, it would also counteract the niche that the petitioner in *VG Hamburg Az. 8 E 3301/08* had found and was filling with his offers of assistance.

5.3.5. Concluding Remarks

What is striking about the cases is that – apart from *Koch* – they are not brought by the individual wishing to die, asking for a right to die or for the provision of assistance. Instead, they are brought against the person who is about to or has already provided assistance. Reasons for this can only be speculations. But whether it is based on assisted dying being perceived as a taboo in society, the legal situation being utterly unclear or any other reason, with a right to die in place, altruistic assistants would be protected from prosecution.

In Germany, there is a grey area and a legal uncertainty in cases of assisted dying.[1123] German case law demonstrates the complicated legal situation concerning assisted dying. With assistance in committing suicide being *per se* legal, yet physicians and spouses holding a guarantor's duty, law in place that prohibits the prescription of lethal medication and an unease towards any form of assistance offered against a fee, German law concerning assisted dying is in dire need for clarification. While the courts' stress of autonomy is an important aspect in the development of a right to die, it is only a starting point which needs more facets added on to achieve a proper right to a dignified death with assistance if need be.

[1122] See ibid, 1641.
[1123] See Frank Czerner, *Das Euthanasie-Tabu – Vom Sterbehilfe-Diskurs zur Novellierung des §216 StGB* (Humanitas 2004), 31-33.

5.4. Suggested Legislative Changes Concerning Assisted Dying

Similar to the situation in England, where the judges state that it is not for the courts to decide on a change of legislation concerning assisted dying, in Germany it is not the task of judges to change the law deciding over life and death.[1124] Therefore, the much needed change of legislation has to be addressed by Parliament. As was seen above, German judges express even less of an opinion or evaluation than English judges, they only apply the law as it stands. Therefore, it is apparent that a change has to come from the legislature.

A death in dignity can be seen to be indirectly guaranteed by the GG, because death is a natural part of life, the dignity of which is guaranteed by Article 2 GG.[1125] This would then call for a positive regulation of assisted dying, since according to carers and nurses about 23% of people in Germany die an undignified death.[1126] Naturally, not all of these would ask for assistance in dying. But looking at the case law it becomes apparent that there is a need for legislation that makes assisted dying possible.

This has been recognised by various groups and individuals and attempts at change have been made. So far, none of them have come to fruition, on the contrary, currently the Federal Government is debating a further restriction of available assistance, seeking to criminalise commercial (i.e. for a profit) forms of assisted suicide. The need to change §216 StGB was addressed from very early on. In 1906 the *Deutscher Monistenbund* (German Monism Association) published a call for the legalisation of assisted dying for the terminally ill.[1127] A first attempt to reform the provision concerning 'killing on request' was made in 1909 with the intention of lowering the punishment.[1128] However, while the debate continued throughout the 20th century, no actions were taken. After the Second World War, the issue was dealt with even more cautiously. In 1962, a State criminal law commission drafted a new criminal code which would have set a minimum penalty of sixth months for assisted dying and

[1124] See for example Wolfgang Rupieper, 'Discussion', in Lothar Knopp and Wolfgang Schluchter (eds) *Sterbehilfe – Tabuthema im Wandel?* (Springer 2004), 27.
[1125] See for example Lothar Knopp, 'Aktive Sterbehilfe aus Europäischer und Nationaler Verfassungsrechtlicher Sicht', in Lothar Knopp and Wolfgang Schluchter (eds) *Sterbehilfe – Tabuthema im Wandel?* (Springer 2004), 65.
[1126] See Annette Wallenburg, 'Palliativmedizin und Hospizpflege – Alternative zur Sterbehilfe', in Lothar Knopp and Wolfgang Schluchter (eds) *Sterbehilfe – Tabuthema im Wandel?* (Springer 2004), 103.
[1127] See Dunja Lautenschläger, *Die Gesetzesvorlagen des Arbeitskreises Alternativentwurf zur Sterbehilfe aus den Jahren 1986 und 2005* (Interdisziplinäres Zentrum Medizin-Ethik-Recht 2007), 2.
[1128] For the development of the debates around changing the provisions of 'killing on demand' see for example Große-Vehne (n 36).

would have included compassionate assisted dying.[1129] Still, the law remained unchanged.

5.4.1. *Alternativentwurf* 1986

In 1986, at the 56th *Deutscher Juristentag* (German Jurists Forum),[1130] the criminal law division debated a right to die and an *Alternativentwurf* (alternative draft) for a law regulating assisted dying. The basis for the debate were the advances in medicine and general deliberations as to the rights and limits of medical conduct.[1131] The main aim of the *Alternativentwurf* was to acknowledge the dignity of the patient and respect for the patient's autonomy, securing both, the rights of the patient and those of the physician.[1132] While not aiming at legalising active assisted dying, the draft included the possibility for courts to abstain from punishment[1133] and meant to expressly legalise passive assisted dying and indirect assisted dying.[1134] The first paragraph of the draft listed the conditions under which passive assisted dying was to be lawful (e.g. if the patient requested it or was in a persistent vegetative state), the second was to legalise indirect assisted dying, the third aimed to declare the non-hindrance of suicide legal and the fourth was to regulate assisted dying, giving courts the possibility to let cases go unpunished.[1135] The aim was to secure the protection of life without creating a duty to live.[1136] While agreeing with the points of the *Alternativentwurf* in general, the majority of the assembly voted against it.[1137] It was not taken up for discussion by the Federal Government.[1138] However, it was not completely result-less in that it constituted the basis for debates and for the first time possible preconditions for passive assisted dying were proffered.[1139]

For each debate at the *Juristentage,* an expert report is published in advance. Concerning the *Alternativentwurf*, the report was drafted by Otto, professor of criminal law. According to him the *Alternativentwurf* was not

[1129] See Lautenschläger (n 1127), 3.
[1130] The German Jurists Forum is an assembly held every other year by the Association of German Jurists in order to review the German law and draft changes to perceived shortcomings. The Association of German Jurists is a non-governmental organisation that suggests changes of the law to the Government.
[1131] See Lautenschläger (n 1127), 6.
[1132] See ibid, 8.
[1133] See *Gesetzestext des AE-Sterbehilfe von 1986*, §216 (2).
[1134] See ibid, §214.
[1135] See ibid, §214-216.
[1136] See Lautenschläger (n 1127), 10.
[1137] See ibid, 16.
[1138] See ibid, 18.
[1139] See ibid.

needed. The basic law could not be interpreted to include a right to die.[1140] While it could be argued that a right to commit suicide belonged to a freedom of action, to him suicide ran counter to moral law, the basic principles of Christian conduct and the beliefs of the majority of Germans.[1141] He could see no possible answer to the purely legal question whether there could be a right to die, since that question was directly related to the questions whether there was a right to a dignified death[1142] and furthermore whether the need to protect and value human life had to give way to respecting human dignity in the act of dying.[1143] Looking at human dignity he found that the need to respect a person as an autonomous being called for respect for liberty and autonomy which would then ask for a right to one's own death.[1144] This also meant that the duty of the physician to save life was limited by the duty to respect dignity in dying.[1145] Therefore, passive assisted dying was needed to realise the autonomy of the patient.[1146] However, abolishing §216 StGB was out of the question since active assisted dying was still a form of killing; an addition to said paragraph listing exemptions was not needed.[1147] What could be thought of instead would be an addition to §59 and §60 StGB, which regulate the punishment of crimes, to make it possible to abstain from punishment in cases of compassionate assisted dying in accordance with a strong, voluntary wish to die.[1148] The general arguments of the debate will be presented below at 5.4.3.

5.4.2. *Alternativentwurf* 2005

Between 1986 and 2005 the focus in the debates around assisted dying changed. While initially the focus had been on autonomy, it then shifted towards a stress of the dignity of those not able to express themselves (anymore).[1149] In 2003, the Federal Minister of Justice had set up a commission dealing with patient autonomy at the end of life and in 2005 the conference of justice ministers of the *Länder* debated assisted dying

[1140] See Harro Otto, 'Recht auf den Eigenen Tod? Strafrecht im Spannungsverhältnis zwischen Lebenserhaltungspflicht und Selbstbestimmung', in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 56. Juristentag. Band I, Gutachten*, *Teil D* (Beck 1986), 11-12.
[1141] See ibid, 13-16.
[1142] See ibid, 21.
[1143] See ibid, 24.
[1144] See ibid, 27-28.
[1145] See ibid, 37.
[1146] See ibid, 42.
[1147] See ibid, 90.
[1148] See ibid, 93.
[1149] See Lautenschläger (n 1127), 19.

with the task of coming up with a Bill on assisted dying.[1150] While the three paragraphs of that Bill were similar to that of the draft in 1986, in that they meant to regulate passive assisted dying in legalising the non-treatment of patients, legalise indirect assisted dying and declared the non-hindrance of suicide legal, one major difference was the inclusion of living wills.[1151] The main difference to the draft of 1986 was an added point that meant to criminalise the supporting of suicide for financial reasons.[1152] Concerning assisted dying, the draft no longer included the sub-point that the courts were free to let cases go unpunished if the assisted dying was meant to help patients end their suffering if no other option was available.[1153] The debate had changed towards aspects of end-of-life care.[1154] In contrast to the draft of 1986, active assisted dying was to remain illegal without any exemptions or mitigating factors.[1155] The reasoning behind that were the developments in the sector of palliative care[1156] which were claimed to make assisted dying redundant. This is an interesting aspect since in debates on assisted dying, palliative care is often used as an argument against the need for assisted dying (see for example the debates in the House of Lords, chapter 4.4.6.). However, as in the debates in the House of Lords, this argument was not unanimously accepted.

In a second part the commission had drafted a *Sterbebegleitungsgesetz* (law on end-of-life care). The first paragraph stressed the need for doctors to document the medication and dosage of medication if they did embark on indirect assisted dying.[1157] The same was to hold true for passive assisted dying.[1158] The fourth paragraph intended to legalise physician assisted suicide, once all other therapeutic measures had been tried and if it happened according to the patient's wishes.[1159]

Again, an expert report had been published for every section of the *Deutscher Juristentag*, the one concerning assisted dying was drafted by Verrel, director of the criminological department at the Universität

[1150] See ibid, 19.
[1151] See *Gesetzestext des AE-Sterbebegleitung von 2005,* §214-215.
[1152] See ibid*,* §215a.
[1153] See ibid*,* §216.
[1154] See Lautenschläger (n 1127), 21.
[1155] See *Gesetzestext des AE-Sterbebegleitung von 2005*, §216.
[1156] See Lautenschläger (n 1127) 27.
[1157] See *Entwurf eines Sterbebegleitungsgesetzes*, §1.
[1158] See ibid, §2.
[1159] See ibid, §4.

Bonn.[1160] According to him, the debate had changed since the discussion at the 56th *Deutscher Juristentag*, away from repressive criminal law versus pre-emptive civil law, to a need for lasting legal certainty when patient autonomy was debated at the 63th *Deutscher Juristentag*, and now back to the role of criminal law.[1161] What had led to a change in the general debate since the 56th *Juristentag* were not only developments in the field of medicine, and confusing decisions by civil courts,[1162] but also the general view on living wills which were finally seen as being essential.[1163] However, debating living wills only made sense when the legal framework for assisted dying was defined.[1164] Like Otto in his expert report for the previous *Juristentag*, Verrel did not see a need to abolish §216 StGB. Still, upholding that paragraph required complete autonomy of patients concerning indirect and passive assisted dying.[1165] He furthermore stated that the need to regulate assisted dying could not be done away with by simply referring to palliative medicine and claiming that indirect assisted dying did not exist.[1166]

5.4.3. The Debates

On 10 September 1986, the criminal law division of the *Deutscher Juristentag* started the debate of the alternative draft concerning assisted dying with two introductory presentations, the first by a medical practitioner, the second by a judge. This already was an indication for what was to come, in that the debate turned out to centre on the question of how far law could regulate medical conduct, and not the underlying questions of life and death, autonomy and dignity. Hiersche in his presentation focussed on the role of the physician. While recalling that suicide can – if truly voluntary – be a *Signatur der Freiheit* (signature of freedom)[1167] he stated that there was no enforceable right to die. While seeing the role of physicians as curing illnesses and reducing suffering, they were not meant to prolong life senselessly, thereby degrading the

[1160] See Torsten Verrel, 'Patientenautonomie und Strafrecht bei der Sterbebegleitung', in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 66. Juristentag. Band I, Gutachten, Teil C* (Beck 2006).
[1161] See ibid, 9.
[1162] See ibid, 10.
[1163] See ibid, 29.
[1164] See ibid, 58.
[1165] See ibid, 63.
[1166] See ibid, 33.
[1167] See Hans-Dieter Hiersche, 'Referat', *Teil M, Strafrechtliche Abteilung. Thema: 'Recht auf den Eigenen Tod? Strafrecht im Spannungsverhältnis zwischen Lebenserhaltungspflicht und Selbtsbestimmung'* in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 56. Juristentag. Band II, Sitzungsberichte* (Beck 1986), 10.

patient. According to him, the existing differentiation of passive, indirect and active assisted dying was not useful for the reality of the profession and the aim should not be assistance in dying but help against suffering.[1168] While being of the opinion that people should be free to choose the time of their own death, he found it dishonourable to request others (for example physicians) to perform the killing.[1169] His conclusion was that the whole area of assisted dying should not be regulated by law. The fixed norms of laws were not suitable to regulate medical conduct and the existent guidelines for physicians were sufficient.[1170]

Seeing that some of his points are valid, and while it is understandable that he would not want there to be any sort of duty to kill patients, his claim that assisted dying should not be regulated by law is not desirable. The cases that had appeared in front of the courts, concerning assisted dying, demonstrate that the lack of regulation poses problems.

The second presentation by a retired President of a Regional Court, Tröndle, was along similar lines, in addition he saw no right to commit suicide, since a right to dispose of one's life would have implications for the whole legal and social order.[1171] Though finding that passive assisted dying was to be accepted due to autonomy ranking higher than the duty to protect life, and seeing that indirect assisted dying was necessary to prevent a denial of assistance (as prohibited under §323c StGB), any form of active life-shortening was deliberate killing and had to remain prohibited. He did not see any kind of connection between letting a patient die and hastening death, since the latter was the disposal of another's life.[1172] What to him was the strongest argument against making any form of active assisted dying legal was the danger of a slippery slope. The fact that the *Alternativentwurf* already mentioned extreme exceptional cases to him was evidence of such a threat.[1173]

In the ensuing debate arguments were mainly made concerning the need for unambiguous laws for physicians versus the law being incapable of regulating medical conduct. Few arguments were made as to the non-existence of a right to die and the patient's autonomy. Compared to the debates in the House of Lords concerning assisted dying Bills (see chapter

[1168] See ibid, 16.
[1169] See ibid, 21.
[1170] See ibid, 24.
[1171] See Herbert Tröndle, 'Referat', *Teil M, Strafrechtliche Abteilung. Thema: 'Recht auf den Eigenen Tod? Strafrecht im Spannungsverhältnis zwischen Lebenserhaltungspflicht und Selbtsbestimmung'* in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 56. Juristentag. Band II, Sitzungsberichte* (Beck 1986), 29.
[1172] See ibid, 33.
[1173] See ibid, 39.

4.4.6.), the debate was highly unemotional and shied away from the underlying issues of suffering, dignity and autonomy. This is not surprising in that those aspects are almost always left out in German debates around assisted dying, the judgments of assisted dying cases and the discussed regulations. However, those are exactly the aspects that ask for a change of the current legislation. It is therefore regrettable that they are not being addressed.

The debate at the 66th *Deutscher Juristentag* on 20 September 2006 started like the one 20 years earlier with different presentations. The first to speak was former Chief Judge at the BGH, Kutzer. His general point of view was that while criminal law was there to set boundaries for those that were to decide over medical procedures concerning the dying, it did not have to sanction every breach of civil law or rules of professional conduct.[1174] Concerning active assisted dying he stressed that there was a consensus that it had to remain illegal.[1175] The prohibition of assisted dying was based on the high value of human life. There could be no exception in order not to differentiate between life worth living and life not worth living. Furthermore, the prohibition was in place to prevent hasty decisions, maybe even forced by others, a protection against being killed against one's will, the danger of a slippery slope, and the lacking necessity of assisted dying in preventing suffering.[1176] Concerning that last point Kutzer claimed that palliative care would be sufficient to prevent suffering and in the rare cases where it was not able to do so, one could still use palliative sedation.[1177]

A further point he addressed was physician assisted suicide. Assisting suicide is not a criminal offence in Germany which means that a physician could supply a patient with a deadly medication if the patient so wished.[1178] However, the rules of professional conduct of the medical profession prohibit assistance in suicide.[1179] According to Kutzer, the State does not have to accept any conduct that has the intention of ending life,

[1174] See Klaus Kutzer, 'Referat', *Teil N, Strafrechtliche Abteilung. Thema: 'Patientenautonomie und Strafrecht bei der Sterbebegleitung'* in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 66. Juristentag. Band II/1, Sitzungsberichte* (Beck 2006), 9.
[1175] See ibid, 20.
[1176] See ibid, 20-21.
[1177] See ibid, 21.
[1178] See ibid, 31.
[1179] See for example the preamble of the guidelines of the German Medical Association concerning end-of-life care, 2011. 'Grundsätze der Bundesärztekammer zur Ärztlichen Sterbebegleitung', (2011) 7 *Deutsches Ärzteblatt* 1.

therefore a prohibition of physician assisted suicide was not unconstitutional.[1180]

The second presentation, by lawyer Putz, was along the same lines, in that he stressed that palliative care was sufficient and would remove the patient's wish for assisted dying.[1181] According to him, active assisted dying had to remain criminal since it was not needed. Palliative care and legal indirect and passive assisted dying were sufficient means to deal with dying patients and suffering at the end of life.[1182]

The third presentation was by Borasio, professor of palliative medicine. He asserted that there was no such thing as indirect assisted dying, since reducing pain could actually prolong life.[1183] Instead of new legislation or additions to the existing StGB-paragraphs he saw a need for all doctors to receive training in palliative care.[1184] According to him, physician assisted suicide had to remain prohibited in that it would have a negative impact on the doctor-patient-relationship and would run counter to the ethical guidelines of the profession.[1185] Also, most suicides that happened were based on a mental problem which negated the voluntariness.[1186]

In 2006, the debate was generally on living wills and not on a right to die. Other issues that came up were the role of physicians in suicides and, as in the previous debate, the need for regulation versus the unsuitability of criminal law to regulate medical conduct. Again, the debate shied away from the real questions: the autonomy of patients, the right to an autonomous and dignified death, the need for some to receive assistance in order to set an end to their suffering. The main focus in the debate was on living wills. While living wills are of importance when it comes to the unconscious patient, what is even more important is the general underlying issue of autonomy. Since this thesis is concerned with active assisted dying the parts of the debate on living wills will not be analysed further.

5.4.3.1. Autonomy

Although the later debate did not further engage with the question, the first discussant in 1986, the president of the *Deutsche Gesellschaft für*

[1180] See Kutzer (n 1174), 31.
[1181] See ibid, 40.
[1182] See ibid, 52.
[1183] See ibid, 58.
[1184] See ibid, 59. He did however, at the end of the debate, state that palliative care would never be able to remove the suffering of all and that there will always be requests for assisted dying. See ibid, 195.
[1185] See ibid, 66.
[1186] See ibid, 64.

Humanes Sterben (DGHS - German Society for Dying with Dignity) Atrott, did stress that the central question was not what a physician might or might not do, but which rights a dying patient had.[1187] He also engaged with the right to life and claimed that it did not include a duty to live, and that if a duty to live existed it would be questionable why the human right to life was to be interpreted differently than the other human rights.[1188]

His opinion was backed up by the second discussant, a retired minister of justice, Klug, who claimed that autonomy would have to include a right to commit suicide and that religious dismissal of suicide could not be a basis for the decisions of the legislature.[1189] To him, Articles 1 and 2 GG called for autonomy which would then make a reform of the criminal law concerning a right to commit suicide necessary.[1190]

Judge Kleb-Braun stressed that so far the patients had to pay the price for the fear of the physician to face prosecution.[1191] To solve this situation a coherent provision was needed. What she had in mind was a provision that gave the patient a say in his or her treatment, not only in whether he or she wanted a specific form of treatment or not, but also a way out if he or she could not live with the consequences of a treatment.[1192] This situation has by now become reality with a stress on the patient's right to refuse treatments and the importance of living wills.

5.4.3.2. Need for Unambiguous Law

Brändel, lawyer at the BGH, claimed that there was a need for the legislature to solve the fear of physicians when it came to assisted dying[1193] and that the judiciary was not in the position to clarify matters since it was afraid of embarking on the wrong way.[1194] This is in accordance with the general view in Germany and England that it is for Parliament, not courts, to bring about a change in the law. Rolinski found that the *Alternativentwurf* would give physicians legal certainty and could take away the fear from patients that they would be coerced to undergo

[1187] See *Teil M, Strafrechtliche Abteilung. Thema: 'Recht auf den Eigenen Tod? Strafrecht im Spannungsverhältnis zwischen Lebenserhaltungspflicht und Selbtsbestimmung'* in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 56. Juristentag. Band II, Sitzungsberichte* (Beck 1986), 58.
[1188] See ibid, 58-59.
[1189] See ibid, 60.
[1190] See ibid, 60-61.
[1191] See ibid, 159.
[1192] See ibid, 159-60.
[1193] This view was for example share by former chief physician Markus von Lutterotti who furthermore claimed that facing a judicial inquiry after the death of a patient would be a moral burden with an impact on the job and the self-confidence of the physician. See ibid, 76.
[1194] See ibid, 61-62.

treatment against their will.[1195] He was doubtful as to for how long the ethical provisions concerning medical conduct would remain sufficient and claimed only legal regulation would give security to those involved.[1196]

Chief physician Hiersche claimed that the past involvement of the judiciary in medical issues had had the consequence of too many over-long therapies, out of fear of being accused of denial of assistance.[1197] While stating that the law can help physicians in reassuring them about what they can do without facing legal consequences, Principal von Bülow claimed that the *Alternativentwurf* did not cover all necessary areas and that sufficient treatment of the pain would take away all need for active assisted dying,[1198] so palliative care was enough and there was no need for assisted dying.

The President of the DGHS, Atrott, further claimed that not having a regulation opened the door to finding legal grounds for a conviction in hindsight, a fact that was clearly not acceptable for a state of law.[1199] Furthermore, as an argument against the danger of a slippery slope, Koch alleged that the *Alternativentwurf* would prevent a loosening of the protection of life in that it would codify the proper conduct of the physicians.

For Verrel in 2006, living wills were an important issue but only one part of end-of-life care.[1200] Additionally, a legal regulation of assisted dying had to be achieved since physicians still found it difficult to differentiate between active and passive, direct and indirect assisted dying.[1201] He stressed that criminal lawyers were not enemies of the medical profession; instead they wanted to define the areas in which physicians could act and decide without any risk.[1202] Verrel claimed that what was needed was the expansion of palliative care and additionally the creation of a legal framework.[1203] Later on in the debate he further stressed the need to regulate indirect assisted dying, due to its closeness to active assisted dying, alleging that from the outside they were not distinguishable.[1204]

[1195] See ibid, 135.
[1196] See ibid, 136-37.
[1197] See ibid, 85.
[1198] See ibid, 95-96.
[1199] See ibid, 130.
[1200] See *Teil N, Strafrechtliche Abteilung. Thema: 'Patientenautonomie und Strafrecht bei der Sterbebegleitung'* in Ständige Deputation des Deutschen Juristentages (ed), *Verhandlungen des 66. Juristentag. Band II/2, Sitzungsberichte* (Beck 2006), 106.
[1201] See ibid, 107.
[1202] See ibid.
[1203] See ibid.
[1204] See ibid, 167.

Opposed to the idea of regulation was for example Tondorf who stated that singular cases could not be the cause for an action by the legislator.[1205] He furthermore warned of a slippery slope and claimed that such a slope could be seen in the Netherlands.[1206] Also against the proposed regulations was Bickhardt who claimed that no law should contribute to lowering the inhibition threshold of suicide.[1207]

The President of the *Bundesärztekammer* (German Medical Association), Hoppe expressed the opinion that while it was a physician's duty to care for someone who was dying, it was not their job to help someone in committing suicide.[1208] Hoppe stated that from the medical point of view there was no difference between assisting someone in committing suicide and killing on request under §216 StGB.[1209] Since assisting in committing suicide was against the ethos of vocation of the medical profession, he also objected to the suggested provision concerning the non-hindrance of voluntary suicide,[1210] especially since only very few suicides could be seen to be the voluntary choice of a capable adult.[1211]

An interesting point was made by Verrel, who – after stating that the problem to him did not seem to be a careless approach towards the life of the old and sick but rather the inability to let dying happen –[1212] claimed that the assistance of a physician in committing suicide would – if legalised – be as non-demandable as the performance of an abortion,[1213] therefore giving the physician the possibility to object while giving individuals in exceptional cases the chance to receive help.

5.4.3.3. Law Unsuited to Regulate Medical Conduct

According to Jähnke, judge at the BGH, medical conduct concerned individual cases which could not be regulated in a better way than they already were. The consequence of something like the *Alternativentwurf* would mean coldness and mercilessness towards the patient.[1214] Brändel, lawyer at the BGH, felt that patients were afraid of going into the hospital because they feared signing off their right to self-determination. However, according to him that could be solved without changing the law, by simply

[1205] See ibid, 176.
[1206] See ibid, 177. He did, however, give no numbers to prove his claim.
[1207] See ibid, 182.
[1208] See ibid, 92.
[1209] See ibid, 92.
[1210] See ibid, 93.
[1211] See ibid.
[1212] See ibid, 186.
[1213] See ibid, 187.
[1214] See *Teil M, Strafrechtliche Abteilung* (n 1187), 83. This view was for example shared by public prosecutor Helga Franzheim, see ibid, 137.

applying the existing law more compassionately in not criminalising assistance in dying and in being more lenient in differentiating between passive and active assisted dying.[1215]

Hirsch feared that the medical profession would have to pay a high price should their conduct be regulated by the StGB.[1216] It could not be seen as the task of the StGB to regulate the conduct of specific professions.[1217] Slightly less drastic, but still opposed to a regulation via the StGB was Lackner, who stressed that it was superfluous to regulate something which already had a consensus. According to him, the *Alternativentwurf* only spelled out matters that were already followed in reality and there actually was no criminal prosecution in those areas of assisted dying that the *Alternativentwurf* tried to address.[1218]

According to lawyer Claussen, the *Alternativentwurf* would not solve the real problem which was that physicians were not sure about what was legal and what was not when it came to treating a dying patient.[1219] However, for him the right way would not be a regulation via the StGB.[1220] But as most opponents, he did not explain what the right way according to him would be. Still, an interesting point he made was one contradicting Hirsch, who had claimed that Germany should not become a pioneer in assisted dying regulation, in that he stated that especially due to the country's past and the historical (ab)use of the term assisted dying, it was for Germany to now address the topic and find an acceptable way forward in dealing with patients who did not wish to live anymore.[1221] Yet, his only suggestion was to not use the term 'euthanasia' and instead talk of *Sterbehilfe*,[1222] something that was already being done.

Opposition was not always voiced concerning the whole draft, sometimes opposition concerned only one aspect of assisted dying. While seeing it as the task of the *Juristentag* to lead to a clarification of the law and reduce fears by initiating a legal regulation of the issue at hand, Otto was not favouring a regulation of passive assisted dying. He claimed that it would turn the fear of being kept alive against one's wishes into a fear to not receive full treatment and instead be left to die.[1223] Though claiming

[1215] See ibid, 97.
[1216] See ibid, 125.
[1217] See ibid, 126.
[1218] See ibid, 127. This view was shared by a former President of a Regional Court, Tröndle. See ibid, 140.
[1219] See ibid, 148.
[1220] See ibid.
[1221] See ibid, 149.
[1222] See ibid.
[1223] See ibid, 123.

that medical conduct does need legal norms, especially with a stabilising and trust-creating function at the borders of life, Schreiber was of the opinion that the legalisation of active assisted dying would have negative implications for the legal system,[1224] and should therefore not take place.

While the established opinion is that it is for Parliament to regulate assisted dying, and not the courts, Otto and Chief Judge at the BHG, Salger, claimed the opposite, that it was a problem that had to be addressed by the judicature.[1225] This is doubtable, since, based on the specifics of the German legal system and demonstrated by the case law, the courts are depending on the law to change first, before they can engage with assisted dying in a different way.

5.4.3.4. Right to Die

An issue that hardly found discussion at all was the right to die and the implications such a right – or lack of a right – might have on society. As Hiersche claimed, killing could not be a medical assignment, neither could be help to die, the only task of the physician was to reduce suffering.[1226] According to Hirsch, indirect assisted dying was sufficient in helping the individual, and anything more would run counter to the need to protect the individual.[1227] Also, due to the misuse of the term 'euthanasia' during the Nazi-regime, the German legislature should not become a pioneer in assisted dying legislation.[1228] Later on he stressed the danger the *Alternativentwurf* would entail, in that every new regulation that led to impunity would have a power of attraction. Therefore, it would be a dangerous thing to bring about a legislation like the *Alternativentwurf*.[1229] For Kreuzer, there could be no constitutional right to commit suicide, since otherwise everyone trying to prevent someone's suicide would act counter to the constitution.[1230] It would be preferable to keep suicide in the area of the un-prohibited, without any valuation by the legal order.[1231]

Wawersik, however, claimed that it was not assisted dying that was envisaged with the *Alternativentwurf* but help in situations of physical suffering. It was not about assisted dying but about treatment of the

[1224] See ibid, 67-69.
[1225] See ibid, 168-71.
[1226] See ibid, 85.
[1227] See ibid, 64.
[1228] See ibid.
[1229] See ibid, 141-42.
[1230] See ibid, 116-17.
[1231] See ibid, 117.

dying.[1232] Generally, this is what the focus in the German debates was and still is. Not so much the right of the individual to choose when and how he or she wants to die but rather the regulation of medical conduct and palliative care. As Merkel stated, in discussions the underlying moral questions were not being debated openly.[1233] However, the only point he then brought up was the stress in the *Alternativentwurf* of the fact that the non-hindrance of suicide was to be declared to not be illegal if the suicide happened voluntarily.[1234] This can still be claimed to avoid the underlying moral question of whether there is a right to die that would then make a call for assistance possible.

One of the rare contributions to the discussion in 2006 that not only engaged with the questions concerning the legal status of living wills or the question whether criminal law was the right area of law to regulate assisted dying, was made by Chief Principal Lüttig. According to him, the debate around assisted dying had increased again after the founding of the German section of Dignitas in 2005.[1235] He expressed the opinion that the professional bringing about of a quick death could not be the answer to the question of a death in dignity.[1236] Furthermore, organised forms of assisted dying would challenge the non-disposability of human life.[1237] He claimed that suicide was not a question of autonomy since it always also had an impact on the family and society.[1238] According to him, we have to call a halt to seeing a quick death as a way out of crises, old age or illness.[1239] This view was shared by the Minister of Justice of Thuringia, Schliemann, who claimed that assistance in committing suicide was not compatible with the value order of the society and that suicides were mainly cries for help.[1240]

The equally rare expression of the opposite view was stated by former Principal Heitman, who voiced the opinion that he personally would want the possibility of an assisted suicide in certain end-of-life scenarios and that without a change of §216 StGB there was no escape from suffering and instead one had to accept divinely ordained fate.[1241] He ended his contribution on assisted dying with a quote by Sophocles: „Der Tod ist

[1232] See ibid, 77.
[1233] See ibid, 80.
[1234] See ibid.
[1235] See *Teil N, Strafrechtliche Abteilung* (n 1200), 108.
[1236] See ibid, 109.
[1237] See ibid.
[1238] See ibid, 111.
[1239] See ibid.
[1240] See ibid, 170-71.
[1241] See ibid, 126.

doch das Schlimmste nicht, vielmehr den Tod ersehnen und nicht sterben können".[1242]

Putz claimed that we do have a right to self-determination, even if we make unwise choices.[1243] According to him, just because a misuse might lead to a criminal action, that was not an argument against assisted dying.[1244]

5.4.3.5. Concluding Remarks

Striking about both debates in the *Deutschen Juristentagen* is on what a technical level they were held. What was not debated were for example implications of dignity and the right to life. Instead, the debates focused on whether criminal law could be used to regulate medical conduct and in the second debate more specifically the role of living wills. Compared to the debates in the House of Lords (see chapter 4.4.6.) it is interesting to see that neither populist nor religious argumentation was used. The dignity of the dying, the sanctity of life, the implications of a right to life, the fears of the old and vulnerable, all those areas were left out of the debates. Instead the focus was on how far law could regulate medical conduct.

One of the reasons why the focus in the debates was so different can be seen in the composition of the groups debating assisted dying. While the House of Lords is comprised of Lords and Ladies of various backgrounds, thereby having input from diverse points of views, the *Juristentag*, being a lawyers assembly, has a more limited focus. Due to the nature of the topic, physicians were invited to share their views which offered a second angle, but naturally not as many perspectives as in the House of Lords.

A further reason for the difference can be seen in the Germans' more careful and restrained approach towards assisted dying. With it still being a taboo, it is harder to be discussed forthrightly and without restraints. Openly being in favour of assisted dying is more difficult in Germany than it is in England.

[1242] See ibid, 126, which translates to "Death is not the worst thing; rather, when one who craves death cannot attain even that wish".
[1243] See ibid, 160.
[1244] See ibid.

5.4.4. Further Ethical Publications on Assisted Dying

Two ethical reports have been published that are important to and show the focus of debates on assisted dying.[1245] The bioethics commission of Rhineland-Palatinate in its report of 2004 made a claim in favour of passive assisted dying based on the developments in medicine but against active assisted dying which – like physician assisted suicide – should only be permitted in exceptional cases. The commission listed a number of commands, like for example the expansion of hospices and a reinforcement of a right to a self-determined death in dignity. While the right to a self-determined death was seen to be part of a self-determined life, a prohibition of active assisted dying could still be based on the State's duty to protect life. The commission recommended taking up the *Alternativentwurf* of 1986 again and introduce it – with some changes – into the legislative procedure.[1246]

In 2006, the national ethics committee[1247] published a commentary on autonomy and care at the end of life.[1248] While dying was seen as a highly personal matter, it also involved ethical responsibilities, legal requirements and religious expectations.[1249] The committee furthermore saw autonomy coming into play at the end of life but furthermore stated that there are moral duties towards oneself that limit one's autonomy.[1250] One of those duties could be seen in respect towards one's own life.

What could not be seen in the right to life was a duty to continue living, which asked for the availability of passive assisted dying.[1251] The autonomous choice of the patient had to serve as basis and limit of medical conduct.[1252] The main problem in regulating those forms of assisted dying was seen in the conflict of protecting life versus autonomy.[1253] Most decisively, the national ethics committee stated that commercial assisted

[1245] See Bioethik-Kommission Rheinland-Pfalz, 'Sterbehilfe und Sterbebegleitung. Ethische, Rechtliche und Medizinische Bewertung des Spannungsverhältnisses Zwischen Ärztlicher Lebenserhaltungspflicht und Selbstbestimmung des Patienten', 23 April 2004 and Nationaler Ethikrat, 'Selbstbestimmung und Fürsorge am Lebensende. Stellungnahme', (Berlin 2006) .
[1246] See Bioethik-Kommission Rheinland-Pfalz (n 1245), 129.
[1247] The national ethics committee (*Nationaler Ethikrat,* since 2008: *Deutscher Ethikrat*) is a non-governmental, independent body which monitors ethical, legal and medical questions arising from developments in science which have an impact on human life. It drafts advisory opinions for the Government, either on their request or self-determinedly, and on an annual basis reports to the Government on its activities and provides updates on the public debates concerning bioethical issues. See http://www.ethikrat.org/ueber-uns/auftrag, accessed 28 September 2013, 10.00am.
[1248] See Nationaler Ethikrat (n 1245).
[1249] See ibid, 9.
[1250] See ibid, 20-21.
[1251] See ibid, 59.
[1252] See ibid, 60.
[1253] See ibid, 71.

dying should be prohibited since it was ethically not acceptable and that killing on request ought to remain illegal.[1254]

5.4.5. Draft Bill Concerning the Prohibition of Commercial Assisted Suicide

Recent debates in the German Parliament show the problem behind the lack of regulation. Brought up for debate was the need to criminalise commercial assisted suicide.[1255] What can be seen as the start of that debate was the introduction of a German branch of the Swiss organisation Dignitas in 2005. Dignitas charges membership fees and additional fees for preparing the suicide.

In 2006, the *Länder* Saarland, Thuringia, and Hesse introduced a Bill into the *Bundesrat* (Federal Assembly) with the aim of criminalising commercial assisted suicide.[1256] In June the *Rechtsausschuss* (Judiciary Committee) and the *Gesundheitsausschuss* (Health Select Committee) published their recommendation, stating that the Bill should be introduced into the *Bundestag* (German Federal Parliament).[1257] On 4 July 2008 the *Bundesrat* stated that commercial assisted suicide should be addressed by the legislature that same year.[1258] In the 846th meeting on 4 July 2008, 7 speeches were held concerning that Bill, a further statement was added to the minutes.

This first debate briefly touched upon the arguments that are generally brought up in discussions.[1259] Dignity was used as an argument against assisted dying, but also as an attribute of dying. Protection was seen to be needed for the old and vulnerable, and for life itself. Palliative care should be stressed and extended and the worth of human life not forgotten. However, people were autonomous beings and had a right to self-determination. Like in the debates of the *Juristentage*, even the question of the suitability of criminal law for regulating assisted dying was brought up.

[1254] See ibid, 90, 95.
[1255] Commercial assisted suicide meaning that the service of assisting in committing suicide is not offered on the basis of compassion but as a commercial transaction for the purpose of making a profit. It does not include altruistic help, provided by friends or family, but only those individuals or organisations which take money in order to provide assistance.
[1256] See Bundesrat Drucksache 230/06, 27.03.06, Gesetzesantrag der Länder Saarland, Thüringen, Hessen, *Entwurf eines Gesetzes zum Verbot der geschäftsmäßigen Vermittlung von Gelegenheiten zur Selbsttötung.* It does not include altruistic help, provided by friends or family, but only those individuals or organisations which take money in order to provide assistance.
[1257] See Bundesrat Drucksache 436/08, (Grunddrucksache 230/06), 24.06.08.
[1258] See Bundesrat Drucksache 436/1/08, 04.07.08.
[1259] Since the debate was very brief and did not add much substance to existing debates, it will not be dealt with in more detail, instead the focus will be on the debates on the Bill which followed in 2012.

After the seven speeches, the Bill was returned to the committees.[1260] However, following that, the *Länder* could not agree on the actual terms of a Bill.[1261]

5.4.6. Commercial Assisted Suicide Bill 2012

In the second half of 2012, a draft Bill was introduced by the Federal Government, first into the *Bundesrat* and then into the *Bundestag*. On 31 August 2012, the Bill was introduced into the *Bundesrat* to be considered by the *Rechtsausschuss* (Judiciary Committee) and the *Ausschuss für innere Angelegenheiten* (Committee for Internal Affairs). The Bill's aim was to add a new paragraph into the StGB which would in its first part make commercial assisted suicide a criminal offence and in its second part stress that non-commercial assisted suicide, by relatives or persons otherwise close to the one committing suicide, should remain legal.[1262] The reasons the Government gave for the suggested change in law were first of all, that commercial offers of assistance would make assisted suicide too easily available and could lead desperate individuals to seek death who would, without the commercial offer, not do so. Furthermore, a weight of expectation could develop for the sick and old to avail themselves of such an offer. People should never feel they have to justify their wish to continue living. The Government justified those claims with numbers from countries where commercial assisted suicide is available, the Netherlands, Belgium and Switzerland. In all three countries the number of assisted suicides has risen since it became legally available (whether on a commercial basis or not).[1263] However, it is debatable whether the rise is really due to vulnerable persons being coaxed into committing suicide or whether it is a sign that legalisation is needed to help those who want assistance, but seek it on a legal way. Also, more objectively, the question is whether the numbers are simply higher due to a more thorough registration. Even the Government admitted in the explanation to the Bill, that there has so far been no causal proof of a connection between

[1260] See Bundesrat, Stenografischer Bericht, 846. Sitzung, Berlin, Freitag, den 4. Juli 2008, 219C.
[1261] See Bundesrat, Drucksache 515/12, 31.08.12, Gesetzentwurf der Bundesregierung, *Entwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung*, 2.
[1262] See Bundesrat, Drucksache 515/12, 31.08.12, Gesetzentwurf der Bundesregierung, *Entwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung*, Artikel 1.
[1263] See ibid, 3-4.

commercial offers for assistance in committing suicide and the rise in the numbers of those seeking it.[1264]

The Bill was seen as compatible with the GG and the ECHR in that none of those documents actually give rise to a right for assistance in suicide and in that the proposed Bill did not touch upon the right of the individual to decide freely over the circumstances of his or her own death.[1265] According to the Government, the Bill went far enough in that assisted suicide was not to be criminalised as such, and also in that assistance offered by non-commercial organisations was to remain legal, since what is legal for an individual cannot be a crime if carried out by an organisation.[1266]

5.4.6.1. The Debates

On 28 September 2012, the *Rechtsausschuss* published its recommendation to the *Bundesrat*, which was to reject the Bill since it did not offer an appropriate solution to the problem of assisted dying. It was considered questionable to exempt the medical profession from punishment should they assist patients in dying. The *Ausschuss für innere Angelegenheiten* on the contrary did not have any objections.[1267] In its 901th meeting on 12 October 2012, the *Bundesrat* debated the Bill together with a draft Bill to change the StGB concerning the culpability of advertising assisted suicide, following a petition by Rhineland-Palatinate.[1268] After four speeches, the assembly voted to not pass the Bill concerning the culpability of advertising assisted suicide on to the Federal Government and to not issue a statement on the Bill concerning the prohibition of commercial assisted suicide.[1269] Compared to the debates in the House of Lords in England and in the German Lawyer Assembly, this was not really a debate but merely the presentation of four opinions. Interestingly, no presentation was made against assisted dying *per se*. The focus was therefore not the sanctity of life or the stress of autonomy;

[1264] See ibid, 4.
[1265] See ibid, 5.
[1266] See ibid, 6.
[1267] See Bundesrat, Drucksache 515/1/12, 28.09.12, 'Empfehlungen der Ausschüsse, R-In, zu Punkt... der 901. Sitzung des Bundesrates am 12. Oktober 2012'.
[1268] See Bundesrat, Drucksache 149/10, 23.03.10, *Entwurf eines Gesetzes zur Änderung des Strafgesetzbuches*
- *Strafbarkeit der Werbung für Suizidbeihilfe*. Suggesting a new §217 StGB to criminalise any form of advertisement for assisted suicide. On 28 September 2012 the *Rechstausschuss* recommended to not pass the Bill on to the *Bundestag.* See Bundesrat Drucksache 572/12*, 28 September 2012.
[1269] See Bundesrat, 'Stenografischer Bericht, 901. Sitzung, Berlin, Freitag, den 12. Oktober 2012', 441C.

instead the stress was on the need to protect the vulnerable by not making assisted suicide too easily available. Dignity and autonomy were not mentioned at all. The focus was generally on the extent of the suggested Bills, not so much the content. This was different in the following debate.

The Bill on the prohibition of commercial assisted suicide next moved on to the *Bundestag* where it found discussion in the 211th meeting on 29 November 2012. Six speeches were added to the minutes and without any discussions or votes the Bill was then assigned to the *Rechtsausschuss* and the *Innenausschuss* (Home Affairs Select Committee).[1270] In this debate (which again was not a proper debate but merely a presentation of opinions), the three main points were the need to protect life and dignity, the role of palliative care and the need to respect autonomy.

The *Rechtsausschuss* to whom the Bill was handed subsequently decided to have a public hearing which took place on 12 December 2012. Nine experts had submitted statements on the issue. The experts came from both, the legal and medical profession, similar to the discussants at the *Deutsche Juristentage* (see above at 5.4.1. and 5.4.2.). In those nine expert opinions the same views found expression that had been brought forward in the *Bundestag* and *Bundesrat* before. The need for proper palliative care was stressed and autonomy versus the need to protect life. The right to a dignified death was brought up and the need to prevent suicides. Also, the suitability of the Bill and of criminal law in general found mentioning.

In its 214th session, the *Bundestag* further assigned the Bill to the *Ausschuss für Gesundheit* (Committee for Health).[1271] In its manifesto for the federal election in 2013, the CDU[1272] not only promised to extend the availability of palliative care and promote dying in dignity, but also stressed that they were against active assisted dying and would continue to campaign for criminalising organised, commercial assisted suicide.[1273] In early 2014, it was announced that the Bill would find discussion in the *Bundestag* soon, however, this has not happened to date.

[1270] See Deutscher Bundestag, 'Stenografischer Bericht, 211. Sitzung, Berlin, Donnerstag, den 29. November 2012', 25893A.
[1271] See Deutscher Bundestag, 'Stenografischer Bericht, 214. Sitzung, Berlin, Donnerstag, den 13. Dezember 2012', 26193D.
[1272] Christian Democratic Union, governing party at the time of the writing of this thesis.
[1273] See 'Gemeinsam erfolgreich für Deutschland', Regierungsprogramm 2013 – 2017, CDU/CSU, 49.

5.4.6.1.1. Protect Life

One of the main criticisms concerning assisted dying in general and in this case commercial assisted suicide is the perceived duty of the State to protect life.[1274] In the first debate this argument was brought forward by Minister of State Hartloff (Rhineland-Palatinate).[1275] In order to protect life, advertising assisted dying should be prohibited to prevent the coercion of desperate individuals.[1276] With advertising assisted suicide the respect for life would be endangered, turning suicide into something mundane, a commodity even.[1277]

In the second debate a stress on the need to protect life was made by Heveling (CDU/CSU). While stating that the autonomous choices regarding one's own life should be respected,[1278] he stressed that it was the task of criminal law to protect human dignity against developments that would pose a threat to it.[1279] To protect life also at the end of it, he found it vital to counteract organised forms of assisted suicide.[1280] In order to prevent people from throwing away their lives, who would not do so without the existence of such organisations, the Bill was needed and would be an improvement to the current legal situation.[1281]

Geis (CDU/CSU) also stressed the importance of protecting life. That protection ranked higher than the respect for autonomy, since there could be no autonomy without life. Furthermore, he claimed that 90% of suicides were not based on autonomous choices but on depressions that could be cured.[1282] Based on the value of life ranking higher than autonomy, the State had the duty of protecting life, even against the person's own wish, and could not tolerate suicides. For him the Bill did not go far enough. Helping someone to die should in general be punishable, not just if carried out for commercial gain.[1283]

[1274] This was also stressed by Prime Minister Beck (Rhineland-Palatinate) and Minister Rauber (Saarland) concerning the Bill of 2006. See Bundesrat, 'Stenografischer Bericht, 846. Sitzung, Berlin, Freitag, den 4. Juli 2008', 214C and 243*B-C

[1275] See Bundesrat, 'Stenografischer Bericht, 901. Sitzung, Berlin, Freitag, den 12. Oktober 2012', 437B.

[1276] See ibid.

[1277] See ibid.

[1278] See Deutscher Bundestag, 'Stenografischer Bericht, 211. Sitzung, Berlin, Donnerstag, den 29. November 2012', 25953B.

[1279] See ibid, 25953C.

[1280] See ibid, 25953D.

[1281] See ibid, 25954B.

[1282] See ibid, 25954D.

[1283] See ibid, 25955B. The commercial aspect of assistance also found discussion in the debates concerning the Bill of 2006, for example by Minister of State Mackenroth (Saxony), who saw a negative aspect in the organisations offering assistance for profit in that they did not provide a reliable and controllable counselling service with a life-affirming perspective and instead focussed simply on the execution of a wish to die, see Bundesrat, 'Stenografischer Bericht, 846. Sitzung, Berlin, Freitag, den 4. Juli 2008', 217C.

In the third debate, Schwarz, from the Universität Würzburg, supported the Bill but suggested a change from 'commercial' to 'routinely and self-interested'.[1284] Even though patients clearly had the right to refuse treatment, and could make decisions over their life in that respect, this could not lead to the conclusion of abolishing the non-disposability of life.[1285] Without such a Bill, assisted suicide would not only be tolerated but accepted as a normal deed.[1286] While assisted suicide for pure humanitarian reasons should stay in the legal sphere, every financially motivated form had to be sanctioned, with the primary reason for punishment being the financial aspirations, followed by the wish to prevent suicides.[1287]

Saliger, from the Bucerius Law School, Hamburg, criticised the Bill for being contradictory and unconstitutional.[1288] The Bill was neither a suitable, nor a needed means to promote the protection of life.[1289] He doubted that the Bill was going to criminalise something that was actually taking place in Germany and criticised the lack of examples in the draft.[1290] The existing assisted suicide organisations did not have a provable aim of making a profit from assisting in suicides, the German organisation *Verein Sterbehilfe Deutschland e.V.*[1291] even paid back all membership fees should it come to a suicide.[1292] Seeing that the Bill did not address an actually existing problem, the question was how successful it would be in preventing the danger of tempting suicidal individuals to end their lives.[1293] It could even be the case that commercial offers of assisting in suicide would act as a deterrent in that the fees would be a barrier for some.[1294] According to him, administrative law would be a more successful means in securing the desired protection. Regulating the licensing and control of organisations could be more effective than their criminalisation.[1295] Furthermore, the aspired §217 would not fit in with the existent paragraphs concerning homicides, since the other paragraphs all concerned

[1284] See Kyrill-Alexander Schwarz, 'Sachverständige Stellungnahme zu dem Gesetzentwurf der Bundesregierung ("Entwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung") vom 22. Oktober 2012 (BT-Drs. 17/11126)', 2.
[1285] See ibid, 3.
[1286] See ibid, 5.
[1287] See ibid, 6.
[1288] See Frank Saliger, 'Schriftliche Stellungnahme zur öffentlichen Anhörung des Rechtsausschusses des Deutschen Bundestages am 12.12.2012 zum Entwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung', 1.
[1289] See ibid, 2.
[1290] See ibid.
[1291] An organisation founded in 2009 which offers assistance in committing suicide.
[1292] See ibid, 3.
[1293] See ibid, 4.
[1294] See ibid, 5.
[1295] See ibid, 9.

deeds that have actually happened and not the mere abstract threats.[1296] Also, it would create difficulties in distinguishing the prohibited form of commercial assisted suicide from other forms of permitted assisted dying which would remain legal.[1297]

The *Bundesärztekammer* was also in favour of the Bill. Gaining financial profit from an existential crisis could not be compatible with the basic values of society.[1298] The Bill did not go far enough in that any form of organised assisted suicide should be punishable.[1299] Just because individuals were seen to be autonomous did not mean that they had a right to any form of assistance in committing suicide.[1300] Additionally, advertising for organised assisted suicide should be prohibited to prevent the impression that it would be a commonplace service.[1301] Furthermore, the exceptions under the Bill for relatives and other close personnel did not find acceptance by the German Medical Association since it could not be true that they in every case only acted out of compassion.[1302] What was needed was support for programmes aimed at suicide prevention, the expansion of palliative care and the enabling of a dignified care for the old and sick.[1303]

5.4.6.1.2. Palliative Care

An aspect brought up in the second and third debate was the need for palliative care. For example, Franke (SPD) stressed the need for proper palliative care and an extension of hospice care.[1304] This view was shared by Senger-Schäfer (Die Linke). Everyone deserved the best care possible. People would only want to die if they felt lonely and helpless,[1305] problems that could be solved differently than offering assistance for committing suicide.[1306] Palliative care would make assisted dying and assisted suicide

[1296] See ibid, 10.
[1297] See ibid, 11.
[1298] See 'Stellungnahme der Bundesärztekammer zu dem Regierungsentwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung (BT-Drs. 17/11126)', 4.
[1299] See ibid.
[1300] See ibid, 5.
[1301] See ibid, 6.
[1302] See ibid, 7.
[1303] See ibid, 10.
[1304] See Deutscher Bundestag, 'Stenografischer Bericht, 211. Sitzung, Berlin, Donnerstag, den 29. November 2012', 25956C.
[1305] This is an argument which is closely linked to the need to protect the vulnerable. In the debate concerning the Bill of 2006 this was for example stressed by Senator Steffen (Hamburg), see Bundesrat, 'Stenografischer Bericht, 846. Sitzung, Berlin, Freitag, den 4. Juli 2008', 216B - 217B and Reinhart (Baden-Wuerttemberg), to whom the debate centred on the society's approach towards the old and dying, see Bundesrat, 'Stenografischer Bericht, 846. Sitzung, Berlin, Freitag, den 4. Juli 2008', 218C.
[1306] See ibid, 25957C.

superfluous,[1307] a reason why the hospice movement needed structural, financial and media support.[1308]

Leutheusser-Schnarrenberger (Federal Minister of Justice) stressed that this was an issue were it was highly unlikely to find consensus.[1309] While palliative care was needed and could help some people, she did not see it as the solution for everyone.[1310] However, commercial assisted suicide was too great a threat to vulnerable, undecided people, which made a prohibition necessary.[1311]

In the third debate, Freynhagen, specialist for palliative medicine and pain therapy, favoured the Bill since palliative care could provide patients with all the care they needed to die in dignity without suffering and pain, so that there was no need for suicides and therefore also no need for assistance in suicides.[1312] While palliative medicine and care still needed to be expanded and promoted, this would then be a sufficient approach to the death wish of patients, making it morally reprehensible to want to make a profit from the wish to die of patients by offering commercial assisted suicide.[1313]

The *Patientenschutzorganisation Deutsche Hospiz Stiftung* (patient protection organisation, German hospice foundation) was generally in favour of the attempted criminalisation but saw flaws in the drafting of the Bill. Starting their statement by stressing that the basic law grants everyone the right to self-determination (Arts 1.1, 2.1 and 2.2 GG) they went on to claim that this did not exclude measures by the State to protect life and did not lead to any basis for claims concerning help in committing suicide.[1314] The main flaw they saw was that assisted suicide without any commercial aspirations could have the same negative effects that commercial assisted suicide was feared to have, the Bill therefore falling short.[1315] While it was the legislator's duty to enable a life and death in dignity, seeing that some people prefer death over depending on care

[1307] See ibid, 25957D.
[1308] See ibid, 25958A.
[1309] See ibid, 25959B.
[1310] See ibid, 25959C.
[1311] See ibid, 25959C.
[1312] See Rainer Freynhagen, 'Persönliche Stellungnahme zum Entwurf eines Gesetzes zur Strafbarkeit der Gewerbsmäßigen Förderung der Selbsttötung (BT-DRS 17/11126)', 3.
[1313] See ibid, 6.
[1314] See Eugen Brysch, 'Stellungnahme des Sachverständigen Eugen Brysch, Vorstand der Patientenschutzorganisation Deutsche Hospiz Stiftung zum „Entwurf eines Gesetzes zur Strafbarkeit der gewerbsmä§igen Förderung der Selbsttötung" (BT-DRS 17/11126) anlässlich der Anhörung im Rechtsausschuss des Bundestages am 12. Dezember 2012', 2-3.
[1315] See ibid, 3-4.

meant that the legislator was not fulfilling his responsibility in offering satisfactory care.[1316]

5.4.6.1.3. Autonomy

Also an aspect finding discussion in the second and third debate was autonomy. Montag (Die Grünen) stressed the right for autonomous choices. While stating that the numbers from countries like the Netherlands and Belgium did not show an increase in suicides after the legalisation of assisting activities,[1317] he stressed that there was no intention in Germany to legalise assisted dying.[1318] However, since assisting suicide was legal for an individual, it followed under German law that it would also have to be legal for an organisation.[1319] While not wanting to incite or tempt anyone to commit suicide, he stressed the need to accept and respect the autonomous decision to want to commit suicide which was why suicide and assisted suicide had to remain legal.[1320] However, to protect the autonomous choice from any organised heteronomy or manipulation, there might be need for some regulation,[1321] especially due to the need to protect the legally protected value 'life'.[1322] While not being completely opposed to a Bill regulating commercial assisted suicide, Montag claimed that a Bill would have to be drafted differently, with other justifications.[1323]

In the third debate The *Humanistische Union* (Humanist Union) expressed a very explicit opinion against the Bill. What they were opposed to was the Bill's negation of a person's right to a dignified death in doubting the person's capacity to make that choice.[1324] Instead, they favoured the *Alternativentwürfe* discussed at the *Deutsche Juristentage* (see above at 5.4.1. and 5.4.2.), especially the idea of legalising physician assisted suicide.[1325] The Bill as presented now concerned a problem that could not be proven to exist.[1326] If the danger that suicide rates would rise was real, then any form of assistance in dying had to be prohibited.[1327]

[1316] See ibid, 11.
[1317] See Deutscher Bundestag, 'Stenografischer Bericht, 211. Sitzung, Berlin, Donnerstag, den 29. November 2012', 25958B-C.
[1318] See ibid, 25958C.
[1319] See ibid, 25958C.
[1320] See ibid, 25958D.
[1321] See ibid.
[1322] See ibid, 25959A.
[1323] See ibid, 25959B.
[1324] See 'Stellungnahme der Humanistischen Union zum Referentenentwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung', 2.
[1325] See ibid.
[1326] See ibid, 3.
[1327] See ibid, 2.

While the Bill followed a legitimate goal, to protect the highest value, 'life', the means applied seemed not justified, since there was no causal connection between offers of commercial assisted suicide and rises in suicide rates.[1328] The Bill was seen as unconstitutional in trying to criminalise the assistance of a non-criminal act and disproportionate in connection to Article 12 GG, granting freedom of profession.[1329] Furthermore, it was seen as difficult to make the distinction between organisations offering it for financial profit and those without aiming for profit. Dignitas Germany, for example, charges a joining fee and a membership fee, but no fee for the assistance itself. The question would be whether this counts as a commercial organisation or not.[1330] Concluding, the humanist union found that the Bill would only lead to a further complication in the area of assisted dying. It would not lead to legal certainty but just make the criminalization of some organisations possible. Instead of defining clearly which forms of assisted dying would be permissible, the Bill would only further the taboo.[1331]

The criminal law division of the *Deutscher Anwaltsverein* (German Bar Association) was opposed to the idea of sanctioning commercial assisted suicide under criminal law. They did appreciate the worries that offers of commercial assisted suicide could be a threat to the life of vulnerable individuals and also found that a complete legalisation of encouraging suicides would run counter to the protection of life under basic law (Article 2.2 GG).[1332] However, what also had to be respected was the individual's autonomy.[1333] According to the lawyer association, individuals who wished to die had to be presented with help in order to be able to fulfil their wish.[1334] Like Saliger and Rosenau, they saw the way forward in a form of regulation outside the scope of criminal law.[1335] This was also based on the rule that what was legal for the individual could not be illegal for an organisation.[1336] Furthermore, if organisations were made illegal it would have a negative consequence on the autonomy of those individuals that were incapable of committing suicide unaided and did not have friends or

[1328] See ibid, 5.
[1329] See ibid, 7.
[1330] See ibid, 9.
[1331] See ibid, 16.
[1332] See 'Stellungnahme des Deutschen Anwaltvereins durch den Strafrechtsausschuss zum Referntenentwurf des Bundesministeriums der Justiz: Entwurf eines Gesetzes zur Strafbarkeit der gewerbsmäßigen Förderung der Selbsttötung (Stand: 18.07.2012)', 5-6.
[1333] See ibid, 6.
[1334] See ibid.
[1335] See ibid, 7.
[1336] See ibid, 8.

relatives that were willing to help.[1337] So while organisations needed to be regulated to protect the vulnerable, it should only be commercial regulation and not prohibition, to also respect the right to self-determination enshrined in the constitution.[1338]

5.4.6.1.4. Criminal Law Not Suited

What was brought up in the third debate was furthermore the idea that criminal law was not suited for regulating assisted dying. Rosenau, of the Universität Augsburg, was opposed to the Bill in that the assistance of a non-criminal act could not be criminal. Suicide itself should remain legal because criminalising it would lead to a form of paternalism that was not compatible with the liberal understanding of the German constitution.[1339] Furthermore, he claimed that the Bill lacked a legally protected good, since life could not be protected against the individual's wish.[1340] To him, the Bill was a political reaction to an opinion held by part of the public.[1341] Also, since suicidal individuals needed professional help, organisations like Dignitas and Exit in Switzerland could even do some good, in providing suicidal individuals with a form of attention that the medical profession was often not willing to give.[1342] Many individuals contacting those organisations did in fact never commit suicide.[1343] Like Salinger, he would favour regulation and control of organisations over their prohibition.[1344]

5.4.6.1.5. Concluding Remarks

The prevailing idea in the debates around legal change is that while there is a right to self-determination and while we are autonomous beings, there should be a limit to the choices one can make. The question is whether the limit to our autonomy based on the need to protect the vulnerable is justified and needed, or whether the vulnerable could actually be protected while at the same time providing others with the assistance they wish (or need) to receive in ending their lives. While safeguards can never prevent all possible abuse, the safeguards entailed in the latest version of the UK Assisted Dying for the Terminally Ill Bill (for example the need for written declarations by the patient, see chapter 4.4.5.) go a long

[1337] See ibid.
[1338] See ibid, 10.
[1339] See Henning Rosenau, 'Stellungnahme zum geplanten §217 StGB n.F. – BT-Drs. 17/11126', 1.
[1340] See ibid, 2.
[1341] See ibid.
[1342] See ibid, 3.
[1343] See ibid.
[1344] See ibid.

way in order to prevent most cases of abuse. The protection of life should only go as far as the holder of that life wishes it to go. The German debates have excluded the effect that the law in question will have on already suffering individuals. While talking about those human beings that need protection, no attention was given to those actually suffering unbearably but needing assistance to end that suffering.

While in the debates human dignity, autonomy and the absence of a right to die were mentioned, what was not engaged with was the idea of life as sacred or God-given. Compared to English debates, where quite a few religious arguments were made, religious ideas did not find expression in any of the German debates. This could be due to the fact that in the House of Lords there are religious representatives, whereas in the *Bundesrat* and *Bundestag* the presentations are made by politicians without a religious affiliation. However, as was seen in the analysis of the debate in the House of Lords (see chapter 4.4.6.), religious arguments were also used by members not holding a religious office. Still, no German politician used religion as a basis for argumentation.

While the claim to a dignified death does surface at times, dignity is mainly used as a constraint in German debates. The dignity of the vulnerable and old in the debates has the purpose of underlining the need for a prohibition of assisted dying. While their dignity of course may not be overlooked, this argumentation falls short. Those who ask for assistance do not ask for their dignity to be ignored. Instead, they also base their claim on their own personal dignity. Rather than being used as a constraint, dignity should be used as a source of empowerment in assisted dying. The dignity of the individual asks not only for a dignified life, but also for a dignified death.

What is striking is the reoccurring claim that people will not want to die with adequate care, if they get enough attention and are not made to feel they are a burden. While this may of course be true for some – or even most – scenarios, it is certainly not true for each and every individual case. Mrs Wittig and Mrs Koch for example did not take any comfort in the availability of palliative care. Furthermore, palliative care concerns treatments in the terminal stages of an illness. It can reduce suffering and take away (some) pain. But it does not help people who do not wish to live anymore. This is an aspect that was not mentioned in the German debates: the fact, that there are individuals who want to have the right to

end their lives, but for one reason or another need help in accomplishing that goal.

5.4.7. Academics' Views on the Suggested Changes of Legislation

Similar to the critique concerning the English Bills (discussed at 4.4.), the German suggested legal changes found criticism with regard to their scope and definitions. Lautenschläger, for example, criticised that the requirement for passive assisted dying in the *Alternativentwurf* of 1986, namely the fact that an unconscious patient had to be believed to never regain consciousness again, was difficult to ascertain.[1345] Also, concerning the letting die of terminally ill and unconscious new-borns, she criticised the lack of definition of those conditions.[1346] While these issues do not concern assisted dying of a capable adult, they demonstrate that the criticism faced by suggested legislation in Germany is very similar to that in England. Regarding the provisions in the *Alternativentwurf* on the non-prevention of suicides, she furthermore claimed that one could not group all kinds of suicide together, which made one legal provision for all problematic.[1347] Lautenschläger recalled the criticism by the *Arbeitsgemeinschaft Medizinisch-Wissenschaftlicher Gesellschaften* (AMWG - Association of the Scientific Medical Societies in Germany), which rejected the *Alternativentwurf.* According to the AMWG, palliative care was sufficient in treating the suffering of dying patients,[1348] a criticism which is often brought forward against the legalisation of assisted dying.

Noske, without evaluating the provisions of the *Alternativentwurf* of 2005, stated that the amount and variety of suggested legal provisions concerning assisted dying and living wills showed a real need for legal reform.[1349] According to her, the strikingly emotional debate highlighted the legal uncertainties that physicians faced under the current law.[1350] Renner agreed that the debate in 2006 showed a real need for legal reform,[1351] and that autonomy was seen as rating decidedly high.[1352]

Concerning the attempt to criminalise commercial assisted dying, Lorenz analysed if assisting others could be seen as falling under Article 12

[1345] See Lautenschläger (n 1127), 10-11.
[1346] See ibid, 11.
[1347] See ibid, 14.
[1348] See ibid, 17.
[1349] See Esther Noske, 'Beratungen und Beschlüsse des 66. Deutschen Juristentags 2006' (2006) 7 *Zeitschrift für Rechtspolitik* 232, 233.
[1350] ibid.
[1351] See Thomas Renner, 'Die Beschlüse des 66. Deutschen Juristentags zur Patientenautonomie' (2007) 3 *Familie Partnerschaft Recht* 85, 85.
[1352] See ibid, 86.

GG, the freedom of occupation,[1353] which would make a prohibition of it more complicated. While an occupation did not necessarily have to be legal to find protection under Article 12 GG,[1354] there were professions which were seen as fundamentally wrong and did not fall under the protection, like drug dealing and contract killing.[1355] The problem for making assisted dying fall outside the scope of Article 12 was that the criterion of being detrimental to society and its norms and values was vague and open to changes.[1356] However, seeing the leeway the State had in defining the scope of the right to life (as can be seen in the regulation of abortion and self-defence),[1357] Lorenz saw no issue in exempting assisted dying from the freedom of occupation.[1358]

According to Lüttig, the German Government was now facing the question whether it wanted to allow for assisted dying organisations to become part of society, thereby accepting a change in the value system, or to prohibit it as violating a fundamental consensus.[1359] Lüttig strongly supported the creation of a §217 to criminalise commercial offers of assisted suicide.[1360] Schütze instead criticised the suggested §217 as opening the door to a legalisation of assisted dying in allowing for assistance in committing suicide by individuals close to the person wishing to die.[1361] All such a regulation would do is make organisations try to avoid any sign of commerciality.[1362] Rieser also criticised the suggested law for exempting not only relatives and friends from punishment but also physicians and carers. This would lead to too wide a legalisation of assisted dying.[1363]

5.5. Overall Conclusion

What the case law demonstrates is that a change in legislation is much needed. While assisted suicide is not illegal, active assisted dying is, and receiving any kind of assistance in dying is a difficult endeavour with a strong likelihood of legal consequences for the assistant. This is not

[1353] See Dieter Lorenz, 'Sterbehilfe als Beruf?' (2010) 28 *Medizinrecht* 823.
[1354] See ibid, 825.
[1355] See ibid.
[1356] See ibid 826.
[1357] See ibid 827.
[1358] See ibid.
[1359] See Frank Lüttig, '"Begleiteter Suizid" durch Sterbehilfevereine: Die Notwendigkeit eines Strafrechtlichen Verbots' (2008) 2 *Zeitschrift für Rechtspolitik* 57, 60.
[1360] See ibid 59.
[1361] See Richard Schütze, 'Neuregelung zur Strafbarkeit der Sterbehilfe' *The European,* 26 November 2012.
[1362] See ibid.
[1363] See Sabine Rieser, 'Verbot gewerblicher Sterbehilfe: Referentenentwurf sorgt für Ärger' (2012) 109 *Deutsches Ärzteblatt.*

acceptable in that it discriminates against those unable to commit suicide unaided. While there are some moves for a more permissive regulation of active assisted dying, the current focus of the German Government is to criminalise a sub-form of assisted dying. While the motives behind this are understandable, it is a step in the wrong direction, since what is needed is a legal way for everyone to end their lives if they so wish. What is neglected in debates around active assisted dying is that only a small percentage of individuals are affected by the prohibitions. However, their suffering is of such a nature that they should receive the help that they want and need. The German argument, that 'we cannot discuss assisted dying, let alone practice it because the Nazis have done it' is dangerous and discredits the demand for autonomy of people seeking assistance in dying.[1364] It is understandable that the drafters of the constitution had the prevention of any form of disrespect for human life in mind.[1365] Still, if there were legal ways to receive active assisted dying (maybe even by a physician), then the commercial agencies offering their help in dying would be deprived of their clientele.

As in England, the unavailability of active assisted dying has dire consequences for a small number of individuals. If one is in a physical and mental condition that necessitates a suicide with assistance, this is in theory legally possible, though it is highly problematic to get access to deadly medication which will bring about a pain-free and quick death, as the cases *Hackethal* and *BGH 5 StR 474/00* illustrated. If a person is not able to commit suicide even with assistance, more desperate measures are needed – either travelling to Switzerland to be able to die with the help of Dignitas, or even tricking someone like in *BGH 5 StR 66/03*. While the first way discriminates against those who lack the financial means to travel and will be much more onerous physically and emotionally than dying at home, the latter poses a problem for the person doing the deed. Both ways negate the idea of an autonomous death in dignity. If we were to accept those two ideals, autonomy and dignity, then we should enable desperate individuals to die a quick and pain-free death according to their wishes – be that at home or in a clinic of their choice.

The Bills introduced to regulate assisted dying do not go far enough in that they seek to keep active assisted dying a crime. What is needed is not a further criminalisation but a careful legalisation of active assisted dying.

[1364] See Frieβ (n 11), 17.
[1365] See Antoine (n 34), 253.

This has to come from Parliament, as the German courts can only ever apply the law as it stands, without evaluating or developing it. A more desirable way forward would be a regulation similar to Lord Falconer's Bill (see chapter 4.4.5.). With strict safeguards in place, active assisted dying should be a legal option for terminally ill patients who cannot bear their suffering anymore. Ideally, everyone should receive assistance in dying when wishing to end their life. However, too lax a regulation would be too dangerous for the vulnerable and could have disastrous effects on the right to life. But that fear cannot be used as a prohibition of all kinds of assisted dying.

6. Conclusion

The previous chapters have demonstrated that assisted dying is a highly controversial topic and its regulation is being discussed on different levels in various European jurisdictions. The impossibility to receive active assistance in order to be able to die – without the assistant facing legal sanctions – not only discriminates against those who cannot commit suicide unaided but also condemns some suffering individuals to die an agonising death.

The analysis of the legal situation of England and Germany in chapters 4 and 5 demonstrates that we are far away from a right to die to counterbalance the right to life as guaranteed by Article 2 ECHR. A right to die is needed to base claims for assistance in dying on, to guarantee everyone a dignified, autonomous death, regardless of the amount of help they require or desire. However, the analysis of the ECtHR's approach in chapter 3 showed that the Court is currently not in a position to create a right to die and instead applies its margin of appreciation. Based on its idea of subsidiarity and the need for European consensus in matters concerning the interpretation and evaluation of human rights provisions, for assisted dying to become possible under Articles 2 and 8, let alone for a right to die to emerge, there would be a need for consensus amongst the Member States.

Compared to England, where the major problem is that the law discriminates against those who cannot commit suicide unaided, in Germany the problem starts at an earlier point, with the incapacity to address the topic due to the shadows of the past. Based on the condemnable practices carried out in Nazi Germany, areas like genetic research (see for example the debates around the legalisation of pre-implantation genetic diagnosis in 2011),[1366] abortion based on disabilities and, most prominently, assisted dying are difficult to address in an objective way, directly conjuring up the Nazi regime and their idea of eugenics as an argument bringing every debate to an instant halt. However, the wish to protect all life and the inability to address sensitive matters like assisted dying has led to a legal situation that disrespects the right to autonomy and self-determination in that it is over-protective.

[1366] On the debates regarding pre-implantation genetic diagnosis see for example https://www.bundestag.de/dokumente/textarchiv/2011/35036974_kw27_de_pid/205898, accessed 03 Mai 2015 at 2:05pm. See also Kurt Seelmann and Daniela Demko, 'Gutachten im Auftrag des Bundesamtes für Gesundheit zum Thema: „Präimplantationsdiagnostik (PID) und Eugenik"', 21 January 2013.

Another noteworthy difference between England and Germany is the kind of cases that the courts have to deal with concerning assisted dying. In England, cases are brought that challenge the existing law, like for example that of Ms Purdy who asked for clearer guidelines by the DPP regarding his prosecution policies in cases of assisted dying, or Mr Lamb in *Nicklinson* asking for a defence of necessity to be added to the criminal law concerning the offence of homicide. The cases are in general ones of capable adults bringing a claim to enable them to die with assistance. In Germany on the other hand, apart from the exceptional case concerning Mrs Koch, and Dr Hackethal asking for immunity before assisting a patient, the cases are brought after an act of assistance has occurred to challenge the conduct of the assistant.

When looking at the German cases another distinction between the English and German systems is striking. German judges generally do not comment on the law, or develop or interpret it. A comment like that in *BGH 5 StR 66/03*, stating that the right to life turns into a duty to live, is very rare. Based on the specifics of the legal system, German judgments are generally a mere expression of the legal provisions that apply and the consequences arising from their application. An expression of sympathy, as happened in *Pretty*, would be highly unlikely in a German judgment.

The law in both countries differentiates between passive and active assisted dying in that one is an omission and one an act, the latter being more intrusive and therefore less (or not at all) desirable. But as was stressed in chapter 2.1.1.1., the aspect to look at is the effect of the action. And whether it is an act or an omission, the result is that a person who wishes to die can end his or her life. Based on this it should not matter whether the assistance is active, passive or indirect. And individual should be able to receive the kind of assistance he or she is asking for, regardless of whether it is an act or omission.

While England seems to base its rejection of assisted dying quite heavily on religious views and the need to prevent a slippery slope, Germany's rejection rather is based on a historic incapacity to approach the topic. So while parliamentary discussions in England become heated and emotional, German debates stay on the surface, dealing with the legal implications rather than the personal ones. Both approaches have their advantages and disadvantages. While the emotional and personal nature of the debates in England brings up a great variety of arguments, which adds many facets to the debate, it also makes them very subjective and thereby

harder to attack and even discard. On the other hand, the German approach of not addressing any of the underlying aspects like dignity and a right to die makes the debates very superficial and leaves out the most fundamental and important aspects. While the technical level and language make them appear more sophisticated, they would need more substance to actually be able to tackle the problem efficiently.

What makes the debates quite different in nature are also the forums in which they are carried out. While the reform debates in the House of Lords involve Lords and Ladies from a variety of backgrounds, German debates are more constrained. They either take place in the *Bundesrat* or *Bundestag,* which means that politicians argue according to their party affiliation, or during a *Juristentag* which means that lawyers (and individuals with a medical background who were invited to participate) express their views. Both scenarios limit the focus more than in England.

Furthermore, in the House of Lords a range of religious views find expression, while in Germany the Christian churches act as one unified religious group, as well as being the only faith being heard, opposing assisted dying. Thus, the religious argument that life is sacred finds more expression, and is seemingly given more weight, in English debates than in German ones. This can again be based on the fact that German debates shy away from underlying issues and stay on a technical level.

The comparison of England and Germany shows that a European consensus is still far away. While it is time for England and Germany to change their laws on active assisted dying, it cannot be expected of the ECtHR to change its approach any time soon, as it relies on European consensus due to the principle of subsidiarity, as was elaborated upon in chapter 3.3. European pluralism and the subsidiary role of the Court are the basis for the Court to rely on its margin of appreciation and not create an implied right to assistance in dying. However, the question is what the purpose of the ECtHR is, if it cannot express a strong opinion until there is European agreement amongst the Member States. Of course, it does have a clear stance concerning the express rights of the Convention, however, it would be desirable if the Court also had a distinct approach to other vital aspects not yet dealt with directly by the Convention and its protocols. The right to life is one of the most fundamental articles of the Convention, which, taken together with the stress the Court puts on dignity, should lead to a stronger stance by the Court towards a possible right to die.

Arguments against the legalisation of active assisted dying are not completely unfounded which makes them harder to refute. The claim that legalisation would threaten the vulnerable, especially the old and sick, is not completely void of a basis. However, as was stated above at 2.1.1.2., the solution is not a prohibition but stringent safeguards. Also, the argument introduced at 2.1.1.3. that palliative care is sufficient in dealing with the suffering of dying individuals, and therefore makes a legalisation of assisted dying superfluous, does not hold true for every dying individual. As was seen in the analysis of the cases occurring in England and Germany, the availability of palliative care is not the right solution for everyone.

What might be the hardest counter-argument to refute is that of life being sacred. Yet, as was stated at 2.1.1.4., a religious argument should not be the basis for a law in a secular society. While life has an intrinsic value, what matters is the personal value we attach to our own life. As was highlighted by the analysis of the national case law, the current legal situation discriminates against those who cannot commit suicide unaided. As was argued in 2.1.2.3., without a right to die there is an unsufficient basis to rest a discrimination claim on, as there is no express right to commit suicide, but only a liberty.

What is needed is for national legislatures to acknowledge the discriminatory status of the current law and to then start changing the law towards a greater legalisation of assisted dying. Following the argumentation of autonomy and dignity asking for the right to die when and how one wishes, with as much assistance as needed, would require a complete legalisation of assisted dying, regardless of the physical condition of the person voicing that request. The need for such overarching legalisation is also deductible from the cases the ECtHR had to engage with. While two, those of Mrs Pretty and Mrs Koch, concerned physically ill individuals who needed help in order to be able to commit suicide, the other two, Mr Haas and Mrs Gross, were not physically incapable of committing suicide. Mr Haas was suffering mentally and wanted assistance for a dignified, guaranteed death and Mrs Gross was suffering of old age and also wanted help to die a dignified, guaranteed death. This shows that it is not just those physically unable to die at their own hands who would benefit from legalisation. However, a complete legalisation of assisted dying for everyone proves difficult in reality. To prevent abuse and a slippery slope, effective safeguards need to be in place. While the Assisted

Dying Bill proposed by Lord Falconer (see chapter 4.4.5.) can be criticised on some accounts – for example for the arbitrariness of the six months timeframe which would have neither applied to Mrs Pretty nor to Mrs Koch – the legalisation on such strict terms, together with further provisions like the requirement for medical and psychological reports, has the benefit of providing safeguards for the old and vulnerable. Once such a limited legalisation has been tested and studies can be conducted as to the effectiveness of the legalisation, a further extension can and should be considered. An expansion would be desirable as hardly any of the individuals whose cases have been considered in chapters 4 and 5 actually would have fallen within the scope of the proposed Bill, as those asking for assistance were not all within the last six months of their lives, some not even terminally ill.

Based on autonomy and dignity, a right to die is required so individuals have a basis for claiming assistance in dying. As was seen in chapter 2.2.2., autonomy is a relational concept in that full autonomy depends on us existing within a society which helps us strive. Based on us being vulnerable to different extents at various times of our lives, we are all dependent on assistance. As was argued in 2.2.3., vulnerability is a highly individual matter, yet we are united by the fact that we are all prone to it at different stages of our lives. Consequently, seeking assistance in dying should neither be a taboo nor illegal. Based on autonomy, and acknowledging the relational nature of it, there should be a right to assistance in dying. To refute the claim that there is no right to assistance as there is no right to commit suicide for anyone, there is furthermore a need for a right to die which finds a strong basis in our right to a dignified life. What we perceive as dignified is to some extent subjective. The statement that life itself is dignified is wrong, as it depends on the own perception of one's life (see chapter 2.3.2.). Thereby, if one feels one's life has become undignified, one should be allowed to end it. The right to a dignified life should consequently entail a right to a dignified death (see chapter 2.3.4.). Dignity asks for a right to die, autonomy asks for the legalisation of assistance in dying.

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