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A Comparative Study of the Law of Palliative Care and End-of-Life Treatment

Danuta Mendelson and
Timothy Stoltzfus Jost

Since the Supreme Court of New Jersey decided the *Quinlan* case a quarter of a century ago, three American Supreme Court decisions¹ and a host of state appellate decisions have addressed end-of-life issues.² These decisions, as well as legislation addressing the same issues, have prompted a torrent of law journal articles analyzing every aspect of end-of-life law. In recent years, moreover, a number of law review articles, many published in this journal, have also specifically addressed legal issues raised by palliative care.³ Much less is known in the United States, however, as to how other countries address these issues. Reflection on the experience and analysis of other nations may give Americans a better understanding of their own experience, as well as suggest improvements to their present way of dealing with the difficult problems in this area.

This article offers a conceptual and comparative analysis of major legal issues relating to end-of-life treatment and to the treatment of pain in a number of countries. In particular, it focuses on the law of Australia, Canada, the United Kingdom, Poland, France, the Netherlands, Germany, and Japan.

The legal analysis of end-of-life and pain treatment is complex. It can involve issues of criminal law and the law of battery and negligence (tort/delict) as well as constitutional and international law. Legal analysis of these problems is shaped by the juridical system and philosophy of each country, as well as by international conventions that have been incorporated into the law of the respective countries.

Poland, France, the Netherlands, Japan, and the United Kingdom (devolved administration in Scotland, Wales, and Northern Ireland) are unitary systems, whereas Canada, Germany, and Australia are federations, in which the legislatures of constituent provinces or states have the power to regulate

the practice of medicine and the conduct of medical practitioners. The United Kingdom, Canada, and Australia have common law systems in which the law is based on judge-made precedents as well as legislation. The legal systems of Poland, France, Germany, Japan, and the Netherlands are based primarily on national civil and criminal codes, though their appellate courts do make authoritative rulings on the law. This article will examine the common law countries together, as they share a common legal tradition and common precedents, while the civil law systems, which are more diverse, will be examined separately.

To add to the complexity, national laws of members of the European Union, including the United Kingdom, Germany, the Netherlands, and France, are subject to the European Convention on Human Rights and Fundamental Freedoms⁴ (ECHR) as interpreted by the European Court of Human Rights in Strasbourg. Poland, as an aspiring member of the European Union, is adapting its laws to fit in with the European Union's jurisprudence.⁵

Finally, the national laws of individual countries are shaped by the history, community values, economics, culture, religious orientation, and current predominant legal philosophy of those countries. In this article, we will highlight only the major issues, similarities, differences, and problems raised by these factors.

CONSENT AND REFUSAL OF TREATMENT

As a general rule, all common law and most civil law jurisdictions presume every adult person to have the mental capacity to consent to or to refuse any medical intervention, including life-saving or life-sustaining treatment, unless and until that presumption is rebutted.⁶ It is irrelevant that the refusal may not be in the best interests of the patient, or that the decision may entail a risk of death.⁷ The refusal must,

however, be unequivocal and often must be recorded in writing. The right to refuse medical treatment is based on the principle of personal autonomy, and was upheld by the European Court of Human Rights in *Pretty v. the United Kingdom*,⁸ which noted that the right to refuse treatment conforms with the privacy guarantees contained in Article 8 of the ECHR.⁹

LEGAL APPROACHES TO END-OF-LIFE TREATMENT IN COMMON LAW COUNTRIES

In general, the common law countries (the United Kingdom, Canada, and Australia) have adopted very similar philosophical and juridical approaches toward end-of-life treatment. This is true with respect to palliative care, withholding and termination of life-sustaining treatment, assisted suicide, and active euthanasia.

Palliative care

The most controversial legal issue with respect to palliative care in the countries under consideration has been the use of opioids to alleviate patients' suffering in their final stages of life, particularly when the opioids are suspected of causing death. In the 1957 English case of *R. v. Adams*,¹⁰ Dr. John Bodkin Adams was charged with murder when it was discovered that he had treated a number of elderly patients who had died in his care with high doses of narcotic analgesics. In his address to the jury, Lord Justice Devlin said that a physician "is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life."¹¹

This approach is sometimes called the doctrine of double effect. Under this doctrine, the cause of death of patients who die while receiving pain treatment will be attributed to the underlying disease in situations where the patient's pain and other discomforts are controlled through properly calibrated titration of dosages, even if the dosages are high.¹² This is because the law sees a sharp distinction between appropriate palliative care, offered with an intention to ease a patient's pain and suffering, and actions specifically aimed at ending a patient's life.¹³ This approach has been adopted by the House of Lords,¹⁴ the Supreme Court of Canada,¹⁵ and the Supreme Court of the United States.¹⁶

The High Court of Australia has yet to determine this issue. However, the South Australian Consent to Medical Treatment and Palliative Care Act of 1995¹⁷ provides that medical practitioners will not incur civil or criminal liability for administering medical treatment with the intention of relieving the pain or distress of patients in the terminal phase of a terminal illness, even though an incidental effect of the treatment would be to hasten the death of the patient, providing they do so "with the consent of the patient or the patient's representative; and in good faith and without negli-

gence; and in accordance with proper professional standards of palliative care." If these requirements are met, then "for the purposes of the law of the State, the administration of medical treatment for the relief of pain or distress ... does not constitute an intervening cause of death."¹⁸

Withdrawal and withholding of medical treatment from incompetent or unconscious patients where there is no advance directive

In England, Wales, and Northern Ireland, but not in Scotland,¹⁹ the discontinuance of artificial nutrition and hydration for a patient in a vegetative state requires the prior sanction of a High Court²⁰ by way of a declaration based on the best interests test.²¹ The seminal common law case on the withdrawal of artificial life supports from incompetent persons is *Airedale N.H.S. Trust v. Bland*.²² Anthony Bland, at the age of 17, sustained catastrophic and irreversible damage to the higher centers of his brain, which left him in a persistent vegetative state. The House of Lords decided that doctors might lawfully discontinue biochemical and other life support systems from a patient in a persistent vegetative state where the cessation of nourishment and hydration is an omission, and not an act.

The House of Lords reasoned that nonconsensual treatment violates the principle of personal autonomy. Incompetent patients may, however, be treated nonvoluntarily on the basis of the doctrine of necessity where their best interests require that the treatment be administered "for the protection of the plaintiff's health and possibly his [sapient] life."²³ Once it becomes clear that the patient is permanently comatose or in a persistent vegetative state, however, his or her interests in being kept alive have ceased, taking with them the justification for the nonconsensual medical treatment, even though termination of life supports will also not further the person's best interests. In such circumstances, according to the House of Lords, there is no longer a duty to provide nourishment and hydration, and therefore failure to do so cannot constitute a criminal offense. Thus, Lord Goff of Chieveley observed:

For my part, I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition.²⁴

In 2001, the High Court of England in *National Health Service Trust A. v. M.; N.H.S. Trust B. v. H.*²⁵ reexamined and affirmed the reasoning of the House of Lords in *Bland* in light of the ECHR.²⁶

In Australia, doctors must apply the best interests standard when treating incompetent patients who have not executed a binding advance directive. The legal situation

regarding withdrawal and withholding of life-saving or life-sustaining treatment is, however, unclear. In *Marion's Case*,²⁷ the High Court of Australia determined that where persons are disabled by age or mental incapacity from giving valid consent, an order or direction must be sought from the Family Court or Guardianship Board for authorization of nontherapeutic procedures. Since discontinuance of life-sustaining treatment is nontherapeutic, it might be prudent for doctors to seek similar directions.²⁸

The South Australian Consent to Medical Treatment and Palliative Care Act is an exception to this general rule insofar as it provides that, in cases where there is no valid prior direction to the contrary, a medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness is "under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state."²⁹ In such cases, "the non-application or discontinuance of life sustaining measures ... does not constitute an intervening cause of death (i.e. *novus actus interveniens*: a cause that breaks a pre-existing chain of causation)."³⁰

In Canada, a similar regime prevails. The Manitoba Court of Appeal has ruled that physicians have a unilateral right to make nontreatment decisions.³¹

Assisted suicide and active euthanasia

The common law distinguishes between a physician's conduct in letting a patient die from an underlying disease and conduct that makes the patient die. It is the intention to bring about the death of another that forms the basis of the crimes of assisted suicide and murder.

In Canada, the question of whether the right to refuse life-saving treatment should encompass the right to assisted suicide was determined in 1993 in *Rodriguez v. British Columbia (Attorney General)*,³² a case involving a 42-year-old woman who suffered from amyotrophic lateral sclerosis. Mrs. Rodriguez argued that the right to refuse medical treatment was a "liberty and security of the person" interest, protected by § 7 of the Canadian Charter of Rights. She contended that she had a constitutional right to have a qualified physician set up technological means by which she might end her life when she was no longer able to enjoy life, by her own hand, and at the time of her choosing. She applied for an order that § 241(b) of the Criminal Code,³³ which prohibits the giving of assistance to commit suicide, be declared invalid on the ground that by precluding a terminally ill person from committing "physician-assisted" suicide, it violated her rights under § 7.

A majority of the Supreme Court of Canada determined that the Canadian Charter does not require lifting the statutory ban against assisted suicide because § 7 of the Charter

protects three fundamental values: (1) the notion of personal autonomy relating to the right to make choices concerning one's own body; (2) freedom from state interference with respect to control over one's physical and psychological integrity and basic human dignity; and (3) the sanctity of life. The court noted: "even when death appears imminent, seeking to control the manner and timing of one's death constitutes a conscious choice of death over life."³⁴ Even though the prohibition of assisted suicide in § 241(b) of the Criminal Code impinged upon the first two values, these were trumped by the third value — protecting and maintaining respect for human life. In 1995, the Canadian Senate Special Committee on Euthanasia and Assisted Suicide recommended that the prohibition against assisted suicide remain intact.³⁵

A 2001 English case with very similar facts and outcome was determined by the House of Lords in *R. (Pretty) v. the Director of Public Prosecutions*.³⁶ Dianne Pretty had a motor neurone disease, a progressive neuro-degenerative disease of motor cells within the central nervous system. She was paralyzed from the neck downwards and confined to a wheelchair.³⁷ She requested the Director of Public Prosecutions (DPP) of the United Kingdom to agree in advance not to prosecute her husband were he to help her to commit suicide. Under § 2(1) of the Suicide Act of 1961 (U.K.),³⁸ it is a criminal offense with a maximum penalty of 14 years imprisonment for a person to aid, abet, counsel, or procure the suicide of another.

The House of Lords determined, and the European Court of Human Rights affirmed (unanimously dismissing Mrs. Pretty's appeal), that there is no right to assisted suicide under common law or statute, and that no such right is guaranteed by the ECHR. The European Court of Human Rights declared that Article 2, which safeguards the right to life, cannot be interpreted as "conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life."³⁹ The court noted that although the conditions of terminally ill individuals vary, many patients will be vulnerable, and it is the vulnerability of the class that provides the rationale for the law against assisted suicide.⁴⁰

There have been no appellate decisions regarding assisted suicide in Australia. As in all other common law jurisdictions, aiding and abetting suicide is a statutory offense punishable by imprisonment in all Australian states and the Australian Capital Territory.⁴¹

Active euthanasia or mercy killing is a crime in Australia, Canada, and the United Kingdom. In Australia, in 1995, the Northern Territory's Parliament enacted the Rights of the Terminally Ill Act of 1995 (RTIA),⁴² which decriminalized physician-assisted suicide and euthanasia by designating such conduct as legitimate "medical treatment."⁴³ In 1997, the Federal Parliament, pursuant to the plenary powers vested in it to make laws for the government of the Territories un-

der § 122 of the Commonwealth Constitution, enacted the Euthanasia Laws Act of 1997 (Cth), which amended the Northern Territory (Self-Government) Act of 1978 nullifying the RTIA.⁴⁴

In 2001, the Supreme Court of Canada in *R. v. Latimer* determined the issue of mercy killing motivated by the "necessity" of eliminating pain.⁴⁵ Robert Latimer, a Saskatchewan farmer, asphyxiated his 12-year-old daughter, Tracy, who had a severe form of cerebral palsy, by venting exhaust fumes from his pickup truck's tail pipe into the cab where he had placed Tracy. He was convicted of second-degree murder⁴⁶ and received the mandatory minimum sentence of life imprisonment without parole eligibility for 10 years.⁴⁷ The Supreme Court of Canada in an unanimous decision dismissed Latimer's appeals against conviction and sentence.⁴⁸ The court stated that "[t]he harm inflicted in this case was ending a life; that harm was immeasurably more serious than the pain resulting from Tracy's operation, which Mr. Latimer sought to avoid,"⁴⁹ concluding that:

Killing a person — in order to relieve the suffering produced by a medically manageable physical or mental condition — is not a proportionate response to the harm represented by the non-life-threatening suffering resulting from that condition.⁵⁰

POLAND

Medical practice in Poland is governed by the Medical Profession Act (2002),⁵¹ the Health Service Institutions Act (1991),⁵² the Law on Physicians' Associations (1989),⁵³ and the Code of Medical Ethics (1993), as well as the Polish Penal Code (1997)⁵⁴ and the Constitution of the Polish Republic (1997).⁵⁵

The Code of Medical Ethics includes provisions relating specifically to treatment of patients at the end of life. It is not a legal statute, however, and as such is not a source of law. Nevertheless, the Polish Constitutional Tribunal in its Opinion of October 7, 1992⁵⁶ determined that, although the norms set out in the Code of Medical Ethics have the character of deontological norms rather than legal rules,⁵⁷ they can be used to define more precisely the content of legal rules. Indeed, in medical courts, specific articles of the Code are invoked in proceedings against medical practitioners.⁵⁸ Medical practitioners, therefore, are under a legal obligation to adhere to the ethical norms of the Code of Medical Ethics.⁵⁹ This general rule, however, is subject to qualification in cases where there is conflict between the norms of the Code and substantive (statutory) law. According to the Constitutional Tribunal's Opinion of March 17, 1993, a medical practitioner cannot be penalized for practicing medicine in accordance with the law, even if such conduct is contrary to a principle of professional ethics.⁶⁰ Conversely, medical practitioners will be punished if they infringe the law, but not the Code of

Medical Ethics, or if they act contrary to both the law and the Code.

The conflict between legal rules and ethical norms is particularly acute in the case of withdrawal and withholding of life-saving treatment. There are no substantive law provisions in Poland that specify limits to the medical duty to institute or continue to provide life-sustaining treatment to incompetent terminally ill patients. Article 38 of Chapter 5, headed "Principles of Medical Practice," in the Medical Profession Act of 2002 provides, however, that a "physician may decide to discontinue or not institute a treatment (unless prompt medical intervention is necessary)...."⁶¹

The qualifying clause "unless prompt medical intervention is necessary" refers to the "duty to rescue" provision contained in Article 30 of the Medical Profession Act.⁶² Article 30 imposes upon medical practitioners a duty to always save human life when a delay would result in death or serious physical or mental injury, or in other cases of emergency.⁶³ The positive duty to act to save human life is in line with "the duty to rescue" expressed in Article 162.1 of the Penal Code, which provides a punishment of up to three years imprisonment for failure to help a person who is in immediate danger of death or serious injury, where rendering such help is possible without the risk of death or serious injury to oneself.⁶⁴

It is difficult to reconcile Article 162 of the Penal Code and Article 30 of the Medical Profession Act with Article 32 of the Code of Medical Ethics that vests in the medical practitioner the right to decide whether to discontinue resuscitation or "persistent treatment," having regard to the patient's medical chances of survival. Article 32 of the Code provides:

- (1) In terminal states the physician does not have the duty to undertake and continue resuscitation or persistent treatment, nor to resort to extraordinary measures, and
- (2) The decision to discontinue resuscitation rests with the physician and should be based on the assessment of the likely therapeutic success.

Yet, unless the conflict between the substantive civil and criminal law and the Code of Medical Ethics can be resolved, substantive law — that is, the duty to rescue — will prevail over deontological and ethical principles.⁶⁵

Under Article 150 of the Polish Penal Code (1997),⁶⁶ mercy killing is prohibited by law, but may or may not attract a custodial penalty. Article 31 of the Code of Medical Ethics prohibits the practice of active euthanasia.⁶⁷ According to the Constitutional Tribunal's Opinion of March 17, 1993, medical practitioners who practice euthanasia — conduct that is contrary to the substantive law⁶⁸ and medical ethics — will be held legally responsible for the patient's death, even if they personally regard such intervention to be justified.⁶⁹

FRANCE

Since 1989 the French Council of State (*Conseil d'Etat*)⁷⁰ has given priority to European Union law over inconsistent national law,⁷¹ and the Constitutional Council (*Conseil constitutionnel*) has obliged all French courts to apply the provisions of the ECHR where a French statute is incompatible with the ECHR.⁷²

Following the May 1999 draft recommendation by the Council of Europe, encouraging member states to give incurable and dying patients the right to palliative care,⁷³ the French Parliament enacted the law of June 9, 1999 directed at guaranteeing access to palliative care for anyone "whose state of ill health requires it."⁷⁴ The law of June 9, 1999 reinforces Article 38 of the 1995 Code of Medical Deontology, which, unlike the Polish Code of Medical Ethics, has statutory force, and is thus legally binding.⁷⁵ The Code of Medical Deontology mandates that:

a dying person must be attended until the last, and given appropriate care and suitable support to preserve the quality of the life which is ending. A patient's dignity should be protected, and his or her entourage comforted.⁷⁶

Though the emphasis is on alleviation of "sufferings" (*les souffrances*), and on the preservation of the dying person's quality of life, the law provides statutory encouragement for doctors to treat their patients with adequate doses of analgesic medication. The care provided must be "conscientious and accord with the scientific data."⁷⁷

Article 37 of the Code of Medical Deontology cautions medical practitioners to "avoid any unreasonable obstinacy in pursuing investigations and treatments." In the context of the provision, the reference is presumably to avoid "aggressive" or "futile" treatment, which may or may not encompass withdrawal or withholding of life-sustaining treatment.⁷⁸

Competent patients in France have a statutory right to refuse proposed treatment.⁷⁹ The law also grants relatives the right to be warned and informed, but gives them no power to make binding treatment decisions on behalf of an incompetent patient.⁸⁰ France has neither statutory rules nor medicoethical guidelines⁸¹ governing the withholding and withdrawal of life-sustaining treatment from incompetent patients. Indeed, the legal position relating to withholding and withdrawal of life-sustaining treatment is complex. One of the problems stems from the definition of fault in French law. At common law, the question of whether an omission amounts to a legal fault depends on the scope of the duty. In cases of withholding or discontinuance of treatment, the question is whether the physician is under a duty to undertake or continue life-sustaining treatment for the particular patient. In France, for purposes of legal responsibility, the concept of fault by omission in the sense of abstention within an action (*faute d'abstention dans l'action*)⁸² is governed by a

general principle rather than case-specific considerations: Once the treatment has been undertaken, withdrawal of treatment that leads to the deterioration of the patient's condition and consequent death will amount to a legal fault. Under the French doctrine of "unity of criminal and civil faults," physicians who withdraw or terminate treatment may be liable under civil as well as criminal law.

Just as in Poland, the well-entrenched positive duty to rescue a person in danger embodied in Article 223-6(2) of the new 1992 Criminal Code (Article 63 of the old Criminal Code) makes a failure to rescue an offense (*délit*).⁸³ The medical duty to assist is expressed in a mandatory form in Article 9 of the Code of Medical Deontology.⁸⁴

The crime of failure to rescue belongs in the category of "endangering behavior" offenses (*mise en danger délibérée de la personne d'autrui*);⁸⁵ the category also includes the offense of deliberately exposing a person to danger of death or injury (Article 223-1 of the new Criminal Code). Decisions to discontinue vasopressive drugs, undertake terminal weaning from ventilation, or withhold cardiopulmonary resuscitation and mechanical ventilation from a patient would fall within these categories of offense. In 1996, an anesthesiologist who decided to extubate and withhold resuscitation from a patient who had no chance of recovery or survival was convicted of involuntary homicide by the Court of Appeal of Rouen on the grounds that the doctor's conduct was "against all logic, medical ethics and accepted rules of good practice."⁸⁶ The Court of Cassation (*Cour de Cassation*) dismissed the physician's appeal.⁸⁷ French jurists have interpreted the decision in the context of the debate about legalizing the practice of euthanasia and assisted suicide.⁸⁸ The Court of Cassation's reasoning is in harmony with the second clause of Article 38 of the Code of Medical Deontology, which mandates that a physician "has no right to deliberately bring about death."

Inciting (*provoquer*) another to commit suicide is a crime under Article 223-13 of the Criminal Code, punishable by three years imprisonment. Providing drugs, lethal substances, or mechanical devices designed to enable a patient to commit suicide would come within the ambit of this offense. Encouragement and advertising of methods to commit suicide are offenses against the person under Article 223-14 of the Criminal Code. However, with the advent of the World Wide Web, this law may be difficult to police.⁸⁹

With regard to active euthanasia, Article 221-1 of the Criminal Code states: "voluntarily killing another constitutes murder," and is punishable by 30 years imprisonment. The offense of homicide has to be a positive intentional act rather than an abstention that causes death.⁹⁰ Killing another person on request would fulfill the requirement. The French Criminal Code includes a specific offense of poisoning, defined as "attacking the life of another through the use or administration of substances that cause death," which is also punishable by 30 years imprisonment.⁹¹ In the prosecution of employees from the French National Blood Transfusion

Centre (*Centre National de Transfusion Sanguine*) for knowingly placing on the market unheated blood products infected with HIV, the Court of Cassation did not exclude the possibility that the offense of poisoning could be made out without the specific intention to kill.⁹²

In 1999, a criminal penalty was imposed on a hospital physician for "accompanying into death" a 92-year-old comatose and hemiplegic woman who developed gangrene. The physician injected the patient with 5 grams of potassium chloride.⁹³ The National Council of the Order of Physicians suspended the defendant for one year from medical practice for violation of the second clause of Article 38 of the Code of Medical Deontology.⁹⁴

GERMANY

Article 2, ¶ 2 of the German Constitution recognizes that "everyone has a right to life and to bodily integrity." In the context of other medicolegal controversies, such as those involving abortion or research involving human embryos, Germany has taken a strong "pro-life" position. Indeed, Germany's historical burden from the Nazi period is often invoked as imposing upon Germany the obligation to provide leadership to the world in fighting to recognize and preserve the sanctity of life.⁹⁵

The German Constitution also, however, recognizes rights to "free development of personality,"⁹⁶ "inviolable freedom,"⁹⁷ and "inviolable dignity."⁹⁸ In fact, as the law of decision-making at the end of life has developed in Germany, the right to free and autonomous decision-making has uniformly trumped the right to life. German law governing end-of-life decisions is at this point driven primarily, indeed almost solely, by the principle of autonomous decision-making.

Since at least the 1950s, the German courts have recognized the right of patients to refuse medical treatment.⁹⁹ It is beyond dispute that a competent dying patient in Germany can refuse treatment intended to extend his or her life. If an informed patient refuses life-sustaining treatment, the treatment must be terminated. This is referred to in Germany as "passive *Sterbehilfe*," and is generally accepted.

The right to self-determination for the competent patient extends beyond this, however. Suicide is not illegal in Germany.¹⁰⁰ While the law does prohibit active euthanasia,¹⁰¹ in a 2001 case, the German Supreme Court (*Bundesgerichtshof*) held that the psychologist-leader of an assisted suicide group who aided an elderly woman suffering from multiple sclerosis and other infirmities to commit suicide by supplying a deadly drug was not guilty of causing her death.¹⁰² The court accepted that the patient was responsible for her own death, and that the defendant, who assisted her by supplying the means of death, was not responsible. However, the court did affirm the defendant's conviction for violating the controlled substances laws in supplying the drug, rejecting the defendant's defense of necessity.

A doctor's assistance in a patient's suicide can collide with the well-recognized duty of rescue imposed upon doctors by German law. In the 1984 *Wittig* case, the German Supreme Court held that a doctor who does not try to forestall the consequences of an attempted suicide may be criminally liable.¹⁰³ In the 1988 *Hackethal* case, however, the Supreme Court suggested that the doctor may be freed from the obligation to rescue if the patient experienced his life as torture and wanted to escape it;¹⁰⁴ and in the 2001 case noted above, the court held that the duty of rescue did not apply since the patient, upon taking the drug, became rapidly unconscious and beyond help.

The right of self-determination recognized in these cases does not end when the patient becomes incompetent. In its judgment of September 13, 1994, the German Supreme Court explicitly recognized the right of an incompetent patient's representative to refuse treatment. In that case, the son and the physician of a 70-year-old patient with irreversible brain damage had requested the nursing staff of an institution to discontinue nutrition and hydration.¹⁰⁵ The nursing staff refused and notified the guardian court, which in turn informed the prosecutor, resulting in the physician's and the son's prosecution for attempted manslaughter. The Supreme Court reversed a guilty verdict, recognizing that the patient's right to self-determination encompasses a right to refuse life-sustaining treatment, and that this right could be exercised on behalf of incompetents where sufficient evidence exists, based on the patient's written or oral statements, religious views, and values, that the person would have declined treatment.

German law presently provides several avenues for decision-making for incompetents.¹⁰⁶ The first possibility is the living will (*Patientverfügungen*).¹⁰⁷ Patients may, while competent, expressly spell out what they want done in the event of future incapacity. Living wills do not seem to have the force that they have in the United States, but are rather a datum to consider in making end-of-life determinations. In practice, however, if a recent living will is available that addresses the situation at hand, it will probably be followed. Second, patients may grant another person a power of attorney to make medical decisions (*Vorsorgevollmachten*) in the future event of incapacity; this must be done expressly in writing while competent.¹⁰⁸ Third, a patient may nominate a guardian (*Betreuer*) for the guardianship court to appoint in the event of incapacity. Under the guardianship law, the guardianship court must approve any medical decisions made by a guardian or power of attorney that threaten death or will have long-lasting effects on health.¹⁰⁹ In its widely reported decision of July 20, 1998, the State Supreme Court of Frankfurt am Main held that the daughter and guardian of an 85-year-old woman in a persistent vegetative (but not terminal) condition could have artificial nutrition and hydration withdrawn (in accordance with the earlier expressed wishes of the mother), but that the approval of the guardianship court needed to be obtained. It is arguable, however, that

guardian court approval is not necessary if the patient is in the process of dying.¹¹⁰

Where no living will, person holding a power of attorney, or guardian exists, the attending physician must attempt to determine what the incompetent patient would have wanted done in the situation (*mutmaßlichen Willen*). This should be discerned considering the patient's earlier statements, religious convictions, and attitude toward pain, as well as from the seriousness of the patient's current condition.¹¹¹ If it is impossible to sort out the patient's presumed will, the doctor should decide in the patient's best interests.

Though German law places a heavy emphasis on the patient's right of self-determination, it also emphasizes the obligations of physicians to dying patients. In particular, the doctor has an obligation to protect the patient from pain. In several cases, health care professionals have been found liable in civil and criminal law for causing unnecessary pain to patients by failing to provide adequate pain therapy.¹¹² Moreover, the doctor who does attempt to protect a patient from pain can expect the protection of the law. In a 1996 case, the German Supreme Court held that a doctor who provided a dying patient with medically indicated pain medication in accordance with the expressed or presumed wishes of the patient, perhaps hastening the patient's death as a result, did not break the law.¹¹³ This process is referred to in the German literature as *Indirekt Sterbehilfe*.

Nevertheless, some critics have charged that German doctors are reluctant to provide adequate pain therapy. A recent article by Klaus Kutzer, a justice of the German Supreme Court, quotes Professor Dr. Zens as stating that prescribing opiates in Germany for pain treatment lags 10 years behind other European countries.¹¹⁴ Dr. Kutzer suggested that this might in part be due to restrictive interpretations of the German controlled substances regulations. Despite a commitment to palliative care as an alternative to euthanasia, palliative care still seems underdeveloped in Germany.¹¹⁵

JAPAN

The law respecting end-of-life decisions seems somewhat less developed in Japan than in the other countries in our study.¹¹⁶ No statutory scheme has emerged for dealing with end-of-life decisions, and only a handful of judicial precedents give guidance. There is also little legal authority on pain management.

Patient autonomy is not as firmly established in Japan as in other countries. The principle of patient decision-making is certainly recognized. Indeed, a recent Japanese Supreme Court decision unanimously concluded that doctors who transfused a Jehovah's Witness against her express instructions had infringed her personal rights, and awarded damages for emotional distress.¹¹⁷ Nevertheless, Japanese doctors are reluctant to disclose much information to their patients, and

generally expect patients to follow their directions.¹¹⁸ In particular, doctors are reluctant to disclose (and patients perhaps reluctant to receive) terminal diagnoses (especially a diagnosis of cancer), apparently believing that the patient will give up trying to survive in the face of such a diagnosis. Japanese doctors are more likely to disclose the diagnosis to the family, and work with the family to deceive the patient.¹¹⁹

Article 202 of the Japanese Criminal Code prohibits assistance in suicide or killing another on request. Physicians rely on this statute in refusing requests to terminate end-of-life treatment. On the other hand, once doctors decide that further treatment is not indicated, they can rely on Article 35 of the Criminal Code, which offers a defense of justification for acts done "in the course of legitimate business."¹²⁰

Two reported court decisions involving euthanasia are the primary sources of end-of-life decision-making law in Japan. The first was the 1962 Nagoya High Court decision,¹²¹ in which a son was charged with "ascendant homicide" (the aggravated crime of killing one's ancestor) for poisoning his terminally ill father, who was suffering great pain, allegedly at the father's request.

The court countenanced the possibility that euthanasia could be legally permissible, but identified six conditions that had to be present: (1) the patient must be suffering from an incurable and imminently terminal condition; (2) the patient must be suffering unbearable and unrelievable pain; (3) the patient must be killed with the intention of alleviating the pain; (4) the act should be done only at the patient's explicit request; (5) the euthanasia should normally be carried out by a physician; and (6) the euthanasia must be carried out through ethically acceptable means.

The court held that the final two conditions had not been met in the particular case, and thus convicted the son, though he was sentenced to only four years in prison, with three suspended, for what was a potentially capital crime. In four subsequent cases of euthanasia by relatives, various courts found one or more criteria to be lacking and thus found the defendants guilty, but in each case the defendant was given a relatively light sentence.¹²²

The other reported case involving euthanasia, a 1995 case from the Yokohama District Court, involved the criminal prosecution of a doctor who had, in response to a patient's family's insistent and incessant requests, first terminated nutrition and hydration, then injected the patient with high doses of analgesics, and finally injected the patient with verapamil hydrochloride and potassium chloride, causing the patient's death.¹²³ The court convicted the doctor of murder, but sentenced him to only two years in prison.

The court held that treatment of patients can be terminated if death is unavoidable and the patient is in the final stages of an incurable disease. The court suggested that more than one doctor should make the judgment of the impossibility of recovery and the patient should make an informed

expression of his or her wish that treatment cease. If the patient is unable to consent, the family should be given accurate information about the patient's condition and then be allowed to state the patient's "inferred intent," based on its knowledge of the patient's character and values. The court expressed its hope that patients would have living wills in the future, but also stated that if a living will was vague or remote in time it might not be of much use. The court concluded that life support measures (including artificial nutrition and hydration) could be terminated as well as other treatment measures, but the decision regarding the timing and termination of treatment was a medical judgment, presumably primarily for doctors to make.

With respect to euthanasia, the court distinguished between passive euthanasia (the cessation of life-sustaining treatment), indirect euthanasia (terminal sedation), and active euthanasia. The court stated that euthanasia is only appropriate if: (1) the physical pain is difficult to bear (mental suffering does not suffice); (2) the time of unavoidable death is near; (3) methods of eliminating the pain are exhausted; and (4) there is a clear expression of intent to accept death. Active euthanasia is permissible only if death is imminent, but indirect euthanasia can be used to hasten death. Active euthanasia is also only permissible if there is a clear expression of the patient's intent — substituted judgment does not suffice. Passive euthanasia, on the other hand, can be based on medical judgment as to futility and on the family's statement of intent, based on the patient's inferred intent, as noted above.

In the particular case (where the doctor had injected the patient with verapamil hydrochloride and potassium chloride at the family's request), the court held that active euthanasia was inappropriate because there was no informed consent on the part of the patient (who had not been told he was dying of cancer), the patient was unconscious and therefore not experiencing pain, and the family had not been told that the patient was not in pain. The court also faulted the doctor for relying on the family's judgment, as he had only known them a short time, and for buckling under the son's insistence on euthanasia, given the doctor's "higher status and position."

The law that emerges from these cases contrasts with the law of the United States and other common law countries in that it is more open to active euthanasia, but more reticent to accept withdrawal of treatment (which is effectively treated as a form of euthanasia). The two court decisions, for example, did not seem to countenance withdrawal of life-sustaining treatment for a nonterminal patient in a persistent vegetative state. Advance directives have no particular legal status in Japan, though several organizations offer advance directive forms and encourage their use.¹²⁴

Japan has a very strict narcotic law, and medical use of narcotics is much more limited than in other countries.¹²⁵

One expert states: "Such a rigid and complicated system of justifying the use of narcotics has forced many cancer patients with treatable pain to suffer compared with other advanced countries."¹²⁶ Physicians seem to fear that use of narcotics to control pain might lead to addiction or shorten the patient's life.

THE NETHERLANDS

The Netherlands was until recently the only nation in the world to have legalized active euthanasia (it was joined in 2002 by Belgium). In fact, the Dutch Criminal Code, like the German and Japanese codes, prohibits taking the life of another person "at the other person's express and earnest request," and also prohibits murder, manslaughter, and assisted suicide.¹²⁷ Since the mid-1900s, however, Dutch prosecutors have refrained from prosecuting doctors who committed euthanasia when the doctors conformed with certain substantive and procedural requirements established by the Supreme Court.¹²⁸ The court based these requirements on its interpretation of Article 40 of the Criminal Code, which provides: "A person who commits an offense as a result of a force that he could not be expected to resist [*overmacht*] is not criminally liable."¹²⁹ In the 1984 *Schoonheim* case, a general practitioner was prosecuted for killing a 93-year-old woman who was near the end of her life and suffering terribly, and had urgently requested euthanasia. The court accepted the argument that the killing was justified because the doctor had resolved in a responsible way the conflict between the professional duty to preserve life and the duty to spare a patient from suffering, and thus met the defense of necessity recognized by Article 40.¹³⁰

In April of 2001, the Dutch Parliament, after two decades of debate, adopted the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which also amended the Criminal Code and the Burial and Cremation Act. This statute, which came into effect in 2002, legalizes the practice of euthanasia and of assistance in suicide by physicians where specific substantive and procedural requirements are met.¹³¹ The Act amends Articles 293 and 294 of the Criminal Code, which prohibit killing on request and assistance in suicide, to provide that those acts are not illegal "if committed by a physician who fulfills the due care criteria" of the Termination of Life on Request and Assisted Suicide Act, "and if the physician notifies the municipal pathologist" in accordance with § 7(2) of the Burial and Cremation Act.¹³²

The "due care" criteria of § 2 of the Termination of Life on Request and Assisted Suicide Act require that:

- a. the physician holds the conviction that the request by the patient was voluntary and well-considered;
- b. the physician holds the conviction that the patient's suffering was lasting and unbearable;

- c. the physician has informed the patient about the situation he was in and about his prospects;
- d. and the patient holds the conviction that there was no other reasonable solution for the situation he was in;
- e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a–d; and
- f. has terminated a life or assisted in a suicide with due care.

The Act further requires that a doctor who performs active euthanasia or assists with suicide under the statute must notify the local coroner of the death, providing the coroner with a detailed report on compliance with the due care requirements.¹³³ The coroner must in turn notify a regional review committee established under the Act for reviewing euthanasia cases.¹³⁴ The coroner may also notify the prosecutor, who may in turn inform the coroner and regional review committee if he objects to the burial or cremation of the patient.¹³⁵ The regional review committee (which must include at least one legally trained member (the chair), one physician, and one ethicist) reviews the report, and decides whether the doctor has complied with the due care criteria.¹³⁶ The committee may inform the prosecutor or the regional health care inspector if it concludes that the statutory procedure has not been complied with.¹³⁷

Doctors have long been expected to report cases of active euthanasia or assisted suicide to the local coroner.¹³⁸ Reporting has lagged well behind practice, in part because of the reluctance of doctors to report their conduct to local prosecutors.¹³⁹ Under the new procedure, the government hopes that reporting will become more accepted, as the committees will have the power to shield reporting physicians from the threat of prosecution.¹⁴⁰

The recent legislation also clears up two matters that had not been resolved in earlier court decisions. The first of these is how the euthanasia law operates with respect to children. Under the statute, a physician may terminate the life of a child aged 16 to 18, or assist with his or her suicide at the child's request, after consulting the child's parents.¹⁴¹ If the child is between 12 and 16, the attending physician may only honor a request for euthanasia or assistance in suicide if the child's parent or guardian agrees.¹⁴² The second issue is that of persons who are incompetent, but who had prior to becoming incompetent executed an advance directive requesting that their lives be terminated upon reaching some future state of deterioration.¹⁴³ The physician may honor this request if otherwise in compliance with the due care criteria.

The statute does not require that the patient be in a terminal condition. It does not even require that the suffering be physical. In the *Chabot* case in 1994, the Supreme

Court recognized that the patient's "unbearable and hopeless suffering" could be mental rather than physical, though it upheld the conviction of the psychiatrist in the particular case for violating other requirements in euthanizing an inconsolably grieving woman at her request.¹⁴⁴ Every year a handful of psychiatric patients (2–5) are euthanized or assisted in suicide.

The statute does not address several important issues, some of which are otherwise resolved by court decisions, others of which remain unresolved. First, it does not address the practices of withdrawal of medical treatment or of terminal sedation. These practices are generally accepted in the Netherlands, and are specifically not considered to be euthanasia.¹⁴⁵ Dutch law, of course, permits competent patients to request that life-sustaining treatments (including artificial nutrition and hydration) be withdrawn or withheld.¹⁴⁶ Written advance directives, executed by a patient while competent and refusing treatment under specified circumstances, are also recognized under Article 450(3) of the Medical Contracts Act, though the statute also permits doctors to override the refusal if there are "well founded reasons for doing so."¹⁴⁷ Physicians may also withdraw or withhold treatment that they regard as "futile."¹⁴⁸ And doctors are permitted to administer drugs as necessary to relieve pain, even though the pain medication may hasten death.¹⁴⁹ These practices are regarded as "normal" medical practice, and deaths resulting from them are regarded as natural deaths. They account for far more deaths than euthanasia or assisted suicide, 38.5 percent versus 2.7 percent, according to a 1995 study.¹⁵⁰

Finally, the statute does not address the situation of patients in a persistent vegetative state (except if they have already executed an advance directive). A recent case found a general practitioner guilty of murder for killing an 84-year-old dying patient who was in a coma, but the court imposed only a suspended fine as a sanction.¹⁵¹ Because the patient was incapable of voluntarily requesting euthanasia, the case was not covered by the statute. Surveys, however, show that killing patients in the absence of a voluntary request is not uncommon (perhaps about 1,000 cases a year), and might in some cases be found to be justified under the defense of necessity where sustaining life could be regarded as inhumane.¹⁵²

The practice of euthanasia in the Netherlands has been widely condemned by external commentators, and is not universally accepted within the Netherlands.¹⁵³ The new Conservative government elected this past summer has pledged to review the practice of euthanasia. A significant majority of the Dutch population, however, seems to have accepted the current practice of euthanasia. Dutch commentators also often claim that other countries permit very similar medical practices, but simply do not admit to doing so. Without joining this debate, we must observe that the Netherlands firmly holds down the most extreme position in its end-of-life law of any country in our survey.

CONCLUSION

Each of the countries surveyed here addresses end of life and pain management from its own unique legal perspective. There seems to be consensus on a few issues (the right of competent persons to refuse treatment), near-consensus on more issues (the impermissibility of active euthanasia), yet more diversity on others (the withdrawal of life-sustaining treatment). Most countries recognize the use of large doses of narcotics at the end of life to ease pain, yet in a number of countries experts believe that pain remains undertreated. While the common law countries on the whole take similar approaches, the civil law countries are more varied in their responses. Learning from the perspectives of other countries might help us to understand our own law better, and perhaps to improve it.

REFERENCES

1. *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990).
2. N.L. Cantor, "Twenty-Five Years after *Quinlan*: A Review of the Jurisprudence of Death and Dying," *Journal of Law, Medicine & Ethics*, 29 (2001): 182-194.
3. See, e.g., "Symposium: The Undertreatment of Pain — Legal, Regulatory, and Research Perspectives and Solutions," *Journal of Law, Medicine & Ethics*, 29 (2001); "Symposium: Legal and Regulatory Issues in Pain Management," *Journal of Law, Medicine & Ethics*, 26 (1998); "Symposium: Appropriate Management of Pain," *Journal of Law, Medicine & Ethics*, 24 (1996).
4. *European Convention on Human Rights and Fundamental Freedoms*, Rome (November 4, 1950), T.S. 71 (1953) (Cmd. 8969).
5. A.P. Den Exter, "Legal Reforms of the Polish Health Care System in View of Accessing the European Union," *European Journal of Health Law*, 8 (2002): 5-25.
6. See, e.g., England: *Re M.B. (Medical Treatment)* [1997] 2 F.L.R. 426 at 437; *Ms. B. v. An N.H.S. Hospital Trust* [2002] E.W.H.C. 429 (Fam.) [104]; Australia: *Secretary, Department of Health and Community Services (N.T.) v. J.W.B. and S.M.B. (Marion's Case)* (1992) 175 C.L.R. 218; *Boughy v. The Queen* (1986) 60 A.L.J.R. 422 at 428; France: Article 36 of the 1995 Code of Medical Deontology: "In every case, the consent of the person examined or attended should be sought. When the patient, in a condition to express his will, refuses the investigations or the proposed treatment, the doctor should respect this refusal having informed the patient of all its consequences."
7. See, e.g., Canada: *Malette v. Shulman*, (1990) 67 D.L.R. 4th 321, at 328, per Robins, J. See also *Nancy B. v. L'Hotel Dieu de Quebec* (1992), 69 C.C.C. (3d) 450; the United Kingdom: *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871 at 904-05; *Re T. (An Adult) (Consent to Medical Treatment)* [1993] Fam. 95 at 102; *Re M.B. (Medical Treatment)* [1997] 2 F.L.R. 426 at 437; *R. (Pretty) v. the D.P.P.* [2001] U.K.H.L. 61 at [55] per Lord Steyn, citing *St. George's Health Care Trust v. S.* [1999] Fam. 26; *Ms. B. v. An N.H.S. Hospital Trust* [2002] E.W.H.C. 429 (Fam.) [104].
8. *Pretty v. the United Kingdom*, The European Court of Human Rights (Fourth Section), Strasbourg, April 29, 2002 (Application no. 2346/02).
9. *Id.* at [61]. Article 8 states: "(1) Everyone has the right to

respect for his private and family life ... and that (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society...."

10. *R. v. Adams* [1957] Crim. L.R. 365.
11. P. Devlin, *Easing the Passing: The Trial of Dr John Bodkin Adams* (London: Faber and Faber, 1986): at 71.
12. See W.C. Wilson et al., "Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Clinically Ill Patients," *JAMA*, 267 (1992): 949-53. In this study, patients who were given large doses of opioids by way of palliation following the withdrawal of life supports lived on average as long as patients who were not so treated. The study suggests that the determining factor of the time of death is the underlying disease, rather than opioid medication.
13. See, e.g., England: *Re J.* [1991] Fam. 33; *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789.
14. *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789; *R. (Pretty) v. the D.P.P.* [2001] U.K.H.L. 61.
15. *Rodriguez v. Attorney General of Canada*, [1994] 2 L.R.C. 136; *R. v. Latimer*, [2001] 1 S.C.R. 3.
16. *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997).
17. *Consent to Medical Treatment and Palliative Care Act* (1995), § 17(1).
18. *Id.* § 17(3)(a).
19. *Law Hospital N.H.S. Trust v. Lord Advocate* (1996) S.L.T. 848.
20. Laurence Oates, Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults Who Lack Capacity) [2001] 2 F.L.R. 158 [7.2].
21. *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789 at 805.
22. *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789.
23. *Marshall v. Curry* (1933) 3 D.L.R. 260 at 60.
24. *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789 at 867.
25. *N.H.S. Trust A. v. M.; N.H.S. Trust B. v. H.* [2001] 1 All E.R. 801; 1 F.C.R. 406; 2 W.L.R. 942; 2 F.L.R. 367.
26. Following the enactment of the Human Rights Act (1998) (U.K.), previous English decisions, such as that in the *Bland* case, have become subject to the *European Convention on Human Rights and Fundamental Freedoms*. By virtue of § 6(6) of the Human Rights Act, public authorities are bound in relation to their omissions as well as their actions.
27. *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B. (Marion's Case)* (1992) 175 C.L.R. 218 (sterilization).
28. To date, there have been no reported cases in Australia regarding withdrawal or withholding of treatment in the terminal stages of life, though in 2000 the Master of the Supreme Court of New South Wales granted an injunction, requested by the patient's family, to restrain the hospital from withdrawing artificial hydration and alimentation until a firm diagnosis could be obtained.
29. *Consent to Medical Treatment and Palliative Care Act* (1995) (S.A.), § 17(2). The Northern Territory's Natural Death Act (1989) (N.T.) stated that withholding or withdrawal of "extraordinary measures" at the direction of a person suffering from a terminal illness does not constitute a cause of death. For the provision to be operative, the patient must have been diagnosed as "terminally ill" (Natural Death Act (1989) (N.T.), § 6).
30. *Consent to Medical Treatment and Palliative Care Act* (1995) (S.A.), § 17(3)(b).
31. *Child and Family Services of Central Manitoba v. R.L. and S.L.H.*, (1997) 123 Man. R. (2d) 35. The plaintiff in this case had claimed that there exists a positive right that obliges a physician to

provide treatment that is requested by the patient or surrogate. The court denied such a right by ruling that a patient (or a family member) cannot enforce a demand for treatment considered by the physician to be futile. See also *Sawatzky v. Riverview Health Centre Inc.*, (1998) 133 Man. R. (2d) 41 (Q.B.).

32. *Rodriguez v. British Columbia (Attorney General)*, (1993) 3 S.C.R. 519.

33. Criminal Code (1985) (Can.), ch. C-46, § 241 provides: "Every one who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years."

34. *Rodriguez v. British Columbia (Attorney General)*, (1993) 3 S.C.R. 519 at 521.

35. Senate of Canada, *Of Life and Death: Report of the Senate Special Committee on Euthanasia and Assisted Suicide* (1995). In 1997, the Parliament of Alberta enacted the Personal Directives Act, ch. P-4.03 (1997) (Alberta), the Preamble to which states that Albertans "should be able to provide advance personal instructions regarding their own personal matters while recognizing that such instructions cannot include instructions relating to aided suicide, euthanasia or other instructions prohibited by law."

36. *R. (Pretty) v. the D.P.P.* [2001] U.K.H.L. 61.

37. Mrs. Pretty had virtually no decipherable speech, but apparently her intellect and capacity to make decisions remained unimpaired, including the ability to instruct her lawyers (her husband acted as her interpreter).

38. Suicide Act (1961) (9 & 10 Eliz. 2, c. 60), § 2.

39. *Pretty v. the United Kingdom*, The European Court of Human Rights (Fourth Section), Strasbourg, April 29, 2002 (Application no. 2346/02): at [39].

40. *Id.* at [74]. Both the House of Lords and the European Court of Justice in *Pretty* adopted the reasoning of the majority in *Rodriguez v. British Columbia (Attorney General)*, (1993) 3 S.C.R. 519 at 521, which stated that the long-standing blanket statutory prohibition against assisted suicide fulfills the government's objective of protecting the vulnerable, is grounded in the state interest in protecting life, and reflects the policy of the state that human life should not be depreciated by allowing life to be taken.

41. Crimes Act (1900) (A.C.T.), §§ 17-18; Crimes Act (1900) (N.S.W.), §§ 31A-31C; Criminal Code (Qld.), § 311; Criminal Law Consolidation Act 1935 (S.A.), § 13A; Criminal Code (Tas.), § 163; Crimes Act 1958 (Vic.), §§ 6A-6B; Criminal Code (W.A.), § 288.

42. Received assent by the Administrator on June 16, 1995.

43. § 4 of RTIA provided that "a patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient" could request "the patient's medical practitioner to assist the patient to terminate the patient's life." Part 1, § 3, defined the medical practitioner's assistance "in relation to death or proposed death of a patient" as involving "the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self administration, and the administration of the substance to the patient." By virtue of Part 4, § 18(2), this kind of "assistance" was to be "taken to be medical treatment for the purposes of the law."

44. The Euthanasia Laws Act (1997) (Cth), Schedule (1). Additionally, the Commonwealth Parliament disempowered the Legislative Assembly of the Northern Territory from enacting "laws which permit or have the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life."

45. *R. v. Latimer*, [2001] 1 S.C.R. 3.

46. Latimer was convicted of murder in two trials: (1997) 121 C.C.C. (3d) 326 (Sask. Q.B.); (1998) 131 C.C.C. (3d) 191.

47. Latimer pleaded that the conviction should not stand because the trial judge erred in removing the defense of necessity from the jury. The necessity consisted of the pain his daughter was thought to experience during seizures, which she suffered daily, and additional pain that was due to weight loss caused by a lack of nutrients in her spoon-feeding regimen. The final aspect of "necessity" was the recommendation of hospital doctors that in order to relieve pain caused by a dislocated hip, Tracy should undergo surgery to remove her upper thigh bone. Latimer perceived this procedure as mutilation, and "formed the view that his daughter's life was not worth living." *R. v. Latimer*, [2001] 1 S.C.R. 3 at 13.

48. *Id.* at 12. The Supreme Court rejected all three arguments, and determined that the defense of necessity was misconceived. Latimer himself did not face any peril, and Tracy's ongoing pain did not constitute an emergency. The court emphasized that though severely disabled, Tracy was not terminally ill. She "enjoyed music, bonfires, being with her family and the circus. She liked to play music on a radio, which she could use with a special button. Tracy could apparently recognize family members and she would express joy at seeing them. Tracy also loved being rocked gently by her parents." For further discussion of Tracy's chronic pain, see *id.* at 24.

49. *Id.* at 26.

50. *Id.*

51. Medical Profession Act (Ustawa o Zawodzie Lekarza of December 5, 1996; consolidated on August 30, 2002), available at <<http://www.rzeczpospolita.pl/prawo/doc/2>>.

52. Health Services Institutions Act (Ustawa o Zakładach Opieki Zdrowotnej of August 30, 1991) (*Dziennik Ustaw* Nr 91, poz. 408).

53. Ustawa o Izbach Lekarskich of May 17, 1989 (*Dziennik Ustaw* Nr 30, poz. 158 ze zm).

54. Penal Code (Kodeks Karny) of June 6, 1997 (*Dziennik Ustaw* Nr 88 z dn. 2.08.1997).

55. Konstytucja Rzeczypospolitej Polskiej of July 16, 1997 (Constitution of the Polish Republic).

56. Opinion of October 7, 1992 (U. 1/92).

57. According to the Opinion of October 7, 1992, deontological norms per se do not have a legal character, because only nominated medical associations (*izby*), and not the legislature or state administrative organs, have the power to define deontological principles on the basis of the system of values recognized by these medical corporations.

58. T.M. Zielonka, "Na marginesie Kodeksu Etyki Lekarskiej," *Gazeta Lekarska*, Numer 10/2001.

59. M. Żelichowski, "Kodeks Etyki Lekarskiej," *MP OnLine*, available at <http://www.mp.pl/prawo/show.php?aid=11643&PHPSESSID=774E4A57B83C485D9157CFC77EB63942&_tc=A2FA152C344C467D8DE4B597BFDEA1EC> (last visited December 6, 2002).

60. Polish Constitutional Tribunal Opinion of March 17, 1993 (W 16/92), available at <http://www.mp.pl/prawo/show.php?aid=11643&PHPSESSID=774E4A57B83C485D9157CFC77EB63942&_tc=1671BBE14697414F9A356C6729138ECD>.

61. The provision entrenches the autonomy of medical practitioners' decisions regarding treatment options. It also imposes on medical practitioners an obligation to inform patients of alternative medical treatments. However, the parenthetical clause, which is an exception relating to the necessity for prompt medical intervention, makes it unclear whether medical discretion extends to instances of withholding or withdrawal of life-saving

or life-sustaining treatment.

62. "The physician may decide to discontinue or not institute a treatment (unless prompt medical intervention is necessary), but is obliged to inform the patient before doing so and suggest other factual opportunities for obtaining medical treatment. If the physician is employed at an institution, the consent of his/her superior must be obtained."

63. Medical practitioners have a duty to render medical help in each case where a delay would cause a risk of loss of life or serious physical or mental injury or in other cases of emergency. Medical Profession Act of December 5, 1996 (Ustawa o Zawodzie Lekarza).

64. See also Penal Code, Article 162.2: "No offense will arise where a private person does not render help to another, if the latter must undergo a medically necessary procedure, or where it is possible to obtain immediate help from an institution or a person under a duty to help" (emphasis provided).

65. Zelichowski, *supra* note 59. Consequently, a medical practitioner who infringes Article 162 of the Penal Code or Article 30 of the Medical Profession Act, while adhering to Article 32 of the Code of Medical Ethics, will be punished.

66. Penal Code (Kodeks Karny of June 6, 1997; *Dziennik Ustaw* Nr 88 z dn. 2.08.1997).

67. "A medical practitioner must not practice euthanasia."

68. Article 38 of the Constitution provides that "the Polish Republic guarantees each person a legal right to protection of life."

69. Zelichowski, *supra* note 59.

70. France ratified the *European Convention on Human Rights and Fundamental Freedoms* in 1974. Consequently, under Article 55 of the French Constitution, the international law embodied in the provisions of the ECHR prevails over domestic legislation.

71. French appellate courts have the power to make decisions as *arrêts de principe*, which lay down new principles of law for application in subsequent cases. B.J. Boyron and S. Whittaker, *Principles of French Law* (Oxford: Oxford University Press, 1998): at 19.

72. *European Convention on Human Rights and Fundamental Freedoms*, *supra* note 4.

73. Conseil de l'Europe, Assemblée Parlementaire, Commission des Questions Sociales, de la Santé et de la Famille, *Protection des Droits de l'Homme et de la Dignité des Malades Incurables et des Mourants*, Rapport, Doc. 8421 (1999).

74. Loi n° 99-477 of June 9, 1999, Visant à Garantir le Droit à l'Accès aux Soins Palliatifs (JO 10 06 99: 8487). See also Article L-711-4 of the Code of Public Health, which provides that "health care establishments give preventive, curative, or palliative care to patients as required by their state of health and ensure the continuity of such care once they are discharged."

75. The Code of Medical Deontology sets normative standards for medical practice, the violation of which exposes medical practitioner to disciplinary sanction by the French Order of Physicians. French courts of law use provisions contained in the Code both to define legal obligations and as a guide to understanding the ethical nature of the doctor-patient relationship.

76. See also the first clause of Article 37 of the Code of Medical Deontology, which states: "In any circumstances, the physician should do his utmost to alleviate the sufferings of his patient, and give him moral solace."

77. Article 32 of the Code of Medical Deontology states: "the doctor undertakes to personally provide the patient with conscientious care, devoted to and based on the acquired scientific data..."

78. A.M. Duguet, "Euthanasia and Assistance to End of Life Legislation in France," *European Journal of Health Law*, 8 (2001):

109-23, at 114. In its report on *End of Life, Ending Life, Euthanasia*, the French National Consultative Ethics Committee for Health and Life Sciences pointed out: "a medical decision to abstain from resuscitation, to refrain from prolonging or initiating deep sedation ... on occasion described by some as being passive euthanasia ... is not a deliberate ending of life; it is simply recognizing that ensuing death is the consequence of the disease or of certain therapeutic decisions which it may have prompted. In fact, these situations when therapeutic procedures are curtailed are consistent with a rejection of futile and aggressive therapy and should not be criticised on ethical grounds." French National Consultative Ethics Committee for Health and Life Sciences (CCNE), Report N° 63 (January 27, 2000), available at <http://www.ccne-ethique.org/english/avis/a_063.htm#deb>.

79. According to Article 36 of the Code of Medical Deontology: "In every case, the consent of the person examined or attended should be sought. When the patient, in a condition to express his will, refuses the investigations or the proposed treatment, the doctor should respect this refusal having informed the patient of all its consequences." The right to refuse medical treatment is reinforced under the palliative care law of June 9, 1999, which states that "a sick person may refuse to submit to investigation or therapy of whatever kind." The burden of proving a patient's consent to treatment rests on the doctor. The Council of State [le Conseil d'Etat] law of January 5, 2000.

80. Article 36.3 of the Code of Medical Deontology.

81. E. Ferrand et al., "Withholding and Withdrawal of Life Support in Intensive-Care Units in France: A Prospective Survey," *The Lancet*, 357, no. 9249 (2001): 9-14.

82. See, e.g., H. Mazeaud, L. Mazeaud, and A. Tunc, *Traité Théorique et Pratique de la Responsabilité Civile* (Paris: Montchrestien, 1965): at 524-25; F. Terré, P. Simler, and Y. Lequette, *Droit Civil, Les Obligations*, 6th ed. (Paris: Dalloz, 1996): at 688.

83. "Any one who has intentionally (*volontairement*) failed to render or to obtain assistance for an imperilled person (*une personne en peril*) when such was possible without danger to himself or others, shall be subject to like punishments [specified in paragraph 1 as up to 5 years of imprisonment and 75,000 euros]." Article 223-6(2) of the Criminal Code.

84. "Every doctor, who is in the presence of a patient or of a wounded person in danger, or informed that a patient or a wounded person is in danger, must provide assistance or make sure that that person receives the necessary care."

85. C. Dadamo and S. Farran, *French Substantive Law: Key Elements* (London: Sweet & Maxwell, 1997): at 212.

86. Rouen Court of Appeal, March 6, 1996, discussed in H. Nys, "Physician Involvement in a Patient's Death: A Continental European Perspective," *Medical Law Review*, 7 (1999): 208-46, at 225.

87. Cour de Cassation, Criminal Chamber, February 19, 1997, discussed in Nys, *supra* note 86, at 225.

88. *Editions Dalloz* (1998), 236 comments of B. Legros; *Jurisclasseur périodique, Semaine Juridique* (1997), II, 22.889, comments of R.-M. Chevallier.

89. The uncontrolled sale of medicines over the Internet makes it relatively easy to obtain lethal medicines. The Economic and Social Committee of the Commission of the European Communities has suggested that Articles 2 and 3 of Council Directive 92/28/EEC of March 31, 1992, which ban advertising of medical products for human use that can only be supplied by medical prescription, be updated by national authorities in light of the promotion and distribution of these drugs over the Internet. Opinion of the Economic and Social Committee of the Commission of the European Communities, "The Role of the European

- Union in Promoting a Pharmaceutical Policy Reflecting Citizens' Needs: Improving Care, Boosting Innovative Research and Controlling Health Spending Trends," *Official Journal*, C 014, 16/01/2001 P. 0122-0132 (January 16, 2001): § 10. However, it is up to the member states to ensure that the market is monitored in terms of advertising in accordance with the provisions of the directive. Article 223-14 of the Criminal Code might be regarded as imposing a penalty for a very serious infringement of the directive.
90. Article 121-3(1) provides that intention is an essential element of major crimes. Article 121-3 of the Criminal Code (Loi n° 96-393 of May 13, 1996; Loi n° 2000-647 of July 10, 2000, art. 1, the *Official Journal of the French Republic* of July 11, 2000).
91. Article 221-5.
92. Cour de Cassation, Criminal Chamber, June 22, 1994, Bull. Crim., No. 248.
93. Duguet, *supra* note 78, at 110.
94. Code of Medical Deontology, Decret n° 95-1000 of September 6, 1995.
95. See J.M. Scherer and R.J. Simon, *Euthanasia and the Right to Die, A Comparative View* (Lanham: Rowman and Littlefield Inc., 1999): at 68; H.-M. Sass, "Images of Killing and Letting Die, of Self-Determination and Beneficence," in H.-M. Sass, R.M. Veatch, and R. Kimura, eds., *Advance Directives and Surrogate Decision Making in Health Care* (Baltimore: Johns Hopkins University Press, 1998): at 154-56.
96. Article 2, ¶ 1.
97. Article 2, ¶ 2.
98. Article 1, ¶ 1.
99. Bundesgerichtshof decision, November 28, 1957.
100. Bundesgerichtshof decision, 5 St. R. 474/00, judgment of February 7, 2001 (LG Berlin).
101. St. G.B. § 216. Killing another at that person's "express and serious request" is a lesser offense than murder or manslaughter, punishable by 6 months to 5 years in prison, compared to 1 to 10 years for manslaughter.
102. Bundesgerichtshof decision, 5 St. R. 474/00, judgment of February 7, 2001 (LG Berlin).
103. Nys, *supra* note 86, at 232.
104. *Id.* at 233.
105. See a description of the case in Nys, *supra* note 86, at 228-29, and in H.-G. Koch, "The Decision to Aid Dying and Related Legal Issues," in Sass, Veatch, and Kimura, eds., *supra* note 95, at 114, 119-121.
106. See J.G. Meran and H. Poliwooda, "Clinical Perspectives on Advance Directives and Surrogate Decision Making," in Sass, Veatch, and Kimura, eds., *supra* note 95, at 95-113; Koch, *supra* note 105, at 124-31.
107. See Bundesärztekammer, *Handreichungen für Ärzte zum Umgang mit Patientenverfügungen*, October 13, 1999.
108. This possibility has existed for some time, but was expressly recognized in amendments to § 1904 of the Bürgerliches Gesetzbuch in 1999.
109. Bürgerliches Gesetzbuch, § 1904, ¶ 1.
110. Bundesärztekammer, *supra* note 107, at ¶ 1.2.
111. See Bundesärztekammer, *Grundsätze der Bundesärztekammer zur ärztlichen Sterbebegleitung*, September 11, 1998, § IV.
112. K. Kutzer (Chief Judge, German Supreme Court), *Pain Therapy from the Legal Perspective*, Saarland Pain Forum, October 20, 2001, available at <www.soziales.saarland.de/medien/inhalt/StatementKutzer.pdf>.
113. Nys, *supra* note 86, at 232, citing Bundesgerichtshof decision of November 15, 1996, Bundesgerichtshof St. 42, 301. See also K. Kutzer, "Rechtliche Aspekte der Behandlung Schwerstkranker bei irreversiblen Schädigungen," *Europäisches Akademie Newsletter* (June 2001): at 2.
114. Kutzer, *supra* note 112.
115. See W. Sohn, "Care for the Dying between the Right to Self-Determination and the Obligation to Provide Treatment," in W. Sohn and M. Zenz, eds., *Euthanasia in Europe* (Stuttgart: Schattauer, 2001): 67-70; H. Csef, "Euthanasia as an Ethical Problem," in *id.* at 71-80, at 78.
116. See generally Scherer and Simon, *supra* note 95, at 85-89.
117. *Takeda v. State*, 54(2) Minshu 582, 1710 Hanrei Jiho 97, 1031 Hanrei Taimuzu 158 (Sup. Ct., Feb. 29, 2000).
118. See R.B. Leflar, "Informed Consent and Patients' Rights in Japan," *Houston Law Review*, 33 (1996): 1-112. See also M. Hayashi and T. Kitamura, "Euthanasia Trials in Japan: Implications for Legal and Medical Practice," *International Journal of Law and Psychiatry*, 25 (2002): 557-71.
119. R. Kimura, "Death, Dying and Advance Directives in Japan: Sociocultural and Legal Points of View," in Sass, Veatch, and Kimura, eds., *supra* note 95, at 189.
120. *Id.* at 192.
121. See *id.* at 195-97.
122. *Id.* at 197.
123. By way of analogy to the United States, a decision from the district court level in Japan is somewhat greater than a respected federal district court decision in the United States. An English translation of the case by Robert Leflar can be found in T.S. Jost, ed., *Readings in Comparative Law and Bioethics* (Durham: Carolina Academic Press, 2000): at 354. A commentary on the case can be found in F. Yamazaki, "A Thought on Terminal Care in Japan," in K. Hoshio, ed., *Japanese and Western Bioethics* (Dordrecht: Kluwer Academic Publishers, 1997): 131-34, and in E. Gutierrez, "Debate on Euthanasia Encouraged in Japan," *The Lancet*, 349 (1997): 409. A similar case from Kawasaki, south of Tokyo, was widely reported in the Japanese press in the spring and summer of 2002, though that case has not yet been reported in legal reports.
124. Kimura, *supra* note 119, at 193-94.
125. Hayashi and Kitamura, *supra* note 118, at 564-65.
126. Kimura, *supra* note 119, at 189.
127. Articles 293 (taking the life of another on request); 287 (manslaughter); 289 (murder); and 294 (assisting in suicide).
128. A translation of the *Schoonheim* decision, *Nederlandse Jurisprudentie* 1985, no. 106, is found in J. Griffiths, A. Bood, and H. Weyers, *Euthanasia and the Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998): at 322.
129. Translation from *id.* at 307.
130. The court rejected alternative arguments that the prohibition against taking life did not extend to medical situations or that the defendant's conduct had only amounted to an insubstantial violation of the law. See *id.*
131. See G. Kimsma and E. van Leeuwen, "The New Dutch Law on Legalizing Physician-Assisted Death," *Cambridge Quarterly of Healthcare Ethics*, 10 (2001): 445-50.
132. An English translation of the Act is available at <http://www.minbuza.nl/OriginalDocuments/c_55024.pdf> (last visited December 6, 2002).
133. Burial and Cremation Act, as amended (2001), § 7.
134. *Id.* § 10.
135. *Id.*
136. *Id.* § 8.
137. *Id.* § 9. The Committee must inform the physician of its decision within 6 weeks (with one possible 6-week extension).
138. Failure to report is in fact a separate offense under the Criminal Code, Article 228(1).

139. Griffiths, Bood, and Weyers, *supra* note 128, at 236-40.
140. Nys, *supra* note 86.
141. Burial and Cremation Act, § 2(3).
142. *Id.* § 2(4).
143. *Id.* § 2(2).
144. Chabot, *Nederlandse Jurisprudentie* 1994, no. 656, is reproduced in Griffiths, Bood, and Weyers, *supra* note 128, at 329. See also R. Cohen-Almagor, "The Chabot Case: Analysis and Account of Dutch Perspectives," *Medical Law International*, 5 (2001): 141-59.
145. The Dutch reject terms like "passive euthanasia" or "indirect euthanasia," used elsewhere, reserving the term "euthanasia" to mean only the taking of another's life in response to that person's request.
146. Nys, *supra* note 86, at 233.
147. *Id.* at 234.
148. This practice was approved of in the *Stinissen* case in 1976. Nys, *supra* note 86, at 234-35.
149. Nys, *supra* note 86, at 236. In the Netherlands, euthanasia tends to be defined as a form of palliative care: J. Keown, "Euthanasia in the Netherlands: Sliding Down the Slippery Slope?," in J. Keown, ed., *Euthanasia Examined* (Cambridge: Cambridge University Press, 1997): 261-97, at 269.
150. Griffiths, Bood, and Weyers, *supra* note 128, at 210.
151. T. Sheldon, "Dutch GP Found Guilty of Murder Faces No Penalty," *British Medical Journal*, 322 (2001): 509.
152. Griffiths, Bood, and Weyers, *supra* note 128, at 131-33.
153. R. Cohen-Almagor, "An Outsider's View of Dutch Euthanasia Policy and Practice," *Issues in Law & Medicine*, 17 (2001): 35-68.