

# A HUMAN RIGHTS APPROACH TO END OF LIFE? RECENT DEVELOPMENTS AT THE EUROPEAN COURT OF HUMAN RIGHTS

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## ABSTRACT

Medically assisted death (“MAD”) has, to date, only been accepted as a right in a limited number of countries. The main goal of this article is to address the evolution of MAD in the jurisprudence of the European Court of Human Rights (ECtHR) through a comparative analysis. This paper analyses the development of the law governing MAD in the *European Convention on Human Rights* (the “*European Convention*”),<sup>1</sup> and discusses whether a right to death with dignity is emerging within the *European Convention* framework. This paper focuses on the legal rights of those suffering from terminal illnesses with no chance of improvement in sight. It seeks to understand whether the rights enshrined in the *European Convention* for an interpretation that would allow MAD. Finally, this paper seeks to demonstrate that a right to a MAD may be recognized within the framework of the *European Convention*. However, the paper acknowledges that the right to MAD which may ultimately be recognized by the ECtHR is unlikely to impose a positive obligation upon the signatory states of the *European Convention*.

## Keywords

Assisted death; death with dignity; European Convention.

## I. INTRODUCTION

There is nothing more certain in life than death. The right to life is guaranteed within the supreme laws of most countries’, and within universal and regional human rights

conventions. Typically, the definition of a ‘right to life’ encompasses and presupposes the right to live with a degree of dignity. Conversely, in death an individual may not be afforded such a degree of dignity. In an all too familiar scene, family members, friends, and medical professionals understandably attempt to prolong a loved one’s life, ultimately sacrificing their loved one’s dignity in the process.

Medically assisted death (“MAD”) has, to date, only been accepted as a right in a limited number of countries. The main goal of this article is to address the evolution of MAD in the jurisprudence of the European Court of Human Rights (ECtHR) through a comparative analysis. This paper analyses the development of the law governing MAD in the *European Convention on Human Rights* (the “*European Convention*”),<sup>2</sup> and discusses whether a right to death with dignity is emerging within the *European Convention* framework.

Part I of this paper looks into the history of euthanasia and physician assisted suicide (“PAS”), and then proceeds with a discussion of how these two terms have been defined within the legal frameworks of jurisdictions recognizing the right to a MAD. Part II seeks to understand the jurisprudential construction of the rights recognized by the *European Convention* invoked in the context of MAD. Despite the small number of cases in this subject to date, every case attempted to assert the existence of a right to a MAD. Finally, this paper briefly discusses recent developments in the case-law in Canada as a point of comparison in the analysis of jurisprudential construction of death within dignity.

This paper focuses on the legal rights of those suffering from terminal illnesses with no chance of improvement in sight. It seeks to understand whether the rights enshrined in the *European Convention* for an interpretation that would allow MAD. Finally, this paper seeks to demonstrate that a right to a MAD may be recognized within the framework of the *European Convention*. However, the paper acknowledges that the right to MAD which may ultimately be recognized by the ECtHR is unlikely to impose a positive obligation upon the signatory states of the *European Convention*.

## II. LEGAL DEFINITIONS, HISTORICAL DEVELOPMENT, AND CURRENT CONTROVERSIES SURROUNDING MEDICALLY ASSISTED DEATH IN EUROPEAN JURISDICTIONS

A review of the legal aspects of MAD found in different European jurisdictions (who are parties to the *European Convention*) can help provide a common linguistic framework for the discussion that follows.

### 1. Euthanasia and Physician Assisted Suicide

A physician typically has three choices during the final stages of a patient's life. The three choices include euthanasia, PAS, or palliative sedation. The first two methods actively assist a terminally ill patient to end their life. Palliative sedation typically involves alleviating a terminally ill patient's distress through sedatives and should not be categorized as a form of MAD. While the legal requirements for euthanasia and PAS are discussed here, palliative sedation is outside of the scope of this article.

#### A. Euthanasia

The definition adopted by the State Commission on Euthanasia in the Netherlands in 1985 states that euthanasia, in its most elementary form, is the intentional and active termination of a person's life at that person's explicit request.<sup>3</sup> What makes euthanasia legal is that the law allows it provided that the procedure is performed by a medical doctor.<sup>4</sup>

The requirements for euthanasia as set out by the laws of the three European countries

allowing the practice are remarkably similar. The relevant sections of the laws are found in Article 2 of the Dutch *Assessment Act*,<sup>5</sup> Article 3 of the Belgian *Euthanasia Act*,<sup>6</sup> and Chapter 2 of the Luxembourgian *Euthanasia Act*.<sup>7</sup> The legal requirements for euthanasia can broadly be divided into two categories: 1) the requirements of the patient; and 2) the requirements of the physician. A patient must qualify for euthanasia based upon their particular medical and mental status. A doctor must ensure they fulfil a legal duty of care owed to the patient which seeks to ensure proper medical care is provided.

Both Belgium and Luxembourg require the patient to be deemed a "mentally capable person"; the Netherlands does not explicitly require this but it is implied by the wording of Paragraph 2 of Article 2 of the *Assessment Act*. In all three jurisdictions, the request for euthanasia by the patient must be based on their free will, should demonstrate it is well-considered, and should be made repeatedly. Euthanasia may only be performed if the patient has a medical condition which brings about unbearable and constant pain, from which no improvement, or relief, is expected. If the patient fulfils all the criteria, they are eligible for euthanasia.

Despite the requirement that a patient be mentally capable, and be in unbearable and constant pain, both Holland and Belgium have embraced controversial practices when applying euthanasia laws. In these two countries, examples can be found of individuals suffering from Alzheimer's or dementia (purely mental diseases) being euthanized, as well as minors and those who feel they have completed their life. These controversial applications of euthanasia will be addressed briefly below.

Prior to performing euthanasia, a doctor must fulfil an additional set of criteria. A doctor must always inform the patient about their medical condition and their life expectancy, about any alternative treatment options, and about the nature and effect of following through on their decision to end their life. A doctor must be satisfied, by holding several consultations with the patient, that euthanasia is the only suitable course of action, and that the patient has no doubt this is the solution they desire. Additionally, a second doctor, with access to the patient and their entire medical history, must be consulted. This second doctor must establish their own independent medical evaluation of the

patient's situation and must satisfy themselves of the legal requirements concerning the status of the patient, mentioned above. In the Netherlands, euthanasia without consent is not counted as euthanasia. Finally, after a physician euthanizes a patient, a report must be filed with the regional euthanasia commission, which details the entirety of the procedure.

These are the legal requirements adopted by three different countries which, as can be seen, all in principle require the same conditions to be fulfilled. The laws on euthanasia all emphasize the need for the patient to be fully informed, and all require the involvement of multiple medical doctors endorsing the decision before a euthanasia request can be granted. These requirements work together in order to prevent hasty decisions, and ensure all options are considered prior to a final decision being made.

#### **a) Physician assisted suicide**

PAS is a form of medical support where a doctor advises a patient about ways they can end their life and provides necessary medication in order to assist the patient to do so. However, PAS leaves the actual act of administering the drug to the patient. The assistance is limited to the provision of information or materials, as helping to administer the medication would amount to euthanasia.

In some jurisdictions, PAS helps to overcome fears that responsible physicians may be held responsible for murder. PAS allows doctors to avoid criminal liability. For example, in Germany, intentionally killing an individual in order to relieve their pain is prohibited but assisting an individual to commit suicide is a legal act, therefore, in the proper context, it is legal for a physician to assist an individual to commit suicide to relieve pain.<sup>8</sup> In Switzerland, PAS is criminal if it is done for selfish reasons such as when an assistant benefit from the death of the patient. Consequently, any assistance rendered to a person who wishes to commit suicide, if done out of compassion and for unselfish reasons, is legal and allowed.<sup>9</sup>

Given recent European history, the deregulation of PAS, particularly in Switzerland, is remarkable. The reason both Switzerland and Germany do not have equally progressive euthanasia laws as the Benelux (Belgium, Netherlands, and Luxembourg) stems in large part from the Nazi regime and its official policy

of 'euthanasia' carried out against marginalized segments of society.<sup>10</sup> In response, the systems that have arisen in Switzerland and Germany do not embrace euthanasia, and do not require very much government oversight. Instead right-to-die associations in Switzerland have developed internal codes of professional conduct that have created a more stringent regulatory regime than provided for by law.<sup>11</sup>

## **2. Historical Background**

The right to a MAD can be better understood by reflecting upon its historical development. It is important to recognize that the concept of a *right* to a MAD is relatively new. Prior to the Second World War, the practice of MAD had generally been abandoned. Beginning in medieval times, MAD fell out of practice, and was in fact outlawed in many countries.<sup>12</sup> Some physicians believed they were prohibited from performing the procedure as it appeared to conflict with sections of the Hippocratic oath.<sup>13</sup> Arising out of the global human rights movement, the concept only gained traction in the period following the Second World War.

Beyond the Hippocratic oath, an important barrier to the widespread acceptance and development of MAD, even today, arises out of the moral traditions of the Abrahamic religions (Judaism, Christianity, and Islam) which has helped shape European legal tradition. Abrahamic religious morality has influenced social norms, and has guided the legislative process, of European countries which has in turn limited the positive development of many of the civil rights that are now taken for granted.<sup>14</sup> Besides euthanasia, Abrahamic religious morality has worked to limit the development of the right to an abortion, the right to a divorce, and the right to marriage equality. Abrahamic religious morality remains central to on-going public debates about the scope of these rights.

Abrahamic belief in the sanctity of life plays a key role in the debate about whether a right to MAD should be recognized. Suicide, and by extension PAS, is prohibited within Judaism, Christianity, and Islam.<sup>15</sup> This prohibition led to the criminalization of suicide in some jurisdictions.<sup>16</sup> The impact of religious beliefs on the practice of MAD in Europe will be addressed in the following chapter addressing the ECtHR's jurisprudence.

Today, most of the laws prohibiting suicide have been abolished in order to avoid criminalizing the mentally ill and to encourage them to seek assistance. However, the act of assisting an individual to commit suicide remains widely prohibited. One primary reason for the prohibition of PAS arises out of concerns about the inherent difficulty of proving a deceased individual's desires once they are no longer alive. Without such evidence, assistance to suicide in the eyes of the law is akin to murder, and thus a criminal offence. Although, in law, there remains a clear distinction between suicide and homicide, the lack of evidence may mean that assisting someone to suicide may be charged as murder.

A second concern advanced in support of the prohibition of euthanasia or PAS are fears that permissive legislation may lead down a 'slippery slope', leading to a devaluation of the sanctity of life.<sup>17</sup> This is a legitimate concern; however, it is one which may be effectively countered through the implementation of a sufficiently comprehensive system of oversight. Such a comprehensive system has been suggested by the ECtHR and has been implemented by all states permitting MAD.<sup>18</sup> Despite this oversight, concerns remain that they may not be stringent enough to prevent abuse, particularly with respect to the mentally ill, and minors.

### 3. Two Traditions in Europe

#### a) *The Benelux*

The gradual shift in attitudes towards MAD started in the Netherlands. In 1973, Dutch courts came to the conclusion that a patient's life does not always need to be prolonged if doing so would only lead to unnecessary and purposeless suffering. This decision arose out of a case involving a physician whose mother was suffering from an illness from which she was unlikely to recover. Despite the mother's requests to her treating physicians, she was repeatedly declined to authorize a MAD. As a result, her daughter helped end her mother's life. In response, the daughter was convicted of murder, and sentenced to one week of suspended imprisonment.

However, after having found the daughter guilty of murder, the court took the opportunity to outline a set of criteria a medical doctor could use to defend themselves against the

legal implications of carrying out a MAD.<sup>19</sup> In the aftermath of this case, a public debate on euthanasia arose, leading Dutch courts to recognize the practice of euthanasia as long as particular criteria were met by the physician. This jurisprudence was finally enacted into legislation passed in 2002,<sup>20</sup> ensuring statutory law reflected the judicial framework used by the courts since the 1980's.<sup>21</sup> Following the Dutch example, Belgium legalised the practice of euthanasia in 2002,<sup>22</sup> followed by Luxembourg in 2009.<sup>23</sup> To date, these are the only states in Europe that have allowed euthanasia.

#### b) *Germany and Switzerland*

While euthanasia has been accepted within the Benelux, Germany and Switzerland have instead embraced PAS, each adopting their own unique regulatory framework. In Germany, the legal foundation for PAS arises out of the personal autonomy accorded to the patient under the law.<sup>24</sup> Thus, PAS may be permitted if the patient has a terminal illness, and there is an advance directive stating the patient does not want to be treated.

Switzerland has taken the development of the right to a PAS a step further.<sup>25</sup> Switzerland has embraced rules which differ from most other permissive jurisdictions in two major ways. First, a foreigner in Switzerland for the express purpose of ending their life, can do so using prescription medication acquired in a Swiss clinic.<sup>26</sup> Therefore, it appears as though anyone physically, and financially able to travel to Switzerland may be able to qualify for PAS. Most countries have decided to prohibit foreigners from accessing such services since the treating physician cannot be as intimately involved in the process.<sup>27</sup> The second major difference is that the person administering the procedure does not necessarily have to be a physician.<sup>28</sup> It can be argued that a physician is not necessary since a psychiatrist must first assess a patient's mental state and approve the procedure, and it is the patient themselves, and not the physician, who undertakes the final physical act. Nevertheless, it is certainly a novel approach in a field where the aim has always been to ensure the patient dies in a manner which does not cause any additional suffering. The criteria applied in instances of PAS would be virtually identical to the requirements in jurisdictions which have authorized euthanasia.<sup>29</sup>

**c) Current Controversies**

The most controversial recent development may be the legalisation of euthanasia on very young children which is currently being discussed in both the Netherlands and Belgium. The Dutch *Assessment Act* prohibits euthanasia on children under twelve years of age and euthanasia without the consent of the patient. However, the Dutch *Groningen Protocol*<sup>30</sup> (the 'Protocol') provides guidelines used by medical professionals to decide whether to end the life of a new born child (a child younger than one year of age). The Protocol requires that the decision to commit euthanasia on a child be affirmed by the parents, or legal guardians, of the child.<sup>31</sup>

The Protocol, which has been adopted as a ministerial regulation, sets out a procedure under which a physician's decision is assessed by a review board, exempting the doctor from criminal liability. Due to its status as a ministerial regulation, the Protocol carries a force akin to law. Thus, it expands the scope of the previous *Assessment Act*.

In Belgium, the legislature authorized child euthanasia as an amendment to the Belgian Euthanasia Act. Since February 2014, children suffering from physical pain with no likely end in sight may request to be euthanized. In order to euthanize a child, Belgium, like the Netherlands, requires the affirmative consent of the child's parents, or legal guardian. This model assumes that since a parent or legal guardian is competent to make the decision for themselves they are equally competent to authorize the procedure for their child.<sup>32</sup> Of particular concern with this model is that minors, normally deemed incapable of making decisions affecting their rights under the law, are given broad discretion to decide to pursue euthanasia, albeit with their parent's consent.

Similar concerns exist with regards to the euthanasia of individuals with purely mental illnesses such as Alzheimer's disease and dementia. While informed consent may be given prior to the onset of these diseases, but there are questions about whether this consent is still valid after a patient becomes afflicted by the disease. Given the nature of these mental illnesses, it may be impossible to confirm whether and individual who has given prior informed consent to be euthanized still prefers this course of action given they may not be in significant physical pain.

**III. DEATH WITH DIGNITY BEFORE THE EUROPEAN COURT OF HUMAN RIGHTS: THE PANOPLY OF INVOKED RIGHTS**

The European Court of Human Rights (the 'ECtHR' or the 'Court') has addressed the right to PAS and euthanasia in a number of separate cases. However, the ECtHR has also noted on multiple occasions that the state of the European law governing euthanasia, and its related practices, at this time does not represent a unified affirmation by signatories to the *European Convention* that such a right exists. This declaration has not prevented patients and their relatives from applying to the ECtHR in order to find recourse to a terminal illness. Seeking a death with dignity, applicants presented a variety of arguments to the ECtHR. Many sought the right to a MAD on the basis of what appears at first glance to be a different bundle of rights: the right to life.<sup>33</sup>

Applicants asked the Court to interpret the right to life to include a right to determine one's own time of death, and the right to be free from inhuman or degrading treatment.<sup>34</sup> Applicants argued that such rights included a right to end the suffering from illness through a MAD, or alternatively, that a blanket prohibition on MAD conflicted with and individuals right to a private life.<sup>35</sup> Accordingly, Applicants argued that, through prohibition, governments were interfering in essentially private matters, which should be divorced from the state, and did not implicate the public interest.

All these arguments to secure relief were denied. In cases where the Court was inclined grant a particular request, it cited the divergent views of the member States as the reason why the decision was not theirs to make. Instead, the Court found that the jurisdiction lay with the courts of the member States in question.<sup>36</sup>

As the review above demonstrates, the national laws of the member States of the Council of Europe governing MAD are widely divergent making it difficult for the ECtHR to pronounce on the subject. However, in addition to their domestic legislation, all members have international obligations as signatories to the *European Convention*. These obligations, as well as any further interpretation by the bodies

of the Council of Europe giving content to these obligations, should be considered by the ECtHR.

Despite the ECtHR's reluctance to pronounce upon a right to a MAD, there have been a limited number of cases which have been decided on their merits by the ECtHR. Three cases dealing with MAD demonstrate that a wide spectrum of arguments have been advanced at the ECtHR

In the following section, the fact patterns of each case, which share similarities, are first described in chronological order. Second, each case will be examined according to the articles of *European Convention* relied upon in court. Finally, the legal impact of each decision will be discussed.

### 1. The relevant case-law of the European Court of Human Rights

*Pretty v the United Kingdom*, was the first case before the ECtHR to consider MAD. Diane Pretty had been suffering from the advanced stages of motor neurone disease, which progressively weakened Ms. Pretty's muscles in her arms, legs and chest. As a result, Ms. Pretty had been left physically paralysed. Despite the diseases mental ravages, it was determined that Ms. Pretty retained her full mental capacity. As both euthanasia PAS are prohibited in the United Kingdom, she and her husband sought to a guarantee that no criminal prosecution would follow if her husband assisted her to commit suicide, as she was unable to do so on her own. This request was denied. The denial was subsequently appealed all the way to the ECtHR.<sup>37</sup>

In *Haas v Switzerland*, the applicant was suffering from bipolar disorder. His mental illness caused Mr. Haas great distress leading him to attempt suicide on multiple occasions. With the help of the Dignitas Association, a group advising and assisting those who wish to pursue MAD in Switzerland, Mr. Haas sought the medication necessary to carry out his wishes through the Government. This request was denied. It was appealed to the Federal Court, and then to the ECtHR.<sup>38</sup>

As opposed to the cases above dealing with the terminally ill, *Gross v Switzerland* considered the right of the elderly, but not necessarily ill, to end their lives. Ms. Gross did not want to go through what she felt was the undignified process

of ageing which would lead to the degeneration of her physical and mental capabilities. As required in Switzerland, a psychiatrist examined her and found she was of sound mind but was unwilling to provide the medication she needed. She was repeatedly denied by various medical practitioners. A direct request to the government for the medicine was also denied, as the applicant was not suffering from an illness. This led to a series of appeals which eventually reached the ECtHR.<sup>39</sup> Interestingly, the applicant, whilst awaiting a hearing before the ECtHR, obtained the necessary medication and committed suicide before the case could be heard. Furthermore, neither Ms. Gross, nor her counsel, informed the Court of the steps she had taken. As a result, the ECtHR delivered judgment on the case.

However, Ms. Gross' trial did not end there. Upon becoming aware that Ms. Gross was deceased, the Swiss government took action and informed the Court. The Swiss government's appeal raised a preliminary objection, claiming that that Ms. Gross' application was an abuse of the right to file an application. The Grand Chamber of the ECtHR determined upheld this preliminary objection and subsequently dismissed the application altogether.<sup>40</sup> However, the decision to dismiss the application came after the Court had already passed judgment, as such, the decision still exists and can be analysed to provide insight on the way the ECtHR may rule in subsequent applications.

A recent decision, released in June 2015, in a French case considered palliative sedation. Although palliative sedation is not within the scope of this paper, *Lambert and others v France*<sup>41</sup> is useful as it may help in the interpretation of the scope of the right to death in the *European Convention*. The Applicants in *Lambert* were the parents and siblings of Mr. Lambert, a tetraplegic in a vegetative state as the result of an accident. There was no chance of recovery. As allowed under French law, Mr. Lambert's wife began the extensive procedure to request palliative care. During this application process, all possible legal protections were invoked as a result of a dispute between two sides of the family, leading the parents and others to apply to the Court. The parents held the view that providing palliative care would violate their religious beliefs as observant Catholics. They also argued that that palliative care was a violation of the right to life.<sup>42</sup> Although there

are questions whether this view is correct, as standard palliative care typically does not extend or shorten a patient's life span.

Having discussed the underlying facts of the above-mentioned cases it is useful to explore the argumentation, and the several Articles of the *European Convention* considered by the Court in reaching its conclusions.

### A. The Right to Life

Perhaps the most obvious related right is the right to life, found in Article 2 of the *European Convention*. This right, often held to be one of the most important, if not the most important, provision of the Convention provides that life nearly always needs to be protected. Article 2 Paragraph 1 reads:<sup>43</sup>

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

As it is, the only exception to this protection is an act of self-defence, or in defence of a third party as laid out in Paragraph 2. The death penalty has now been abolished on account of Protocols 6 and 13 to the *European Convention*. This means that there is an extensive positive obligation on the state to protect life. This obligation is broad in scope and goes so far as to place a duty on the government to actively protect a suicidal individual in its care.<sup>44</sup>

In *Pretty v the United Kingdom*, the Applicant argued that Article 2 should be interpreted in a way so that a government's obligation to protect life would only be engaged when it sought to protect third parties, rather than protecting a mentally sane individual against themselves.<sup>45</sup> In other words, the protection of the right to life should not be exercised in questions of euthanasia, or PAS. In the eyes of the Court however, no particular interpretation of Article 2 could imply that an individual has a right to determine the point in time of his/her death. Consequently, it follows from this holding that no right to die exists under this article.<sup>46</sup> Thus, the obligation of the government to protect life is absolute, and the reading of Article 2 presented by the Applicant was considered to a 'distortion of language' contained in the *European Convention*. Due to the clarity, and seemingly unambiguous

decision of the ECtHR, the *Pretty*-case remains, to date, the last attempt to read in a right to a MAD the guarantee of a right to life in Article 2 of the *European Convention*.

However, Article 2 was once again advanced in *Lambert and others v France*. Now the question dealt with palliative care rather than MAD. The applicants contended that the State could not allow the withdrawal of a patient's nutrition and hydration, as part of its obligations under Article 2 to protect the right to life.<sup>47</sup> The applicants further submitted that this conduct would in fact amount to the commission of euthanasia.<sup>48</sup> In its decision, as with many decisions before,<sup>49</sup> the ECtHR held that broad discretion must be given to member states in order to allow them to develop their own legislation addressing complex questions of life and death.<sup>50</sup> However, in order to answer the challenge brought according Article 2, the Court applied three rules to assess whether the a States positive obligation to protect life under Article 2 was violated.<sup>51</sup> First, the Court must determine if there is a functional regulatory framework; second, the Court must take into account the wishes of the individual in combination with the opinions of medical professionals; third, the court will considering if functional regulatory framework permits recourse to the courts in case of doubts about whether a patient's interests are being served. In the end, no violation of Article 2 was found, and the assessment criteria were thus met: the French domestic laws allowing the suspension of treatment with the possibility of death were consistent with the provisions of the *European Convention*.<sup>52</sup>

Despite the ruling, in the eyes of the ECtHR, *Lambert* does not directly affirm a right to a MAD under Article 2. However, there are remarkable similarities between what the test advanced by the ECtHR in *Lambert*, and the previously discussed regulatory framework for euthanasia adopted within the Benelux. This suggests that the Court may, in the future, be willing to recognize a right to a MAD under a similar framework.

### B. The Right to Be Free from Inhuman or Degrading Treatment

One argument which has been advanced, with a potentially higher likelihood of success, posits that unnecessarily prolonging a patient's life despite their express wish to end their life

may be inhuman or degrading treatment as it prolongs the suffering experienced by the patient. Article 3 of the European Convention seeks to protect individuals against inhuman and degrading treatment, as well as torture. Article 3's single paragraph states:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.<sup>53</sup>

The right expressed within Article 3 has no exceptions whatsoever, and certain exemptions which apply to some other rights do not apply.<sup>54</sup> Article 3 is absolute in nature and is worded so as to avoid any dispute over the content of the right enshrined within it.<sup>55</sup> This should make it relatively easy to determine the content of a state's obligation, and to determine if Article 3 is broad enough to permit MAD in order to protect an individual from unnecessary suffering.

Article 3 was advanced as an argument in *Pretty v the United Kingdom*. In *Pretty*, the ECtHR held that Article 3 is one of the most fundamental provisions contained within the European Convention, and represents one of the core principles of democracy: that no government can violate an individual's bodily integrity.<sup>56</sup> This ruling reflected the holding in *Soering v the United Kingdom* which concerned the extradition of a foreign prisoner suffering from AIDS. *Soering* demonstrated the wide scope of a state's obligation to protect individuals under its authority from inhuman or degrading treatment.<sup>57</sup> In *Pretty*, the Applicant argued that Article 3 created a positive obligation upon a State to take action to stop her suffering, making the government's inaction a violation of her rights. The Applicant argued that the complete ban on PAS in the United Kingdom, and the government and courts unwillingness to make an exception given Ms. Pretty's particular circumstances, namely that Ms. Pretty was of a sane mind, amounted to a form of inhuman or degrading treatment.<sup>58</sup> While, the ECtHR recognized the Applicants degenerating illness, and unavoidable death, would be a difficult burden to bear, it concluded by holding that Article 3 simply did not impose a positive duty upon a State to assist an individual to end their life.<sup>59</sup>

No further attempts have been made to advance a positive right to a MAD based on Article 3's prohibition against inhuman or degrading treatment.

### C. The Right to Private Life

In its most basic form all applicants requesting the right to a MAD before the ECtHR are truly requesting a right to determine their own fate. In its most basic form this right requests that the government take a hands-off approach, essentially giving an individual autonomy over a personal matter over which the state arguably has little interest.

The right to a MAD is one of many areas susceptible to the arguably arbitrary morality embraced by governments around the world. This morality often governs an individual's immutable personal characteristics such as an individual's sexual identity, or personal choices such as reproductive practices.<sup>60</sup> Debate continues about whether these issues should be properly outside of the scope of a government's control and oversight given their personal nature. In the *European Convention*, Article 8 contains the right to a private life:

Everyone has the right to respect for his private and family life, his home and his correspondence.<sup>61</sup>

The basic rule laid out therein is in principle without any exceptions, except for those provided in Paragraph 2 of the same Article:

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.<sup>62</sup>

This is a standard list of exceptions which can be applied, and have been included, to protect the greater good of society. However, it is arguable that there is nothing more private than an individual's right to choose the manner and timing of their death. Furthermore, it can be argued that giving an individual such a right is unlikely to have a significant negative effect on the community as a whole, especially if the right to a MAD is implemented with a of sound regulatory framework governing acceptable practices and procedure, as is the case all jurisdictions allowing euthanasia.

In *Pretty*, the Applicant argued that the right to a private life encoded in Article 8 represents the embodiment of an individual's



right to self-determination. It follows that the strongest expression of self-determination an individual can make is to decide when and how to die. The Court, acknowledged that the notion of autonomy embedded in Article 8 represented the embodiment of the notion of personal autonomy within the *European Convention*,<sup>63</sup> and protected an individual's right to pursue dangerous conduct including refusing medical treatment.<sup>64</sup> However, the ECtHR held that a state's duty to protect life trumped the Applicants persuasive argument under Article 8.

In rejecting Ms. Pretty's argument the ECtHR held that while the treatment of Ms. Pretty may amount to a violation of the first paragraph of Article 8,<sup>65</sup> concerns for the terminally ill as a group precluded the Applicant's argument. The decision held that because the terminally ill are vulnerable and may not be able to fully comprehend the nature of their decision the Court does not consider a state's action to protect this class of individuals an unjustified interference with Article 8.<sup>66</sup> Although concerns for the terminally ill as a group may be justified, the Court's holding effectively disregarded Ms. Pretty's personal circumstances, upon which it had been asked to rule.<sup>67</sup>

In *Haas v Switzerland*, Mr. Haas argued that the requirement in Switzerland which called for a thorough psychological assessment in order to obtain medication needed to commit suicide was in violation of his right to a private life as well.<sup>68</sup> The Court held that, although an individual may have a right to terminate their own life in Switzerland,<sup>69</sup> it is essential that access to these services are well regulated due to the finality of the decision being made.<sup>70</sup>

In *Gross v Switzerland* Article 8 was once again advanced. Ms. Gross alleged that denying her the medication she required to end her life in dignity violated her private right to choose the time and manner of her death. Citing the *Haas* case, the ECtHR pointed out that an individual capable of making sound choices should be allowed to decide when to end their life.<sup>71</sup> However, the regulations in Switzerland only provided for patients with a medical condition, whereas Ms. Gross only suffered from being elderly which is not a medical condition per se.<sup>72</sup> This made applying the governing provisions to Ms. Gross' case difficult. While this led to a possible violation of her rights, the Court only required the State to clarify the existing

regulations. The Court did not provide its opinion on how regulations should be amended, in line with the doctrine of the margin of appreciation giving deference to State legislatures.<sup>73</sup>

#### D. Life and Death in the Decisions of the Court, Read Together

The case law discussed above makes it quite clear that the Court has no intention to recognize a positive right in the European Convention to a MAD. However, when holdings in the cases mentioned above are taken as a whole in conjunction with the Courts reasoning, a number of preliminary conclusions can be drawn.

As mentioned above, according to the ECtHR in *Pretty*, the right to life does not contain a right to a MAD. However, the right does directly prohibit the practice of the terminating a patient's life by withholding of medical care and food as seen in *Lambert*. Although it is likely a distinction without a difference, these holdings can seemingly be justified because the performance of the latter act is not severe enough to be prohibited as it is merely the cessation of an action, while the former is perceived as too severe as it requires an intentional action to end the life of a patient. A second justification arises because the notion of death does not fit clearly within a right created to protect life. For example, in *Pretty*, the Applicant's private life was made subordinate to the protection of the sanctity of life.

With respect to Article 3's guarantee seeking to preventing inhuman or degrading treatment, no attempts have been made to extend the obligation of the State to end suffering from disease since *Pretty*. So, according to existing caselaw, there is no such obligation.

The personal autonomy of an individual has always been recognized by the Court. This right also shows the most promise to be used as an avenue through which the ECtHR may recognize the right to a MAD. However, a right to death remains subject to the supremacy of the right to life.

In the next part of this paper, we analyse some key aspects of the interpretation of the right to life in the jurisprudence of the Court and then focus on the notion of the right to life in the context of assisted death. Through the analysis of the evolving interpretation by the

Court of the right to life, we argue that a right to death with dignity can be read into the right to life under the *European Convention*, permitting MAD.

### E. The interpretation of the “Right to Life” in the jurisprudence of the European Court of Human Rights

Before turning to an analysis of the right to life in the specific context of assisted death, it is relevant to discuss the interpretation of the right to life in the Court’s jurisprudence. Article 2 of the *European Convention* provides for the “right to life” and its protection “by law”.<sup>74</sup> Importantly, it has been observed that the right to life is, in many respects, “the most basic right of all, as, without it, all the other rights become [illusory]”.<sup>75</sup> A distinctive “pre-eminence” is given to Article 2 throughout the Court’s jurisprudence due to its supreme significance.<sup>76</sup> This is evidenced in part by the fact that the right is ‘non-derogable’: it may not be denied even in a “time of war or other public emergency threatening the life of the nation.”<sup>77</sup> Furthermore, the Court has stated that Article 2 must inform the interpretation of other parts of the Convention, such as Article 8.<sup>78</sup> Individual member states also generally hold the right to life in higher regard than other commonly invoked rights.<sup>79</sup> Tellingly, the right to life has been described by the Court as “one of the basic values of the democratic societies making up the Council of Europe” (*Makaratzis v Greece*).<sup>80</sup>

In the context of Article 2, “life” is limited to human life, as opposed to animal life or juridical-person life.<sup>81</sup> Beyond this, the precise meaning of “life” is not readily observable upon consideration of the Convention.<sup>82</sup> Furthermore, it has been suggested that the Court’s “interpretation and application of Article 2 has left a large degree of ambiguity inherent in Article 2 even after 60 years of consideration”.<sup>83</sup> One thing that is known is that only in certain narrowly prescribed situations may an individual have their right to life breached. For example, when the death penalty is provided for by law following a criminal conviction or when the State uses force in a manner that is “no more than absolutely necessary” (“a stricter and more compelling test... than that normally applicable”- *Mc Cann and Others v United Kingdom*<sup>84</sup>) to protect someone from unlawful violence.<sup>85</sup> In

saying this, it has been noted that the legality of the death penalty is now questionable, at least when a member state is experiencing “times of peace” (according to Protocol No. 6).<sup>86</sup>

Not only does Article 2 prevent the State from intentionally taking an individual’s life but it also imposes a positive obligation upon the State “to take appropriate steps to safeguard the lives of those within its jurisdiction” (see *LCB v United Kingdom*).<sup>87</sup> This means that mere negligence on the part of the State in protecting life has the potential to draw liability.<sup>88</sup> The obligation on States to protect life has been recognized in a variety of contexts, including dangerous industrial activities – whether privately or publicly operated – due to the fact that it is States which have the authority to establish safety regulations (*Öneryildiz v Turkey*).<sup>89</sup> This duty to protect life also applies in circumstances where individuals in the State’s care (such as a detainee, psychiatric patient, or one carrying out mandatory military service) pose a “‘real and immediate risk’ of suicide” (*Keenan v United Kingdom, Ataman v. Turkey*).<sup>90</sup> The right to life also requires States to investigate every death brought about by a non-natural cause<sup>91</sup>.

It is important to note that just because the State is not directly responsible for a given death that does not necessarily mean that Article 2 will not apply (*Angelova and Iliev v Bulgaria*).<sup>92</sup> In saying this, Article 2 ought not to be interpreted in such a way that it “impose[s] an impossible or disproportionate burden on the authorities” (*Osman v the United Kingdom*).<sup>93</sup> Importantly, the specifics of the State’s obligation in relation to the right to life are highly contingent upon the facts of each particular situation<sup>94</sup>.

### F. The “Right to Life” and Medically Assisted Death

The right to life has been described as the “most important interest at stake in the debate involving physician assisted suicide”.<sup>95</sup> As such, it is important to consider how the Court treats MAD in light of the right to life.

It has been noted that there is a “consistent emphasis” on the State’s duty to “protect life” found throughout the Court’s jurisprudence on the right to life.<sup>96</sup> The idea is to protect life with virtually no regard from the Court as to the quality of the life that it seeks to protect.<sup>97</sup> Furthermore, the right to life has been held not

to have a negative aspect; specifically, in *Pretty v United Kingdom*, a unanimous Court stated that “Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die”<sup>98</sup>. It has been noted that the Court justified this holding “from a purely legal perspective, giving emphasis to a literal and systemic interpretation and eschewing a more ‘dynamic’ or ‘evolutive’ approach”.<sup>99</sup> More will be said about the reasoning for the Court’s position below.

It has been suggested that the Court’s posture in relation to the right to life in connection with PAS emanates from the diversity with which the various European member States approach PAS<sup>100</sup> (ultimately stemming from the contentious nature of the practice). Given this diversity, the Court seems to have decided to invoke a “self-imposed mechanism of judicial restraint”, considered to be a “core principle” of the Court known as the “margin of appreciation”.<sup>101</sup> This doctrine stands for the notion that deference should be given to member States regarding issues in which there is no clear or detectable consensus.<sup>102</sup> The margin of appreciation plays a particularly noteworthy role in the reasoning of *Pretty*.<sup>103</sup> Although this doctrine was not openly discussed by the Court in relation to the right to life, it has been argued that the application of the margin of appreciation “to the issue raised in... *Pretty* is the quintessential illustration of its proper usage”.<sup>104</sup> The margin of appreciation also played a key role in *Haas*.<sup>105</sup>

Another explanation for the Court’s stance is the influence that religion has had – and continues to have – on the way human rights are interpreted. The “right to life” tends to be used synonymously/interchangeably with the “sanctity of life”.<sup>106</sup>

Yet another reason for the Court’s refusal to include assisted death within the right to life is the historical context/legacy of the Convention.<sup>107</sup> As one scholar notes, the Convention was brought into existence following World War Two – one of the most damaging atrocities known to humankind.<sup>108</sup> It was concerned with constructing a “new Europe” – with casting a vision for a better society<sup>109</sup>. Contentious ethical issues such as PAS were not in contemplation.<sup>110</sup> Given that the Convention was not designed to encompass issues of this nature, the Court has

been hesitant in its approach towards medically assisted death.<sup>111</sup>

### G. Interpreting the “Right to Life” as Encompassing Assisted Death

As noted above, the Court held in *Pretty* that “Article 2 cannot, without a distortion of language, be interpreted as conferring... a right to die”.<sup>112</sup> However, it has been submitted that the Court’s “distortion of language argument” can be overcome.<sup>113</sup> Specifically, Article 2 guarantees that no one will be *deprived* of his/her life.<sup>114</sup> To be deprived of something is to have said thing taken away against one’s will.<sup>115</sup> Given this, it has been argued that it does not make sense to “say that someone is deprived when he urgently and insistently requests it”.<sup>116</sup> Following from this line of reasoning, the only way to make sense of this dilemma is if one interprets the “right to life” as a sort of “duty to live”.<sup>117</sup> However, it has been noted that such an interpretation is inconsistent with the very title of the Convention – which purports to protect rights and freedoms; not impose duties and obligations.<sup>118</sup>

In *Pretty*, a number of arguments pertaining to Article 2 were advanced in hopes of securing a right to die. For example, it was argued that Article 2 protects “the right to life and not life itself”.<sup>119</sup> As such, it protects the right to *choose* to live.<sup>120</sup> As well, it was argued that by not being granted permission to have assistance with suicide, the Court would, in effect, be declaring the countries which do permit assisted dying to be in breach of Article 2.<sup>121</sup> Ultimately, the Court did not accept these submissions and found that there was no violation of Article 2<sup>122</sup>.

There are also ethical/moral, as opposed to legal, arguments pertaining to “the right to life” and its relationship – if any – to a “right to die.” For example, one scholar has noted that while a common criticism of PAS is that it leads to an overall devaluation of human life or a devaluing of every human life<sup>123</sup> (which is for obvious reasons problematic), this can be overcome. Specifically, it has been suggested that while life undoubtedly has intrinsic value, a portion “of its value lies in the fact that our life is, in part, our own creation”.<sup>124</sup> Individuals choose values and assign dignity (at least in part) to their own lives. Thus, if one believes that to continue living life under a given set of circumstances (e.g. severe

illness, untreatable pain) would devalue said life, “it is the very intrinsic value of life itself that mandates ending it”.<sup>125</sup> Assisted death can be seen as an expression of value “of a particular life”.<sup>126</sup> It almost goes without saying that one who places more emphasis on the “investment” that God or nature has made in human life (rather than the human component) is unlikely to be persuaded by this argument.<sup>127</sup>

The case *X v. Germany* can provide a means of transforming assisted dying into a protected right in a manner closely connected to the right to life.<sup>128</sup> This case concerned a prisoner who went on a hunger strike. He was eventually forced to eat (against his will). The Court held that this sort of treatment was acceptable because the authorities responsible were simply acting in the “best interest” of the prisoner.<sup>129</sup> If applied in the PAS context, the logic behind this case allows one to at least argue that denying a terminally ill individual’s request to die with dignity is to dispense with the best interests of said individual.<sup>130</sup>

Thus, the right to life should be interpreted in a fluid manner, taking into account not an abstract idea of the “sanctity of life” but rather the human component of life, and the human desire to live, and that the right to a MAD should be read in Article 2 of the *European Convention*. As a point of comparison, considering the parallel development of the jurisprudence on assisted dying before the European Court and in Canada, the next section examines the evolution of Canadian law on assisted dying.

#### IV. THE EVOLUTION OF ASSISTED DEATH IN CANADIAN JURISPRUDENCE: A POINT OF COMPARISON

Although Canada is not a party to the *European Convention*, a brief survey of its judicial response to PAS is nonetheless instructive given the similarities between the rights guaranteed by the *Canadian Charter of Rights and Freedoms* (the ‘*Charter*’) and the *European Convention*. Jurisprudence emanating from the SCC demonstrates that despite previous proclamations denying a right to MAD exist within the *Charter* have been reevaluated. It is important to consider the reasons for this change in position, the content of the right proclaimed by the SCC, and whether this reevaluation could be followed by the ECtHR.

When the right to PAS came before the SCC in 1993, it was held that Canada’s blanket prohibition on PAS as set out in the *Criminal Code* did not violate any of the rights or freedoms protected by the *Charter*,<sup>131</sup> and in particular the right to life, liberty and security of the person (Section 7). Twenty-one years later, the Supreme Court had the opportunity to re-evaluate its prior decision. The Court unanimously “overturned” itself, ultimately rendering Canada’s blanket prohibition on PAS – the same provision previously upheld as constitutional- “void and of no legal effect”.<sup>132</sup> The basis of the Court’s decision to strike down the ban was that it violates Section 7 of the *Charter*.<sup>133</sup> Given the stark contrast between these two decisions – *Rodriguez* (1993) and *Carter* (2015) – a comparative analysis may demonstrate the reasoning which allowed the SCC to revise its position, and whether a similar revision is likely to be made by the ECtHR.

The facts giving rise to both the *Rodriguez* and the *Carter* cases are noticeably similar. Both decisions centre largely on individuals – Sue Rodriguez and Gloria Taylor respectively – who had been diagnosed with amyotrophic lateral sclerosis, a fatal neurodegenerative disease which causes an irreversible and continuing break down in muscle capacity.<sup>134</sup> Both individuals shared the desire to exercise at least some control over the manner and timing of their death.<sup>135</sup>

The arguments advanced by Ms. Rodriguez and Ms. Taylor displayed a number of similarities, with a couple of noteworthy differences. Specifically, in *Rodriguez*, it was argued that the prohibition on PAS violates s. 7 of the *Charter* – as well as s. 12 (guaranteeing freedom from cruel and unusual punishment), and s. 15 (guaranteeing equality rights) – primarily by precluding one from having influence over one’s death.<sup>136</sup> This line of reasoning – as has been noted in the scholarship – is an appeal to autonomy and dignity.<sup>137</sup> As noted above, the Court did not accept this argument as the blanket prohibition was seen as necessary to protect vulnerable people from being pressured into choosing PAS.<sup>138</sup>

As mention above, similar concerns seeking to protect the greater good of society motivated the ECtHR to reject a right to a MAD under Article 8 guaranteeing a right to a private life. The arguments made to the ECtHR advanced

similar notions about placing restrictions upon individual autonomy.

In *Carter*, it was argued that the choice between taking one's own life prematurely and renouncing all control over the means and timing of one's own death – an effect of the impugned blanket prohibition on PAS – infringed upon one's right to life.<sup>139</sup> Interestingly, scholars have observed that this particular argument goes further than the argumentation present in *Rodriguez* by appealing to inconsistency (i.e. the ban on PAS – which is intended to preserve life – actually jeopardizes life) and “because consistency is a matter of logic, cases built on it tend to be more convincing than those built on the standard stuff of values.”<sup>140</sup> This new argumentation in *Carter* found favour with the Court as it stated that “a prohibition on assisted death would create a duty to live and such a duty would be inconsistent with the legality of consenting to the withdrawal or refusal of life-sustaining treatment”.<sup>141</sup> Furthermore, the Court suggested that while a profound respect for the value of human life lies at the heart of Section 7, it “also encompasses life, liberty and security of the person during the passage to death.”<sup>142</sup> Thus, while the need to protect the vulnerable was acknowledged, the blanket prohibition on PAS – insofar as it affects “competent, fully informed, and un-coerced individuals” – was found to be overbroad and therefore not in accordance with the principles of fundamental justice.<sup>143</sup>

In *Carter*, the Court provided at least two reasons for reversing the position it had taken in *Rodriguez*. The first is “changes in Charter jurisprudence... [especially in relation to] the doctrine of overbreadth”.<sup>144</sup> The second is changes in the social “factual matrix” (i.e. the advent of regulated assisted dying in other countries).<sup>145</sup> In fact, it has been argued that decision hinged primarily on whether a blanket prohibition was necessary to protect the vulnerable and further, that it was the example of other jurisdictions who have successfully implemented PAS which tipped the balance.<sup>146</sup>

One again, the SCC's decision recognized the argument which has been rejected by the ECtHR with respect to Article 2 of the *European Convention*, guaranteeing the right to life. Notably the SCC was clear that a right to life, liberty, and security of the person does not impose a “duty to live”. This distinction has not been seriously advanced before the ECtHR and may

have a higher chance of success as it advances a legal argument based on logic, rather abstract and subjective concepts such as dignity, and personal autonomy which may be understood differently within different jurisdictions and segments of society.

Rather, the SCC's decision appears to be a compromise position, one which recognizes personal autonomy, order parliament to legislate a framework to govern the practice according to social and legal norms, without imposing a positive obligation on the state to provide access to MAD services. This may be an avenue through which the ECtHR could achieve a compromise between its desire to recognize the legislative autonomy of the signatories to the *European Convention*, while recognizing that a blanket prohibition on MAD practices without recognizing an individual's unique personal circumstances and beliefs is overbroad. This may not amount to a recognition of a positive right on the government to provide MAD services, but could open the door to specialized organizations willing to undertake the necessary procedures.

Thus, the Canadian experience in relation to the legalization of assisted death has been to look at other jurisdictions and learn lessons that could be applied in the Canadian context. In Canada, the right to life has allowed for the inclusion of a right to assisted death, while not imposing a positive obligation on the state to provide MAD services. The study of the Canadian experience and analysis of the evolution of assisted death before the European Court. In the same way Canada has looked to European jurisdictions for guidance, the ECtHR may be able to borrow from Canadian jurisprudence allowing signatories of the *European Convention* to develop their own legislative frameworks which do not impose complete bans upon the practice. In this sense, European states would be the functional equivalent to Canadian provinces who have been empowered to develop their own frameworks.

## V. END OF LIFE BEFORE THE EUROPEAN COURT: TOWARDS A RECOGNITION OF THE RIGHT TO DEATH WITH DIGNITY?

In Europe, an initial overview of the number of countries providing access to MAD

makes it abundantly clear that a consensus about the legality of the practice has not been reached. It has been left up to the individual legislatures of the member States, which in many cases are reluctant to embrace MAD for their own reasons. At this time, the right to a death in dignity is not formally recognized under the *European Convention*.

However, the review of the state of the law and jurisprudence within European jurisdictions, and the evolution of the law in Canada, a number of recommendations can be made on how a right to MAD under the *European Convention* could be developed. Taking into account the requirements for euthanasia with in the Benelux, along with the practice of PAS in Switzerland and Germany it appears that a level of regulation at a local level can actually help develop new strategies to ensure that access to MAD services are not abused.

It seems that the framework that is included in *Lambert v. France* actually serves as a blueprint for an effective MAD system. A regulatory framework with clear rules and effective review procedures, the inclusion and consideration of the patient's wishes, and the ability of family and guardians to protect the best interests of the patient through a judicial body takes away most of the criticisms surrounding the right to assisted death. Such a framework would allow and individual to make a personal decision regarding timing and manner of their death in the certainty that their wishes will be

respected and that they will be protected by procedural safeguards.

In Canada, the SCC has been careful to avoid developing a system of positive rights which would place an obligation on the State to provide services which may overburden the government or be politically controversial when no consensus exists. However, this reluctance has not stopped the SCC from taking steps to ensure that moralistic views held by particular segments of society do not conflict with the desires of those who do not hold such views. It is likely the ECtHR could pursue a similar path by stating that the right to life does not impose a duty to live, and subsequently holding that neglecting to develop a permissive framework respecting an individual's autonomy and beliefs is akin to a State subjecting an individual to inhuman or degrading treatment.

The Canadian example demonstrates how, in the span of two decades, judicial decisions believed to be final can be reversed. The jurisprudence from the ECtHR indicates that to date all arguments seeking the Court to declare a right to MAD have failed. However, it is possible that future arguments based in logic rather than abstract principles, and calling attention to the *Carter* decision in Canada, may help the Court revise its position to declare that current prohibitions against MAD are a violation of the rights enshrined in the *European Convention*.

NOTES

1. *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) [ECHR or Convention].
2. *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) [ECHR or Convention].
3. Netherlands, The State Commission on Euthanasia, *Rapport van de Staatscommissie Euthanasie Volume 1* (The Hague, Staatsuitgeverij, 1985) at 26.
4. Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002, Stb 2001, 194 (entered into force 2002) [The Dutch Act]; The Belgium Act of Euthanasia, 2002, c 2 s 3, [Belgium Euthanasia Act].
5. The Dutch Act, *supra* note 3.
6. Belgium Euthanasia Act, *supra* note 3 at 3.
7. Euthanasia and Assistance to Suicide Act, 2009 at 2 [Luxembourg Euthanasia Act].
8. *Criminal Code* (Germany), 1998, s 216.
9. *Swiss Criminal Code* (Switzerland), 2016, s 115.
10. John Griffiths, Heleen Weyers & Maurice Adams, *Euthanasia and Law in Europe*, 1st ed (Oxford, UK: Hart Publishing, 2008) at 463.
11. *Ibid* at 474-476.
12. Joseph M Pierre, "Culturally Sanctioned Suicide: Euthanasia, Seppuku, and Terrorist Martyrdom" (2015) 5:1 World J Psychiatry 4 at 5.
13. Kyriaki Mystakidou et al, The Evolution of Euthanasia and Its Perceptions in Greek Culture and Civilization, (2005) 48:1 Perspect Biol Med 95-104.
14. *Ibid*.
15. See the Talmud, *Avodah Zarah*, 18a; the Bible 1 Corinthians 6:19 – 20; and from the Quran 2:195.
16. See e.g. *Suicide Act*, 1961 (UK), 9 & 10 Eliz 2, c 60, s 1; *Criminal Law (Suicide) Act*, 1993 (Ireland), s 2 (1).
17. David Benatar, "Assisted Suicide, Voluntary Euthanasia and the Right to Life" in Jon Yorke, ed, *The Right to Life and the Value of Life: Orientations in Law, Politics and Ethics* (Farnham: Ashgate, 2010) at 302 [Benatar]; Tom Campbell, "Euthanasia as a Human Right" in Sheila AM McLean, ed, *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate, 2006) at 451-452.
18. Benatar, *supra* note 16.
19. *Postma*, District Court, Leeuwarden, 21 February 1973, NJ 1973 N° 183) (Netherlands).
20. Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (*Act for the Assessment of Ending Life upon Request and Assisted Suicide*, 2002, Netherlands) [*Assessment Act*].
21. Judith A C Rietjens et al, "Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?" (2009) 6:3 Journal of Bioethical Inquiry 271 at 272-273.
22. Belgium Euthanasia Act, *supra* note 3.
23. Luxembourg Euthanasia Act, *supra* note 6.
24. Jochen Taupitz & Amina Salkic, "Advance Directives and Legality of Euthanasia under German Law" in Stefania Negri, ed, *Self-determination, Dignity and End-of-Life Care: Regulating Advance Directives in International and Comparative Perspective* (Leiden: Martinus Nijhoff, 2011) at 350-352.
25. Georg Bosshard, "Switzerland" in John Griffiths, Helen Weyers & Maurice Adams, eds, *Euthanasia and Law in Europe* (Oxford: Hart, 2008) 463 at 470 [Bosshard].
26. *Ibid*.
27. See e.g. *Koch v Germany*, No 497/09, [2012] V ECHR [Koch].
28. Bosshard, *supra* note 24, at 471-472.
29. *Ibid* at 473.
30. Eduard Verhagen & Pieter J J Sauer, "The Groningen Protocol – Euthanasia in Severely Ill Newborns" (2005) 352:10 The New England Journal of Medicine 959.
31. Staatscourant (Netherlands Gazette) vol 46 p 10 s 2.3 (6 March 2007).
32. *Belgium Euthanasia Act*, *supra* note 3 as amended by *Act amending the Act of 28 May 2002 on euthanasia*, sanctioning euthanasia for minors 28 February 2014 (Belgium).
33. ECHR, *supra* note 1 art 2.
34. ECHR, *ibid*, art 3.

35. ECHR, *ibid* art 8.
36. *Koch*, *supra* note 26, at para 71.
37. *Pretty v UK*, No 2346/02, [2002] IV ECHR at paras 7-15 [*Pretty*].
38. *Haas v Switzerland*, No 31322/07, [2011] I ECHR at paras 7-18 [*Haas*].
39. *Gross v Switzerland* [GC], No 67810/10, [2013] ECHR at paras 6-21 [*Gross*].
40. *Gross*, *ibid* at paras 16-19, 37.
41. —
42. —
43. ECHR, *supra* note 1 art 2(1).
44. *Keenan v United Kingdom*, N<sup>o</sup> 27229/95, [2001] III ECHR at para 91.
45. *Pretty*, *supra* note 40 at para 35.
46. *Pretty*, *ibid* at para 39.
47. *Lambert*, *supra* note 44 at para 113.
48. *Lambert*, *ibid* at para 119.
49. *Haas*, *supra* note 41 at para 55; *Koch*, *supra* note 26 at para 70.
50. *Lambert*, *supra* note 44 at paras 144, 147.
51. *Lambert*, *ibid* at para 143.
52. *Lambert*, *ibid* at para 182.
53. ECHR, *supra* note 1 art 3.
54. ECHR, *ibid*, art 15.
55. Nigel S Rodley, "Integrity of the Person" in Daniel Moeckli et al, eds, *International Human Rights Law* (Oxford: Oxford University Press, 2010) 212.
56. *Pretty*, *supra* note 40 at para 49.
57. *Soering v UK*, No 14038/88, [1989] ECHR at para 88.
58. *Pretty*, *supra* note 40 at paras 44–46.
59. *Ibid* at paras 55-56.
60. *Ibid* at para 61.
61. ECHR, *supra* note 1 art 8 (1).
62. *Ibid*, art 8(2).
63. *Pretty*, *supra* note 40 at para 65.
64. *Ibid* at para 63.
65. *Ibid* at para 67.
66. *Ibid* at para 74.
67. *Ibid* at para 59.
68. *Haas*, *supra* note 41 at para 32.
69. *Ibid* at para 51.
70. *Ibid* at paras 56-57.
71. *Gross*, *supra* note 42 at para 59.
72. *Ibid* at para 65.
73. *Ibid* at para 69.
74. Brunilda Bara & Gentian Vyshka, "A Right to Die: A Comparing Discourse of Case Laws in United States of America, European Court of Human Rights, United Kingdom and Albania" (2014) 5:9 *European Journal of Bioethics* 135 at 145.
75. Juliet Chevalier-Watts, "A Rock and a Hard Place: Has the European Court of Human Rights Permitted Discrepancies to Evolve in Their Scrutiny of Right to Life Cases?" (2010) 14:2 *Intl JHR* 300 at 301; Laura-Cristiana Spataru-Negură, "Death on Request" (2011) *Challenges of the Knowledge Society* 794 at 794.
76. HJJ Leenen, "Assistance to Suicide and the European Court of Human Rights: The *Pretty* Case" (2002) 9 *Eur J Health L* 257 at 269.
77. Daniel Rietiker, "From Prevention to Facilitation? Suicide in the Jurisprudence of the ECtHR in the Light of the Recent *Haas v Switzerland* Judgment" (2012) 25 *Harv Hum Rts J* 85 at 89 [Rietiker].
78. Shawn HE Harmon & Nayha Sethi, "Preserving Life and Facilitating Death: What Role for Government after *Haas v Switzerland*?" (2011) 18 *Eur J Health L* 355 at 360; Isra Black, "Commentary: Suicide Assistance for Mentally Disordered Individuals in Switzerland and the State's Positive Obligation to Facilitate Dignified Suicide" (2012) 20 *Med L Rev* 157 at 162.
79. Rietiker, *supra* note 80 at 122.
80. End of Life and the European Convention on Human Rights, "Fact Sheet", *European Court of Human Rights Press Unit*, at 1 [Fact Sheet].
81. Elizabeth Wicks, "The Meaning of 'Life': Dignity and the Right to Life in International Human Rights Treaties" (2012) 12 *Hum Rts L Rev* 199 at 200.
82. *Ibid* at 200-201.
83. *Ibid* at 201.
84. *Ibid* at 1.
85. Brunilda Bara & Gentian Vyshka, "A Right to Die: A Comparing Discourse of Case Laws in United States of America, European Court of Human Rights, United Kingdom and Albania" (2014) 5:9 *European Journal of Bioethics* 135



- at 145; Juliet Chevalier-Watts, "A Rock and a Hard Place: Has the European Court of Human Rights Permitted Discrepancies to Evolve in Their Scrutiny of Right to Life Cases?" (2010) 14:2 *Intl JHR* 300 at 302.
86. Ben Livings, "A Right to Assist? Assisted Dying and the Interim Policy" (2010) 74 *J Crim L* 31 at 44; Gregor Puppink & Claire de La Hougue, "The Right to Assisted Suicide in the Case Law of the European Court of Human Rights" (2014) 18 *Intl JHR* 735 at 735.
87. *Ibid.*
88. Dimitris Xenos, "Asserting the Right to Life (Article 2, ECHR) in the Context of Industry" (2007) 8 *German Law Journal* 231 at 235 [Xenos].
89. *Ibid* at 236-237.
90. Rietiker, *supra* note 80 at 99-106.
91. *Ibid* at 89.
92. Fact Sheet, *supra* note 83.
93. *Ibid.*
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