Is there a right to die?
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I. Problem

Georgio Welby, Italy; Diane Pretty, England; Terry Schiavo, USA; German „death tourists“ who travel to Switzerland in order to be given a fatal dose of medicine:

Do or did these people have a “right to die”? Do authorities have the right or even the obligation to impede their death? Is it inhuman to “force” these people to continue living? Or is it a frightening sign of an inhuman society, when critically ill and seriously disabled people think that dying, with the assistance of others, might be a better alternative than living? Is the individual right to die realised, when the total parenteral nutrition of a patient in persistent vegetative state is stopped on the grounds that such a life is not worth living? Is this assisted dying or killing?

More and more questions […] and the media staging of such spectacular destinies does not provide answers but only creates new disbelief and uncertainty. Collective moral convictions that could give an orientation do not exist. Not even in religious norms. The “Fiat voluntas tua […]“ is not a binding guideline in the liberal European societies (anymore). On the contrary: Life and death are permanently intervened with and manipulated by other human beings. The progress of intensive care possibilities, the increasing number of elderly and incurably sick people and the growing financial pressure on health care systems automatically lead to the fact that thousands of decisions on people’s time and kind of death are daily taken in our hospitals und care facilities. It is no longer a question of whether or not someone is in the position to make decisions on life and death, but rather who should actually have the authority to make this decision.[1]

With the following considerations I will try to present some elementary aspects from the constitutional perspective. I will do so in three steps:

[1] *Kämpfer*, Die Selbstbestimmung Sterbewilliger – Sterbehilfe im deutschen und amerikanischen Verfassungsrecht, 2005, passim.

(1) First, I will demonstrate that the fundamental and human right to live and of physical inviolability holds a double guarantee: the *maintenance* and *design* of integrity.

(2) On this basis, I will reconstruct the terminology of the discourse on euthanasia and bring it into line with crucial constitutional standards: autonomy *and* integrity.

(3) Finally, I would like to demonstrate that the recognition of a right to die does not entitle a human being to physician assisted suicide. It rather means an obligation for the state to find effective measures against external or other-determined violations of integrity.

II. The double guarantee of the fundamental right of integrity

1. Guarantees in the international and constitutional law

The human right to live and of physical inviolability is recognised in international legal systems as well as in national or European constitutional law. These constitutions explicitly guarantee either only the right to live or supplement this right by protecting the physical inviolability. This happens not only in Germany, but also in Greece, Italy, the Netherlands, Portugal, Sweden and many other European countries.[2] The extensive concept of protection is now being pursued by the Charter of Fundamental Rights of the European Union.[3] Physical integrity as a fundamental requirement for human development is therefore a crucial element of the collective constitutional tradition in European countries.[4]

2. Double guarantee

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2 Art. 23 Abs. 1 Const./Belgium; Art. 2 Abs. 2 S. 1 1. Alt, Art. 102 GG/Germany; Art. 1, 2 ZP 6; § 16 Const./Estonia; § 7 Abs. 1 u. 2 (§ 9 Abs. 4 S. 2) Const./Finland; Art. 5 Abs. 2 u. 5, 7 Abs. 3 S. 2 Const./Greece; § 1 I lit. a, c britHuman Rights Act v. 1998/Great Britain i.V.m. Art. 2 EMRK; Art. 15 Abs. 5 Nr. 2, Art. 40 Abs. 3 Nr. 2 u. 3 (Abs. 4 Nr. 5) Const./Ireland; Art. 27 Abs. 2, 4 Const./Italy; Art. 93 Const./Latvia; Art. 19 Const./Lithuania; Art. 18 Const./Luxembourg; Art. 33 Const./Malta; Art. 114 Const./Netherlands; Art. 85 B-VG/Austria; Art. 2, 6. ZP EMRK (östVerfG), Art. 63 StV v. St.-Germain (VerfG/Austria); Art. 38 Const./Poland; Art. 19 Abs. 6, Art. 24 Const./Portugal; Kap. 2 § 4, § 22 Nr. 3 Const./Sweden; Art. 15 Const./Slovakia; Art. 17 Const./Slovenia; Art. 15 Const./Spain; Art. 3 Const./Czech Republic i.V.m. Art. 6 tschechGR-Deklaration; § 54 I Const./Hungary; Art. 7 Const./Cyprus.

3 Article 3 of the Charter of Fundamental Rights of the European Union – Right to the integrity of the person.

4 *Höfling/Rixen*, Recht auf Leben und Verbot der Todesstrafe, in: Heselhaus/Nowak (Hrsg.), Handbuch der Europäischen Grundrechte, 2006, § 10, Rn. 1 ff.; *Höfling*, in: Stern/Tettinger (Hrsg.), Kölner Gemeinschaftskommentar zur Europäischen Grundrechte-Charta, 2006, Art. 2, Rn. 11.

The fundamental right of integrity – so I'm going to name it hereinafter – accomplishes two functions:

- On the one hand, it protects a human's physical condition against assaults by others. This is the aspect known as *maintenance* of integrity.
- On the other hand, it contains the aspect of *design* of integrity. In doing so the fundamental right of integrity protects self-determination.[5]

The German Federal Constitutional Court has therefore given this fundamental right the attribute „right of freedom/liberal right": "The fundamental right guarantees the protection of freedom in the area of physical and mental integrity."[6] The determination of one's integrity is "part of the originally private personality. The human being is – in constitutional terms – free to choose his/her standards and to live and make decisions in accordance to these standards."[7]

3. Informed consent and right to die

This concept has been accepted as the relationship between patients and physicians in the ethical rule of informed consent, which was elevated to constitutional status by Art. 3 II of the European Charter of Fundamental Rights.[8] The guiding principle in the relationship between the patient and the physician is therefore the patient's informed and reflected will – voluntas aegroti. The competent patient is thus able to reject – actually indicated – medical treatment.

The consequence of such a concept is the acceptance of a right to die. The "right to die" is realised, when a rejection of treatment is not only considered by the physician, but also leads to the patient's death. There might be good reasons for constraining this right or tying it to

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5 *Höfling/Rixen*, Recht auf Leben und Verbot der Todesstrafe, in: Heselhaus/Nowak (Hrsg.), Handbuch der Europäischen Grundrechte, § 10, Rn. 5; *Höfling*, in: Stern/Tettinger (Hrsg.), Kölner Gemeinschaftskommentar zur Europäischen Grundrechte-Charta, 2006, Art. 2, Rn. 31.

6 BVerfGE 52, 171 (175).

7 BVerfGE 89, 120 (130).

8 Article 3 – Right to the integrity of the person
1. Everyone has the right to respect for his or her physical and mental integrity.
2. In the fields of medicine and biology, the following must be respected in particular:
- the free and informed consent of the person concerned, according to the procedures laid down by law,
- the prohibition of eugenic practices, in particular those aiming at the selection of persons,
- the prohibition on making the human body and its parts as such a source of financial gain,
- the prohibition of the reproductive cloning of human beings.

procedural conditions. I will refer to this later. But please note, that in a liberal constitution the constraint of basic rights is always connected to the need of a justification.[9]

It would be a questionable argument to deny such a “right” by claiming the inalienability of life. This kind of argument would lead to a paradox: Otherwise, the subjective right of respect for the integrity related self-determination would be reinterpreted into an obligation. The holder of the right would then be identical with the subject of the obligation that corresponds with the right. This is not a stringent concept. Again: It is not my purpose to deny the fact, that every right might be accompanied by corresponding obligations. But these obligations cannot be derived from the right itself; rather they need a different origin.[10]

By the way: the often discussed judgment of the European Court of Human Rigths in the case of Pretty vs. The United Kingdom does not conflict with the outlined conception. The jugdes did indeed decline to derive a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life from the right of life in Art. 2 European Convention on Human Rights.[11] But with reference to the jurisdiction of the Canadian Supreme Court[12] the European Court of Human Rigths was „not prepared to exclude that this [The applicant was prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life.] consitutes an interference with her right to respect for private life as guaranteed under Article § 1 of the Convention“.[13] However, the European Court of Human Rigths regarded the Suicide Act of the English criminal law that criminalises persons who aid, abet, counsel or procure the suicide of another human being as a justified – because in a democratic society necessary – interference and concluded that there had been no violation of Article 8 of the Convention.[14] In this context it has indeed to be taken into account that the present case did not simply deal with a right to die but the wilful causing of death with the assistance of a third person. I will refer to this later.

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9 *Alexy*, A Theorie of Constitutional Rights, 2002, passim; *Höfling*, Offene Grundrechtsinterpretation, 1987, S. 47 ff.

10 *Merkel*, Früheuthanasie, 2001, S. 313 ff.

11 European Court of Human Rights, Pretty v. The United Kingdom, 29th of April 2002, Rec. 2002-III, 155/203, No. 40; Breitenmoser, Das Recht auf Sterbehilfe im Lichte der EMRK, in: Petermann (Hrsg.), Sterbehilfe – Grundsätzliche und praktische Fragen, 2006, S. 167 ff.; Faßbender, Lebensschutz am Lebensende und Europäische Menschenrechtskonvention, JURA 2004, S. 115 ff.

12 Rodriguez v. the Attorney General of Canada, (1994) 2 Law Reports of Canada 136.

13 European Court of Human Rights, Pretty v. The United Kingdom, 29th of April 2002, Rec. 2002-III, 155/203, No. 67.

14 European Court of Human Rights, Pretty v. The United Kingdom, 29th of April 2002, Rec. 2002-III, 155/203, No. 68-78; Schweizer Bundesgericht, Urt. V. 03. November 2006, 2A.48/2006/ble, 2A.66/2006, ZfL 2007, S. 22 ff.

III. The right to die in the context of the euthanasia debate

Based on this intermediate result I would like to analyse the terminology used in the euthanasia debate. A part of this terminology is confusing and distracts from fundamental legal measures.[15]

1. The irrelevance of the differentiation with the criteria "active" and "passive"

First of all: The common differentiation of active from passive euthanasia seems irrelevant to me. This kind of differentiation applies to the mode of action, which has no explanatory statement. Much more decisive from the constitutional perspective is something different from that:

- The physician has to consider an informed rejection of treatment. In this case the physician is not only to omit further intervention (passive behaviour), but also to stop already induced treatment (active behaviour). The death of the patient through omission or action cannot be classified as "active" or "passive" euthanasia. The patient's life ends because he/she has ceased the medical mandate.
- The differentiation of "active" and "passive" euthanasia does not even work in situations, in which a valid rejection of treatment does not exist. The physician is to induce or continue all needed measures as long as the patient is not in a terminal condition. If the physician does not act according to this and therefore causes the patient's death, he/she is not giving assistance to die**,** but killing. It does not matter, whether the physician is "passively" omitting further intervention or "actively" stopping already induced life-sustaining treatment.

2. In particular: Patients that are not competent to decide their own will

This conclusion is not only to be drawn in case the patient does not reject further treatment, but much more in case he/she wishes medical treatment. A situation in which the patient's

[15] *Höfling*, Integritätsschutz und Patientenautonomie am Lebensende, Deutsche Medizinische Wochenschrift (DMW) 2005, S. 893 ff.

own will (or presumed will)[16] is not detectable is more complicated and therefore needs further explanation. An example of a person who is unable to express his/her own will is a patient in a persistent vegetative state.[17] (The interaction with children is another specific problem, since their parents can be consulted as their constitutionally authorised representatives.) Provided that according to the concept of informed consent every medical treatment needs a justification based on the patient's will, one might conclude that the physician is unable to act in cases where the patient's will is not detectable. Some draw this conclusion for people who are critically ill or for those who have irreversibly lost their consciousness – arguing that this procedure would be in the patient's best interest.

This line of argument is not convincing to me. I will now explain the reasons for my opinion:

The physician finds himself/herself with a dilemma: either he/she treats the patient without being entitled to do so, or he/she omits therapeutic intervention and in doing so causes the patient's death because he is not able to ascertain the patient's own will (maybe even against a wish for treatment that is not detectable). Integrity should be protected in this situation, since the irreversible loss of life is the greater evil.

And another aspect to mention is human dignity. Human dignity is not only guaranteed by a number of European and non European constitutions but also by the Charter of Fundamental Rights of the European Union. The guarantee of human dignity protects the inviolable value of a human being. All humans are recognized as equal and of equal dignity by society – independent from their status or health condition. No one should decide on their belonging to society. This is why it is impossible to judge whether or not someone else's life is worth living. As a consequence, there is no way of solving the described dilemma at the expense of life by saying that death is a more dignified alternative. In this way an incorrectly interpreted "in dubio pro dignitate" would be played off against the maxim "in dubio pro vita". But the fact that a human being is living never can collide with his/her dignity. I will stick to my evaluation/opinion: The medical treatment of a patient who is not able to decide on his own will should be continued in case his/her presumed will is not possible to detect. A decision against life on the basis of the objective category of "best interest" – as happened in the Brit-

16 The presumed will cannot be based on pure guesswork or objective criteria, on the contrary each case has to be considered individualy which means that individual related aspects have to be taken into account.
17 *Höfling* (Hrsg.), Das sog. Wachkoma, 2. Aufl. 2007, passim.

ish “leading case” Tony Bland[18] – seems dubious to me from the constitutional perspective. In accordance to this position in Summer 2007 the *Congregation for the Doctrine of the Faith* has decided to reply to questions of the United States Conference of Catholic Bishops in the way that (artificial) nutrition is owed to patients in persistent vegetative state.[19]

3. Directive vs. indirective

Likewise misleading is the term of (active-)indirective euthanasia, which describes the cases of life shortening pain treatment. It completely misses the point of the medical conduct. In this context it is often argued, that the physicians concerned don’t intend to hasten dying but reduce suffering. But another aspect is decisive:

A physician who withholds a palliative treatment indicated and requested by the patient is possibly guilty of bodily injury. So he has to treat, and new studies show that palliative care lengthens rather than shortens life.[20] But any kind of treatment includes risk. This risk is realised, if the patient prematurely dies, and it is the consequence of the illness and its treatment.[21] In this case the physician has not removed the sufferer by removing the suffering. The various practices of so-called terminal sedation deserve special attention. The transition from palliative care to euthanasia appears to be smooth in some countries.[22]

4. Ordinary vs. extraordinary means

On the grounds of a constitutional perspective, that protects the human’s informed self-determination as well his/her integrity from other-determined and external violations, I would like to outline the traditional (catholic) doctrine of “ordinary” and “extraordinary” means:

Even “ordinary” therapeutic measures must be withheld or withdrawn, when an informed patient has rejected medical treatment. Patients who are not competent to express their own will in non terminal condition should be treated with all medically indicated means. The terms

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18 *Tolmein*, Keiner stirbt für sich allein, 2007, passim.

19 Amtsblatt für die Diözese Regensburg, Nr. 8, 28. September 2007, S. 91.

20 *Höfling/Brysch* (Hrsg.), Recht und Ethik der Palliativmedizin, 2007, passim.

21 *Sahm*, Selbstbestimmung am Lebensende im Spannungsfeld zwischen Medizin, Ethik und Recht, Ethik in der Medizin 2004, S. 133 ff.; *Schmoller*, Lebensschutz bis zum Ende?, ÖJZ 2000, S. 361 (371); *Dreier*, Grenzen des Tötungsverbots, in: Joas (Hrsg.), Die Zehn Gebote – Ein widersprüchliches Erbe?, 2006, S. 65 (94 ff.).

22 *Nauk/Jaspers/Radbruch*, Terminale bzw. palliative Sedierung, in: Höfling/Brysch (Hrsg.), Recht und Ethik der Palliativmedizin, 2007, S. 67 ff.

"ordinary" and "extraordinary" are acceptable as long as they refer to the status of indication. But there is a risk that these terms become a gateway to contemplate the point of or quality of someone else's life. Such a concept collides with the fundamental right of integrity and with the guarantee of human dignity.

III. The protection of self-determination and integrity

The terminology "the right to die" should not be misinterpreted. Speaking about a "right to die" does not implicate the authentication of a formalistic model of autonomy nor does it implicate the renouncement of public and social responsibility for the protection of integrity.

I would like to present two final thoughts in this matter:

1. Enabling and protecting free and reflected decisions

Self-determination requires the ability to do so. The ideal of a "mature human" is not a matter of course in reality.[23] Especially critically ill people may not be as autonomous as suggested. Hopelessness, fear and the feeling of losing control are not a good basis for free and reflected decision-making. There is a risk that – in the phrase of *D. Callahan* – "self-determination runs amok".[24] This is why appropriate health services and a trusting relationship between the physician and the patient are of fundamental importance. Premature decisions contra vitam can be avoided by an adequate offer of palliative care and concepts of advanced care planning. The state has a responsibility to accomplish these goals, and it is the task of law to provide elementary conditions of liberty.

The debate on living wills has to be analysed critically against this background. The binding character of an anticipated rejection of treatment can only be put into effect on the basis of a few procedural standards: writing, expert consultation, timeliness and certainty. The renouncement of these standards under reference to formal autonomy would undermine integrity.

2. No entitlement to physician assisted suicide or voluntary euthanasia

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[23] *Duttge*, Selbstbestimmung aus juristischer Sicht, Deutsche Medizinische Wochenschrift (DMW) 2006, S. 48 ff.

[24] *Callahan*, When Self-Determination Runs Amok, Hastings Center Report 22 (1992), pp. 52 ff.

The "right to die" does not implement an enforceable entitlement to physician assisted suicide or voluntary euthanasia. The authorities are bound to protect human dignity and integrity. To fulfil this duty, the state may create restrictive regulations and prohibitions. Legitimate reasons the state can rely on when fulfilling this duty are:[25]

- The state has to provide measures for the prevention of misuse and external determination. The risk of misuse and external determination is characteristic for the inclusion of others in the process of dying. Even "compassion" can be fatal!
- The mutual trust of patient and physician can be strained, once the physician is given the role of an assistant in dying.
- The protection of integrity and human dignity as a philosophy has to be sustained in the consciousness of society by the state. The more end-of-life-decisions are disconnected from the patient's individual will, and the more these decisions are organized and institutionalised, then the objective guarantee of life will be weakened. This could lead into an increasing social pressure on elderly and ill people. It is the state's duty to prevent such social pressure.

V. Final remarks

Finally to summarise my thoughts:

The "right to die" means the acceptance of reflected self-determination over physical integrity. This right is guaranteed in the (European) constitutional law. It is a fundamental part of a human's subjective quality. Nevertheless, the recognition of this right doesn't mean to devalue or to deregulate the protection of life. It is an essential task of law to enable reflected decisions and to guarantee the integrity of patients who are not competent to decide their own will.

The prior obligation of state and society is not to assist dying but to assist living. It is crucial for society to prevent an atmosphere, in which critically ill or people with terminal illness think dying is the realisation of freedom, because they do not want to be a burden on others.

[25] *Kämpfer*, Die Selbstbestimmung Sterbewilliger – Sterbehilfe im deutschen und amerikanischen Verfassungsrecht, 2005, passim; *Schulze-Fielitz*, in: Dreier (Hrsg.), Grundgesetz Kommentar, Bd. 1, 2. Aufl. 2004, Art. 2 II, Rn. 84.