INTERNATIONAL HUMAN RIGHTS LAW AND THE DEBATE ON EUTHANASIA – A VIEWPOINT

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ABSTRACT

Over the past few years, euthanasia and physician assisted suicide have become prominent public issues in many countries. Several countries or regions of countries have debated legislation on euthanasia and / or physician assisted suicide. Although there is growing public acceptance of physician-assisted deaths all over the world; many professional organizations remain opposed to it. Most of the debates on the issue are usually framed, as issues of morality while many basic empirical questions remain unanswered. For example, how many patients actually make these requests? Would improved treatment of pain lead fewer patients to make these requests? How do physicians respond to these requests? To what extent these practices occur? etc. Can internationalization of the euthanasia debate help to resolve these issues and build the consensus, and can International Human Rights Law provide an adequate basis for such a debate? This paper attempts to examine these questions.

Key Words: End of life decisions, Physician-assisted deaths, Physician-assisted suicides, Euthanasia

INTRODUCTION

Euthanasia has been defined as the administration of drugs with the explicit intention of ending the patient's life, at the patient's explicit request[1]. In the Netherlands, it is defined as 'intentional termination of the life of a patient by a physician, at patient's request'[2]. The meaning of euthanasia has evolved over the centuries to focus on a "good way" of ending the life of a suffering patient with less emphasis on the patient's psychological state of well being. It has been argued that euthanasia is homicide, but the physician who commits it always has what he thinks is a merciful, unselfish motivation[3].

From the historical background, the doctor's goal had been two-fold: to preserve life and to relieve sufferings. There were no conflicts among these goals till 1960s. However, with the advancements in science and technology in general and the medical sciences in particular, the concept of death changed. The older concept of death being characterized by the cessation of respiration ("the breath of life") was replaced by the absence of heartbeat ("the pulse of life"). Recently death has been defined by the cessation of brain function, a concept that arose for four reasons: (1) Cardiopulmonary arrest is no longer always the end of life. Endotracheal intubation with mechanical ventilation may sustain gas exchange and cardio-pulmonary resuscitation techniques may restore adequate cardiac activity. (2) Modern life support techniques have enabled brain death to be recognized as an entity (originally described as 'coma depasse') where cerebral cortical function is totally and irreversibly lost while the function of the other organs can be maintained artificially. (3) There is an increasing awareness of futility of existence in the absence of cognitive brain function. (4) Patient with an extensive and irreversible brain damage may not meet the criteria of brain death, but nevertheless may be in an analogous situation in that no form of social relation can be recovered. In these patients prolongation of care does not prolong or restore any meaningful survival. The concept of 'quality of life' here came in conflict with the concept of 'preservation of life' and progressed to the present day legalized physician assisted deaths (active as well as passive) in the Netherlands and over forty States in USA.

In November 1994, Oregon became the first state to legalize physician-assisted suicide when voters approved a ballot initiative, 'the Oregon Death with Dignity Act'. Implementation of the measure, however, was barred by an injunction when in August 1995, a federal district judge ruled the measure unconstitutional[4]. Although legally prohibited in most of the countries, the majority of the population accepts euthanasia, as medical practice. The dominant debates in the media no longer address the morality of euthanasia as such but, rather, focus on procedural arrangements to regulate the practice as carefully as possible. The guiding principles of medicine -autonomy, beneficence, non-maleficence and justice - are often argued to be less concerned with consequences[5]. On the other hand, euthanasia is often considered taboo in the context of medical practice even though it is the topic of debate in many countries. The Dutch physicians are sometimes aggressively addressed for killing instead of caring by the

opponents of euthanasia. Current international opinion is highly polarized and an open international debate in this regard is desirable. Such a debate will encourage openness in medical practice and provide a forum for a wide range of opinions. Furthermore, within an international context, the Dutch policy on euthanasia will receive stimuli to consider and reconsider the fundamental morality of euthanasia.

International Human Rights Law as a consensual basis for an open debate on euthanasia

None of the International Human Rights Instruments addresses euthanasia directly. This however, does not mean that euthanasia would be inconsistent with International Human Rights Law. The perspective that international law is entirely a decision making process and not just the reference to the trend of past decisions which are termed as 'rules', makes it possible to address relevant articles of the International Covenant on Civil and Political Rights (ICCPR)[6] and the European Convention for the protection of Human Rights and Fundamental Freedoms (ECHR)[7], which can provide a consensual basis for an open debate on euthanasia.

Proponents of euthanasia, often use the argument of the **'principle of human self-determination'**, which contend that human self-determination is not derived from the state and that the state in principle is not entitled to impose on its citizens ethical rules which interfere with their private lives. For an encroachment upon individual rights strong arguments must be available, leading to the inevitable conclusion that, without such rules, essential values of the society would be endangered.

According to the opponents of euthanasia, right of self-determination is a hybrid right. It is not mentioned in the ECHR but the ICCPR refers to it explicitly in Article 1, the General Comment on which states that, "the right of self-determination is of particular importance because its realization is an essential condition for the effective guarantee and observance of individual human rights and for the promotion and strengthening of human rights"[8]. This implies that an individual cannot bring a claim to protect his or her rights of self-determination but that a state should take individual self-determination into consideration while interpreting other rights in the Covenant.

It can be argued that these essential values of society will not be in danger when no alternatives exist. Denying the right to euthanasia in that case would force people to suffer against their will, which would be cruel and against their human dignity. On the other hand it can be questioned whether it is not so much the right to self-determination as the duty to prevent suffering which is crucial.

The right to life is the supreme right from which no derogation is permissible even in time of public emergency, which threatens the life of the nation. However, it is not an absolute right, like the right not to be tortured. There are some limitations. According to ICCPR, the interpretation of the right to life should be broad and should for instance include the duty of states to reduce infant mortality and to increase life expectancy. However, the traditional approach to the right to life is focussed more on the limitations explicitly mentioned in Article 6 of the ICCPR and Article 2 of the ECHR. The word 'arbitrary deprivation' in Article 6 can be considered as justifying the putting to end of someone's life. According to the General Comment on Article 6, the only explicitly mentioned justifiable limitation of the right to life is the death penalty. As far as other limitations are concerned, the General Comment only states that "the deprivation of life by the authorities of the State is a matter of utmost gravity"[9]. According to Ramcharan[10], ‘contemporary issues such as abortion, euthanasia and the death penalty can affect the realization of the right to life'.

The right to life can be used as an argument in favor as well as against euthanasia. Those opposed to euthanasia argue that 'the right to die' would be in contradiction to the right to life. According to them, the right to life is a supreme right in which human dignity and self-determination (and also other rights) are grounded. They stress that International Law has not discussed this issue and that Articles 6 and 2 do not provide any possibilities to make euthanasia justifiable. Arguments in favor of euthanasia are that the right to life is a right to life worth living. This is a more subjective interpretation and presents a more liberal approach to self-determination and human dignity. In this sense, the request of the patient is of decisive importance. The right to life is a liberty right and also a positive right, as it provides patients with the opportunity to refrain from it. According to Nowak[11], "the State's duty to ensure does not go so far as to require that life and health be protected against the express wish of those affected. An obligation to sanction suicide with Criminal Law, can not be derived from Article 6. As a result of the accessory character, this conclusion is also applicable to the offence of aiding a suicide".

The right not to be subject to cruel, inhuman or degrading treatment

The aim of Article 7, according to General Comment is "to protect both the dignity and the physical and mental integrity of the individual. It is the duty of the State party to afford everyone protection through legislative and other measures as may be necessary against the acts prohibited by Article 7"[12]. Since most of the cases, concerning Article 7 and 3 deal with the treatment of persons in detention, so their application in this context could be questioned. However, the fact that neither Article contains any definition of the concepts which it covers or acts that are prohibited, does not allow limitations which may suggest that cruel, inhuman or degrading treatment is allowed in any case. This supposes that Article 7 can be interpreted broadly that failing to

provide, or inadequately providing, palliative care to a person who suffers unbearably constitutes lack of proper medical care.

The practice of euthanasia has arisen against a background of developing medical technologies. Arguably, medicine itself shares responsibility for legalized Dutch euthanasia practice. High-tech medicine can disproportionally provide cruel, inhuman or degrading treatment and disproportionally lengthen a patient's suffering. Invasive medical treatment and its side effects may well lead a patient to request euthanasia. As to the duty of States, Articles 7 and 3 imply that States have much responsibility to protect persons against cruel, inhuman and degrading treatment. This would plead for a further development of palliative care.

Distinguishing the end of life decisions

It is important that a clear demarcation is done in the withdrawal of life support, physician assisted suicide and euthanasia. Euthanasia is defined as the administration of drugs with the explicit intention of ending the patient's life, at the patient's explicit request. It means the direct killing of a patient at his request. Physician-assisted suicide is defined as the prescription or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. Physician-assisted suicide means the intentional killing of oneself with the indirect aid of a physician. These definitions exclude the concept of allowing death to occur by withdrawing or withholding life-supporting treatment[13].

In the Netherlands, Article 293 Dutch Penal Code makes it an offence, punishable with up to twelve years imprisonment, for a perso death of another person at the latter's express request. It covers what is called active voluntary euthanasia. Article 293 Dutch Penal Code makes it an offence, punishable with up to three years imprisonment, for a person to intentionally incite, assist, or procure the means for another to commit suicide. It covers what is known as physician-assisted suicide. However, physician-assisted suicide and euthanasia are ethically/morally inseparable acts because in both instances the physician's intent is the same; he is a necessary element in the causal chain of events, and the consequences are the same[14]. The consequences, though same in cases of withholding or withdrawing life support measures but the physician's intent and the chain of events are different.

Many courts have approved requests to end life support for persons in Persistent Vegetative State. Permanent unconsciousness is a cogent justification for ending life support. Legal controversies usually center on whether life support can be lawfully withdrawn from individuals whose preferences are unknown or unknowable. Under the *Conroy* court's formula, life support can be stopped if there is "clear and convincing" proof that the burdens of sustaining exceed the benefits of continuing survival[15]. In making this "objective" determination, the court indicated that physical pain is the operative burden and that proof of intractable pain is necessary before the burden of survival should be taken as outweighing the benefits of remaining alive. A patient would thus need enough awareness to experience demonstrably intractable pain before life support could be stopped under this "objective" prong of the *Conroy* formula, a requirement that obviously excludes individuals in a Persistent Vegetative State.

PRESENT GLOBAL SCENARIO

The Northern Territory parliament in Australia has sparked an international debate after passing the Rights of the Terminally Ill Bill, effectively making Australia a world test case for legal euthanasia. Although voluntary euthanasia is sanctioned in the Netherlands and Oregon, in the US ; the Northern Territory is the first parliament to pass a law making it legal. The new law means that terminally ill patients can end their lives with medical help as long as strict guidelines are met, including diagnosis by two experienced doctors, one of whom has psychological qualifications. Among amendments passed in a 14 hours debate was one that gave the government the power to specify which drugs will be used to hasten death.

The bill has drawn fire from the Catholic church, the Islamic faith, the Australian Medical Association, right to life organizations, lawyers, and some politicians but won praise from people with AIDS right to die groups, the Doctors Reform Society, and most politicians. The Australian Medical Association opposed the bill at its national conference, reaffirming its support of the world Medical Association's stance that euthanasia, even it at the patient's request, was unethical. Dr. David Weedon, the president of the association, predicted there would be practical problems with the new law and said that these would hope fully deter other states from adopting similar legislation. Vice President Dr. Keith Woolard said that, instead of adopting similar laws, the states should improve palliative care. "We believe that euthanasia debate is based largely on fear and ignorance, ignorance of the fact that good palliative care services are available through Australia," he said. "The solution to this problem is not to give sanctions to the killing of other people but to educate and provide appropriate serves to the community."[16]

In the Northern Territory there was a mixed reaction from the public. A parliamentary report has found that some aborigines already dislike visiting medical centers for fear of being "given a needle". The widening gap that we see between public opinion and professional opinion is more apparent than real and stems at least in part from misconceptions about what a doctor is and is not permitted to and what is generally possible.

It has been argued that by euthanizing patients, we demean the concept of the sanctity of life, leading to a gradual erosion of its value, with subsequent liberalization of the criteria of euthanasia and the eventual euthanization of the demented, the deformed and even the non-productive. The Remmelink Committee report of 1991 on the Dutch experience on euthanasia revealed that about 1000 patients were being “euthanized” without their unequivocal consent, each year[17].

EUTHANASIA IN THE NETHERLANDS

In the Netherlands, physician assisted deaths have been practiced with increasing openness since the 1970s and were supported by public opinion till November 28th 2000, when the law providing for the addition of a special "criminal liability exclusion" clause to the Article 293 and 294 of the Dutch Penal Code was passed by a vote of 104 to 40. "A law whereby the considered wishes of a dying patient to put an end to his life are permitted has its place in a mature society," remarked the Dutch justice minister Mr. Benk Korthals, welcoming the passage of new law by the Lower House of the Dutch Parliament.

The new clause recognizes the validity of written requests by the patients for termination of their life. These are called 'euthanasia requests'. To respond to a euthanasia request from a patient suffering unbearable pain from an incurable condition, the physician must follow certain 'due care ' criterion. He must:

(1) be convinced that the request was voluntary, well considered and lasting;
(2) be convinced that the patient was facing unremitting and unbearable suffering;
(3) have informed the patient about his situation and prospects;
(4) have reached the firm conclusion with the patient that there was no reasonable alternative solution;
(5) have consulted at least one other independent physician who has examined the patient and formed a judgement about the patient stated above; and
(6) terminate life in a medically appropriate fashion.

Insofar as the sixth criterion is concerned, the practice is to administer an injection to render the patient comatose, followed by a second injection to stop the heart[13].

The Dutch Supreme Court had accepted euthanasia as far back as in 1984 when overturning a doctor's criminal conviction for accepting an euthanasia request from a 95 year old patient, the court agreed with the doctor's defense that he faced a conflict of responsibilities between preserving the patient's life on one hand and alleviating her sufferings on the other. The court held that this conflict must be resolved on the basis of the doctor's responsible medical opinion measured by the prevailing standards of medical ethics. This, the Alkmaar ruling, was sufficient to place the Dutch judiciary leagues ahead of its counterpart in any other country. A decade later in 1994, the Chabot case, was even more of a landmark, for it dealt with suffering that was not physical but purely psychological. "There is no reason, why the defense of necessity (pleaded by Dr. Chabot) could not apply where the patient's suffering is purely psychological" ruled the Dutch Supreme Court[18].

CURRENT STATUS IN INDIA

While euthanasia is not explicitly stated as a criminal offence in the Indian Penal Code (IPC), it is generally accepted that it is covered either under the offence of attempted suicide (Section 309 IPC), or abatement of suicide (Section 306 IPC). However, judicial opinion acknowledges that euthanasia is a “grey area” in Indian criminal law. This unsettled status has been brought into stark focus in several recent cases, e.g., Prathinam V. Union of India (1994), Smt. Gian Kaur V State of Punjab (1996), etc. As per the Supreme Court’s view, passive voluntary euthanasia can be visualized as a fundamental right protected by Article 21 of the Indian Constitution, which assures the right to privacy, since such right to privacy can be said to encompass the right of a patient to refuse life saving medical treatment. In other words, the right to “personal liberty” as guaranteed by Art. 21 of the constitution include the freedom to die with dignity. Active euthanasia (voluntary or otherwise) is of course unambiguously viewed as a crime, though convictions have not been brought so far against any individual in India for the commission of such an “offence”.[16]

Discussing euthanasia at International level

The liberal debate on euthanasia and its legalization, in the Netherlands has been criticized in many countries. However, considering euthanasia as a taboo or taking secretive measures to hasten a patient's death are equally unacceptable. Although International Human rights Law Instruments do not address euthanasia directly, but taking into consideration not just the rules but the entire decision making process makes it possible for euthanasia to be discussed on an international level. The ICCPR and the ECHR focus on issues such as self-determination, human dignity, the right to life and the right not to be subject to cruel, inhuman

or degrading treatment, that are central in several euthanasia debates around the world. Nowadays, morality is more and more pervaded by the liberal notion of autonomy. This has, for example, led to the acceptance of homosexuality. However, with regard to euthanasia it seems imperative to acknowledge the limits of autonomy.

The transition to a more liberal morality is also demonstrated by the doctrine of 'a margin of appreciation'. This means that the state is allowed a certain measure of discretion on account of the non-existence of consensus, with regard to what is necessary for the protection of morality. With regard to euthanasia, a State needs to balance the protection of vulnerable people (for example, the dying) with the protection of the right to freedom of others[19]. A state has a duty to provide terminal care and to prevent at least excesses with regard to euthanasia, which supposedly may occur not only in Netherlands but also in many other countries. In this respect it is imperative that an International Debate is started on the practice of euthanasia. Openness of both proponents and opponents will be vital if they are to constructively criticize each other on such topics as good terminal care, self-determination and the right to life versus the duty to live.

It has been argued by many that Netherlands has no palliative care because it has euthanasia, implying that euthanasia occurs as a premature solution or that Netherlands has euthanasia because it does not have palliative care, implying that adequate palliative care makes a liberal euthanasia policy unnecessary[20 - 22]. With regard to the 'slippery slope' it has been often argued that the Netherlands has had a development in which assisted suicide, then voluntary euthanasia, then non-voluntary euthanasia and finally involuntary euthanasia were successfully accepted[23]. Furthermore, it is held that a development from euthanasia on terminally ill patients to euthanasia on psychiatric patients may not be far away. In other opinions, the number of euthanasia cases in the Netherlands is increasing faster than is apparent from official reports[24].

Many argue that legalizing euthanasia would plant in the minds and hearts of severely ill, but still conscious patients a seed of despair; a sense of defeat before the end of battle that would, in turn, complicate their collaboration in their own treatment. In the lay community and among “less productive” or “non productive”, old, or incapacitated people, there would be a fear of being put on a “death list” as a result of a not-very-clear process. All these would damage the medical profession’s standing and image in the community[25]. It is important to distinguish between treatment aimed at ending the patient’s life and medical treatment around the life, or between decisions aimed at ending the patient’s life (which are non-medical) and decisions that treatment would be disproportionately burdensome to the patient, as death seems inevitable[26]. Good care aims at ending patient’s suffering, not their life[27].

Another argument of enacting a regulation by the Governments of different countries to regulate the practice of euthanasia, reminds us the following words of Miguel A. Faria[28], "The lessons of history sagaciously reveal that wherever the government has sought to control medical care, medical practice and physicians (whether directly or indirectly) the results have been as perverse as they have been disastrous. In our own century, in the Soviet Union, in Nazi Germany and in fascist Italy, medicine regressed and descended to unprecedented barbarism under the aegis of or in partnership with, the state."

CONCLUSION

In the debate on euthanasia major disagreements relate to weight that is given to the self-determination of the patient. It is argued that denying the right to euthanasia would amount to forcing people to suffer against their will, which would be cruel and against their human dignity. The proponent's view on euthanasia seems to be a consequence of the infrastructure of the society and its interaction with the aspirations of people. A major factor in the acceptance of euthanasia is that the moral values in the modern society have become somewhat detached from religious values, creating a seemingly permissive culture. Multiparty political system in many countries, further keeps the political parties away from taking any initiative on a sensitive issue like euthanasia. Accordingly, the internationalization of the euthanasia debate seems imperative and International Human Rights Law, surely, can provide an adequate basis for such a debate. Clear guidelines regarding the criterion and methodology of euthanasia need to be and can only be worked out by an open debate.

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