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To live with dignity

To die with dignity

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Voluntary Assisted Dying in the ACT Consultation

Submission by “DIGNITAS – To live with dignity – To die with dignity” Forch, Switzerland

for and on behalf of the 113 Australian and 4 ACT members
of DIGNITAS – To live with dignity – To die with dignity
submitted by email to VADsubmissions@act.gov.au

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1) Introduction

This submission comments on a few points of the themes / questions put up for discussion by the consultation on voluntary assisted dying in the ACT¹. It does not claim to, and it cannot cover the issue in all details.

The Swiss non-profit membership association “DIGNITAS – To live with dignity – To die with dignity” (hereafter abbreviated “DIGNITAS” for easier reading and writing) provides this submission based on its work of nearly 25 years which includes know-how and experience from conducting over 3,400 cases of physician-supported assisted/accompanied suicide (PSAS)² in line with Swiss law, including 3 individuals from the ACT of 40 individuals from overall Australia³. The reason for providing this submission is obvious from the aims and further information available on the website of DIGNITAS⁴.

For many years, DIGNITAS has, besides other work, focussed on implementing and safeguarding the human right and freedom of individuals to decide on time and manner of their own end in life and to have access to professional help to put this into practice in a legal and safe way at their home, which includes having the choice of voluntary assisted dying (VAD). Individuals requesting VAD (and their loved ones) should not have to carry the burden of going abroad to DIGNITAS or being left to turn to lonely risky do-it-yourself suicide attempts, with all the negative consequences thereof. Alongside this, DIGNITAS and the country of Switzerland should not need to take care of an issue which can be resolved by the countries where these individuals travel from. The aim of DIGNITAS is that the “medical tourism of assisted dying” stops and DIGNITAS becomes obsolete for these people⁵.

DIGNITAS finds that the ACT Voluntary assisted dying consultation is an important step forward and agrees with the ACT Government that “all Canberrans should have end of life choices that align with their rights, preferences and values”, which consequently includes VAD, something most Canberrans support as the Government acknowledges. Permitting VAD is to improve health, in the words of Julian Gardner, Chairperson of the Voluntary Assisted Dying Review Board of the state of Victoria⁶: “Having some control of the dying process may lift psychological and general health. For many people, having access to medication gives them the option to exercise their autonomy and die on their own terms. Some of those people choose not to have the medicine dispensed and some have the medication and choose not to take it. We know from feedback they do receive comfort from that⁷.”

DIGNITAS is happy to give further evidence, personal, oral and written, if the Voluntary assisted dying policy team would wish so, as DIGNITAS already did in other consultation processes in Australia and elsewhere. They are also welcome to visit DIGNITAS.

¹ <https://yoursayconversations.act.gov.au/voluntary-assisted-dying-in-ACT>

² See subheading 4 “terms and abbreviations used in this submission”.

³ http://www.dignitas.ch/index.php?option=com_content&view=article&id=32&Itemid=72&lang=en

⁴ E.g. “The basic information at a glance and a ‘click’” on <http://www.dignitas.ch/index.php?lang=en>

⁵ See “The goal of DIGNITAS”, page 19 herein:

<http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-pecskc-london-24022023.pdf>

⁶ <https://www.safecare.vic.gov.au/about/vadrb/members>

⁷ <https://www.theage.com.au/national/victoria/why-some-people-with-euthanasia-drugs-do-not-take-the-fatal-dose-20221207-p5c4d4.html>

2) Comments on some themes / questions of the consultation

On eligibility criteria

With voluntary assisted dying (VAD), the base should be what the European Court of Human Rights (ECtHR) held in its judgment *HAAS v. Switzerland* mentioned in subheading 3 of this submission, which is that the individual “...is capable of freely reaching a decision on this question and acting in consequence...” Since it is acknowledged that an individual has the freedom and right to decide on time and manner of their own end in life, eligibility criteria should be such that medical professionals or others do not (need to) pass judgement on whether or not someone has a certain medical diagnosis, whether or not it is progressive and whether or not this is expected to cause death in a certain time estimate. Rather, criteria should put centre stage what the individual considers to be quality of life. The focus would then be on establishing that the individual requesting assisted dying:

- understands the information relevant to the decision relating to access to assisted dying and the effect of the decision; and
- has reached a voluntary decision without coercion or duress; and
- is informed as to palliative, hospice and other care options – this should include information as to the potential negative effects of unguided do-it-yourself (DIY)-suicide attempts; and
- is able to communicate the decision and their views and needs as to the decision in some way, including by speech, gestures or other means, and also able to administer the life-ending medication themselves; and
- has discussed the matter with their loved ones with the aim of avoiding a negative “surprise effect” and impact for these loved ones.

One eligibility criterion which should not be applied in VAD law-making is that of any life expectancy limit. No one, not even the most expert medical professional, is able to predict the future and to *know* whether a patient is still alive in 6, 12 or any other number of months. There may be life expectancy *estimates* based on experience, depending on the diagnosis; however, there is also the experience of exceptions. In result, the criterion of a certain limited life expectancy is a hypothetical, and it leads to arbitrariness and inequality: someone may hold the opinion that the patient is going to die in 6 months, but someone else may estimate this to be 6 months plus one day.

Some claim the criterion of a limited life expectancy to be a “safeguard”. The opposite is the case. Individuals who do not meet this eligibility criterion, in their despair might try an unguided DIY suicide, or they will turn to DIGNITAS. Both outcomes are undesirable. The limited life expectancy criterion is a copy-paste from the now over 20-year-old and outdated Death with Dignity Act of the state of Oregon USA. Most European assisted dying legal frameworks, i.e. Belgium, the Netherlands, Luxembourg, Switzerland (with the longest-standing professionally-medically assisted dying practice of over 35 years; DIGNITAS notes that the Comparative guide, Appendix C of the consultation discussion paper, page 42,⁸ lacks Switzerland despite this fact)) and Germany, do not have such restrictive criterion.

Linked with the limited life expectancy criterion is the one that the individual would have to be diagnosed with a “terminal” illness. Again, this criterion should not be applied in the ACT VAD legislation. To only allow access to VAD for individuals who face an illness leading to

⁸ https://hdp-au-prod-app-act-yoursay-files.s3.ap-southeast-2.amazonaws.com/8416/7567/8207/Voluntary_assisted_dying_Discussion_Paper_PDF_version.pdf

death is to discriminate against individuals who suffer from health conditions that are, by medical opinion, not progressive and/or reasonably expected to cause death. For example, individuals such as the late PAUL LAMB, who was paralysed from the neck downwards after an accident, and who fought in the UK courts to obtain access to assisted dying⁹.

Specifically in regard of mental health criteria, two aspects are to be noted:

First, it needs to be remembered that, in principle, people who are of age are assumed to be mentally competent unless there are indications that their mental capacity is limited or no longer present. This is the basis in common law which recognises – as a “long cherished” right – that an adult is presumed to have decision-making capacity unless shown otherwise¹⁰. Second, the criteria should not exclude from VAD and such discriminate against individuals with psychiatric ailments. In fact, the very applicant before the ECtHR, Mr. HAAS, who brought about the judgment acknowledging the human right/freedom to decide on the time and manner of one’s own end in life, was suffering from a psychiatric ailment but not a physical and/or terminal disease¹¹. A psychiatric illness may impact a person’s capacity to make decisions, such as the one to choose VAD, but it need not.

Sometimes it can be observed, especially amongst opponents of VAD working in the fields of psychiatry and psychology, that it is insinuated that individuals requesting VAD would up-front not have capacity. This approach not only tries to turn upside down the legal basis that a person is presumed to have capacity, but it labels and stigmatises people who contemplate end-of-life choices – with the negative effects of entrenching the taboo on suicide, on VAD, and on death, and potentially leading these people to not talk to doctors, therapists and their loved ones but “to take matters in their own hands”¹².

In regard of the question whether VAD should be restricted to people above a certain age (for example, people 18 and over), it can be expected that requests for VAD in the ACT will come forward mainly from individuals aged over 18. To compare: in Switzerland, according to the Federal Office of Statistics analysing the years 2010-14, most PSAS cases took place in the age group 75-84, and overall 94% of the persons concerned were over 55 years old¹³. Yet, there may be cases of younger than 18-year-old individuals with an illness which impairs their quality of life grievously to the point of them possibly wishing to have the option of VAD. The assisted dying laws of Belgium and the Netherlands adhere to this and allow for under-18 to access assisted dying under specific circumstances¹⁴. The ACT should take this as an example. A 17-year-old young may well have capacity to understand the consequences of a diagnosis of a severe illness, may it be terminal cancer or any other, and what VAD implies. Furthermore, if a 17-year-old is permitted to set up and/or have respected an advance directive

⁹ The case of Paul Lamb (and Tony Nicklinson) was finally referred to the ECtHR, yet the ECtHR declared LAMB’s complaint inadmissible because the rule of exhaustion of domestic remedies had not been observed.
<https://hudoc.echr.coe.int/eng?i=001-156476>

¹⁰ Consultation document page 10. Also Swiss law bases on the assumption that everybody is assumed to have capacity of judgment; this, unless there are clear signs that such is not the case, see article 16 of the Swiss Civil Code
<https://www.admin.ch/opc/en/classified-compilation/19070042/index.html#a16>

¹¹ Case of HAAS v. Switzerland, application no. 31322/07, <https://hudoc.echr.coe.int/eng?i=001-102940> ; see also sub-heading 3 in this submission.

¹² Cf. the TEDx talk “Cracking the taboo on suicide is the best means to prevent suicide attempts and deaths by suicide” <http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-tedxzurich-08072021.pdf>

¹³ <https://www.bfs.admin.ch/bfs/en/home/statistics/catalogues-databases/publications.assetdetail.3902308.html>

¹⁴ <https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request>

to refuse treatment, which will hasten death if applied (passive euthanasia), it does not make sense to bar such young person from VAD which leads to the same result¹⁵.

As to a residency and/or citizenship requirement, all discrimination should be avoided. The issue of potential “medical tourism of assisted dying”, i.e. people from other parts of Australia (e.g. if eligibility criteria in the ACT VAD law would be more progressive-liberal than in other Australian States and the Northern Territory) or even beyond (trying to) access VAD in the ACT, should not be solved with setting up discriminating criteria, but with engaging in the decriminalisation and further development of VAD in other legislations, so that such people would not need to consider at all turning to the ACT. In this context it is also to be noted that the residency criterion for assisted dying of the US State of Oregon was challenged to be unconstitutional in the *GIDEONSE v. BROWN, et al.* court case, which on 18 March 2022 led to a settlement in which the Oregon Health Authority, Oregon Medical Board, and the Multnomah County District Attorney have all agreed to “not apply or otherwise enforce the residency requirement” in the Oregon Death with Dignity Act, and the Oregon Health Authority agreed “to submit a legislative concept that would repeal the residency requirement”¹⁶.

On the process for request and assessment

DIGNITAS suggest the Voluntary assisted dying policy team to refer to the request and assessment process that bases on the Swiss legal framework for PSAS, as it is outlined, in short, on page 18ff in the booklet “Aims – Philosophy – Activities of DIGNITAS”¹⁷ and, more in detail, on page 3ff in the booklet “How DIGNITAS works”¹⁸. And, in its submission to the Joint Committee on End of Life Choices South Australia, in July 2019, DIGNITAS provided a draft act to introduce assisted dying in South Australia based on the Swiss system of PSAS¹⁹.

As to involving two health professionals, a coordinating and a consulting one: whilst DIGNITAS acknowledges that involving two separate doctors in the process of assessing and possibly supporting an individual’s request for assisted dying may be seen as a safeguard, it adds an unnecessary hurdle that consumes time who an individual with rapidly declining health may have little left of, and it prolongs the suffering. In the Swiss legal system of PSAS, one doctor is seen as sufficient²⁰. This doctor may choose to reach out to one or several colleagues if, for example, the individual’s situation and request for assisted dying appears complex and the doctor wishes for support and second opinion(s). This has proved to work well for over 35 years, and DIGNITAS suggests this approach.

Re question 9: When a registered medical practitioner declines the role of a coordinating or consulting health professional, it should be required that they refer the person to another health professional – unless there is a public available list of health professionals willing to be involved in VAD, or a specific state or private body (such as a VAD organization²¹) entitled to support individuals in finding such health professional.

¹⁵ Cf. judgment by the Austrian Constitutional Court of 11 December 2020 mentioned in subheading 3 of this submission.

¹⁶ https://compassionandchoices.org/docs/default-source/legal/rec-doc-20-1-exhibit-wm.pdf?sfvrsn=6041423c_1 and <https://compassionandchoices.org/legal-advocacy/recent-cases/gideonse-v-brown-et-al>

¹⁷ <http://www.dignitas.ch/images/stories/pdf/broschuere-verein-e.pdf>

¹⁸ <http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf>

¹⁹ <http://www.dignitas.ch/images/stories/pdf/diginpublic/stellungnahme-submission-end-of-life-choices-south-australia-31072019.pdf>

²⁰ See footnotes 17 and 18.

²¹ e.g. “Dying With Dignity ACT (inc)”; in Switzerland, organizations such as DIGNITAS take on this task.

Re question 10: No witnesses should be required. In the proposal for VAD in the ACT, health professional will anyway interact with the individual requesting VAD and therefore can verify the formal request. In the Swiss legal system of PSAS there is no mandatory witnessing provision, and it does not appear to have posed a problem in 35 years of this being practice.

Re question 11: No cooling off²² period before accessing VAD should be required. VAD in the ACT should adhere to the approach of Canada, Belgium, the Netherlands, New Zealand, Switzerland and Germany which have no such waiting period in law²². The experience of DIGNITAS derived from having conducted over 3,400 PSAS is that, generally, people who contemplate end-of-life-choices make up their mind as part of their “personal life philosophy” long before they would face a health situation in which they would get in touch with DIGNITAS to request PSAS. Any imposed minimum timeframe for a waiting period appears arbitrary and paternalistic, and leads to possibly prolonging the suffering.

Re question 12 - 14: Both approaches, that is, self-administration and administration by an administering health professional of the VAD substance should be available and applied depending on the circumstances. There may be situations a patient cannot self-administer anymore, e.g. someone with far advanced motor neurone disease. Is it a matter best determined between the registered medical practitioner and the patient.

Re question 15 + 16: This issue could be resolved if the ACT adopted “the Swiss PSAS model” which, besides a medical practitioner assessing the request for PSAS and (possibly) prescribing the PSAS substance, involves trained staff by not-for-profit organizations such as DIGNITAS: they monitor and conduct the PSAS process, serve as witnesses, ensure a chain of custody for the substance including returning it to the pharmacy if it has not been taken, etc.

On the role of health professionals

The consultation document notes: “In a small jurisdiction like the ACT, with limited health resources and a relatively small workforce, imposing narrow or inflexible health professional qualification requirements is likely to restrict the pool of health professionals who are eligible to participate in voluntary assisted dying, which in turn may restrict a person’s access to voluntary assisted dying.” In the light of this situation, again, the ACT could adopt “the Swiss PSAS model” which requires just one medical practitioner; the trained staff involved by not-for-profit organizations such as DIGNITAS do not need to be health professionals, though they are trained specifically for conducting PSAS, of course.

Re question 20 - 24: Assisted dying is about the right and freedom to choose; this concept of free choice should apply for the individual who wishes to make use of VAD just as much as for those (co-)decisive in and conducting a VAD process. Consequently, there should be no “gag clause” and no obligation on anyone to participate in VAD.

Education on the side of those providing VAD is a key factor in ensuring a safe VAD scheme, as is transparency, honesty, and making information easily available / accessible to those inquiring about and/or requesting VAD about *all* their health care options, and the general public.

²² Cf. the Assisted Dying in Jersey Consultation Report, page 33, para 76.a.
<https://www.gov.je/SiteCollectionDocuments/Health%20and%20wellbeing/Assisted%20Dying%20Consultation%20Report.pdf>

On the role of health services

Re question 25: The ACT could consider adopting the Swiss approach: the Swiss Federal Supreme Court ruled that a health service facility (in the case, a charitable care home) *subsidised by state funds* has to allow/tolerate PSAS taking place at its facility; the right and freedom of those living at such facility outweighs the freedom of religion and conscience (article 15 of the Swiss Federal Constitution) of the operator of the care home²³. In other words, only fully privately funded health service facilities may reject VAD taking place on their premises.

Taking the individual's / patient's perspective and the fact that a facility is the person's (new) home, non-discrimination demands that a person should be allowed to access VAD at the facility – they would not be denied having the option if they still lived outside of the facility in their private house or flat.

In this context, a recent research should be considered which found that in Victoria institutional objection adversely affected access to VAD and the wider end-of-life experience for patients and caregivers; this in a VAD system “that is already procedurally challenging, particularly given the limited window patients have to apply.”²⁴ Surely, the ACT is in the position to now implement a VAD system which will not lead to the same undesirable effects.

3) Assisted dying European perspective: a human right, freedom and choice

All European states – with the exception of the Vatican, Belarus and Kosovo – have adhered to the European Convention on Human Rights (ECHR)²⁵. In specific cases, set legal situations may be questioned whether they would be in line with the basic human rights and liberties enshrined in the ECHR. The European Court of Human Rights (ECtHR)²⁶ has developed an important jurisdiction on basic human rights, including the issue of the right to choose a voluntary death. According to its preamble, this international treaty is not only a fixed instrument, “securing the universal and effective recognition and observance of the rights therein declared” but also aiming at “the achievement of greater unity between its members and that one of the methods by which that aim is to be pursued is the maintenance and further realisation of human rights and fundamental freedoms”²⁷. The ECHR text and case law as well as further supreme court judgments may serve as an additional perspective in discussing a VAD law for the ACT, which is why DIGNITAS herewith outlines aspects of a selection of the ECtHR judgments, and further court judgments in relation to a self-determined and self-enacted end of suffering and life.

In the judgment of the ECtHR in the case of *DIANE PRETTY v. the United Kingdom* dated 29 April 2002²⁸, at the end of paragraph 61, the Court expressed:

“Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.”

²³ Judgment BGE 142 I 195 of 13 September 2016

²⁴ <https://bmcmethics.biomedcentral.com/articles/10.1186/s12910-023-00902-3>

²⁵ The Convention: http://www.echr.coe.int/Documents/Convention_ENG.pdf ; Member States:

<http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/005/signatures>

²⁶ <https://www.echr.coe.int>

²⁷ http://www.echr.coe.int/Documents/Convention_ENG.pdf page 5.

²⁸ Application no. 2346/02; Judgment of a Chamber of the Fourth Section <http://hudoc.echr.coe.int/eng/?i=001-60448>

Furthermore, in paragraph 65 of this judgment, the Court expressed:

“The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.”

On 3 November 2006, the Swiss Federal Supreme Court recognized that someone’s decision to determine the way of ending his/her life is part of the right to self-determination protected by article 8 § 1 of the ECHR, stating:

“The right to self-determination within the meaning of Article 8 § 1 [of the Convention] includes the right of an individual to decide at what point and in what manner he or she will die, at least where he or she is capable of freely reaching a decision in that respect and of acting accordingly.”²⁹

In that decision, the Swiss Federal Supreme Court had to deal with the case of a man suffering not from a physical but a psychiatric / mental ailment. It further recognized:

“It must not be forgotten that a serious, incurable and chronic mental illness may, in the same way as a somatic illness, cause suffering such that, over time, the patient concludes that his or her life is no longer worth living. The most recent ethical, legal and medical opinions indicate that in such cases also the prescription of sodium pentobarbital is not necessarily precluded or to be excluded on the ground that it would represent a breach of the doctor’s duty of care. [...] Where the wish to die is based on an autonomous and all-embracing decision, it is not prohibited to prescribe sodium pentobarbital to a person suffering from a psychiatric illness and, consequently, to assist him or her in suicide. [...] The question of whether the conditions have been met in a given case cannot be examined without recourse to specialised medical – and particularly psychiatric – knowledge and is difficult in practice; the respective assessment requires an in-depth psychiatric appraisal...”

Based on this judgment, the applicant made efforts to obtain an appropriate assessment, writing to 170 psychiatrists – yet he failed to succeed. Seeing that the Swiss Federal Supreme Court had obviously set up a condition which in practice could not be fulfilled, he took the issue to the ECtHR.

On 20 January 2011, the ECtHR rendered the judgement *HAAS v. Switzerland*³⁰ and stated in paragraph 51:

“In the light of this case-law, the Court considers that an individual’s right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention.”

²⁹ BGE 133 I 58, page 67, consideration 6.1 (translated) <http://bit.ly/BGE133I58>

³⁰ Application no. 31322/07; Judgment of a Chamber of the First Section: <http://hudoc.echr.coe.int/eng?i=001-102940>

In this, the ECtHR adhered to the Swiss Federal Supreme Court and acknowledged that the freedom to choose the time and manner of one's own end in life is a basic human right protected by the ECHR.

In a further case, *ULRICH KOCH v. Germany*, the applicant's wife, suffering from total quadriplegia after an accident, demanded that she should have been granted authorisation to obtain 15 grams of pentobarbital of sodium, a lethal dose of medication that would have enabled her to end her ordeal by choosing suicide at her home. In its decision of 19 July 2012, the ECtHR declared the applicant's complaint about a violation of his wife's Convention rights inadmissible, however, the Court held that there had been a violation of Article 8 of the Convention in that the [German] domestic courts had refused to examine the merits of the applicant's own rights he claimed³¹. The case had to be dealt with by the German domestic courts again. Finally, the German Federal Administrative Court corrected the lower courts judgments: The general right to personality article 2,1 (right to life) in connection with article 1,1 (protection of human dignity) of the Basic (Constitutional) Law of Germany comprises the right of a severely and incurably ill patient to decide how and at what time his or her life shall end, provided that he or she is in a position to make up his or her own mind in that respect and act accordingly. The Court found, even though it was generally not possible to allow the purchase of a narcotic substance for the purpose of suicide, there had to be exceptions³².

In the case of *GROSS v. Switzerland*, the ECtHR further developed its jurisdiction. The case concerned a Swiss woman born in 1931, who, for many years, had expressed the wish to end her life, as she felt that she was becoming increasingly frail, and she was unwilling to continue suffering the decline of her physical and mental faculties. After a failed suicide attempt followed by inpatient treatment for six months in a psychiatric hospital which did not alter her wish to die, she tried to obtain a prescription for sodium pentobarbital by Swiss medical practitioners. However, they all rejected her wish; one felt prevented by the Swiss code of professional medical conduct as the woman was not suffering from any life-threatening illness, another was afraid of being drawn into lengthy judicial proceedings. Attempts by the applicant to obtain the medication to end her life from the Health Board were also to no avail.

In its judgment of 14 May 2013³³, the ECtHR held in paragraph 66:

“The Court considers that the uncertainty as to the outcome of her request in a situation concerning a particularly important aspect of her life must have caused the applicant a considerable degree of anguish. The Court concludes that the applicant must have found herself in a state of anguish and uncertainty regarding the extent of her right to end her life which would not have occurred if there had been clear, State-approved guidelines defining the circumstances under which medical practitioners are authorised to issue the requested prescription in cases where an individual has come to a serious decision, in the exercise of his or her free will, to end his or her life, but where death is not imminent as a result of a specific medical condition. The Court acknowledges that there may be difficulties in finding the necessary political consensus on such controversial questions with

³¹ Application no. 479/09, Judgment of the Former Fifth Section: <http://hudoc.echr.coe.int/eng?i=001-105112>

³² See the respective press release by DIGNITAS <http://www.dignitas.ch/images/stories/pdf/mediennmitteilung-08032017.pdf> (in English); link to the judgment by the Federal Administrative Court of Germany: <http://www.bverwg.de/entscheidungen/entscheidung.php?ent=020317U3C19.15.0> (in German).

³³ Application no. 67810/10; Judgment of a Chamber of the Second Section: <http://hudoc.echr.coe.int/eng?i=001-119703>

a profound ethical and moral impact. However, these difficulties are inherent in any democratic process and cannot absolve the authorities from fulfilling their task therein.”

In conclusion, the Court held that Swiss law, while providing the possibility of obtaining a lethal dose of sodium pentobarbital on medical prescription, did not provide sufficient guidelines ensuring clarity as to the extent of this right and that there had been a violation of article 8 of the Convention. However, the case was referred to the Grand Chamber of the ECtHR by the Swiss government as, prior to a public hearing on the case, it became known that the applicant had passed away in the meantime. This led to the case not being pursued.

Another important judgment was rendered on 26 February 2020 by the Federal Constitutional Court of Germany³⁴: The court declared unconstitutional and void § 217 of the German Criminal Code (“geschäftsmässige Förderung der Selbsttötung”), a statutory provision that had criminalised repeated – and thus professional – advisory work and assistance for a self-determined ending of one’s own life³⁵. The Court held:

“As an expression of personal autonomy, the general right of personality (Art. 2(1) in conjunction with Art. 1(1) of the Basic Law) encompasses a right to a self-determined death. The right to a self-determined death includes the freedom to take one’s own life. Where an individual decides to end their own life, having reached this decision based on how they personally define quality of life and a meaningful existence, their decision must, in principle, be respected by state and society as an act of personal autonomy and self-determination. The freedom to take one’s own life also encompasses the freedom to seek and, if offered, make use of assistance provided by third parties for this purpose. [...] The right to a self-determined death, as an expression of personal freedom, is not limited to situations defined by external causes. The right to determine one’s own life, which forms part of the innermost domain of an individual’s self-determination, is in particular not limited to serious or incurable illness, nor does it apply only in certain stages of life or illness. [...] The right to a self-determined death is rooted in the guarantee of human dignity enshrined in Art. 1(1) GG; this implies that the decision to end one’s own life, taken on the basis of personal responsibility, does not require any explanation or justification. [...] What is decisive is the will of the holder of fundamental rights, which eludes any appraisal on the basis of general values, religious precepts, societal norms for dealing with life and death, or considerations of objective rationality [...].”

On 11 December 2020, the Austrian Constitutional Court³⁶ rendered its judgment on a constitutional complaint against the prohibition of assistance in suicide and voluntary euthanasia. § 78 “participation in self-murder” (sic!) of the Austrian criminal code, which was set up in the Austro-fascist 1930s, said: “Any person who incites another to commit suicide [literally: ‘kill himself’], or provides help in this, is liable to a custodial sentence of six months to five years.” The Court found the second part of § 78 (“or provides help in this”) unconstitutional, with effect from 1 January 2022. In essence the Court held:

³⁴ https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2020/02/rs20200226_2bvr234715en.html

³⁵ See: <http://www.dignitas.ch/images/stories/pdf/medienmitteilung-26022020-e.pdf>

³⁶ Abstract in English provided by the Court: https://www.vfgh.gv.at/downloads/Bulletin_2020_3_AUT-2020-3-004_G_139_2019.pdf; respective press release by DIGNITAS: <http://www.dignitas.ch/images/stories/pdf/medienmitteilung-11122020-e.pdf>

“A right to free self-determination is to be derived from several constitutional guarantees, in particular the right to private life, the right to life, as well as the principle of equality. This right also extends to the freedom to end one’s own life. Where a person decides to end his or her own life, this decision must be respected by the State provided that it is based on the free will of the individual concerned. The right to end one's own life also includes the freedom to seek and, where offered, make use of assistance provided by third parties for that purpose. [...] From a fundamental rights perspective there is no difference between a patient that refuses life-prolonging or life-maintaining medical measures within his or her sovereignty over treatment or by exercising his or her right to self-determination within his or her living will, and a person willing to commit assisted suicide as part of his or her right to self-determination in order to die in dignity. In both cases, the decisive aspect is that the decision is taken on the basis of free self-determination.”

In this context the so-called ARTICO-jurisdiction based on the ECtHR judgment of 13 May 1980, series A no. 37, no. 6694/74, paragraph 33³⁷ needs to be remembered:

“The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective; ...”

Dignity and freedom of humans mainly consists of acknowledging the right and freedom of someone who does not lack capacity to decide even on existential questions for him- or herself, without outside interference. Everything else would be paternalism compromising dignity and freedom of choice. In the judgment *PRETTY v. the United Kingdom* mentioned before, the Court correctly recognized that this issue will present itself increasingly – not only within the Convention’s jurisdiction, but internationally – due to demographic developments and progress of medical science.

It also presents itself increasingly because a growing part of the public wishes to have the freedom and right to choose the course of their own life *and* their end in life³⁸. Yet sometimes it can be observed that politics and linked administrative authorities take another stand and block or delay assisted dying legislation, despite a majority of the public being in favour of such choice being legalised. The public opinion is relevant from an ECHR perspective: in the judgment *OLIARI AND OTHERS v. Italy* dated 21 July 2015, the ECtHR observed a reflection of the sentiments of a majority of the (in this case Italian) population as shown through official surveys³⁹.

4) Terms and abbreviations used in this submission

Assisted dying: an umbrella term including PSAS and/or voluntary euthanasia with the support of and/or carried out by doctors/physicians. In this submission, depending on the context, it is used as defined in the consultation discussion paper.

Assisted/accompanied suicide and physician-supported accompanied suicide (abbreviation: **PSAS**): this is what is made possible for members of DIGNITAS in the frame of Swiss law. A person wishing to put an end to their suffering and their life chooses a well-considered, carefully prepared self-administration of a lethal substance provided by a (Swiss) physician

³⁷ <http://hudoc.echr.coe.int/eng?i=001-57424>

³⁸ E.g. <https://yonderconsulting.com/largest-ever-poll-on-assisted-dying-conducted-by-populus-finds-increase-in-support-to-84-of-the-public>

³⁹ <https://hudoc.echr.coe.int/eng?i=001-156265> paragraph 181 / 144.

usually at their home. The physician has assessed the person's request and medical file, the person is accompanied by professionals all through the process until the end, and next-of-kin and friends are involved.

Voluntary assisted dying (abbreviation: **VAD**): as defined in the ACT discussion paper page 4.

Voluntary euthanasia: a person wishing to end his/her suffering and life requests and permits a third person to put an end to his/her life, for example by injection of a lethal medication. This is prohibited in Switzerland, yet legal under certain circumstances in some countries such as Belgium, Luxembourg and the Netherlands.

Passive euthanasia: (termination of treatment, "to let die"): ending or not starting life-maintaining and life-prolonging therapies, renouncing treatments, waiving food and drink.

Palliative care: an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (as defined by the World Health Organisation WHO).

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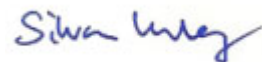
Yours sincerely,

DIGNITAS

To live with dignity - To die with dignity



Ludwig A. Minelli



Silvan Luley