Medical, legal, social and bioethical assessment of euthanasia

Any reflection on euthanasia should be made from a medical, social and bioethical perspective. See, continue to read or pass to Part II Bioethical aspects – Part III Legal and social aspects

I – Medical aspects

As has been the case on and off for many years, the call for the legal regulation of euthanasia — defined by the Oxford English Dictionary as "the ***painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma***" — has once again entered modern-day political and social discourse.

Euthanasia is based on the ***administration of drugs and other substances with the intent to cause the death of a person*** at their request or that of their representatives, in order to bring about death using a "**theoretically safe, relatively quick and painless method".**

Euthanasia current definition

While the legal definition of euthanasia varies across countries, one Spanish law (1) defines euthanasia as actions that:

- a) cause the death of patients, that is, directly and intentionally by means of a single, immediate cause-effect relationship,
- b) are carried out at the express and informed request, repeated over time, of competent patients,
- c) is carried out in a context of suffering considered unacceptable by the patient due to an incurable disease that has not been successfully mitigated by other means, for example, by palliative care, and
- d) are performed by healthcare professionals who know the patient personally and who have a significant clinical relationship with him/her.

Limitation of treatment

Unlike euthanasia, **"limitation of treatment"** (LOT) is defined as: the withdrawal or non-implementation of a life support measure (see HERE our bioethical approach) or any other intervention which, given the poor prognosis of the person in terms of future quantity and quality of life, constitutes, in the opinion of the healthcare providers involved, something futile, which merely contributes to prolonging a clinical situation that lacks reasonable expectations for improvement.

Assisted suicide

It is also important to bear in mind the definition of assisted suicide, which consists of **providing the person who wishes to die with drugs or other substances that may be self-administered to induce his or her death.**

Difference between euthanasia, assisted suicide and limitation on treatment – LOT

There are, therefore, important differences between euthanasia, assisted suicide, and LOT. While in euthanasia and assisted suicide, death is deliberately and intentionally caused through the administration of an external agent, in LOT, death occurs as a result of the disease, which is what causes the death of the patient. Only in this latter context (LOT) can the action of the clinician, through palliative care, be considered good clinical practice (following the proper actions), regardless of the time elapsed between taking the decision to limit treatment and death. During this period, the activities of the medical team are aimed at relieving pain and alleviating suffering, and death will occur as a consequence of the disease and not as a result of the administration of drugs or other agents.

Medical procedures to produce patient death

In the Netherlands, there are various procedures to produce death of the patient, none of which are related to symptom relief; instead, they **seek to cause death directly through cardiac arrest**. The most commonly used method is the *administration of high-dose barbiturates to induce coma in the patient, followed by the administration of muscle relaxants that cause respiratory arrest and, consequently, cardiac arrest. On other occasions, intravenous potassium chloride is used to directly induce cardiac arrest.*

In 367 cases of euthanasia investigated by Van de Wal investigations, the most widely used drugs for euthanasia purposes were: neuromuscular relaxants in 55 % of cases, barbiturates in 49%, benzodiazepines in 34%, morphine in 29% and other drugs in 9%. In 23% and 20% of cases, the benzodiazepines and barbiturates, respectively, were combined with a muscle relaxant.

The cause-effect relationship between the administration of drugs to induce euthanasia and the time of death is so evident that in several series on the practice of euthanasia in Holland, the death of the patient occurred within the first hour after administration of the drug in more than 60% of cases.

The reality of the practice of euthanasia globally goes far beyond the very definition of euthanasia

The reality of the practice of euthanasia globally goes far beyond the very definition of euthanasia insofar as "death occurs in patients in the terminal stages of incurable diseases". Because, although it is true that, on many occasions, euthanasia is applied to terminally ill patients, in other cases it is applied to individuals with irreversible, but not terminal, disease.

One group of diseases that have often been associated with euthanasia are the **neurodegenerative diseases**, most notably amyotrophic lateral sclerosis (ALS), which causes progressive muscle weakness that ends in respiratory failure. Accordingly, in a Dutch study conducted in ALS patients, 20% chose euthanasia or assisted suicide to bring about death. Just as the decision to opt for euthanasia with assisted suicide bore no relationship with the clinical aspects of the disease, it was observed that patients who considered religion to be important in their lives were less inclined to request or want euthanasia.

Not terminally ill but have irreversible diseases, not in the terminal stage

In Belgium (see HERE), most patients who undergo euthanasia are not terminally ill but have irreversible diseases, although. Thus, in some studies, cancer patients accounted for almost 70% of cases in whom euthanasia or assisted suicide was performed. In contrast, in other studies, such as one that analysed death certificates issued in Flanders (Belgium), the ***vast majority of diseases that generated a demand for euthanasia were neurologica***l: neurological deficit secondary to cerebrovascular disease in 28.2 % of cases and non-vascular neurological processes in 22.4%. Other diseases accounted for 26.5%, cardiovascular disease 14.4%, and cancer 14.4% (2).

Bioethical assessment of medical professional deliberately causing someone's death

In order enter into the bioethical assessment of deliberately causing someone's death, according to whether or not certain conditions are met, these must be evaluated, as must the lawfulness of the medical intervention and the compatibility of this practice with ***the respect for human dignity that everyone merits***, regardless of their circumstances.

Suffering at the end of life, a realistic analysis

The suffering reported by patients in chronic, terminal or agonising processes includes symptoms that are difficult to control using routine therapeutic measures, which place a burden that can seem unbearable in certain cases. These symptoms have been defined as "refractory" and "difficult" symptoms.[1] (Cherny & Portenoy, 1994;)

The term "refractory" can be applied to a symptom when it cannot be adequately controlled despite efforts to find a tolerable treatment, within a reasonable timeframe, without compromising the patient's consciousness.

However, the term "difficult" can be applied to a symptom that, in order to be adequately controlled, requires an intensive therapeutic intervention, beyond the usual measures, from a pharmacological, instrumental, and/or psychological perspective.

The most common clinical symptoms in these cases are **intense pain**, **dyspnoea, delirium and psychological distress**. To these should be added the psychological suffering of the patient who fears its outcome, the suffering that might ensue, *the solitude with which he or she must confront* it or the lack of existential sense to positively face an experience like this.

Nevertheless, in many cases in which patients have requested euthanasia, the individuals in question are not dying, but are patients whose ***physical limitations make it impossible to live a normal life, often due to insufficient family and/or social support***. Many patients do not wish to die because of the presence of

unbearable pain but, above all – as shown in the literature – because of the *loss of autonomy and the perception of little dignity*.[2]
It is these circumstances that can trigger the so-called Desire for Hastened Death in the suffering patient, which should be considered as a further consequence of the degenerative process itself. Far from being a reason for applying euthanasia, it instead represents another symptom that should be included in the comprehensive palliative treatment required by the patient.

Suffering in the final stage of life or in advanced chronic disease is therefore not limited to clinical symptoms, but affects the person as a whole, i.e. it also affects their psychological and spiritual or transcendent dimensions.

It is imperative to clearly establish the foregoing to successfully formulate the intervention required by these patients, which as can be inferred, goes beyond the treatment of refractory or difficult symptoms.

To support or to end life?

The dilemma arises in the case of a patient who is experiencing, or who is afraid of experiencing, *unbearable suffering at a certain time during their illness or in a state of deep anguish, not always related with a physical disease.*

The development and gradual implementation of palliative medicine (hospital units and multidisciplinary professionals), specialised in the support and treatment of all the symptoms that accompany patients in these circumstances, has opened new perspectives in the approach to suffering in chronic, incurable or terminal process.

Frequently we find in the defenders of euthanasia and assisted suicide – including peer-reviewed articles – a devaluation or a total silence about palliative care efficiency to give quality of life to the terminally ill patient.

Palliative care offers a support system to help the patient and their family to adapt during the disease and in the bereavement. It uses a team approach to respond to the needs of patients and their families, including emotional support in the bereavement, when indicated. It improves quality of life and can also positively affect the course of the disease.

It can be applied at an early stage, in conjunction with other life-prolonging treatments, such as chemotherapy or radiotherapy, and includes those tests required to better understand and manage complex clinical situations.[3]
Palliative care includes the possibility of sedation, which means loss of consciousness, to differing degrees according to the needs of each situation. Thus, the sedation can be temporary, palliative or terminal, depending on its characteristics. It entails a reduction in the consciousness of patients to varying extents and, consequently, will be reversible or irreversible.

Euthanasia: the "failure" of palliative medicine?

The approach of the possibility of ending the life of a patient suffering from some of the symptoms described is a clear example of the failure of palliative medicine (staff) or, perhaps, the consequence of its non-use.

The aims of medicine include pain relief in the patient, the alleviation of suffering, care of incurable patients and the search for a peaceful death.[4]
In fact, article 28.1 of the Spanish Medical Association Code of Ethics and Professional Conduct (*Código de Ética y Deontología Médica de la Organización Médica Colegial española*) states that "The physician

must never intentionally seek the death of a patient, not by his own decision, nor when the patient or his or her relatives request it, nor by any other imperative. Euthanasia or 'compassionate homicide' is contrary to medical ethics".
Accordingly, from a professional conduct perspective, there seems to be no room to consider the lawfulness of medical interventions — irrespective of what they are — aimed at achieving, as the first effect, the death of the patient, regardless of their circumstances.

Article 28.2 of the aforementioned Code also clearly sets out the following: "In the case of incurable and terminal disease, the doctor must limit him- or herself to relieving physical and moral pain, maintaining as far as possible the quality of a life that is ending, and trying to avoid implementing or continuing therapeutic actions that are hopeless, futile or obstinate. He or she must attend the patient to the end, with the respect that human dignity deserves".

Accordingly, undertaking actions aimed at ending the life of a patient implies sidestepping the ethical obligation that all professionals contract with their patients, adopting a position that is the exact opposite to the one that justifies their professional practice, aimed at providing health and relieving the suffering of people who experience it, as a requirement that springs from human dignity and the right to live.

Palliative care: Efficient Antidote to eutanasia

"The World Health Organization (WHO) reports that palliative care continues to be 'insufficient' at the global level since each year only 14% of patients who need it receive it. Palliative care reaches its highest degree of efficacy when implemented at an early stage during the course of the disease, according to the WHO website, given that it 'not only improves the quality of life of patients, but it also reduces unnecessary hospitalisations and the use of health services' (We don't understand why palliative care is not included in WHO Universal Health Coverage (UHC) recent goals).[5]
In Spain, according to the Spanish Society for Palliative Care (SECPAL) in 2014, comprehensive end-of-life care is a right that is not guaranteed for all patients and families who suffer an advanced, chronic and irreversible disease, and its physical, emotional and spiritual consequences.[6] The lack of equity in the distribution of palliative resources means that coverage reaches less than 60% of the Spanish population, which is a cause of avoidable suffering for thousands of people. As Álvaro Gándara, president of SECPAL, explains, palliative care is "the only way of alleviating the suffering caused by advanced, chronic and irreversible diseases, and the best strategy to confront the death of these patients in a dignified manner".

The development of palliative care services when there is good care from teams of palliative care professionals with the involvement of the community and a volunteer network significantly reduce the number of demands for euthanasia or assisted suicide.

According to Christoph Ostgathe, president of the scientific committee of the 15th World Congress of the European Association for Palliative Care held in Madrid in 2017, "the development of palliative care services makes it possible to reduce the number of demands for euthanasia or assisted suicide". Similarly, Rafael Mota, president of the SECPAL says that "when there is good care from teams of palliative care professionals, with the involvement of the community and a volunteer network, these requests continue to diminish".[7]

Consequences of the legalisation of euthanasia: A slippery slope

As we published on the Bioethics Observatory website,[1] a study conducted every five years to determine the causes of death in the Dutch population revealed that more than 400 of its citizens lost their lives as a result of euthanasia without having given their consent.[2]
As the Euthanasia Prevention Coalition indicates, the study, which covers the period 2010-2015, recorded 7,254 assisted suicides, 431 of which were "termination of life without request".

Now, a recent study published in the British Medical Journal[3] has presented findings for the last five years, where the number of people who have died by euthanasia in the Netherlands has risen by 67%: from 4,188 in 2012 to more than 7,000 in 2017.
Another study concluded that euthanasia and assisted suicide increase in countries where both practices are legal, mainly in patients with cancer.9

Furthermore, a study conducted in Flanders in 1996 found that 3.3% of cases of euthanasia had occurred without the mandatory patient request. In other words, it was “involuntary euthanasia”, while another — also conducted in Flanders — found that there had been ***1,796 cases of involuntary euthanasia*** (3.2%).[4] A more recent analysis from 2007 found that the percentage of involuntary euthanasia, i.e. not requested by the patient, was 1.8%,[5]while another in 2013 found 1.7%.[6] However, in patients who were 80-years-old or over, the percentage of involuntary euthanasia, not requested by the patient, rose to 52.7%, while in those with diseases other than cancer, this figure reached 67.5%. The decision was not discussed with the patient in 77.9% of cases. [7]

Legalisation of paediatric euthanasia

To this list of problems should be added the legalisation of paediatric euthanasia, which was recently approved by the Belgian Senate.[8] There is also the possibility of applying euthanasia merely because a healthy patient requests it, i.e. without an objective medical cause that induces unbearable suffering, but simply because they are “tired of living”. In 2014, the Dutch coalition government ordered a report by a committee of specialists who were charged with assessing the legal viability and social dilemmas that would be entailed in decriminalising the assisted suicide of people who consider that “their life is complete”.[9]
Likewise, patients with a severe chronic disability, who cannot be considered patients at the end stage of life, would be affected by this slippery slope. Just as an evolution towards definite death is expected in terminally-ill patients, and consequently what is probably needed is good medical, spiritual and family care, with comfort or palliative therapy, patients with a chronic disability have an expected survival that is often identical to that of patients with no disability or healthy persons.

These scenarios show the true face of euthanasia which, devoid of all compassionate attitude, is shown openly as a **legal homicide**.
The *desire* to die as a premise of a subjective right with prospects of reaching constitutional rank
The right to life is a fundamental value of the legal system, a *prius* for recognition of the other rights inherent to the human being and enforceable against all, and should be respected both by individuals and by any power or authority. The right to life falls within so-called personal rights, considered as a subjective right inherent to the human being due to the mere fact of being one and of existing, regardless of the life stage.
Those in favour of recognising the right to die, or what they characterise as the right to a dignified death, propose abolishing the penal sanction for euthanasia, which contradicts the above. They also suggest that its prohibition and penalisation is a violation of several fundamental rights of the person: the right to life, to physical and moral integrity and to personal autonomy. All this would lead us to stop considering assisted suicide and medical assistance “to die” as a crime, and to recognise it as a right of the person.

Following on from the previous point, conflicting values of central importance should be weighed up: On one side, the sanctity of life, all of it worthy, and the need to protect the vulnerable from possible abuses and errors, and on the other, the scope of the autonomy of a capable adult who requests death in response to a serious and irreversible medical condition.

Analysing the different rights at stake, one can argue what is set forth below:

1. **Human life, as a personal right of a person, cannot be renounced**

There is international recognition of human life as a fundamental and supreme value of the judicial system upon which other values and rights of the individual are based and exercised, such as freedom, equality and justice – foundations, likewise, of political order and social harmony. [10]
The right to life — essential and basic — is the first and foremost of the human rights affected in this matter in connection with the right to physical and moral integrity, and recognised as such in the vast majority of the constitutions of democratic countries.

In the discussion on euthanasia, one issue to debate is whether the fundamental right to life includes the freedom to dispose of it, at least in certain cases, and, if so, in and under which circumstances. Another issue that should be raised is in which constitutional precept should this new so-called "right to die" that is demanded be enshrined, without it being included in the shadow of the right to life, precisely because both concepts are opposing per se.[11]
The constitutional regulation, in western countries, of the right to life[12] has been understood as an argument to establish the prohibition of euthanasia, on the basis that the constitutionally guaranteed right to life has the primary meaning of a guarantee against the State, which obliges it to respect and protect the life of everyone, with a positive protection content that prevents it from being configured as a right to freedom that includes the right to one's own death. Therefore, it confers on the State the obligation to respect and protect life, even against its bearer. [13] It is not appropriate, in my opinion, to include this desire to die in the shadow of the right to life, insofar as it fails to recognise that the right to legal protection of life includes the freedom to dispose of it.
This does not prevent, however, acknowledging that life being a right of a person, he or she can tactically decide over some aspects of their own death. This provision constitutes a manifestation of *agere licere,* inasmuch as acceptance of death itself is an act that the law does not prohibit (in the sense of accepting palliative care or opposing therapeutic obstinacy, we should add) and not, in any way, a subjective right that involves the possibility of mobilising the support of public authority to overcome the resistance that opposes the will to die,[14] nor, much less, a subjective right of a fundamental nature in which that possibility is extended even against the resistance of the legislator, attempting to modify the regulation and stripping of guarantees the right to introduce reductions in its essential content. It is impossible to accept that recognition of the right to life itself includes the right to death itself, to dispense with one's own life, in such a way that one can validly consent to one's death. Therefore, it cannot be concluded that there is a subjective right to death itself guaranteed in any national or international legal instrument.[15]
Having consequently analysed and excluded the right to die, a new front is opened: if the right to die does not fit, the advocates of euthanasia raise the question of dignity in dying or the right to live the process of dying with dignity. We change the noun: "right" to "dignity".

In the usual discussion on dignity and the right to die, the question that arises is whether all human life is worthwhile, or if below an undefined quality threshold, the demand for death is enshrined in a right, specifically the misnamed dignity of death. Dying when one wants, without interference from anyone, is not a right to dignified death. [16] The desire to die put into practice does not endow death with greater dignity.
On the contrary, in the debate on euthanasia, two trick arguments arise:

- **the quality of life of the individual**
- **and their desire to die.**

And two attitudes demanded of the State and the community: that of abstaining from punishable sanctions in the decision to kill an individual, on one side; and that of collaborating in the assisted suicide or medical death caused by human, pharmacological, technical and economic means.

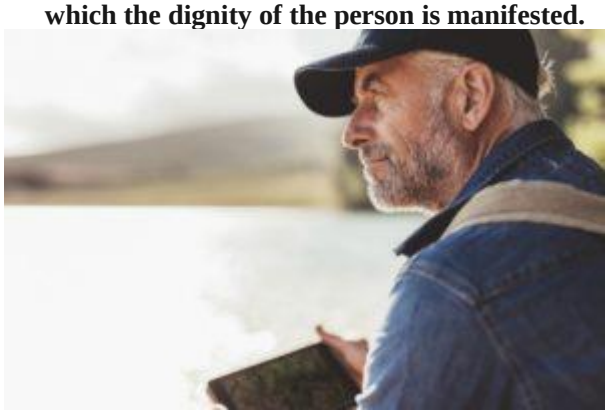
The desire to no longer continue living in certain circumstances, which would include palliative care and LOT, i.e. assistance "in dying", in which death is not intended, either as an end or as a means, but only expected and tolerated as inevitable, should not be confused with medical assistance "to die", which includes physician-assisted suicide and direct active medical euthanasia. At present, most democratic countries permit medical assistance "in the dying", but ban medical assistance "to die". *To kill* or *to commit suici*de is not the same as *to let oneself die*. In the first two cases, the cause of death is the act of a third party or the patient himself, while in the third, the cause of death is the underlying disease. [17]
Those in favour of euthanasia try to put the emphasis and justification for their demand on the existence of lives lacking in life value, i.e. unworthy.[18] This inadequate distinction between human beings, worthy and

unworthy, had serious consequences in recent periods of the last century,[19] and it is presently intended that those considered unworthy lives can be ended at the will of the individual and perhaps later on, of interested third parties: relatives, doctors, health service or pensions managers, and also, unfortunately, law courts, etc. In any case, it should be prevented — prosecuted even — that legal interests as important as life and the dignity of the person are left to the fate of the random opinions and emotions of healthcare providers, legal practitioners or the patient's family or relatives. At the root of the controversy is the classification of what should be considered as an unworthy life and who decides this: the State, the courts, doctors, relatives? This entails an uncertain future for some groups such as the disabled and minors, on which others could decide, and for the elderly, a very vulnerable group that could be pressured to request assisted suicide.
If laws are passed that lay the foundations for the validity of suppressing lives "unworthy" of living, not only would it be recognising the existence of unworthy lives and diseases, it would also be differentiating individuals with worthy lives who no longer want to go on living them. Because if a right to die is recognised, why limit it to just a few individuals? This, unfortunately, would be the next slippery and very dangerous step.

In any case, the sanctions imposed by the criminal legislation of different countries mean that the so-called right to dispose of one's life is not recognised in that positive legal framework; otherwise, acts of cooperation to the practice of assisted suicide could not be treated as unlawful. The penal sanction for medical assistance "to die" – which it is now hoped to abolish – reflects the severity with which the system considers the decision to deprive oneself or another of life and the reluctance to accept or promote such decisions. If they are decriminalised, this would reflect a change of assessment towards those behaviours. They would become one more means in the arsenal of medical treatments, with the added risk that this involves and the lack of guarantees in the defence of human life and dignity of the patient.

2. **Banning suicide and assisted suicide, is not a violation of the right to physical and moral integrity** The right to physical and moral integrity that is protected with the recognition of the right to life is invoked not only against attacks aimed at harming his or her body or spirit, but also, against any type of intervention in those assets that lacks the consent of his or her owner, so this constitutional right will be affected when medical care is imposed on a person against their will and, consequently that coercive medical care will constitute a limitation that violates the fundamental right, unless it has constitutional justification. Nevertheless, we should bear in mind that some laws prevent the individual from putting their physical integrity — and therefore their lives — at risk, but this does not mean that they violate the fundamental rights to life, physical integrity and freedom. Moreover, not only should the right to life not be the object of attacks by the Public Authorities, but, in addition, these should act to ensure and support such an important right. This should be linked with that set out below.

3. **The right to freely dispose of one's life as a false corollary of the right to self-determination in which the dignity of the person is manifested.**



The desire of the human being to end his life, for various reasons, does not constitute a subjective right of freedom, as we have already discussed. The rights of the person are irrevocable even for the subject who holds them.

Has the exercise of self-autonomy limits?

The decision to end one's life in the exercise of the autonomy of the will collides head-on with its limits: the law, the moral and public order. Freedom

is not a right or a value of the legal system that ranks higher than 0the right to life.

The fact that criminal law has for some years ceased to punish a suicide attempt — due to the obvious futility of imposing a sentence on someone who is willing to impose the most serious thing one can imagine on themselves — does not make their unlawful act a right to suicide. As a result, if the person who takes his own life does not exercise a right, neither can he transmit it to another person nor give rise to the emergence of a duty to provide – assisted suicide – which would correspond against all logic to a non-existent right. The consequence of this reasoning is that the executive or cooperative intervention in someone else's suicide cannot, in principle, remain outside criminal law.

The right to freedom and personal autonomy does not include the freedom to demand lethal measures or drugs that pursue the aim of death of the subject, the person who requests it since life is no longer desirable for him. Those who postulate the acceptance of the right to assisted suicide understand that self-determination of one's own life not only implies freedom in the conduct of each person's life project, but also the power to decide when and in which circumstances one should put an end to its realisation.

This desire to die does not constitute a right that accords a subjective choice to the dignified liking of each individual to choose their own death; it does not suppose a subjective right that compels the State to a certain provision, a supposition that would once again lead us to active euthanasia. On the contrary, on the basis of the autonomy of the will, the freedom of the patient to reject certain therapeutic treatments can be argued and therefore, on the one hand, it guarantees that a medical treatment is not prolonged against their will (therapeutic obstinacy), and on the other, that in the irremediable process of death, the person/patient does not suffer unnecessarily, i.e. that they can receive palliative care and their pain treated, alleviated as much as possible.

This, in contrast, does guarantee and protect the right to a dignified death.

Conclusion

Have euthanasia and assisted suicide the background of suicidal acts?

The ethical judgment of euthanasia and assisted suicide shows the contradiction that underlies these practices when trying to establish the difference between the right to euthanasia and suicide. Certainly, in our opinion, both actions are essentially very similar insofar as they express the desire of a person to take their own life, and in both cases most likely for a painful reason that affects them deeply. This might be seen more clearly in euthanasia acts, but we believe that it also always exists in the ***background of suicidal acts.***
In response to this, we could ask: Why in the euthanasia act does the idea of helping the person to achieve their goal prevail, even with the participation of third parties, and in contrast, in suicide, one tries to dissuade the person from suicide by all means, even sometimes

endangering the life of other people or intervening medically to restore their health if the attempt has been frustrated?

It could be said that a type of "social evolutionary genetics" linked to the survival instinct and the natural inclination to respect the dignity of oneself and others prompts us to know that we must always try to save people's lives, even if their explicit intention is to take it, as happens with suicides.

Euthanasia and freedom

Is ending one's life a truly free act? This question is relevant because free acts are those that strengthen freedom, those that enhance our abilities to live and that improve the person. Therefore, an act that ends one's own life would be an act that would prevent further acts, it would go against that possibility of enhancing our capacity for freedom. Consequently, would suicide not be an act contradictory to human freedom? According to this premise, an act that prevents new acts being carried out contradicts freedom. If freedom denies itself in its exercise, what is it really?

"Primum non nocere"

This Latin phrase, attributed to Hippocrates, establishes a professional conduct and bioethical framework for the practice of medicine in respect for human dignity. It is hard to imagine the greater harm that can be caused to a person than to take their life. It is the definitive harm, the irreversible harm.

There are no differences in the ethical judgement of euthanasia and assisted suicide; neither can it be established for any other case in which available clinical means are not used to cure or alleviate but to exterminate.

Euthanasia and assisted suicide disgrace medicine, betray its principles and vilify those to propose, defend, justify or facilitate them.

The extension, improvement and specialisation of palliative care as an effective means to address suffering in serious and incurable disease or terminally-ill patients in any circumstance that requires it shows, in contrast, the kind face of medical science, which devotes its efforts to *treating any suffering person with the dignity that they deserve, including as a component of this suffering the desire for a hastened death.*
As Pope John Paul II said, "euthanasia is one of those dramas caused by an ethic which seeks to establish who can live and who must die. Even when it is motivated by sentiments of a poorly understood compassion, euthanasia, instead of redeeming the person from suffering, suppresses."

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[9]http://www.elmundo.es/sociedad/2016/10/13/57ffc565ca4741cc1c8b4602.html.
[10] The Universal Declaration of Human Rights adopted by the United Nations General Assembly on 10 December 1948 proclaims in art. 3 that "everyone has the right to life"; the Convention for the Protection of

Human Rights and Fundamental Freedoms of Rome 1950, in art. 2.1-1, establishes that "everyone's life shall be protected by law"; and the International Covenant on Civil and Political Rights of 19 December 1966 begins Part III with art. 6.1, which states that "every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life"; art. 4.1 of the Pact of San José (also known as the American Convention on Human Rights) states that "every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception…"; And the African Charter on Human and People's Rights, art. 4: "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person…".

[11]Rey Martínez, F. Critical commentary on the sentence of the Supreme Court of Canada of February 6, 2015 in the matter of Carter v. Canada).

[12]Among others, by way of example and by no means exhaustive: the Spanish Constitution begins Section 1, "Fundamental Rights and Public Liberties", within Chapter II on "Rights and Liberties" of Part I "Fundamental Rights and Duties", with art. 15, which proclaims that "everyone has the right to life", i.e. it makes no distinction of the life stage of the individual to proclaim their recognition without limits, establishing, for its part, art. 9.1 of the aforementioned Fundamental Law that "Citizens and public authorities are bound by the Constitution and all other legal provisions". This is also included in article 2 of the German Constitution; article 1 of the Mexican Constitution; article 66 of the Ecuadorian Constitution; article 19.1 of the Chilean Constitution

[13] Spanish Constitutional Court rulings STC 120/1990, of 27 June (Legal Basis 7) and STC 137/1990, of 30 July (Legal Basis 5) in relation to the hunger strike of some GRAPO prisoners. However, the aforementioned rulings have been considered as relevant in the discussion on the right to life in relation to euthanasia.

[14] The abundant jurisprudence of the ECHR is significant; this denies the right to assisted suicide or euthanasia for being contrary to the European Convention on Human Rights, specifically ECHR ruling, Pretty v. the United Kingdom, of 29 April 2012 (Judgement of the Court). The applicant was dying of motor neurone disease, a degenerative disease affecting the muscles for which there is no cure. Given that the final stages of the disease are distressing and undignified, she wished to be able to control how and when she died. Because of her disease, the applicant could not commit suicide alone and wanted her husband to help her. But, although it was not a crime in English law to commit suicide, assisting a suicide was. As the authorities refused her request, the applicant complained that her husband had not been guaranteed freedom from prosecution if he helped her die. The Court held that there had been no violation of Article 2 (right to life) of the Convention, finding that the right to life could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die. The Court also held that there had been no violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention. Even if it could not but be sympathetic to the applicant's apprehension that without the possibility of ending her life she faced the prospect of a distressing death, nonetheless, the positive obligation on the part of the State which had been invoked would require that the State sanction actions intended to terminate life, an obligation that could not be derived from Article 3. The Court lastly held that there had been no violation of Articles 8 (right to respect for private life), 9 (freedom of conscience) and 14 (prohibition of discrimination) of the Convention.

[15] Marcos Del Cano, A. M., La eutanasia. Estudio filosófico-jurídico, Marcial Pons, Madrid, 1999, p. 153.

[16] Miguel Serrano, J., Sentencias constitucionales sobre la muerte digna. *Persona y Derecho*,54 (2006) p. 237 en http://eprints.ucm.es/12001/1/PD_541_12_sentencias_constitucionales_sobre_la_muerte_digna.pdf obt. 9 de mayo 2018.

[17]Rey Martínez, F., La ayuda médica a morir como derecho fundamental. (Comentario crítico de la sentencia de la Corte Suprema de Canadá de 6 de febrero de 2015, asunto *Carter v. Canadá*), Diario La Ley, Nº 8512, Sección Doctrina, 1 de abril de 2015, p.10.

[18] The person makes up an integral and complete whole, which incorporates both purely material, physical and biological aspects, as well as those of a spiritual, mental and psychic nature. Their life and health, to truly correspond to human dignity, requires the confluence of all these factors as essential, insofar as they help to shape the whole of the individual.

[19] Curiously, article 1 of the current German Constitution recognises that "Human dignity is inviolable. To respect and protect it is the duty of all state authority".

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