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Critical Analysis the on the Citizens' ‘Right to Die’

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Abstract: *The law needs to protect citizens' "right to die". With the rapid development of modern medical technology, extending life in an artificially limited way has become possible. Accordingly, the "right to die", especially the choice of life self-determination and end-of-life medical treatment, has become a social and legal issue that cannot be avoided. In this article, we will analyse specific cases from the perspectives of competent and incompetent patients to demonstrate the connection between the "right to die" and the human rights of citizens and explore the legal protection of the "right to die". The paper will discuss the need for legal protection of the "right to die". It is argued that the safety of the 'right to die within the framework of human rights is the basis for protecting the right to self-determination and dignity of citizens and the defence of Article 8 rights in the framework of the European Convention on Human Rights. The security of the patient's right to self-determination and dignity, based on the best interests principle, will help build consensus in the legal. Medical and ethical fields promote the construction of a legal system of death that aligns with traditional culture and the modern concept of the rule of law.*

Keywords: *Assisted Suicide, Incompatibility, Euthanasia, Dignity, Persistent Vegetative State, Best interests*

1. Introduction

The law needs to protect citizens' "right to die". With the rapid development of modern medical technology, extending life in an artificially limited way has become possible. Accordingly, the "right to die", especially the choice of life self-determination and end-of-life medical treatment, has become a social and legal issue that cannot be avoided. In this article, we will analyse specific cases from the perspectives of competent and incompetent patients to demonstrate the connection between the "right to die" and the human rights of citizens and explore the legal protection of the "right to die". The paper will discuss the need for legal protection of the "right to die". It is argued that the safety of the 'right to die within the framework of human rights is the basis for protecting the right to self-determination and dignity of citizens and the defence of Article 8 rights in the framework of the European Convention on Human Rights. The security of the patient's right to self-determination and dignity, based on the best interests principle, will help build consensus in the legal. Medical and ethical fields promote the construction of a legal system of death that aligns with traditional culture and the modern concept of the rule of law.

2. "Right to die" concerns the right of citizens' self-determination and dignity

Based on Kant's philosophy, the key to human dignity lies in the subject's autonomy. As a dignified individual, subject autonomy is prominently embodied in life autonomy, independent decisions on lifestyles and life choices[1]. The right to refuse medical treatment represents a product of the core spirit of protecting citizens' right to self-determination under the European Convention on Human Rights and is central to preserving individual freedom and dignity.

2.1 The right of refusal medical treatment

Considering the refusal of medical treatment as "voluntary, passive euthanasia" means that the refusal of medical treatment does not violate the rights and obligations arising from the right to life under Article 2 of the European Convention on Human Rights. Firstly, the implementation of passive euthanasia requires only the cessation of treatment that continues the patient's life, an act that is not

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considered a direct deprivation of life but only a negative attitude. Secondly, the protection of the right to life does not impose an obligation to live, and competent patients can waive their right to life by refusing treatment[2]. The cessation of treatment for incapacitated patients (e.g. PVS, MCS) is subject to the best interests principle, discussed in Section 3 of this paper.

While the legalisation of passive euthanasia does not logically violate Article 2 of the ECHR in law, The exercise of this right would conflict with the principle of the sanctity of life. In the case of ReT, the Court overturned T's refusal because it was held that T was not aware that this was the only treatment option when he made his decision (to refuse a blood transfusion)[3]. The Court said that mentally competent adult patients can decide whether to refuse treatment, even if the refusal may result in the patient's death. However, the doctor must override the patient's refusal and administer treatment based on the patient's best interests if the doctor believes that the patient's decision was influenced and misguided. This decision defines a fuzzy boundary for the patient's right to self-determination: on the one hand, it recognises that the reasons for refusing medical treatment need not be rational, but on the other hand, it judges the validity of consent/refusal by measuring whether the patient's decision has been influenced. In the case of Malette v. Shulman, the patient made an explicit statement before treatment that, as a Jehovah's Witness with strong faith, the patient requested that the doctor not inject blood or any blood products into the patient during treatment. However, the doctor administered the blood to the patient for treatment purposes and challenged whether the patient's statement continued to represent the patient's intentions in the particular circumstances[4]. In its Judgment, the Court upheld the patient's right to self-determination and suggested that: refusal must be respected. Also, in the case of ReB, the Court, having accepted evidence from the doctor and Ms B herself, proved that Ms B could make decisions. Therefore the continued treatment constituted an unlawful assault on Ms B in circumstances where Ms B had expressly refused treatment.[5] The Court again reiterated the ruling in Re T, where the patient's interests and the interests of the society in which the patient lives conflict. The patient's right to self-determination should be upheld - the patient has the right to continue their life as they wish, even if this is detrimental to the patient's health or even leads to death.

The cases discussed above illustrate that understanding the meaning of life is different for each individual who enjoys the right to life. The sanctity of life provides the obligation to protect the right to life and the value of renouncing it. When a patient's decision is made through the exercise of self-determination, it conflicts with the general understanding of the right to life. Such as a refusal of medical treatment leading to death because of religious beliefs (often not be understood by doctors or even loved ones), the protection of the patient's 'right to die' as a protection of the patient's right to self-determination is key to improving the human rights framework.

While the Re B case was the first time in the UK that a ventilator-dependent patient had successfully won the right to have the ventilator switched off, the case raised the question of whether, because of Ms B's paralysis, the switching off of the ventilator needed to be carried out by a doctor. Was the doctor's act of turning off the ventilator directly related to the patient's death? If the doctor's act of switching off the ventilator is considered a cessation of ongoing treatment, the Act is "passive euthanasia" by omission. If the Act is seen as an active element leading to the patient's death, it constitutes 'active euthanasia'. This is another aspect of the current debate on the 'right to die', namely whether a person can consent to be killed.

2.2 Death with dignity

Does a person have the right to decide when they die? Before the Suicide Act 1961, suicide in England and Wales was considered a felony - 'felonia de se' - and the property of the person who committed suicide was forfeited. Following the enactment of the Suicide Act 1961, suicide was no longer considered an offence, but taking life by intervention or with the assistance of a third party was still considered an offence of assisting suicide by section 2(1) of the Suicide Act 1961. This Act prevented the legalisation of active euthanasia (AVE) and physician-assisted suicide (PAS) in the UK and even restricted the right of patients who were suffering from illness to seek euthanasia abroad. For example, in Pretty v. the United Kingdom, where the patient had to be tube-fed daily to maintain minimal bodily functions due to paralysis, the patient wished to end his life to escape suffering and avoid humiliation. Still, because of the paralysis, the patient could not commit suicide[6]. The patient applied to the Director of Public Prosecutions (DPP) to see if the DPP could not prosecute the patient's husband if the husband assisted the patient in committing suicide. this application that the House of Lords ultimately refused because the DPP did not have the power to decide whether to prosecute before a further offence was committed. Moreover, the House of Lords held that the essence of the right to human dignity, as described in Article 3 of the European Convention on Human Rights, was concerned

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only with living with dignity and did not include the right to die with dignity. This understanding of dignity is unidirectional and places human dignity within the compulsory framework of protecting the right to life. For patients who can consent but cannot act, the suffering and invasive treatment of the disease is all that is required of them at this stage of their lives, and the patient does not have the right to 'live with dignity, which is why the patient wish to end their lives.

Successful cases upholding a citizen's 'right to die' based on the principle of dignity include Carter v Canada (AG), in which the plaintiff claimed that the definition of assisted suicide as a criminal offence under Canadian law prevented patients with degenerative diseases from dying with dignity[7]. The plaintiffs claim that if the law is not changed, seriously ill patients will continue to suffer against their will and lose their right to choose and dignity, violating their rights under Section 15 of the Canadian Charter of Rights and Freedoms. Furthermore, because the patient himself does not have the physical means to end life without help, the patient may end life prematurely. In contrast, the patient can still end life because the patient does not want to suffer in the future, violating the patient's Section 7 right to life. The Court ultimately ruled in favour of the plaintiff, granting Canadian citizens the right to medical assistance in carrying out a "right to die" when they are of sound mind but suffer intolerable and irreversible suffering.

The legal recognition and protection of citizens 'right to die' is key to protecting the right to self-determination and preserving patients' dignity. It has become increasingly essential to incorporate the framework of the principle of grace into the 'Death with dignity'. Organisations seeking to promote the legalisation of euthanasia at this stage prefer the terms 'death with dignity' or 'assisted dying' to the former terms 'euthanasia' or 'assisted suicide.'[8]. The principle of dignity requires the law to value the intrinsic value of life and focus on the patient's personal feelings rather than discussing the compulsory nature of the right to life only in macro terms. The European Court of Human Rights has recognised that "the essence of the Convention" comprises human dignity and human freedom. It is contrary to the European Convention on Human Rights core spirit that a patient suffering from irreversible pain must endure it or opt for "suicide tourism" because they are in a country where the law does not support euthanasia.[9]

It is not the intent of the right to life for human beings to perpetuate a painful and undignified life. The conceptual and institutional shift from the early days of the UK, when suicide was considered a crime, to the decriminalisation of suicide fully reflects the respect for individual autonomy, especially the autonomy of life. In countries and regions where death with dignity has been legalised, the patient's right to self-determination of life has been recognised in law. For example, Section 5 (b) of the Voluntary Assisted Dying Act 2017 in Victoria, Australia, clarifies that each individual's autonomy should be respected. In death with dignity, recognition of the right to self-determination of life means freedom to choose a dignified death when the patient is terminally ill or dependent on life-sustaining medical measures.

3. "Right to die" is protected under Article 8 ECHR

Article 8 of the European Convention on Human Rights provides respect for the right to private and family life, and 8(2) also provides that public authorities may not interfere with exercising these rights except because they are "necessary in a democratic society". In the case of Haas v. Switzerland, the Court explicitly recognised that the right to private life is respected under Article 8 and that an individual has the right to decide when and how to end their life when it can be shown that they have a sound mind and free will[10]. In the case of Gross v Switzerland, the Court ruled that the Swiss authorities had violated the plaintiff's rights under Article 8, establishing that the choice of death, as well as the search for a dignified death through suicide, fell within the protection of Article 8[11].

At the same time, the European Court of Human Rights has suggested that there is no uniform understanding of PAS and AVE across Europe and therefore retains the freedom of national law in the area of the 'right to die. However, in contrast to the ECtHR's 2002 decision in Pretty v. the United Kingdom, where the Court held that although preventing the applicant Pretty from exercising her right to choose constituted an interference with Article 8. The Court found there was no violation of Article 8, that such interference was "necessary in a democratic society to protect the rights of others" based on Article 8(2) and that there was. In Haas and Gross, the European Court of Human Rights accepted the plaintiffs' claims based on its previous decisions in Pretty, which suggests that protecting a citizen's "right to die" is covered by the scope of Article 8 of the European Convention on Human Rights. However, based on the current understanding of the right to life in European law, recognising that the

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ECHR contains protection of the 'right to die' may result in incompatibility with national law[12].

In the case of R (Nicklinson) v Ministry of Justice, the patient had suffered a severe stroke resulting in total paralysis, and the patient wanted to end his life. Still, his physical condition did not make him eligible to commit suicide. The patient applied to the Supreme Court for 1. A declaration that it was lawful for a doctor to assist the patient in committing suicide, and 2. if the first application was refused, a declaration that the existing law was incompatible with Article 8 of the European Convention on Human Rights and violated the patient's right to private life[13]. Is it incompatible with Article 8 of the European Convention on Human Rights that assisting suicide is an offence under Section 2 of the UK Suicide Act 1961? Lady Hale argued that the current law was incompatible with the Convention rights and that the general prohibition was interference with Article 8. Lady Hale also suggested that the current law's general ban on assisted suicide was unfair because there was no clear definition of any exceptions, contrary to the law's original intent of attempting to protect oppressed people. Although the majority held that the general prohibition was a severe interference with patients' Article 8 rights, the judges did not declare incompatibility. It was up to Parliament to discuss the issue and choose to relax or amend the current law. In the subsequent case of Conway, R (On the Application Of) v The Secretary of State for Justice (Rev 1), the Court upheld the logic of the decision in Nicklinson in the face of similar arguments by the applicant to those in Nicklinson. However, the Court still did not declare a declaration of incompatibility in the hope that Parliament would resolve the legal issue "satisfactorily."[14] The Court recognised that the general prohibition on assisted suicide arising from section 2 of the Suicide Act 1961 violated the applicants' rights under Article 8 of the European Convention on Human Rights. The judgement opinion based on the appeal case suggests that the law on the assisted suicide ban in the UK needs to be changed, for example, by recognising an exception to the Suicide Act. However, Parliament may conclude that the prohibition of assisted suicide is necessary based on the purposive nature of ECHR 8(2). However, this incompatibility will persist[15]. Just because the Court took a conservative approach in Conway, it does not mean that it will not still declare a declaration of incompatibility when the next similar case arises in the future. Inclusion of the 'right to die in the protection of the law is, therefore, key to protecting the rights of citizens under Article 8 of the European Convention on Human Rights.

4. Protecting the "right to die" of incapacitated patients – the principle of best interests

Modern medical measures to perpetuate life establish the prerequisites for a 'right to die. If human life could only end naturally, there would be no need to discuss the "right to die" without medical measures. Modern medical technology has developed rapidly in recent years, and even if a patient is unconscious or even brain-dead, life can be extended by medical measures. This artificial continuation of life through medical interventions has transcended the boundaries of natural energy and has created a state of controlled or even alienated life. Patients in a persistent vegetative state (PVS) and minimally conscious state (MCS) cannot consent/refuse medical treatment. The continuation/termination of life-sustaining treatment for PVS, MCS becomes an issue in the medical and legal realm, where the best interest principle arises.

In Airedale NHS Trust v Bland, the Court upheld for the first time the cessation of artificial nutrition and hydration (ANH) for patients in a persistent vegetative state (PVS)[16] Bland was constantly vegetative due to accidental injuries and was kept alive by machines and tube feeding. Bland was maintained in a persistent vegetative state by machines and tube feeding. After diagnosis by two neurologists, it was confirmed that Bland was unlikely to recover from the PVS state. In the Judgment, Lord Donaldson MR suggested that because there is a powerful presumption of preservation of life, it must be shown that the suffering experienced by the patient outweighs the benefit of preserving the patient's life to justify the cessation or withdrawal of treatment. In that case, the Court held that a doctor must maintain the patient's best interests and that situations requiring invasive and dangerous measures to protect life are not in the patient's best interests. Therefore the doctor is not obliged to continue the patient's life through such medical treatment. Furthermore, the Court held that the actual cause of Bland's death was due to the significant injuries sustained at Hillsborough and that although it could not cause or hasten Bland's death, it was lawful to withdraw the treatment that had prolonged Bland's life. The decision, in this case, reflects the Court's fundamental respect for the dignity of life. On this basis, the British Medical Association's Medical Ethics Committee has developed practice guidelines for the cessation of life-prolonging medical treatment, which refer to the fact that the decision to provide life-prolonging medical treatment should be based on the principle of the patient's best interests when the patient cannot decide[17]. In 2010, the UK General Medical Council published its End of Life Care report, which again emphasised the principle of the best interests of the patient as the basis for

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making decisions about life-sustaining medical treatment based on the mutual wishes of the doctor and the patient[18]. Although these initiatives in the UK are primarily concerned with the cessation of life-sustaining medical treatment, the principle of the patient's best interests, as a core requirement, provides the rationale for protecting the 'right to die of incapacitated patients.

A similarly case concerning the "right to die" of incapacitated patients, such as the case of Cruzan v. Director in the United States, in which the United States Supreme Court upheld an earlier decision of the Missouri Supreme Court that required "clear and convincing evidence" as a prerequisite for a patient's withdrawal from life-sustaining treatment[19]. The U.S. Supreme Court held that an agent could abuse his duty by failing to act to protect the patient and had that the substituted Judgment. The Judgement of the next of kin was not entirely acceptable because there was no substantial evidence that it was consistent with the patient's views. In this case, the Court, emphasised the importance of the patient's wishes during life and that the patient's factors should play a decisive role in the choice of life and death. Anthony Lester cites this Judgment in the Bland case as one of the conditions for weighing the patient's best interests.

As medicine evolves, a new measure of incapacitated patients' status has emerged - the minimally conscious state (MCS), similar to PVS. The main difference between the two states is that PVS is in a state of complete unconsciousness. In contrast, MCS patients have a degree of consciousness and signs of reflection[20]. In the case of W v. M and Others, the Court ruled for the first time whether MCS had a 'right to die in law[21]. In this case, the Court was asked for the first time to authorise the withdrawal of artificial nutrition and hydration (ANH) from a patient with MCS who had fallen into a minimally conscious state (MCS) due to a viral meningitis injury. The judge used sections 4(6) and 4(7) of the Mental Capacity Act 2005 (MCA) as the framework for determining the best interests of a person with MCS, which requires that in assessing the best interests of an incapacitated person. Should consideration be given to M's past wishes and feelings, M's dignity, M's potential for suffering and prospects for recovery, and the sentiments of M's family members and carers. This framework establishes a more refined standard for measuring the best interests of an incapacitated patient. The judge also suggested that any decision to withdraw ANH from a person with MCS must be brought before the Court, which represents the inclusion of the best interests of the incapacitated patient measure in the context of legal protection, measuring the best interests of the patient from a legal perspective.

The protection of the 'right to die of incapacitated patients is necessary to protect the human rights of incapacitated patients by incorporating it into the legal framework and not just as a matter of medical and ethical ethics. In the case of Aintree University Hospitals NHS Foundation Trust v David James and Others, where the patient was in a minimally conscious state (MCS) as a result of a stroke, the medical team considered that the patient's condition was generally deteriorating while he was receiving treatment and that the treatment of the patient was The medical team considered that the patient's condition was generally deteriorating while receiving treatment and that the treatment was "invasive" and that it would be "overly burdensome" and "futile" to continue[22]. The medical team concluded that the patient's life-sustaining treatment should be stopped based on the patient's best interests. Still, notably, the patient's family disagreed with this medical opinion. In the Supreme Court decision, Lady Hale emphasised that whether treatment was "futile" for the patient was not a reason to refuse it, but rather the fundamental question was whether it was in the patient's best interests to give it[23]. And Lady Hale rebutted Lord Justice Ward's reasoning, arguing that judging treatment as 'futile' based on 'cure or alleviation of symptoms' would set too high a standard of care, inconsistent with the 2005 MCA established. The 2005 MCA framework for measuring the best interests of patients.

The best interests principle has been used many times to measure whether to withdraw from maintaining treatment for incapacitated patients. Although there are many critiques of using this principle, some scholars are concerned about the impact of its use on the inviolability of life ethics (IOL). It is also impossible to maintain a completely objective position on the measurement of the best interests of incapacitated patients, as the lack of a uniform standard for best interests measurement has resulted in the possibility of opposite outcomes in similarly situated cases[24]. However, the best interests principle considers the protection of the incapacitated patient's right to life and the quality of life of the incapacitated patient, the wishes of the individual and the family and carers, among many other things factors, into the scope of the weighing. The inclusion of the best interests principle in the legal framework is a way of protecting the patient's real needs. Caring more about the wishes and feelings of the incapacitated patient rather than mechanically following the principle of life and making decisions in the best interests of the incapacitated patient, even if this need would result in the patient's death. Therefore, the best interests principle is not used to achieve the goal of killing the patient but to

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uphold the patient's 'right to die' through the law.

5. Conclusion

The "right to die" should be protected by law, as it is based on the concept of human rights. In the case of competent patients, the 'right to die' should be regarded as a fundamental human right of a particular subject in a particular situation. This right is the basis for protecting the patient's dignity and autonomy of choice. The general prohibition of assisted suicide in current UK law violates the rights of citizens based on Article 8 of the European Convention on Human Rights. Changing the law or creating a framework to protect exceptions is a way to address the incompatibility. In the case of incapacitated patients, not only insisting on life support but giving incapacitated patients the "right to die" of their choice through more careful consideration of their circumstances through the principle of best interests is also vital to better protecting the human rights of this group of patients.

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