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End of life: on the Vincent Lambert case

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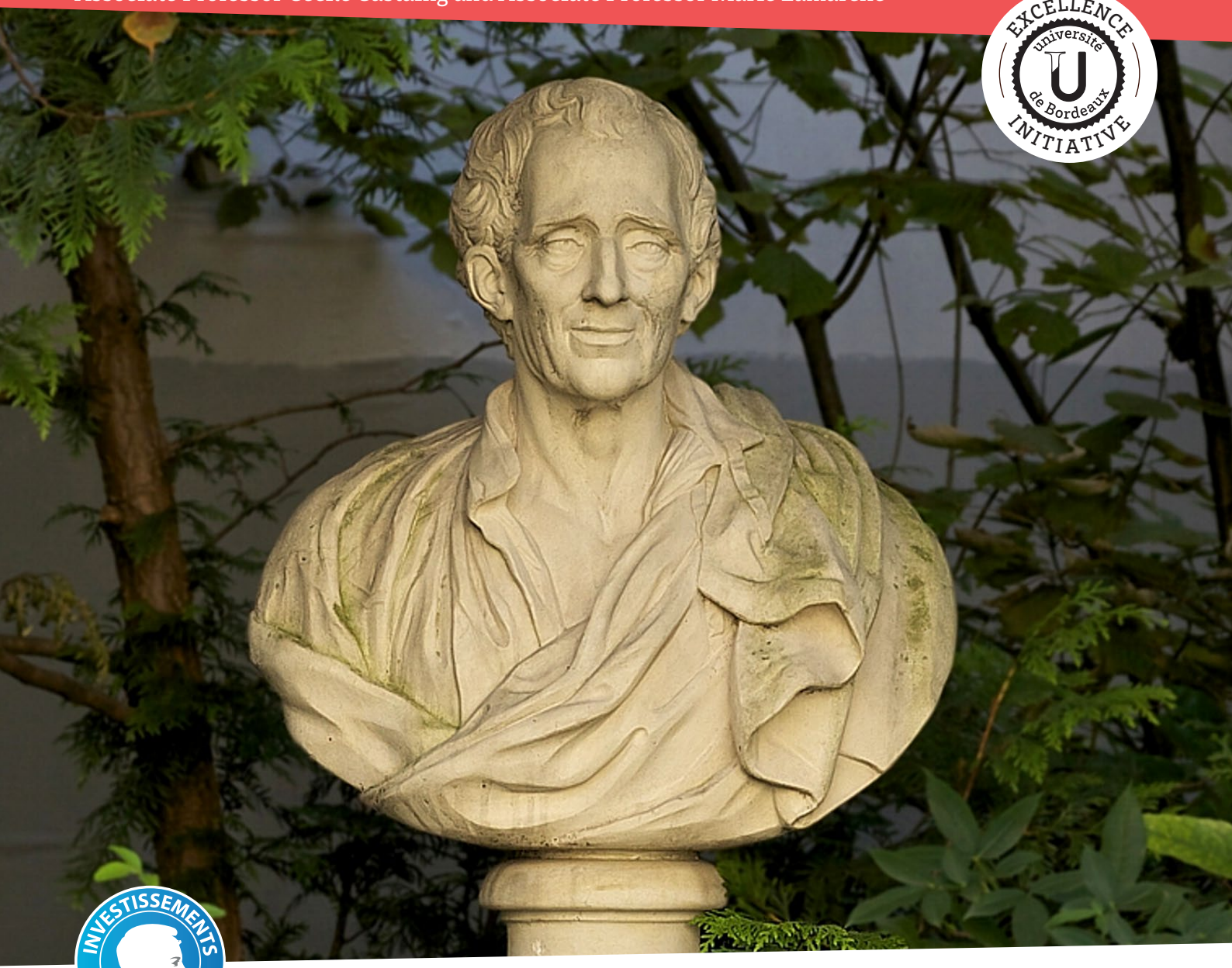

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Civil law:

The end-of-life decision: the Vincent Lambert case

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After the medicalization of the end of life, the "jurisdictionalization" of the end of life demands that the issue be re-addressed in terms of the legal restrictions on individual autonomy. In light of the prohibition on ending a person's life and of individual freedom opposed by those invoking a right to die with dignity (1), the balance sought from a legislative point of view compels a court to intrude into a troubling sort of "medico-legal intimacy". The distinctive feature of the end-of-life decision is that it results in a person's death. It concerns not only those persons at end-of-life, but any person who decides to end their life. In French medical law, the end-of-life decision is the choice made by a doctor and the patient where the latter is able to express their wish to terminate treatment, the consequence of which is to bring about the patient's death.

The scientific, legal and ethical issues raised by this decision affect each person's moral or religious convictions, society's choices and the fundamental rights of the individual.

While some foreign legislations have already made the final leap and, as in Belgium (2), allow end-of-life applications to be granted, discussions are ongoing in Europe which may result in a legislative framework for "assisted dying" (3).

In France, the *Conseil d'Etat* had the opportunity to rule for the first time on the end-of-life decision, in the context of an appeal brought against an interlocutory order, where it had to decide whether the medical decision to stop Vincent Lambert's artificial nutrition and hydration was legal.

Vincent Lambert has been hospitalized since 2009 following an accident that left him in a vegetative, then a minimally conscious state. He is fed and hydrated through tubes but does not receive any other medical treatment. On 10 April 2013, Vincent Lambert's attending physician decided to stop artificial nutrition and reduce hydration and implemented the decision. The patient's parents asked the doctor to resume treatment and, when the doctor refused, applied to the administrative court for an interim order ordering the hospital to resume the patient's usual nutrition and hydration. As the interlocutory application to the court concerned the safeguarding of a fundamental freedom (Article L. 521-2 of the *Code de justice administrative* (4)), the urgency and the serious and manifestly unlawful violation of a fundamental freedom had to be characterized. The urgency is characterized "*where the action or failure to act on the part of the establishment creates a characterized and imminent danger to a patient's life*"; there is indeed a serious violation of the right to life (5), as stopping artificial nutrition and limiting hydration reveals a danger to the patient's life. Where the patient is not at end-of-life, it is not the special provisions contained in the Law of 22 April 2005 (known as the *loi Léonetti*) that apply but rather the ordinary law on patients, in particular Article L. 1111-4 para. 5 of the *Code de la santé publique* (Public Health Code) under which "*where the person is not in a state to express his wishes, the limitation or termination of treatment likely to put his life in danger may not be carried*

out without following the collegiate procedure […] and without consulting the person of trust […] or the family or, failing which, a relative and, where necessary, the person's own advance directives". Having qualified artificial nutrition and hydration as care or treatment that could therefore be limited or stopped altogether, the *tribunal administrative* (administrative court) at Châlons-en-Champagne considered that the failure to follow the collegiate procedure constituted sufficient grounds for the injunction requested to be granted (6). This case reveals one of the difficulties arising from the duty imposed on a doctor to initiate a collegiate procedure. In the present case, the patient had not appointed a person of trust or drawn up any advance directives, but there remained the family to be consulted. The administrative court held that while the patient's wife had been involved in the collegiate discussion, the same could not be said for his parents, who had not even been informed of it.

Following another collegiate procedure, Vincent Lambert's attending physician again decided on 11 January 2014 to stop artificial nutrition and hydration as of 14 January 2014, though the implementation of this medical decision would have to be deferred in the event of an application to the administrative court. The patient's parents made another interim application to the administrative court, following the same procedure, to order the hospital to forbid the termination of artificial nutrition and hydration. In order to characterize the serious and manifestly unlawful violation of a fundamental freedom, the panel of judges had to rule on two issues: could the doctor base his decision to stop treatment on a wish that the patient allegedly expressed that he not be kept alive in a state of high dependency, although this statement was made outside any formal framework? Did the continued nutrition and hydration constitute "unreasonable obstinacy", thus justifying the interruption thereof? The administrative court, sitting in plenary session, found in the negative on both points and consequently held that the disputed medical decision constituted "a serious and manifestly unlawful violation of Vincent Lambert's right to life" (7).

The patient's wife, other family members and the *centre hospitalier universitaire* (university hospital) in Reims appealed the decision to the *Conseil d'Etat* which, in light of the "extreme gravity of the situation", decided to bring the dispute before the General Assembly of the *Conseil d'Etat* sitting as a panel of judges. The formation of the court, prior to staying proceedings, enshrined a new fundamental freedom to stand alongside the right to life and the right to consent to a medical procedure (8): the right "not to undergo a treatment that may result from unreasonable obstinacy". The Assembly hearing the case also stated that the legislative provisions on the notion of unreasonable obstinacy are of general application and apply in respect of all users of the French health system, be they at end-of-life or not. The *Conseil d'Etat* decided to stay proceedings while awaiting, on the one hand, new expert evidence which would describe the patient's clinical state, the irreversible or otherwise nature of his brain damage, his ability to communicate with the people around him and to respond to the care given to him; and, on the other hand, observations, as *amici curiae*, from the *Académie nationale de médecine* (French National Academy of Medicine), the *Comité consultatif national d'éthique* (National Consultative Ethics Committee), the *Conseil national de l'ordre des médecins* (French national medical association), and Mr. Jean Léonetti, author of the bill that passed into law on 22 April 2005 on the end of life (9).

The *Conseil d'Etat* finally gave judgment on 24 June 2014. Given the importance of the decision, the novelty of the issues brought before the court and the exceptional nature of the consequences of the court's decision, the *Conseil*'s General Assembly again gave judgment sitting as a panel of

judges. It held that the medical decision to stop treatment was lawful, both in terms of the procedures imposed by law and in terms of its soundness. The *Conseil*'s decision does not, however, bring the legal soap-opera to a close as the European Court of Human Rights, following an application by the patient's parents, asked the French Government to suspend the *Conseil d'Etat*'s judgment until it has ruled on the merits of the case.

The Vincent Lambert case has fuelled the ongoing debate on the end-of-life decision and the continuation of discussions instigated by the commitment made by the President of the Republic, during the presidential campaign, to legislating on the end of life. Where a person is in no condition to express his or her wishes, the end-of-life decision is a medical one, the consequence of which is a person's death. The peculiarity of the issues related the end of life and the quickening pace of scientific, medical and social developments are seen in the demand for new rights to be secured. Consequently, the temptation to legislate is strong and the number of laws continues to grow. While it is far from certain that the issue requires further regulation with regard to existing law, consideration is being given to the amendment of the Law of 22 April 2005 and the legalisation of assisted dying in order to respond to the President's commitment. The case of Vincent Lambert allows the current legislative framework to be compared with medical conditions, the judicial review of the medical decision on the end of life to be analysed, and then further consideration potentially to be given to the opportunity of legislating on the issue once again.

1. The patient's legal position

The Law of 22 April 2005 on patients' rights and the end of life (10) established the legal framework in which the decision to limit, interrupt or not to undertake treatment may be taken. A number of procedures were laid down, which differ depending on a patient's medical condition. There is a set of legal rules applicable to each medical condition. It is the patient's ability to express his wishes that determines which procedure applies; in this respect, the 2005 Law follows the logic behind the Law of 4 March 2002 on patients' rights and the quality of the French health system (11) which enshrines the patient's right to consent to treatment and, therefore, his right also to refuse it. Where the patient is able to express his wishes, this must be respected even when he refuses the treatment and care on offer; in such circumstances, the doctor must inform the patient of the consequences of his choice (12). The law reinforces the procedural requirements incumbent on the doctor, as he must "make every effort to convince the patient to accept essential treatment"; he may, furthermore, call upon another member of the medical profession and the patient must above all reiterate his refusal to be treated. In any case, regardless of whether the patient is at end-of-life when he expresses his wishes, where the refusal of treatment puts the patient's life in danger, the doctor must safeguard the dying person's dignity and guarantee the quality of end-of-life by administering palliative care.

It is where the patient is in no condition to express his wishes at the time when the question of stopping treatment is under consideration that the doctor again has full decision-making power, without being legally bound by wishes other than his own. Where a patient is not at end of life, which is the case for Vincent Lambert, the decision to restrict or stop treatment, which is likely to put the patient's life in danger, cannot be made without having followed the collegiate procedure and consulted the appointed person of trust, the family or relatives as well as any advance directives where these have been drafted (13). When the patient is at end-of-life, the law expressly frees the doctor of his obligation to provide treatment, providing that he may decide to limit or stop treatment that would amount to unreasonable obstinacy subject to a number of conditions,

which are the same as those applicable when a patient was not at end of life when the decision to stop treatment was taken: collegiate procedure and consultation of the appointed person of trust, the family or the relatives as well as any advance directives where these have been drafted (14).

Legally, Vincent Lambert is at the stage when the first decision to stop artificial nutrition and hydration resides with the patient who is not at end of life and is unable to express his wishes. The medical decision is based on Articles L. 1110-5 and L. 1111-4 *(5)* of the *Code de la santé publique* (Public Health Code). Article L. 1110-5 prohibits medical acts pursued on grounds of unreasonable obstinacy; the only legal duty incumbent on the doctor deciding to stop treatment is to safeguard the dying person's dignity and guarantee the quality of end-of-life by administering palliative care. This provision is general in scope, and the procedure to be followed in order to make the decision depends on the patient's medical condition.

2. Review by the administrative courts

The law is quite clear on one point: it is the doctor, and the doctor alone, who bears full responsibility for the decision to stop treatment where the patient is not able to express his wishes. This does not imply that his decision goes completely unsupervised or that it is made in isolation: the legislature has set the legal framework in which the decision can be made. Where the attending physician is considering limiting, stopping or not starting treatment and the patient is unable to express his wishes, the doctor is legally bound to instigate the collegiate procedure in order to make the necessary decision. The decision must be reasoned, and a continuation of treatment as may amount to unreasonable obstinacy is clearly a legal ground allowing – even requiring – the doctor to halt treatment. From the moment when the doctor considers, "following discussions with the healthcare team where applicable and on the basis of the reasoned opinion of at least one doctor" (15), that continuing artificial nutrition and hydration amounts to unreasonable obstinacy, taking into account any wishes as the patient may have expressed beforehand and discussions with the relatives will allow the doctor to make a legally sound decision.

While there is nothing unusual in the courts reviewing medical decisions, the decision to stop treatment bringing about the patient's death is such as to justify close judicial scrutiny. It is in those terms that the *Conseil d'Etat* recalled that it fell to it to ensure that the medical decision "had met the conditions laid down by law so that a decision may be made to end a treatment, the continuation of which would amount to unreasonable obstinacy". It thus went on to check whether the collegiate procedure had been followed; whether the patient's medical condition would bear the hallmarks of unreasonable obstinacy if treatment were to be continued; and whether the patient's wishes and requisite opinions of third parties had been sought.

Following the collegiate procedure

The *Conseil d'Etat* considered that the collegiate procedure had been followed and that the doctor treating Vincent Lambert had even gone beyond what was required under the code of ethics, having consulted six other doctors where the law requires only "the reasoned opinion of at least one doctor". The *Conseil* did not have to rule on the issue raised by the first decision of 11 May 2013 concerning the concept of "family", who must be informed that the collegiate procedure has been instigated and whose opinion must be sought; this was because a new collegiate procedure had begun between the first two decisions.

The hallmarks of unreasonable obstinacy

The *Conseil d'Etat* also reviewed the legal classification of the patient's medical condition. The doctor had taken the view that to continue artificial nutrition and hydration amounted to unreasonable obstinacy in light, on the one hand, of the patient's state of health and, on the other hand, the certainty that the patient did not wish to live under such circumstances. The *Conseil d'Etat* reviewed these two aspects. In order for the continuation of treatment to be qualified as unreasonable obstinacy, French law has set down three alternative criteria, the meaning of which emerges from the parliamentary work on the subject and was clearly explained in the public rapporteur's conclusions on the judgment of 14 February 2014 (16). These are: effectiveness of treatment; proportionality of treatment; and artificial life support. Effective treatment being understood as that which will cure a patient or improve his health, this criterion does not apply to artificial nutrition which compensates for a failing vital function but does not cure.

The relevant parliamentary debates serve to qualify as "disproportionate any treatment, the benefit of which is average compared to its aggressiveness or painfulness for the patient, even the suffering that it may entail" (17). As artificial nutrition and hydration are not aggressive techniques and do not appear to entail real suffering, this criterion does not apply either, except to consider that given the state of Vincent Lambert's health, any treatment seems disproportionate. It was the artificial life support criterion that was applied in this case by the doctor and confirmed by the various experts. Artificial nutrition and hydration indisputably allow Vincent Lambert to be kept alive, but the crux of the issue is whether they have this "sole effect" (18) and therefore amount to unreasonable obstinacy or, on the contrary, they have another effect.

The administrative court in interlocutory proceedings on 16 January 2014, taking inspiration from Jean Léonetti's report evaluating the Law of 22 April 2005 (19), ruled that the fact that treatment allowed the patient to maintain "a relationship" was sufficient grounds to dismiss the unreasonable obstinacy argument. However, the limits of unreasonable obstinacy are difficult to define and that one fact did not suffice in resolving the issue of unreasonable obstinacy, in the view of the *Conseil d'Etat*, taking inspiration from the same evaluation report, which concluded that "*the law clearly condemns any watch-and-wait attitude, the consequence of which would be to allow individuals unable to express their wishes to waste away over many years, without a convincing argument particular to each case being constructed, formulated and communicated*". This is why the *Conseil d'Etat* preferred to stay proceedings on 14 February 2014 while another expert opinion was sought. Once this was done, and in light of the results thereof, the *Conseil* considered on 24 June 2014 that the expert opinions confirmed the attending physician's analysis of the patient's health, and in particular the fact that his brain damage was irreversible, his consciousness was deteriorating, his clinical prognosis was poor and his response to treatment could not be interpreted.

Taking account of the patient's wishes

From the moment when the attending physician considered that to continue artificial nutrition and hydration amounted to unreasonable obstinacy, the collegiate authority – together with the consideration of the wishes the patient would have expressed and discussions with the relatives – allowed him to make his decision. Where the patient is unable to express his wishes at the time when the decision to stop treatment must be made, as in the present case, the attending physician must establish whether the patient has expressed those wishes previously. The Law of 22 April 2005 laid down various possibilities for persons in such situations. The patient may have

expressed his wishes by drawing up an advance directive or by appointing a person of trust to whom he may have confided his wishes.

Advance directives (20) are instructions given in advance by persons in good health or who are affected by old age or a terminal illness, on the action to take in the event that they find themselves unable to express their wishes. This practice has developed in a number of Western countries, but the indicative or binding value of such directives varies. The choice made by the French legislature is to confer purely indicative value; it is even stipulated that an advance directive must be drawn up at least three years before the patient's unconscious state in order that the attending physician "take it into account". The various reports submitted in 2014 highlight the confusion surrounding the concept of advance directives, founded on a lack of knowledge on two counts: people (be they healthy or ill) often do not know about the measure and the very existence of a directive is not always known insofar as provisions on keeping and publicising advance directives are phrased in rather vague terms (21). Furthermore, the purely indicative nature of advance directives may undermine the measure and may not incite people to draft their own. It is for that reason that the most recent report from the CCNE, published in October 2014, recommends that directives be made binding (22).

The law also provides that the patient may appoint a person of trust to whom they may have confided their wishes as to the end of their life for the time when they may no longer be able to express them (23). The law states that the opinion of the person of trust prevails over any other non-medical opinion, thus recalling the principle under which the decision ultimately falls to the attending physician. When the patient's wishes have thus been expressed in this formal framework, the law simply requires that the attending physician take these into account when he makes his decision: they constitute an element that will be taken into consideration but the physician will in no way be bound by them. The only duty that the formal expression of the patient's wishes may imply is an ethical one: the physician must initiate the collegiate procedure (24).

Outside this formal framework, the law does not prohibit the patient's wishes being taken into account in another form. The code of ethics states that the physician must take into consideration "the wishes that the patient may have expressed previously, in particular [therefore not only] in advance directives". This issue was raised before the administrative court in the Vincent Lambert case, the administrative tribunal having refused, in its order of 16 January 2014, to take into account the wishes that Lambert had expressed before his accident. The *Conseil d'Etat* overturned this point and went further in considering that the physician must "pay special attention to the wishes that the patient may, where applicable, have expressed previously, whatever the form and meaning" (25). Thus, in terms of the order of importance to be given to the opinions taken into consideration, it must be understood that the patient's wishes prevail over those of the family or the relatives. Where those wishes have been expressed outside the formal framework provided by law, the attending physician checks that they have been expressed clearly, in full knowledge of the facts and with conviction. This is how, in its decision of 24 June 2014, the *Conseil d'Etat* noted that the patient and his wife were nurses and were therefore well versed with the issue of the end of life, that Vincent Lambert had "clearly and a number of times" expressed the wish not to be kept on life support in the event that he should find himself in a state of high dependency, that the content of those wishes had been accurately reported by his wife, confirmed by one of his brothers and was not disputed by the parents, who nevertheless opposed the termination of treatment. In

such circumstances, not only must the wishes expressed be taken into consideration by the physician, but he must also pay special attention thereto.

Discussions with the family and/or relatives

It was the problem posed by the very notion of "family" whose opinion must be sought, and by that of "relatives" as regards the observance of the collegiate procedure (mentioned above), that emerged as the focus for discussion from the media's point of view. In making the relevant medical decision, where the patient is no longer able to express his wishes, the law requires the physician to consult either the person of trust, or the family or, failing that, one of the patient's relatives (26).

In the initial order, the administrative tribunal considered that it did not suffice that the deciding physician should involve one or several members of the family only and that he must, as far as possible, seek the opinion of each family member – or at least those closest to the patient. The tribunal's decision seems unfortunately to complicate a situation for the physician that is already highly complex on the facts, particularly where the family members do not share the same opinion on the end of the patient's life. To which circle should the consultation be extended? And which opinion takes priority where there is disagreement? (27)

In the absence of any indication as to the persons to be consulted, should the notions of family and relatives be understood within the meaning of Article L. 1231-1 of the *Code de la santé publique* (Public Health Code) on the removal of organs from living persons? Under the terms of the latter provision, the donation may only proceed in the direct therapeutic interests of the recipient, and the law states that the donor must have capacity as the father or mother of the recipient, before enumerating a list of persons likely, by way of derogation, to have capacity as donor: sons or daughters, grandparents, uncles or aunts, first cousins, together with the partner of the patient's father or mother. The law also adds that the donor may be "any person able to provide proof of communal life with the recipient for a period of at least two years, as well as any person able to prove a close and stable bond of affection with the recipient for a period of at least two years". The tribunal's decision gave no guidance and Vincent Lambert's attending physician had to initiate another collegiate procedure, involving the parents as well as the patient's wife and siblings. However, such an approach does not seem appropriate as, transposed to the end-of-life decision to stop treatment, on principle the patient's parents would have to be consulted first, while the other family members or relatives would only be consulted by way of exception. The administrative court ruling on the case of Vincent Lambert gave priority to the those persons who had remained close to the patient, requiring the physician to "strive to achieve a consensus" (28) and clearly stating that although those opinions had to be taken into consideration by the physician, the fact that the persons consulted did not hold a unanimous view as to the direction of the medical decision to be made would not constitute an obstacle to that decision (29).

3. Is further legislation needed?

Would a new law improve the current legal measures? The issue of a new law on the end of life is regularly raised and, just as regularly, proposals are tabled but go no further (30): proposal on the right to end life with dignity (31), proposal to guarantee patients at end of life the right to die with dignity (32), proposal on the free and informed choice of medical assistance for a dignified end of life (33). The process of reflection on the amendment of the Law of 22 April 2005 and the legalisation of active assistance in dying supports these proposals and is ongoing. It is a response

to President François Hollande's commitment during the 2012 electoral campaign, where he stated that, if elected, he would propose that "any person of legal age, at an advanced or terminal stage of an incurable illness, causing unbearable physical or psychological suffering, under clear and strict circumstances, benefit from medical assistance in ending their life with dignity" (34). In line with that commitment, the President set up a mission entrusted to Professor Sicard; since then, other consultations have taken place and given rise to the adoption of reports, texts or instructions (35). The reports unanimously acknowledge that the Law of 22 April 2005 is apparently "an unknown and untaken path" (36) but which nevertheless responds to the majority of situations, thus dismissing the need for a new law; only the *Conférence des citoyens* (citizens' conference) declared itself in favour of an amendment of the 2005 Law. However, the most recent report from the CCNE on the end of life accepts the use of "deep sedation" (37).

The law as it stands allows treatment or care to be limited, stopped or not begun at all, whether the patient is at end of life or not, when the patient requests it or, when they are no longer able to express themselves, by following an enhanced procedure. The current legislative framework is therefore sufficient to respond to Vincent Lambert's situation, and all the more so given that his continued treatment amounts to unreasonable obstinacy according to the physicians on the one hand, and the *Conseil d'Etat* on the other. Obviously the fact that he did not draw up any advance directives or appoint a person of trust has undoubtedly made the decision-making process more complex.

According to the various reports and opinions, the text of the law has been poorly circulated, poorly explained and misunderstood by all, particularly as regards the procedure for stopping or limiting treatment for patients at end of life. The merely indicative nature of advance directives is unanimously singled out, but the reports are ultimately fairly reluctant to make them binding (38), as such instructions can lose their meaning between the time when they are drawn up (when the person is in good health) and the time when the person is ill. The only constraints that may result from a directive expressing the wish not to be artificially kept alive could be that of initiating a collegiate discussion and to raise the issue of sedating the patient to alleviate suffering. The reports all decry the absence of any real culture of collegiality; the latter ought to be applied more widely and thoroughly for any decision involving the end of life, and be opened systematically to the patient or, failing that, to the person of trust, the family or relatives. Again, the Vincent Lambert case reveals the difficulties encountered in implementing a real process of collective deliberation for any decision involving the end of life.

In a more limited way, the law provides for situations in which the attending physician may take positive action, i.e. administer a substance, the effect of which would be to bring the patient's life to an end. The only scenario is that of a patient who is at end of life and suffering; the attending physician may then administer a product intended to alleviate pain, even where the secondary effect of that treatment is to shorten the patient's life (39). However, the qualifications remain extremely difficult to establish and the various attempts to distinguish legal medical interventions from criminal acts – as shown by a circular from the French Ministry of Justice dated 20 October 2011 (40) published the day after media coverage of the Bonnemaison case – struggle to account for the variety of situations and the distinction between the intention to alleviate suffering and the intention to kill within the meaning of Article 221-5 of the *Code pénal* (Penal Code) (41). The terminological subtleties – see in particular the difference between *le traitement qui peut avoir pour effet secondaire d'abréger la vie* ("treatment which may have the secondary effect of

shortening life") under Article 1110-5 of the *Code de la santé publique* and *la possibilité d'un geste accompli par un médecin, accélérant la survenue de la mort* ("the possibility of an action performed by a doctor, accelerating death") considered in the Sicard Report (42) - are but a reflection of a development that co-operation between physicians and judges can make easier.

In any event, the possibility of a "treatment which may have the secondary effect of shortening life" does not concern patients who are not at end of life or those patients, even at end of life, who are not suffering.

The reports have considered exceptional situations not taken into account by current legislation: patients suffering from a serious and incurable illness, who are not at end of life yet wish to accelerate their death; patients who are unable to express their wishes, are not at end of life, have never formulated their wishes as to their death and for whom treatment does not amount to unreasonable obstinacy; or patients at end of life, who are not suffering, who refuse any and all treatment and ask to die. It is in respect of these situations that the issue arises as to "terminal sedation for distress" (43) or a real "right to sedation" (44), assisted suicide or even a euthanasia exception. The United Kingdom Supreme Court gave a decision on 25 June 2014 on three separate cases that were similar on the facts: each of the men concerned suffered "such a distressing and undignified life that he had long wished to end it but could not do so himself because of his acute physical incapacity" (45). Each claimed a right to "assisted suicide" and all three argued that English law on assisted suicide, and in particular Section 2 of the Suicide Act 1961 on criminal liability for complicity in another's suicide, infringed their fundamental human rights, particularly Articles 2 and 8 of the ECHR. In a 132-page decision, the Supreme Court (exceptionally composed of nine law lords) dismissed the appeals brought by the three appellants and ruled that national legislation (in the context of the State's margin of appreciation, as acknowledged by the ECHR) still prohibited assisted suicide whatever the circumstances and that it was for Parliament to decide, it being "institutionally inappropriate" for the Court to do so. In this sense, the Assisted Dying Bill is currently at the committee stage.

In France, a quick comparison between the President's commitment and such situations shows a lack of political will to resolve the difficulties raised by these exceptional cases. The President's commitment was to propose that "any person of legal age, at an advanced or terminal stage of an incurable illness, causing unbearable physical or psychological suffering, under clear and strict circumstances, benefit from medical assistance in ending their life with dignity" (46). The scope is voluntarily limited to persons of legal age at end of life and suffering. The question put before the *Comité consultatif national d'éthique* in 2013, in line with that same political commitment, is doubtless even more restrictive: "By what procedures and under what strict conditions can a conscious and independent patient, suffering from a serious and incurable illness, be permitted to be supported and assisted in his wish to end his own life?" (47). The legalisation of assisted suicide considered through that question would only benefit conscious and independent patients at end of life and physically capable of administering the lethal substance to themselves, therefore excluding requests made by third parties for persons who are no longer able to express themselves, persons who are not at end of life and also excluding the scenario of a lethal act administered by a third party.

Notes:

(1) See ECHR, *Pretty v United Kingdom*, Application n° 2346/02, 29 April 2002

(2) After extended assisted dying to children, Belgium has seen a surge in the number of problematic cases. In particular, a second inmate (imprisoned for nearly 30 years in the closed psychiatric wing of a prison near Antwerp, for the rape and murder of a 19 year-old student) has asked to be euthanized, a request granted by the Belgian courts on 14 September 2014.

(3) This is the case particularly in Scotland, where the Parliamentary Justice Committee is preparing to debate a bill allowing assisted suicide from the age of 16 for terminally ill patients or suffering from serious illnesses with low life expectancies. In the United Kingdom, the Assisted Dying Bill ([HL] 2014-2015) comes over ten years after the decision in *Pretty*. In Germany, however, a bill put forward by the Christian Democrat Union should soon be put before the Bundestag, prohibiting organised assistance for suicide and thus fill what seems to be a legislative void and allows charities to offer lethal substances for patients to inject themselves.

(4) Translator's note: Article L. 521-2 reads: Where such an application had been made, the urgency of which is justified, the court in interlocutory proceedings may order any and all measures necessary to safeguard a fundamental freedom that a public body or a private body entrusted with the operation of a public service may have seriously and manifestly unlawfully violated in the exercise of one of its powers. The court shall give a ruling within forty-eight hours.

(5) The right to life has already been described as a fundamental freedom within the meaning of Article L. 521-2 of the *Code de justice administrative* (Administrative Justice Code): CE, Sect., 16 November 2011, Ville de Paris et Société d'Economie Mixte PariSeine, n°s 353172 and 353173.

(6) TA Châlons-en-Champagne, 11 May 2013, n° 1300740.

(7) TA Châlons-en-Champagne, 16 January 2014, *M. Pierre Lambert et autres*, n° 1400029.

(8) CE, 16 August 2002, *Mme Valérie Feuillatey et Mme Isabelle Feuillatey*, n° 249552.

(9) CE, Ass., 14 February 2014, *Mme Lambert et autres*, n°s 375081, 375090 and 375091.

(10) Loi n° 2005-370 du 22 April 2005 relative aux droits des malades et à la fin de vie (Law n° 2005-370 of 22 April 2005 on patients' rights and the end of life), JORF n°95 23 April 2005 page 7089.

(11) Law n° 2002-303, *JORF* 5 March 2002, p. 4118; Section L. 1111-4 CSP.

(12) Article L. 1111-4 para. 2 and L. 1111-10 CSP.

(13) Article L. 1111-4 para. 5 CSP.

(14) Article L. 1111-13 CSP.

(15) Article L. 4127-37 CSP.

(16) Rémi Keller on CE, Ass., 14 February 2014, *Mme Lambert et autres*, n°s 375081, 375090 and 375091, RFDA 2014, p. 255.

(17) See conclusions of Rémi Keller, *ibid*.

(18) Article L. 1110-5 CSP.

(19) *Rapport d'évaluation de la loi n° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie* (Evaluation Report on Law n° 2005-370 of 22 April 2005 on patients' rights and the end of life), 28 November 2008, AN n° 1287, p. 52.

(20) Article L. 1111-11 CSP.

(21) *Décret n°2006-119 du 6 février 2006 relatif aux directives anticipées prévues par la loi n° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie et modifiant le code de la santé publique (dispositions réglementaires)* (Decree n°2006-119 of 6 February

2006 on advance directives provided by Law n° 2005-370 of 22 April 2005 on patients' rights and the end of life and amending the *Code de la santé publique* (regulatory provisions); Articles R. 1111-17 to R. 1111-20 CSP.

(22) CCNE Report, 23 October 2014, on the end of life. Directives must, according to Professor Aubry, a member of the CCNE, embody "the patient's thoughts on his future".

(23) Article L. 1111-12 CSP.

(24) Article R. 4127-37 CSP.

(25) CE, Ass., 24 June 2014, para. 17.

(26) Article L. 1111-4 para. 4 CSP and L. 1111-13 CSP in particular.

(27) Questions arise in the same way regarding funeral arrangements, or the choice of burial for the urn containing the deceased's ashes (see, on the last point Cass. *1ère civ*. 30 April 2014, n° 13-18.951, which found in favour of the mother, sister and son of the deceased against the spouse).

(28) CE, Ass., 24 June 2014, para. 17.

(29) CE, Ass., 24 June 2014, para. 31.

(30) *Proposition de loi relative au droit de finir sa vie dans la dignité* (Proposal on the right to end one's life with dignity), AN n° 1960, 7 October 2009, rejected at first reading by the National Assembly on 24 November 2009, TA n° 361.

(31) *Proposition de loi, visant à renforcer les droits des patients en fin de vie* (Proposal aiming to enhance the rights of patients at end of life), AN n° 754, 27 February 2013.

(32) *Proposition de loi visant à assurer aux patients en fin de vie le droit de mourir dans la dignité* (Proposal aiming to guarantee patients at end of life the right to die with dignity), AN n° 1140, 13 June 2013.

(33) *Proposition de loi relative au choix libre et éclairé d'une assistance médicalisée pour une fin de vie digne* (Proposal on the free and informed choice for medical assistance for a dignified end of life), Sénat n° 182, 2 December 2013.

(34) Proposal 21 of presidential candidate François Hollande, 2012.

(35) See in particular « *Penser solidairement la fin de vie* », the Report of the *Commission de réflexion sur la fin de vie en France*, *dite* « *Commission Sicard* » (Sicard Report), 18 December 2012; « *Fin de vie, "Assistance à mourir"* », by the *Conseil national de l'ordre des médecins*, 8 February 2013; Report from the *Comité consultatif national d'éthique* (CCNE Report), June 2013; Opinion of the *Conférence de citoyens*, 14 December 2013.

(36) *Commission de réflexion sur la fin de vie en France, dite « Commission Sicard » « Penser solidairement la fin de vie »* (Sicard Report), 18 December 2012, p. 42.

(37) CCNE Report, 23 October 2014.

(38) Except the CCNE Report of 23 October 2014.

(39) Article L. 1110-5, final para..

(40) *Circ. 20 octobre 2011, concernant la mise en œuvre de la loi du 22 avril 2005 relative aux droits des malades et à la fin de vie et de traitement judiciaire des affaires dites de « fin de vie »* (Circular of 20 October 2011, on the implementation of the Law of 22 April 2005 on patients' rights and the end of life and the judicial treatment of "end of life" cases), NOR : JUSD1128836 : BO min. justice n° 2011-10, 31 October 2011.

(41) The Pyrénées-Atlantiques Assize Court, ruling at first instance on 25 June 2014, was not convinced of Nicolas Bonnemaison's guilt in making attempts on the life of seven patients through the use or administration of substances likely to cause death as it had not been proven that, in proceeding with the injections, he had intended to kill within the meaning of Article 221-5 of the French Penal Code.

(42) Sicard Report, p. 93. See also the Opinion of the CCNE (para. 4) which envisages the possibility of implementing a euthanasia exception under the supervision of the French judicial authorities.
(43) Sicard Report and CCNE Report.
(44) CCNE and *Conférence des citoyens*.
(45) R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent); R (on the application of AM) (AP) (Respondent) v The Director of Public Prosecutions (Appellant); R (on the application of AM) (AP) (Respondent) v The Director of Public Prosecutions (Appellant) [2014] EWCA Civ 961
(46) Proposal 21 of presidential candidate François Hollande, 2012.
(47) CCNE Report, June 2013.