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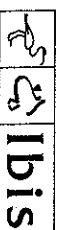
a cura di

Amedeo Santosuosso
Silvia Garagna
Barbara Bottalico
Carlo Alberto Redi



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Le scienze biomediche e il diritto
Biomedical Sciences and the Law

End-of-life decisions.

Spanish and European Legislation. A discussion of concepts

Margarita Boladeras*

I would like to congratulate Professor Meisel on his interesting and very clearly presented lecture. In my reply I will discuss the situation in Spain and in other countries in Europe, and I will debate certain concepts and their limits.¹

1. The withdrawal of treatment

Professor Meisel has spoken of a consensus in the US on the respect for the autonomy of the competent patient who requests the interruption of medical treatment, even when this may cause his death. This is extended to the case of incapacitated patients whose interests and wishes are represented by a family member who acts as a surrogate and makes decisions, or to the case of incapacitated patients who have signed an advance directive (or a combination of these two situations). In Spain, the General Health Act of 1986² established that informed consent is necessary for all forms of medical treatment, and that the patient has the right to refuse treatment. The 41/2002 Act, on the Autonomy of the Patient and Rights and Obligations regarding Clinical Information and Documentation,³ reformulates these rights in accordance with the guidelines of the European Convention for the Protection of Human Rights and the Dignity of the Human Being with regard to the Application of Biology and Medicine, signed in Oviedo in 1997.

* Professor of Moral and Political Philosophy – University of Barcelona. Member of the Catalan Bioethics Committee.

2. *Voluntades antieutanas o instrucciones previas* (advance directives)

In Spain there are laws that recognize the validity of the "advance directive" as the expression of the patient's decision regarding how he or she wishes to be treated should he reach a state in which he or she is no longer able to manifest his or her wishes. I say "laws", in the plural, because it is the regional governments that have power over health matters and each one has passed its own legislation on this issue.⁴ Catalonia, the first region to do so, created an on-line advance directive registry so that a patient's advance directive would appear in his or her clinical history and would also be accessible to all doctors in Catalonia. The Catalan Act 21/2000 on Patients' Rights with regard to Health Information and Autonomy and on Clinical Documentation guarantees the right to draw up an advance directive which must be respected by health professionals. It also establishes the conditions in which the document is valid.⁵

Article 11.1 of the Spanish Act 41/2002 mentioned above defines the meaning and the scope of the advance directive:

"By means of the advance directive, a person of legal age, of sound mind and body, manifests in advance his wishes, so that these wishes may be respected if he reaches a situation in which he or she may not be able to express them personally, regarding the care and treatment of his or her health, or, at the time of death, regarding the fate of his body or the organs thereof. The signatory of the document may also appoint a representative so that, should the case arise, the latter should act as interlocutor with the doctor or health staff to ensure the observance of the directive."

These laws comply with the requirements of the European Convention mentioned above, which states, in article 9: "The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his wishes shall be taken into account."

Nonetheless, there are many disagreements in professional and confessional sectors (especially inside the Catholic Church) regarding the decisions that should be taken when treatment withdrawal will imply the death of the patient. The interruption of dialysis, assisted respiration, assisted hydration and feeding, for example, are controversial issues, as several recent cases illustrate.

3. Cases and application of the legislation

Jorge León Escudero, a health professional and sculptor, was found dead at his home in Valladolid on 4 May 2006, at the age of 53. He had taken a sedative and another person had disconnected the ventilator that kept him alive. What was the reason for this "clandestine" death? Some years before, Jorge had been almost totally paralysed after a fall while working out at home. First he

needed a wheelchair; then, during the last six years of his life, he needed mechanical ventilation. His situation came to light because he started an internet blog in which he explained how unbearable his situation was and in which he expressed his wish to die. After his death, an enquiry was set up to establish the cause, but it was closed on 22 September 2006 because there were no grounds for bringing charges against any one individual.

Jorge León requested euthanasia, which is an offence under article 143 of Spain's Criminal Code.⁶ No one advised him of the possibility of asking for treatment interruption, in which case the action would have been protected by law.

This was the situation of Inmaculada Echevarría from Granada. Nonetheless, her case illustrates clearly the many obstacles that she had to overcome before her right to interrupt treatment prevailed.

In 2006, Echevarría asked that the mechanical ventilator that was keeping her alive should be switched off. She was 51 years old and had suffered from progressive muscular dystrophy since the age of 11. Both her parents died young; she had a brother, but had little contact with him. Her partner was involved in a road accident and she had to have her baby adopted because she was unable to care for him. By the age of 30, she had lost the use of her limbs and could only move her fingers slightly; the illness spread to the muscles of her tongue, face and neck, and since 1996 she had been connected to a mechanical ventilator. A friend put her in touch with the association *Derecho a Morir Dignamente* (The Right to Die in Dignity), which gave her advice. At the beginning she wanted "an injection to stop my heart beating, a dignified, painless death". But if a doctor had given her this injection, it would have been a case of euthanasia, which is an offence under article 143 of the Criminal Code. Echevarría changed her plan and asked for her treatment to be interrupted, and also asked to be given a sedative to avoid the pain that disconnection from the machine would cause. Her wish was finally granted in 2007, after a very lengthy process. Although the right of the patient to request the interruption of medical treatment is legally recognized, the Hospital de San Rafael in Granada, which had treated her over so many years, belonged to the religious order of San Juan de Dios and the Bishop tried to stop her request being carried out. The request was passed on to the Andalusian Health Service, the Permanent Commission of the Consultative Council of Andalusia and the regional government's Commission for Health Ethics and Research, which recognized her right, in accordance with the current legislation, to interrupt her treatment. She was moved to another hospital, where finally she died as she had wished.

Fernando Rey discusses the case from the legal perspective:

"Disconnecting a machine is, in the practical sense, an action, not an omission, but

its effect is the interruption of treatment, that is, the omission of this treatment in the future; the bodily movement (essential in some cases, but not in others, to disconnect the machine) cannot be divorced from the aim of the action, which is to withdraw treatment, and should thus not be considered an offence: it is atypical passive euthanasia, and not direct euthanasia, which would be an offence. According to the prevailing opinion in Germany and Spain this situation is defined as "omission by action". For an omission to be valid in the legal sense the decisive factor is, according to C. Roxin, whether the measure "can be interpreted as the cessation of treatment, compared with the "naturalistic criterion" which considers the performance or non-performance of bodily movements; that is, the withdrawal of intensive care equipment is, in the legal sense, an omission."⁷

This author also mentions the arguments of the Judgement of 27 February 2007, of the Permanent Commission of the Consultative Council of Andalusia. This Judgement accepted the current juridical doctrine of the Spanish Constitutional Court regarding health care and the consent of the individuals affected, in the light of the following: article 15 of the Spanish Constitution, the sentences of this Court regarding the coercive medical care given to the members of GRAPO while in prison (SSTC 120/1990 and 137/1990), the 48/1986 sentence of this Court concerning the refusal to allow the release from jail of a prisoner with a serious, incurable heart condition, the 166/1996 and 154/2002 sentences concerning blood transfusions in Jehovah's Witnesses, and the Pre-Sentence of the European Court of Human Rights, of 29 April 2002. On the basis of the reasons presented in these sentences, the Judgement considers that "from the perspective of the Spanish Constitution and the European Convention on Human Rights, there is no right to die that forms part of the right to life and physical and moral integrity".⁸ The self-determination projected over one's own life or the acceptance of death is a matter of "the freedom of the individual and for this reason is a manifestation of *agere licet*, something that the law does not prohibit, but is not in itself a right to die that requires protection from the public authorities; this view is also expressed in the case law of the European Court of Human Rights". The text then deals with the regulations of the patient's autonomy and the patient's right to accept or refuse a treatment, that is to say, the Oviedo Convention and the 2002 Act, and makes it clear that any medical intervention performed against the will of the patient is at odds with the concept of human dignity and the prohibition of inhuman or degrading treatment. The Andalusian legislation makes the same point, and article 20.1 of the Statute declares the right of all persons to "full dignity in the process of his or her death". The conclusion of the Judgement is as follows:

"It must be made clear that legislation at both State and regional government levels conceives the principle of autonomy of the patient's will in such broad terms as to

leave no doubt that the rejection of a specific intervention, the withdrawal of care or the refusal of a particular treatment may be legitimate decisions, even when they may lead to situations that gravely affect the health of the patient and may even lead to death".⁹ [...] the applicable legislation allows [...] that any patient who suffers an irreversible and mortal disease may take a decision such as the one taken by Ms LE. [...] It is [...] a request that is supported by the right to refuse treatment and her right to live in dignity, and is not overruled by any of the legal provisions specifically examined [...] which would allow the continuation of medical care without the patient's consent. [...] health professionals are required to act in such a way that the right of the patient to refuse life support equipment is respected."¹⁰

4. Similar cases in Europe

The case of Immaculada Echevarría had a precedent: the case of Miss B in Great Britain. Miss B (her full name was not given, in order to respect her privacy) was a social worker who, in 1999, had been diagnosed with a malformation of the blood vessels of the spinal cord. At the age of 43, she was totally paralysed and lived connected to a mechanical ventilator. She received moral and economic support from the actor Christopher Reeves. Miss B asked to be disconnected from the ventilator, but the doctors attending her at the hospital in London did not accept her decision. She lodged a legal appeal which reached the High Court. The judge Elizabeth Butler-Sloss, who visited her in her hospital room so that she could make her declaration, acknowledged in her ruling that Miss B "had the necessary mental capacity to give consent or to refuse consent to life-sustaining medical treatment" and resolved that the doctors were obliged to respect her decision.

These cases contrast with others in Italy, such as those of Piergiorgio Welby and Eliana Englaro.¹¹ The views of Amedeo Santuosso during the debate on these cases are particularly interesting:

"In my opinion, it is impossible to claim seriously that contemporary medicine, which takes account of psychological aspects of illness and health in many fields, justifying in its name interventions of plastic surgery, *in vitro* fertilization, interruption of pregnancy and even sex change should ignore the extreme physical and mental suffering of someone who, near to death, wishes to end his or her life but is unable to do so without asking the doctor for help.

I think we can go further: if in general, other than in cases of terminal illness, a doctor can be declared professionally responsible for having been negligent in not attending to the mental suffering of the patient, and for having provoked or failed to relieve it, it can also be said that taking responsibility for the mental suffering of the patient close to death who, in the terms mentioned above, wishes that his treatment be interrupted, constitutes a duty that the doctor cannot evade.

From this perspective, the doctor who, in particular conditions, receives a request to interrupt treatment or to assist suicide, finds him or herself in a situation of great

conflict, on the one hand it is his or her duty to attend to the suffering of the patient, but on the other he may be charged with assisting suicide and homicide. The conflict can be solved by applying the exemption from performing a duty, article 51 of the Criminal Code, which exonerates a person who fulfils a legally imposed obligation: the new profiles of the doctor, as defined above, place the application of this distinction in a decidedly new light.¹²

Santusosso also refers to the case of the British woman Diane Pretty, who requested euthanasia. The British courts considered that the right to life does not include a right to die that obliges other people or institutions to participate in the act. Pretty's appeal to the European Court of Human Rights was also turned down. The sentence (29 April 2002, *Case of Pretty v. United Kingdom*) ruled that the right to life does not imply the diametrically opposite right, the right to die; such a conclusion cannot be derived from Article 2 of the Convention, nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life; the sentence affirms that "to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse", thus attributing legal validity to the "slippery slope" argument.

Armedo Santusosso¹³ has challenged this ruling of the European Court for using "a common sense argument", rather than legal ones. "In effect, saying that the opposite of the right to life is the right to death confuses the idea of life as a *biological phenomenon* and life as the *content of a right*. If in biological terms the opposite of life is death, in legal terms the opposite of the right to life is the obligation to live. For the right to life, in itself a right that cannot be renounced, to remain such, it must be free in the acts in which it is exercised; these acts can only be referred to the free determination of its holder, who may even choose to refuse health treatment that might save his life. If we proceed otherwise, we arrive at the inadmissible transformation of the right to life into the obligation to live."¹⁴

5. Conflictive concepts: active, passive, direct and indirect euthanasia

Until recently there was a great deal of terminological confusion regarding the different types of medical actions or omissions at the end of life. Today, the majority of Spanish experts (with the exception of some Catholics) coincide in the general tendency to call each of these practices by its name: treatment interruption, terminal sedation, assisted suicide, and euthanasia. These concepts are all different and must not be confused; documents such as "The report on

euthanasia and assisted suicide" of the Catalan Bioethics Consultative Committee (2006)¹⁵ and the declaration of a leading group of experts in the article by P. Simon and others (2007), "Ethics and death with dignity: a proposal for consensus on the correct use of words", stress that no adjectives should be added to the term "euthanasia".¹⁶

However, the terminology used in the current Spanish legislation does little to further these attempts at clarification. Carmen Tomás-Valiente, a specialist in Criminal Law and end-of-life decisions,¹⁷ notes that in article 143 of the Spanish Criminal Code non-necessary cooperation in suicide is not an offence, since the text only punishes "necessary and direct acts". This distinction may be clear in some cases, but not in others.

"On some occasions it will be relatively simple to decide that an act of cooperation is "necessary" or "non-necessary" in nature. For instance, it is clear that a case of non-necessary collaboration would be that of a doctor who merely advises a patient of the dose of a specific substance that he would have to take in order to be sure of ending his life in a safe but relatively painless way; in this case, the patient could simply have killed himself by taking a huge dose of the substance without asking the doctor for any advice, although this action may have caused a more drawn-out and painful death. At the opposite extreme, the aid provided by the person who places the mortal substance in the mouth of a paraplegic is obviously essential, because a person suffering from total paralysis cannot take his own life without outside help.

However, in many other cases it is not at all straightforward to distinguish whether the aid provided is essential or not, since everything will depend on the perspective we adopt. If we start from an abstract position, most acts that aid suicide – acts of euthanasia or not – could be qualified as mere complicity exempt from punishment, because, with the exception of extreme cases such as the one mentioned above, it could almost always be said that the subject could have killed himself "in another way". In contrast, from a perspective that considers the particular situation and the way in which the death occurs, one would tend much more towards the qualification of acts as necessary, punishable cooperation, because from this perspective it is easy to argue that without the aid in question the subject would not have been able to commit suicide "in the particular manner in which he did so". For example, in the case of the doctor who procured for a patient a lethal substance that is very difficult to obtain, it could be argued that this aid was non-necessary from an abstract perspective, applying the reasoning that the patient could have committed suicide by other means – for example, by jumping out of the window of a tall building. However, if we adopt a more concrete point of view, it could be said that without the doctor's aid the patient would not have been able to take his own life in the way he did, since through his own means he would not have been able to obtain the substance used."¹⁸

Tomás-Valiente considers that the legislator introduced this distinction without any clearly defined reason, and that its implications have not been thoroughly examined or explained. If Spanish legislation had proceeded differ-

ently, the country's legal situation could have been on the same footing as that of Oregon in the United States, where a law was passed by referendum in 1994 allowing doctors to prescribe lethal doses of medication to their patients to enable them to end their lives, always with the proviso that certain specific requirements are met.

Tomás-Valiente also notes that conducts that are not active or direct (the misnomers "passive" or "indirect" euthanasia) are not considered to be offences by Article 143. Examples are cases in which a doctor, family member or friend who witnesses a patient taking his own life does not intervene to prevent it, or cases in which patients who are near death are administered substances such as morphine which alleviate suffering but which also hasten death:

"It is equally clear that a doctor or health professional who does not administer a patient specific treatment on the latter's request, however essential for the patient's survival it might be, and even though failure to administer it or its withdrawal might lead to the patient's death, is acting in a legitimate manner. This conclusion does not derive solely from Art. 143.4 of the Criminal Code, but is the inevitable consequence of the obligatory respect for the right of patients to decide on their medical treatment, a right enshrined in many international regulations which are binding in Spain, in the 2002 Act on the Autonomy of the Patient and Rights and Obligations regarding Clinical Information and Documentation, and in all the legislation passed by the Autonomous Communities referring to the subject. In other words, the point is not that the doctor who abstains from administering a treatment that the patient does not want is performing an act that cannot be legally sanctioned; it is that this abstention constitutes a legal obligation for the doctor; it is in fact when the doctor acts against the wishes of the patient that he might in fact be held criminally responsible."¹⁹

Tomás-Valiente also considers the difficulties posed by Article 143 for qualifying the act of disconnecting mechanical ventilators and similar equipment. Several interpretations are possible; there is "a blurred line between the licit and the illicit". [...] So again we must criticize the legislator in 1995 for having selected as the criterion that distinguishes between the two spheres a parameter — the concept of "action" versus "omission" — that is by no means established beyond dispute.²⁰

6. Conceptual clarification

The legislation that has decriminalized euthanasia in the Netherlands and Belgium defines euthanasia and assisted suicide as follows:

Assisted suicide: "Intentionally assisting the suicide of another person or administering the means indicated in art. 294, paragraph 2 of the Criminal Code, so that another person may do so."²¹

Euthanasia: "Intentionally retarding life by someone other than the person concerned, at the latter's request."²²

It is important to define the actions understood in these two cases, and to distinguish them from other courses of action. Although the various legal traditions may be an obstacle, it is important that the international debate should produce a consensus on essential questions such as these.

In this regard, the Catalan Bioethics Consultative Committee (2006) proposed the following definitions:

Euthanasia: This term refers to actions performed by others, on the explicit and reiterated request of a patient who is enduring physical or mental suffering due to an incurable illness and who finds this situation unacceptable and unworthy, to cause the patient's death swiftly and painlessly. These actions are carried out for the sake of the patient and in accordance with his wishes — an essential requirement to distinguish between euthanasia and homicide — with the aim of ending or avoiding intolerable suffering. In euthanasia there exists a direct, immediate causal link between the action performed and the patient's death. Since the introduction of informed consent, the misleading term "passive euthanasia" should no longer be used.

Therapy limitation (TL): Limiting therapy involves accepting the irreversible nature of an illness and the desirability of abandoning treatments that aim to prolong life; only treatments necessary to guarantee the patient's welfare as far as possible are maintained.

Withholding or withdrawing life-sustaining treatments: This is part of the concept of TL just mentioned, and consists of withholding or withdrawing treatments such as mechanical ventilation, cardio-pulmonary reanimation, dialysis, artificial nutrition (enteral and parenteral) or artificial hydration (in unconscious patients), when an acute complication occurs at the end of an incurable illness. The aim is to facilitate the evolution of the illness towards death without unnecessarily prolonging the process with invasive treatments.

Relentless therapy: Initiating or continuing medical measures with no other aim than to prolong the patient's life even though the process of death is irreversible.

Refusal of treatment: The legally recognized right that a person suffering an illness may express, either verbally or in writing, his wish not to accept a specific medical measure.

Terminal sedation: The administration of drugs to relieve physical or psychological suffering that cannot be achieved using other measures, by a sufficiently profound and irreversible decrease in consciousness, in a patient who will die in the very near future and who gives implicit or explicit consent or who has delegated another person to give this consent.

Assisted suicide: The action of a person suffering an irreversible illness, in order to end his life, with the help of another person who provides the information and the means to do so. When the person helping is a doctor, this is termed medically assisted suicide.

Advance directives: The expression of the wishes, priorities or decisions of a person formulated at an earlier time in his life to provide for a later situation in which he may be in a state of incapacity that does not allow him to express them. The advance directive allows the patient to continue exercising his rights and ensures that these rights are respected when he or she is in a situation of vulnerability.

I think there is a broad consensus among professionals on most of these definitions, but two urgent tasks currently face us. First, must obtain professional consensus on all of them; and second, we must continue to provide society with clear information so as to counteract the constant manipulation and the atmosphere of confusion created by ideologies that oppose the recognition of the individual's autonomy in these areas.

As regards the social situation in Spain, I can say that in spite of the intense campaigns carried out by the Catholic Church, an opinion survey conducted by the Noxa Institute in September 2008 published by the Barcelona newspaper *La Vanguardia* showed that 79% of those consulted declared themselves to be in favour of changing the current legislation to allow patients suffering incurable and illnesses to ask their doctor to put an end to their life, and that only 15% declared themselves to be against the proposal. I think that public opinion in many countries supports measures that politicians are reluctant to introduce because of the strength of certain pressure groups.

References

- 1 The ideas presented here are discussed in more depth in my book *El derecho a no sufrir. Argumentos para la legalización de la eutanasia*. Barcelona, Los libros del lince, 2009.
 - 2 Spanish General Health Act, 14/1986, 25 April.
 - 3 This Act was passed on 14 November 2002.
 - 4 The laws passed by Spain's regional governments regarding "advance directives" are the following: in Catalonia, the 21/2000 Act, 29 December; in Andalusia, the 5/2003 Act, 9 October; in Aragón, the 6/2002 Act, 15 April; in the Balearics, the 5/2003 Act, 4 April; in the Canaries, the 13/2006 Decree; in Cantabria, the 7/2002 Act, 10 December; in Castile La Mancha the 6/2005 Act; in Castile Leon, the 8/2003 Act, 8 April; in the Basque Country, the 7/2002 Act of 12 December; in Extremadura, the 10/2001 Act of 28 June, the 3/2005 Act and the 6/2005; in Galicia, the 3/2001 Act of 28 May and the 3/2005 Act; in La Rioja, the 9/2005 Act; in Madrid, the 3/2005 Act; in Murcia, the 80/2005 Decree; in Navarre, the 11/2002 Act of 6 May and the 29/2003 Act; in Valencia, the 1/2003 Act, 28 January.
 - 5 Article 8. Advance directives: 1. The advance directive is a document addressed to the attending physician, in which a person of legal age, with full capacity and of their own free will, expresses instructions specifying what actions should be taken for their health in the event that they is no longer able to express their wishes due to illness or incapacity. In this document, the person may also appoint a representative as their interlocutor with the physician or health staff to substitute them in the event that they are no longer able to express their wishes.
 2. It must be demonstrated that this document has been drawn up in the conditions stipulated in section 1. The advance directive declaration must be made in the circumstance described below:
 - a) In the presence of a notary. In this case, the presence of witnesses is not required.
 - b) In the presence of three witnesses of legal age with full capacity to act, at least two of whom may not have more than second degree kinship with the person in question or have any economic association.
 3. Advance directives that include provisions that are against the law, run contrary to sound clinical practices, or do not correspond exactly to the case that the subject intended at the moment of issuing them will not be taken into account. In such cases, the situation will be recorded in the patient's clinical history.
 4. If an advance directive exists, the person in question, their family or representative must present the document to the health centre where the person is being treated. This advance directive should be included in the patient's clinical history.
- ⁶ Spanish Criminal Code I, Article 143:
1. Any person aiding suicide with necessary acts will be liable to a prison sentence of between two and five years.
 2. Any person who induces another person to suicide will be liable to a prison sentence of between four and eight years.
 3. If the cooperation goes as far as to cause death, the sentence will be between six and ten years.
 4. A person who causes, or cooperates actively with necessary and direct acts, in the death of another, by the explicit, serious and unequivocal request of this, in the event that the victim were suffering a serious illness that will necessarily lead to death or produces constant and unbearable suffering, will receive a punishment one or two degrees lower than those indicated in sections 2 and 3 of this article."

⁷ Rey, F. (2008), *Eutanasia y derechos fundamentales*, Centre for Political and Constitutional Studies, Madrid, p. 24.

⁸ Judgement of the Permanent Commission of the Consultative Council of Andalusia, 27 February 2007, p. 29, quoted by Rey (2008), p. 26.

⁹ Judgement... p. 49, quoted by Rey (2008), p. 26.

¹⁰ Judgement... p. 51, quoted by Rey (2008), p. 27.

¹¹ Santosuosso, A. (2008), "La voluntad oltre la coscienza: la Cassazione e lo stato vegetativo", in *La Nuova Giurisprudenza Civile Commentata*, Parte seconda, CEDAM, p. 3.

¹² Santosuosso, A. (2008), pp. 5-6.

¹³ Santosuosso, A. (1996), "Diritti dei pazienti e doveri dei medici nel caso dell'eutanasia", in *Vialora (comp.) Damaio merino/Bioetica e diritto nel dibattito sull'eutanasia*, Gregoriana Libreria Editrice, Padua, pp. 207 ff. Santosuosso, A. (2001), *Corpo e libertà. Una storia tra diritto e scienza*, Raffaello Cortina Editore, Milan.

¹⁴ Santosuosso, A. (2008), "La volontà oltre la coscienza: la Cassazione e lo stato vegetativo", in *La Nuova Giurisprudenza Civile Commentata*, Parte seconda, CEDAM, p. 3.

¹⁵ Catalan Bioethics Consultative Committee (2006), *Informe sobre la eutanasia y la ayuda al suicidio*, Department of Health, Government of Catalonia, Barcelona <http://www.gencat.cat/salut/depsalut/pdf/eutanasia.pdf>

¹⁶ Sison, P. et al (2007), "Ética y muerte digna: propuesta de consenso sobre un uso correcto de las palabras", in *Colección Asistencia*, 23 (6), p. 271-285.

¹⁷ Carmen Tomás-Vallente is a professor of Criminal Law at the University of Valencia. Her doctoral thesis entitled *La disponibilidad de la propia vida en el Decreto Penal*, was published by the Centre for Political and Constitutional Studies, Madrid, 1999 and is an invaluable reference point for studies of euthanasia. She is also the author of *La cooperación al suicidio y la eutanasia en el nuevo Código Penal (artículo 143)*, Tirant lo Blanc, Valencia, 2000 and "La regulación de la eutanasia activa solicitada en el Código Penal español", in Gómez Tomillo, M. (dir.), *Aspectos médicos y jurídicos del dolor, la enfermedad terminal y la eutanasia*, Unión Editorial/Fundación Lilly, Madrid, 2008.

¹⁸ Tomás-Vallente, C. (2005), *Parbilidades de regulación de la eutanasia solicitada*, Working document 71/2005, Fundación Alernarkas, Madrid, p. 10-11.

¹⁹ Tomás-Vallente, C. (2005), p. 13.

²⁰ Tomás-Vallente, C. (2005), p. 13.

²¹ The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, The Netherlands, 2001, article 1.b. The attending physician must be satisfied that the patient has made a voluntary request and that the level of suffering is unbearable.

²² The Euthanasia Act of 28 May 2002, article 2, Belgium. According to article 3, the patient must be in a "medical situation that is beyond hope", "serious and incurable", and that his/her "physical or mental suffering... is constant and unbearable".

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