

Policy Paper on Euthanasia

Dilemmas related to ending life have come to the forefront of interest in many parts of the world in recent decades. Modern medicine can lengthen the dying of patients even by years, which means that health-care professionals, patients and their relatives occasionally have to face decisions that were not known in the past. Public perception of death underwent changes as well: there are many people today who do not believe it to be inevitable that they should bear the pains attendant on dying and therefore expect health-care professionals to assist them in making their dying shorter.

The right to die in dignity and the right to euthanasia entailed by it are emerging these days as fundamental human rights. The Hungarian Civil Liberties Union (HCLU) has taken the following position on this issue:

- terminally ill people have the right to make a decision about their fate;
- when a patient with decision-making capacity requests that his* life-sustaining treatment be withdrawn, his request must be honored;
- when a patient who is suffering from unbearable pains requests analgesics, his request must be honored even if such drugs may cause his death;
- a terminally ill patient has the right to ask for medical assistance to end his life.

What is euthanasia?

A physician helping his patient who suffers from an incurable (and lethal) disease, to die, (for example, by withdrawing life support measures or by refraining from taking such measures), performs euthanasia, provided that he acts in the best interest of the patient. Euthanasia may be performed at the patient's request

* For the case of simplicity, *he* and *his*, always include *she* and *her*.

(*voluntary euthanasia*) or without the patient's consent if the patient is not in a state to be consulted (*non-voluntary euthanasia*). Experts often distinguish active from passive euthanasia. Such distinction is not based on whether or not the physician brings about euthanasia by action or by omission. In the case of *passive euthanasia*, the physician refrains from giving treatment to his patient (for instance, he does not apply resuscitation) or withdraws a treatment (unplugs the patient from the mechanical respirator), and thereby lets his patient die. In the case of *active euthanasia*, the patient's death is caused by an act of the physician, which would cause the death of a healthy person as well (for instance, administering a lethal injection). A third case is when the physician assists a patient in suicide (for instance, by giving the patient the lethal drug).

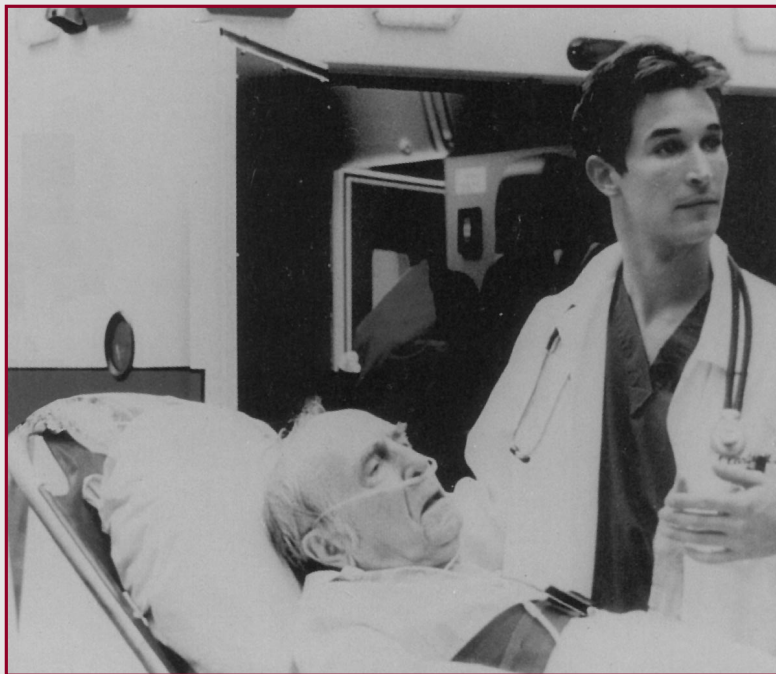


Photo: RTV Részletes Újság

A most important condition for an act to qualify as euthanasia is that a physician must act *in the best interest of the patient*. Opponents of euthanasia occasionally mention under the heading of euthanasia the eugenics programs applied in Hitler's

Germany. The eugenics program, however, was pursued against the interests of those killed, and aimed at eliminating certain categories of people. It is not justified to speak about euthanasia when a patient dies because the health care facility concerned did not possess the equipment to prolong his life (for instance, there were two mechanical respirators for three patients).

Do we have the right to refuse life-sustaining treatment?

The right to self-determination in the context of health care means that patients have the right to make decisions on questions related to their treatment: whether or not they make use of health care, which medical interventions they consent and which they refuse.

According to the HCLU's position people have the right to self-determination even in the state of terminal illness. The presumption is that the life of all patients has to be sustained and, that, patients must receive effective treatment. However, the purpose of medicine cannot in all cases consist in postponing death – in other words, in prolonging the dying of patients – at any price. In case a patient does not want to delay his death, it is not necessary to apply all measures. It follows from the recognition of the right to self-determination that even the life-sustaining and life-support measures may only be taken with the consent of the patient concerned.

Besides the right to self-determination, freedom of conscience must be taken into account in this respect. Not everybody consider life to be a value in absolute terms. Many people are unwilling to prolong their lives temporarily at the price of suffering and defenselessness. Instead, they would opt for an "easy death" in exchange for reducing the

In the past couple of decades patient rights have gained legal recognition and judicial protection, and the right to self-determination has come to be regarded as justifying the rejection of all kinds of medical treatment.

In the United States, physician-patient relations are shaped by the principle of informed consent: a physician may only conduct necessary examinations and interventions on the basis of voluntary authorization from an appropriately informed patient. From the 1970s on, more and more judicial decisions recognized the right of competent adults to self-determination to extend to the rejection of life-sustaining treatment: at the request of a patient on a respirator he must be unplugged from the device; a paralyzed person may reject artificial nutrition, Jehovah's Witnesses may reject blood transfusion etc. The decision of the Supreme Court made in 1990 in *Cruzan v Director, Missouri Department of Health*, became a standard: according to it, medical treatment may be stopped only if the patient's intentions have been unambiguously and convincingly ascertained. At the same time the decision acknowledged the constitutional right of patients to reject treatment and choose natural death. In compliance with the principle of judicial updating, all federal states enacted legal institutions of living wills on the rejection of certain forms of treatment and advance directives identifying a health care proxy. In an act on the patients' right to self-determination, Congress obligated health care establishments to inform patients about the opportunity to issue these kinds of legal declaration.

The precedent set by these practices in the United States was followed by other democratic countries, where the idea that not even a dying person may be treated against his will became generally accepted. If a patient becomes incapable of making a decision and his earlier relevant desire cannot be ascertained, courts in certain states include weighing the patient's interests in their decision-making. For instance, in *Airedale NHS Trust v Bland* the House of Lords (Great Britain) decided that life sustaining treatment for Anthony Bland, a young man who had suffered an irreversible brain damage, could be legitimately discontinued because it was in his best interests. In a similar case the Irish Supreme Court declared that the interests of a woman who had been lying unconscious for over twenty three years, were best served by a discontinuation of her artificial feeding. The most important case in Canada was *Nancy B v Hôtel Dieu de Québec*, in which a twenty-five-year-old patient paralyzed as a result of a neural disease living on a respirator requested the court to obligate her physicians to switch off the respirator. The judge explained that he would be glad to see the patient change her mind but said he had to recognize her desire as justified and, therefore, ordered the physicians to stop the respirator.

length of their lives. The state must acknowledge that people have different conceptions about the meaning of life.

By accepting the right to refuse life-sustaining treatment, we accept *the right to voluntary passive euthanasia*. According to that right, it is not permitted forcibly to apply the mechanical respirator to a patient who opposes that; it is not permitted to amputate the leg of a patient who opposes that; it is not permitted to apply a treatment that temporarily lengthens a patient's life in case he asks for the withdrawal of such treatment because of his pains.

The HCLU position is that any patient with decision-making capacity may refuse life-sustaining treatment. A patient has decision-making capacity if he

- is capable of understanding information that is necessary for the decision;
- is capable of weighing his options according to his values and objectives;
- is capable of understanding the possible consequences of the decision;
- is capable of informing the persons who give him treatment about his decision.

A patient with decision-making capacity will pass a decision about his treatment on the basis of his own moral values. Decision-making capacity is different from competence

in the legal sense. Persons who do not have full competence in the legal sense might still be capable of making informed decisions about their medical treatment. It cannot be ruled out that a person who is slightly disabled mentally or suffers from a psychiatric illness and is incapable of making decisions about his financial situation, can make a valid decision about the withdrawal of his treatment. Furthermore, 16 or 17 years old young people are not fully competent in the legal sense but cannot be excluded from the opportunity of meeting autonomous decision in the state of terminal illness.

It often occurs that a patient does not have decision-making capacity because in the course of his treatment, he has received an overdose of tranquilizers or analgesics. In such cases, health-care providers must aim to restore the patient's decision-making capacity as much as possible.

Do we have the right to make an advance directive about the refusal of life-sustaining treatment?

There are several diseases and injuries which result in a loss of consciousness or decision-making capacity. A patient in this state is

incapable of making a statement on whether or not he accepts treatment. However, the right to self-determination entails the need in legislation to ensure that citizens should be able to make *advance directives* for such occasions. An advance directive is a written document in which a patient makes a statement in advance about his intentions related to future medical care he is supposed to receive. The advance directive may take any of two possible forms:

- *Advance directive about the forms of treatment*: a person makes a statement on that, should he irreversibly lose decision-making capacity because of a disease or an accident, he refuses receiving life-sustaining treatment; which means then that he should let die. In addition, it is also possible to define in advance those forms of treatment which the patient making the statement would not accept under any conditions (for instance, the application of mechanical respirator, dialysis, or the refusal of resuscitation).

- *Advance directive on a proxy decision-maker*: in such a statement, the patient names a person who makes a decision in his stead in case he loses his decision-making capacity. Rather than making his decision on the basis of what *he* believes is the best choice for the patient, the proxy decision-maker is supposed to rely on what he believes *the patient* would consider as the best choice, taking into consideration the patient's assumed intentions and interests.

Legislation must make it clear that patients have the right to withdraw or amend their advance directives at any time. A proxy decision-maker also has the right to change his opinion as long as such a change does not run contrary to the advance intentions of the patient. The life-sustaining treatment of a patient may only be withdrawn or omitted provided the patient's intentions have been proven unequivocally.

What is to be done when a patient lacking decision-making capacity did not make an advance directive in the past? The HCLU position is that in such cases, decision-making should be vested in the legal representative of the patient (in a parent or a guardian). We regard it indispensable that, in such cases, the directive given by the proxy decision-maker to withdraw the life-sustaining treatment is approved by a court. Life-sustaining treatment may only be withdrawn provided that such a move conforms to the intentions and best interests of the patient as far as they can be known.



What is involved in humane treatment for patients in the terminal phase?

The right to die in dignity implies that humane provision must be secured for the terminally ill person. The patient must not be left alone when he is deciding about discontinuation of life-sustaining treatment. Arrangements must be made to ensure that relatives may stay close to him during this time, even continually if necessary. It must be pointed out to the patient that a rejection of certain kinds of life-sustaining treatment does not exclude him from receiving other forms of treatment. Health care staff have the primary obligation to provide the patient with supportive treatment: suffering must be reduced with the help of pain killers, tranquilizers and attentive care. Pain can sometimes only be reduced with the help of narcotics which render the patient unconscious. This can be legitimately done only with the patient's prior consent to this kind of treatment.

Patients in the terminal phase have the right to hospice care. Establishments offering hospice care must be given a place in the health care system and patients must be informed



Diana Pretty before the European Court of Human Rights.

Photo: MTI

about the roles hospice care can fulfill. Someone who asks for admission into hospice care gives up on aggressive life-sustaining intervention and acquiesces in pain killing and alleviation of symptoms as the main aims of the treatment. Hospice care concentrates

not only on the reduction of physical suffering but aims equally at alleviating the patient's emotional and mental strain. Hospice nurses are devoted to the aim that the patients should spend the rest of their lives in comfort and in conditions befitting the dignity of a human being, in a supportive atmosphere created by their family, if that is feasible.

In some European countries, for instance, in Switzerland and Sweden, no clear-cut distinction is made between discontinuing treatment and handing over of a lethal drug. Even in those countries, it is not allowed for physicians to give lethal injections, but in case a physician writes a prescription about, or hands over a lethal drug, he does not commit a crime.

In view of the great variety discernible in European regulations, the European Court of Human Rights took a cautious stand on the issue in the Pretty case in 2002: in accordance with the European Convention on Human Rights, states cannot be obligated to provide legal immunity to persons assisting in the suicide of incurably diseased persons. At the same time the Court drew attention to the fact that attitudes to the law in democratic states are undergoing significant changes, and the right of patients to self-determination is being given effect more and more extensively.

In the United States, physician assisted suicide was associated for a long period of time with the name of Dr Kevorkian. Dr Kevorkian prepared a device to inject into the patient's organism a lethal dose of a drug after a button was pressed. In all those cases, the device was activated by the patient himself or herself. Dr Kevorkian assisted over a hundred persons to die in that manner. For a long time, no court was available to convict Dr Kevorkian for such action. However, there was a case when Dr Kevorkian himself gave a lethal injection to one of his patients. In that case, he administered active euthanasia, for which he was imprisoned. The State of Oregon was the first, in the US, to repeal the absolute ban on physician assisted suicide, and to recognize a legal right of terminally ill patients to seek medical assistance to end their lives (Death with Dignity Act). The law on death with dignity was enacted in 1994 but owing to constitutional objections, it did not come in force before 1997. Assistance from the physician may be requested by patients above 18 in a terminal state and in command of their decision making capacity, and physicians are only allowed to put the substance at the patient's disposal but may not administer it themselves. The right secured for Oregonians by law has not become a right due everyone under the Constitution. In two cases in 1997, the Supreme Court overruled the verdicts brought by appellate courts in the states of New York and Washington in which it was concluded, with reference to the Federal Constitution, that the terminally ill had a right to a physician's assistance in their suicide. The Supreme Court held that the Federal Constitution could not be interpreted as entailing the right of individuals to avail themselves of a physician's assistance in suicide (*Vacco et al v Quill et al*; *Washington et al v Glucksberg et al*). Thus, in the United States, it is up to the legislative bodies of individual states whether or not they will further push the limits of the right to self-determination.

May patients request medical assistance to terminate their lives?

Occasionally, a patient's request that his dying be shortened cannot be met simply by the discontinuation of his treatment. That can occur in the following cases:

- Numerous terminal diseases take a long time before they end the patient's life, while applying life-sustaining treatment is of no help and, therefore, it is not experimented with.
- In other cases, life-sustaining treatment would be possible, but its discontinuation would result in shorter or longer periods of unbearable sufferings. For instance, when a mechanical respirator is switched off, the patient's death by asphyxiation may take hours; and when an operation is refused, the terminal stage of a dying person can be rather lengthy.

It is the conviction of the HCLU that patients have the right to die in dignity also in cases when they cannot achieve that by refusing treatment. In such cases, a physician may assist a patient in ending his life fast and in a painless manner by giving the patient a drug that causes the patient's death. We are in favor of a regulation which allows a physi-



Photo: Ferency Europress

cian to give such a drug for the patient along with adequate information. In support of this position, one can appeal to three constitutional rights of the individual:

- *The right to human dignity* requires that the physician gives assistance to his patient to avoid unbearable physical and spiritual sufferings.
- A patient with decision-making capacity exercises his *right to self-determination* when he requests for the assistance of the physician and when, making use of that assistance, he puts an end to his life at his own decision.
- It is a part of the *right to life* to exercise the right to end one's life. A patient must have the freedom to dispose of his own life and it is not permissible to force him to remain alive in case it has become impossible to continue his life in a meaningful manner.

In case a patient – after thoroughly weighing the pros and cons of the case – makes the decision that his final days would not mean a life for him that is worthy of a human person, he is justified in requesting assistance for suicide. *In other words, he has a justified claim for medical assistance to suicide.*

We regard it essential that legislation ensures safeguards against abuses. Only patients who have decision-making capacity should have the right to request assistance for suicide, and such request should be appropriately documented. The physicians have to establish whether or not the patient who applied for assistance for suicide is in possession of the necessary information, whether or not the request was based on the patient's considered decision, and whether or not the patient appropriately considered the pros and cons of such a decision. The patient must

get information about the use of the drug concerned. Another physician, who does not take part in the treatment of the patient, must confirm that the patient's state justifies his receiving a lethal drug, and that the latter must make sure that the assistance to suicide takes place on the basis of the patient's autonomous decision. It goes without saying that physicians are also protected by freedom of conscience and, therefore, no

physician can be obliged to take part in such an action if that runs contrary to his conviction.

Is a physician who does active euthanasia guilty of a crime?

The HCLU has taken the position that a physician who performs active euthanasia at the request of his terminally ill patient is not guilty of a crime. The majority of the dying are afraid of pains more than death. Most patients need that their sufferings should be alleviated, and it is the duty of the physician to apply such therapy. Patients must receive information about the techniques of pain relief, and narcotics or other means must be used at the request of the patient even if that involves the risk of causing death. In order to alleviate the sufferings of the dying, the destruction of nerve tracks by the application of the injected drugs is acceptable and so is giving addictive narcotic drugs. The HCLU is of the view that if need be, a terminally ill patient may even receive such a dose of narcotics that is likely to shorten the life of the patient by impeding his breathing.

It must be made clear in the penal code that a physician does not commit homicide or any other crime when a patient dies of a large dose of narcotic if:

Recognition of "the right to terminate one's life" or "the right to dying" continues to be an exception, and active euthanasia administered at the patient's request counts as a criminal act in most countries. Active euthanasia gets a milder court sentence in, among other countries, Germany, Poland, Italy, Denmark and Switzerland, where there is a separate legal provision for "killing at the patient's request".

The Netherlands is the only country where active euthanasia is widely exercised and officially accepted for more than a decade. In the 1984 Alkmaar case, the Dutch Supreme Court ruled that when a physician, confronted by the dilemma between "thou shalt not kill" and "alleviate the patient's pains", as a result of being addressed by the request of a patient to help him to die, does indeed extend the requested assistance, he is acting in an emergency and is therefore not liable to punishment. Unwilling to legalize euthanasia, the Dutch parliament regulated the physicians' duties in this regard in a 1993 law on funeral procedure. According to that law, no criminal procedure is initiated against a physician provided he abides by the following rules: (1) Euthanasia shall not take place unless it is requested repeatedly by the patient, and there is no doubt that the patient indeed wants to die. (2) The patient shall be fully informed about his disease and the opportunities for further treatment. (3) The patient undergoes unbearable physical and spiritual suffering and no treatment whatsoever that would be acceptable for him could alleviate his pains. (4) The physician shall make preliminary consultation with another physician.

Research data show that the majority of Dutch physicians consider euthanasia an accepted part of their profession. According to surveys, active euthanasia is occasionally applied in the absence of the request of the patient. This usually happens when a patient undergoes incurable and unbearable sufferings and he is not in a state to be able to respond to questions. In such cases, the physicians make consultation prior decision with the relatives and other physicians. Parliament put an end to the uncertainties involved in legal regulations by enacting a law specifically addressing euthanasia, in 2001.

Yet the Dutch law was not to be the first euthanasia act in the world: in May 1995 the Parliament of the Northern Territory of Australia enacted the law on the rights of terminally ill patients. According to that law a physician is permitted to prescribe, prepare and hand over as well as inject a lethal drug to his patient, subject to certain strict procedural requirements. Soon after that law was made operative, it was annulled by the Federal Parliament of Australia. The Dutch example was followed by Belgium, where the act which decriminalized voluntary euthanasia came into force in 2002.



- the patient suffered from an incurable disease and he experienced unbearable pains;
- a patient who has decision-making capacity, or his proxy decision-maker, has given informed consent to applying high-risk analgesics;
- narcotics given in smaller doses would not have alleviated the sufferings of the patient;
- it was the sole purpose of the physician to alleviate the patient's sufferings.

Provided these conditions are jointly met, no criminal procedure should be initiated against the physician. It is sufficient that the physician makes preliminary consultation with another physician, and afterwards he writes a report about the case. A physician should only be called to account if he violated the above requirements. In medical practice it is conceivable that a physician brings about the death of a patient with such a method that cannot qualify as pain relief: after examining the state of the patient he concludes that prescribed dose of the narcotic is insufficient to alleviate the growing pains of the patient. Therefore, at the request of the patient, he gives him a greater dose of the narcotic with the aim of allowing the patient to die within a short time and without pains. Such action – where the aim of the intervention is causing death rather than relieving pain – is *active euthanasia*, which is usually considered by law as homicide.

Voluntary active euthanasia is the clearest case in personal self-determination. HCLU holds, nevertheless, that government interference is not completely out of place in such cases, because the permission to practice active euthanasia confers enormous power on the physician, and such power, particularly under the present state of the Hungarian health care system, can be misused in the pursuit of aims not endorsed by the patient. We think, therefore, that those cases where a physician brings about the death of his patient deliberately by giving a lethal injection or in some other manner must be subject to a thoroughgoing official investigation leading to a court decision. At the same time, the court must have the power to declare the physician „not guilty” and to refrain from applying any sanctions on him. This is because the court might find that the physician had to face an insolvable dilemma: he ran out of the means to alleviate the sufferings of his patient, but the patient was no more in a state to end his own life and, therefore, he asked for a lethal dose of narcotic. In case the physician refuses to fulfill that request, he deprives his patient of the opportunity to die in dignity. Conversely, if he fulfils the request,

he takes the life of his patient. When a physician opts for active euthanasia, he has to be prepared to stand for a trial and defend his decision in public. The court, on the other hand, must have a wide discretion to decide on legal responsibility on the basis of a serious weighing of the circumstances of the particular case.

The right to die in dignity in Hungary

Before 1998, there was no comprehensive law in Hungary to protect the rights of patients. Provisions covering the welfare of terminally ill patients were also incomplete. As a rule, all forms of euthanasia were generally considered forbidden. The only legal provision that covered this field was as follows: “A physician is obliged to treat with utmost care even that patient whom he considers incurable.” The consent of the patients was only requested before non-life-saving operations, and the question what treatment to apply was always decided by the physician. Depending on the conduct of the physician, euthanasia was considered either as homicide, assistance to suicide or omission of giving help.

It goes without saying that euthanasia occurred in Hungary notwithstanding. Matters related to the welfare of terminally ill patients were decided without consultation with the patients. It was solely within the discretion of the physicians to decide whether or not to omit resuscitation or withdraw a patient from a mechanical respirator, and often physicians injected analgesics in such a dose that hastened death. In that period, the patient was the object rather than the subject of the treatment.

The new Health Care Act, which came into effect in 1998, broke with that attitude, clarifying the rights patients have in the course of their treatment. It stipulates that medical treatment is subject to the consent of the patient, and the patient has the right to refuse health care. A patient even has the right to refuse life-sustaining treatment in case he suffers from an incurable disease which – even if he receives appropriate medical treatment – is assumed to cause death within a short period of time. Verbal expression of a refusal of treatment – except some cases – is not valid, though. It is legally required that the patient makes a written statement duly signed. The 1998 Health Care Act also empowers indi-

In the last couple of years, inquiries about the frequency of cases of euthanasia have been conducted in various countries. These inquiries invariably led to the result that most of the physicians have been confronted, in the course of their practice, by the request for an assistance in terminating life. They also showed that – against all legal prohibition – part of the physicians do in fact provide the requested help in certain cases. More often than not, euthanasia is administered in secret in order to avoid legal punishment.

According to a survey published, in 1994, by British Medical Journal, 60 % of the physicians reported on having been asked to help in terminating life. 32 % of these did provide their patients with the requested assistance, and a further 46% said they would not refuse the assistance if the legal ban were to be lifted. According to a survey conducted by Sunday Times, a British newspaper, 14% of the physicians asked by the pollsters reported on having provided life-curtailing assistance to their patients. An 1997 Survey conducted in Norway, there are about 20 cases of physician-performed voluntary active euthanasia in this country, notwithstanding of the legal ban on such activities.

A 1996 Australian survey on the role of the physicians in the death of their patients has shown that there are more cases of voluntary and non voluntary euthanasia in this country than in the Netherlands where euthanasia is permitted under certain conditions. Researchers claim that about 1.8% of all deaths are due to voluntary euthanasia and physician assisted suicide.

Similar results have been yielded by a study conducted in Flanders, Belgium before the adoption of the Euthanasia Act. Voluntary active euthanasia and assisted suicide were responsible for 1.3% of all deaths, while 3.2% were due to euthanasia performed without an explicit request, and 18.5% to pain relief with a double effect.

All these empirical data point towards the conclusion that active euthanasia is practiced even in those countries where it is under an explicit or implicit legal ban. Under such conditions, the risk of abuses is not smaller than under the circumstances of permission conditional on satisfying strict procedural requirements. Moreover, in countries with prohibitive policies the final decision is taken more often by the physician rather than the patient, in violation of the right to personal self-determination.

viduals to make an advance directive about the medical procedure to be followed in case they suffer an accident or develop a serious disease. Such a statement can be made at a notary public.

It is undoubted that the present law foresees a highly complicated procedure for the exercise of such rights and, that, it fails to ensure the right to use their self-determination for all patients capable of making decisions about themselves. For instance, those patients who suffer from an incurable and painful disease but could be kept alive for some time with aggressive life-prolonging measures do not have the right to refuse life-sustaining treatment. Neither can those patients use their right of self-determination who are not incurable by present-day medicine but whose disease is likely to cause endless and unbearable sufferings. Despite all these shortcomings, Hungary has taken the initial steps towards a regulation that is similar to those of the Western states.

At the same time, few changes have been made to the institutional system of health care. Services designed for caring for patients in the terminal phase are still not available with the required frequency and at the required level of quality. Hungarian hospice organizations, if they fully exploit their resources, are capable of caring for two thousand terminally

sick patients a year. This is a disproportionately low number as compared to a hundred and thirty thousand persons dying a year and over thirty thousand patients suffering of cancer a year.

The Constitutional Court issued a decision on euthanasia in 2003. This decision states that, in the case of a terminally ill person, the right to self-determination includes a right to choose between life and death, and to choose the time of his own death. Accordingly, effective Hungarian regulations, which do not allow the patient to reduce the amount of his suffering by asking for medical assistance in bringing closer the time of death, impose a restraint on the right to self-determination of the person. However, the decision adds, such conditions may not be arbitrary if the conditions are not ripe for lifting them. According to the Court, it is up to legislators to decide whether or not this is the case: whether appropriate procedures can be elaborated to guarantee that the patient's request for assistance will be a genuine expression of his free will rather than a result of external pressure, and whether the system of health care institutions and their professional staff are at the appropriate level of development for adequately functioning on such legal terms. As to passive euthanasia, the Court failed to examine, whether patients suf-

fering from an incurable disease are in fact in the position to practice their right to refuse treatment, a right recognized by the Health Care Act. Thus, the decision left the review of the provisions on refusing treatment to the legislature.

It is our considered conviction that patients' rights will not be adequately secured in Hungary unless further steps are made

- to ensure that the patients could exercise their right to refuse medical treatment in abundance by the new Health Care Act;

- to ensure that the various forms of advance directive become known as widely as possible;

- to ensure that every patient with decision-making capacity can exercise his right of self-determination;

- to create conditions for the humane care of terminally ill persons;

- to promote legislation recognizing the right to die in dignity;

- to promote legislation defining the conditions of physician-assisted suicide;

- to ensure that physicians who carry out active euthanasia at the request of patients should go unpunished in the eye of the law and according to court practice.

Published by

HCLU
HUNGARIAN CIVIL LIBERTIES UNION

December 2003.

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This publication is supported by the Ford Foundation.