Decision 22/2003 (IV. 28.) AB

IN THE NAME OF THE REPUBLIC OF HUNGARY

On the basis of petitions seeking a posterior examination of the unconstitutionality of a statute and the establishment of an unconstitutional omission of legislative duty, the Constitutional Court – with concurring reasoning by dr. András Holló, dr. István Kukorelli, and dr. Éva Tersztyánszky-Vasadi, Judges of the Constitutional Court, and dissenting opinions by dr. Mihály Bihari, dr. Árpád Erdei, dr. András Holló, and dr. István Kukorelli – has adopted the following

d e c i s i o n :

1. The Constitutional Court rejects the petition claiming that Act CLIV of 1997 on Healthcare restricts in an unconstitutional manner the right to self-determination of terminally ill patients by not allowing the termination of their lives with the aid of a physician.

2. The Constitutional Court rejects the petition referring to an unconstitutional omission of legislative duty by the failure of the legislature to harmonise Sections 166 to 168 of Act IV of 1978 on the Criminal Code with Article 54 para. (1) of the Constitution.

3. The Constitutional Court rejects the petitions claiming that Section 15 para. (2), Section 20 paras (3) and (4), Section 22 para. (4), and Section 23 para. (1) of Act CLIV of 1997 on Healthcare restricts in an unconstitutional manner the right to self-determination of terminally ill patients in respect of refusing life-supporting or life-saving medical intervention.

4. The Constitutional Court rejects the petitions seeking the establishment of the unconstitutionality and the annulment of Section 17 para. (1) item a) as well as the text “or in the case specified under para. (1) item b)” in Section 18 para. (2) of Act CLIV of 1997 on Healthcare.

5. The Constitutional Court refuses the petition aimed at the establishment of the unconstitutionality and the annulment of Sections 15 to 19 of Act CLIV of 1997 on Healthcare.

6. The Constitutional Court refuses the petitions aimed at the establishment of the unconstitutionality and the annulment of Section 3, Section 5 para. (2), Section 6, Section 7, and Section 10 para. (2) of Government Decree 117/1998 (VI. 16.) Korm. on the Detailed Rules of Refusing Certain Forms of Medical Care.

The Constitutional Court publishes this Decision in the Hungarian Official Gazette.

R e a s o n i n g

I

The Constitutional Court has received several petitions concerning the right of patients suffering from terminal illnesses to end their lives with dignity.

1. Two petitioners filed a joint petition on 25 November 1993, asking the Constitutional Court to establish the unconstitutionality of, and to annul the last sentence in Section 43 para. (2) of Act II of 1972 on Healthcare (hereinafter: the "Act"). In addition, they proposed that the Constitutional Court establish that the legislature had caused an unconstitutional situation in the form of omission of legislative duty by its failure to harmonise Sections 166 to 168 of Act IV of 1978 on the Criminal Code (hereinafter: the CC) with Article 54 para. (1) of the Constitution.

They based their petition concerning the Act on it obliging physicians to treat with maximum care the patients they consider terminally ill although, as held by the petitioners, the right to human dignity granted under Article 54 para. (1) of the Constitution contains the right to end one's life with dignity, too. In the case of a terminally ill patient, this means that the physician should not be forced to lengthen – against the patient's will – the physical and mental suffering caused by the illness.

The petition concerning Sections 166 to 168 of the CC was based on referring to an omission of legislative duty, as the provisions of the CC punishing various forms of homicide, adopted before the introduction of Article 54 para. (1) of the Constitution, had not been harmonised with the Constitution. As a result, certain acts – such as medical aid provided to a terminally ill patient for the effectuation of his death – were punished by the law although such acts should be deemed lawful on the basis of the patient's constitutional right. The petitioners claimed it to be unconstitutional in itself that certain cases of non-requested active aid-in-dying were not separated by the legislature from the statutory definition of homicide under the denomination of "mercy killing", and that "(…) facilitating the death of a terminally ill and suffering patient without an express intention to die, on the grounds of acceptable mercy" was not treated as a privileged case.

In view of the changes introduced by Act CLIV of 1997 on Healthcare (hereinafter: the AH) as compared to the provisions of the Act concerning physicians' obligation to care for patients suffering from terminal illnesses, the petitioners amended and supplemented their petition in a document filed on 5 June 2001. It is emphasised in the amended petition that although in certain cases, the AH acknowledges – contrarily to the Act – the right of terminally ill patients to end their lives in a manner reconcilable with their dignity, such right is still restricted in an unconstitutional manner. In this respect, the petitioners complain about Section 15 para. (2) of the AH restricting the right to self-determination of terminally ill patients: "Restricting with reference to Section 20 the right to self-determination specified under Section 15 para. (2) of the AH is, in our opinion, contrary to (…) the right to self-determination resulting from human dignity. More specifically, pursuant to Section 20 para. (3) of the AH, the right to refuse treatment in respect of life-supporting or life-saving interventions may only be exercised if, according to the state of medical science at the time concerned, the illness will lead to death within a short period of time despite adequate healthcare, and is incurable." They also hold that Section 20 para. (4) of the AH, too, is inconsistent with the rule on the right to human dignity under Article 54 para. (1) of the Constitution, "(…) the core of which provision is the right to self-determination. The patient's right to refusal of treatment may not be made dependent on whether he has accepted to undergo medical examination as a separate condition for exercising the right to self-determination. This restriction is disproportionate and contrary to the essence of the right to self-determination." The petitioners also requested the Constitutional Court to establish the unconstitutionality of, and to annul Section 22 para. (4), Section 23 para. (1), and the whole of Sections 15 to 19 of the AH.

The petitioners' arguments for the unconstitutionality of certain provisions of the AH are as follows: "The normative contents of the constitutional principles of the rights to life and to human dignity include the right to euthanasia as a form of 'dignified', 'good' or 'humane' death." This is the basis on which the petitioners claim the unconstitutionality of the Act not allowing aid-in-dying given to a terminally ill patient by terminating a life-supporting or life-saving intervention if the patient has not expressed his definite will to die: "We hold that even if the patient's express order is missing, passive euthanasia should be allowed when there is no interest identifiable within the realm of human dignity in sustaining the life of the patient struggling with imminent death." The petitioners claim that it is consistent with the constitutional right to human dignity to put an end to the life of a terminally ill patient on request by the patient concerned, and therefore they hold that prohibiting the above is unconstitutional.

They claim that it is unconstitutional to restrict the right to terminate one's life in a manner reconcilable with human dignity also because it results in restricting the essential contents of a fundamental right and as such, it is prohibited in Article 8 para. (2) of the Constitution. "Self-determination is the core of the right to human dignity, relating to the free development of one's personality as well as to realising one's personal freedom on the basis of self-determination. In this respect, the State's obligation of institutional protection – and the constitutional definition thereof – is nothing else but ensuring self-determination that follows from human dignity. All other obligations of the State would violate the essence of the fundamental right to human dignity, i.e. personal self-determination, and as such, they would be contrary to the guarantee for protecting the essence of the fundamental right granted in Article 8 para. (2) of the Constitution. Therefore, one should conclude that human dignity may not be protected by violating the right to self-determination, which represents the essence thereof."

In the petitioners' opinion – although the various views of life, religions, ideologies, and their followers often represent different opinions about euthanasia, contradicting one another – the State must be ideologically neutral in evaluating euthanasia. The petitioners draw this conclusion partly from Article 2 para. (1) of the Constitution, according to which the Republic of Hungary is an independent democratic state under the rule of law, and partly from Article 2 para. (3) of the Constitution, stating that no activity of any citizen may be directed at the

forcible acquisition or exercise of public power, or at the exclusive possession of such power. According to the petitioners, "this principle requires the State to be neutral concerning citizens' acts and conduct with the exception of forcible and exclusive activities incompatible with the democratic rule of law. The above interpretation is supported by Article 60 paras (1) to (3) of the Constitution, too, declaring the freedom of thought, conscience and religion, (…) as well as the separation of the Church and the State." The petitioners hold that, as a result, the State should not base its attitudes to the various views of life, religions, and ideologies existing within society on a specific ideology; consequently, a democratic State under the rule of law must be neutral in terms of ideology.

In their amended and supplemented petition, the petitioners upheld their petition related to Sections 166 to 168 of the CC.

Furthermore, the petitioners requested the Constitutional Court to establish the unconstitutionality of, and to annul Section 17 para. (1) item a) as well as the text "or in the case specified under para. (1) item b)" in Section 18 para. (2) of the AH.

Finally, the petitioners proposed the establishment of the unconstitutionality and the annulment of Section 3, Section 5 para. (2), Section 6, Section 7, and Section 10 para. (2) of Government Decree 117/1998 (VI. 16.) Korm. on the Detailed Rules of Refusing Certain Forms of Medical Care (hereinafter: the GD).

2. Another petitioner suffering from a serious and painful disease asked the Constitutional Court to establish the following: it violates his right to human dignity that the law does not allow his physician to provide for him substances that he could use to terminate his life.

The Constitutional Court has consolidated the petitions and judged them in a single procedure.

Upon request by the Constitutional Court, the Minister of Health has also delivered his opinion about the questions raised in the petitions.

II

The Constitutional Court has made its decision on the basis of the following statutory provisions, most of which are referred to by the petitioners as well.

A) The relevant provisions of the Constitution:

"Article 2 para. (1) The Republic of Hungary is an independent democratic state under the rule of law."

"Article 8 para. (1) The Republic of Hungary recognises inviolable and inalienable fundamental human rights. The respect and protection of these rights is a primary obligation of the State.
(2) In the Republic of Hungary regulations pertaining to fundamental rights and duties are determined by law; such law, however, may not restrict the basic meaning and contents of fundamental rights."

"Article 54 para. (1) In the Republic of Hungary everyone has the inherent right to life and to human dignity. No one shall be arbitrarily denied of these rights."

"Article 70/A para. (1) The Republic of Hungary shall respect the human rights and civil rights of all persons in the country without discrimination on the basis of race, colour, gender, language, religion, political or other opinion, national or social origins, financial situation, birth or on any other grounds whatsoever."

B) The relevant provisions of Act XXXII of 1989 on the Constitutional Court (hereinafter: the ACC):

"Section 20 The Constitutional Court shall act on the basis of a petition by an entitled petitioner."

"Section 22 para. (2) The petition shall contain a definite request and the cause forming the ground thereof."

C) The relevant provision of the Act:

“Section 43 para. (2) The physician shall perform with maximum care and circumspection all measures necessary for the prevention of illnesses, for saving the life of the patient, for curing the patient, and for the restoration of the patient’s ability to work. The physician shall treat with maximum care even the patient he deems to be terminally ill.”

D) The relevant provisions of the AH:

“Section 3 For the purposes of this Act (...)
m) invasive intervention: a physical intervention penetrating into the patient’s body through the skin, mucous membrane or an orifice, excluding interventions which pose negligible risks to the patient from a professional point of view;”

“Section 10 para. (1) The patient’s human dignity shall be respected in the course of healthcare.”

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“Section 13 para. (1) The patient shall have a right to complete information provided in an individualised form.
(2) The patient shall have the right to receive detailed information on:
a) his state of health, including its medical evaluation,
b) the recommended examinations and interventions,
c) the possible benefits and risks of performing or not performing the recommended examinations and interventions,
d) the planned dates of performing the examinations and interventions,
e) his right to decide in respect of the recommended examinations and interventions,
f) the possible alternative procedures and methods,
g) the course of care and its expected outcome,
h) additional care, and
i) the recommended lifestyle.
(3) The patient shall have the right to pose additional questions during the provision of information and subsequently.
(4) The patient shall have the right to be informed of results, failure, or unexpected outcome and its causes, after an examination or intervention has been performed in the course of his care.

(5) An incapable patient or a patient with limited disposing capacity shall also have the right to information corresponding to his age and psychic state.
(6) The patient shall have the right to know the identity, qualifications and position of those directly providing care for him.
(7) The conditions necessary for the exercise of the rights pertaining to information shall be provided by the entity running the healthcare facility.
(8) The patient shall have the right to be informed in a manner comprehensible for him, with due regard to his age, education, knowledge, state of mind and his wish expressed on the matter. If necessary and possible, the services of an interpreter or a sign language interpreter shall be supplied for the provision of information."

"Section 15 para. (1) The patient shall have the right to self-determination, which may only be restricted in the cases and in the ways defined by an Act.
(2) Within the framework of exercising the right to self-determination, the patient is free to decide whether he wishes to use healthcare services and which procedures to consent to or refuse when using such services, taking into account the restrictions set out in Section 20.
(3) The patient shall have the right to be involved in the decisions concerning his examination and treatment. Apart from the exceptions defined in this Act, the performance of any healthcare procedure shall be subject to the patient's consent thereto granted on the basis of appropriate information, free from deceit, threat and coercion (hereinafter: "consent").
(4) The patient may give his consent specified in paragraph (3) verbally, in writing or through implicit conduct, unless provided otherwise by this Act.
(5) Invasive procedures shall be subject to the patient's written consent, or if the patient is not capable of this, to his declaration made verbally, or in some other way, in the joint presence of two witnesses.
(6) The patient may, at any time, withdraw his consent given to the performance of a procedure. However, if the patient withdraws his consent without good cause, he may be obliged to reimburse any justified costs that are incurred as a result of such withdrawal."

"Section 16 para. (1) A patient with full disposing capacity – unless otherwise provided by the present Act – may in a public document, in a private document of full probative force or – if unable to write – in a declaration made in the joint presence of two witnesses
a) name the person with full disposing capacity who shall be entitled to exercise the right of consent and refusal in his stead, and who is to be informed in line with Section 13,

b) exclude any of the persons defined in paragraph (2) from exercising the right of consent and refusal in his stead, or from obtaining information as defined in Section 13, with or without naming a person as in item a).

(2) If a patient has no disposing capacity, and there is no person entitled to make a statement on the basis of paragraph (1) item a), the following persons shall be entitled to exercise, in the order indicated below, the right of consent and refusal within the limits set out in paragraph (4), subject to the provisions of paragraph (1) item b):

a) the patient's lawful representative, and in the absence thereof,

b) the following individuals with full disposing capacity and sharing household with the patient:

ba) the patient's spouse or domestic partner, and in the absence thereof,

bb) the patient's child, and in the absence thereof,

bc) the patient's parent, and in the absence thereof,

bd) the patient's sibling, and in the absence thereof,

be) the patient's grandparent, and in the absence thereof,

bf) the patient's grandchild;

c) in the absence of a relative indicated in item b), the following individuals with full disposing capacity and not sharing household with the patient:

ca) the patient's child, and in the absence thereof,

cb) the patient's parent, and in the absence thereof,

cc) the patient's sibling, and in the absence thereof,

cd) the patient's grandparent, and in the absence thereof,

ce) the patient's grandchild.

(3) In the event of contrary statements made by the individuals qualified in the same line to make a statement, the decision that is likely to impact upon the patient's state of health most favourably shall be taken into account.

(4) The statement of the persons defined in paragraph (2) shall be made exclusively following the provision of information prescribed in Section 13, and it may only cover giving consent to invasive procedures recommended by the attending physician. However, such a declaration – with the exception of the case defined in Section 20 para. (3) –, apart from the risks inherent in the intervention, may not unfavourably affect the patient's state of health, and in particular it may not lead to serious or lasting impairment to health. The patient shall be informed of such statements immediately after he regains his full disposing capacity.

(5) In making decisions on the health care to be provided, the opinion of a patient with no disposing capacity or with limited disposing capacity shall be taken into account to the extent professionally possible also in cases where the right of consent and refusal is exercised by the person defined in paragraph (2).

"Section 17 para. (1) The patient's consent shall be assumed to be given if the patient is unable to make a statement of consent as a result of his health condition and

a) a) obtaining a declaration from the person defined in Section 16 para. (1) item a) would cause a delay;

b) in the case of invasive interventions, if obtaining a declaration from the person defined in Section 16 para. (1) item a) or in Section 16 para. (2) would result in a delay and the delayed performance of the intervention would lead to a serious or lasting impairment of the patient's state of health.

(2) The patient's consent shall not be required if failure to carry out the given intervention or action

a) would seriously endanger the health or physical integrity of others, also including the foetus beyond the 24th week of pregnancy, furthermore,

b) if the patient's life is in direct danger – also taking into account Sections 20 – 23."

"Section 18 para. (1) If, in the course of an invasive intervention, an extension thereof becomes necessary which was not foreseeable, in the absence of a consent to such extension – with the exception of the case defined in paragraph (2) –, it may only be carried out if

a) justified by a state of emergency, or

b) failure to do so would impose a disproportionately serious burden on the patient.

(2) If the extension of the intervention defined in paragraph (1) would lead to the loss of an organ or a part of the body or to the complete loss of the function thereof, in the absence of consent to such extension, the intervention may only be extended if the patient's life is in direct danger or in the case defined in paragraph (1) item b)."

"Section 19 para. (1) The patient's written consent shall be required for the utilisation of any of his cells, cell components, tissues, organs and body parts removed while alive and in connection with the intervention, for any purpose not related to the patient's health care. The patient's consent shall not be required for the destruction of these materials in the usual manner.

(2) Within the framework of this Act, the patient shall have a right to provide for any interventions regarding his cadaver in the event of his death. On the basis of the provisions of this Act, the patient may prohibit the removal of any organ and tissue from his cadaver for the purposes of transplantation, treatment, research or education."

"Section 20 para. (1) In consideration of the provisions set out in paragraphs (2)–(3) and with the exception of the case defined in paragraph (6), a patient with full disposing capacity shall have the right to refuse healthcare, unless the lack of such healthcare would endanger the lives or physical integrity of others.

(2) A patient may refuse the provision of any care the absence of which would be likely to result in serious or permanent impairment of his health only in a public deed or in a private deed with full probative force, or in the case of inability to write, in the joint presence of two witnesses. In the latter case, the refusal must be entered in the patient's medical record and certified with the signatures of the witnesses.

(3) Life-supporting or life-saving interventions may only be refused, thereby allowing the illness to follow its natural course, if the patient suffers from a serious illness which, according to the state of medical science at the time concerned, will lead to death within a short period of time even with adequate health care, and which is incurable. The refusal of life-supporting or life-saving interventions may be made in compliance with the formal requirements set out in paragraph (2).

(4) Refusal as defined in paragraph (3) shall be valid only if a committee composed of three physicians has examined the patient and made a unanimous, written statement to the effect that the patient has taken his decision in full cognizance of its consequences, and that the conditions defined in paragraph (3) have been met, furthermore if on the third day following such statement by the medical committee, the patient repeatedly declares his intention of refusal in the presence of two witnesses. If the patient does not consent to his examination by the medical committee, his statement regarding the refusal of medical treatment may not be taken into consideration.

(5) The members of the committee defined in paragraph (4) shall be the patient's attending physician, one physician specialising in the field corresponding to the nature of the illness who is not involved in the treatment of the patient, and one psychiatrist.

(6) A female patient may not refuse a life-supporting or life-saving intervention if she is pregnant and is considered to be able to carry the pregnancy to term.

(7) In the event of refusal as defined in paragraphs (2) and (3), an attempt shall be made to identify the reasons underlying the patient's decision through a personal discussion and to alter the decision. In the course of this, in addition to the information defined in Section 13, the patient shall be informed once again of the consequences of the non-performance of the intervention.
(8) The patient may withdraw his statement regarding refusal at any time and without any restriction upon the form of withdrawal."

"Section 21 para. (1) In the case of a patient with no disposing capacity or with limited disposing capacity, healthcare as defined in Section 20 para. (2) may not be refused.
(2) If in the case of a patient with no or limited disposing capacity healthcare as in Section 20 para. (3) has been refused, the healthcare provider shall institute proceedings to obtain the required consent from the court. The attending physician shall be required to provide all medical care necessitated by the patient's condition until the court passes its final and absolute decision. In the case of a direct threat to life, it shall not be required to obtain a substitute statement by the court for the necessary interventions to be carried out.
(…)
(4) In the course of the proceedings aimed at substituting for the statement defined in paragraph (2), the court shall act in non-litigious proceedings and with priority. Due to their nature, such proceedings shall be exempt from charges. Unless it follows otherwise from this Act or from the non-litigious nature of the proceedings, the provisions of Act III of 1952 on Civil Procedure shall apply, as appropriate."

"Section 22 para. (1) A person with full disposing capacity, in case he should become incapable in the future, may refuse in a public deed,
a) certain examinations and interventions defined in paragraph (1) of Section 20,
b) the interventions defined in paragraph (3) of Section 20, and
c) certain life-supporting or life-saving interventions if he has an incurable illness and as a consequence of the illness is unable to take care of himself physically or suffers from pain that cannot be eased with appropriate therapy.
(2) A person with full disposing capacity may name in a public deed, for the event of his possible subsequent incapacity, the person with full disposing capacity who shall be entitled to exercise the right defined in paragraph (1) in his stead.

(3) The statement defined in paragraphs (1) and (2) shall be valid if a psychiatrist has confirmed in a medical opinion given not more than one month earlier that the person had made the decision in full awareness of its consequences. The statement shall be renewed every two years, and may, at any time, be withdrawn, regardless of the patient's disposing capacity and without formal requirements.
(4) In the case of a declaration of refusal of medical intervention made by a person with full disposing capacity defined in paragraph (2), the committee defined in paragraph (4) of Section 20 shall make a declaration on whether
a) the conditions set out in paragraph (1) are met, and
b) the person defined in paragraph (2) has made the decision in cognizance of its consequences."

"Section 23 para. (1) An intervention as defined in paragraph (3) of Section 20 may only be terminated or dispensed with if the will of the patient to that effect can be established clearly and convincingly. In case of doubt, the declaration made by the patient later and personally must be taken into account; in the absence of such declaration, the patient's consent to the life-supporting or life-saving intervention shall be assumed."

E) The relevant provisions of the GD:

"Section 3 para. (1) When a life-supporting intervention is refused, the head of the medical institution or a person designated by him shall arrange for convening without delay the committee specified under paragraph (4) of Section 20 of the AH.
(2) The physician specialising in the field corresponding to the nature of the illness who is a member of the Committee shall make a statement on whether the patient's illness is one meeting the criteria specified in Section 20 paragraph (3) of the AH.
(3) The psychiatrist member of the Committee shall establish whether the patient is in possession of the capacity for judgement necessary for making such a decision. When assessing the patient's capacity for judgement, the patient shall be heard in all cases, and the relative of the patient [Section 16 paragraph (2) of the AH] shall be heard if possible.
(4) (4) If on the third day following the decision by the Committee the patient repeats – in the presence of two witnesses – his will to refuse the continuation of a life-supporting intervention, then the refused care shall be terminated, or it shall not even be started."

“Section 5 para. (2) The Committee shall make a written statement in relation to the decision by the deputy decision-maker, specifying whether the statutory conditions are met, and whether the deputy decision-maker has capacity for judgement [Section 22 para. (4) item b) of the AH].”

“Section 6 para. (1) The rules on convening the Committee are to be governed in the house rules of the institution. Upon completing the necessary examinations the Committee shall adopt without delay a unanimous decision on the validity of the refusal of life-supporting intervention, and the resolution shall be put down in writing and signed by the members of the Committee.
(2) Before adopting its decision, the Committee may request the ethics committee operating in the institution to make a statement.
(3) In the course of its operation, the Committee shall also examine whether the patient has been informed in compliance with the statutory requirements.”

“Section 7 para. (1) If the Committee has not established the validity of refusing the life-supporting intervention, the patient and the deputy decision-maker may file a claim at the court in order to have a court ruling establishing the validity of refusing the life-supporting intervention. Section 21 para. (4) of the AH shall apply to the court’s procedure.
(2) The patient shall have the right to repeatedly refuse the life-supporting intervention if the Committee has not established the validity of refusing the life-supporting intervention.”

“Section 10 para. (2) The healthcare provider shall ensure the operation of the Committee as needed.”

F) The relevant provisions of the CC:

“Section 166 para. (1) The person who kills another person, commits a felony, and shall be punishable with imprisonment from five to fifteen years.”

“Section 167 The person who kills another person in the heat of passion arising from an appreciable reason, commits a felony and shall be punishable with imprisonment from two to eight years.”

"Section 168 The person who persuades somebody else to commit suicide, or offers aid to the perpetration thereof, commits a felony and shall be punishable with imprisonment of up to five years, if the suicide is attempted or perpetrated."

III

1. The legislature has long been faced with a difficult decision in relation to terminally ill patients who wish to terminate medical support sustaining their lives, or who ask for aid by a physician in ending their lives.

2. Earlier statutory regulations in Hungary did not provide for a direct prohibition of aid-in-dying requested by terminally ill patients: "The problem of aid-in-dying is not as significant today as to be incorporated in the statutes of criminal law, even as a specific, qualified case of homicide" (László Jámbor: A halálbasegítés (Aid in Dying), 1936). However, since Act V of 1878, the criminal law statutes in force in Hungary have been consistent in punishing homicide regardless of being perpetrated by a physician at the request or in the interest of a terminally ill patient. The works of renowned scholars of law reflect the theoretical bases found in the above rules of criminal law. Ferenc Finkey held about the aid given by a physician to a patient in dying that this was not acceptable even in the case of terminally ill patients (Finkey: A magyar anyagi büntetőjog jelen állapota (The Present State of Hungarian Substantive Criminal Law), 1923). Pál Angyal also described aid-in-dying as an act incompatible with the requirements of law: "The establishment of life being valueless may only be done on an insecure ground, and it may never be as strong as to invalidate the essential moral norm that prohibits the killing of humans" (Angyal: A magyar büntetőjog kézikönyve II, Az ember élete elleni bűncselekmények és a párviadal (The Handbook of Hungarian Criminal Law II, Crimes Against Human Life and Duel), Budapest, 1928, Athenaeum).

3. In 1997, the AH introduced changes that also affected the questions raised in the petitions. First of all, it rearranged the relationship between the physician and the patient; this is reflected in the following critical statement made about the Act in point 5 of the General Reasoning reflecting the intentions of the legislature: "The Act in force does not clearly regulate the rights and obligations of the parties in the relations within the healthcare system. For example, certain entitlements of the patients are only expressed as obligations of the

healthcare staff – as the opposite party – although such rights should have been declared as subjective ones in order to render their enforcement possible." Another typical feature of the AH is the strengthening of patient's rights, partly expressed in "the obligation of the State to ensure the enforcement of patients' general human and civil rights as well as of their rights as patients in the course of medical care" (General Reasoning, point 4).

It follows form the objectives of the Act that, by virtue of his right to self-determination, the patient is entitled to decide whether he wishes to use medical care, and also to consent to or refuse interventions in the course of medical care. The provision of the AH stating that it is the fundamental right of the patient to gain information on a continuous basis about his own state is a guarantee that the patient is aware of his state, of the nature of his illness as well as of its expected course when consenting to or refusing any intervention. The AH provides that the patient shall enjoy the right to self-determination based on his right to human dignity, regardless of the nature, i.e. mild or serious course of his illness, or of the chances of recovery. Consequently, the right to self-determination may also be exercised by a person suffering from a terminal illness which will lead to death within a short time despite appropriate medical care. However, the AH requires special conditions for exercising the patient's right to refuse life-supporting or life-saving medical care. Although this will be discussed in detail later on, it is pointed out by the Constitutional Court at this point that a terminally ill patient may only refuse life-saving or life-supporting medical care in a public deed or a private deed of full probative force, or – if the patient is incapable of writing – by declaration in the presence of two witnesses. Such refusal is only valid if a medical committee consisting of three members has examined the patient and unanimously declared that the patient suffers from a terminal illness and has made his decision in full cognizance of its consequences. On the third day following this statement by the medical committee, the patient has to repeatedly declare his intention of refusal in the presence of two witnesses. The AH provides for the composition of the medical committee, too: one physician specialising in the field corresponding to the nature of the illness and one psychiatrist. The Act requires that in the case of a refusal of intervention an attempt be made to identify the reasons underlying the patient's decision through personal discussion and to alter the decision. The AH also provides for detailed rules governing the cases when the terminally ill patient concerned is a person with no or limited disposing capacity.

The Act also allows persons with full capacity for judgement in anticipation of their potential future incapacity to refuse in advance life-saving interventions for the cases of becoming terminally ill or incapable of providing for themselves physically, or for the case when their pains cannot be relieved despite adequate medical treatment.

4. Therefore, according to the laws in force in Hungary since 1997, a person suffering from a terminal illness considered by the medical staff to lead to death within a short time despite the most appropriate care has the right to refuse life-supporting medical intervention "in order to let the illness follow its natural course". This statutory provision, while granting complete freedom of acquiescence for those who do not wish to influence the coming about of their deaths, offers a chance for those suffering from terminal illnesses to choose a way of ending their lives that is reconcilable with their dignity.

5. As demonstrated in the presentation of the petitions, the petitioners express their constitutional concerns in three directions about the provisions on the exercise of the right to self-determination of patients suffering from terminal illnesses as provided for in the AH and the related GD.

First, the petitioners hold that the legislature unconstitutionally restricts the right to self-determination of persons who suffer from terminal illnesses by allowing only the refusal of life-supporting or life-saving interventions. In their opinion, the Act would only be in line with the right to human dignity granted for all, including patients, in Article 54 para. (1) of the Constitution if the legislature vested additional rights on terminally ill patients, in the form of providing for the right to receive aid-in-dying by a physician, upon request, in order to terminate their lives with dignity. They hold that it also follows from the constitutional provision granting the right to human dignity that the physician should be empowered to facilitate the death of a dying patient with a view to preserving the patient's human dignity even in the absence of an express wish by the patient to that effect.

Secondly, although they hold that "the provisions of the AH – including the ones challenged by us – offer far more room for the realisation of human dignity than the former Act II of 1972 on Healthcare", they are of the opinion that the Act in force still applies unjustified and, therefore, unconstitutional restrictions to the right of terminally ill patients to refuse life-supporting or life-saving medical interventions. In this respect, the petitioners express their

concrete constitutional concerns about Section 15 para. (2), Section 20 paras (3) and (4), Section 22 para. (4), and Section 23 para. (1) of the AH.

Thirdly, some of the petitioners' constitutional concerns are related to some further provisions of the AH and the GD which are not directly related to the provisions of such statutes on the termination of the lives of terminally ill patients in a manner reconcilable with their dignity, but apply to the right of all patients to self-determination.

6. The Constitutional Court emphasises the following: having regard to Section 20 and Section 22 para. (2) of the ACC, and acting in line with its consistent practice about its own procedure being limited to the claims made in the petitions, in accordance with the contents and the orientation of the petitions, the Constitutional Court has reviewed the constitutionality of the provisions of the AH challenged by the petitioners only in terms of whether they restrict in an unconstitutional manner patients' right to human dignity.

The Constitutional Court also emphasises that basically the petitioners hold the current provisions to be incompatible with Article 54 para. (1) of the Constitution. They do not refer to other human rights granted by the Constitution as well the violation of which is usually claimed in complaints filed – with contents similar to those of the petitions – to the courts of foreign countries and international courts. For example, in the Case Pretty mentioned later on, the petitioner claimed that the statutory provision prohibiting the termination of the patient's life with dignity as construed by the patient was incompatible with the prohibition of torture and cruel, inhuman or humiliating treatment or punishment, with the right to respect for privacy, with the right to the freedom of conscience and religion, and with the prohibition of negative discrimination. Therefore, the Constitutional Court, acting in compliance with Sections 20 and 22 para. (2) of the ACC, has reviewed the constitutionality of the statutes specified by the petitioners only in the scope referred to above.

7. The Constitutional Court has held it necessary to survey the issues forming the contents of the petitions in an international context. As a result, the following conclusion has been drawn: although it is prohibited in most countries of the world to facilitate the death of a patient by a physician on any ground, on request by either the patient or a relative, there have been debates in the last decades in both scientific circles and legislation on how to grant the right to end one's life with dignity for patients suffering from terminal illnesses – often involving great

pain – without causing undesired effects by easing the prohibition of homicide. Two important developments are worth mentioning in this respect.

On the one hand, in the last decades of the 20th century, the legislature and/or the judiciary of several countries acknowledged that although the full prohibition of acts against life is to be upheld regardless of the motivation of their perpetration, the former practice is to be changed by acknowledging the patient's right to refuse medical intervention aimed at sustaining or lengthening his life even if this would most probably result in his death. In certain countries, such as Hungary, this right has been acknowledged by the legislature. In other countries, such as the United Kingdom, the patient's right to refuse care has been elaborated in the judicial practice (e.g. Ms B. v. an NHS Hospital, Court of Appeal Judgment of 22 March 2002). The same has happened in the United States of America (see Case Cruzan v. Director, Missouri Department of Health, also mentioned below).

On the other hand, in certain countries where the prohibition of giving aid-in-dying to a terminally ill patient is maintained, the physician is still not punished when the patient's death has resulted as an unavoidable side effect of the substance prescribed by the physician in order to relieve the pain of the patient being in the terminal stage of his illness. Examples for this are in the United Kingdom the Case Re J [1991] Fam 33, and in Germany the position taken by the Supreme Court in 1996, according to which using medically justified analgesics, upon the express or assumed will of the dying patient, is not deemed unlawful even if it may have the unavoidable, foreseeable, but not intended consequence of hastening the patient's death (BGHSt 42, 305).

Despite the above developments, in most countries there is little readiness to ease or eliminate the prohibition of aid-in-dying to terminally ill patients. For example, in the United Kingdom, where in 1980 it was proposed during the revision of the statutory definition of the criminal offence of assistance in suicide to introduce a privileged case – with a significantly lower term of imprisonment of up to two years, as compared to the earlier regulations – for the so-called "mercy killing" committed under the motivation of compassion towards the dying person, the proposal was finally set aside, as – among other reasons – in seeking a definition for mercy killing, no solution was found that would completely ensure the protection of old and weak patients in a handicapped situation from their lives being endangered on the basis of the new statutory definition, contrarily to their will. In 1994, the medical ethics committee of the

House of Lords examined the questions related to euthanasia and concluded that there was not enough ground for easing the regulations on intended homicide in order to allow certain forms of euthanasia.

A recent decision of the House of Lords acting as a court of appeal reflects that in the United Kingdom not only the legislature, but also the judiciary is reluctant to take steps towards easing traditionally applicable prohibitions. In the Case Dianne Pretty v. Director of Public Prosecution, the plaintiff, a patient in the final phase of a terminal illness causing complete disability to move, asked for the establishment of the violation of her fundamental human rights, including the prohibition of inhumane treatment and her right to life, caused by the refusal of the prosecution authority to undertake not to charge her husband with homicide if he assisted her in dying. She held that the decision of the prosecution authority violated her right to life by depriving her of the right to decide whether she wanted to live on, and the relevant decision had changed her right to life into an obligation to live on till the end.

In the judgment of 29 November 2001, the House of Lords established the following: the plaintiff had no right to have the prosecution authority grant exemption from punishment for her husband if he gave her assistance in dying ([2001] UKHL). This way, the legalisation of that form of homicide by a judicial decision was rejected.

8. So far, there have only been a few statutes adopted world-wide that allow requested aid-in-dying given to patients suffering from terminal illnesses. However, even in such countries, debates are still going on about the constitutionality of such practices.

In the Netherlands, easing of the complete prohibition previously applied was started by the judicial practice. Since 1973, there have been several judgments acquitting physicians who gave aid-in-dying to terminally ill patients, relieving them from the charges of homicide on the ground of their acting in emergency. The Supreme Court ruled in 1984 in a judgment as a principle that although the killing of another person was still considered a criminal offence under criminal law, a physician giving aid-in-dying to a patient may, under certain circumstances, refer to perpetrating the homicide in a situation of emergency. The conditions for this have been elaborated in the judicial practice. These conditions are the following: the physician acts on the basis of the patient's will expressed freely, upon consultation with another physician independent from both the physician in charge and the patient; the patient's

request – expressed on a continuous basis – is based on an informed decision based on thorough consideration; the patient suffers from intolerable pain, and there is no chance foreseen for the improvement of the patient's condition; finally, there are no means available to relieve the suffering.

The above ruling of the Supreme Court had an effect on legislation, too. In 1994 the Criminal Code and the statutory provisions on examining cases of death were amended. According to the amended provisions, the physician giving aid-in-dying to a terminally ill patient is bound to report all such cases to a special committee set up for the purpose, and that committee shall make a statement about the lawfulness of the physician's act and send a report to the public prosecutor, who is in charge of deciding whether or not to initiate a criminal procedure against the physician.

Based on the practical experience gathered in applying the above regulation, a comprehensive Bill entitled "On the Revision of Cases of Requested Life-Terminating Action and Assistance in Suicide" was submitted to the legislature. Both houses of the legislature passed the Bill, which became effective on 1 October 2001.

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With the amendment of the criminal law regulations, the Act grants exemption for the physician by relieving him from the charges of homicide or assistance in suicide, provided that the physician has acted with due care and circumspection and reported his assistance in the patient's death to the coroner in charge. The Criminal Code provides for the conditions of due care and circumspection, too. Accordingly, the practice of the physician is deemed to comply with the requirement of due care if he has verified that the patient's state is hopeless, the patient's sufferings are intolerable and unrelievable, and there is no other reasonable solution at hand. Due care is exercised when the physician has informed the patient in detail about his state and prospects, and the patient has expressed his wish to die, based on his free will and informed decision. It is a further requirement for the physician to consult at least one other physician independent from the patient, and to prepare a written report on the existence of the above conditions, justifying that he has taken due care, and finally to facilitate the patient's death with due medical care.

In the Netherlands, regional supervisory committees are in charge of examining the circumstances of such deaths. Every committee consists of at least three members. They

conduct investigations with the participation of the physician who has assisted in the patient's death. If it is verified that the doctor has acted with due care, they close the files, while in a case to the contrary, they notify the prosecutor to consider initiating a criminal procedure.

Pursuant to the Act, young persons at the age of 16 to 17 are also entitled to decide upon their own deaths, but their parents are to be involved in the decision-making process. In the case of children at the age of 12 to 15, the Act provides for obtaining the parents' approval.

The Act applies strict guarantees in allowing the patient to make a written declaration, before reaching the terminal phase of his illness, requesting his physician to assist in his death.

In Belgium, an Act was passed on 28 May 2002 on allowing the physician to end the life of a terminally ill patient if he has requested so. The Act calls this euthanasia, and uses the following definition: euthanasia is an act performed by the physician in order to end, in a wilful manner, the patient's life.

According to the Act, the physician performing euthanasia does not commit a criminal offence if he has established that the patient is of full age, with full disposing capacity, who has reached the decision on choosing euthanasia voluntarily, upon due consideration and without external influence, whose state is hopeless in a medical sense, and who is in a constant state of unbearable physical or mental suffering caused by his terminal illness, or injury in an accident.

The patient must himself write and sign the request for euthanasia. If the patient is incapable of doing so, the request shall be drawn up by a person of full age chosen by the patient, provided that such person does not gain financial benefit from the patient's death. The person concerned has to write the request in the physician's presence, indicating the reason and the fact that the patient himself is incapable of writing the request.

Performing euthanasia is conditional upon the physician giving detailed information to the patient about his state of health, life prospects, and the possible therapeutic or analgesic methods. The physician must verify the patient's firm determination in the course of discussions with the patient.

The attending physician's consultation with another physician is a further condition of euthanasia. The consulting physician is required to be professionally qualified in the field of the given disease, and to be independent from both the attending physician and the patient. The consulting physician has to examine the patient, with all data and documents relating to the patient's state to be put at his disposal. The consulting physician is obliged to verify the constant, unrelievable and unbearable nature of the patient's suffering. The consultant must prepare a summary report. The patient is informed of the contents of the consultant's report by the attending physician.

The attending physician has to ascertain that the patient has had a chance to discuss his decision with those he wished to see; if so requested by the patient, the physician has to talk to the relatives named by the patient.

For the case when according to the attending physician, the patient's death is not expected within a short time, the Act provides for two additional conditions of euthanasia. First, the attending physician has to consult a second physician, preferably a psychiatrist, or an expert specialising in the pathologic field concerned, and being independent from the patient, the physician and the physician first consulted. The patient has to be informed of the results of the second consultation as well.

The second condition is that at least one month must lapse between the patient's request and the euthanasia.

The Act also provides for the possibility of a person of full age and with full disposing capacity to make a written declaration requesting euthanasia for the case of his future illness, taking into consideration the case of becoming unable to express his will, provided that it is verified by the physician that he suffers from a terminal illness, has lost his consciousness, and his state is irreversible according to the then current state of the art of medicine. The written declaration may only be taken into account when prepared or repeatedly confirmed not more than 5 years before the commencement of the terminal illness.

The Act provides that the physician is not bound to exercise euthanasia, nor are other persons obliged to participate in it. If the physician refuses the patient's request for euthanasia, he has to forward the request, if asked by the patient to do so, to a physician named by the patient.

If the physician decides to satisfy the patient's request for euthanasia, he has to prepare a written report within four days of the patient's death to the Committee set up in accordance with the Act. The Committee consists of sixteen members, of whom eight members are physicians, with at least four of them being university professors in Belgium, four members are professors of law or lawyers, and four members are experts on the problems of terminally ill patients. The members of the Committee cannot be either MPs or members of the government.

The Committee decides, within two months of submission of the physician's report, whether the euthanasia was performed in compliance with the statutory provisions. If they hold with two-thirds majority that the physician did not comply with the statutory provisions, the documents are forwarded to the public prosecutor.

Following the submission of the Bill on euthanasia, the State Council (Conseil d'État), acting on request by the Upper House of the National Assembly, made a statement about the two Bills on 2 July 2001. It held that the Bills were compatible with the provisions of both the Convention for the Protection of Human Rights and Fundamental Freedoms and the International Covenant on Civil and Political Rights. It also declared that the principles of criminal law were not violated by the provisions in the two Bills relieving physicians from criminal law consequences provided that they acted in accordance with the Act.

During the past decades, there have been significant changes in the United States of America in both the judiciary practice and legislation concerning the rights of patients suffering from terminal illnesses.

a) Earlier, the law did not provide for clear-cut regulations on whether patients attended in healthcare institutions had a right to refuse medical treatment by a physician and – if yes – on what terms. Therefore, patients wishing to terminate their treatment asked the courts to oblige healthcare institutions to respect their will. After several judgments passed in the second half of the last century accepting such requests and obliging the healthcare institutions concerned to stop treatment, it was established by the federal Supreme Court that patients were entitled to refuse medical treatment including ones necessary for sustaining their lives. (Cruzan v. Director, Missouri Department of Health 497 US 261, 1990).

b) Parallel to the development of the judicial practice acknowledging the right to refuse medical intervention, referenda were initiated in several member states of the USA with the aim of statutorily allowing physicians to give aid-in-dying to terminally ill patients. While in California, only one third of the necessary votes were cast in a referendum held in 1988, four years later 48 per cent of those participating in the referendum voted for putting on the agenda the changing of the statute strictly prohibiting all forms of making one's life end. In the State of Washington, a referendum was held in 1991 where 46.4 per cent of the participants supported the adoption of a statute allowing physicians to give aid-in-dying. Oregon is the first – and so far only – state of the USA where the relevant referendum resulted in a majority of 51% in support of the law allowing suicide assisted by a physician. The Act adopted on the basis of the referendum held in 1994 was put into force in 1997.

The Oregon Death with Dignity Act (1994) allows the attending physician to place at the disposal of a terminally ill patient a substance (preparation) that can be used by the patient to end his life. This may only take place at the oral and repeated written request of a patient of full age and with full capacity for judgement, provided that the attending physician and at least one consulting physician has verified that the terminally ill patient is in the final phase of his illness. Two witnesses have to verify that the patient has expressed his will to die; such witnesses may not be relatives of the patient in any way, nor may they be the patient's heirs or persons who might gain any benefit from the patient's death. Neither the attending physician, nor any employee of the healthcare facility where the patient is treated may act as witnesses. The request may be withdrawn at any time.

The patient must notify his close relative of the decision, however, a patient who declines or is unable to notify his relative does not have his request denied for that reason.

Before the patient's request is expressed, the attending physician has to inform the patient in detail about the nature of the disease and its terminal point, and has to refer to the feasible alternatives (including, but not limited to, comfort care, hospice care and pain control). If in the opinion of the attending physician or the consulting physician, the patient concerned may be suffering from a mental disorder or depression causing impaired judgment, either physician must refer the patient to a specialist in the field concerned, and they may only decide on

supplying the substance (preparation) after receiving the specialist's verification that the patient is not in a pathological mental or psychic state.

The statute provides for mandatory waiting periods between the expression of the patient's request and the supply of the given substance.

The Act also contains provisions on the effects of the patient's death caused by the preparation supplied at the patient's request on his testament, contracts and insurance policies.

The Act provides that nothing in its provisions may be interpreted as allowing active euthanasia by the physician, and at the same time, the physician acting in accordance with the statute is granted immunity from charges of homicide, assistance in suicide, or disciplinary action in terms of medical ethics.

The patient's attending physician is not obliged to satisfy the request expressed by the patient in line with the Act. In that case, the patient's medical records have to be handed over to the physician taking over the patient's care.

Finally, the Act provides for the records that are to be kept, and the data to be entered thereto from the moment the patient's request is expressed.

Based on this Act, the right to euthanasia has been exercised in the State of Oregon on many occasions.

Although there is work under way in the federal legislature of the United States to examine the possibilities of annulling the results of the Oregon referendum, there are sixteen other member states where Bills have been submitted to the legislatures for allowing physician-assisted suicide or active aid-in-dying given by physicians to terminally ill patients. At the same time, the legislatures of six member states have adopted statutes aimed at maintaining the current prohibition or rendering it even stricter.

c) The judicial decisions passed recently in the subject concerned are expected to influence in the United States the legal classification and the future statutory regulation of aid-in-dying given by physicians to terminally ill patients at their request.

In the Case Compassion in Dying v. Washington, the claim was aimed at establishing the unconstitutionality of the Act of Washington State as it prohibited physicians from giving their patients aid-in-dying. To support their claim, the plaintiffs referred to the fourteenth amendment of the Constitution, according to which no one may be deprived of his life, liberty or property without a due process of law. In their opinion, the concept of liberty contained in the fourteenth amendment, as construed in the judicial practice of the American courts, covers the freedom of action concerning one's most intimate relations as well, including the commission of physician-assisted suicide by a patient in the final stage of his terminal illness. The court judged in favour of the plaintiff [79 F.3d 790 (9th Cir. 1996)].

Physicians acting as plaintiffs in the Case Quill v. Koppel asked for the establishment of the unconstitutionality of the criminal law of the State of New York prohibiting assistance in, and the facilitation of, suicide. They, too, referred partly to the fourteenth amendment of the Constitution, and partly to the fact that it was unjustified, and thus unconstitutional to statutorily differentiate between the patient's right to refuse medical care and the physician's assistance in suicide. While the first act was not prohibited by the law, and what is more, it was even made expressly possible, the latter one was punishable. Judgement was made in favour of the plaintiff in this case as well [Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996)].

The federal Supreme Court changed both judgements and rejected the claims [Washington v. Glucksberg, 521 U.S. 702 (1997), Vacco v. Quill, 521 U.S. 793 (1997)]. The judgement of the Supreme Court can be seen as an abstract examination of a statute, pronouncing that it is not unconstitutional to statutorily prohibit aid-in-dying given by a physician to a patient in the final stage of a terminal illness. However, there are five papers with concurring reasoning attached to the decision, making it clear that most of the Judges of the Supreme Court tend to consider the right of terminally ill patients with full capacity of discretion and suffering from great pains to receive aid-in-dying to be equally well-founded as their right to refuse medical treatment having been granted by the law for a long time. Therefore, the Judges of the Supreme Court indicated that they might pass a judgment in favour of the patient should this issue arise in a concrete case.

In Australia, an Act was adopted by the Northern Territories in 1995 on the rights of terminally ill patients (Rights of the Terminally Ill Act 1995). This Act allowed any person of

full age to ask for the assistance of his attending physician in ending his life, provided that his terminal illness was reasonably considered by the physician to lead to death within a short period of time, the illness could not be treated in a way acceptable to the patient, and his serious pain and suffering could not be relieved. The Act contained guarantees of similar strictness as the statutes in the Netherlands, Belgium and Oregon.

However, that Act was in force for approximately two years only. The Commonwealth of Australia, by amending the Act of 1978 regulating the legislative competence of the Northern Territories, declared in 1997 that the competence concerned did not cover the permission of medical activities leading to patients' death through the deliberate acts of physicians. Consequently, the Act was annulled, but the lawfulness of medical aid-in-dying given to patients while the Act had been in force was acknowledged.

To sum up, the laws in force in a limited number world-wide which regulate the ending of the lives of terminally ill patients in a manner reconcilable with their human dignity, as and when requested by the patients, generally allow the above by acknowledging the patients' right to self-determination even in respect of medical interventions aimed at sustaining life. Among the Acts mentioned above, only the Dutch, the Belgian, and the Oregon Acts provide for the possibility of requested active euthanasia (as called by the petitioners).

9. For the past two decades, issues related to ending one's life with dignity have been addressed at the forums of the Council of Europe, too.

9. 1. Although earlier the Strasbourg bodies safeguarding compliance with the European Human Rights Convention had only rarely been addressed with petitions asking for a decision on the right of terminally ill patients to receive assistance by other persons in ending their lives at their will, the European Court of Human Rights passed a recent judgement containing its relevant position on the merits upon the petition submitted by Dianne Pretty. The judgment made by the House of Lords in this case has already been mentioned under point 7. The Court had to rule whether the human rights of the petitioner – being in the final stage of a terminal illness, having full capacity for judgement, but prevented from committing suicide by her inability to move – had been violated by the refusal of the prosecution authority to grant immunity for her husband in case he killed her wife at her request.

The Court held that the refusal by the British authorities of the request for immunity had not violated the petitioner's rights granted in the European Human Rights Convention, including among others Article 2 declaring the right to life. The right to life may not be interpreted as including the right to death. "The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention." (Pretty v. the United Kingdom Judgment of 29 April 2002, point 40).

9.2. Certain arguments for taking a position on the questions raised in the petitions are found in Act VI of 2002 on the promulgation of the Council of Europe's Convention adopted in Oviedo on 4 April 1997 for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: the Convention on Human Rights and Biomedicine, as well as the Convention's Additional Protocol adopted on 12 January 1998 in Paris on the Prohibition of Cloning Human Beings. It is stated that an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it, and that the person concerned may freely withdraw consent at any time (Article 5).

9.3. The Parliamentary Assembly of the Council of Europe has already addressed on several occasions the issue of the fundamental human rights of terminally ill patients [Resolution 613 (1976), Recommendation 779 (1996)]. It was pointed out in the latter recommendation that the prolongation of life should not in itself constitute the exclusive aim of medical practice, which must be concerned equally with the relief of suffering.

The Assembly presented its views in the question concerned in a comprehensive manner in Recommendation 1418 (1999) adopted on 25 June 1999.

The basic idea of the recommendation is the following: "The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. This respect and protection find their expression in the provision of an appropriate environment, enabling a human being to die in dignity" (point 5).

The recommendation provides for two fundamental requirements in addition to encouraging the Member States to adopt wide-scale measures in order to ease the pain and the physical and

mental sufferings of dying patients, and to relieve patients' anxiety and loneliness – among others, by using hospice care.

The first requirement is that the Member States must ensure that no terminally ill or dying person is treated against his will while ensuring that he is neither influenced nor pressured by another person.

The other requirement is that the Member States must guarantee patients' right to life by maintaining the prohibition of deliberate killing of terminally ill or dying patients, and they must ensure that a terminally ill patient's wish to die does not form any legal ground for having his life ended by someone else's act. This requirement includes that such patients' wish to die may not form any legal ground for acts aimed at causing death.

IV

1. According to the petitioners, the fact that the provisions of the AH only allow terminally ill patients to refuse the medical care necessary for sustaining their lives, and in the petitioners' opinion, not even this possibility is granted in as wide a scope as needed, while patients are not allowed to use a physician's aid in ending their lives, is incompatible with patients' right to human dignity. For the same reason, the petitioners hold that the provisions on defining the criminal offence of homicide and setting the punishments thereof in the Criminal Code are unconstitutional as they do not take account of the fact that the conduct is committed at the request or in the interest of the patient. They hold that the statutory provisions claimed by them to be unconstitutional take away the chance of dying with dignity from patients in the final stage of terminal illnesses who might decide that they do not want to live on in this period of their lives, filled with physical and mental sufferings. This is considered to violate their right to human dignity granted under Article 54 para. (1) of the Constitution.

2. As the petitioners argue that the legislature has failed to solve in compliance with the constitutional requirements the conflict, arising from the situation of a terminally ill patient, between two constitutional fundamental rights, i.e. the right to life and the right to human dignity, the Constitutional Court has primarily surveyed its judicial practice about the rights to life and to human dignity.

3. The detailed elaboration of the contents of the right to human dignity was started in the decisions adopted at the beginning of the Constitutional Court's operation, and the process is still under way. It is stated in one of the first decisions passed by the Constitutional Court that the right to human dignity is one of the phrases used to designate the general personality right. The Constitutional Court has consistently considered the general personality right (the various aspects of which are, for example, the right to free development of one's personality, the general freedom of action, the right to privacy or – what is particularly important with regard to judging upon the present petitions – the right to free self-determination) to be a "mother right", i.e. a subsidiary fundamental right to be referred to by both the Constitutional Court and the ordinary courts for the protection of one's autonomy in any case where none of the specifically named fundamental rights are applicable to the particular facts of the case [Decision 8/1990 (IV. 23.) AB, ABH 1990, 42, 44-45]. In its judicial practice, the Constitutional Court still adheres to the above evaluation repeated and reinforced in one of its recent decisions [Decision 36/2000 (X. 27.) AB, ABH 2000, 241, 256-257]..

4. The Constitutional Court holds the right to human dignity to be of special importance among the fundamental rights. This is reflected by the fact that this right, together with the right to life, is found in the Constitution at the beginning of the chapter on fundamental rights and obligations, and the Constitution declares this right to be an inherent right of man, and as such, it is the "greatest value over all the others" as termed in Decision 23/1990 (X. 31.) AB (ABH 1990, 88, 93). As already established by the Constitutional Court in the above decision, the right to human life and the right to human dignity are considered to be an unrestrictable fundamental right of indivisible unity. Later on, the Constitutional Court elaborated the context of the unrestrictable nature of human dignity. The Constitutional Court has held that the right to human dignity is absolute and unrestrictable only as a determinant of one's human status and in its unity with life. [Decision 64/1991 (XII. 17.) AB, ABH 1991, 297, 308, 312] Therefore, the component rights derived from it as a mother right (such as the right to self-determination and the right to one's physical integrity) may be restricted in accordance with Article 8 para. (2) of the Constitution just like any other fundamental right. [Decision 75/1995 (XII. 21.) AB, ABH 1995, 376, 383]

5. The Constitutional Court has, in several of its decisions, dealt with the constitutional issues related to the beginning and the end of human life. However, these decisions [such as Decision 23/1990 (X. 31.) AB, (ABH 1990, 88), Decision 64/1991 (XII. 17.) AB, (ABH

1991, 297), and Decision 48/1998 (XI. 23.) AB, (ABH 1998, 333)] address aspects of the relations between the right to life and the right to human dignity other than the ones to be examined on the basis of the present petitions. Thus, the first question to decide is whether the aspects of the right to human dignity reflected in former decisions of the Constitutional Court may serve as a satisfactory basis for judging upon the petitions.

In the opinion of the Constitutional Court, the principles elaborated by the Constitutional Court in the course of its practice concerning the nature, essence, and restrictability as per Article 8 para. (2) of the Constitution of the right to human dignity guaranteed under Article 54 para. (1) of the Constitution are suitable for serving as a basis for taking a stand in the questions raised by the petitions.

From the various aspects of the right to human dignity, it is fundamentally the right of humans to self-determination that is considered by the Constitutional Court to be the manifestation of the right to human dignity on the basis of which the position taken by the Constitutional Court is to be elaborated with regard to the constitutional concerns addressed by the petitions.

Approaching the constitutional concerns addressed by the petitions from the aspects of the right to self-determination is in line with the international tendencies as well. According to a judgment passed by the Supreme Court of Canada, acting as a constitutional court in this respect, the statutory prohibition of satisfying the wish of a terminally ill patient to have his life ended by his physician is considered to be a restriction of the patient's right to self-determination (deemed in the concrete case to be a lawful restriction) (Rodriguez v. the Attorney General of Canada [1994] 2 LRC 136). The European Court of Human Rights expressed a similar opinion in the judgment passed in the Pretty Case referred to above, pointing out that primarily in the case of old or seriously ill patients kept alive by means of modern medicine, the statutory prohibition of having their lives ended by someone else upon their request was a restriction of their self-identity and of their right to self-determination (Pretty Case Judgment, point 66).

6. Looking at the questions raised in the petitions from the aspects of the right to life and the right to self-determination as part of the right to human dignity, the Constitutional Court has formed the following opinion:

6.1. The decision of a terminally ill patient not to live until the natural end of his life filled with sufferings is part of the patient's right to self-determination and, therefore, it falls within the scope of Article 54 para. (1) of the Constitution. The right to decide upon one's own death is to be enjoyed by all persons, regardless of being healthy or ill – either terminally, according to the current state of the art of medicine, or not. This is one of the reasons why the modern systems of law, including that of Hungary, only prohibit assistance in suicide but not suicide itself, contrarily to former times, when suicide was sanctioned at many places: those who committed suicide had various sanctions imposed on them after death (e.g. they were buried outside the cemetery, their property was confiscated, etc.).

A legal system based on ideologically neutral constitutional foundations may not reflect either a supporting or a condemning view about one's decision to end one's life; this is a sphere where, as a general rule, the State has to refrain from interference. The role to be played by the State in this respect is limited to the absolutely necessary measures resulting from its obligation of institutional protection concerning the right to life.

6.2. According to the Constitutional Court, there are two conclusions following from the above.

On the one hand, the decision of a terminally ill patient not to live until his natural death in order to shorten his sufferings and pain, or for any other reason, and the related refusal of the medical intervention absolutely necessary to keep him alive, are part of his right to self-determination, the exercise of which may be restricted – but not prevented – by an Act of Parliament to the degree necessary for the protection of another fundamental right. Only the justification for restricting this right to self-determination may be raised as a constitutional concern, for example, in the case of pregnant mothers, where the law does not provide for this option, or the fact that the exercise of such right is conditional upon certain procedural requirements.

On the other hand, the wish of a terminally ill patient to have his life ended not merely by the refusal of a life-supporting or life-saving medical intervention, but by the active aid of a physician cannot be considered from constitutional aspects such an integral part of his right to self-determination about his life or death that could not be limited – or even completely

prohibited – by the law in the interest of protecting any other fundamental right. In this case, another person becomes involved in the process as an active party, i.e. the physician attending the patient, when the patient decides to die in a manner reconcilable with his dignity. The role of the physician is not limited to performing the patient's will; he is necessarily involved – often substantially – in forming the patient's decision by informing the patient about the nature and the course of his illness, his life prospects, and the possibilities of controlling the pain and suffering resulting from the illness.

V

1. As it is in the context of the relations between the right to human life and the right to human dignity that the petitioners claim that the legislature has unconstitutionally restricted the right to die with dignity, the Constitutional Court has to first examine to what extent its position elaborated in its earlier decisions, i.e. that the right to human dignity is only unrestrictable when manifesting itself in unity with human life, is applicable when judging upon the present petitions.

In the opinion of the Constitutional Court, the statement that the right to human dignity is unrestrictable when manifesting itself in unity with human life only applies to cases where life and human dignity inseparable therefrom would be restricted by others. This constitutional interpretation was clearly elaborated in the first decision of the Constitutional Court on abortion [Decision 64/1991 (XII. 17.) AB], where the question to decide upon was the nature of human life being taken away by others (ABH 1991, 297-317). However, the question about the right to die with dignity is raised not in the context of one's life being taken by others, but in that of ending one's life at his own will, even if in certain forms of euthanasia the patient wishing to die wishes to use the assistance of another person, i.e. the physician. Consequently, the right to die with dignity, in the constitutional context presented in the petitions, does not manifest itself in unity with the right to life; on the contrary: human dignity is violated by forcing a terminally ill patient to live on in a stage of life where the serious physical and mental sufferings that result from his illness, as well as the feeling of hopelessness and defencelessness cause a conflict between his life and his dignity.

It follows from the above that the constitutional questions related to ending a terminally ill patient's life in harmony with his right to human dignity are – in contrast to the constitutional

questions related to capital punishment or abortion – marked by the fact that the right to human dignity does not manifest itself in inseparable unity with the right to life, but conversely: the enforcement of either right may result in limiting the other. Therefore, it cannot be established with due ground merely by reference to the unrestrictable nature of the right to human dignity in unity with the right to life as elaborated in earlier decisions of the Constitutional Court that a terminally ill patient has an unrestrictable right to self-determination also in respect of ending his life in a manner reconcilable with human dignity.

2. However, the above statement does not apply to all constitutional concerns raised by the petitioners with regard to the present statutory regulation. In their opinion, the unconstitutionality of the regulation lies not only in the fact of limiting the possibilities of a terminally ill patient to end his life in a manner reconcilable with his human dignity practically to the refusal of life-saving medical intervention. They also claim the unconstitutionality of the Act prohibiting the physician from ending the patient's life in the absence of a request to that effect by the terminally ill patient, by terminating life-supporting or life-saving interventions, provided that there is no interest identifiable within the realm of human dignity in sustaining the life of the patient struggling with imminent death. In addition, they claim the unconstitutionality of prohibiting the facilitation, on the basis of acceptable mercy, of a terminally ill and suffering patient's death in the absence of his express will to that effect.

The Constitutional Court holds that terminating a life-saving or life-supporting medical intervention or facilitating a patient's death in the absence of an express desire by the terminally ill patient would eliminate from making a decision on continuing or stopping a life-saving or life-supporting medical intervention the essential element – i.e. the patient's consent – that forms a link between the choice of ending or continuing life and the patient's right to self-determination. In such cases, a person other than the patient, i.e. the physician, would decide what is, and what is not consistent with the patient's human dignity. It was clarified in earlier decisions – most recently in Decision 36/2000 (X. 27.) AB – of the Constitutional Court about the right to human dignity that the patient's right to human dignity with regard to the patient's status is enforced through his right to self-determination. "The AH contains provisions guaranteeing the right to human dignity specified in Article 54 para. (1) of the Constitution in respect of the patient's right to self-determination. The patient's right to self-

determination includes – among others – the right to consent to or to refuse medical interventions or care." (ABH 2000, 241, 254-255)

Consequently, it is not in a direct constitutional relation with the right to self-determination of a terminally ill patient that the law prohibits and sanctions ending the life of a terminally ill patient by a physician or anyone else in the absence of a relevant request by the patient concerned even if such act is committed with the intention of protecting the patient's human dignity. In this regard, the Constitutional Court points out that – as seen in the international overview above – such acts are prohibited even by the legislatures of those states that take the lead in easing the restrictions applied in the past.

VI

1. As already stated by the Constitutional Court under point IV.6.1, the decision of a terminally ill patient not to sustain or extend his life by means of a life-supporting medical intervention is part of the patient's right to self-determination, and only the justification for restricting the exercise of this right to self-determination may be examined as a constitutional concern.

With regard to the above, the Constitutional Court has examined whether the non-prohibition by the legislature of refusing a life-supporting medical intervention by a terminally ill patient – as a manifestation of the patient's right to self-determination – results in an obligation of the State not to prohibit other ways of ending the lives of terminally ill patients in consistence with their human dignity.

2. The Constitutional Court emphasises that the scope of action of the legislature is limited due to the fact that while, on the basis of his right to self-determination, a terminally ill patient has the right to refuse a life-supporting or life-saving medical intervention in order to end his life in a manner reconcilable with his human dignity, special attention is to be paid to excluding by means of the relevant regulations any form of violation of the right to life. It necessitates the evaluation of several factors of very different natures to define the boundary beyond which the prohibition of the exercise of a terminally ill patient's right to self-determination leads to an unconstitutional restriction of his right to human dignity. This is true vice versa as well: when the legislature allows the exercise of the right to have one's life

ended in a manner reconcilable with one's human dignity without providing for adequate guarantees, this may lead to taking one's life arbitrarily, and therefore such regulation may be unconstitutional. Therefore, the legislature may only allow the enforcement of a terminally ill patient's right to self-determination to the extent it is able to ensure that the decision represents the patient's own true will formed free of external influence. The regulation must take into account the fact that allowing the enforcement of the right to self-determination should not result in weakening confidence in medical institutions in the case of those who do not wish to use such an option. The legislature should also take note of the fact that if the legislature fails to react in due time and in an adequate manner to the critical situation of terminally ill patients in the final stage of their illnesses, then – as seen in many countries – the application of illegal or unlawful solutions may emerge in the everyday medical practice.

The special set of conditions applied in the legal regulation of refusing life-supporting or life-saving interventions follows from the above.

3. In the opinion of the Constitutional Court, the fact that termination of life-supporting medical intervention by a physician at the request of a terminally ill patient and the ending of a terminally ill patient's life by a physician at the patient's request were prohibited in almost all countries of the world until quite recently is undoubtedly due to the legislatures' conviction that the conditions for even partially easing the strict prohibitions formerly applied in order to protect the right to life have only emerged recently. Several decisions made by the European Commission of Human Rights and the European Court of Human Rights can serve as examples for the tendency that the changing circumstances, including the development of science, have rendered obsolete certain restrictions on human rights formerly deemed legitimate (e.g. Case Sutherland v. United Kingdom, the Commission's Report of 1 July 1997; Case Goodwin v. United Kingdom, the Court's Judgment of 3 July 2002).

The Constitutional Court holds that in the field of the statutory regulations pertaining to the enforcement of terminally ill patients' right to self-determination, there is no boundary determined once and for all between unconstitutional and constitutional measures; the level of knowledge, the state of development, i.e. the advanced or underdeveloped nature of the individual institutions, and a range of other factors may influence the evaluation of the constitutionality of this issue.

In the relevant Hungarian regulatory framework, too, the route has lead from a long period of complete prohibition to annulling in 1997 the provision of the Act that had required physicians to treat with maximum professional care even those patients whom they deemed to be terminally ill, and to allowing terminally ill patients to refuse life-saving or life-supporting interventions, i.e. to exercise their right to self-determination – at least within this scope. This way, the legislature has allowed patients to decide upon having their lives ended in a manner reconcilable with their human dignity. At the same time, the legislature has created several provisions to guarantee that patients make an informed decision, being fully aware of its consequences, without any external influence.

4. The right of terminally ill patients to refuse life-supporting or life-saving medical interventions under Section 20 para. (3), Section 21 para. (2) and Section 22 paras (1) and (2) of the AH follows from the general right to self-determination enjoyed not only by terminally ill patients but by all patients on the basis of Article 54 para. (1) of the Constitution. This right is specifically named in Section 15 of the AH. It is the essence of patients' right to self determination that they may freely decide whether they wish to use medical care and what interventions they agree to or refuse during medical care. The above interpretation of patients' right to self-determination is supported by the former decisions of the Constitutional Court that are to be followed when interpreting everyone's right to human dignity as applied to the specific situation of ill people. It is an important element of the patient's human dignity that under no circumstances may a human be made an instrument or an object: "The right to human dignity means that the individual possesses a core of autonomy and self-determination beyond the reach of all others, whereby – according to the classic formulation – the human being remains a subject and cannot be transformed into an instrument or object" [Decision 64/1991 (XII. 17.) AB, ABH 1991, 297, 308]. Another aspect that follows from the patient's right to human dignity is the fundamental right to physical integrity. "Thus the right to human dignity includes both the constitutional fundamental right to freedom of self-determination and the fundamental right to one's physical integrity" [Decision 75/1995 (XII. 21.) AB, ABH 1995, 376, 381]. The Constitutional Court holds that the right to physical integrity means in respect of patients that, as a general rule, no one is allowed to touch the patient's body without his consent or approval.

In contrast, the desire of a terminally ill patient to have his death induced by a physician, for example, by supplying or administering an appropriate substance is – as indicated by the

Constitutional Court in point IV.6.2 – beyond that part of the patient's right to self-determination that is unrestrictable, both in part or in whole, by the law, as in such cases, death is actively induced by another person, i.e. the physician. Therefore, the possibility of a physician actively inducing the death of a terminally ill patient at the patient's request cannot be deduced from the general right to self-determination enjoyed by all patients.

Thus, in the opinion of the Constitutional Court, in view of the significant differences between dispensing with an intervention necessary for sustaining the life of a terminally ill patient and actively inducing with the aid of a physician the death of such a patient, the fact that the former act is allowed by the law does not impose a constitutional obligation on the legislature to allow the latter one as well.

VII

The Constitutional Court has already elaborated its position in point IV.6.2. about the wish of terminally ill patients to end their lives in a manner reconcilable with their dignity, with the aid of a physician, stating that in constitutional terms, this cannot be deemed to be included in that part of the patient's right to self-determination about his own life or death which may not be statutorily restricted.

The Constitutional Court holds that the statutory prohibition of the physician actively inducing – by supplying or administering a substance or preparation, or by any other means – the death of a terminally ill patient at the patient's request is a restriction of the right to self-determination as per Article 8 para. (2) of the Constitution. Statutorily prescribing certain conditions for exercising terminally ill patients' right to refuse life-supporting or life-saving medical interventions is also a restriction of that right.

Below it is examined by the Constitutional Court whether the above restrictions comply with the constitutional requirements for restricting fundamental rights.

VIII

The Constitutional Court first examined whether the petitions are well-founded in claiming that the statutory prohibition of a physician actively inducing the death of a terminally ill

patient upon the patient's request is an unconstitutional restriction of the patient's right to self-determination.

1. The criteria for the compliance of statutory regulations with the constitutional requirements of restricting fundamental rights have been elaborated in several decisions of the Constitutional Court [e.g. Decision 2/1990 (II. 18.) AB, ABH 1990, 18, 20, Decision 20/1990 (X. 4.) AB, ABH 1990, 69, 71, Decision 30/1992 (V. 26.) AB, ABH 1992, 167, 171, and Decision 6/1998 (III. 11.) AB, ABH 1998, 91, 98-99]. According to the consistent practice of the Constitutional Court, it is not considered an unconstitutional restriction of a fundamental right when – among others – the restriction is absolutely necessary for the protection of another fundamental right, and the injury caused by the restriction is in proportion with the importance of the specific regulatory objective.

2. In the constitutional examination of the restriction of fundamental rights challenged in the petitions, the approach followed by the Constitutional Court is based upon the view that in the case of terminally ill patients, the obligation of the State to protect life is to be enforced with special emphasis, having due regard to the situation (state of health) of such patients. This is justified by the fact that persons in an advanced phase of a terminal illness, being generally worn by the sufferings caused by the illness and, therefore, having limited capacity to enforce their own interests, are especially exposed to influences from their environment in making a decision on life or death. The family, relatives, friends and acquaintances, the healthcare staff, as well as the fellow patients may influence the patient's decision on requesting his physician to give him aid-in-dying. Clarifying whether any external influence has played a determining role in forming the patient's decision is only possible if the performance or refusal of the patient's request is the result of a transparent and controllable procedure taking account of all potential aspects and excluding the possibility of false judgment or potential abuse.

However, the introduction of a procedure complying with these requirements is not only a question of intention, since it depends on many conditions. Such conditions include an advanced level of medical knowledge and general state of development of healthcare institutions, and the availability of a sufficient number of well-trained and experienced professionals for the purpose of deciding upon and/or performing the patient's request.

3. Although it is within the competence and responsibility of the legislature to decide whether the conditions for easing the present statutory restrictions applicable to the rights of self-determination to be exercised by terminally ill patients with regard to ending their lives in a manner reconcilable with their human dignity are met, the legislature's decision may be reviewed by the Constitutional Court in respect of its constitutionality, within the limits specified in the ACC.

In examining the constitutional conditions for a restriction, the Constitutional Court has consistently followed the principle that "the State may only use the tool of restricting a fundamental right if this is the sole way to secure the protection or the enforcement of another fundamental right or liberty or to protect another constitutional value. Therefore, it is not enough for the constitutionality of restricting the fundamental right to refer to the protection of another fundamental right, liberty or constitutional objective, but the requirement of proportionality must be complied with as well: the importance of the objective to be achieved must be proportionate to the restriction of the fundamental right concerned." [Decision 30/1992 (V. 26.) AB, ABH 1992, 167, 171].

In the opinion of the Constitutional Court, the fact that the Act only partially allows the enforcement of terminally ill patients' right to self-determination with respect to ending their lives in a manner reconcilable with their human dignity, while this right is partially restricted, is a manifestation of the obligation of the State to protect life in accordance with Article 8 para. (1) of the Constitution.

4. The obligation of the State to protect life in this respect is to ensure that no external influences interfere with the complex process of the patient deciding whether or not to refuse a life-supporting or life-saving intervention. The State obligation of protection concerning institutions must be enforced in respect of the protection of the life of not only patients choosing between life and death but, in a broader sense, also of everybody else who may face the same challenge in the future. This approach followed by the Constitutional Court is consonant with its position elaborated at the beginning of its operation, according to which "it follows, however, from the objective side of the right to life that the duty of the State goes beyond its obligation not to violate one's right to life, and to employ its legislative and administrative measures to protect this right. This obligation is not limited to the protection of the life of individuals, but it also includes the protection of human life in general and the

conditions of its existence. This latter duty is qualitatively different from the aggregate of the protection of the right to life of individuals, it is ‘human life’ in general, and thus human life as a value, that is the subject of protection. [Decision 64/1991 (XII. 17.) AB, ABH 1991, 297, 303] Having regard to the petitions judged upon in this Decision, the Constitutional Court supplements the above arguments with the importance of public confidence in medical services and institutions, which can only be based upon all members of the community, including both patients and their relatives, being able to use medical services in the knowledge that they can rely on adequate statutory guarantees when making a decision on their lives and dignity.

Accordingly, the Constitutional Court holds that restricting terminally ill patients’ right to self-determination as challenged in the petitions is necessary for the protection of another fundamental right, i.e. the right to life.

5. The aspects applied when examining the necessity of a restriction are to be taken into account when examining its proportionality, too. Restricting a fundamental right for the purpose of protecting another one is deemed disproportionate if it is of an unreasonably wide scale. In addition, a restriction formerly not disproportionate may become disproportionate if the preconditions for easing or eliminating the prohibitions and restrictions have emerged over time, but the legislature fails, without a due ground, to alleviate the restrictions.

It is pointed out by the Constitutional Court that it was in 1997 that the legislature reached the conclusion that the total prohibition applied earlier in this field had become obsolete. Therefore, the AH has allowed terminally ill patients whose illnesses are expected, according to the current state of the art of medicine, to lead to death within a short time, to refuse life-supporting or life-saving interventions in order to choose a dignified way of ending their lives. According to the Constitutional Court the opinion of the Minister of Health that further limiting the scope of restrictions presently applied would entail significant risks concerning the protection of the right to life further supports the view that the present level of restrictions cannot be deemed disproportionate in relation to the aim to be protected, i.e. the right to life.

In view of the above, the Constitutional Court has concluded that the statutory restriction of terminally ill patients’ right to self-determination is not disproportionate.

6. Therefore, the result of the test of necessity and proportionality performed on the basis of Article 8 para. (2) of the Constitution is that the restriction of terminally ill patients' right to self-determination as objected to by the petitioners is justified by the protection of the right to life, and that, on the basis of the prominent constitutional value of the interest protected by the restriction, the scope of restriction cannot be considered disproportionate.

In view of this, the Constitutional Court has rejected the petition aimed at establishing that the AH unconstitutionally restricts patients' right to self-determination by not allowing the ending of terminally ill patients' lives with the aid of a physician, either on request by the patient or, in the absence of such a request, on the basis of the patient's assumed interest.

IX

The Constitutional Court then examined the petitioners' claim about an unconstitutional restriction of patients' right to self-determination by the provisions of the Act that have, since 1997, allowed the refusal of life-saving or life-supporting interventions by terminally ill patients only in the case of the fulfilment of certain conditions.

First, the Constitutional Court reviewed in general how the right to self-determination enjoyed by patients pursuant to Section 15 of the AH is realised in the case of terminally ill patients.

Section 15 para. (2) of the AH provides that "within the framework of exercising the right to self-determination, the patient is free to decide whether he wishes to use healthcare services and which procedures to consent to or refuse when using such services, taking into account the restrictions set out in Section 20." In the opinion of the Constitutional Court, the reference to Section 20 in the statutory provision declaring patients' right to self-determination makes it clear that the legislature intended to apply in the case of specific categories of seriously ill patients special – and more stringent than the general one – rules in respect of the right to self-determination manifesting itself in the refusal of interventions.

The mere fact of the legislature's applying special rules – as compared to the general ones – in the scope where the patient's exercise of his right to self-determination influences the life of the patient or of any other person cannot serve as the basis of a well-founded constitutional objection. The special rules on the patient's right to self-determination – as compared to the

general rules – in the scope concerned are justified by the State's obligation of institutional protection concerning the right to life. The terminally ill patient's right to self-determination manifested in refusing life-supporting or life-saving intervention undoubtedly falls into that scope.

However, even such special regulation has to comply with the requirements set out in Article 8 para. (2) of the Constitution.

In the case of terminally ill patients, the essence of these special rules is that a life-saving or life-supporting intervention may only be refused when the given illness is considered to lead to death within a short period of time, even if appropriate medical care is provided; in addition, the Act provides for specific formal requirements to be met when refusing the intervention. Such formal requirements include making the refusal in a public deed or a private deed of full probative force, or in the presence of two witnesses if the patient is unable to write. The refusal of the intervention is only valid upon a medical committee consisting of three members examining the patient and declaring unanimously that the patient has made his decision in full awareness of the consequences thereof, and that the statutory criteria of the refusal are met, i.e. the patient has disposing capacity and suffers from a serious and – according to the current state of the art of medicine – terminal illness that would lead to death within a short time, despite appropriate medical care. On the 3th day following this statement by the medical committee, the patient has to repeatedly declare his intention of refusal in the presence of two witnesses. A pregnant patient expected to bear her child successfully may not exercise the right of refusal.

The Act requires that in the case of a refusal of intervention an attempt be made to identify the reasons underlying the patient's decision through personal discussion and to alter the decision.

In the case of patients with no or limited disposing capacity, the Act provides for further conditions for the refusal of life-supporting or life-saving intervention.

The petitions do not contest in general the grounds for the application of such special rules. The petitioners specify five concrete elements of the regulation where they deem the statute to unconstitutionally restrict terminally ill patients' right to self-determination.

1. According to the petitioners, it is contrary to the right to self-determination resulting from human dignity that "pursuant to Section 20 para. (3) of the AH, the right to refuse treatment in respect of life-supporting or life-saving interventions may only be exercised if, according to the state of medical knowledge at the given time, the illness will lead to death within a short period of time despite adequate healthcare, and is incurable." The petitioners hold this provision to be unconstitutional for two reasons. One reason is that it follows from the provisions of the Act, namely from Section 20 para. (4) of the AH that the shortness of the remaining part of the patient's life is judged not by the patient but by the medical committee deciding whether the patient has validly refused the intervention. The other reason is that only such a terminally ill patient may refuse a life-saving or life-supporting intervention whose illness is expected to lead to death within a short period of time. This is claimed to be an unconstitutional restriction of the right to self-determination of terminally ill patients whose illness is, according to the current state of the art of medicine, expected to inevitably lead to death although not within a foreseeable short period of time.

The opinion of the Constitutional Court about the above statement made by the petitioners is the following: if the patient's life expectancy were determined under the law not by the patient, but by the medical committee (in a subjective manner), this would undoubtedly raise constitutional concerns. The patient clearly feels that the period of time not considered by the medical committee short enough to justify the refusal of the intervention concerned is infinitely long. If the statutory provisions had the contents assumed by the petitioners, this would certainly mean that it is not the patient but others who can decide what way of ending the patient's life is reconcilable with the patient's right to human dignity.

However, the Constitutional Court holds that it is clear from Section 20 paras (3) and (4) of the AH that it is not in the arbitrary discretion of the (members of the) medical committee, and it is not based on their empathy about the patient's situation to decide whether or not the statutory conditions for refusing a life-saving or life-supporting intervention exist – including the fact that the patient suffers from a terminal illness expected to lead to death within a short period of time, despite appropriate medical care. It is on whether the illness is expected, according to the state of medical knowledge at the given time, to lead to death within a short period of time that the medical committee has to form an opinion. Thus, the Act does not grant such primacy against the patient to an outside body, the medical committee, in deciding upon the patient's right to human dignity, which primacy would have the effect of prevailing

over the patient's right to self-determination. This provision is to be interpreted as an objective element introduced in the regulation: the patient is only allowed to refuse a life-saving intervention if his illness is deemed terminal and it is expected to lead to death within a short period of time – according to the state of medical knowledge at the given time. Therefore, as according to the Act, the length of the patient's life expectancy is to be assessed on the basis of the state of medical knowledge at the given time, rather than on the basis of the patient's subjective feelings about this period of time being short or long, the position to be taken by the medical committee is not related to the realm covered by the patient's right to self-determination.

There is another aspect of connecting the terminally ill patient's right to self-determination and the state of medical knowledge, and it has not been taken into account by the petitioners in raising their constitutional concerns.

Making the refusal of a life-saving or life-supporting intervention conditional upon the state of medical knowledge at the given time is to be applied – from among the criteria set out in Section 20 para. (3) of the AH – not only to the shortness of the time but to the terminal nature of the illness as well. Clearly, an illness considered terminal on the basis of the current state of the art of medicine may, in the near or distant future, become one that can be cured, as a result of the development achieved in science, curative and therapeutic treatments, technology, available substances and preparations, and, perhaps mainly in physicians' expertise concerning the treatment of illnesses formerly deemed terminal. There have been several examples for this world-wide as a result of the spectacular development experienced in recent decades in the realm of medical sciences, too. The curing of illnesses formerly deemed terminal is greatly supported by the present easier access to the scientific results achieved and the curative methods applied in other countries.

The fact that some illnesses formerly deemed terminal have become or are becoming curable is the basis of the Constitutional Court's following statement. Contrarily to the opinion of the petitioners claiming that the legislature has unconstitutionally restricted the right to refuse life-supporting or life-saving interventions of terminally ill patients whose illnesses are not expected to lead to death within a short period of time on the basis of the state of medical knowledge at the given time, the Constitutional Court holds this provision to be motivated by the reasonable intention of protecting the right to life and, therefore, it is not deemed to be of

an arbitrary nature. Consequently, on the basis of the State's obligation of institutional protection concerning human life, with due account to what has been stated under point VIII.3 above, the legislature's position on not allowing at present the refusal of life-saving or life-supporting medical interventions by those who suffer from serious and – according to the current state of the art of medicine – terminal illnesses, but who are likely to die only in the long term according to the current state of the art of medicine, is not considered unconstitutional.

Taking all the above into account, the Constitutional Court has rejected the petition as unfounded.

2. In the opinion of the petitioners, Section 20 para. (4) of the AH, too, is inconsistent with the rule on the right to human dignity under Article 54 para. (1) of the Constitution, "(…) the core of which provision is the right to self-determination. The patient's right to refusal of treatment may not be made dependent on whether he has accepted to undergo medical examination as a separate condition for exercising the right to self-determination. This restriction is disproportionate and contrary to the essence of the right to self-determination."

According to the provision in Section 20 para. (4) of the AH challenged by the petitioners refusal is valid only if a committee composed of three physicians has examined the patient and made a unanimous, written statement to the effect that the patient has taken his decision in full cognizance of its consequences, and that the conditions defined in paragraph (3) have been met, furthermore if on the third day following such statement by the medical committee, the patient repeatedly declares his intention of refusal in the presence of two witnesses.

The Constitutional Court holds it to follow from the State's obligation of institutional protection concerning the right to life that the refusal of life-saving or life-supporting interventions should be allowed only within the framework of the relevant statutory provisions. It is obviously intended to serve the above purpose that the Act provides for a committee composed of three physicians in charge of checking the criteria for refusing life-supporting or life-saving intervention. This committee, and in particular its psychiatrist member must interview the patient [Section 3 para. (3) of the GD] to verify that the patient suffers from a terminal illness and that the patient's will of refusing the intervention is clear and unambiguous [Section 23 para. (1) of the AH]. In this respect, the Constitutional Court

emphasises that according to the Act, only persons with full disposing capacity, i.e. who are able to foresee the consequences of their conduct, may decide on refusing the intervention [in the case of patients with no or limited disposing capacity, the procedure set out under Section 21 para. (2) of the AH applies]. The medical committee also has to take into account the requirement specified in Section 20 para. (3) of the AH, according to which the rule that only persons with full disposing capacity may refuse life-saving or life-supporting interventions is to be enforced also if the patient is deemed to be without disposing capacity on the basis of Section 17 para. (1) of Act IV of 1959 on the Civil Code, although he has not been put under guardianship excluding or limiting his disposing capacity. The above is referred to in Section 3 para. (3) of the GD, providing for the obligation of the psychiatrist member of the medical committee to make a statement about the patient possessing the capacity for judgement necessary for making the relevant decision.

Therefore, in view of the prominent constitutional value of the right to life, providing for the condition that a medical committee must verify before terminating a life-saving or life-supporting intervention that the statutory requirements of refusal are met – as a criterion for the refusal to be valid – can be regarded as neither unnecessary nor disproportionate. As the medical committee can only form an opinion on the validity of the refusal upon the patient's consent to the examination to be made by the committee, the Constitutional Court has rejected as unfounded the petition aimed at the establishment of the unconstitutionality of the statutory provision specifying that the patient's refusal of a treatment may not be taken into account if the patient has not accepted to be examined by the committee.

3. According to the petitioners, "restricting with reference to Section 20 the right to self-determination specified under Section 15 para. (2) of the AH is contrary to (…) the right to self-determination resulting from human dignity. More specifically, pursuant to Section 20 para. (3) of the AH, the right to refuse treatment in respect of life-supporting or life-saving interventions may only be exercised if, according to the state of medical knowledge at the given time, the illness will lead to death within a short period of time despite adequate healthcare, and is incurable. Limiting the patient's right to self-determination with reference to Section 20 para. (3) excludes the exercise of the patient's right to self-determination, for example, if the amputation of any of his limbs becomes necessary for reasons other than a terminal illness. Such a limitation of the right to self-determination is contrary to the principle of self-determination resulting from human dignity."

In the opinion of the Constitutional Court, it undoubtedly follows from Section 20 para. (1) of the AH that a patient with full disposing capacity may at any time refuse care provided that exercising this right does not endanger the life or the physical integrity of others (i.e. persons other than the patient). The wording in Section 20 para. (1) specifying that this right is enjoyed by the patient "in consideration of the provisions set out in paragraphs (2) and (3)" makes it clear that according to the Act, interventions may be refused not only by a terminally ill patient whose illness will lead to death within a short period of time, but also by a patient – e.g. a patient facing the amputation of his limbs as mentioned in the petition – who refuses care "the absence of which is likely to result in a serious or permanent impairment of his health" [Section 20 para. (2)].

Therefore, in the case of a patient facing the amputation of any of his limbs as referred to by the petitioners, the refusal of the medical intervention is governed by Section 20 para. (2) rather than by Section 20 para. (3) of the AH. Section 20 para. (2) of the AH provides for the conditions of refusing care the absence of which is likely to result in a serious or permanent impairment of the patient's health. The criteria of refusal in the case of patients suffering from such illnesses are simpler that in the case of terminally ill patients. The Constitutional Court holds that in the case of a refusal on the basis of Section 20 para. (2) of the AH (and this is what applies to the patient facing amputation as referred to in the petition), the sole applicable requirement, namely that the patient's refusal must take the form of a public deed or a private deed of full probative force, guarantees in the patient's interest that a medically justified intervention may only be dispensed with on the basis of the patient's unambiguous request verifiable subsequently as well, therefore such a restriction is both necessary and proportionate.

Thus the petitioners' claim that "Limiting the patient's right to self-determination with reference to Section 20 para. (3) excludes the exercise of the patient's right to self-determination, for example, if the amputation of any of his limbs becomes necessary for reasons other than a terminal illness" is unfounded.

Consequently, the Constitutional Court has rejected the petition seeking the establishment of the unconstitutionality and a declaration of the nullification of Section 15 para. (2) and Section 20 para. (3) of the AH.

4. According to the petitioners, the provision contained in Section 22 para. (4) of the AH is a restriction of the patient's right to self-determination violating Article 54 para. (1) of the Constitution.

Although the petition claims the unconstitutionality of only Section 22 para. (4) of the AH, the Constitutional Court has had to consider the provisions of Section 22 not referred to by the petition – without taking a position about their constitutionality – because of the interrelations among the various paragraphs of the Section concerned.

Pursuant to Section 22 para. (1), for the event of his possible subsequent incapacity, i.e. as regards future events, a person with full disposing capacity may refuse in a public deed certain examinations or interventions, and such a patient may refuse life-supporting or life-saving interventions in case he should have a terminal illness leading to death, according to the then current state of the art of medicine, within a short period of time despite appropriate medical care, furthermore the patient may refuse certain life-supporting or life-saving interventions if he has a terminal illness and as a consequence, becomes unable to care for himself physically or suffers pain that cannot be eased even by appropriate therapy.

Pursuant to Section 22 para. (2) a person with full disposing capacity may name in a public deed, for the event of his possible subsequent incapacity, the person with full disposing capacity who shall be entitled to exercise the right defined in Section 22 para. (1) in his stead.

Section 22 para. (3) provides that the statements defined in paragraphs (1) and (2) shall be valid if a psychiatrist has confirmed in a medical opinion that the person had made the decision in full awareness of its consequences.

Finally, Section 22 para. (4) challenged by the petitioners provides that the committee specified in Section 20 para. (4) shall declare whether the criteria set out in Section 22 para. (1) have been met, and whether the patient specified in Section 22 para. (2) has made his decision in full cognizance of its consequences.

The petitioners challenge the above provision on the following ground: for the validity of a decision made by a person with full disposing capacity on refusing a medical intervention for

the case of his future incapacity or on authorising another person to make such a refusal, the Act requires the separate approval of a medical committee despite the fact that, according to the Act, a psychiatrist had to confirm earlier that the person concerned had made his decision in full cognizance of its possible consequences. The petitioners claim the above requirement of double approval to constitute an unjustified restriction of the right to self-determination.

The Constitutional Court points out that the petition is based on an erroneous interpretation of Section 22 of the AH. The medical committee takes a stand not on the same question as the one already decided by the psychiatrist, i.e. whether the person with full disposing capacity has made his decision for the case of his becoming incapable in full cognizance of the possible consequences of the decision, but it decides on the question whether the other person (i.e. the deputy decision-maker) acting on behalf of the already incapacitated principal on the basis of the authorisation for refusal of medical intervention given by the principal when having full disposing capacity has made the decision about refusing the medical intervention in full cognizance of the consequences of the decision. Consequently, contrarily to what is claimed by the petitioners, the AH does not require the verification of the existence of the same requirement by two different bodies or physicians in two separate procedures.

Thus, the provision concerned does not qualify as an unjustified restriction of the right to self-determination. Therefore, the Constitutional Court has rejected the complaint.

5. According to the petitioners, Section 23 para. (1) of the AH may result in raising subsequent doubts about the patient's right to self-determination, and therefore this provision is contrary to the requirement of legal certainty in a state under the rule of law specified in Article 2 para. (1) of the Constitution and the patient's right to human dignity.

The petitioners argue as follows:

Pursuant to Section 20 para. (2) of the AH, the right to refuse care may only be exercised if the relevant formal requirements are met. In this context, the further requirement set out in Section 23 para. (1), demanding the will on refusing or terminating care to be clear and convincing, restricts the essence of the right to self-determination and is thus unconstitutional. Since the application of the above provision may result in raising subsequent doubts about the

patient's decision made when exercising his right to self-determination, it also violates the requirement of legal certainty.

The Constitutional Court holds that the petition is based on a misinterpretation of the provisions of the AH. Section 23 para. (1) of the Act only refers to Section 20 para. (3) and not to Section 23 para. (2), and thus it only applies to Section 20 para. (3) granting the right to refuse life-saving and life-supporting interventions for terminally ill patients who suffer from illnesses leading to death within a short period of time. On the other hand, the provision in Section 23 para. (1) prescribing that the termination or non-performance of the intervention may only take place if the patient's will to that effect can be verified clearly and convincingly is a rule based on the State's obligation of institutional protection to safeguard human life, and as such, it does not restrict in any way the patient's right to self-determination, nor does it endanger legal certainty.

Accordingly, Section 23 para. (1) of the AH is not related to the provisions under Section 20 para. (2) of the AH referred to by the petitioners. Therefore, the Constitutional Court has rejected the petition.

X

1. The petitioners have raised constitutional concerns of two types about Sections 166 to 168 of the CC.

On the one hand, they hold that the legislature's failure to harmonise Sections 166 to 168 of the CC with Article 54 para. (1) of the Constitution has resulted in a situation of unconstitutional omission. They argue that the right to human dignity granted in Article 54 para. (1) of the Constitution, introduced in the amendment of the Constitution by Act XXXI of 1989, includes the right to choose between the right to life and the right to dignity, however, the provisions of the CC ordering the punishment of the various cases of homicide have remained in force since 1989, still prescribing sanctions for physicians who give aid-in-dying to terminally ill patients if requested so by the patients or in some cases without such a request. Although the petitioners do not go into details as to whether, in their view, the total decriminalisation of acts against human life committed with the purpose of preserving human dignity, or their transformation into privileged criminal offences would be more in accordance

with Article 54 para. (1) of the Constitution, they hold that the legislature has failed to adapt the relevant provisions of the Criminal Code to the provision of the Constitution in force since 1989.

On the other hand, the petitioners claim it to be unconstitutional that certain cases of non-requested active aid-in-dying are not separated by the legislature from the statutory definition of homicide under the denomination of "mercy killing", and that "(…) facilitating the death of a terminally ill and suffering patient without an express intention to die, on the grounds of acceptable mercy" is not treated as a privileged case.

2. As already established in this Decision by the Constitutional Court, it is part of the terminally ill patient's right to self-determination to end his life in a manner reconcilable with his human dignity.

However, the Constitutional Court does not regard as well-founded the petitioners' claim that since the 1989 amendment of the Constitution acknowledging the right to human dignity as a constitutional fundamental right, terminally ill patients' right to end their lives in a manner reconcilable with their human dignity has been a right, deducible from Article 54 para. (1) of the Constitution, that may not be subject to statutory restriction.

The Constitutional Court has furthermore established that the restriction of the right to human dignity challenged by the petitioners is justified by the State's objective obligation of institutional protection concerning the right to life, and due to the prominent constitutional value of the right to life, the extent of the restriction is proportionate and, as such, not unconstitutional.

Therefore, apart from the AH allowing in 1997 the refusal of life-saving or life-supporting intervention, the Act continues to prohibit ending the life of a terminally ill patient – either at his request or without that, for the purpose of preserving his right to human dignity – by, or with the assistance of, a physician or anyone else. In consideration of the arguments set out in parts IV to VII of the present Decision of the Constitutional Court, essentially stating that the right concerned is not unrestrictable, this prohibition cannot be deemed unconstitutional with reference to the terminally ill patient having an unrestrictable constitutional right to use the assistance of another person when choosing between his life and his dignity.

Those who act against this prohibition are seriously sanctioned by other statutory provisions in addition to the CC (including sanctions under civil law, labour law, and administrative law). However, the Constitutional Court holds that due to the prominent constitutional value of the right to life, it is indeed justified to apply sanctions under criminal law as well against those who act against the prohibition in question.

Therefore, the petitioners' claim that an unconstitutional omission of legislative duty has occurred by the failure of the legislature to adapt the provisions of the CC to Article 54 para. (1) of the Constitution after the 1989 amendment of the Constitution is unfounded.

3. The Constitutional Court holds that the petitioners' arguments are also unfounded in referring to an unconstitutional omission of legislative duty by the failure of the legislature to create, after the 1989 amendment of the Constitution, separate statutory definitions for homicide and requested active aid-in-dying. Nor has it resulted in an unconstitutional situation manifested in an omission that the legislature has failed to sanction as a privileged case the act of facilitating the death of a terminally ill patient on the basis of acceptable mercy, without an express request by the patient to that effect.

The Constitutional Court holds the following: as it cannot be deduced from the right to human dignity introduced into the text of the Constitution in its 1989 amendment that the legislature is, on this basis, obliged to separate requested active aid-in-dying from the criminal law definition of homicide, or to sanction less severely than before the acts of homicide committed on the basis of mercy towards the terminally ill patient, no situation of unconstitutional omission can be considered to exist. The motives of persons involved in inducing the death of a terminally ill patient are to be evaluated by the court when imposing the punishment.

Therefore, the petitions calling for the establishment of the unconstitutionality of omitting a legislative duty are rejected by the Constitutional Court.

XI

The Constitutional Court has judged upon further petitions related to certain provisions of the AH and the GD as follows:

1. According to the petitioners, Section 17 para. (1) item a) of the AH violates legal certainty, which is part of the principle of the rule of law declared in Article 2 para. (1) of the Constitution.

The Constitutional Court holds that the provision challenged by the petition is one of the provisions on the right to self-determination in Sections 15 to 19 in Chapter II Title 2 of the AH, specifying patients' rights and obligations. The general rule pertaining to the right to self-determination is that the patient is free to decide which interventions he agrees to and which ones he refuses [Section 15 para. (2)]. The Act allows patients with full disposing capacity to name, in a public deed or a private deed of full probative force, a person who shall be entitled to exercise on his behalf the right of approval or refusal [Section 16 para. (1) item a)]. The challenged provision of Section 17 para. (1) item a) of the Act is connected to the above, stating that if the patient is unable to make a declaration of approval due to his state of health, and obtaining a declaration from the person defined under Section 16 para. (1) item a) would result in a delay, the patient's consent to the intervention shall be presumed.

According to the petition, the text "would result in a delay" in Section 17 para. (1) item a) of the AH is unclear wording resulting in legal uncertainty that can lead to completely emptying the right to self-determination. The petitioners argue that a certain period of delay is inevitable in the case of obtaining any declaration, but the Act does not provide for details on the expected negative consequences for the avoidance of which the exercise of the patient's right of disposal may be dispensed with.

The petition is unfounded.

According to the Constitutional Court, the legislature cannot be expected to give an exhaustive statutory definition of the situations where obtaining the declaration of the person designated by the patient can be dispensed with in view of the danger of delay, as there can be numerous situations of different natures during medical practice. Therefore, any statutory definition of the concept of delay would inevitably limit the possibilities of performing medically justified and necessary interventions. When adopting the Act, one could not foresee

and define the exhaustive list of situations – e.g. the person designated by the patient is away at an unknown place – that could justify the application of Section 17 para. (1) item a) of the AH.

The Constitutional Court holds that giving an exhaustive list as the definition of delay would pose a threat to legal certainty, as in practice, new situations the legislature could not think of may emerge on a continuous basis, for which reason there can be situations with respect to which the legislature did not allow dispensing with the declaration of the person designated by the patient. This would lead to a need to frequently amend the Act.

For the above reasons, the Constitutional Court has rejected the petition.

2. According to the petitioners, the text "or in the case specified under para. (1) item b)" in Section 18 para. (2) of the AH violates Article 54 para. (1) and Article 2 para. (1) of the Constitution.

Section 18 para. (2) of the AH provides that if during an invasive intervention an extension becomes necessary which would lead to the loss of any of the patient's organs or body parts or to the complete loss of the function thereof, in the absence of the patient's consent to such extension, the intervention may only be extended if the patient's life is in direct danger or if failure to do so would impose a disproportionately serious burden on the patient.

The petitioners hold that in the absence of the patient's consent, such an extension of the intervention is not duly justified by the fact that failure to do so would impose a disproportionately serious burden on the patient, as this statutory provision restricts the essence of the patient's right to self-determination in a manner contrary to the requirement of legal certainty under the rule of law as defined in Article 2 para. (1) of the Constitution.

The petition is unfounded.

In the opinion of the Constitutional Court, it undoubtedly follows from an interrelated analysis of paragraphs (1) and (2) of Section 18 of the Act that in both cases of extending an invasive intervention as regulated by the Act, the legislature intended to allow only the least and – in the patient's interest – absolutely necessary restriction of the patient's right to self-

determination. Accordingly, an invasive intervention may only be extended if it was unforeseeable, and therefore the patient could not be informed about it in advance, and, in the case specified in Section 18 para. (1) (extension not leading to the loss of any of the patient's organs or body parts or to the complete loss of the function thereof), if it is justified by an urgent need or if failure to do so would impose a disproportionately serious burden on the patient; or, in the case regulated under Section 18 para. (2) (extension leading to the loss of any of the patient's organs or body parts or to the complete loss of the function thereof), if the patient's life is in direct danger or if failure to do so would impose a disproportionately serious burden on the patient.

Using the term challenged by the petitioners – "a disproportionately serious burden on the patient" – undoubtedly leaves a certain margin of discretion for the physician performing the invasive intervention in deciding what to consider a burden of disproportionate weight that could result from failure to extend the intervention. However, it is emphasised by the Constitutional Court that due to the indefinably wide spectrum of the illnesses of very different natures necessitating invasive interventions, the age and the general state of health of the patient, the state of medical knowledge, and many other circumstances occurring only in the case of a particular intervention, the legislature cannot be expected to define for each kind of intervention the cases where a failure to extend the intervention would qualify as a burden of disproportionate weight for the patient. Due to the nature of invasive interventions, applying an unnecessarily rigorous regulation of the criteria for extending interventions would in fact hinder the performance of successful medical interventions. In this respect, the Constitutional Court also points out that physicians' conduct in unexpected situations arising during invasive interventions is regulated not only by Section 18 of the AH, but also by the rules of the medical profession, physicians' code of ethics, and the wide range of norms on legal liability – all aimed at ensuring that maximum account is taken of the patient's right to self-determination when it is necessary to extend an invasive intervention.

With regard to judging the constitutionality of the term "disproportionately serious burden" used in the AH and challenged by the petitioners, it is finally pointed out by the Constitutional Court that it follows form several provisions of the AH – including Section 13 paras (1) and (2), and Section 15 para. (3) – that the patient has the right to obtain extensive information from his physician before giving consent to the intervention, during which – according to the correct interpretation of the Act – he must gain information about the possibility that in the

course of the intervention it may become necessary to extend the scope of the intervention in accordance with the nature of the illness and of the intervention.

Therefore, the text challenged by the petitioners in Section 18 para. (2) of the AH does not violate the requirement of legal certainty under the rule of law guaranteed in Article 2 para. (1) of the Constitution.

On this ground, the Constitutional Court has rejected the petition.

3. According to the petitioners, the contents of the provisions on self-determination contained in Sections 15 to 19 of the AH are contrary to Article 54 para. (1) and Article 8 para. (2) of the Constitution, thus the petitioners have asked for the annulment of these provisions. However, in respect of the above, the petitioners have not filed any definite petition specifying the grounds of their position. Consequently, the Constitutional Court has refused the petition without actual examination, in accordance with Section 22 para. (2) of the ACC.

4. The petitioners have initiated the annulment of certain provisions of the GD on the basis of their relation to the implementation of the provisions of the AH deemed unconstitutional by the petitioners. The petitioners have not put forward further arguments to support their claim on the unconstitutionality of the provisions of the GD challenged by them.

As explained in this decision, the Constitutional Court has not found unconstitutional the provisions of the AH to which the challenged provisions of the GD are related or which they implement. Therefore, these provisions of the GD cannot be deemed unconstitutional merely on the above ground. As the petitioners have raised no other arguments to support their claim on the unconstitutionality of certain provisions of the GD, the Constitutional Court has rejected the petition.

The publication in the Hungarian Official Gazette of this Decision of the Constitutional Court is ordered with due account to the constitutional importance of the issues mentioned in the decision.

Budapest, 28 April 2003

Dr. János Németh
President of the Constitutional Court
presenting Judge of the Constitutional Court

Dr. István Bagi
Judge of the Constitutional Court

Dr. Mihály Bihari
Judge of the Constitutional Court

Dr. Ottó Czúcz
Judge of the Constitutional Court

Dr. Árpád Erdei
Judge of the Constitutional Court

Dr. Attila Harmathy
Judge of the Constitutional Court

Dr. András Holló
Judge of the Constitutional Court

Dr. László Kiss
Judge of the Constitutional Court

Dr. István Kukorelli
Judge of the Constitutional Court

Dr. János Strausz
Judge of the Constitutional Court

Dr. Éva Tersztyánszky-Vasadi
Judge of the Constitutional Court

In witness thereof:

Concurring reasoning by Dr. Éva Tersztyánszky-Vasadi, Judge of the Constitutional Court

I agree with the provisions in the majority Decision rejecting the petitions.
It is not necessary from constitutional aspects to widen the scope of the right to refuse care as regulated in the AH. Therefore, I agree with the Decision in stating that the AH does not restrict in an unconstitutional manner the right to self-determination of terminally ill patients by not allowing the termination of their lives with the aid of a physician. I also agree that the right to self-determination pertaining to refusing life-saving or life-supporting medical intervention is not restricted by the AH in an unconstitutional manner.

However, I agree only partially with the reasoning of the Decision. In addition, I hold it particularly important to stress that the Decision has reviewed the constitutionality of the provisions in the AH only as far as the contents and the orientation of the petitions are concerned (part III point 6).
This means that the Decision has examined whether it is unconstitutional to prohibit the facilitation of a terminally ill patient's death by terminating a life-saving or life-supporting intervention in the absence of his relevant request, and whether the legislature is obliged to allow other methods, not specified in the AH at present, of ending (by either active or passive assistance) a terminally ill patient's life at his request.

I accept that Sections 20 and 22 para. (2) of the ACC can be interpreted in the manner it is done in the Decision: the Constitutional Court's scope of action is limited by the contents and the orientation of the petitions. Thus, in the present case, in the absence of a relevant petition, the question has remained open whether the rules of the AH allowing directly or indirectly a decision to be made not by the patient without any influence, but by other persons deciding on his behalf about refusing care with regard to life-saving or life-supporting interventions [Section 20 para. (4) of the AH, Section 22 para. (2) of the AH] are reconcilable with the right to life.

Differently from the reasoning of the Decision, I give the following reasons to support the decisions found in the holdings.

Acknowledging earlier decisions of the Constitutional Court, I am convinced that human life and human dignity form an indivisible unity and constitute a paramount constitutional value prevailing over all other values. The rights to life and to human dignity form an unrestrictable and indivisible fundamental right which is the source and the condition of many other rights [Decision 23/1990 (X. 31.) AB, ABH 1990, 88, 93].

I hold that dignity is a quality coterminous with human existence, a quality which is indivisible and cannot be limited, hence belonging equally to every human being. The right to equal dignity, coupled with the right to life ensures that the value of human life may not be legally differentiated. The human dignity and the life of every human being are inviolable, irrespective of physical and intellectual development and condition as well as of the extent of fulfilment of the human potential and the reasons therefor [Decision 64/1991 (XII. 17.) AB, ABH 1991, 297, 309].

With respect to the present case, it follows from the above arguments that if the AH allowed the termination of the lives of terminally ill patients with the – either active or passive – aid of a physician on request by the patient or even without that, this would qualify as an unconstitutional restriction of the right to life. That is to say, not only is such restriction of the right to self-determination not unconstitutional, but conversely: a rule allowing the termination of one's life with medical assistance would itself be inconsistent with the right to

life. In this context, the right to self-determination does not include one's right to use one or several persons to fulfil his personal decision.

Although the right to human dignity is absolute and unrestrictable only as a determinant of human status and in its unity with the right to life, the component rights derived from it as a mother right (such as the right to self-determination and the right to one's physical integrity) may be restricted in accordance with Article 8 para. (2) of the Constitution just like any other fundamental right. [Decision 75/1995 (XII. 21.) AB, ABH 1995, 376, 383]

However, in the case concerned, all petitioners – and consequently the Decision, too – refer to dignity as against the right to life.

The reasoning of the majority Decision is based upon the assumption that the right to die with dignity – as it occurs in the context of ending one's life on the basis of one's own decision – manifests itself not in unity with the right to life, and human dignity is violated by the fact that although the patient concerned is terminally ill, his life may not end at the point where a conflict emerges between his life and his dignity (Part V point 1).

The infinity of human dignity applies not only to healthy human life, and the dignity of a person with no disposing capacity (resulting from the patient's age or state of health) may not be restricted, either. All men have equal dignity, even though a patient torn by serious physical and mental suffering that results from his illness, or who feels hopeless and defenceless might feel differently. The right to dignity is not identical to the sense of dignity. It is conceptually impossible to imagine a situation where a human should choose between his life and his dignity: renouncing life "in order to preserve dignity" results in losing dignity as well. Thus, life and dignity are conceptually inseparable. Consequently, a misinterpretation of the concept of human dignity is reflected in any argument raising the possibility of a conflict and choice between life and dignity. I am convinced that any approach not acknowledging the unconditional dignity of human life bears an unforeseeable danger in itself.

Nor do I agree with the statement made in the Decision as the theoretical foundation of the reasoning, namely that deciding on one's own death (Part IV, point 6.1), such as committing suicide, is part of the right to self-determination. The right to decide on one's own death or the

right to commit suicide cannot be deduced from the right to human dignity or from the right to self-determination derived therefrom; such rights are non-existent.
The lack of sanctions for those who commit suicide is not the result of the right to self-determination; it is caused by the fact that suicide is a situation outside the realm of law: it is not punished, but may not be supported by the law.
In this context, the majority Decision is not right in referring to the principle of the State's ideological neutrality when stating that a legal system which is constitutionally neutral with respect to any ideology may reflect neither a supporting nor a condemning view about one's decision to end his life. The neutrality of the State does not exclude the possibility of it being committed to fundamental values and rights contained in the Constitution as well; indeed, the State may take a firm stand in support of life, what is more, it is even obliged to do so.

Thus, any wording that refers to the cultural determination of decisions about euthanasia (e.g. Part VI, point 3) and suggests that thinking about life might fundamentally change in the future qualifies as an unacceptable relativisation of the right to life. The legal protection of life may be extended in the future (i.e. in the direction of acknowledging the rights of the foetus on a broader scale), but any approach that might lead to decreasing the protection of life – with formal reference to the right to self-determination or to other rights, but in practice, possibly on the basis of economic interests – must be definitely combated. It would have unpredictable consequences if the legislature allowed even a tiny chance for differentiating between "valuable" and "less valuable" lives.

The Constitution protects the right to life. Neither the right to human dignity, nor the right to self-determination derived therefrom may be interpreted so as to provide for a right to die as a result of the act of another person or with the support of the State, or a "right to dignified death"; patients must only have the chance to refuse certain interventions on the basis of well-defined criteria.
I hold that in the field of the statutory regulations on the enforcement of the right to self-determination, the division line between constitutional and unconstitutional regulation is set once and for all. Only a regulation providing for the possibility to make an informed, personal and free decision about refusal without any external force or influence is constitutional. Such a refusal of care does not cause death, but it only accepts the incapacity to prevent death. A regulation providing for anything more in the scope examined is unconstitutional, as the Constitution excludes the possibility of restricting the right to life. Taking away intentionally

the lives of terminally ill or dying patients, i.e. any act or omission aimed at causing death in a direct or indirect way, must remain prohibited.

In view of the above, in my opinion, it is not necessary for the enforcement of the right to human dignity to regulate the right to refuse care more extensively than regulated in the AH at present.

Budapest, 28 April 2003

Dr. Éva Tersztyánszky-Vasadi
Judge of the Constitutional Court

In witness thereof:

Concurring reasoning and dissenting opinion by Dr. András Holló, Judge of the Constitutional Court

I

1. I agree with points 1.2.4 and 5 of the holdings in the Decision as well as with the reasoning related thereto.

In point 1 of the holdings, the Constitutional Court rejects the petition according to which the AH restricts in an unconstitutional manner the right to self-determination of terminally ill patients by not allowing the termination of their lives with the aid of a physician.
In relation to the reasoning attached to point 1 of the holdings, I wish to note and add the following.

2. According to its consistent practice, the Constitutional Court also establishes the existence of an unconstitutional omission if the regulation under review is unconstitutionally incomplete as far as its contents are concerned, i.e. it does not provide for guarantees that can be directly deduced from the Constitution. [Decision 22/1995 (III. 31.) AB, ABH 1995, 108, 113; Decision 2/2000 (II. 25.) AB, ABH 2000, 25, 33]

According to the Decision of the Constitutional Court "…in the field of the statutory regulations pertaining to the enforcement of terminally ill patients' right to self-determination, there is no boundary determined once and for all between unconstitutional and constitutional measures; the level of knowledge, the state of development, i.e. the advanced or underdeveloped nature of the individual institutions, and a range of other factors may influence the evaluation of the constitutionality of this issue." (point V.3)

In my opinion, it necessarily follows from the right to human dignity granted in Article 54 para. (1) of the Constitution – and more specifically, from the right to self-determination as interpreted in the practice of the Constitutional Court – that the law must allow passive euthanasia (the right of refusal). In the absence of that, an unconstitutional omission of legislative duty should have been established on the basis of the practice of the Constitutional Court. A broader interpretation of the right to self-determination aimed at ending one's life with dignity depends on the discretion of the legislature concerning the objective obligation of the State to protect life as well as the extent, limits and contents of that obligation. The present constitutional justification of the right to self-determination, setting its limits, does not preclude the potential constitutionality of a – *pro futuro* – wider interpretation of this right with appropriate guarantees. The constitutional concept of the right to self-determination may not be limited to the relation between the "active" conduct of the party exercising self-determination and the "passive" conduct of the party affected by the disposal. It follows form the interpretation by the Constitutional Court of the constitutionality of the mother's right to self-determination [Decision 48/1998 (XI. 23.) AB, ABH 1998, 333] that the legal relation based upon the right to self-determination, i.e. the "disposal" can induce not only passive conduct by the other party, but also active assistance by the physician. (The constitutionally acknowledged right to self-determination of a mother who wishes to undergo abortion results in an expressly active medical intervention.)

The evaluation "not unconditionally unconstitutional" is accepted in the practice of the Constitutional Court. [Decision 995/B/1990 AB, ABH 1993, 515, 523; Decision 35/1991 (X. 23.) AB, ABH 1991, 266, 268; Decision 57/1995 (IX. 15.) AB, ABH 1995, 284, 286] As referred to in several decisions of the Constitutional Court, it is within the discretion of the legislature to extend the scope of regulation in the direction of "potential constitutionality". Consequently, provisions not unconditionally unconstitutional may be regarded – with regard to *pro futuro* rules – as belonging to the potential realm of constitutional regulation. The

present constitutional limits of the right to self-determination aimed at ending one's life with dignity (the claim that an unconstitutional omission has occurred being rejected) does not preclude the possibility and does not entail the unconstitutionality of a potential broader interpretation of the right to self-determination in the future. It is up to the legislature to decide on that.

II

1. I do not agree with points 3 and 6 of the holdings and with the related reasoning in the Decision. The statutory provisions referred to, together with the closely related provisions of the GD, should have been annulled.

2. In addition to defining the guarantees of a controlled (democratic) exercise of public authority, it is an important function of the Constitutional Court to secure the fundamental legal conditions for one's self-definition and way of life in line with his individual conviction. Declaring (guaranteeing) fundamental rights serves the purpose of preserving human dignity. This is how the right to human dignity becomes part of the essence of all other (fundamental) rights.
It follows from Article 54 of the Constitution that self-realisation, self-evaluation, and in particular making decisions about one's own life are the most personal rights of everyone. The inner conviction that drives this process is part of human dignity – a realm that may not be under the authority of the State or any other forcing power: it is the untouchable essence. This is what follows from the unity and the inseparability of the right to life and the right to human dignity.

The absolute contents of human dignity are embodied in the equal dignity of all people [Decision 35/1995 (VI. 2.) AB, ABH 1995, 163, 166]. The right to self-determination derived from the absolute and unrestrictable right to human dignity [Decision 8/1990 (IV. 23.) AB, ABH 1990, 42, 45] must be enforced with different emphases and roles to play, depending on its contents.
The weight and the role of the right to self-determination are determined by the orientation of its contents. For example, the right to the freedom of marriage [Decision 19/1992 (I. 30.) AB, ABH 1992, 115.], the right of disposal related to the party's participation in litigation [Decision 22/1992 (IV. 10.) AB, ABH 1992, 122.], and the right of disposal related to

prevailing in litigation [Decision 4/1998 (III. 1.) AB, ABH 1998, 41] reflect a role and weight in the enforcement of the right to self-determination different from those of the right to self-determination aimed at ending one's life in a dignified way.

Similarly to the special treatment of the right to the freedom of expression, due to its prominent role, in the case of the right to self-determination aimed at ending one's life in a dignified way – having the same prominent role – the Constitutional Court has to take account of the standard applied in the former case: the Acts restricting this right have to be "interpreted strictly". [Decision 30/1992 (V. 26.) AB, ABH 1992, 167, 178] It is in this context that I hold it necessary to interpret the protection, as per Article 8 para. (2) of the Constitution, of passive euthanasia acknowledged in Act CLIV of 1997 on Healthcare (AH), as the right to self-determination aimed at ending one's life with dignity.

3. Passive euthanasia, the refusal of life-supporting care, is a constitutionally justified realm of the right to self-determination aimed at ending one's life in a dignified way (hereinafter: the right to self-determination). In a broader sense, the right to self-determination also means choosing between the exercise of the right of refusal or asking for life-supporting care. The evaluation of the loss of dignity entailed by maintaining life is part of one's right to self-determination.

Therefore, the fundamental question is whether or not the State respects the essence of the right to self-determination, i.e. whether it restricts this right only to the extent necessary and proportionate. In order to be able to decide upon the above from the point of view of the State's obligation to protect life, one has to clarify the contents of the obligation of the State to protect life in the case of the above-mentioned form of passive euthanasia:

a) guaranteeing the enforcement of the right to self-determination in order to establish a legal framework in which self-determination can be exercised independently from any external influence (by any other person) (in order to prevent potential abuse), or

b) the obligation of the State to protect life is more than that: the obligation of the State to protect life should form a counterweight against self-determination.

4. The constitutionality of restricting the right to self-determination is to be examined on the basis of the test of "necessity" and "proportionality" elaborated by the Constitutional Court.
The aspect of objective institutional protection in the case of the right to self-determination is – according to the Constitutional Court's interpretation [Decision 64/1991 (XII. 17.) AB, ABH 1991, 297, 302-303] – the obligation of the State to protect fundamental rights, directed at securing the actual enforcement of the fundamental right (the right to self-determination), since here, it is not against others that one's life is to be protected. The State has to ensure the conditions guaranteeing the enforcement of this right and the prevention of potential abuse in order to ensure that it indeed be the person concerned who disposes over the last stage of his life.

The procedure of passive euthanasia as regulated in the AH, i.e. the provisions referred to in the Decision, restrict unnecessarily and disproportionately the right to self-determination of terminally ill patients concerning the refusal of life-supporting treatment:

a) Section 20 para. (3) of the AH provides for the right of refusal in the case of seriously ill patients whose illness is terminal and expected to lead to death within a short period of time. The term "within a short period of time" is a vague concept that can lead to problems of interpretation and to arbitrary interpretation as well. The Constitutional Court has already interpreted in several of its decisions the requirement of the clarity of norms to be an essential part of legal certainty stemming from the rule of law declared in Article 2 para. (1) of the Constitution. [Decision 11/1992 (III. 5.) AB, ABH 1992, 77, 84; Decision 26/1992 (IV. 30.) AB, ABH 1992, 135, 142]
In addition to the problems of interpretation, the provision referred to above results in excluding from the scope of exercising the right to self-determination those patients who suffer from great pains in a terminal illness that leads to death. (The development of medical science, as hoped for, which is, beyond doubt, a possible cause of terminal illnesses becoming curable, should not be taken into account from the aspect of the constitutional contents of the right to self-determination, since the time-frame of the expected results is insecure.)

b) According to Section 20 para. (4) of the AH, the legislature automatically raises doubts about the patient's capacity for judgement by requiring the active role of a medical committee of three members in the form of an examination, despite the patient's making a written declaration on refusal (in line with the provision under Section 20 para. (2) of the

AH). The automatic questioning of the patient's capacity for judgement is also reflected in the above-mentioned statutory provision stating that refusing to undergo examination by the committee shall invalidate the former declaration on the refusal of medical care, i.e. the patient's right of disposal [Section 20 para. (2) of the AH]. If the unanimous decision of the medical committee verifies compliance with the statutory criteria [Section 20 para. (3) of the AH], the patient has to repeatedly declare his intention of refusal in the presence of two witnesses on the third day following the statement by the medical committee. Instead of statutorily providing for the mandatory role of the committee, it would be satisfactory to make it dependent on the statutory condition of "in the case of doubt" about the patient's capacity for judgement, which would be a necessary and proportionate restriction of the right to self-determination, which is not the case under Section 23 para. (1) of the AH, to be detailed later on.

However, requiring the patient to make a subsequent repeated declaration is an unnecessary restriction of the right to self-determination.

c) The constitutionality of Section 20 para. (7) of the AH has not been challenged by the petitioner. It is the consistent practice of the Constitutional Court [Decision 3/1992 (I. 23.) AB, ABH 1992, 329, 330; Decision 25/1993 (IV. 23.) AB, ABH 1993, 188, 193; Decision 10/2001 (IV. 12.) AB, ABH 2001, 123, 149] to include in the constitutional review those provisions as well that have a close relation with the contents of the challenged statutory provisions. According to the paragraph (7) referred to above, even if the patient's refusal complies with all statutory conditions, "an attempt is to be made" to change his decision. This provision essentially ignores the patient's right to self-determination, not regarding it as a constitutional fundamental right; in fact, it qualifies as a restriction of the essence of this right, and thus it is unconstitutional.

d) Section 23 para. (1) of the AH is also a statutory relativisation of the contents of a fundamental right, as it, with reference to Section 20 para. (3), specifies a criterion that allows abstract and vague interpretation, providing for the enforcement of the right to self-determination in compliance with the statutory provisions in question only "if the patient's will to that effect can be established clearly and convincingly. In case of doubt, the declaration made by the patient later must be taken into account."

The first sentence of the above-mentioned statutory provision is a serious restriction of the right to self-determination. Compliance with the procedural rules specified in the AH (which does not equal constitutionality!) is to guarantee that the declaration of will is made "clearly and convincingly" as intended by the Act. The provision concerned relativises this procedure by "setting it aside" and starting it again.
The second sentence is difficult to interpret as the patient may withdraw his declaration at any time. [Last sentence in Section 20 para. (4) of the AH]

5. In summary:

The above-mentioned provisions of the AH do unnecessarily and disproportionately restrict the right to self-determination aimed at ending one's life with dignity by forming a significant counterweight not justified constitutionally, and this way, the essence of that right is emptied.
The objective life-protecting obligation of the State (the concept of the AH) is to be aimed at acknowledging the right to self-determination – without external pressure and with the constitutionally required restrictions – as a real right, through the legal procedure ensuring its enforcement.

In view of all the above, the unconstitutional paragraphs (3), (4), and (7) in Section 20 of the AH should have been annulled *pro futuro*, together with Section 20 para. (1) in respect of its reference to the unconstitutional paragraph (3). Similarly, the provisions of the GD, not unconstitutional in all respects, as referred to in point 6 of the holdings in the present Decision, should have been annulled in respect of the implementation of the provisions of the AH that I hold unconstitutional.

According to the permanent practice of the Constitutional Court, provisions not deemed to be unconstitutional but related closely to unconstitutional provisions are to be annulled, too, if the remaining statutory provisions would in themselves lose their regulatory function. In such cases, the field of law under review is to be re-regulated in a complex manner, due to the nullification of unconstitutional and not unconstitutional rules, in compliance with the constitutional requirement that follows from Article 2 para. (1) of the Constitution. [Decision 33/1990 (XII. 26.) AB, ABH 1990, 191, 196; Decision 16/1995 (III. 13.) AB, ABH 1995, 464, 466]

Budapest, 28 April 2003

Dr. András Holló
Judge of the Constitutional Court

I concur with the concurring reasoning and dissenting opinion.

Dr. István Kukorelli
Judge of the Constitutional Court

In witness thereof:

Dissenting opinion by Dr. Mihály Bihari, Judge of the Constitutional Court

I do not agree with point 3 of the holdings in the Decision of the Constitutional Court, rejecting the petitions aimed at the establishment of the unconstitutionality of the restriction in Section 20 paras (3) and (4) of Act CLIV of 1997 on Healthcare (hereinafter: the AH) of the right to self-determination of terminally ill patients in respect of refusing life-saving or life-supporting medical interventions.

In connection with the above, I do not agree with the Constitutional Court rejecting, in point 6 of the holdings of the Decision, the petitions aimed at the establishment of the unconstitutionality and the annulment of Section 3 para. (3) of Government Decree 117/1998 (VI. 16.) Korm. on the Detailed Rules of Refusing Certain Forms of Medical Care (hereinafter: the GD).

In my opinion, the provision in Section 20 para. (3) of the AH according to which a life-saving or life-supporting intervention may only be refused if the patient suffers from a "terminal" illness expected to lead to death "within a short period of time" is unconstitutional in respect of the two quoted expressions. Article 54 para. (1) of the Constitution declares that "every human being has the inherent right to life and to human dignity, of which no one shall be arbitrarily deprived." It has been established by the Constitutional Court in several of its decisions that the fundamental right to human dignity results in one's right to self-determination. Article 8 para. (2) of the Constitution provides that "regulations pertaining to fundamental rights and duties are determined by law; such law, however, may not restrict the basic meaning and contents of fundamental rights." In my opinion, the above-mentioned two

parts of the text of Section 20 para. (3) of the AH qualify as a restriction of the essence of the right to self-determination and, therefore, they are unconstitutional.

For the same reason, similarly unconstitutional are the provisions in Section 20 para. (4) of the AH, according to which the refusal of life-saving or life-supporting treatment is only valid "if a committee composed of three physicians has examined the patient and made a unanimous, written statement to the effect that the patient has taken his decision in full cognizance of its consequences […], furthermore if on the third day following such statement by the medical committee, the patient repeatedly declares his intention of refusal in the presence of two witnesses." Consequently, similarly unconstitutional is Section 3 para. (3) of the GD adopted for the implementation of the AH, according to which it is necessary to have the declaration by the committee consisting of three members in order to allow the patient to refuse life-saving or life-supporting treatment. The physician specialising in the field corresponding to the nature of the illness who is the member of the committee verifies that the patient's illness is terminal, leading to death within a short period of time, and the psychiatrist member of the committee establishes whether the patient is in possession of the capacity for judgement necessary for making such a decision. The Constitutional Court should have established the unconstitutionality of the relevant statutory provisions, and should have annulled them.

I accept point 1 of the holdings, but in my opinion, it would have been more exact for the purpose of setting the constitutional limits to categorically reject requested active euthanasia – as opposed to what is requested in the petition – in point 1 of the holdings in the following way: "The Constitutional Court rejects the petition claiming that Act CLIV of 1997 on Healthcare restricts in an unconstitutional way the right to self-determination of terminally ill patients by not allowing the termination of their lives through their physicians' active intervention and assistance."

I

The relation between the right to self-determination stemming from human dignity and euthanasia

The petition calls for the interpretation of a realm of the right to self-determination as part of the right to human dignity granted in Article 54 para. (1) of the Constitution that has not been dealt with so far in the decisions of the Constitutional Court.

The right to human dignity – and the right to self-determination as part of that – includes the right of the patient to refuse any medical care – including even life-supporting and life-saving care. I fully agree with this statement made in the Decision.

It has already been stated by the Constitutional Court in its earlier decisions that one's right to life and human dignity is an absolute right that is absolute and unrestrictable as a determinant of one's human status and in its unity with life. Consequently, the component rights deduced from this mother right, such as the right to self-determination, may be restricted in accordance with Article 8 para. (2) of the Constitution just like any other fundamental right. [Decision 75/1995 (XII. 21.) AB, ABH 1995, 376, 383]

One's rights to life and human dignity are enjoyed in unity and absolutely by the subject of these rights, i.e. they are unrestrictable. It follows from the absoluteness of the rights to life and to dignity that their restriction to any extent is unconstitutional – not only if it affects the essence of a fundamental right. Restrictions not affecting the essence of other fundamental rights are only constitutional if they are necessary and proportionate with regard to the enforcement of another fundamental right.

With regard to the rights to life and to dignity having absolute (unrestrictable) contents, it is not only the case that it is conceptually impossible to apply the limitation defined in Article 8 para. (2) of the Constitution, i.e. a constitutionally approved restriction, for the purpose of protecting the essence, but it is also impossible to set "another" fundamental right against the rights to life and to human dignity, based on which the rights to life and to human dignity could be restricted.

However, the concrete rights deduced from the rights to life and to human dignity may be constitutionally restricted.

The right to life cannot be broken down into so-called concrete life-rights or life-contents. The unity of the right to life is indivisible and indissoluble. In any specific social relation, the right to life may only be interpreted and enforced in its own unity and completeness. The constitutional protection of human life is enjoyed in its unity, without any restriction, by all people until the moment of death.

However, the right to human dignity exists in the form and is the aggregate of many – in principle uncountable – specific rights. The fundamental rights deduced from the right to human dignity, such as the patient's right, deduced from the right to self-determination, to refuse life-saving, life supporting, or any other treatment, are to be judged in terms of their own concreteness with regard to whether the restriction complies with the requirements set

out in Article 8 para. (2) of the Constitution as well as with the requirements of necessity and proportionality, moreover, whether the restriction is applied in the interest of enforcing another constitutionally protected fundamental right.

To sum up, I deem that while the right to life only exists in its indivisibility and unrestrictability, the abstract right to human dignity is the aggregate of concrete separable fundamental rights. The restriction of concrete component rights comprising human dignity can be accepted as constitutional if it is in line with the Constitution, if it is of an extent absolutely necessary and proportionate, and if it serves the purpose of protecting another fundamental right.

In relation to the petition, in the present case, the subject of the constitutional review can be the meaning – in general terms and in the manifested concrete forms – of human life and human dignity as a constitutional and unrestrictable right enforced and to be enforced in unity. In my opinion, the right to human life does not mean, and cannot be interpreted so as to mean, an obligation to live either a dignified or an undignified human life, or to extend human life – by means of various medical treatments – despite the patient's express will to the contrary. Turning the right to human life into an obligation to live is a restriction of the right to self-determination, more specifically, a restriction of the very essence thereof. Such restriction is unconstitutional on the ground of violating Article 8 para. (2) of the Constitution specifying that fundamental rights may only be restricted in Acts of Parliament and without affecting the essence of the right concerned.

Thus, a human being may not be obliged to live a life deemed either "dignified" or "undignified"; the obligation of the State to protect life should not be so strong and of the extent as to restrict one's liberty and right to self-determination by prohibiting the right of humans to end their lives. The above argument is also supported by the "freedom" to commit suicide, i.e. a person committing an unsuccessful suicide attempt is not punished for the attempt, and his act has no other negative legal consequences.

As one may not be forced to live a "normal" (healthy and happy) life, nor may one be forced to continue a life in which he loses his dignity by becoming completely defenceless, powerless, and unable to care for himself, and in which he has to face pain, agony and suffering that are almost unbearable. A life filled with suffering and defencelessness may be a life without human dignity for the individual. The individual may not be forced to "live" such a life or to "live it on" based on the extension of his life by means of continuous medical treatment, and the patient is free to refuse the lengthening of such a life without dignity for

him.

No objective borderline can be set between life with and without dignity for humans. It is within the concrete individual's subjective evaluation process to decide what kind of life he deems to be dignified for himself and what he considers to be without dignity. This is to be decided in the individual's subjective and absolute discretion, and only he may decide what form, kind or contents of life, or what extent of suffering, defencelessness, powerlessness, inability to care for himself etc. he refuses as undignified human life for him, resulting in a will not to live on.

Preventing the natural course of death by life-supporting or life-saving treatment despite the patient's will means obliging the person to live a life deemed undignified by him, i.e. it is a serious violation of the individual's right to self-determination, leading to an unconstitutional restriction.

It is a further element of the right to self-determination stemming from human dignity granted under Article 54 para. (1) of the Constitution that the rights to life and to dignity include not only the right to accept life but also the right to end life and the right to make a choice about such an end, including the choosing of the manner or the time of ending life. Thus, making a choice about ending one's life is part of the right to human life and dignity. As it is an absolute right, it follows from the nature of legal relations of absolute structure that the individual's right stemming from such self-determination – i.e. the right to end one's life freely – is to be respected by everyone. Therefore, everyone must refrain from keeping someone alive with life-saving or life-supporting intervention against the patient's express will to the contrary, and if the patient wishes to accept the natural course of death, then this will – resulting from the his self-determination – has to be accepted by everyone. Similarly, everybody must acknowledge and accept the will and the right to self-determination of any person who is not ill but wants to die for any other reason, e.g. love distress, losing limbs etc.

An individual's relation to himself is the most personal relation, where he enters into a contact of intellectual evaluation and analysis, and into an emotional relation with himself. The conscious relation of the human being to himself is – in its entirety – absolutely autonomous and free. The individual's emotional, intellectual, and evaluatory relations to his own life, quality of life and the acceptability of that life are part of the above absolutely free self-evaluatory relation. The joint and interrelated evaluation of one's life and death is the most personal realm of an individual, which is to be most respected, and it is protected by the law to the greatest extent. One's right to self-determination in respect of making a decision about

one's own life and death is part of the above "self-consciousness" manifested in concrete acts as well. One's right to self-determination is manifested in his decisions – including the ones about his life and death.

The freedom of making a decision about one's own life and death is an unrestrictable and essential part of the right to self-determination. It is included in the freedom of making a decision stemming from the above right to self-determination that both a healthy person and a – perhaps terminally – ill patient may decide when and how he chooses to die or accepts the natural course of death. Similarly, it falls into this realm to decide upon what one considers to be a life with an acceptable degree of suffering and what kind of life he deems to be one without dignity (i.e. full of complete defencelessness, inability to care for oneself, suffering, agony and pain), justifying his will not to live on. Therefore, in such a case, one does not choose death, but refuses human life filled with suffering and without dignity, and he refuses to "be obliged" to continue living such an undignified human life, and to be dependent on the decision of another person (physician, nurse, relative etc.) in respect of the continuance/length of the life deemed undignified by the individual. One's refusal to continue an undignified life full of suffering and helplessness is based on his freedom resulting from his human dignity and right to self-determination, whereby he refuses to accept life-supporting or life-saving treatments preventing the natural course of death. It is completely within the individual's judgement when he considers his life to have reached an unacceptable phase where it is without human dignity. It is also part of the right to self-determination to decide what period, form or way of life he accepts as dignified and what he refuses as undignified or unbearable for him.

One may choose to have such – for him undignified – life lengthened by artificial means over and over again, but he may also opt for refusing such life, i.e. the form and period of life that means for him no human dignity, but only helplessness. Therefore, in this case, the emphasis is on refusing a certain kind of life and not primarily on choosing death. The frequently heard reference to choosing between life and death is incorrect, as a terminally ill patient's choice is not simply between life and death, but he has to choose between two kinds of life: undertaking to continue a life full of grave sufferings, or not undertaking to live such a life.

The right to self-determination originating from human dignity – in the case of both healthy and ill persons – encompasses not only the free decision to choose death, but also refusing to continue living a life deemed undignified by the individual, or the shortening of the period of living on, thus allowing death to take place. This choice can be deduced from the right to self-determination that forms part of the right to human dignity granted in Article 54 para. (1) of

the Constitution, and it follows from the provisions of the AH allowing the patient to refuse life-saving or life-supporting treatment. This freedom of choice is basically ensured at present by the provisions of Section 20 of the AH.

However, the freedom of refusing life-supporting or life-saving treatments does raise a constitutional problem, resulting from the entry of another person (the physician) into the above relational system, who is bound by the rules of his profession and by his oath to cure the patient or – in the case of a lethal illness – to provide life-supporting or life-saving treatment up to the moment of death. Thus there is a conflict between the will of the patient refusing life-supporting or life-saving treatment and the physician's obligation to provide medical care. The relevant conflict emerges not between two rights (the patient's and the physician's right), but between the patient's right of refusal stemming from his right to self-determination and the physician's legal, professional and moral obligation – binding the physician on the basis of his oath. The conflict can only be solved in a constitutional manner if the physician's professional obligation "retreats", letting ground for the patient's right of refusal stemming from his right to self-determination. In the case of such a conflict between a right and an obligation, the priority of the constitutional right is to be ensured, and thus the physician has to accept the patient's will originating from his right to self-determination, i.e. the refusal of life-saving, life-supporting or any other treatment. The physician is obliged to keep on supplying analgesics and other necessary treatments to the patient, but he has to let death occur naturally, i.e. he may not postpone death or slow it down by providing life-supporting or life-saving treatment. In the above relation, this is an obligation of the physician, and this obligation makes the physician a special participant in passive euthanasia. However, the latter aspect raises no constitutional concerns, as in that case the patient's right to self-determination prevails over performing the physician's professional medical obligation. This way, the physician becomes an "escort" on the way to death, i.e. a passive participant thereof, only by not supplying life-saving or life-supporting treatment, thus – in accordance with the patient's will – letting the physiological process leading to death follow its natural course.

The AH currently in force basically models and regulates the above life-situation. The need for the inclusion of provisions on the physician in the legal regulation and the fact that the requirement of the physician's passive conduct is to be treated and regulated together with the patient's constitutional right to self-determination is the result of the conflict between the patient's right to self-determination and the physician's obligation to cure and provide care for

the patient (the physician is bound to try to sustain or save life even if there is no chance for cure). This is also important because immunity for the physician in relation to his failure to perform his professional obligations is to be granted on the above basis.
Nevertheless, one should note that the physician may not be obliged, either, to take part in passive euthanasia if he does not want to do so; the physician may refuse – on moral or professional grounds – to terminate life-supporting or life-saving treatment in the case of a particular patient despite the patient's firm and clear request to the contrary. In this case, the physician should be allowed to leave the process of treatment and let another physician – or a relative or other person – become involved in the process which leads to death. Thus, in the case of passive euthanasia, the physician may not be obliged to perform even such passive conduct if he cannot accept it for reasons stemming from conviction, morals or professional ethics, and he should be allowed to leave the relation, and to terminate, on his part, treatment and care of the patient. Then the treatment of the patient is to be assigned to another physician if and when it is necessary to have a physician for the further treatment of the patient, and the physician leaving the treatment process may not be held responsible for the patient's future treatment. The physician taking over the patient's treatment shall be the one who passively accompanies the patient on his way to death, he shall be responsible for controlling the patient's pain and for providing other medical care, but he must refrain from performing life-saving or life-supporting treatments, due to the priority of the patient's right to self-determination.

However, the situation is different with regard to the physician's role and position in the case of active euthanasia based on the patient's self-determination and requiring at the same time the physician's active conduct as well. In active euthanasia, although at the patient's definite request, the physician has to act actively in facilitating death. In my opinion, this is the point where the constitutional division line can be set, as here the patient's right to self-determination extends beyond disposing over his own life (deemed to be without dignity) and another person becomes involved in the performance of the patient's decision: a physician or other person (medical staff member or relative). In this case, the physician not merely allows death to come its natural way, but facilitates it, i.e. hastens death and shortens the life considered by the patient to be undignified. The patient's right to self-determination cannot be extended to that, i.e. it cannot be aimed at obliging any person – either a physician or other person – to perform an active death-inducing act. As the patient's right to self-determination does not include the latter, this is the point where the division line is to be set between passive

euthanasia based on self-determination, as a constitutional phenomenon, and active euthanasia based on self-determination, as an unconstitutional event beyond the realm of the patient's right to self-determination.

This is where the constitutional standard and borderline can be found. This is why I do not agree with the petitioners requesting the establishment of the constitutionality of not only passive euthanasia, but also of active euthanasia performed with the active assistance of a physician or other person, on the basis of the patient's self-determination, since in the latter case, exercising the right to self-determination would oblige another person (subject of law) to act actively in, i.e. contribute actively to the process of facilitating death. However, no one may be obliged to do that, and no one may be exempted from the consequences thereof with reference to another person's right to self-determination.

Thus, the summary of my position is that the patient's right to self-determination to refuse life-saving or life-supporting treatments does not include the right to oblige the physician or another person to act actively in causing death. Nor does the patient's right to self-determination constitute due justification for granting exemption from criminal law liability to any person who has actively facilitated death.

II

Setting the constitutional limit and definition of the various types of euthanasia

The Decision of the Constitutional Court refrains from defining the concept of euthanasia either by description or by concrete definition, and similarly it does not differentiate among the various possible types of euthanasia. Although there are two typologies used by the petitioners, which can be subject to debate, this is not the reason why it is necessary – in my opinion – to give a definition of euthanasia together with its types: the reason is that the Constitutional Court has to set the borderline of constitutionality among the various types of euthanasia. This delimitation is only possible if the concept of euthanasia is well-defined, and the particular types of euthanasia are distinguished on the basis of (probably more than one) definite criteria.

1. The concept of euthanasia

Not all forms of choosing death fall into the category of euthanasia, as we call it not euthanasia but (for example) suicide when a healthy person or a person whose illness is not terminal chooses death. According to science, the literature of sociology, ethics and medical sciences, euthanasia is defined in general as choosing death, or the inducement of death, by a terminally ill patient or a patient whose illness results in significant suffering, restricting human dignity, and almost leading to an undignified human situation. Choosing death can be manifested in one's request not to have his life filled with suffering and pain and considered by him to be undignified extended by artificial means, and to be let die. The concept of euthanasia also includes the inducement of death (before it would occur naturally) by the active conduct of the patient himself or with the assistance of someone else, on request by the terminally ill patient, instead of waiting for the natural occurrence of death.

2. The basis of the typology

When differentiating between the various types of euthanasia, the first criterion is *whose decision* the death-wish, the death-choice, or the will to end the life, deemed undignified, of the person concerned – in the situation of life described above – is based upon. The second criterion to be examined is *who participates by what conduct* in performing the patient's will or intention. On the basis of the above, four essential types of euthanasia can be distinguished:

a) Passive euthanasia based on the patient's *self-determination*. In this case, the decision is made by the patient, and the contributing physician's or other person's conduct is passive, i.e. limited to not providing or performing life-saving or life-supporting treatment.

b) Active euthanasia based on the patient's *self-determination*. In this case, too, it is the patient who makes a decision about not wanting to keep on living a life considered by him to be without dignity, but death can only be induced by the expressly active conduct of someone else – the physician, a relative or other person.

I hold that the constitutional division line lies between the above two types of euthanasia. Active euthanasia based on self-determination is – as set out above – beyond the scope of the patient's right to self-determination based on Article 54 para. (1) of the Constitution, since it involves another person in the procedure by forcing or authorising him to act actively in

inducing death. In my opinion, the latter cannot be deduced from the patient's right to self-determination, and no immunity can be granted for the person involved in actively inducing death. Neither a physician, nor any other person may be obliged or authorised to engage actively in inducing death, and granted immunity upon such contribution to death.

c) Passive euthanasia *based on another person's decision*. In this case, it is not the patient who makes the decision, but it is the physician or other person who detects the terminal nature of the illness or the unbearable extent of the sufferings, and this external person is the one who decides upon terminating or ceasing the life-supporting or life-saving treatment. Here, the decision is made not by the patient, but by someone else instead of him – with or without him knowing about that. In this case, the "activity" is manifested in passivity, by letting the physiological processes leading to death follow their natural course, and by terminating life-saving or life-supporting treatment. The unconstitutionality of this type of euthanasia is due to the fact that it is not the patient who decides upon ending life or refusing life considered by him to be undignified, but another person instead of him, and this person might also be a physician who otherwise would be obliged – on the basis of both the AH and his professional-ethical-moral commitments – to continue life-saving or life-supporting treatment even if the illness is – according to the state of medical knowledge at the given time – terminal, and there is no hope for curing the patient. The physician's decision actually violates his obligation to provide treatment and care for the patient, and thus he must be liable for the consequences without immunity. The above type of euthanasia is unconstitutional and unacceptable.

d) Active euthanasia *based on another person's decision*. In this case, too, it is not the patient but another person who decides upon terminating life-supporting or life-saving treatment and, in addition, this person hastens death by active conduct, in fact, he induces death. Active euthanasia based on another person's decision is – in line with the above reasoning – unconstitutional and unacceptable.

Table of the various types of euthanasia

		Decision	**Activity**

Based on self-determination	**passive euthanasia***	the patient decides	passive: terminating or not starting life-saving or life-supporting treatments
	The constitutional limit deducible from the right to self-determination granted in Article 54 para. (1) of the Constitution can be drawn here		
	active euthanasia	the patient decides	active: facilitating death by active conduct or intervention
Not based on self-determination	**passive euthanasia**	not the patient decides	passive: terminating or not starting life-saving or life-supporting treatments
	active euthanasia	not the patient decides	active: facilitating death by active conduct or intervention

* Including cases when, instead of a person with no or limited disposing capacity, another person decides on refusing life-saving or life-supporting treatment on the basis of the patient's declaration made in the past in accordance with Section 22 of the AH. The patient exercised his right to self-determination earlier when he refused in general all treatments that would force him to continue a life deemed (by him) undignified by preventing the natural course of the terminal illness. What the deputy decision-maker specified by the patient [Section 22 para. (2) of the AH] decides is whether the actual situation of life is one that would be deemed by the patient to be unacceptable for himself due to its inhuman and undignified nature, and therefore whether he should refuse – on the basis of the earlier authorisation by the patient – life-supporting or life-saving treatments on the patient's behalf.

There are other acts partly related or similar to euthanasia (e.g. the problem of the so-called "mercy killing", or the statutory definition in criminal law of assistance in suicide). It is not the subject of the present dissenting opinion to define them in detail, or to distinguish them from euthanasia. With respect to such other acts, I agree with the decision and the arguments contained in the Decision.

III

Constitutional and unconstitutional limitations upon the right to self-determination in the AH and the GD

1. The procedure of refusing life-supporting or life-saving treatments is regulated by the AH

and the GD issued to implement it as follows:

a) According to Section 20 para. (3) of the AH, the patient may refuse life-saving or life-supporting intervention (in order to allow the illness to follow its natural course) in the following cases:

– the patient suffers from a serious illness which, according to the state of medical knowledge at the given time, will, *within a short period of time* and despite adequate healthcare,

– *lead to death* and

– which is *terminal*.

b) When the patient wishes to exercise his right to refuse medical care, and he refuses life-supporting or life-saving treatment, he has to be informed again on the expected consequences of his decision (omission of the intervention), and on the conditions of exercising his right. In the event of refusing care, an attempt shall be made to identify the reasons underlying the patient's decision through a personal discussion and to alter the decision. [Section 20 para. (7) of the AH, Section 2 para. (1) of the GD]

c) If the patient maintains his original intention, the statutory conditions necessary for exercising his right have to be secured without delay. Arrangements must be made in order for the patient to be able to make the declaration in compliance with the relevant formal requirements. [Section 2 para. (2) of the GD]

d) A person with full disposing capacity may refuse such treatment in a public deed or a private deed of full probative force, or – if he is incapable of writing – by declaration in the presence of two witnesses. [Section 20 paras (2) and (3) of the AH]

e) The head of the medical institution or a person designated by him shall arrange for convening without delay a committee consisting of three members. The members of the committee are the patient's attending physician, one physician specialising in the field corresponding to the nature of the illness who is not involved in the patient's treatment, and one psychiatrist. [Section 20 para. (5) of the AH, Section 3 para. (1) of the GD]

f) The physician member of the committee verifies that the patient's illness meets the criteria set out in Section 20 para. (3) of the AH, and the psychiatrist member of the committee establishes whether the patient is in possession of the capacity for judgement necessary for making such a decision. When assessing the patient's capacity for judgement, the patient shall be heard in all cases, and the relative of the patient shall be heard if possible. [Section 3 paras (2) and (3) of the GD]

g) The refusal shall only be valid if a committee composed of three physicians has made a unanimous written statement to the effect that the patient has taken his decision in full

cognizance of its consequences, and that the conditions specified in Section 20 para. (3) of the AH exist, and

h) on the 3th day following the statement by the medical committee, the patient repeatedly declares his intention of refusal in the presence of two witnesses. [Section 20 para. (4) of the AH]

i) In this case, the refused care shall be terminated, or it shall not even be started. [Section 3 para. (4) of the GD]

j) The patient may withdraw his statement regarding refusal at any time and without any restriction upon the form of withdrawal. [Section 20 para. (8) of the AH]

k) A female patient may not refuse a life-supporting or life-saving intervention if she is pregnant and is considered to be able to carry the pregnancy to term. [Section 20 para. (6) of the AH]

l) The patient's declaration on refusal is deemed void if he refuses to be examined by the committee consisting of three members, or if the committee establishes that the conditions specified in Section 20 para. (3) of the AH are not meet. [Section 20 para. (4) of the AH]

m) If the three-member committee has not established the validity of refusing the life-supporting intervention, the patient and the deputy decision-maker may file a claim at the court in order to have a court ruling establishing the validity of refusing the life-supporting intervention. [Section 7 para. (1) of the GD]

n) The patient has the right to repeatedly refuse the life-supporting intervention if the committee has not established the validity of refusing the life-supporting intervention. [Section 7 para. (2) of the GD]

The procedures started on the basis of the patient's valid declaration made in the past in accordance with Section 20 para. (1) of the AH, or on the basis of a declaration by the deputy decision-maker named in accordance with Section 20 para. (2) of the AH, partly differ, as appropriate, from the procedure described above.

2. In my opinion, in the present case, what is of constitutional relevance is whether or not the statutory provisions under Section 20 paras (3), (4), and (7) of the AH currently in force, as well as certain provisions – in particular Section 3 para. (3) – of the GD for the implementation of the relevant provisions of the AH are compatible with the right to self-determination deducible from human dignity granted in Article 54 para. (1) of the Constitution. One has to examine whether or not these statutory provisions restrict the essence

of the right to self-determination, and if the restriction is not related to the essence of the fundamental right, whether it complies with the requirements of necessity and proportionality. A statutory restriction is constitutional – in accordance with the requirement under Article 8 para. (2) of the Constitution – only if it is necessary for the enforcement of another fundamental right, if it does not restrict the essence of a fundamental right, and if the restriction is in proportion with the desired objective.
The patient's right to refuse life-supporting or life-saving treatments belongs to the essence of the patient's right to self-determination deduced from human dignity. Consequently, it is constitutionally unacceptable to restrict the contents of the right of refusal.
I hold that the vast majority of the rules contained in the statutory provisions referred to above are unconstitutional, as they pose unnecessary and disproportionate obstacles to and restrictions on the enforcement of the right to self-determination deduced from human dignity. In addition, no other fundamental right can be identified the enforcement of which would justify a restriction of the patient's right to self-determination.

3. First, one has to find the restrictions and formal requirements that are not unconstitutional. Then it will be possible to establish that the restrictions beyond the above are unconstitutional, as they either relate to the essence of the right or are unnecessary, or they are necessary but disproportionate.

In my opinion, it is not unconstitutional to provide for certain formal requirements in the AH with regard to the enforcement of the patient's right to self-determination in the scope of refusing life-supporting or life-saving treatments. These requirements are designed to clarify the contents of the patient's will in two respects: on the one hand, it must be verified that the will is truly that of the patient and, on the other hand, that his will is aimed at refusing life-saving or life-supporting treatments. Providing for the use of the forms of public deed or private deed of full probative force commonly used in law is a necessary and adequate tool for the above. Thus, the formal requirements are constitutional if they are aimed at clarifying without any doubt that the patient's will is to have life-supporting or life-saving treatments terminated.

Section 20 para. (2) of the AH contains such constitutional formal requirements: the terminally ill patient's refusal of life-saving or life-supporting medical treatments is to be

made in a public deed or a private deed of full probative force, or – if the patient is incapable of writing – by declaration in the presence of two witnesses.

Such formal requirements ensure not only that the patient's will is verified in a clear and unambiguous way, but also that the patient's will is manifested in a form that has probative force with regard to all external parties.

I hold that such formal requirements are not unconstitutional because of the interest in the verification and the verifiability of the clarity of the patient's will, and in proving the incontestability thereof. The formal requirements not only prove the declaration of the patient's will, but also relieve from professional and legal liability all persons participating in any way in the performance or effectuation of passive euthanasia. The formal requirements not only ensure the immunity of the healthcare staff, but they also verify the clear and incontestable will of the patient – and the declaration thereof – for anyone (including relatives or family members) who might – even subsequently – raise doubts about the patient's will and intention.

As the formal requirements define the framework of the patient's right to self-determination and the form of the manifestation thereof, they do not restrict the essence of the fundamental right, and thus they violate neither Article 54 para. (1), nor Article 8 para. (2) of the Constitution. In my view, the formal requirements defined in the AH are necessary and at the same time satisfactory for verifying beyond doubt the patient's will of refusing treatment.

4. The further conditions and provisions specified under Section 20 paras (3), (4), and (7) of the AH are unconstitutional, as they restrict the essence of the patient's right to self-determination. The unconstitutional restrictions are the following:

a) It is unconstitutional to require that life-supporting or life-saving interventions may only be refused by the patient if he "suffers from a serious illness which, according to the state of medical knowledge at the given time, will lead to death within a short period of time".
I hold that providing for "a short period of time" is unconstitutional, as "a short period of time" is a completely vague legal concept, and therefore requiring it violates the principle of

the rule of law originating from Article 2 para. (1) of the Constitution and the constitutional requirement of the clarity and unambiguity of norms stemming therefrom.

Sensing, identifying or defining "a short period of time" is a completely subjective process. For a person torn by incredible pain and suffering, a few days of further suffering may be felt as an unbearably long period, while another person may tolerate an illness causing exceptionally great pain even for weeks, months or years.

Therefore, providing for "a short period of time" violates, on the one hand, the requirement of the clarity of norms as part of the rule of law defined in Article 2 para. (1) of the Constitution, and, on the other hand, the term "a short period of time" cannot be defined at all in legal terms. Consequently, what follows from the above is not that the legislature should define the period of short time exactly in days or weeks, but that it should not use this criterion in the regulation at all. It is completely within the patient's freedom of discretion to assess the shortness or the length of "a period of short time" filled with pain, suffering, humiliation and defencelessness. The patient should assess what "a short period of time" means for him, and no one may state against this evaluation that the patient can or should tolerate the remaining few (5, 10, 20 etc.) days or hours not considered to be "a short period of time".

In my opinion, no argument may be raised against the patient's subjective evaluation, and therefore the Constitutional Court should have established the unconstitutionality of, and annulled the term "within a short period of time" in Section 20 para. (3) of the AH. The unconstitutionality results not from the legislature's failure to specify exactly (in days, weeks or hours) the period of time, but from the fact that the legislature has applied such a criterion – that falls exclusively into the scope of the patient's subjective evaluation – as a normative condition for the refusal of life-saving or life-supporting treatment.

b) It is also unconstitutional to provide that the patient may only refuse life-supporting or life-saving treatment if his illness is "terminal".

I hold that providing for "terminal" illnesses is unconstitutional because the right to refuse life-saving, life supporting, or any other treatment is to be granted to any person having an illness that seems to be curable, or that can only be cured in many years, or a terminal illness which can be stabilised at a certain level of health (which can also be a near-to-death state). The concept of "being terminal" is a completely vague legal concept, despite the explanation added by the AH that the patient may exercise the right to refuse life-supporting or life-saving treatment in the case of having an illness which is terminal "according to the state of medical knowledge at the given time".

The issue of the curability or terminal nature of almost each and every illness can be – and usually is – the subject of scientific debates.
Consequently, I hold that the Constitutional Court should have established the unconstitutionality of, and annulled the term "terminal" in Section 20 para. (3) of the AH.

c) Furthermore, it is unconstitutional that the committee consisting of three members not only has to examine what illness the patient suffers from, and whether he has made a declaration about refusing life-supporting or life-saving treatment, but it also has to state whether the patient has made the decision about refusing medical interventions in full cognizance of the consequences thereof. On the basis of the above rule, the committee examines and establishes the level of the patient's capacity for judgement – i.e. whether it is full, limited or missing – in respect of the decision on refusing care. On the one hand, this provision is contrary to the provisions of Act IV of 1959 on the Civil Code, and on the other hand, it is unconstitutional to require the examination, by the committee consisting of three members, of the patient's actual relevant capacity for judgement – practically, his disposing capacity – when the patient decides to express his will on refusing life-saving or life-supporting treatment, i.e. choosing passive euthanasia by exercising the right to self-determination.
In the absence of other factors presuming the lack or the limited nature of the patient's capacity for judgement or disposing capacity, the patient may not be forced to prove his capacity for judgement or disposing capacity, and it is seriously objectionable to make the enforceability of the patient's will and self-determination dependent on the declaration by the three-member committee or by the psychiatrist member of that.
The declaration made by the three-member committee can restrict the essence of the patient's right to self-determination; moreover, it can not only restrict, but, in a given case, even prevent the enforcement of the patient's right to self-determination. Consequently, I hold that the present form of the regulation is unconstitutional, and therefore, the Constitutional Court should have established the unconstitutionality of, and annulled the above provision in Section 20 para. (4) of the AH.

d) I also hold it to be an unconstitutional restriction that on the third day following the original declaration, the patient has to repeatedly declare in the presence of two witnesses his intention to refuse life-saving or life-supporting intervention [last but one sentence-part in Section 20 para. (4) of the AH]. In my opinion, this obligation to repeat the declaration of intention and will restricts the essence of a fundamental right. According to the general rule

under Section 20 para. (8) of the AH, the patient may, at any time, withdraw his declaration – i.e. it can be withdrawn in 1 hour, 1 day, 3 days, or 5 days, or at any time – without any limitation or deadline. The right to change his own decision is part of the patient's right to self-determination, but requiring him to repeat the declaration upon three days in the presence of two witnesses is an unconstitutional restriction of the patient's will and intention.
Consequently, the Constitutional Court should have established the unconstitutionality of, and annulled the relevant provision in Section 20 para. (4) of the AH.

e) It is an unnecessary and disproportionate, i.e. unconstitutional restriction of the patient's right to refuse life-saving or life-supporting treatment based on the his right to self-determination, to provide in Section 20 para. (7) of the AH that in the case of refusing such treatments, an attempt shall be made to identify the reasons underlying the patient's decision through personal discussion and to alter the decision. The attempt aimed at altering the decision puts the patient into a situation of debate between him and the physician, although the patient has already made his decision. While making the decision upon short or long consideration, the patient evaluated his own state of health as well as the consequences of refusing the necessary life-saving or life-supporting treatment, and made a choice on the basis of that. Besides, he may withdraw that decision at any time. In my opinion, it is an unconstitutional restriction of the patient's right to self-determination to provide in the AH that the physician is obliged to attempt to alter the patient's decision. Consequently, the Constitutional Court should have established the unconstitutionality of, and annulled Section 20 para. (7) of the AH.

f) As several provisions – and in particular Section 3 para. (3), but also, for example, Section 4 – of the GD deal with the rules on the implementation of those parts of the AH I deem to be unconstitutional, in my opinion, the Constitutional Court should have declared the unconstitutionality of, and annulled the relevant provisions of the GD as well.

To sum up, I acknowledge on the basis of Article 54 para. (1) of the Constitution the right to refuse life-saving or life-supporting treatment as specified in Section 20 of the AH. I hold that the formal requirements on exercising the right to self-determination are not unconstitutional as such formal requirements serve the purpose of verifying the clarity of the patient's will. However, I am of the opinion that requiring conditions in addition to the above, and the provisions hindering and delaying the procedure do restrict the right to self-determination in

an unconstitutional manner. Consequently, in my view, the provisions of the AH and the GD referred to in the present dissenting opinion should have been annulled by the Constitutional Court on the ground of their unconstitutionality.

Budapest, 28 April 2003

Dr. Mihály Bihari
Judge of the Constitutional Court

In witness thereof:

Dissenting opinion by Dr. Árpád Erdei, Judge of the Constitutional Court

1. I agree with points 1, 2, 3, 5, and 6 of the holdings, as well as with the part of point 4 dealing with Section 17 para. (1) item a) of the AH, but I do not agree with rejecting the petition aimed at the establishment of the unconstitutionality of, and at annulling the challenged text in Section 18 para. (2). The text in question should have been annulled by the Constitutional Court.

I agree with the reasoning of the majority Decision in establishing that the joint interpretation of paragraphs (1) and (2) in Section 18 of the AH can reveal an intention of the legislature to restrict the patient's right to self-determination to the least extent, but as a whole, the relevant provision constitutes a restriction beyond that scope. It allows the physician performing an invasive intervention to extend that intervention on the basis of his own will, without taking into account the patient's right to self-determination.

2. According to Section 18 of the AH, an invasive intervention may be extended without the patient's consent in two sets of cases. Paragraph (1) only deals with the unforeseeable nature of the need to extend the intervention, and thus it is possible upon the existence of the preconditions to extend any kind of invasive intervention without the patient's consent – with the exception provided for in paragraph (2). Paragraph (2) provides for the case when the extension of the intervention (the necessity of which is unforeseeable – following from both the concepts applied and the reference to the first paragraph) shall result in the loss of an organ or a body part or the complete loss of the functions thereof.

In the case of paragraph (1), the extension of the intervention is justified by urgent need, while in the case of paragraph (2), by the existence of a direct threat to life. In addition to the above, the invasive intervention may be extended without the patient's consent if failure to do so would impose a disproportionately serious burden on the patient – as provided for expressly in paragraph (1) item b) and by using a reference in paragraph (2). The petitioner has challenged the text which contains the reference to the preceding part.

The concept of a disproportionately serious burden is not clear in itself. It is impossible to determine on what basis of comparison a failure to extend the invasive intervention may result in a serious burden imposed on the patient, nor is the meaning of the word "burden" clear. The provision does not even provide a clue on what factors the physician performing the intervention is to take into account. As the text connected with a reference to Section 18 para. (2) of the AH is of a vague content, it violates the requirement of legal certainty resulting from Article 2 para. (1) of the Constitution, and therefore the relevant reference in Section 18 para. (2) should have been annulled.

3. In my opinion, the text affected by the petition in terms of content violates the patient's right to self-determination as well. It allows the physician to take into account only the rules of his profession, and to decide on the extension of an invasive intervention on the basis of the alleged prevailing importance of such rules, without due account to the affected patient's opinion about what a "disproportionately" serious burden means for him. Consequently, the provision concerned violates Article 54 para. (1) of the Constitution.

The existence of an urgent need mentioned in Section 18 para. (1) of the AH, or that of a direct threat to life mentioned in para. (2) can be established on the basis of the rules of the medical profession and the professional knowledge and experience of the physician engaged in the intervention. If the information given to the patient on the planned invasive intervention could not be comprehensive, and the intervention has to be extended over the originally planned extent due to new factors revealed in the course of the intervention itself – the restriction of the right to self-determination can be accepted as constitutional in view of the urgency or the direct threat to life. In my opinion, however, it is unconstitutional to restrict the right to self-determination on the basis of a statutorily undefined factor considered a disproportionately serious burden for the patient, the assessment of which should primarily

depend on the patient's own discretion, but which is established in the concrete case without knowing the patient's actual opinion.

According to Section 15 of the AH, the patient may decide what interventions he agrees to and which ones he refuses, and it is necessary to have the patient's declaration made in writing or otherwise in the presence of two witnesses in order to perform an invasive intervention. I hold that the enforcement of the patient's right to self-determination is to be ensured to the maximum extent not only in the case of choosing an invasive intervention but also in the case of extending it. Therefore, if the extension of an invasive intervention is not justified by an urgent need or a direct threat to life, it is unconstitutional not to obtain the patient's consent.

4. The petitioners have challenged and claimed the unconstitutionality of the reference to paragraph (1) item b) in Section 18 para. (2) of the AH. However, I hold that the text of paragraph (1) item b) ["…b) failure to do so would impose a disproportionately serious burden on the patient."] is unconstitutional in accordance with the above arguments in the context of both paragraph (1) and paragraph (2) as it violates Article 2 para. (1) and Article 54 para. (1) of the Constitution. Therefore, the Constitutional Court should, in accordance with its permanent practice, have annulled Section 18 para. (1) item b) of the AH as well, in view of the close relation between the relevant provisions.

Budapest, 28 April 2003

Dr. Árpád Erdei
Judge of the Constitutional Court

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