Towards a new Legal Statute for the dying person [Hacia un nuevo Estatuto Jurídico para la persona que está muriendo]

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Gonzalo Figueroa Yáñez
Professor of Bioethics and Civil Law
at the Universities of Chile and Diego Portales
Chile

I. INTRODUCTION

The Chilean Civil Code refers to the unborn creature in the mother's womb as "that which is to be born", but which has not yet seen the light of day; it understands "birth" as the complete separation of aforementioned creature from its mother, as long as it manages to survive the separation at least for a moment, and refers to natural persons as all those individuals of the human race *that have been born* (1). Consequently "that which is to be born" *is not a person until it is born*. In this way the Code establishes a rather curious distinction between an individual of the human species on the one hand, and a "person" on the other. Current doctrinal debate, which sometimes has become quite passionate for ideological reasons, has particularly hinged on the determination of the moment when "that which is to be born" begins, with some upholding the conception thesis, while others affirm the idea of the implanting in the uterine wall, with the rest defending the idea of the beginning of brain activity (2). We will not linger on this debate, but we do believe it interesting to point out that *from that moment which is under debate in terms of doctrine*, in which "that which is to be born" begins, *and up to the very moment of birth, the embryo or foetus is not recognised as a person* by Chilean Law, notwithstanding the fact that there are laws that do protect it in several ways. This circumstance leads us to the conclusion that "that which is to be born" *is subject to laws,* even though it lacks the quality of a person (3).

This subject in possession of rights, but which has not yet become a person, *enjoys a precise and specific legal protection statute*, both in civil matters, especially with respect to its rights to succession, as well as criminally, particularly as regards the crime of abortion.

Our aim in this paper is to explore the situation in which people find themselves when they are in a situation of "that which is about to die" (4); a situation in which they are quite often as unprotected as when in the situation of "that which is about to be born", and as far as possible, to propose for these people a suitable legal statute to provide protection. We believe that the various statutes that are currently in force to protect such individuals in the majority of countries in the western world, if not in all, contain shortcomings, and prove to be both inadequate and ignominious for those whom they are meant to protect.

II. OLD AGE AND DISCRIMINATION

A. Some figures

There is little doubt that humanity is increasingly becoming a more aged society (5). Professor Fernando Lolas speaks of an "age boom" as part of the universal demographic

boom that has characterised recent centuries (6). "Old people" will grow in numbers in forthcoming generations as a result of the advances in medicine and health care, while "young people" will keep on dropping in numbers, if the current downward trend persists. The demographic pyramid will tend to become square-shaped. This issue is a source of concern to demographers, economists and politicians alike, and is an extremely serious matter. In the world that awaits us, one in which the very young will increasingly live together with the very old, it will be essential to find inter-generational lines of improved co-existence, with greater affinity, and if you like, some degree of social peace and balance (7).

Let's have a look at some figures that will serve to back up what we have been saying. According to the Argentinean journal IntraMed, many qualified workers will have left work over the next 25 years: in Japan alone some 10 million people will be retiring, while 25% of the current European Union workforce will be going the same way. These circumstances have led many thinkers to propose emergency measures, such as extending the retirement age, or having the oldest members of the population continue to work half-day shifts, after their official retirement age. Such measures are currently being taken experimentally in Switzerland and Sweden.

At the beginning of the 19th century, the world population was estimated to stand at 1,000 million. Over the course of that century, this figure increased by 650 million, which meant that the world population at the beginning of the 20th century stood at 1,650 million. By the end of the 20th century, however, the world population stood at 6,000 million, an increase of 4,350 million people (9). This increase in population is especially marked by ageing: in 1950, the average age of the world population was 23.5, a figure which had risen to 26.4 by 2000, and which is expected to reach 37.8 by 2050. In 1950, 8.1% of the total world population were over 60, a figure that will have reached 22.1% by 2050 (10). Over the next few years the world will face a genuine "geriatric boom", in the words of the sociologist Lorenzo Agar (11). According to Agar, life expectancy in Latin America and the Caribbean increased by 20 years in the second half of the 20th century, thus seeing it approach the 80 year mark in the majority of countries in the region (12).

In the USA, people of over 85 constitute the biggest growing population group: they are 21 times more numerous than they were a mere 100 years ago, while the over 65 group has grown 8 times bigger since then (13).

This "geriatric boom" has already brought with, and will continue to do so in the future, a set of extremely serious ethical, social, political and economic problems. Fernando Lolas reminds us of how *there is no solidarity shown with old animals* in the majority of the species, and that the lifestyle of the aged is unknown to them: the helplessness of the old animal makes it easy prey for its enemies (not to mention for the younger of its own species), for other predators and for nature itself. "The herd abandons the aged" (14). *Old age is only possible through the solidarity of the species, but it does not seem to be very clear whether, or not, such solidarity exists among the human species*. Aged humans are discriminated against and are pushed aside from the herd by the younger ones. This is what is happening in practically the four corners of the earth nowadays. We believe that the times that are coming will demand greater care, greater concern for the most aged members of the population. We even think that a time will come when the degree of development of cultures will be measured by the greater, or lessor, care afforded to their oldest members.

B. Age discrimination

Age discrimination clearly exists in today's world.

As far as medical assistance is concerned, given that these are resources in which there are always shortages, thus making it necessary to ration them, those who have access to same have it at the expense of those who are left without such assistance. In such circumstances, young people are always given precedence, while old people are left without receiving medical assistance. Some people think that this is a fair solution, given that young people represent the future, whereas old people have already lived their lives and, therefore, represent the past. Others claim that health policies should take into account all age groups regardless, and that resources

should be shared out fairly, in such a way as to promote the common good.

Whatever the criterion employed to approach the issue of resources' allotment, it remains quite clear that age discrimination does exist in terms of the social exclusion to which old people are subject (15). As of 45 or 50 years of age, one begins to feel such exclusion, when the interested party perceives that there are no jobs for those who have reached his or her age. As is obvious, with the passing of time this sensation worsens: exclusion becomes stigmatised and hostile, finally ending up in the loss of essential rights. In this sense, Fernando Lolas distinguishes between "social death" (by way of segregation and the loss of rights) and "real", or biological, death.

Old aged people's helplessness greatly exceeds the economic production scale, and stretches its tentacles as far as the world of ideas, the world of culture: it is not a good idea to see oneself as old, or to look old, even when one already is indeed old. Prevailing cultural mores extol vigour, youth and fitness; meanwhile, the old person tries by way of physical exercise, and even by means of cosmetic surgery, to hide from the inexorable march of time. It goes without saying that in this 21st century civilisation in which old age has been demonised, the death process has suffered even more so in this sense.

We believe it discriminatory to apply the economic concepts of greater return, investment to achieve greater productivity, cost – profit ratio, and others of a similar nature, to people who have reached a certain age, without taking into account the efforts made heretofore by these people, as if productivity were the only goal in life. What is more, there is no evidence whatsoever to enable us to accredit lower performances after reaching a certain age, even in jobs that require physical force (16).

Discrimination also exists against old people in training programmes that are drawn up by many companies in order to obtain a greater return from its workers. As older workers are not allowed to take part due to their age, they do not receive proper training, which in turn is to their detriment, given that they produce less as a result of the lack of training.

In Chile, institutions known as "ISAPRES" are entrusted with the private financing of health. These receive monthly contributions from the workers who are members of same. As the contributor advances in age, *the amount of his or her respective contribution also increases. The older you are, the more costly the contribution to be made*, when it should be quite the reverse. Consequently, a time comes when the wages received by the old person do not enable him or her to continue paying the contribution. This is an ill-conceived system and one that poses a threat to the older members of the population, which is the one most in need, precisely because they are coming to the end of their lives.

It seems quite unreasonable – as is the case in many countries around the world, Chile included – to set a certain age as the compulsory retirement age (60 or 65). Clearly individuals age in a variety of ways and may, or may not, be suited to certain activities at different moments in time. There are even "old ages" that do not affect one's work performance. An estimating engineer, a philosopher, a university lecturer normally get "older" later than surgeons, sportsmen and women and truck drivers. In these circumstances, one cannot pinpoint a reason for making all of the people involved in these professions retire when they reach a given age. There is greater age discrimination as regards the former, who are still suitable, than the latter, who are no longer fit to do the job. We believe that a change of retirement mentality is needed. As of a certain minimum age, everybody should be able to independently set the date of his or her retirement, in accordance with the strengths and skills that he or she feels to be in possession of. What cannot go on with respect to old people is the currently patronising attitude of "the poor tired old man/woman, let's send him off too rest".

As we have already pointed out, for some authors there is a "social death" that precedes "real death". "Social death" begins to structure itself in the collective conscience during the third stage of life, though, it is at the beginning of the fourth stage when things really begin to get worse for old people, "when dependence, several losses and disability begin to set in, when senile dementia (…

rears its head), awaiting a sure demise" (17). As of the third stage of life, but especially during the fourth, isolation and abandonment increasingly threaten old people, the tragedy of loneliness becoming their fate. When they are no longer "useful", they are excluded from society and forgotten (18). The more generous of their offspring lock them up in old people's homes, which are far from rest homes, but rather asylums where they are kept before forgetting about them completely. The less generous children, simply forget them, because it is a lot cheaper (19).

C. Discrimination against old age did not exist in ancient cultures

In some ancient cultures, and even in our own in the past, old people were venerated. This veneration arose from having been considered to be carriers of the historical memory of the group, the reserve of ancestral memory. On the other hand, the experience of the older members of such societies was also the reserve of wisdom: they were resorted to for advice, mediation and inspiration. They were the "wise members" of the group, they handed stories down that had been turned into legends, legends that had become myths, myths that were converted into religion. They were the point of contact with ancestors, with the lares et penates, the household gods. They were the pride of the clan, the wizards and enchanters, the healers, the judges and the educators. In those times, old age was the equivalent of a divine recompense awarded to the just (20).

This quality as custodians of the group memory and wisdom began to decline with the invention of the printing press, with the making of books and with the appearance of written history and the documents that accredit its objectivity. Nowadays, old people are no longer of use to safeguard history, while their ancient wisdom can be acquired by anyone, without any need to accumulate years. Today, it is possible that the advice of an old person be deemed out-of-date by the younger generations.

For this very reason it has been claimed that ancient cultures represented a period of glory, a golden age for the old (21).

D. Classification and characteristics of old people

Since the middle of the 20th century people have been classified into four groups according to their age. All those young people who cannot fend for themselves economically go to make up the first age. This age begins, therefore, on the day one is born and stretches down to the end of one's period of education, which enables one's incorporation into the labour force. The latter date is indeterminate, vague and imprecise, and generally depends on the state of development of the country in question, and even on the family to which the person we wish to pigeonhole belongs. The second age refers to that of the working - or capable of same - and economically active population. It befalls this group to maintain the quality of life of the other three ages.

The third age corresponds to those who are retired, who have now stopped working, but who could still do so; to those who are healthy and active, entrepreneurial and enthusiastic. The fourth age is made up of disabled adults, handicapped or ill, who need external help to survive (22). The Spanish thinker, J. Aranguren, called the former "elderly" or "old people", and the latter, the "aged" or "senescent" (23).

Both the one and other receive retirement pensions as of a certain age (60 or 65). We have stated above that serious thought is being given to raising this age limit for economic reasons, given that the burden being experienced by the working population is increasing every year, thus forecasting the collapse of the entire social security system. Franchises, discounts and incentives for third and fourth age groups are being considered in many countries, such as discounts in travel and entertainment, restaurants, tourism and even in accommodation, all of which serves to increase the burden on the working population.

E. Old age and depression

It seems to us that the big problem that has to be faced by old people is *the need to find some meaning to their lives* (either from what has already been lived through, or for what has still to be lived). This is, without a doubt, the big problem faced by all humanity – children, adolescents, adults, old people – but it is during old age that the need for an answer becomes more pressing: death is felt

A corner in the Atlantic Botanical Garden (Gijón)

to be close, and each one needs to know to what end one has lived.

The "Protestant ethic", or "work ethic", is no longer of any use. It may have justified their lives when they formed part of the working world, of the world of earnings and economic success (24): old people no longer work or produce. Old people are a nuisance for the young, and are no longer of any use. If we are talking about old people with money, the most they can look forward to us consuming what they have managed to make. Their motto, in this case is, to paraphrase Descartes, "I buy, therefore I am", or "I am what I buy" (25). What a miserable "meaning of life" in these cases! As a rule, the old person will not be satisfied with these explanations. Moreover, it is easy to understand that their vital reaction to such explanations results in profound desperation, which will most likely end up becoming a deep depression.

In order to feel that life is worth living, acknowledgement from the community, including the youth, is necessary. Cicero once wrote, "the burden of age is so much lighter for those who feel respected and loved by the youth" (26). Truly religious people also found meaning in their lives in the heaven they hoped to achieve after death: "If this life that is coming to an end was not so good, there is a better one waiting for me afterwards". Having worked hard all their lives, old people feel close to salvation, closer even than the young people that still cannot claim – as they can – that they have worked well.

Nowadays God is more distant; there are increasingly less people that look forward to "a better life" in the hereafter. Life has lost sense for them, especially if speaking of forthcoming death is deemed to be unseemly. All that is left is anxiety, despair and depression.

On reaching this point, we feel that the time has come to ask ourselves if it is reasonable to try and prolong a life in which the individual finds no meaning, and in consequence, if there are justifications for suicide, or for euthanasia in any of its manifestations. We will deal with this below. Let us just say for the time being that depression in old people is intimately related to the loneliness they feel, devoid as they are of any tasks, of friends, of love, abandoned even by their children and family.

In the face of this clearly heartbreaking scenario, we believe that so-called "palliative care" should begin at the start of the third age, even when the individuals in question

are still healthy, strong and vigorous, but when the prospect of despair, disappointment and abandonment are beginning to rear their ugly heads. The aim of this third age palliative care will not yet be the search for a peaceful death, but rather the search for meaning to the life that is still left to be lived.

This new concept of palliative care plays down the importance of the debate that is currently going on as regards the assignment of resources for the terminally ill, for the dying, from which society will not now be able to obtain any use. As long as palliative care is understood as helping not only people to die well, but also to live well, they can opt, on better grounds, for the resources – always scarce – that are assigned to people's health. This problem is especially important in underdeveloped and very poor countries.

III. THE RIGHT TO DIE WITH DIGNITY

A. Death: yesterday and today

All political constitutions around the world guarantee the right to life, in one way or another. The same may be said of criminal laws that punish murder, parricide, infanticide and abortion. Quite a number of legal systems have done way with the death penalty. We believe that this "right to life" not only covers the biological survival of people, in order to avoid third parties taking it way from them, but *must also be extended to "the right of people to lead their lives"*, to live a life in accordance with their wishes, hopes and ambitions, in other words, the *"right of each individual to endow his or her life with meaning"*. Joaquim Clotet explains this idea as follows: it is "the right that every child has to develop in an atmosphere that neither annuls or inhibits his or her biological potential to mature both physically and mentally" (27). *The choice of values made by each individual is of especial importance with respect to this "right to lead one's own life", that is to say*, the axiological or ethical dimension that each one impresses on one's life. *The freedom with which we choose the values by which we live, and the efforts we make to live up to them form the basis of the dignity of human life.* "To live with dignity" is, in fine, to live by our values.

This right to live with dignity obviously lasts up until the time of death. François Sarda points to two basic rights closely bound up with each other: the right to live with dignity, and the right to die with same (28). A dignified life ends with a dignified death.

The same ritual for death was not practised in ancient times, as is practised today. In ancient times, the person facing death was the one who presided the ritual: he or she invited loved ones, friends and relations; advantage was taken of the occasion to put his or her last will and testament, intimate wishes, unfulfilled dreams, disappointments and upsets in order. It was a time to take stock, to bless, to forgive and even to curse. The person facing death paid his or her debts in the presence of those who had paid testimony to his or her life (29) (30).

On the other hand, "to die nowadays, at least in the western world, is normally to die unconsciously, hooked up to tubes, drip fed, sedated, alone, in the hospital, separated from all that once went to make up the fabric of one's life (31). Death itself has become an event that it is best to try and avoid, something on which we should not dwell, something that is not "well looked upon" in our post-industrial society. Death is dressed up: it is something that happens in hospital, the corpse is made to look as if it was still alive, occasionally to the extent of even being embalmed. The death rite has been cut down in size, so as not to threaten life. It is now fashionable to cremate the deceased. In this way, visits to the grave are avoided, and given it no longer exists, this also does away with the floral tribute as there is nowhere to lay wreaths. We must forget as quickly as possible. All of the foregoing has been admirably adapted to modern values: health efficiency, economic return. If the deceased had already paid for his or her funeral beforehand, so much the better.

Advances in medicine and some extraordinary methods to keep the heart beating and vital organs functioning is leading, however, to other types of deaths. Baudouin and Blondeau make a distinction between the "living dead" and the "postponed dead". The former are those who are brain dead, unconscious, in a deep coma, but they are breathing and their hearts are still beating. These are brain

dead, but in body terms, seem to be alive. The "postponed dead", on the other hand, are conscious, they can reason and feel, but science cannot help them to put off their inevitable demise (32). Nowadays, palliative care is applied to the latter. Extraordinary care and dysthanasia treatments, or futile life support therapy, can be applied to both groups. The "postponed dead" can, moreover, opt for suicide (whether assisted or not), and both groups can choose euthanasia. We will deal with both of these options below.

B. Disputes in the face of death

When death comes, especially, when there is some doctor, or health centre, involved, we may find ourselves confronting three poles of opposing interests entering into the dispute: the patient, whose life an attempt is being made to save, his or her close family and the doctor or health centre. What follows is an example of the disputes that most regularly come up between these parties.

1. Disputes between the patient and the doctor, or his or her team

a) The need to get the free and informed consent of the patient with respect to the treatments that the doctor proposes to apply, excluding the authoritarian patronising attitude that even today is still all too commonplace.

b) The distinction between the "ordinary" care that the doctor is obliged to provide to the patient and the "extraordinary" care, which requires special authorisation. This point bears direct relation to the civil and criminal liability of the doctor, where he or she must give special consideration to the prior will of the patient which has been stated in some living will.

c) "Futile life support therapy", relentless therapy, also referred to as dysthanasia, which the doctor applies to the patient, especially if he does so against the patient's, or his or her family's, will.

d) Help provided by the doctor to enable the patient to commit suicide, upon the request of the latter.

e) Euthanasia or wilful death of the patient by a doctor's action or omission, upon explicit request, with or without the consent or will of the patient.

2. Disputes between the patient and his or her family

a) The possibility that the patient's family refuse to respect his or her living will, claiming that these wishes have changed since the date on which they were expressed.

b) The possibility that the family delegate in the doctor the function that the law, or the patient, entrusted it with as regards the treatment to be given to the patient. This problem also comes up with respect to patients that are not able to express their will. In such cases the responsibility falls on the shoulders of the patient's next friend, or legal representative.

c) The possibility that the family wants to impose a futile life support therapy against the wishes of the patient, or the doctor.

d) The determination of what should be understood by the term "family" and the way of making decisions in the event of disagreements within the bosom of same.

3. Disputes between the doctor, or his or her team, and the patient's family

Determining who should resolve any disagreement between the doctor, his or her team, and the patient's family, in the event that the patient is incapable of expressing his or her wishes independently. This dispute occurs particularly in cases where one of the parties involved wishes to apply futile life support therapy procedures, while the other wishes simply to allow the patient to die peacefully.

What follows is a discussion of only some of these disputes. We feel it a good idea at this stage to advise the reader that *we will particularly focus our attention on those patients who, in our opinion, are refused a dignified death*. Unconscious old people, the bedridden, quadriplegics, people in irreversible comas or disabled who cannot put up with any more suffering, to those who are, nonetheless, subject to relentless therapy treatments; but also those terminally ill persons, those suffering from cancer who do not wish to go on living, and in general, all those people who for serious reasons wish to put

an end their lives. We believe that all of these people are being denied a dignified death.

As an individual responsible for his or her life, as someone who lives his or her life with the dignity that befits and is indeed, inseparable from it, the human person must likewise be responsible for the moment in which their life comes to an end, that is to say, for their own death. As far as a dignified death is concerned, we refer below very briefly to relentless therapy, to living wills, to the decriminalisation of co-operating or assisting in an act of suicide and euthanasia desired by the patient. Undesired euthanasia, provoked against the explicit will of the individual, does obviously not constitute a dignified death.

C.- Futile life support therapy

We feel that the big problem of "futile life support therapy" as regards a particular medical treatment is a problem of limits. At what point does what we refer to as "futile" begin? And, at what point does ordinary care come to an end? Only specialists can answer these questions, and the experts in this case are the doctors, those who are in charge of applying the treatment. We make so bold as to suggest proposing "the paramount interest of the patient" as a guiding principle in this matter, in the same way that Family and Filiation Law establishes the "paramount interest of the child" in order to decide on such complex issues as maintenance costs, the education and the care of the children. In this case, the "paramount interest of the patient" does not allow him or her to be caused any pain, have his or her normal life interrupted, or that the patient be taken to unbearable extremes, if the treatment does not achieve objectives that provide greater satisfaction than the damages or inconveniences produced. We have here a simple cost-resturn problem, in which the *preservation of cardio-respiratory activities with no chance of recovering consciousness cannot constitute a desirable goal*. Let us not forget that the life of any human being *always has a meaning*, and that *that meaning is comprised of a set of values*. If the patient cannot appeal to the meaning of his or her life in the future, if he or she cannot continue to exercise the values that justify it, *there is no point in going ahead with any extraordinary treatment, and much less so when futile life support therapy leads to nothing. The patient has the right to die with dignity*. No medical treatment can be an end in itself.

Karen Ann Quinlan's court case, which touched public opinion worldwide, can be said to represent a good way of explaining the excesses to which futile life support therapy can reach when not subject to time limits (33).

On her 21st birthday Karen Ann Quinlan fell into coma as a result of having overdosed on barbiturates during the course of her birthday party. Diagnosticians in charge of her case concluded that the state of unconsciousness in which she found herself was irreversible and that she would never recover. Notwithstanding, she was kept plugged into an artificial respirator, without the aid of which should would inevitably have died. Her adoptive parents, in spite of being Catholics, asked for her to be disconnected and left in peace to die, pursuant to the wishes of Karen herself, who would no doubt have preferred to die before being kept alive by means of artificial respiration. However, the doctors refused, possibly fearful of later on being accused of murder, or active euthanasia. The hospital, for its part, and in order to avoid any liability, demanded judicial authorisation to proceed with the disconnection of Karen from the machine. It must be put on record that the condition of the patient did not allow for her to be declared dead as a result of the cessation of all of her brain functions, given that some stem functions were still working.

The examining magistrate rejected the request made by the parents of the patient that she be disconnected from the machine, though that sentence was overturned by the New Jersey Supreme Court. The appeal decision was grounded on the irreversibility of the patient's condition, pointing out the difference that maintains between "to kill" and "to allow to die", and underlining the lack of quality of a life permanently bound to an artificial respirator. In this sense, the Court distinguished between putting an end to futile life support, or suspending extraordinary treatment, on the one hand, and passive euthanasia, on the other, and further highlighted the right to a dignified life and death.

D.- Living wills

Closely related to futile life support therapy is the establishment of living wills, which enable us to know conveniently the wish of the patient with respect to the application of extraordinary treatments. Moreover, the existence of a living will sets reasonable limits to the doctor's civil liability, enabling him or her to avoid "relentlessly" trying to maintain the patient in question alive at all costs, whenever such a document has been made to this effect. I believe that – in order to duly fulfil its function – *all living testaments must be renewed after a certain period has elapsed since last issued*, because the decision to die, or not, to only receive ordinary treatments, or to receive extraordinary treatment as well, is a decision that may change with the passing of time. A recently renewed living will provides greater certainty as to the true wishes of the patient.

The problems arising from futile life support treatment become much more complex, as is obvious, when there is no living will clearly reflecting the wishes of "that which is about to die". Once these wishes are made known, it seems quite reasonable that the doctor, or the hospital in question, respect them. Sight should not be lost of the fact that *it is the patient who is responsible for his or her own life, who is the person that has lived his or her life and given it a meaning on which its dignity is based, and it is the patient who is also the person who must decide about the dignity of his or her own death*.

E. Suicide and assisted suicide

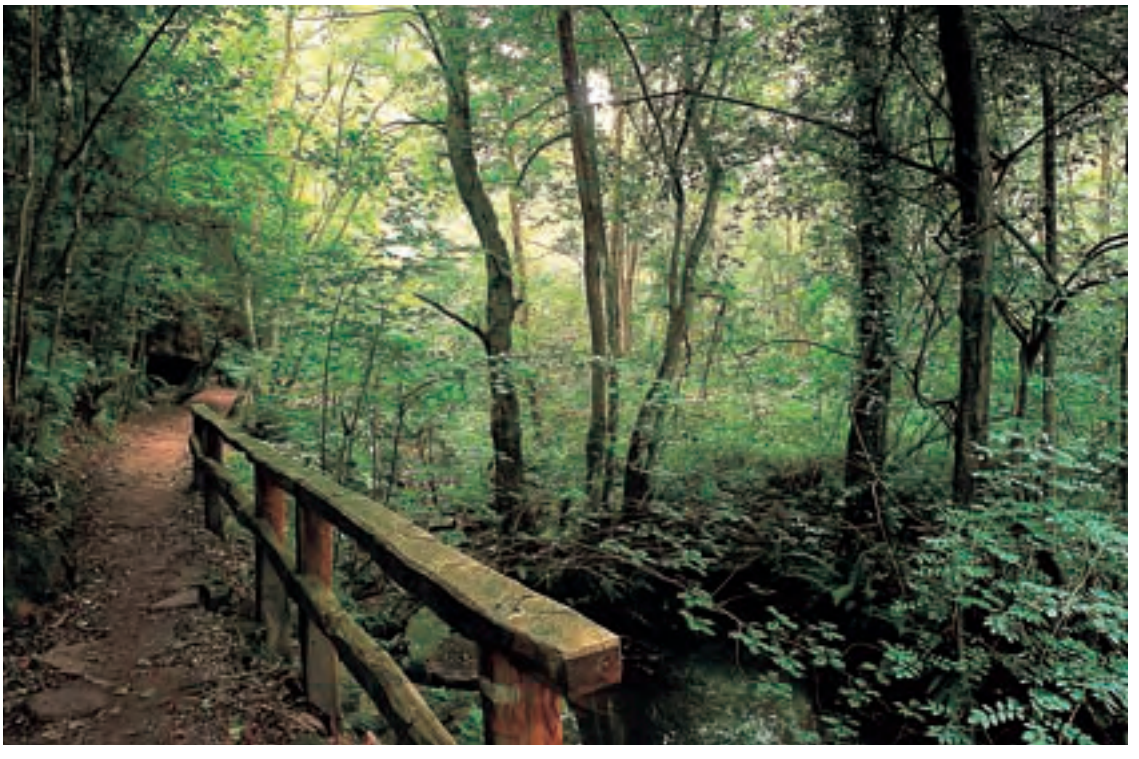
Suicide can be taken as a manifestation of human freedom. If the life in question belongs to the person living it, there should be no problem in accepting that he or she decide to end it, especially in the event of the life having lost its meaning. It is also possible to understand such a decision as the symptom of an illness, or a depression, in which the person is not declaring a clear wish to end his or her life. Is a person contemplating suicide mentally competent to take such a decision? And is the rejection of suicide not a manifestation of a mere patronising authoritarianism?

In their desire to support a person's freedom to end their own life, the authors Baudouin and Blondeau point out that "the freedom not to suffer and the freedom to die are the last conquest of the human person over his or her own humanity. In this way, twentieth century man is recovering the control lost over his destiny and is once again taking the reigns of his own life" (34). Man is recovering the freedom to put an end to his life whenever this has lost its meaning for him. *Today, suicide forms part of the scope of individual freedom*, which does not mean that the State is exempt from providing moral, or psychological, aid to those who may potentially be in danger of committing suicide.

The same situation does not hold for providing assistance in an act of suicide, behaviour that is still, to date, rejected in criminal terms by the majority of legal systems. It is said that this figure may cover up murders, or may encourage people suffering from depression, disillusion or pain to rashly take their own lives. Apparently, the State has not wholly given up its erstwhile patronising character and prefers to watch over the existence of those who may be considering whether, or not, to put an end to their lives.

Notwithstanding, *today opinions abound in favour of decriminalising the cooperation of those who assist others in committing suicide.* If the act of suicide has come to be viewed as falling within the confines of individual freedom, it is held that cooperation in the act should also be decriminalised *whenever this assistance is afforded upon the explicit request of the individual wishing to put an end to his or her life, within a medical context, and the goal of the act is to die with dignity.*

The case of Derek Humphry should invite us to deep reflection (35). Humphry's wife, Jean, suffered from a cancer that had spread all over her body and was causing her great pain. Consequently, Derek helped her to die at a moment of her choosing, by means of a lethal dose of medication which Humphry himself helped her to drink, given that she was too weak to drink it of her own accord. The husband pleaded that he had acted "out of love". It is interesting to point out that immediately after this act, Humphry gave himself in and confessed to everything he had done. The British authorities that heard the case acquitted him.



A rambler's walk around Gijón

We believe that *to help a terminally ill person suffering from great pain to die, should he or she so wish, can be morally acceptable*. In this case, the decision to die can be taken by a free person. However, we do not feel that it is acceptable *to help an adolescent to commit suicide who is depressed over unrequited love*. Neither do we believe *in assisting in the death of a person whose inheritance is being sought after*. There is an inconceivable diversity of cases between acceptable and unacceptable ones. *The problem lies in setting the limits between one extreme and another.*

F. Euthanasia desired by the patient

As we have stated above, we will only deal here with desired euthanasia, when it has been requested by the patient. If this were practiced against his or her will, or knowledge, we would find ourselves before a simple case of murder, and all of the criminal consequences that such an act brings with it.

Undesired euthanasia, or when the patient is not aware that this is being applied to him or her, has been practiced, notwithstanding its criminal implications, on many an occasion in the course of human history; from children being sacrificed on Mount Taygetos in Sparta, as a result of having been born with a disability, to the sacrifice of old people by economic or social prophylaxis in several primitive cultures. Indeed, in the 20th century, Nazi ideology upheld the need to sacrifice Jews, gypsies and others for racial purposes.

On the other hand, Christian religious currents have upheld *the sanctity of human life* since the emergence of same in history: life is a gift from God that no man can dispose of for himself. Consequently, while these Christian currents of thought dominated group life, the subject of euthanasia (either active, or passive) was doomed to prohibition.

It is only over the last few centuries, with the decadence of religious explanations and the boom of scientific discoveries and liberal ideologies, that the idea of human life as belonging to God has come into question. Instead, it is held that each human life belongs specifically to the individual in question. At this particular juncture in history, especially during the course of the 20th century, *euthanasia has begun to be justified in the name of freedom. If human beings have the right to give the meaning that we choose to our lives, if we call this choice a "dignified life", or a "good life", and if we have the right to live and to die with dignity, we must be able to lead our lives at our own discretion and also seek a "good death". This justifies euthanasia,*

as long as the person whose life is in question wishes to end it in this way. The acceptance of euthanasia falls within the extensive field covered by individual freedom. The idea is to add to the freedom of humanity as a whole. María Casado, in tackling this issue, has spoke of the "passing of the sanctity of life to the quality of life" (36). While Miguel Kottow speaks of "the voluntary termination of old age", as we once spoke of the "voluntary termination of pregnancy (37).

In 1950, a group of thinkers, among which Bertrand Russell was one, asked the United Nations to include the voluntary right to euthanasia in the recently adopted Declaration of Human Rights (38).

Several problems arise when it comes to the decriminalisation of euthanasia. The first one is to determine how irreversible must a disease be, or the pain provoked by same, in the person who requests or accepts euthanasia as a solution. The second stumbling block refers to laying down the requirements that must be met by the patient in order to take his or her decision to die as one that is both serious and well thought out. Would it not be enough to allow the patient to reject futile life support therapy, without reaching the extreme of death by consent? Finally, there is the problem of whether or not it is possible and advisable to admit the opinion (and wish) of family members that might have an interest in the demise of the patient.

A French law passed on 12th April 2005 concerning these issues, granted the patient the right to reject the treatment that the doctor offers, *but did not go so far as to authorise euthanasia*. On the contrary, aforementioned law obliged the doctor to "do everything possible" to convince the patient to continue with the treatment suggested by the doctor in question. In the event of the patient refusing such treatment, the doctor must provide him or her with the corresponding palliative care (39).

On the other hand, in the Netherlands, euthanasia, on being requested by the patient, became legal pursuant to Law of 2001, with a Law in the same sense being passed in Belgium in 2002. Switzerland, for its part, decriminalised assisted suicide, as did the State of Oregon in the United States of America (40).

The Nancy Beth Cruzan court case proved to be paradigmatic in terms of the world debate on euthanasia (41). As a result of a car accident, twenty-fiver-year-old Nancy Beth Cruzan irrevocably lost all of her cortical brain functions, nonetheless, though her brain stem remain unharmed, in such a way that her vegetative condition enabled her to breathe without the need for an artificial respirator. Nonetheless, as she did not possess the reflexes to swallow, she had to be fed artificially for the rest of her life. In the light of her irreversible condition, Nancy's parents requested legal authorisation to remove the nasogastric probe by means of which she was fed, which would necessarily give rise to her death by starvation. The Court of First Instance granted their request, however, its decision was overturned by the Missouri Supreme Court arguing that the *supposed wish of Nancy to suspend the treatment had not been sufficiently accredited*. The problem, as can be readily seen, lies in determining the wishes (presumed in this case) of the patient to authorise her own death. When the matter came before the American Supreme Court, this allowed the submission of extraordinary evidence given by witnesses to the effect that it had been Nancy Beth Cruzan's wish to die, instead of spending the rest of her life brain dead and connected to an artificial feeding device. *The requested act of euthanasia was admitted on this evidence.*

Very similar to the aforementioned case was the one involving Terri Schiavo (42), who had also fallen into a permanent vegetative state as a result of having lost her cortical brain functions, but not the stem ones, without having left any instructions by means of a living will, or in some other form, with respect to the possibility of finding herself having to receive possible futile life supporting therapy. In this case, however, the guardian ad litem who had to express the necessary wish to disconnect her was her ex-husband, who had started a new life with another woman. Having requested the disconnection, Terri's parents tried to oppose the decision. In fine, the wishes of the guardian prevailed and she was disconnected from the machine. *Euthanasia had once again been authorised.*

We feel that a serious bioethical debate should take place worldwide in order to

resolve the question of the admission or rejection of euthanasia. We think, moreover, that in such a debate, the guiding principle should be – as in other similar situations – *the paramount interest of the patient, his or her right to "lead the life" that he or she has chosen and his or her right to die with dignity.*

Indeed, the case involving Anthony Bland (43), heard in a British court, found in favour of the paramount interest of the patient. Once again the issue centred around cortical, but not stem, brain death giving rise to an irreversible vegetative condition. The doctor wished to suspend the artificial feeding that maintained his cardio-respiratory functions active and requested legal authorisation to do so. The judge of the First Instance court opined that such an act would constitute murder; an opinion that was afterwards shared by the guardian ad litem appointed by the Court of Appeal. The Court, on the other hand, was prepared to find for the petitioning doctor. The final appeal went as far as the House of Lords, which in the United Kingdom possesses certain jurisdictional functions. In this case, the decision did not centre on the presumed wishes of the patient, but rather *on the paramount interest of the patient himself:* "What is best for the patient?", was the question put before the House, which decided to authorise the disconnection, given that it was impossible for Anthony Bland to recover "that combination of multiple characteristics that we call personality" (44).

IV. DEFINITIONS OF DEATH

There is no single, specific definition of death in Chile; indeed, it could be said that there is not even any type of general definition. Article 78 of the Civil Code of 1857 deems it sufficient to point out that "the person comes to an end with natural death". Traditionally, and in accordance with the interpretive provisions of the law contained in Article 20 and Article 21 of aforementioned Civil Code, the word "death" was given its natural and obvious meaning that prevailed in the country at that time, a meaning with which those who professed to deal in the science of medicine also agreed, that is to say, the definitive end of the cardio-respiratory functions. This is the interpretation that prevails today, given the lack of any other more general legal interpretation.

Notwithstanding, Article 11 of Law No. 19451 concerning Organ Donations and Transplants of 10th April 1996 pointed out that *only for the purposes of that law*, death is accredited by means of a unanimous and unambiguous certificate issued by a group of doctors, one at least of which must be a neurologist or neurosurgeon, who indicates that he or she *has checked the complete and irreversible ending of all encephalic functions.* According to Kottow, this provision seems to include the brain stem, which regulates the respiratory and circulatory functions, in such a way that *the patient who has lost only all his or her cortical functions, but not the stem ones, could be deemed to be still alive.* Notwithstanding the above, Kottow further points out that diagnostic criteria are inaccurate in cases of persistent vegetative conditions, and that it seems quite reasonable to demand merely cortical death as a definition of death, thus relieving the "irreversibly appalic (decorticated) patients from costly and complex therapeutic measures" (not to mention pointless, in our opinion). Kottow suggests adopting the neo-cortical criterion and considering that the definitive loss of supra-stem brain functions means death as a result of the irremediable loss of the patient's identity (45). We agree with this position, based on the argument we have been putting forward in this paper concerning living and dying with dignity.

Whatever the position one may hold as regards the definition of brain death, it must always be left clear for both doctors and relatives alike *whether or not the artificial life support to which the patient will be subject is being applied to a person that still exists, or to one that no longer exists.* As regards answering this question, the wish that the medical team may have in bringing the death of the patient forward must be especially taken into account in order to use the patient's organs in emergency transplants. What is required here – as always – is a coherent answer; one that can apply to both young and old alike.

V. LEGAL REPRESENTATION OF THE DYING PERSON

The brain dead, the individual who is in a permanent vegetative condition, the "living dead" and the "postponed dead" spoken of by Baudouin and Blondeau (46), if they are

of legal age, *are truly disabled because they have no will, or this has been extremely diminished. Legally, however, they are deemed to be capable as long as there is no legal decision to the contrary* (47). This legal decision must be handed down in a court action that is taken against the interested party in order to declare him or her disabled, or unfit.

We feel that this is not a fair solution, either for the patient or the family, which is normally not prepared to air in public matters that are of a strictly private nature, which often *represent a threat against the dignity of the defendant*. For this very reason, we believe that an alternative solution is needed that enables the regulation of the patient with his or her doctors, to administer his or her estate, to resolve future futile life support therapy and even, to regulate for a possible euthanasia, were such an act permitted by law.

The solution sought must avoid court actions, but cannot be left to the discretion of the relatives, all too often interested in prohibition. We feel that *an impartial and independent medical authority*, such as an Ethics Committee, would be the most appropriate solution. It could apply strictly objective scientific criteria *that especially take the paramount interest of the patient into account, and which must also consider any living will that he or she may have made*. Indeed, this impartial medical authority could be the body to ask the Judge, in a non-litigious proceeding, to appoint a person to administer the estate of the patient.

NOTES

1. Arts. 55, 74, 75 and 77 of the Chilean Civil Code.

2. See *Derecho Civil de la Persona – Del genoma al nacimiento*, by FIGUEROA YÁÑEZ, GONZALO, Editorial Jurídica de Chile, Santiago, 2001, pgs. 123 to 131 to learn of the different positions and their defenders.

3. FIGUEROA YÁÑEZ, GONZALO, op. cit. (2), pgs. 150 to 152.

4. The concepts of "that which is about to die" as opposed to "that which is about to be born" were created by the students ARAYA PAVEZ, DELIA DEL ROSARIO and CORNEJO PLAZA, MARIA ISABEL, who used it in the Test Report entitled *"Contenido del concepto jurídico de persona en relación a los pacientes en estado vegetativo permanente"*, that they drew up for their degree in Legal and Social Sciences in the Univsersity of Chile, Santiago, 2006.

5. This is the name employed by Dr. DELIA OUTOMURO, Coordinator of the Chair of Bioethics of the University of Buenos Aires. See her article entitled *"Algunos dilemas bioéticos en torno a la vejez"*, in the *Revista Ars Medica*, Catholic University of Chile, Vol. 8, Nº 8.

6. *Escritos sobre vejez, envejecimiento y muerte,* by LOLAS STEPKE, FERNANDO Ediciones Campus de la University Arturo Prat, Iquique, Chile, 2006, pg. 38.

7. LOLAS STEPKE, FERNANDO shares the same opinion in op. cit. (6), pg. 20.

8. REVISTA INTRAMED, anonymous article entitled *"Vejez y Discriminación"*; 5th April 2006, in http://www.globalaging.org/elderrights/world/2006/agingandiscrimination.htm, pg. 1.

9. *Population Growth, Structure and Distribution. The Concise* by UNITED NATIONS, New York, 2000.

10. UNITED NATIONS SECRETARIAT, *The World at Six Billion. Population Division*, New York, 1999.

11. *"Transición demográfica y envejecimiento en América Latina y el Caribe: hechos y reflexiones sociobioéticas"* by AGAR CORBINOS, LORENZO in the magazine, *Acta Bioética*, Year VII, Nº 1, Santiago, 2000, pg. 31. The author is OPS/OMS Regional Bioethics Programme Consultant. The quotations in the text are taken from cited article.

12. AGAR CORBINOS, LORENZO, op. cit. (11), pg. 37.

13. Figures obtained from the article entitled *"Aging and dying: medical and ethical considerations"* by JAMES F. DRANE in the magazine Acta bioética, Year VII, Nº 1, Santiago, 2000, pg. 103.

14. LOLAS STEPKE, FERNANDO, op. cit. (6), pg. 39.

15. Delia Outomuro y Fernando Lolas llegan a utilizar el término "muerte social" para referirse a la exclusión de que son objeto los viejos en la cultura occidental posmoderna. Véase OUTOMURO, DELIA, op. cit. (5) pg. 8, y LOLAS STEPKE, FERNANDO, op. cit. (6), pg. 45.

16. REVISTA INTRAMED, op. cit. (8) pg. 3

17. *"El envejecimiento: oportunidad para una medicina en busca de sus finalidades"* by BOITTE, PIERRE in *Acta Bioética*, Year VII Nº 1, Santiago, 2000, pg. 11.

18. *La ética ante la muerte y el derecho a morir* by BAUDOUIN, JEAN – LOUIS and BLONDEAU, DANIELLE, Editorial Herder, Barcelona, 1995, pg. 15.

19. See in the same sense, LOLAS STEPKE, FERNANDO, op. cit. (6), pgs. 51 and ff.

20. *"El viejo en la historia"* by TREJO MATURANA, CARLOS in *Acta Bioética*, Year VII Nº 1, Santiago, 2000, pg. 110.

21. TREJO MATURANA, CARLOS, ob.cit. (20) pg. 109.

22. DRANE, JAMES F., op. cit. (13), pg. 99.

23. *La vejez como autorrealización personal y social* by ARANGUREN, J. Instituto Nacional de Servicios Sociales, Madrid, 1992.

24. See in this respect some classic works, such as *The protestant ethic and the spirit of capitalism* by MAX WEBER Ed. Charles Scribner's Sons, Nueva York, 1958, or *Religion and the rise of capitalism* by R.H. TAWNEY Ed. The New American Library, Nueva York, 1954.

25. DRANE, JAMES F., op. cit. (13) pg. 100

26. CICERON, *De Senectute*, 8, 26

27. CLOTET, JOAQUIM, *Preface* to the book *O direito de vir a ser após o nascimento* by AZEVEDO ELIANE ELISA DE SOUZA E Ediciones de la Pontificia Catholic University of Río Grande do Sul, Porto Alegre, 2000, pg. 10 free translation by the author.

28. *Le droit de vivre et le droit de mourir* by SARDA, FRANÇOIS, Ed. Seuil, París, 1975.

29. We have followed BAUDOUIN, JEAN LOUIS, et al very closely here, op. cit. (18) pg. 48.

30. It is what I myself – great admirer perhaps of ancient rites – did by means of my book *Memorias de mis últimos 200 años*, Editorial Andrés Bello, Santiago, 2006.

31. BAUDOUIN, JEAN – LOUIS, et al., op. cit. (18) pgs. 24 and 25.

32. As above pgs. 29 and 30.

33. We took this case from ARAYA PAVEZ, DELIA DEL ROSARIO et. al., op. cit. (4), pgs. 176 to 181.

34. BAUDOUIN, JEAN – LOUIS y BLONDEAU, DANIELLE, op. cit. (18) pgs. 82 and 83.

35. For this case, see the four works written in his own defence by HUMPHRY: *Final exit*, Hemlock Society, Los Angeles, 1991; *"Exit Final" pour une mort dans la dignité*, Le Jour ed., Montreal, 1991, *Jean's way*, Quartel Books, Nueva York, 1978, and *The right to die: understanding euthanasia*, Harper and Row, Nueva York, 1986.

36. *La eutanasia. Aspectos éticos y jurídicos* by CASADO GONZALEZ, MARIA Editorial Reus, Madrid, 1994.

37. *Introducción a la Bioética* by KOTTOW H. MIGUEL, Editorial Universitaria, Santiago, 1995, pg. 154.

38. LOLAS STEPKE, FERNANDO, op. cit. (6), footnote (30) on pg. 47.

39. *Le Monde Diplomatique*, a Chilean edition publsihed in November 2006, pg. 4. According to this magazine, in spite of the criminal typification of euthanasia, it is practiced furtively, both as regards active and passive euthanasia.

40. See previous quote, pg. 5, box.

41. We took this case from ARAYA PAVEZ, DELIA DEL ROSARIO et. al., op. cit. (4), pgs. 181 to 185.

42. This case is also taken from ARAYA PAVEZ, DELIA DEL ROSARIO et. al., op. cit. (4) pgs. 189 to 193.

43. As above, pgs. 186 to 188.

44. *Repensar la vida y la muerte* by Editorial Paidos, Barcelona, 1997, pg. 76

45. KOTTOW H., MIGUEL, op. cit. (37), pg. 151 and 153.

46. See note (32)

47. In Chile Article 1446 of the Civil Code reads: "all legally abled people, except for those declared to be disabled by law". All the disabilities laid down by law (Article 1447), except for those affecting minors, require a legal decision establishing same. As far as the insane are concered, however, it is the condition of insanity itself and not the legal decision that declares the disability, that makes the insane person legally disabled (Article 465). Nonetheless, in this case, a legal decision is still required to declare the legal act in which the insane person took part null and void.