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*THE AUTONOMY OF WILL AND THE PATIENT'S RIGHT TO SELF-DETERMINATION: LEGAL GUARANTEES AND (BIO)ETHICAL DILEMMAS***

Life is a progression of activities constantly heading to death, and slowly but steadily approaching it. Death brings closure to the long-term predicament called life.
Ivo Andrić, Bosnian Chronicle

Abstract: *In the scientific discourse of examining any aspect of euthanasia, it is essential to determine what euthanasia exactly is. The correct definition of euthanasia and its forms, which must include an analysis of the justification of such distinctions, linking euthanasia with similar concepts, are the necessary prerequisites for a reasoned public debate on its legalization. The reason for the debate is provided by the Preliminary Draft of the Civil Code of Serbia, which establishes a new subjective (personal) right - the right to a dignified death (euthanasia), which may be exercised in exceptional circumstances by fulfilling the specifically prescribed humane, psycho-social and medical conditions. Euthanasia entails not only legal and medical but also psychological and social aspects. Thus, the Commission for drafting the Civil Code reserved the right to make a subsequent final statement on this matter, by relying on the arguments of experts from various fields and professional activities. Public educated debate is much needed before the legislator makes the final word, and legal scholars are certainly invited to participate in this*

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discussion. This paper focuses on the correlation between euthanasia and the principle of private autonomy (the right to self-determination) in order to examine whether they can provide a sound ground for defending the right to a dignified death.

***Keywords*:** *the right to life, inviolability (sanctity) of life, private autonomy, self-determination, dignity, euthanasia, patients' rights, refusal of medical treatment, palliative care, bio-ethical dilemmas.*

1. Introduction

The inviolability of life is the foundational principle of law in most jurisdictions worldwide.[1] This principle has also its philosophical, moral, ethical and religious connotations; therefore, it can be approached from various aspects of intellectual inquiry. The doctrine and the principle of inviolability (or sanctity) of life were originally formulated by theologians, who considered it to be of overarching moral value: "human life is sacred, that is inviolable, so one should never aim to cause an innocent person's death by act or omission" (Keown, 2012: 3).[2] The legal cloth for this ethical principle is provided in some of the most important legal documents, both national and international. They all guarantee the right to life, which is often regarded as the most fundamental of all human rights, whose protection is the necessary prerequisite for the establishment and protection of other human rights. The Universal declaration of Human Rights (UDHR)[3] declares that everyone has the right to life, liberty and security of person (Art. 3 UDHR). The European Convention on Human Rights (ECHR)[4] declares that everyone's right to life shall be protected by law and that no one shall be deprived of life intentionally (Art. 2 ECHR). The right

1 John Keown is one of the prominent theorists who advocates for the inviolability of life principle is. His seminal work *The Law and Ethics of Medicine* is entirely devoted to the inviolability of human life, which is in his opinion a strong argument against euthanasia and similar medical practices that hasten patient's life.

2 Looking back in the past, the principle of inviolability of life meant that it is always wrong to intentionally take innocent life. Yet, although some acts do interfere with other person's right to life, they are excluded from this principle: the use of lethal force in self-defense, the prosecution of a just war, and the execution of capital offenders. The person who is excluded from the principle behaves in violent and aggressive way and, thus, he/she actively contributes to unjust aggression.

3 The Universal Declaration of Human Rights (UDHR, 1948), GA Resolution 217A, proclaimed by the UN General Assembly in Paris, 10.Dec. 1948; https://www.un.org/en/about-us/universal-declaration-of-human-rights

4 The Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, 1950) was the first international human rights treaty to protect the right to life in a detailed manner. The Convention was drafted after the Second World War, under the influences

to life is also enshrined in the Serbian Constitution, which stipulates that human life is inviolable (Art. 24).[5]

The inviolability of life has long been a foundational principle of law, but it also transposes to other fields of human activity. It can also be addressed in the medical context, particularly at the end of life, where one faces several dilemmas, one of them being whether the right to life has equal value regardless of the length and quality of person's life. Does its protection by law necessite the continued provision of life-sustaining treatments regardless of its benefit to the individual? The question posed here is: are there boundaries of the right to life, except for those permissible limitations provided in the treaties where this right is guaranteed?[6] Is it possible to find boundaries that can also be justified from the moral and ethical point of view? Which legal principles have the same or, at least, close enough significant weight as the principle of sanctity of life, capable of defending the position that, sometimes, one should not insist on preserving life at all cost.

Autonomy of will and the right to self-determination are often highlighted as valid counter-arguments, as well as the principle of beneficence as one of the foundational principles of biomedical ethics. It is interesting to note that each of these principles can be, and frequently is, used to support either side of the euthanasia ethical debate. One may interpret autonomy as the essence of our personal freedom that also includes the possibility of choosing the way we want to die. From another perspective, one may argue that it is always justified to circumvent that freedom in order to protect the person from making decisions which are harmful to one's life. The principle of beneficence can also be viewed from different angles. One point of view, particularly accepted among health workers, is that death can never promote one's welfare, and that assisted dying contravenes the very essence of this principle. The other point of view is that providing assistance in dying to the person who suffers unbearable pain actually promotes one's welfare, as it shortens one's suffering and hastens death.

Our examination starts with the terminology and classification of all terms used to describe what euthanasia is, or what it is not, and which concepts should or should not be associated with euthanasia. It is followed by thorough analyses of the aforementioned principle.

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of memories of Nazi's gross human rights violations and disregard for the value of human life. For detailed analyses, see: Wicks, 2007: 227 – 231.

5 The Constitution of the Republic of Serbia, *Official Gazette of the RS*, 98/2006, 115/2021.

6 See, for example, Art. 2, para 2 of the ECHR, as well as Art. 20 of the Serbian Constitution.

2. Definitions and classification of relevant concepts: euthanasia and physician assisted dying

2.1. Dying as part of separation

The process of dying has always been an integral part of medical practice. Assistance in the process, in its various forms, has been known in medicine for centuries. It is not something new and unexpected, for the doctors have always been with their dying patients, to alleviate pain and suffering when all medical treatments have proved to be futile. Doctors' support to the patient who faces the inevitable end of life is of the great importance and may be considered as one of doctors' professional duties. At this point, we face the problem of euthanasia or mercy killing (Клајн-Татић, 1994: 340).

Assisted dying, however, has bad reputation among those who strongly object to euthanasia or similar practices which directly or indirectly hasten death of a dying patient. The involvement of a doctor, whose duty is to save lives not to shorten them, is especially unacceptable. Thus, alternative ideations to those associated with assisted dying are often used although they, in fact, do interfere with a natural course of things.

Finding the right approach to the end-of-life decisions is not an easy task, for death is a process during which individual cells in the body cease to function at different times. The complexity of this issue becomes greater due to the advancement of medicine and use of modern technology which can prolong life (but not necessary its quality) even to the point where a person is kept alive solely with the help of life support measures, but without being conscious. Is she alive or dead? A workable answer to this question may well serve as a guideline in making the correct or, at least, the most acceptable end-of-life decisions. We will return to this dilemma later but, first, we must explain the concepts of euthanasia and assistance in dying.

2.2. Definition and classification

The linguistic level will be the first level of interpretation; we start from the etymology of the word *euthanasia*.[7] The term comes from the combination of the Greek words *eu* (meaning good, with the undertone easy) and *thanatos* (meaning death). Loosely translated, the meaning of this word would be good and easy death, or simply mercy killing.

The origin of the word demonstrates that euthanasia is not a novel issue; it has been part of human's inquiry since ancient times. Yet, this fact did not lead either to the consensus about the most acceptable definition of the term or about behaviors which correspond to the concept of euthanasia and those that do not and should be labeled with different terms.

7 For detailed linguistic explanation, see: Nedić, Zibar, Baraban, 2022: 69 – 88.

In the *Encyclopedia of Global Bioethics,* the meaning of the term euthanasia is reduced only to active voluntary euthanasia (Kimsma, 2016: 1179). This definition was largely influenced by the findings of the Commission on the Study of Medical Practice Concerning Euthanasia: the Remmelink Commission, established in 1990 by the Netherland's government with the task of gathering information about the practice of both euthanasia and other medical decisions at the end of life and providing viable definitions.[8] Euthanasia was defined as "intentionally taking the life of a person upon his or her explicit request by someone other than the person concerned" (Kimsma, Van Leuwen, 1993: 24). Explicit and informed consent of the person concerned is of the paramount importance here, for it assumes the role of a criterion for differentiation between the various forms of hastening death.

The Remmelink Commission identified real cases of euthanasia, which correspond to the above definition, and cases they called *phantoms of euthanasia*, which hasten the patient's death but are part of normal medical treatment or palliative care. Thus, the following practices can be considered phantoms: 1) withholding or withdrawing useless medical treatment; 2) the treatment of pain with the additional effect of shortening life; and 3) a refusal of the patient to be treated. These issues do not correspond to the definition of euthanasia for the following reasons: 1) a treatment that has no medical justification and no goal is unjustified from a professional point of view; 2) the treatment of pain follows from the medical duty to care for the patient (here, death is a side effect and the aim is to relieve suffering); 3) the patient has the right to decide whether to accept treatment or not (Kimsma *et al*, 1993: 24).

Some authors consider euthanasia to be an act or omission to act with the intent of bringing about death of a terminally or incurably ill patient in order to end one's pain and suffering (Beširević, 2016: 152). Contrary to the Dutch definition, the proponents of this approach consider a range of activities to fall within the ambit of euthanasia, including those which are already part of an established medical practice but not under the term euthanasia. Thus, euthanasis entails: administration of lethal injection, prescribing recipes for a lethal pill or giving advice about methods that lead to death, administration of sedatives in dosages that may hasten the patient's death, non-treatment of

8 The Netherlands had a prominent role in a number of controversial issues: sexual revolution, legalization of prostitution and abortion, acceptance of non-addictive drugs, democratization of educational institutions, questioning the religious authority, etc. The society shifted its focus to autonomy and individuality, individual choice, and liberation from collective morality. Thus, the great influence of their experience on the debate about euthanasia and death with dignity should not come as a surprise. The Netherlands is the most frequently cited example of a modern approach to the questions of euthanasia and physician-assisted suicide. See more in: Cohen-Almagor, 2014.

treatable conditions, withholding or withdrawing life-supporting systems, and honoring the do-not-resuscitate order (Beširević, 2016: 152).[9]

Another classification offers the terms voluntary active euthanasia and assisted suicide (McCann, 2016: 1). *Voluntary active euthanasia* is understood as the termination of life of another person at the latter's explicit request. *Assisted suicide* refers to the voluntary termination of one's own life by self-administering drugs with the assistance of another person.

Active and passive euthanasia are generally regarded as two separate phenomena, the difference being whether death is the consequences of the commission of an act (*active euthanasia*) or the omission to provide life-prolonging treatment (*passive euthanasia*).[10] Active euthanasia may be considered either as *direct euthanasia*, where the patient death is the direct consequence of the lethal substance provided by the doctor, or *indirect euthanasia*, where death is merely the incidental effect of the measure aimed at easing the pain and suffering of the dying patient (Radišić, 2008: 144-146).

There is also a third approach which finds connection between the physician-assisted suicide and active euthanasia in a direct act intended to cause a patient's death. The difference between the two lies in the degree of doctor's involvement in the dying process: in active euthanasia, a doctor performs the act intended to cause death; in physician-assisted suicide, the patient performs the final act (Spina, 1998: 71).

The definitions presented here presuppose the existence of a valid informed consent (consent model). Similar to the aforesaid definition from Netherland, this position distinguishes voluntary active euthanasia and assisted suicide from certain permissible medical behaviors that potentially shorten life and are often attributed to the term euthanasia. Respecting the patient's wish

9 Beširević also finds no difference between euthanasia and the requests for acknowledging the right to die, which is considered to be a modern euphemism for euthanasia, accepted mostly to avoid undermining the ethical integrity of the medical profession (Beširević, 2016: 152).

10 From the legal standpoint, legal repercussions are usually attributed to a person's active behavior (commission). Yet, omissions may also generate some kind of legal response. Liability for the consequences of an omission usually occurs if a person is under a duty to act, namely, if he/she is in a special relationship to the victim to whom she owes a duty of care. Doctor-patient relationship is a paradigmatic example of such relations, for the patient is under the doctor's care. "Clearly, then, the doctor who does not provide or who withdraws treatment from a patient under his or her care cannot hide behind the general cover that there is no legal duty to rescue. There must be justifiable reason for inaction and, in case of a competent patient, this is dictated by his or her autonomy" (Mason, Laurie, 2011: 583). The will of the patient who is unable to demonstrate it (e.g., a patient in permanent vegetable state) must be substituted either with the will of his proxy or with the medical opinion based on the patient's best interest.

to refuse the treatment or to withdraw from those which are unavailing is one of them. It is interesting to note that most lawyers consider this practice to be passive euthanasia while most medical professionals strongly object to such a designation. The term *indirect euthanasia* is another disputable issues between the members of these professions. Lawyers use this term to describe medical measures which alleviate pain of the dying patient but eventually lead to one's death. Doctors consider it to be part of the patient's palliative care, where death is the consequence of patient's poor health and incurable illness rather than the undertaken measures.

The consent model is based on two premises: the degree of the patient's cooperation, and the doctor's role in the process (Mason, Laurie, 2011: 566). From the patient's point of view, euthanasia/assisted dying can be: *voluntary* (where the patient requests his/her life to be ended), *non-voluntary* (where the patient is unable to express the opinion), and *involuntary* (where the patient is not included in the decision-making process). Involuntary euthanasia amounts to murder and is legally prohibited.

On the other hand, we may observe the status of the person (external agent) involved in the dying process, who is either a doctor (or another health care provider, such as a nurse) or a close relative. Their role is either active, when the death of a patient is a consequence of a commission, or passive, when death occurs due to the omission (Mason, Laurie, 2011: 566). The term *active voluntary euthanasia* describes the positions of both involved parties. Patient is compliant in the (voluntary)act and the doctor is active (she/she is the provider of a lethal substance; then, the patient will complete the action either by committing (assisted) suicide or by administering the substance himself/herself.[11]

The presented definitions and classifications clearly indicate that the practice of euthanasia involves various types of assistance in the death of a terminally ill patient in order to alleviate suffering and demonstrate compassion.[12] Assistance is sometimes active, when a doctor (or another external agent) administers the lethal substance or, more often, withdraws the life-sustaining treatment at the patient's request. In the latter case, although most physicians consider that death occurs as a consequence of the natural course of a terminal

11 This type of a doctor's involvement is labeled *physician accomplished suicide;* see: Mason, Laurie, 2011: 567.

12 The reality of the practice of euthanasia goes far beyond the very definition of euthanasia. In the majority of cases, it is applied to terminally ill patients but there is also a strong support for legal availability of euthanasia for consenting individuals with irreversible but not terminal diseases.

illness, death is actually hastened through human intervention and, therefore, may be attributed to the intervenor.[13]

3. Assessment of euthanasia

In order to properly assess euthanasia, we must look for answers to deeply contentious philosophical issues about human life and its value. We must ask ourselves whether we should still insist on the principle of sanctity of life, or whether it is time to reconsider this concept? Should we search for specific features that make one's life significant and worth living, or for those that transcend simple biological existence?

Many religious, ethical and philosophical arguments have been raised in the euthanasia debate, and all of them deserve to be approached from various fields of inquiry. Lately, other arguments come to the fore, thanks to numerous human rights treaties and a change of paradigm in the doctor–patient relations. One of them is the principle of private autonomy, the foundational principle of private law and the very essence of the right to self-determination. We further focus on the sanctity of life principle and value of life, dignity and private autonomy, for these seem to be the most invoked arguments in the euthanasia debate, both by the proponents and the opponents of this practice.

3.1. The sanctity of life

The principle of sanctity of life is the subject matter of extensive debate in the academic literature. It may seems as a valuable guiding principle in the end-of-life issue, but not without some competing principles which in some situations serve as its corrective. The principles of respect for dignity and private autonomy are competing principles one may use in answering the question whether life should be preserved at all cost.

The principle of sanctity of life has a religious origin: life is considered sacred, a gift from God, the only one who has the right to decide when to take it. Both the Orthodox Church and the Catholic Church strongly reject and condemn any form of euthanasia, for each life is holy and sacred and its termination is always unlawful.[14] The principle applies to all human beings by virtue of their nature and not their abilities, and therefore applies to all human beings equally (Miller, 1996: 33).

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13 For detailed discussion about the definition and classification of euthanasia, see: Petrović, 2010.

14 Human life is highly valued in Eastern cultures and thought as well. The three teachings that shaped the Chinese culture – Confucianism, Taoism and Buddishm – also provide the framework for understanding and resolution of ethical dilemmas in relation to the treatment of terminally-ill patients. See: Qiu, Ren-Zong, 1993: 69 – 76.

Christian theologians invoke several arguments against euthanasia. The first one is that human life is the basis of all goods, and the necessary condition of every human activity and of all society.[15] The disposal of life is in God's hands; man holds life in trust, has the use of it, and therefore, may prolong it, but has no right to destroy it at his will (St. John-Stevas, 1961: 272). That's God's prerogative. Another argument is that no man has the right to take an innocent life, except if it is necessary to defend an individual or common good from the unjust aggression. A third line of argumentation points to the danger of abuse (the slippery slope argument). It is only a matter of time before taking innocent life at person's request (camouflaged with words such as merciful killing or dignified death) will be spread to others who are in vulnerable position or cannot speak for themselves (the incapacitated, the old, the handicapped, and anyone who is considered to be a burden to society). The final argument, which theologians share with the medical community, is that it would undermine the doctor-patient relationship, which is based on mutual confidence, where the patient trusts his/her doctor to do anything possible and medically justified in treating the condition (St. John-Stevas, 1961: 275). From the doctor's point of view, both the Hippocratic Oath and codes of medical ethics oblige him/her to do all he/she can to preserve the patient's life.[16] Catholic theologians point out here that doctor's duty does not entail the use of extraordinary means which give no reasonable hope for recovery and do more harm than benefit, nor is the patient under an obligation to accept such a treatment.[17]

3.2. Keown's doctrine of the principle of the sanctity of life

One of the most prominent advocates of the principle of sanctity of life is John Keown, a Christian ethicist and vigorous opponent of euthanasia. In his doctrine, Keown uses three competing approaches to evaluate human life: vitalism, inviolability of life, and quality of life. (Keown, 2012: 4–6) The last one is of a great value in the euthanasia debate as it acknowledges circumstances where life has lost its quality and it may be proper to intentionally terminate it.

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15 In *Declaration on Euthanasia* (1980), issued by the Sacred Congregation for the Doctrine of Faith, euthanasia is condemned as "a violation of the divine law, an offense against dignity of the human person, a crime against life, and attack on humanity" (Declaration on Euthanasia, 5 May 1980, Rome, Vatican; available at: https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

16 The Hippocratic Oath states: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel". The International Code of Medical Ethics, adopted at the third general assembly of the World Medical Association, London, in October 1949, states that a doctor must always bear in mind the importance of preserving human life until death (WMA, 2023).

17 For detailed explanation of these arguments, see: St. John-Stevas, 1961.

Vitalism is the first approach considered by Keown. Vitalism is built upon the premise that human life is of utmost importance ("the supreme good") and must always be preserved. Life of each patient is valuable and must be preserved at all costs. Regardless of the pain and suffering endured by the patient, regardless of the costs of the life-prolonging treatment, it is always forbidden to shorten the patient's life (Keown, 2012: 4).

On the opposite hand, there is a quality of life approach, which dismisses the predetermined and undeniable value of human life. Human dignity is seen as a mere instrument for living a worthwhile life, a life that must reach a certain level of quality and meaning. Lives of some patients do not meet this quality level due to their health condition. The principle rooted in this approach tells us that certain lives, because of their poor quality, are not worth living and it is right to terminate them intentionally, either by an act or omission (Keown, 2012: 5). Keown rightly criticizes this approach for its discriminative and arbitrary nature; it denies the ineliminable value of each patient's life and the inherent equality of all human lives.

The inviolability of life (IoL) doctrine is the approach which is strongly supported by Keown. The ethical principle of the sanctity of life, as the core of this doctrine, stands in the middle between the two extremes (vitalism and quality of life) described above. Unlike the position in the quality of life approach, where life is consider to be an instrumental good, IoL doctrine holds that human life is a basic, intrinsic good. Thus, "all human beings possess, by virtue of their common humanity, an inherent, inalienable, and ineliminable dignity. They possess the capacities inherent in their nature even though, because of infancy, disability, or senility, they may not yet, or not now, or no longer have the ability to exercise them" (Keown, 2012: 5). In Keown's view, capacities are different from abilities; they must not be confused with one another. Albeit each person has the radical capacities (such as: understanding, rational choice, and free will) which are inherent in human nature, some may not have the ability to exercise them yet (like infants) or no longer have them (like people with dementia, who have lost the ability to exercise some of aforementioned radical capacities).

Every human being has a fundamental worth and dignity, which cannot be taken away as long as one is alive due to their immanent and unconditional nature, which does not rest on a specific personal quality. Human dignity is not dependent on a particular intellectual ability, nor it is this ability required to reach a particular degree. As life has an intrinsic value,[18] the right not to be killed is enjoyed by all humans regardless of inability or disability.

18 In other words and in Kant's tradition, it entails not merely good as a means to an end, but something worthwhile in itself.

Human life is a basic good, but it is not an absolute one, to which all the other basic goods must be sacrificed in order to ensure its preservation (Keown, 2012: 6). The principle of IoL prohibits intentional killing because it is wrong to destroy life, but there are certain limits in its preservation. The doctrine is not vitalistic in that sense: human life is not an absolute good, but prohibition on intentional taking of life is. There are some correctives to this position. Doctors are under no moral obligation to preserve life at all costs. There is no duty to impose treatment which gives no reasonable hope or benefit to the patient; even if it does, the expected benefit would be outweighed by burdens which the treatment would impose (Keown, 1998: 284). Withdrawal of treatment should be based on an evaluation of its worthwhileness, but it does not mean that patient's life is of a less worth due to his poor health.[19] Thus, the utility of the treatment is being evaluated, not the value of patient's life.

The sanctity of human life has had a great influence on contemporary precepts of human rights, for they are also based on the premise of equality of people, who have the right to equal protection of their life, dignity and freedom. The concept of human rights treats all humans as valuable and worthy of respect and, therefore, promotes the idea of human life being sacred (Wicks, 2007: 231). International treaties, domestic laws and jurisprudence guarantee and protect the right to life but also recognize that the sanctity of life principle cannot be an absolute one: the principles of personal autonomy, self-determination and dignity are potentially conflicting principles which may outweigh the sanctity of life principle. They do not deny the right to life but rather serve as the criteria for resolving ethical dilemmas related to the end-of-life decisions. In the next part, we turn to these valuable principles.

4. Autonomy and self-determination

Personal autonomy implies the possibility of a person to freely, and independently of other people's influence, create a rule by which he/she will act. This self-made rule [20] is binding, not only for its creator but also for other people whose duty is to respect it as long as it does not conflict with their respective rights and freedoms. On the one hand, the principle of autonomy creates the field for exercising individual freedom and for making personal choices; on the other hand, it faces the necessary limitations: the law, moral and public order (as general limitations), and rights and freedom of all other members of society.

19 Contrary to this, the quality of life doctrine is not concerned with assessing the usefulness of treatment but assessing the usefulness of the patient's life.

20 The term autonomy is derived from two Greek words*: autos* (self) and *nomo*s (rule, governance, law) which, literally translated, means self-made rule.

An autonomous person is the one who is capable of understanding the essence and the importance of facts, values and other determinants on the basis of which the decision is made, to understand the consequences one's ability to shape his/her ideas according to one's own values and beliefs (moral code), to reflect upon them and to act accordingly (Cohen-Almagor, 2014: 7).

Autonomy without freedom to decide how to live one's life is not a genuine autonomy. They are interrelated: individual freedom to act is based on private autonomy. This foundational principle of private law is also foundational for the person's right to self-determination, which is accomplished by making choices among a range of options. The individual chooses the one that corresponds to his/her beliefs, values and goals pursued. The accomplishment of the chosen option may come with hardship or may even demand some sacrifice, but one is willing to accept them for the goal that is worth pursuing.

There are numerous explanations of individual autonomy but they have some common elements, such as:. freedom (independence from external influence and coercion) and the ability to act consciously and willingly, which are the necessary conditions for exercising autonomy (Simonović, 2011: 456; Beauchamp, Childress; 2001: 57-61). Autonomous choices presuppose some extent of rationality, but not perfect rationality. Therefore, the choice does not have to be the best objective option, a choice that others would make. The choice is always subjective and only by being such (subjective) it truly reflects autonomy and individuality of a person.

The principle of autonomy of will permeates the entire civil (private) law but its application extends to other areas of law and humanities closely related to it, including medical law and medical ethics. Modern medicine has abandoned paternalism and replaced it with the autonomy-based approach, according to which there is a legal duty of the physician (and other health care workers) to respect the patient's decisions about recommended medical treatment (Mujović-Zornić, 2015: 305-307). This new paradigm puts the doctor and the patient in the position of equal partners, involved in mutual cooperation, because it is in the best patient's interest but also because it is a reliable way to a favorable health outcome. The doctor and the patient are united by the same goal they strive for: to heal and/or improve the patient's health; their mutual rights and duties are stipulated to meet this complex task.[21]

The patient's right is to accept the treatment or to refuse it. The corresponding duty of a physician is to respect the patient's decision and act accordingly. What should be the physician's response to the patient's refusal of a life-saving treatment or a more radical patient's request for assistance in dying? Should the physician honor the patient's wishes, or should he/she stay

21 For more on doctor-patient relation, see: Simonović, 2011 and references made therein.

true to his/her primary call – to heal and save lives, not to end them (*primum nil nocere!*[22])?

5. Resolution of ethical dilemmas

Ethical dilemmas posed here relate to euthanasia and assistance in dying which may be legal or illegal. Only few jurisdictions have legalized these practices.[23] Euthanasia and physician-assisted dying can be legally practiced in the Netherlands, Belgium, Luxembourg, Colombia, and Canada. Physician-assisted dying, excluding euthanasia, is legal in five USA states (Oregon, Washington, Montana, Vermont, and California) and Switzerland.[24] The position of the doctor in these jurisdictions is pretty much straightforward: providing that all necessary and legally prescribed requirements are met, the patient's request will be granted.

Prohibition of assisted dying does not necessary mean the absence of such a request. In the countries which prohibit any kind of assistance in the dying process (most frequently, sanctions are provided in criminal law), doctors who (covertly) assist the dying patients experience direct personal impact. Not only do they feel fear of being discovered and reported to the authorities, but they also cannot safely share the emotional load with their colleagues or ask for professional support (MacLeod, Wilson, Malpa, 2012: 90).

Most medical practitioners consider that assisting an individual to die is unethical. They respect the sanctity of life principle, feeling that their duty to heal is above the personal autonomy and wish of a dying patient who, unable to endure pain and suffering, asks for assistance. For patients who place a great value on their independence and autonomy, pain and suffer are not the decisive motives, but rather their fear of loss of dignity and autonomy during the dying process, or becoming a burden to their loved ones. Their autonomy in the dying process expressed in the request for lethal substance collides with the physician's autonomy to refuse to participate in this practice, which should also be respected. On the other hand, the patient's refusal of a life-saving or life-prolonging treatment is one of his/her rights, which the physician must appreciate and adhere to as his legal duty.

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22 This Latin phrase, attributed to Hippocrates, establishes a professional conduct and bioethical framework for the practice of medicine in respect for human dignity.

23 For a detailed explanation of legal developments in the euthanasia debate, see: Ferreira, 2007, 387-407.

24 Switzerland is the only country in the world where the act of assisted dying can be conducted by someone other than a doctor. Non-Swiss residents are also allowed to take advantage of the Swiss law, which eventually led to the so-called "death tourism" and individuals travelling to Switzerland to die by assisted means.

6. Conclusion

The tremendous advances in medical technology and health care provide many options for prolonging a terminally ill patient's life, often beyond the point at which he/she is able to derive value from that life or even live free from pain and suffering. These advances have made the dying process longer and raised many questions, including when it is time to stop the futile treatment and who should decide.

The principle of autonomy and the patient's right to self-determination assume a pivotal role in health care and doctor-patient's relations. They may offer the answer to the previously posed questions: patients should have the right not only to refuse the treatment or to request their discontinuation (which is already an established golden rule of patient's care) but they should also be given the right to request aid in dying.

Euthanasia and other forms of assisted dying are legal in just a few countries but occasional surveys of public opinion indicate a significant and increasing number of people who would support their legalization or, at least, honest public debate on this matter. This has led to the right to die movement which emphasizes the patient's liberty and autonomy to make fatal choices at the end of their life. Liberty, autonomy, dignity, respect and concern (or care for the patient's well-being) are four pillars on which the right to die movement is founded. Their proponents speak about physicians' duty to respect all legitimate concerns and needs of their patients, including the provision of aid-in-dying. Most physicians are reluctant to accept the idea that their professional duties (to heal, relieve pain and suffering, provide care and comfort for the patients) should also include the duty to end life.

These contradictions testify about the complexity of euthanasia issue and the fierce struggle between the proponents and the opponents of euthanasia. This also justifies the need for a public debate on all aspects of euthanasia and related terms before deciding whether to legally allow anyone who is incurably ill to be able to seek medical assistance to die (to die on his own terms and in his own time). The debate should include not only the members of the legal and medical profession but also experts whose knowledge in ethics, bioethics, sociology, gerontology, religion and other fields can provide valuable insights in death and dying. Public opinion should not be ignored either, but the public must be properly informed about all relevant points before taking side: for legalizing euthanasia or against it.

In the Republic of Serbia, the reason for the debate is provided by the Preliminary Draft of the Civil Code of Serbia, which establishes a new subjective (personal) right - *the right to a dignified death (euthanasia)*, which may be exercised in exceptional circumstances by fulfilling the specifically prescribed

humane, psycho-social and medical conditions. Bearing in mind the complexity of exercising the right to euthanasia, which entails not only legal and medical but also psychological and social aspects, the Commission for drafting the Civil Code reserved the right to make a subsequent final statement on this matter, by relying on the arguments of experts from various fields and professional activities.

The term for the "right to a dignified death" can be questioned terminologically. The essence of the right is not the right to death but the right to the comprehensive protection of human dignity, particularly in the context of dying and terminal illnesses. The patient's right to self-determination in relation to such a difficult condition at the end of life should be recognized.

Nevertheless, one must not overlook the importance of palliative care. It has been said that autonomy, in its essence, means freedom of choice. Consequently, if we are considering the legalization of euthanasia, we should also demand enhancement of palliative care, which should first of all include all those who need it and, second, promote all types of services which are considered to be of palliative nature. All of these services should be treated as parts of obligatory health care program and funded from the state budget. The Netherland is often referred to as being a pioneer in the field of assisted dying, but this country has a strong palliative care system as well, available to all in need of this kind of help. This lead us to the following conclusion: prior to the legalization of any kind of assistance in dying, which should be limited only to the physician-assisted dying under strict requirements and supervision, Serbia must improve its palliative care system (particularly in terms of availability and effectiveness) and thus provide various kinds of health care options to its citizens. In accordance with the constitution and laws, all legal options should be available to each person in the state: refusal of treatment, palliative care, and even available forms of medical procedures regarding euthanasia.

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АУТОНОМИЈА ВОЉЕ И ПРАВО НА САМООДРЕЂЕЊЕ ПАЦИЈЕНТА: ПРАВНЕ ГАРАНЦИЈЕ И БИОЕТИЧКЕ ДИЛЕМЕ

Резиме

Невероватан напредак медицинске технологије и здравствене заштите омогућио је различите могућности продужења живота умирућег пацијената, чак дотле да се оправдано можемо запитати о вредности и смислу таквог живота. Вештачке мере одржања умирућих пацијента у животу учиниле су процес умирања дужим, истовремено суочавајући нас с дилемом оправданости окончања медицинске неге која не даје никакве резултате, те питањем ко о томе треба да одлучи.

Савремена парадигма односа лекар – пацијент почива на принципу аутономије воље и пацијентовом праву на самоодређење. Они могу дати смернице у тражењу одговора на постављена питања. У том кључу, пацијент не само да има право да одбије пружање медицинске неге или да захтева прекид већ започете (што је златни стандард бриге о паацијентима), већ му треба омогућити и право на тражење помоћи у умирању.

Мало је земаља у којима су еутаназија и различити облици помоћи у умирању законом дозвољени. У Србији санкционисани су као кривична дела. Нацртом Грађанског законика, ипак, установљава се ново субјективно (лично) право – право на достојанствену смрт (еутаназију), дозвољену под нарочитим условима, уз испуњење посебних људских, психо-социјалних и медицинских претпоставака. Пре законодавчеве коначне речи, неопходна је јавна информисана дебата о овом сложеном питању. Правни стручњаци свакако су позвани на учешће у промишљању предлога о чињењу еутаназије законски допуштеном, као што треба ослушнути и став грађана.

Кључне речи*: право на живот, неповредивост (светост) људског живота, приватна аутономија, самоодређење, достојанство, еутаназија, пацијентова права, одбијање медицинске мере, палијативна нега, биоетичке дилеме.*