Slađana Jovanović*

THE RIGHT TO DIE WITH DIGNITY IN SERBIA

The author poses the questions: Who is entitled to the right to life: an individual or, society/state has some share in it, especially considering the right to choose when and how to die? Do terminally ill patients have an obligation to live in pain and suffering, losing self-esteem, and dignity? They need to commit suicide, or there should be more appropriate way to die with dignity (especially, when they are not capable to end life by themselves, due to severe, terminal illness)? The paper deals with the end-of-life issues such as (assisted) suicide and euthanasia, emphasising the state of play in Serbia, especially the Civil Code Draft provisions on right to dignified death. Author points out that despite raising awareness that there is a real need to regulate end-of-life issues, it is obvious that states (like Serbia), and international institutions keep on avoiding clear answers. These problems remain covered by silence and widespread but ungrounded fear of abuse, along with secret practice. The gap between present ineffective prohibitions and actual uncontrolled practice ought to be overcome by improved legislative solutions. The paper has made a small step forward on the way of making euthanasia legal in Serbia, thus offering to those who suffer to die with dignity (preventing "death tourism", suicide, and different illegal practices).

Keywords: *right to die with dignity, (assisted) suicide, mercy killing, euthanasia, Draft Civil Code of the RS*

* Dr Slađana Jovanović is full professor at the Union University in Belgrade.
Email: sladjana.jovanovic@pravnifakultet.rs

1. Introduction

Right to life (and its protection) is an issue inevitably related to vast array of emotionally charged questions. The right to death (with dignity), (assisted) suicide, and euthanasia are the topics that have been sparking debates for decades. Possible answers reveal complexity of the relation and balance between state paternalistic approach and individual fundamental rights, as well as between the right to life, on the one side and the right to self-determination, to privacy, and even to protection from inhuman and degrading treatment, on the other side.

Whenever the right to life comes into a focus, the most of the authors emphasize its supremacy, and its qualities such as inalienability, inviolability, and even holiness, while the necessity of protection and the most severe sanctions for violators are not questioned. What, however, if such a precious possession loses its value for the one to whom it belongs (due to a severe, incurable illness)? Or maybe the problem is in the "ownership" concept? Are the society/state and the individual some kind of co-owners, with insufficiently clearly defined shares in the highest value, or is it a question of choosing the best model of protection, which is created by the society, and which may include protection from the holder? When the prevailing attitude was that human life belonged to God, things were clearer. By destroying the life given to an individual, the suicide destroyed someone else's property and was punished for it, even (absurdly) by death if he/she remained in the attempt. Nowadays, the act of suicide is not punishable (due to recognition of the individual's right to self-determination), but the act (of accomplished suicide, or its attempt) is usually evaluated negatively by society, and the sanction is (not confiscation of property as it used to be long time ago) but confiscation of intangible values of a suicide and his/her family members – the reputation or belief that he/she is a mentally healthy person who has the right to decide (Jovanović, Simeunović-Patić, 2006: 262).

What happens, however, when an individual cannot end his life on his/her own (when the life has lost its meaning for him/her or represents unbearable suffering). Then, the choice narrows drastically. Calling for help is (most often) inciting to the commission of a crime (even when the act was done out of mercy and compassion due to the great suffering of the other human being). In the latter case (when the other individual is asked for help), the arguments relating to the right to self-determination, to autonomy of the individual, and the right to privacy could not cope with the right to life as the supreme value, so the others have to restrain from taking part in ending someone else's life, even at his request and with altruistic motives. The explanation is usually very short – the dying/suicidal

persons are not completely mentally competent, and it is necessary to prevent possible abuse and misuse.

To the question "what accompanies the right to life: the obligation to live or the right to die?" (Vodinelić, 1995: 29), it seems that we have to say that the first offered answer prevails, because the "right to die" and its "legalization" have been maintaining dramatic tension between proponents and opponents for decades, making debates more and more fierce due to moral and religious judgments related to the sanctity of (the right to) life, autonomy and dignity of an individual (and his/her mental competency), and unavoidable "slippery slope" argument.

The authority such as the European Court of Human Rights has no dilemma - the right to die is not accompanied by the right to life[1], but it did not engage in confronting the right to life with other fundamental human rights. Fortunately, there are legislators (in Europe, too) that dare to specify the relationship between the most important human rights, and have opted to enable the individual to make an informed decision, when life becomes a burden for him/her. He/she could choose to die with dignity in an appropriate procedure, under strictly specified conditions (with an expert /medical practitioner involved). The Republic of Serbia isn't among them.

2. Suicide and Assisted Suicide

The first (but not always dignified) way to end life due to the unbearable suffering that the disease brings (or for the other reasons) is suicide. There are few countries still incriminating suicide attempt[2], but moral and social stigma often accompanies this act, shifting focus of condemnation from suicide as a sin or crime, to the mental disorder of a suicide. Suicide/attempted suicide in Serbia, is not criminalized, but incitement to suicide

[1] The applicant was dying of motor neurone disease, a degenerative disease affecting the muscles for which there is no cure. Given that the final stages of the disease are distressing and undignified, she wished to be able to control how and when she died. Because of her disease, the applicant could not commit suicide alone and wanted her husband to help her. But, although it was not a crime in English law to commit suicide, assisting a suicide was. As the authorities refused her request, the applicant complained that her husband had not been guaranteed freedom from prosecution if he helped her die. The Court held that there had been no violation of Article 2 (right to life) of the Convention, finding that the right to life could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die. *Pretty v. the United Kingdom* (application no. 2346/02), available at: http://hudoc.echr.coe.int/eng-press?i=003-542432-544154, accessed on 17. 9. 2020.

[2] On attitudes towards suicide, its criminalization and decriminalization: Jovanović, Simeunović-Patić, 2006.

and aiding in it are, so the one who cannot deprive himself of life have to incite another individual to commit a crime.

The incrimination of incitement to suicide and aiding in suicide in Serbian criminal law has not been substantially changed since the Penal Code of the Kingdom of Yugoslavia entered into force (in 1930). It has also been envisaged by the Draft Criminal Code of the Kingdom of Serbia (1910) in Art. 134 (Lopičić, 1975: 456). The current incrimination is envisaged in Art. 119 of the Criminal Code of the Republic of Serbia[3] (hereinafter: CC) and it reads:

(1) Whoever incites another to suicide or aids in committing suicide and this is committed or attempted, shall be punished with imprisonment of from six months to five years.

(2) Whoever assists another in committing suicide under provisions of Article 117 hereof, and this is committed or attempted, shall be punished with imprisonment from three months to three years.

(3) Whoever commits the act specified in paragraph 1 of this Article against a juvenile or person in a state of substantially diminished mental capacity, shall be punished with imprisonment from two to ten years.

(4) If the act specified in paragraph 1 of this Article is committed against a child or mentally incompetent person, the offender shall be punished in accordance with Article 114 hereof.

(5) *Whoever cruelly or inhumanely treats another who is in a position of subordination or dependency and due to such treatment the person commits or attempts suicide that may be attributed to negligence of the perpetrator, shall be punished with imprisonment from six months to five years.*

The offence under paragraph 2, and actions representing aiding in the act of suicide are in the focus of this paper. The provision on aiding and abetting from the general part of the CC (Article 35) is important for understanding what acts shall be considered as aiding (in suicide): giving instructions or advice on how to commit a suicide; supply of means for committing a suicide; creating conditions or removal of obstacles, etc.

[3] Criminal Code, Official Gazette RS, No. RS, br. 85/05, 88/2005 , 107/2005, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016, 35/2019.

The acts under paragraph 2 constitute lesser criminal offence (judging by the envisaged punishment) because the perpetrator assists another (seriously ill adult) at his/her serious and explicit request. The perpetrator's motive has to be mercifulness, compassion due to serious illness of another that determines the ethical appropriateness of assisted suicide. Thus, the main actor is, in fact, a person who commits suicide, while the role of the (merciful) other is secondary (he/she supplies, for example, means for committing suicide, but the means is applied by the suicide). Assisting a suicide of a child or mentally incompetent person is punishable as aggravated murder (CC, Art. 114). It should be noted here that in its revision of criminal offences that protect life from the most serious injury, the legislator has envisaged the murder of a child as aggravated murder (Article 114, paragraph 1, item 9), but mentally incompetent persons have obviously been forgotten (even though they are protected within the scope of the Article 119, paragraph 4 as the children are). This inconsistency could be considered as a big gap in the legislator's intention to provide more adequate protection of the right to life of vulnerable categories such as children and mentally incompetent persons (from the assisted suicide).

The offence of incitement to suicide and aiding in suicide has no special share in the structure of crime in Serbia. Last year, there were six criminal complaints for this offence (Statistical Office of the Republic of Serbia, 2020: 3), and one person sentenced to suspended sentence (*Ibid*: 8). In 2018: all criminal complaints (there were four complaints) were dismissed, due to the lack of grounds for suspicion/inexpediency of criminal prosecution (Statistical Office of the Republic of Serbia, 2019: 14). The situation was similar in previous years: there were two complaints in 2017 (one rejected; no charges) (Statistical Office of the Republic of Serbia, 2018: 2014); three criminal complaints in 2016 (two dismissed on the basis of conditional opportunity and due to lack of grounds for suspicion /inexpediency of criminal prosecution; one sentence of imprisonment ranging from three to five years (Statistical Office of the Republic of Serbia: 2017: 12.61). In 2015, there were five criminal complaints (four were dismissed - in two cases the offence was not considered as criminal offence, and in two other cases - due to the lack of grounds for suspicion; in one case a rejecting judgment was rendered due to *non bis in idem* principle (Statistical Office of the Republic of Serbia, 2016: 12,35)). It should be noted that it is unknown whether the issue of interest (related to Article 119, paragraph 2) was among the abovementioned criminal complaints, or judgments. So, it seems that form of the offence does not exist at all in official statistics, or the number of the offences is negligible and /or represents a dark figure. It would be worthwhile to undertake research in this field.

The action of another person, which represents the prevention of another from committing suicide, and especially the application of coercive measures in that case, is also very intriguing (in relation to the right to life (and its protection) v. the right to self-determination) The obligation to intervene in an acute life-threatening situation is based on the general obligation to provide assistance to a person in an imminent danger to life, especially since at the time of danger it couldn't be known whether the exposed person voluntarily or otherwise entered it (Horvatić, 1989: 34). Paternalistic intervention finds its essential justification in the "fact" that suicide is not "rational" act, that it is usually performed in a state of excluded or compromised ability of the suicidal person to assess and realize his own interests (Biro, 1983: 30). In professional (especially medical) circles, there is very strong resistance to the idea of suicide as a "rational" and firm decision to end one's own life. As a rule, it is pointed out that the suicidal impulse is short-lived, ambivalent, and generated by a temporary or permanent mental disorder (usually depression), or acute mental imbalance. Thus, the protection of the suicide's interests is justified by interventions in suicide prevention, and the incrimination of both active contribution to the suicidal act and passivity in relation to such an act is considered justified - failure to provide assistance to a person in imminent danger to life, or failure to provide medical attention to help a person who needs such help (*Ibidem*).

Finally, when the interests of society are seen as predominant over the individual autonomy of the suicidal person, the admissibility of the intervention could extend even to a hypothetical case in which it would be reliably known that suicide is a conscious and voluntary act of a mentally competent person. Horvatić points to the common understanding that suicide is not only an individual phenomenon, but also a sociopathological phenomenon that requires an adequate social reaction, and that "society has to do its part" to prevent suicide in the interest of the suicide, his relatives and society (Horvatić, 1989: 35).

Preventing suicide in the interest of society raises the question "what is really the social harmfulness of suicide?" In addition to the loss of human life, a member of a social community (thus losing his "contribution to society"), the risk of imitation (the so-called "Werther effect") or fear of behavioral "infection" are losses that authors usually explicitly or implicitly referred to. But does society that has not "done its part" to prevent or at least mitigate the effects of social and other factors behind suicide, has the moral right to coercively prevent "in the public interest" the suicide of a person whose life in that society has become unbearably painful, chronically hopeless, or perhaps irreversibly meaningless? (Jovanović, Simenunović-Patić, 2006: 268).

A survey conducted at the Belgrade District Public Prosecutor's Office in relation to suicide cases and suicide attempts committed in 2005 shows that in the group of completed suicides, motivation related to difficulties due to a serious or incurable disease is more common (35%) compared to cases of attempted suicides (10.9%). Suicides committed due to severe illness are mostly completed (87.5%)[4].

People who completed suicide without a history of previous attempts, mostly committed it in the darkness of their basements and attics, away from the eyes of others and the opportunity to be saved, while those with a history of previous attempts acted more often in a public place or in the presence of others. In addition, suicide victims without a history of previous attempts are more likely to opt for "more efficient" means of execution (shooting 33.3% and hanging 37.5%), while those with a history of previous attempts are more likely to choose poisoning (29%), high jump (29%), and cutting /stabbing with sharp objects (12.8%). Finally, 43% of people who have completed suicide have never attempted suicide before, nor have they ever undergone any psychiatric or psychological observation or treatment (Ibid, 269-271). The latter, of course, does not speak in favor or against any assumption about the state of their sanity at the critical time, much less about the presence /absence of mental health in the medical sense, but it certainly indicates that a significant number of suicides still eludes professional observation. Are at least some of their acts so-called "rational" suicides?

2.1. Assisted Suicide in Switzerland

An unavoidable topic related to assisted suicide is the "Swiss model" of incriminating assisted suicide, thus in fact legalizing euthanasia (in a broader context). Assisting in suicide is a criminal offence under the provisions of Art. 115 of the Criminal Code if done out of selfish/base motives. In other words, if the assistance in suicide is motivated by altruistic motives (such as mercy due to serious illness of another person who asks for help in dying) would be no crime of assisted suicide. The specificity is reflected in the fact that the helper could be any person, not just a medical practitioner, and the condition is not even that the passive subject is an incurably ill or dying person. In short, the element that makes the difference is only the motive, and the person who wants to die must

[4] About suicide epidemiology in Serbia (and Belgrade, for the period 1997-2008), and similar findings, and observations regard to seriously ill persons (especially elderly): Knežić, Savić, 2010: 69-80.

undertake the act of killing him/herself (the doctor prescribes a lethal dose of sodium pentobarbital)[5].

The Swiss Academy of Medical Science (SAMS) adopted in 2005 the medical ethics guidelines on the care of patients at the end of life, emphasising that "doctor has to check the following preconditions: the patient's disease justifies the assumption that he is approaching the end of life; alternative possibilities for providing assistance have been discussed and, if desired, have been implemented; the patients is capable of making the decision, his wish has been well thought out, without external pressure, and he persists in this wish (this has been checked by a third party, who is not necessarily a doctor); the final action in the process leading to death must always be taken by the patent himself" (SAMS: 2013: 9).

The (physician) assisted suicide is considered morally more acceptable form of euthanasia (in broader sense), due to the fact that dying person performs the act by him/her self. But, what if dying person can not perform the act on his/her own?

3. Mercy Killing

Mercy killing is the most common synonym for ("real", voluntary active) euthanasia, as opposed to assisted suicide, because its determinant must be taking an action aimed at depriving another person of life (e.g. a physician who injects a lethal injection) (Đerić, 2013: 257). As expected (bearing in mind that aiding in suicide is incriminated), this form of euthanasia is incriminated in Serbia. Namely, Art. 117 of the Criminal Code incriminates deprivation of life out of mercy: *Whoever causes death of an adult from mercy due to serious illness of such person and at such person's serious and explicit request, shall be punished with imprisonment from six months to five years.*

The same punishment is prescribed for the one who aids another in committing suicide, and it is at least attempted (CC, Article 119, paragraph 1), as for the one who plays the key role in depriving another person of life, who undertakes the act of execution, under certain circumstances (mercifulness as a motive, and at an explicit and serious request of seriously ill adult). "Mercy killing"/voluntary active euthanasia, is part of a broader

[5] About „Swiss model", its history, and about the case Gross v. Switzerald before the European Court for Human Rights which has sparked the debates (the applicant, an old lady, was unsuccesful before the competent Swiss authorities to reach a positive response to her request – prescription for the lethal dose of sodium pentobarbital due to non-existed terminal disease, and refusal of medical practicioners to provide her with wanted drug): Strážnická: 2018: 163-170.

context of assisted dying. Anyone can be the perpetrator, but it is expected that it will be someone who is close to the victim (family member). However, it could be also a physician who treats the patient. In this regard, it should be noted that according to the actual regulations (that will be discussed later), the patient may refuse to start or continue medical treatment, even one that would prolong his life. In such a case (so-called *passive euthanasia*) there is no responsibility.

The Criminal Code of the Kingdom of Yugoslavia envisaged the murder at the explicit and serious request "due to pity for the miserable condition of this person". A miserable condition meant a condition that one's illness is incurable or some other hopeless condition combined with great pain and suffering for which there is no help. Feeling someone else's pain as one's own was considered pity (Živanović, 1935: 31).

The claims that Serbian legislation suffered from historical setback after the Second World War[6] seem justified (Petrović, 2018: 183), because there was no mention of this privileged form of homicide, until 1998, and the Draft Criminal Code of the FRY[7], which has envisaged it in Art. 143. In actual CC the name of the incrimination has been changed into "deprivation of life out of mercy". The mere renaming of the act indicates a change in the attitude of society or, more precisely, the attitude of the legislator towards this type of assisted dying, which implies the key role of another person. Thus, the act has been freed from the stigmatizing connotation, the seriously ill are granted the right to receive a help of a person who, according to the law, shall not be called a murderer. However, that person will have to think very carefully whether to respond to the dying person's request (of course, serious and explicit). His/her compassion must overcome the fear of punishment, his humanity must fulfill the emptiness that the state was not ready or was not able to fill by legalizing euthanasia. Why? Due to principal reasons such as sanctity, and inviolability of human life, and due to practical ones - possibilities of abuse and misuse. What is the purpose of this incrimination? To say that there is a readiness to treat unequivocally differently, and to privilege the one who, under precisely defined conditions, shows compassion for the dying person, and at the same time to remain on the line of defending the right to life (by punishing the merciful perpetrator).

[6] Such attitude towards this offence (as well as towards euthanasia) could be linked with actual argument related to possibilities of abuse, and reminding of Hitler's „euthanasia program" which, having in mind its well-known characteristics, should'n t be named „euthanasia" at all in contemporary notion (making this argument completely meaningless).

[7] Federal Ministry of Justice. Draft Criminal Code of FRY. Belgrade, 1998, p. 63.

There is explanation (of the Draft Criminal Code) that a new incrimination has been prescribed, because lack of it had created difficulties in court practice in which the circumstance of the victim's consent could be considered only as mitigating in sentencing, while the perpetrator's action had to be qualified as murder[8]. It is more likely that it is a matter of simply taking over comparative legal provisions (which have been on trial for a long time showing their weakness in practice), rather than the need to respond to the requests of court practice (no research on the case law done on this topic is available in Serbia).

It is difficult to expect many cases of this offence (in the last five years, judging by the official data of the Statistical Office of the Republic of Serbia, there was not a single one) due to the difficulties in detecting this type of crime, and due to the problems with the interpretation of the incrimination. There are also the possibilities of abuse, especially regarding the request of the dying person, determining its existence and interpreting the circle of possible perpetrators (Lazarević, 365-369). Exactly the same arguments are used by the opponents of the euthanasia legalization, so the question remains: what is the real purpose of this incrimination?

In summary: there should be no call for help when life as the greatest value ceases to be such a value for the one who is the most concerned - an individual. If he/she is not able to throw off the burden of the greatest value - life, there is no other choice, because asking another for help is, in its essence, an act of incitement to commit a crime. In both cases, it is difficult to speak of dignity in dying - because someone else will suffer the consequences of the dying person's decision - the one who helped him/her to kill him/herself or killed him/her. The terminological difference – “deprivation of life” in relation to homicide/murder is a weak consolation. It seems to be an expression of the hypocrisy of the legislator not daring to provide a better solution to those who suffer, and their loved ones. Awarding perpetrators of an criminal offence by promising short-term imprisonment is a performance of a hypocritical society that protects the right to life at all costs, but also (more declaratively) understands the needs of those who want to die (due to a serious illness, expressing serious and explicit request), and need someone’s help.

[8] Goverment of the Republic of Serbia: *Draft Criminal Code*, 2005, 4912004.131/33, p. 8.

It is also hypocritical that "letting" a patient die[9], at his request, is considered as more morally acceptable act (even permitted by legal regulations) than taking an action that leads to the death of a dying person. Isn't pulling the plug of the machine keeping the patient alive an action? It is certainly not an omission. Researches show that these widely known facts of medical practice are usually confined to the shadows of discretion or secrecy, and although illegal in most Council of Europe states are rarely punished (Marty, 2003). Isn't it better to regulate the euthanasia procedure than to close eyes to reality?[10]

4. Euthanasia – Right to Dignified Death

The following section is about euthanasia as a "good, easy dying", but in a modern, most common, more precise conceptual definition as a deliberate deprivation of life of an incurable patient, at his/her valid request. Some authors add that it also represents a release from mortal painful agony or unbearable pain, which the existing medical therapy fails to alleviate (Avramidis, 2017: 20), which is an element that narrows the field of the right to autonomy when deciding on one's own death. Refusing medical intervention and artificial prolongation of life is a patient's right, considered as a (morally and legally accepted) type of passive euthanasia. So, the subject of interest and heated debates is certainly "active euthanasia" (and its legalization) which should not be confused with assisted suicide (also, more acceptable procedure)[11].

It has already been pointed out that there is no agreement on the issue of euthanasia legalization. However, as the development of civil rights and freedoms moved away from the concept of criminalization of suicide, so the number of countries that legalize euthanasia is increasing. The rich, developed countries with well-regulated health care systems within which palliative care[12] is well organized and widely available have legal euthanasia procedure. The practice of (active) euthanasia legalization has begun within the Anglo-Saxon legal systems, and in Europe it has been done by the Netherlands

[9] Dying in such cases is not often easy and dignified, which is why the consideration of such procedure as "euthanasia" is questioned (Garrard, Wilkinson, 2005: 64).

[10] As Kambovski put it: "The law illegalizes the lawlessness, but does it illegitimize it?...There is always a conflict between the universalism of lasting values and the particularism of the real and concrete interests of individuals and the possibilities for their realization" (Kambovski, 2018: 33).

[11] On the different conceptual definitions of euthanasia: Đerić, 2013.

[12] About the need for palliative care and its availability in the world, more in: World Health Organization, Palliative Care: Key Facts (2020) available at: https://www.who.int/en/news-room/fact-sheets/detail/palliative-care, accessed on 1. 9. 2020; About Serbia ranking in that context: Worldwide Palliative Care Alliance, World Health Organization (2014) Global Atlas of Palliative Care at the End of Life, available at: http://www.thewhpca.org/resources/global-atlas-on-end-of-life-care, accessed on 1. 9. 2020.

(2001)[13], Belgium (2002), and Luxembourg (2008) [14]. In Serbia, all of us are witnessing the poor functioning of the health care system as a whole, so it is unnecessary to talk about the system of palliative care. That is why the Draft Civil Code, which opened the door to the legalization of euthanasia, has surprised us all.

The Article 92, paragraph 1of the Draft[15] reads: *The right to euthanasia, as the right of a natural person to a consensual, voluntary and dignified end of life, can be exceptionally realized if the prescribed human, psycho-social and medical conditions are met.*

The Commission for the Civil Code Drafting (in its explanation of the Draft) invoked the constitutional right to dignity of a person when introducing the right to euthanasia – the right to dignified death (which emphasizes the autonomy of will in exercising the right to life). However, the Commission immediately emphasizes that it is an exceptional solution, and that fulfillment of humanitarian, psycho-social and medical conditions (specified by a special law) is necessary (if the proposal based on comparative legal solutions would be accepted at all). The imposition of criminal sanctions for the abuse of the right to euthanasia, and changes in criminal legislation are also emphasized, as well as the fact that a small number of European countries have legalized euthanasia, and that the future of the proposal made in Draft is depending on public debate (Commission for the Civil Code Drafting, 2015: 685). Judging by the text of the explanation, it seems that the creators of the above-mentioned proposal have been indecisive, divided, and the provisions in the Draft have made very timid, uncertain step towards regulating the right to a dignified death. Thus, the future of legal euthanasia in Serbia seems to be uncertain from the very beginning. The Commission hasn't forgotten to emphasize possible abuses, especially "obtained unlawful material gain or other benefits" which must be accompanied with criminal liability.

It should be noted that judging by the results of the survey "Are you for or against euthanazia legalization in Serbia?" there are 3/4 of those who have said yes on September

[13] The legal debate concerning euthanasia in the Netherlands took off with the "Postma case" in 1973, concerning a physician who had facilitated the death of her mother following repeated explicit requests for euthanasia. While the physician was convicted, the court's judgment set out criteria when a doctor would not be required to keep a patient alive contrary to their will. This set of criteria was formalized in the course of a number of court cases during the 1980s. (Rietjens, J.A.C., et al. 2009)

[14] About different models and historical perspective: My death – my decision, available at: https://www.mydeath-mydecision.org.uk/info/assisted-dying-in-other-countries/, accessed on 1. 9. 2020.

[15] https://www.mpravde.gov.rs/files/NACRT.pdf, accessed on 13. 9. 2020.

8, 2020 (out of 1797 respondents)[16]. However, the proposal has provoked heated debates and division in medical circles, which has resulted in a joint statement of the Medical Chamber of Serbia and the Serbian Medical Association of May 24, 2016[17], proposing the deletion of the Art. 92, referring to the Hippocratic Oath, Code of Professional Ethics of the Medical Chamber of Serbia, unethical performance of such treatment (but still respecting the patient's desire to indulge in the natural course of the disease in the terminal phase of the disease), provisions from some (legally non-binding) documents of the Council of Europe, emphasizing the sanctity of life and its inviolability regardless of its duration and quality. At the very discussion, there was debate about the dangerousness of abuse (patients would abuse the right and demand death for reasons other than medical!); physicians do not want to be "doctors of death", but there was also a remark that Orthodox countries are explicitly against the legalization of euthanasia[18] (Popović, 2016). The proponents pointed out that the prevalence of passive euthanasia in practice justifies the legalization (*Ibidem*).

We are all witnesses (directly or by hearsay) of the presence of a special type of passive euthanasia in Serbia - social euthanasia. It involves releasing incurable and elderly patients from the hospital earlier and leaving them to the family for further care. This reduces their intensive care to a minimum, which accelerates dying (Šantrić, Šantrić: 2016: 356). The lack of resources, small number of palliative care beds, the limited time for having dying patients in hospitals are not valid arguments for euthanasia legalization? Is it hypocrisy of a system that cannot provide an alternative in the context of well-organized palliative care, and proper functioning of other forms of the health care system? It could certainly be considered as an attack on the dignity of patients, and eventually, on their lives. So much praising the sanctity of life, worrying about the possibilities of abuse, and unethical actions seem also very hypocritical. On the other hand, less hypocritical and well-developed societies with good health care system, and palliative care, have gone a step further by offering one more option for a person who chooses to die with dignity.

[16] Are you for or against euthanasia legalization in Serbia? (on September 8, 2020) 76.96% yes (1383) and no 23.04% (414), available at: https://mondo.rs/Magazin/Zdravlje/a1190201/Eutanazija-legalizacija-u-Srbiji.html, accessed on 8. 8. 2020.

[17] http://www.lks.org.rs/obavestenja-za-lekare/cid71-746/zajednicko-saopstenje-lekarske-komore-srbije-i-srpskog-lekarskog-drustva-u-vezi-eutanazije, accessed on 1. 9. 2020.

[18] This argument should be considered as a strong one in Serbian society due to the fact that religion is being more and more displaced from the private life of an individual into the public sphere, thus making the re-politicization of religion very influential in legislative process (Simović, Petrov, 2017: 80).

Indeed, according to the Law on Patients' Rights[19], a patient in Serbia has the right to freely decide on everything concerning his health and life. It means - no medical measure can be taken on him/her, without consent, which is a confirmation of the principle of autonomy, instead of (abandoned) paternalistic approach (Mujović-Zornić, 2015: 306). The exceptions exist in justified cases, when the principle of presumed consent is applied. The patient can also appoint a person who shall give consent on his/her behalf; who will be informed about taking medical measures in case of inability to make a decision on consent. What is the form of the appointment, who can be that person, etc. is not clear, but it seems to be a hint of an institute of the comparative law - *healthcare proxy* (acting in the interest of the patient if he/she is not able to decide, and decide on all or specified medical treatments, in accordance with patient's instructions[20].

In comparative law, there is also the possibility of compiling a living will or advanced directives[21] for medical decisions in end-of-life situations when patient can't speak for him/herself. This solution should also contribute to the realization of individual autonomy in specific situations, but it is not known to Serbian law. Undoubtedly, the paternalistic approach to end-of-life situations is Serbia is still persistent, while opposite trend is evident in European countries.

Thus, the patient has the right to refuse treatment that saves or prolongs life, if he/she is capable of reasoning and is adequately informed of the consequences of decision. The patient gives a written statement which is kept in the medical documentation, and if he refuses to give a statement, an official note is made about it. Clearly, the refusal of medical treatment is also a choice, but it does not always mean a dignified dying.

In anticipation of the debate that will finally determine the future of Article 92 of the Draft Civil Code, the Dutch legal model of euthanasia will be presented in short lines (as a model that has been functioning very well in practice (Rietjens, J.A.C. et al., 2009).

[19] Law on Patients' Rights (Art. 15-17), Official Gazette RS, no. 45/2013, 25/2019

[20] Stony Brook Medicine, Health Care Proxy/Living Will, available at: https://www.stonybrookmedicine.edu/patientcare/livingwill#decisions, accessed on 3. 9. 2020.

[21] Some European countries attach a prominent value to patient autonomy and to the possibility of making advance directives, while others, which rely more on paternalistic decision-making structures, are still reluctant to legislate in this field (Serbia is among them).Nevertheless, all countries seem to agree that advance directives could eventually play a positive role in health care practice, for instance, in order to prevent futile or disproportionate treatments. More about advanced directives in European countries: Andorno, 2008.

4.1. Dutch Model of Euthanasia

On April 1st, 2002, the *Euthanasia Act* came into force to regulate the ending of life by a physician at the request of a patient who was suffering unbearably without hope of relief. The criteria for due care require a physician to assess that: 1) the patient's request is voluntary and well-considered[22]; 2) the patient's suffering is unbearable and hopeless; 3) the patient is informed about his situation and prospects; 4) there are no reasonable alternatives, 5) Another independent physician should be consulted; and the termination of life should be performed with due medical care and attention.

The Act officially legalized euthanasia, but in effect it mainly legalized an existing practice. Most physicians think that the Act has improved their legal certainty and contributes to the care with which euthanasia and physician-assisted suicide are practiced (*Ibidem*).

Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so. And he or she may only accede to the request while taking into account the due care requirements mentioned in the Act. The due care requirements must be complied with, regardless of whether it involves a request from a lucid patient or a request from a non-lucid patient with a declaration of will. In each case the doctor must be convinced that the patient is facing interminable and unendurable suffering. If he or she believes that this is not so, he or she may not accede to the request for euthanasia, no matter what the declaration of will states (Marty, 2003: 9-10).

5. Concluding Remarks

Attitudes towards sanctity of life, and its inviolability clash with those demanding a re-examination of existing legal solutions that protect the metaphysically interpreted sanctity of life. The new reflections also insist on the sanctity of life, but in its secular form, from the aspect of the individual, the "life owner" and his/he fundamental rights, balancing the power of the right to life and other rights. After all, ending one's life before the natural

[22] Children of 16 and 17 can, in principle, make their own decisions. Their parents must, however, be involved in the decision-making process regarding the termination of their life. For children aged 12 to 16, the approval of the parents or guardian is required.

end is not necessarily an insult to life's values, but can also be their reaffirmation in the case when a person is reduced to a pale shadow of what he once was.

Despite raising awareness that there is a real need to regulate end-of-life issues, it is obvious that many states and international institutions keep on avoiding clear answers and bringing these issues within their scope. Thus, these problems remain covered by silence and widespread but ungrounded fear of abuse, along with extensive secret practice. The gap between present ineffective prohibitions and actual uncontrolled practice ought to be overcome by improved legislative solutions: even if abuse would not disappear with legislation, we could expect it to be remarkably reduced. Such attitudes also shake the criminal law foundations of protection of the right to life in Serbia, relativizing the prohibition of participation of others in deprivation of life, if it is the choice of an individual, presenting that act as an act of exercising the right to life, i.e. the right to (dignified) death.

The brave step should be taken towards elaboration of the Draft Civil Code provisions on euthanasia as the right to dignified death. The models from the Netherlands, or even Switzerland, can be very helpful in drafting new, specific provisions on euthanasia in Serbia. Isn't it hypocritical to hide for so long behind sanctity of life, Orthodoxy, bad memory of the Nazi euthanasia program, etc. knowing that people have been left to die due to lack of hospital beds, devices, appropriate medicines, and procedures, that seriously ill patients have been discharging from hospitals, because they are incurable? Isn't hypocritical to turn a blind eye to daily practice of passive euthanasia, or to promise shorter imprisonment to those who help another human being in great suffering to reach wanted death? It is about time to stop resisting legalization of euthanasia persistently with timeworn arguments.

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