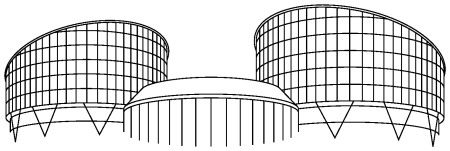

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

GRAND CHAMBER

CASE OF LAMBERT AND OTHERS v. FRANCE

(Application no. 46043/14)

JUDGMENT

STRASBOURG

5 June 2015

This judgment is final but may be subject to editorial revision.

In the case of Lambert and Others v. France,

The European Court of Human Rights, sitting as a Grand Chamber composed of:

Dean Spielmann, *President,*
Guido Raimondi,
Mark Villiger,
Isabelle Berro,
Khanlar Hajiyev,
Ján Šikuta,
George Nicolaou,
Nona Tsotsoria,
Vincent A. De Gaetano,
Angelika Nußberger,
Linos-Alexandre Sicilianos,
Erik Møse,
André Potocki,
Helena Jäderblom,
Aleš Pejchal,
Valeriu Griţco,
Egidijus Kūris, *judges,*
and Erik Fribergh, *Registrar,*

Having deliberated in private on 7 January and 23 April 2015,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case originated in an application (no. 46043/14) against the French Republic lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by four French nationals, Mr Pierre Lambert and Mrs Viviane Lambert, Mr David Philippon and Mrs Anne Tuarze ("the applicants"), on 23 June 2014.

2. The applicants were represented by Mr J. Paillot, a lawyer practising in Strasbourg, and Mr J. Triomphe, a lawyer practising in Paris. The French Government ("the Government") were represented by their Agent, Mr F. Alabrune, Director of Legal Affairs at the Ministry of Foreign Affairs.

3. The applicants alleged, in particular, that the withdrawal of Vincent Lambert's artificial nutrition and hydration would be in breach of the State's obligations under Article 2 of the Convention, would constitute ill-treatment amounting to torture within the meaning of Article 3 of the Convention and

would infringe his physical integrity, in breach of Article 8 of the Convention.

4. The application was assigned to the Fifth Section of the Court (Rule 52 § 1 of the Rules of Court). On 24 June 2014 the relevant Chamber decided to apply Rule 39 of the Rules of Court, to give notice of the application to the Government and to grant it priority.

5. On 4 November 2014 a Chamber of the Fifth Section composed of Mark Villiger, President, Angelika Nußberger, Boštjan M. Zupančič, Vincent A. De Gaetano, André Potocki, Helena Jäderblom and Aleš Pejchal, judges, and Stephen Phillips, Section Registrar, relinquished jurisdiction in favour of the Grand Chamber, neither of the parties having objected to relinquishment (Article 30 of the Convention and Rule 72).

6. The composition of the Grand Chamber was determined according to the provisions of Article 26 §§ 4 and 5 of the Convention and Rule 24.

7. The applicants and the Government each filed written observations on the admissibility and merits of the case.

8. Observations were also received from Rachel Lambert, François Lambert and Marie-Geneviève Lambert, the wife, nephew and half-sister respectively of Vincent Lambert, and from the National Union of Associations of Head Injury and Brain Damage Victims' Families (UNAFTC), the association Amréso-Bethel and the Human Rights Clinic of the International Institute of Human Rights, to all of whom the President had given leave to intervene as third parties in the written procedure (Article 36 § 2 of the Convention and Rule 44 § 3 (a)). Rachel Lambert, François Lambert and Marie-Geneviève Lambert were also given leave to take part in the hearing.

9. A hearing took place in public in the Human Rights Building, Strasbourg, on 7 January 2015 (Rule 59 § 3).

There appeared before the Court:

(a) *for the Government*

Mr F. ALABRUNE, Director of Legal Affairs,
Ministry of Foreign Affairs and International
Development, *Agent*,
Ms E. JUNG, Drafting Officer, Human Rights
Section, Ministry of Foreign Affairs and
International Development,
Mr R. FÉRAL, Drafting Officer, Human Rights
Section, Ministry of Foreign Affairs and
International Development,
Ms S. RIDEAU, Adviser, Legal Affairs Directorate,
Ministry of Social Affairs, Health and Women's Rights,

Ms I. ERNY, Legal Adviser, Users' Rights,
Legal and Ethical Affairs Division, Ministry
of Social Affairs, Health and Women's Rights,
Ms P. ROUAULT-CHALIER, Deputy Director
of Litigation and Legal Affairs, Ministry
of Justice,
Ms M. LAMBLING, Drafting Officer, Individual
Rights and Family Law Office, Ministry of Justice, *Advisers*;

(b) *for the applicants*
Mr J. PAILLOT, Lawyer,
Mr J. TRIOMPHE, Lawyer, *Counsel*,
Mr G. PUPPINCK,
Prof. X. DUCROCQ,
Dr B. JEANBLANC, *Advisers*;

(c) *for Rachel Lambert, third-party intervener*
Mr L. PETTITI, Lawyer, *Counsel*,
Dr OPORTUS,
Dr SIMON, *Advisers;*

(d) *for François and Marie-Geneviève Lambert, third-party interveners*
Mr M. MUNIER-APAIRE, Member of the
Conseil d'État and the Court of Cassation Bar,
Mr B. LORIT, Lawyer, *Advisers.*

The applicants, with the exception of the first applicant, also attended, as did Rachel Lambert, François Lambert and Marie-Geneviève Lambert, third-party interveners.

The Court heard addresses by Mr Alabrune, Mr Paillot, Mr Triomphe, Mr Munier-Apaire and Mr Pettiti, as well as the answers given by Mr Alabrune and Mr Paillot to the questions put by one of the judges.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

10. The applicants, who are all French nationals, are Mr Pierre Lambert and his wife Mrs Viviane Lambert, who were born in 1929 and 1945 respectively and live in Reims, Mr David Philippon, who was born in 1971 and lives in Mourmelon, and Mrs Anne Tuarze, who was born in 1978 and

lives in Milizac. They are the parents, a half-brother and a sister respectively of Vincent Lambert, who was born on 20 September 1976.

11. Vincent Lambert sustained serious head injuries in a road-traffic accident on 29 September 2008, which left him tetraplegic and in a state of complete dependency. According to the expert medical report ordered by the *Conseil d'État* on 14 February 2014, he is in a chronic vegetative state (see paragraph 40 below).

12. From September 2008 to March 2009 he was hospitalised in the resuscitation wing, and subsequently the neurology ward, of Châlons-en-Champagne Hospital. From March to June 2009 he was cared for in the heliotherapy centre in Berck-sur-Mer, before being moved on 23 June 2009 to the unit in Reims University Hospital providing follow-up and rehabilitative care to patients in a vegetative or minimally conscious state, where he remains to date. The unit accommodates eight patients. Vincent Lambert receives artificial nutrition and hydration which is administered enterally, that is, via a gastric tube.

13. In July 2011 Vincent Lambert was assessed by a specialised unit of Liège University Hospital, the Coma Science Group, which concluded that he was in a chronic neuro-vegetative state characterised as "minimally conscious plus". In line with the recommendations of the Coma Science Group he received daily sessions of physiotherapy from September 2011 to the end of October 2012, which yielded no results. He also received 87 speech and language therapy sessions between March and September 2012, in an unsuccessful attempt to establish a code of communication. Attempts were also made to sit the patient in a wheelchair.

A. First decision taken under the Act of 22 April 2005

14. As Vincent Lambert's carers had observed increasing signs in 2012 of what they believed to be resistance on his part to daily care, the medical team initiated in early 2013 the collective procedure provided for by the Act of 22 April 2005 on patients' rights and end-of-life issues (see paragraph 54 below). Rachel Lambert, the patient's wife, was involved in the procedure.

15. The procedure resulted in a decision by Dr Kariger, the doctor in charge of Vincent Lambert and head of the department in which he is hospitalised, to withdraw the patient's nutrition and reduce his hydration. The decision was put into effect on 10 April 2013.

B. Injunction of 11 May 2013

16. On 9 May 2013 the applicants applied to the urgent-applications judge of the Châlons-en-Champagne Administrative Court on the basis of Article L. 521-2 of the Administrative Courts Code (urgent application for protection of a fundamental freedom (*référé liberté*)), seeking an injunction

ordering the hospital, subject to a coercive fine, to resume feeding and hydrating Vincent Lambert normally and to provide him with whatever care his condition required.

17. In an order dated 11 May 2013 the urgent-applications judge granted their requests. The judge held that, since no advance directives had been drawn up by Vincent Lambert, and in the absence of a person of trust within the meaning of the relevant provisions of the Public Health Code, the collective procedure should be continued with his family, despite the fact that the latter was divided as to what should become of the patient. The judge noted that, while Vincent Lambert's wife had been involved in the procedure, it was clear from examination of the case that his parents had not been informed that it had been applied, and that the decision to withdraw nutrition and limit hydration, the nature of and reasons for which had not been disclosed to them, had not respected their wishes.

18. The judge held accordingly that these procedural shortcomings amounted to a serious and manifestly unlawful breach of a fundamental freedom, namely the right to respect for life, and ordered the hospital to resume feeding and hydrating Vincent Lambert normally and to provide him with whatever care his condition required.

C. Second decision taken under the Act of 22 April 2005

19. In September 2013 a fresh collective procedure was initiated. Dr Kariger consulted six doctors, including three from outside the hospital (a neurologist, a cardiologist and an anaesthetist with experience in palliative medicine) chosen by Vincent Lambert's parents, his wife and the medical team respectively. He also had regard to a written contribution from a doctor in charge of a specialised extended care facility within a nursing home.

20. Dr Kariger also convened two meetings with the family, on 27 September and 16 November 2013, which were attended by Vincent Lambert's wife and parents and his eight siblings. Rachel Lambert and six of the eight brothers and sisters spoke in favour of discontinuing artificial nutrition and hydration, while the applicants were in favour of maintaining it.

21. On 9 December 2013 Dr Kariger called a meeting of all the doctors and almost all the members of the care team. Following that meeting Dr Kariger and five of the six doctors consulted stated that they were in favour of withdrawing treatment.

22. On conclusion of the consultation procedure Dr Kariger announced on 11 January 2014 his intention to discontinue artificial nutrition and hydration on 13 January, subject to an application to the administrative court. His decision, comprising a reasoned thirteen-page report, a seven-page summary of which was read out to the family, observed in

particular that Vincent Lambert's condition was characterised by irreversible brain damage and that the treatment appeared to be futile and disproportionate and to have no other effect than to sustain life artificially. According to the report, the doctor had no doubt that Vincent Lambert had not wished, before his accident, to live under such conditions. Dr Kariger concluded that prolonging the patient's life by continuing to treat him with artificial nutrition and hydration amounted to unreasonable obstinacy.

D. Administrative Court judgment of 16 January 2014

23. On 13 January 2014 the applicants made a further urgent application to the Châlons-en-Champagne Administrative Court for protection of a fundamental freedom under Article L. 521-2 of the Administrative Courts Code, seeking an injunction prohibiting the hospital and the doctor concerned from withdrawing Vincent Lambert's nutrition and hydration and an order for his immediate transfer to a specialised extended care facility in Oberhausbergen run by the association Amréso-Bethel (see paragraph 8 above). Rachel Lambert and François Lambert, Vincent Lambert's nephew, intervened in the proceedings as third parties.

24. The Administrative Court, sitting as a full court of nine judges, held a hearing on 15 January 2014. In a judgment of 16 January 2014 it suspended the implementation of Dr Kariger's decision of 11 January 2014.

25. The Administrative Court began by observing that Article 2 of the Convention did not prevent States from making provision for individuals to object to potentially life-prolonging treatment. It likewise did not prevent the doctor in charge of a patient who was unable to express his or her wishes and whose treatment the doctor considered, after implementing a series of safeguards, to amount to unreasonable obstinacy, from withdrawing that treatment, subject to supervision by the Medical Council, the hospital's ethics committee, where applicable, and the administrative and criminal courts.

26. The Administrative Court went on to find that it was clear from the relevant provisions of the Public Health Code, as amended following the Act of 22 April 2005 and as elucidated by the parliamentary proceedings, that artificial enteral nutrition and hydration – which were subject, like medication, to the distribution monopoly held by pharmacies, were designed to supply specific nutrients to patients with impaired functions and required recourse to invasive techniques to administer them – constituted a form of treatment.

27. Observing that Dr Kariger's decision had been based on the wish apparently expressed by Vincent Lambert not to be kept alive in a highly dependent state, and that the latter had not drawn up any advance directives or designated a person of trust, the Administrative Court found that the views he had confided to his wife and one of his brothers had been those of

a healthy individual who had not been faced with the immediate consequences of his wishes, and had not constituted the formal manifestation of an express wish, irrespective of his professional experience with patients in a similar situation. The court further found that the fact that Vincent Lambert had had a conflictual relationship with his parents, since he did not share their moral values and religious commitment, did not mean that he could be considered to have expressed a clear wish to refuse all forms of treatment, and added that no unequivocal conclusion as to his desire or otherwise to be kept alive could be drawn from his apparent resistance to the care provided. The Administrative Court held that Dr Kariger had incorrectly assessed Vincent Lambert's wishes.

28. The Administrative Court also noted that, according to the report drawn up in 2011 by Liège University Hospital (see paragraph 13 above), Vincent Lambert was in a minimally conscious state, implying the continuing presence of emotional perception and the existence of possible responses to his surroundings. Accordingly, the administering of artificial nutrition and hydration was not aimed at keeping him alive artificially. Lastly, the court considered that, as long as the treatment did not cause any stress or suffering, it could not be characterised as futile or disproportionate. It therefore held that Dr Kariger's decision had constituted a serious and manifestly unlawful breach of Vincent Lambert's right to life. It issued an order suspending the implementation of the decision while rejecting the request for the patient to be transferred to the specialised extended care facility in Oberhausbergen.

E. *Conseil d'État* ruling of 14 February 2014

29. In three applications lodged on 31 January 2014 Rachel Lambert, François Lambert and Reims University Hospital appealed against that judgment to the urgent-applications judge of the *Conseil d'État*. The applicants lodged a cross-appeal, requesting Vincent Lambert's immediate transfer to the specialised extended care facility. The National Union of Associations of Head Injury and Brain Damage Victims' Families (UNAFTC, see paragraph 8 above) sought leave to intervene as a third party.

30. At the hearing on the urgent application held on 6 February 2014 the President of the Judicial Division of the *Conseil d'État* decided to refer the case to the full court, sitting as a seventeen-member Judicial Assembly.

31. The hearing before the full court took place on 13 February 2014. In his submissions to the *Conseil d'État*, the public rapporteur cited, *inter alia*, the remarks made by the Minister of Health to the members of the Senate examining the bill known as the Leonetti bill:

> "While the act of withdrawing treatment ... results in death, the intention behind the act [is not to kill; it is] to allow death to resume its natural course and to relieve suffering. This is particularly important for care staff, whose role is not to take life."

32. The *Conseil d'État* delivered its ruling on 14 February 2014. After joining the applications and granting UNAFTC leave to intervene, the *Conseil d'État* defined in the following terms the role of the urgent-applications judge called upon to rule on the basis of Article L. 521-2 of the Administrative Courts Code:

> "Under [Article L. 521-2], the urgent-applications judge of the administrative court, when hearing an application of this kind justified by particular urgency, may order any measures necessary to safeguard a fundamental freedom allegedly breached in a serious and manifestly unlawful manner by an administrative authority. These legislative provisions confer on the urgent-applications judge, who normally decides alone and who orders measures of an interim nature in accordance with Article L. 511-1 of the Administrative Courts Code, the power to order, without delay and on the basis of a 'plain and obvious' test, the necessary measures to protect fundamental freedoms.
>
> However, the urgent-applications judge must exercise his or her powers in a particular way when hearing an application under Article L. 521-2 ... concerning a decision taken by a doctor on the basis of the Public Health Code which would result in treatment being discontinued or withheld on grounds of unreasonable obstinacy and the implementation of which would cause irreversible damage to life. In such circumstances the judge, sitting where applicable as a member of a bench of judges, must take the necessary protective measures to prevent the decision in question from being implemented where it may not be covered by one of the situations provided for by law, while striking a balance between the fundamental freedoms in issue, namely the right to respect for life and the patient's right to consent to medical treatment and not to undergo treatment that is the result of unreasonable obstinacy. In such a case, the urgent-applications judge or the bench to which he or she has referred the case may, as appropriate, after temporarily suspending the implementation of the measure and before ruling on the application, order an expert medical report and, under Article R. 625-3 of the Administrative Courts Code, seek the opinion of any person whose expertise or knowledge are apt to usefully inform the court's decision."

33. The *Conseil d'État* found that it was clear from the very wording of the relevant provisions of the Public Health Code (Articles L. 1110-5, L. 1111-4 and R. 4127-37) and from the parliamentary proceedings that the provisions in question were general in scope and applied to Vincent Lambert just as they did to all users of the health service. The *Conseil d'État* stated as follows:

> "It is clear from these provisions that each individual must receive the care most appropriate to his or her condition and that the preventive or exploratory acts carried out and the care administered must not subject the patient to disproportionate risks in relation to the anticipated benefits. Such acts must not be continued with unreasonable obstinacy and may be discontinued or withheld where they appear to be futile or disproportionate or to have no other effect than to sustain life artificially, whether or not the patient is in an end-of-life situation. Where the patient is unable to express his or her wishes, any decision to limit or withdraw treatment on the ground that continuing it would amount to unreasonable obstinacy may not be taken by the doctor,

where such a measure is liable to endanger the life of the patient, without the collective procedure defined in the Code of Medical Ethics and the rules on consultation laid down in the Public Health Code having been followed. If the doctor takes such a decision he or she must at all events preserve the patient's dignity and dispense palliative care.

Furthermore, it is clear from the provisions of Articles L. 1110-5 and L. 1110-4 of the Public Health Code, as elucidated by the parliamentary proceedings prior to the passing of the Act of 22 April 2005, that the legislature intended to include among the forms of treatment that may be limited or withdrawn on grounds of unreasonable obstinacy all acts which seek to maintain the patient's vital functions artificially. Artificial nutrition and hydration fall into this category of acts and may accordingly be withdrawn where continuing them would amount to unreasonable obstinacy."

34. The *Conseil d'État* went on to find that its task was to satisfy itself, having regard to all the circumstances of the case, that the statutory conditions governing any decision to withdraw treatment whose continuation would amount to unreasonable obstinacy had been met. To that end it needed to have the fullest information possible at its disposal, in particular concerning Vincent Lambert's state of health. Accordingly, it considered it necessary before ruling on the application to order an expert medical report to be prepared by practitioners with recognised expertise in neuroscience. The experts – acting on an independent and collective basis, after examining the patient, meeting the medical team and the care staff and familiarising themselves with the patient's entire medical file – were to give their opinion on Vincent Lambert's current condition and provide the *Conseil d'État* with all relevant information as to the prospect of any change.

35. The *Conseil d'État* decided to entrust the expert report to a panel of three doctors appointed by the President of the Judicial Division on proposals from the President of the National Medical Academy, the Chair of the National Ethics Advisory Committee and the President of the National Medical Council respectively. The remit of the panel of experts, which was to report within two months of its formation, read as follows:

"(i) to describe Mr. Lambert's current clinical condition and how it has changed since the review carried out in July 2011 by the Coma Science Group of Liège University Hospital;

(ii) to express an opinion as to whether the patient's brain damage is irreversible and as to the clinical prognosis;

(iii) to determine whether the patient is capable of communicating, by whatever means, with those around him;

(iv) to assess whether there are any signs to suggest at the present time that Mr Lambert reacts to the care being dispensed to him and, if so, whether those reactions can be interpreted as a rejection of that care, as suffering, as a desire for the life-sustaining treatment to be withdrawn or, on the contrary, as a desire for the treatment to be continued."

36. The *Conseil d'État* also considered it necessary, in view of the scale and the difficulty of the scientific, ethical and deontological issues raised by the case and in accordance with Article R. 625-3 of the Administrative Courts Code, to request the National Medical Academy, the National Ethics Advisory Committee and the National Medical Council, together with Mr Jean Leonetti, the rapporteur for the Act of 22 April 2005, to submit general written observations by the end of April 2014 designed to clarify for it the application of the concepts of unreasonable obstinacy and sustaining life artificially for the purposes of Article L. 1110-5, referred to above, with particular regard to individuals who, like Vincent Lambert, were in a minimally conscious state.

37. Lastly, the *Conseil d'État* rejected the applicants' request for Vincent Lambert to be transferred to a specialised extended care facility (see paragraph 29 above).

F. Expert medical report and general observations

1. Expert medical report

38. The experts examined Vincent Lambert on nine occasions. They familiarised themselves with the entire medical file, and in particular the report of the Coma Science Group in Liège (see paragraph 13 above), the treatment file and the administrative file, and had access to all the imaging tests. They also consulted all the items in the judicial case file of relevance for their expert report. In addition, between 24 March and 23 April 2014 they met all the parties (the family, the medical and care team, the medical consultants and representatives of UNAFTC and the hospital) and carried out a series of tests on Vincent Lambert.

39. On 5 May 2014 the experts sent their preliminary report to the parties for comments. Their final report, submitted on 26 May 2014, provided the following replies to the questions asked by the *Conseil d'État*.

(a) Vincent Lambert's clinical condition and how it had changed

40. The experts found that Vincent Lambert's clinical condition corresponded to a vegetative state, without any signs pointing to a minimally conscious state. Furthermore, they stressed that he had difficulty swallowing and had seriously impaired motor functions of all four limbs, with significant retraction of the tendons. They noted that his state of consciousness had deteriorated since the assessment carried out in Liège in 2011.

(b) Irreversible nature of the brain damage and clinical prognosis

41. The experts pointed out that the two main factors to be taken into account in assessing whether or not brain damage was irreversible were,

firstly, the length of time since the accident which had caused the damage and, secondly, the nature of the damage. In the present case they noted that five and a half years had passed since the initial head injury and that the imaging tests showed severe cerebral atrophy testifying to permanent neuron loss, near-total destruction of strategic regions such as both parts of the thalamus and the upper part of the brain stem, and serious damage to the communication pathways in the brain. They concluded that the brain damage was irreversible. They added that the lengthy period of progression, the patient's clinical deterioration since July 2011, his current vegetative state, the destructive nature and extent of the brain damage and the results of the functional tests, coupled with the severity of the motor impairment of all four limbs, pointed to a poor clinical prognosis.

(c) Vincent Lambert's capacity to communicate with those around him

42. In the light of the tests carried out, and particularly in view of the fact that the course of speech and language therapy carried out in 2012 had not succeeded in establishing a code of communication, the experts concluded that Vincent Lambert was not capable of establishing functional communication with those around him.

(d) Existence of signs suggesting that Vincent Lambert reacted to the care provided, and interpretation of those signs

43. The experts observed that Vincent Lambert reacted to the care provided and to painful stimuli, but concluded that these were non-conscious responses. In their view, it was not possible to interpret them as conscious awareness of suffering or as the expression of any intent or wish with regard to the withdrawal or continuation of treatment.

2. General observations

44. On 22 and 29 April and 5 May 2014 the *Conseil d'État* received the general observations of the National Medical Council, Mr Jean Leonetti, rapporteur for the Act of 22 April 2005, the National Medical Academy and the National Ethics Advisory Committee.

The National Medical Council made clear in particular that, in using the expression "no other effect than to sustain life artificially" in Article L. 1110-5 of the Public Health Code, the legislature had sought to address the situation of patients who not only were being kept alive solely by the use of methods and techniques replacing key vital functions, but also, and above all, whose cognitive and relational functions were profoundly and irreversibly impaired. It emphasised the importance of the notion of temporality, stressing that where a pathological condition had become chronic, resulting in the person's physiological deterioration and the loss of his or her cognitive and relational faculties, obstinacy in administering

treatment could be regarded as unreasonable if no signs of improvement were apparent.

Mr Leonetti stressed that the Act was applicable to patients who had brain damage and thus suffered from a serious condition which, in the advanced stages, was incurable, but who were not necessarily "at the end of life". Accordingly, the legislature, in the title of the Act, had referred to "patients' rights *and* end-of-life issues" rather than "patients' rights *in* end-of-life situations". He outlined the criteria for unreasonable obstinacy and the factors used to assess it and stated that the reference to treatment having "no other effect than to sustain life artificially", which was stricter than the wording originally envisaged (namely, treatment "which prolongs life artificially") was more restrictive and referred to artificially sustaining life "in the purely biological sense, in circumstances where, firstly, the patient has major irreversible brain damage and, secondly, his or her condition offers no prospect of a return to awareness of self or relationships with others". He pointed out that the Act gave the doctor sole responsibility for the decision to withdraw treatment and that it had been decided not to pass that responsibility on to the family, in order to avoid any feelings of guilt and to ensure that the person who took the decision was identified.

The National Medical Academy reiterated the fundamental prohibition barring doctors from deliberately taking another's life, which formed the basis for the relationship of trust between doctor and patient. The Academy reiterated its long-standing position according to which the Act of 22 April 2005 was applicable not only to the various "end-of-life" situations, but also to situations raising the very difficult ethical issue of the "ending of life" in the case of patients in "survival" mode, in a minimally conscious or chronic vegetative state.

The National Ethics Advisory Committee conducted an in-depth analysis of the difficulties surrounding the notions of unreasonable obstinacy, treatment and sustaining life artificially, summarised the medical data concerning minimally conscious states and addressed the ethical issues arising out of such situations. It recommended in particular a process of reflection aimed at ensuring that the collective discussions led to a genuine collective decision-making process and that, where no consensus could be reached, there was a possibility of mediation.

G. *Conseil d'État* judgment of 24 June 2014

45. A hearing took place on 20 June 2014 before the *Conseil d'État*. In his submissions the public rapporteur stressed, in particular, the following:

> "... [t]he legislature did not wish to impose on those in the caring professions the burden of bridging the gap which exists between allowing death to take its course when it can no longer be prevented and actively causing death by administering a

> lethal substance. By discontinuing treatment, a doctor is not taking the patient's life, but is resolving to withdraw when there is nothing more to be done."

The *Conseil d'État* delivered its judgment on 24 June 2014. After granting leave to Marie-Geneviève Lambert, Vincent Lambert's half-sister, to intervene as a third party, and reiterating the relevant provisions of domestic law as commented on and elucidated in the general observations received, the *Conseil d'État* examined in turn the applicants' arguments based on the Convention and on domestic law.

46. On the first point the *Conseil d'État* reiterated that, where the urgent-applications judge was called on to hear an application under Article L. 521-2 of the Administrative Courts Code (urgent application for protection of a fundamental freedom) concerning a decision taken by a doctor under the Public Health Code which would result in treatment being discontinued or withheld on grounds of unreasonable obstinacy, and implementation of that decision would cause irreversible damage to life, the judge was required to examine any claim that the provisions in question were incompatible with the Convention (see paragraph 32 above).

47. In the case before it the *Conseil d'État* replied in the following terms to the arguments based on Articles 2 and 8 of the Convention:

> "Firstly, the disputed provisions of the Public Health Code defined a legal framework reaffirming the right of all persons to receive the most appropriate care, the right to respect for their wish to refuse any treatment and the right not to undergo medical treatment resulting from unreasonable obstinacy. Those provisions do not allow a doctor to take a life-threatening decision to limit or withdraw the treatment of a person incapable of expressing his or her wishes, except on the dual, strict condition that continuation of that treatment would amount to unreasonable obstinacy and that the requisite safeguards are observed, namely that account is taken of any wishes expressed by the patient and that at least one other doctor and the care team are consulted, as well as the person of trust, the family or another person close to the patient. Any such decision by a doctor is open to appeal before the courts in order to review compliance with the conditions laid down by law.
>
> Hence the disputed provisions of the Public Health Code, taken together, in view of their purpose and the conditions attaching to their implementation, cannot be said to be incompatible with the requirements of Article 2 of the Convention ..., or with those of Article 8..."

The *Conseil d'État* also rejected the applicants' arguments based on Articles 6 and 7 of the Convention, finding that the role entrusted to the doctor under the provisions of the Public Health Code was not incompatible with the duty of impartiality flowing from Article 6, and that Article 7, which applied to criminal convictions, was not relevant to the case before it.

48. Regarding the application of the relevant provisions of the Public Health Code, the *Conseil d'État* held as follows:

> "Although artificial nutrition and hydration are among the forms of treatment which may be withdrawn in cases where their continuation would amount to unreasonable obstinacy, the sole fact that a person is in an irreversible state of unconsciousness or, *a fortiori*, has lost his or her autonomy irreversibly and is thus dependent on such a form

of nutrition and hydration, does not by itself amount to a situation in which the continuation of treatment would appear unjustified on grounds of unreasonable obstinacy.

In assessing whether the conditions for the withdrawal of artificial nutrition and hydration are met in the case of a patient with severe brain damage, however caused, who is in a vegetative or minimally conscious state and is thus unable to express his or her wishes, and who depends on such nutrition and hydration as a means of life support, the doctor in charge of the patient must base his or her decision on a range of medical and non-medical factors whose relative weight cannot be determined in advance but will depend on the circumstances of each patient, so that the doctor must assess each situation on its own merits. In addition to the medical factors, which must cover a sufficiently long period, be assessed collectively and relate in particular to the patient's current condition, the change in that condition since the accident or illness occurred, his or her degree of suffering and the clinical prognosis, the doctor must attach particular importance to any wishes the patient may have expressed previously, whatever their form or tenor. In that regard, where such wishes remain unknown, they cannot be assumed to consist in a refusal by the patient to be kept alive in the current conditions. The doctor must also take into account the views of the person of trust, where the patient has designated such a person, of the members of the patient's family or, failing this, of another person close to the patient, while seeking to establish a consensus. In assessing the patient's particular situation, the doctor must be guided primarily by a concern to act with maximum beneficence towards the patient..."

49. The *Conseil d'État* went on to find that it was its task, in the light of all the circumstances of the case and the evidence produced in the course of the adversarial proceedings before it, in particular the expert medical report, to ascertain whether the decision taken by Dr Kariger on 11 January 2014 had complied with the statutory conditions imposed on any decision to withdraw treatment whose continuation would amount to unreasonable obstinacy.

50. In that connection the *Conseil d'État* ruled as follows:

"Firstly, it is clear from the examination of the case that the collective procedure conducted by Dr Kariger ..., prior to the taking of the decision of 11 January 2014, was carried out in accordance with the requirements of Article R. 4127-37 of the Public Health Code and involved the consultation of six doctors, although that Article simply requires that the opinion of one doctor and, where appropriate, of a second be sought. Dr Kariger was not legally bound to allow the meeting of 9 December 2013 to be attended by a second doctor designated by Mr Lambert's parents in addition to the one they had already designated. Nor does it appear from the examination of the case that some members of the care team were deliberately excluded from that meeting. Furthermore, Dr Kariger was entitled to speak with Mr François Lambert, the patient's nephew. The fact that Dr Kariger opposed a request for him to withdraw from Mr Lambert's case and for the patient to be transferred to another establishment, and the fact that he expressed his views publicly, do not amount, having regard to all the circumstances of the present case, to a failure to comply with the obligations implicit in the principle of impartiality, which Dr Kariger respected. Accordingly, contrary to what was argued before the Châlons-en-Champagne Administrative Court, the procedure preceding the adoption of the decision of 11 January 2014 was not tainted with any irregularity.

Secondly, the experts' findings indicate that 'Mr Lambert's current clinical condition corresponds to a vegetative state', with 'swallowing difficulties, severe motor impairment of all four limbs, some signs of dysfunction of the brainstem' and 'continued ability to breathe unaided'. The results of the tests carried out from 7 to 11 April 2014 to assess the patient's brain structure and function ... were found to be consistent with such a vegetative state. The experts found that the clinical progression, characterised by the disappearance of the fluctuations in Mr Lambert's state of consciousness recorded during the assessment carried out in July 2011 by the Coma Science Group at Liège University Hospital and by the failure of the active therapies recommended at the time of that assessment, were suggestive of 'a deterioration in the [patient's] state of consciousness since that time'.

Furthermore, according to the findings set out in the experts' report, the exploratory tests which were carried out revealed serious and extensive brain damage, as evidenced in particular by 'severe impairment of the structure and metabolism of the sub-cortical regions of crucial importance for cognitive function' and 'major structural dysfunction of the communication pathways between the regions of the brain involved in consciousness'. The severity of the cerebral atrophy and of the damage observed, coupled with the five-and-a-half-year period that had elapsed since the initial accident, led the experts to conclude that the brain damage was irreversible.

Furthermore, the experts concluded that 'the lengthy period of progression, the patient's clinical deterioration since 2011, his current vegetative state, the destructive nature and the extent of the brain damage, the results of the functional tests and the severity of the motor impairment of all four limbs' pointed to a 'poor clinical prognosis'.

Lastly, while noting that Mr Lambert was capable of reacting to the care administered and to certain stimuli, the experts indicated that the characteristics of those reactions suggested that they were non-conscious responses. The experts did not consider it possible to interpret these behavioural reactions as evidence of 'conscious awareness of suffering' or as the expression of any intent or wish with regard to the withdrawal or continuation of the treatment keeping the patient alive.

These findings, which the experts reached unanimously following a collective assessment in the course of which the patient was examined on nine separate occasions, thorough cerebral tests were performed, meetings were held with the medical team and care staff involved and the entire file was examined, confirm the conclusions drawn by Dr Kariger as to the irreversible nature of the damage and Mr Lambert's clinical prognosis. The exchanges which took place in the adversarial proceedings before the *Conseil d'État* subsequent to submission of the experts' report do nothing to invalidate the experts' conclusions. While it can be seen from the experts' report, as just indicated, that Mr Lambert's reactions to care are not capable of interpretation and thus cannot be regarded as expressing a wish as to the withdrawal of treatment, Dr Kariger in fact indicated in the impugned decision that the behaviour concerned was open to various interpretations, all of which needed to be treated with great caution, and did not include this aspect in the reasons for his decision.

Thirdly, the provisions of the Public Health Code allow account to be taken of a patient's wishes expressed in a form other than advance directives. It is apparent from the examination of the case, and in particular from the testimony of Mrs Rachel Lambert, that she and her husband, both nurses, had often discussed their respective professional experiences in dealing with patients under resuscitation and those with multiple disabilities, and that Mr Lambert had on several such occasions clearly

voiced the wish not to be kept alive artificially if he were to find himself in a highly dependent state. The tenor of those remarks, reported by Mrs Rachel Lambert in precise detail and with the corresponding dates, was confirmed by one of Mr Lambert's brothers. While these remarks were not made in the presence of Mr Lambert's parents, the latter did not claim that their son could not have made them or that he would have expressed wishes to the contrary, and several of Mr Lambert's siblings stated that the remarks concerned were in keeping with their brother's personality, past experience and personal opinions. Accordingly, in stating among the reasons for the decision at issue his certainty that Mr Lambert did not wish, before his accident, to live under such conditions, Dr Kariger cannot be regarded as having incorrectly interpreted the wishes expressed by the patient before his accident.

Fourthly, the doctor in charge of the patient is required, under the provisions of the Public Health Code, to obtain the views of the patient's family before taking any decision to withdraw treatment. Dr Kariger complied with this requirement in consulting Mr Lambert's wife, parents and siblings in the course of the two meetings referred to earlier. While Mr Lambert's parents and some of his brothers and sisters opposed the discontinuing of treatment, Mr Lambert's wife and his other siblings stated their support for the proposal to withdraw treatment. Dr Kariger took these different opinions into account. In the circumstances of the case, he concluded that the fact that the members of the family were not unanimous as to what decision should be taken did not constitute an impediment to his decision.

It follows from all the above considerations that the various conditions imposed by the law before any decision can be taken by the doctor in charge of the patient to withdraw treatment which has no effect other than to sustain life artificially, and whose continuation would thus amount to unreasonable obstinacy, may be regarded, in the case of Mr Vincent Lambert and in the light of the adversarial proceedings before the *Conseil d'État*, as having been met. Accordingly, the decision taken by Dr Kariger on 11 January 2014 to withdraw the artificial nutrition and hydration of Mr Vincent Lambert cannot be held to be unlawful."

51. Accordingly, the *Conseil d'État* set aside the Administrative Court's judgment and dismissed the applicants' claims.

II. RELEVANT DOMESTIC LAW AND PRACTICE

A. Public Health Code

52. Under Article L. 1110-1 of the Public Health Code (hereinafter "the Code"), all available means must be used to secure to each individual the fundamental right to protection of health. Article L. 1110-2 of the Code provides that the patient has the right to respect for his or her dignity, while Article L. 1110-9 guarantees to everyone whose condition requires it the right to palliative care. This is defined in Article L. 1110-10 as active and ongoing care intended to relieve pain, ease psychological suffering, preserve the patient's dignity and support those close to him or her.

53. The Act of 22 April 2005 on patients' rights and end-of-life issues, known as the Leonetti Act after its rapporteur, Mr Jean Leonetti (see paragraph 44 above), amended a number of Articles of the Code.

The Act was passed following the work of a parliamentary commission chaired by Mr Leonetti and tasked with exploring the full range of end-of-life issues and considering possible legislative or regulatory amendments. In the course of its work the parliamentary commission heard evidence from a great many individuals. It submitted its report on 30 June 2004. The Act was passed unanimously by the National Assembly on 30 November 2004 and by the Senate on 12 April 2005.

The Act does not authorise either euthanasia or assisted suicide. It allows doctors, in accordance with a prescribed procedure, to discontinue treatment only if continuing it would demonstrate unreasonable obstinacy (in other words, if it would mean taking it to unreasonable lengths (*acharnement thérapeutique*)).

The relevant Articles of the Code, as amended by the Act, read as follows:

Article L. 1110-5

"Every individual, regard being had to his or her state of health and the urgency of the treatment required, shall be entitled to receive the most appropriate care and to be given the safest treatment known to medical science at the time to be effective. Preventive or exploratory acts or care must not, as far as medical science can guarantee, subject the patient to disproportionate risks in relation to the anticipated benefits.

Such acts must not be continued with unreasonable obstinacy. Where they appear to be futile or disproportionate or to have no other effect than to sustain life artificially, they may be discontinued or withheld. In such cases, the doctor shall preserve the dignity of the dying patient and ensure his or her quality of life by dispensing the care referred to in Article L. 1110-10 ...

Everyone shall be entitled to receive care intended to relieve pain. That pain must in all cases be prevented, assessed, taken into account and treated.

Health care professionals shall take all the measures available to them to allow each individual to live a life of dignity until his or her death ..."

Article L. 1111-4

"Each individual shall, together with the health care professional and in the light of the information provided and the recommendations made by the latter, take the decisions concerning his or her own health.

The doctor must respect the individual's wishes after informing him or her of the consequences of the choices made ...

No medical act or treatment may be administered without the free and informed consent of the patient, which may be withdrawn at any time.

Where the individual is unable to express his or her wishes, no intervention or examination may be carried out, except in cases of urgency or impossibility, without the person of trust referred to in Article L. 1111-6 or the family or, failing this, a person close to the patient having been consulted.

Where the individual is unable to express his or her wishes, no decision to limit or withdraw treatment, where such a measure would endanger the patient's life, may be taken without the collective procedure defined in the Code of Medical Ethics having been followed and without the person of trust referred to in Article L. 1111-6 or the family or, failing this, a person close to the patient having been consulted, and without any advance directives issued by the patient having been examined. The decision to limit or withdraw treatment, together with the reasons for it, shall be recorded in the patient's file ..."

Article L. 1111-6

"All adults may designate a person of trust, who may be a relative, another person close to the adult, or his or her usual doctor, and who will be consulted in the event that the patient is unable to express his or her wishes and to receive the necessary information for that purpose. The designation shall be made in writing and may be revoked at any time. Should the patient so wish, the person of trust may provide support and attend medical consultations with the patient in order to assist him or her in making decisions.

Whenever he or she is admitted to a health care establishment, the patient shall be offered the possibility of designating a person of trust in the conditions laid down in the preceding paragraph. The designation shall be valid for the duration of the patient's hospitalisation, unless he or she decides otherwise ..."

Article L. 1111-11

"All adults may draw up advance directives in case they should become unable to express their wishes. These shall indicate the wishes of the individual concerned as regards the conditions in which treatment may be limited or withdrawn in an end-of-life situation. They may be revoked at any time.

Provided they were drawn up less than three years before the individual became unconscious, the doctor shall take them into account in any decision to carry out examinations, interventions or treatment in respect of the person concerned ..."

54. The collective procedure provided for in the fifth paragraph of Article L. 1111-4 of the Code is described in detail in Article R. 4127-37, which forms part of the Code of Medical Ethics and reads as follows:

"I. The doctor shall at all times endeavour to alleviate suffering by the means most appropriate to the patient's condition, and provide moral support. He or she shall refrain from any unreasonable obstinacy in carrying out examinations or treatment and may decide to withhold or discontinue treatment which appears futile or disproportionate or the only purpose or effect of which is to sustain life artificially.

II. In the cases contemplated in the fifth paragraph of Article L. 1111-4 and the first paragraph of Article L. 1111-13, the decision to limit or withdraw the treatment administered may not be taken unless a collective procedure has first been implemented. The doctor may set the collective procedure in motion on his or her own initiative. He or she shall be required to do so in the light of any advance directives given by the patient and submitted by one of the persons in possession of them mentioned in Article R. 1111-19, or at the request of the person of trust, the family or, failing this, another person close to the patient. The persons in possession of the patient's advance directives, the person of trust, the family or, where appropriate, another person close to the patient shall be informed as soon as the decision has been taken to implement the collective procedure.

The decision to limit or withdraw treatment shall be taken by the doctor in charge of the patient, after consultation with the care team where this exists, and on the basis of the reasoned opinion of at least one doctor acting as a consultant. There must be no hierarchical link between the doctor in charge of the patient and the consultant. The reasoned opinion of a second consultant shall be sought by these doctors if either of them considers it necessary.

The decision to limit or withdraw treatment shall take into account any wishes previously expressed by the patient, in particular in the form of advance directives, if any, the views of the person of trust the patient may have designated and those of the family or, failing this, of another person close to the patient. ...

Reasons shall be given for any decision to limit or withdraw treatment. The opinions received, the nature and tenor of the consultations held within the care team and the reasons for the decision shall be recorded in the patient's file. The person of trust, if one has been designated, the family or, failing this, another person close to the patient, shall be informed of the nature of and the reasons for the decision to limit or withdraw treatment.

III. Where it has been decided to limit or withdraw treatment under Article L. 1110-5 and Article L. 1111-4 or L. 1111-13, in the circumstances provided for in points I and II of the present Article, the doctor, even if the patient's suffering cannot be assessed on account of his or her cerebral state, shall put in place the necessary treatment, in particular pain relief and sedation, to support the patient in accordance with the principles and conditions laid down in Article R. 4127-38. He or she shall also ensure that the persons close to the patient are informed of the situation and receive the support they require."

55. Article R. 4127-38 of the Code provides:

"The doctor must support the dying person until the moment of death, ensure, through appropriate treatment and measures, the quality of life as it nears its end, preserve the patient's dignity and comfort those close to him or her.

Doctors do not have the right to take life intentionally."

B. Private members' bill of 21 January 2015

56. Two members of Parliament (Mr Leonetti and Mr Claeys) tabled a bill before the National Assembly on 21 January 2015 proposing in particular the following amendments to the Act of 22 April 2005:

- section 2 of the bill specifies that artificial nutrition and hydration constitute a form of treatment;

- advance directives are to be binding on the doctor and there will no longer be a time-limit on their validity (they are currently valid for three years), their drafting will be subject to a prescribed procedure and they will be more accessible. Where there are no advance directives, the role of the person of trust is spelled out (the latter's task is to express the patient's wishes, and his or her testimony takes precedence over any other);

- the bill expressly acknowledges that every individual has "the right to refuse or not to undergo any treatment" and that the doctor cannot insist on continuing with it (previous wording). Nevertheless, the doctor must

continue to provide support to the patient, particularly in the form of palliative care;

- the right not to suffer is recognised (the doctor must put in place all available pain relief and sedation to deal with suffering in the advanced or terminal stages, even if these may have the effect of shortening the time left to live);

- the right of patients in the terminal stages to deep, continuous sedation until death is also recognised: the withdrawal of treatment (including artificial nutrition and hydration) must always be accompanied by sedation. Where the patient is incapable of expressing his or her wishes the bill provides – subject to account being taken of the patient's wishes and in accordance with a collective procedure – that the doctor is required to discontinue or withhold treatment which "has no other effect than to sustain life artificially" (in the current wording, the doctor *may* discontinue such treatment). If these criteria are met, the patient has the right to deep, continuous sedation until death occurs.

The bill was adopted on 17 March 2015 by the National Assembly and is currently being examined in the Senate.

C. Administrative Courts Code

57. Article L. 521-2 of the Administrative Courts Code, concerning urgent applications for protection of a fundamental freedom, reads as follows:

> "Where such an application is submitted to him or her as an urgent matter, the urgent-applications judge may order whatever measures are necessary to protect a fundamental freedom which has allegedly been breached in a serious and manifestly unlawful manner by a public-law entity or an organisation governed by private law responsible for managing a public service, in the exercise of their powers. The urgent-applications judge shall rule within forty-eight hours."

58. Article R. 625-3 of the same Code provides:

> "The bench examining the case may call on any person whose expertise or knowledge might usefully inform its determination of the case to submit general observations on the points in issue.
>
> The opinion shall be submitted in writing. It shall be communicated to the parties ..."

III. COUNCIL OF EUROPE MATERIALS

A. The Oviedo Convention on Human Rights and Biomedicine

59. The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine

(known as the Oviedo Convention on Human Rights and Biomedicine), which was adopted in 1997 and entered into force on 1 December 1999, has been ratified by twenty-nine of the Council of Europe member States. Its relevant provisions read as follows:

Article 1 – Purpose and object

"Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine. ..."

Article 5 – General rule

"An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time."

Article 6 – Protection of persons not able to consent

"1. Subject to Articles 17 and 20 below, an intervention may only be carried out on a person who does not have the capacity to consent, for his or her direct benefit.

...

3. Where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law.

The individual concerned shall as far as possible take part in the authorisation procedure.

4. The representative, the authority, the person or the body mentioned in paragraphs 2 and 3 above shall be given, under the same conditions, the information referred to in Article 5.

5. The authorisation referred to in paragraphs 2 and 3 above may be withdrawn at any time in the best interests of the person concerned."

Article 9 – Previously expressed wishes

"The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."

B. The Guide on the decision-making process regarding medical treatment in end-of-life situations

60. This guide was drawn up by the Committee on Bioethics of the Council of Europe in the course of its work on patients' rights and with the

intention of facilitating the implementation of the principles enshrined in the Oviedo Convention.

Its aims are to propose reference points for the implementation of the decision-making process regarding medical treatment in end-of-life situations, to bring together both normative and ethical reference works and elements relating to good medical practice of use to health care professionals dealing with the implementation of the decision-making process, and to contribute, through the clarification it provides, to the overall discussion on the subject.

61. The guide cites as the ethical and legal frames of reference for the decision-making process the principles of autonomy (free, informed and prior consent of the patient), beneficence and non-maleficence, and justice (equitable access to health care). It specifies that doctors must not dispense treatment which is needless or disproportionate in view of the risks and constraints it entails. They must provide patients with treatment that is proportionate and suited to their situation. They also have a duty to take care of their patients, ease their suffering and provide them with support.

Treatment covers interventions whose aim is to improve a patient's state of health by acting on the causes of the illness, but also interventions which have no bearing on the aetiology of the illness but act on the symptoms, or which are responses to an organ dysfunction. Under the heading "Disputed issues", the Guide states as follows:

> "**The question of limiting, withdrawing or withholding artificial hydration and nutrition**
>
> Food and drink given to patients who are still able to eat and drink themselves are external contributions meeting physiological needs, which should always be satisfied. They are essential elements of care which should be provided unless the patient refuses them.
>
> Artificial nutrition and hydration are given to a patient following a medical indication and imply choices concerning medical procedures and devices (perfusion, feeding tubes).
>
> Artificial nutrition and hydration are regarded in a number of countries as forms of treatment, which may therefore be limited or withdrawn in the circumstances and in accordance with the guarantees stipulated for limitation or withdrawal of treatment (refusal of treatment expressed by the patient, refusal of unreasonable obstinacy or disproportionate treatment assessed by the care team and accepted in the framework of a collective procedure). The considerations to be taken into account in this regard are the wishes of the patient and the appropriate nature of the treatment in the situation in question.
>
> In other countries, however, it is considered that artificial nutrition and hydration do not constitute treatment which can be limited or withdrawn, but a form of care meeting the individual's basic needs, which cannot be withdrawn unless the patient, in the terminal phase of an end-of-life situation, has expressed a wish to that effect.
>
> The question of the appropriate nature, in medical terms, of artificial nutrition and hydration in the terminal phase is itself a matter of debate. Some take the view that

> implementing or continuing artificial hydration and nutrition are necessary for the comfort of a patient in an end-of-life situation. For others, the benefit of artificial hydration and nutrition for the patient in the terminal phase, taking into account research in palliative care, is questionable."

62. The guide concerns the decision-making process regarding medical treatment as it applies to end-of-life situations (including its implementation, modification, adaptation, limitation or withdrawal). It does not address the issues of euthanasia or assisted suicide, which some national legislations authorise.

63. While other parties are involved in the decision-making process, the guide stresses that the principal party is the patient himself or herself. When the patient cannot or can no longer take part in making decisions, they will be taken by a third party according to the procedures laid down in the relevant national legislation. However, the patient should nonetheless be involved in the decision-making process by means of any previously expressed wishes. The guide lists the various forms these may take: the patient may have confided his or her intentions orally to a family member, a close friend or a person of trust designated as such; or they may be set down formally, in advance directives or a living will or as powers granted to another person, sometimes referred to as powers of future protection (*mandat de protection future*).

64. Other persons involved in the decision-making process may include the patient's legal representative or a person granted a power of attorney, family members and close friends, and the carers. The guide stresses that doctors have a vital, not to say primary role because of their ability to appraise the patient's situation from a medical viewpoint. Where patients are not, or are no longer, able to express their wishes, doctors are the people who, in the context of the collective decision-making process, having involved all the health care professionals concerned, will take the clinical decision guided by the best interests of the patient. To this end, they will have taken note of all the relevant elements (consultation of family members, close friends, the person of trust, and so on) and taken into account any previously expressed wishes. In some systems the decision is taken by a third party, but in all cases doctors are the ones to ensure that the decision-making process is properly conducted.

65. The guide reiterates that the patient should always be at the centre of any decision-making process, which takes on a collective dimension when the patient is no longer willing or able to participate in it directly. The guide identifies three main stages in the decision-making process: an individual stage (each party forms his or her arguments on the basis of the information gathered), a collective stage (the various parties take part in exchanges and discussions) and a concluding stage (when the actual decision is taken).

66. The guide points out that sometimes, where positions diverge significantly or the question is highly complex or specific, there may be a

need to make provision to consult third parties either to contribute to the debate, to overcome a problem or to resolve a conflict. The consultation of a clinical ethics committee may, for example, be appropriate. At the end of the collective discussion, agreement must be reached. A conclusion must be drawn and validated collectively and then formalised in writing.

67. If the decision is taken by the doctor, it should be taken on the basis of the conclusions of the collective discussion and be announced, as appropriate, to the patient, the person of trust and/or the entourage of the patient, the care team and the third parties concerned who have taken part in the process. The decision should also be formalised (in the form of a written summary of the reasons) and kept in an identified place.

68. The guide highlights the disputed nature of the use of deep sedation in the terminal phase, which may have the effect of shortening the time left to live. Lastly, it suggests an evaluation of the decision-making process after its application.

C. Committee of Ministers Recommendation

69. In Recommendation CM/Rec(2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity, the Committee of Ministers recommended to member States that they promote these practices, and defined a number of principles to assist member States in regulating them.

D. Parliamentary Assembly materials

70. In Recommendation 1418 (1999) on protection of the human rights and dignity of the terminally ill and the dying, the Parliamentary Assembly recommended to the Committee of Ministers that it encourage the member States to respect and protect the dignity of terminally ill or dying persons in all respects, including their right to self-determination, while taking the necessary measures:

(i) to ensure that patients' advance directives or living wills refusing specific medical treatments are observed, where the patients are no longer able to express their wishes;

(ii) to ensure that - notwithstanding the physician's ultimate therapeutic responsibility - the wishes they have expressed with regard to particular forms of treatment are taken into account, provided this does not violate their human dignity.

71. Parliamentary Assembly Resolution 1859 (2012) entitled "Protecting human rights and dignity by taking into account previously expressed wishes of patients" reiterates the principles of personal autonomy and consent enshrined in the Oviedo Convention (see paragraph 59 above), according to which no one can be compelled to undergo any medical

treatment against his or her will. The Resolution lays down guidelines for national parliaments in relation to advance directives, living wills and continuing powers of attorney.

IV. COMPARATIVE LAW

A. Legislation and practice in Council of Europe member States

72. According to the information available to the Court concerning 39 of the 47 Council of Europe member States, no consensus exists in practice in favour of authorising the withdrawal of treatment designed only to prolong life artificially. In the majority of countries, treatment may be withdrawn subject to certain conditions. In other countries the legislation prohibits withdrawal or is silent on the subject.

73. In those countries which permit it, this possibility is provided for either in legislation or in non-binding instruments, most often in a code of medical ethics. In Italy, in the absence of a legal framework, the withdrawal of treatment has been recognised in the courts' case-law.

74. Although the detailed arrangements for the withdrawal of treatment vary from one country to another, there is consensus as to the paramount importance of the patient's wishes in the decision-making process. As the principle of consent to medical care is one of the aspects of the right to respect for private life, States have put in place different procedures to ensure that consent is expressed or to verify its existence.

75. All the legislation allowing treatment to be withdrawn makes provision for patients to issue advance directives. In the absence of such directives, the decision lies with a third party, whether it be the doctor treating the patient, persons close to the patient or his or her legal representative, or even the courts. In all cases, the involvement of those close to the patient is possible, although the legislation does not choose between them in the event of disagreement. However, some countries operate a hierarchy among persons close to the patient and give priority to the spouse's wishes.

76. In addition to the requirement to seek the patient's consent, the withdrawal of treatment is also subject to other conditions. Depending on the country, the patient must be dying or be suffering from a condition with serious and irreversible medical consequences, the treatment must no longer be in the patient's best interests, it must be futile, or withdrawal must be preceded by an observation phase of sufficient duration and by a review of the patient's condition.

B. Observations of the Human Rights Clinic

77. The Human Rights Clinic, third-party intervener (see paragraph 8 above), presented an overview of national legislation and practice concerning active and passive euthanasia and assisted suicide in Europe and America.

78. The survey concludes that no consensus currently exists among the member States of the Council of Europe, or in the other countries surveyed, regarding the authorisation of assisted suicide or euthanasia.

79. However, there is consensus on the need for passive euthanasia to be tightly regulated in those countries which permit it. In that connection each country lays down criteria in its legislation for determining the point at which euthanasia may be performed, in the light of the patient's condition and in order to make sure that he or she has consented to the measure. Nevertheless, these criteria vary appreciably from one country to another.

THE LAW

I. STANDING TO ACT IN THE NAME AND ON BEHALF OF VINCENT LAMBERT

80. The applicants submitted that the withdrawal of Vincent Lambert's artificial nutrition and hydration would be in breach of the State's obligations under Article 2 of the Convention. In their view, depriving him of nutrition and hydration would constitute ill-treatment amounting to torture within the meaning of Article 3 of the Convention. They further argued that the lack of physiotherapy since October 2012 and the lack of therapy to restore the swallowing reflex amounted to inhuman and degrading treatment in breach of that provision. Lastly, they submitted that the withdrawal of nutrition and hydration would also infringe Vincent Lambert's physical integrity, in breach of Article 8 of the Convention.

81. Articles 2, 3 and 8 of the Convention read as follows:

Article 2

"1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally ..."

Article 3

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

Article 8

"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

A. The applicants' standing to act in the name and on behalf of Vincent Lambert

1. The parties' submissions

(a) The Government

82. The Government observed that the applicants had not stated that they wished to act on Vincent Lambert's behalf, and considered the question whether they could apply to the Court on his behalf to be devoid of purpose.

(b) The applicants

83. The applicants submitted that any individual, irrespective of his or her disability, should be able to benefit from the guarantees afforded by the Convention, including where he or she had no representative. They stressed that their standing or interest in bringing proceedings had never been challenged before the domestic courts, as French law gave the family of a person whose treatment it was proposed to withdraw the right to express a view on the measure in question. This necessarily entailed standing to act in court proceedings not only on their own behalf but also on behalf of the patient.

84. Citing the criteria established by the Court in the *Koch v. Germany* judgment (no. 497/09, §§ 43 et seq., 19 July 2012), the applicants submitted that those criteria were satisfied in the present case because the case concerned a matter of general interest and because of their close family ties and their personal interest in the proceedings. They stressed that they had applied to the domestic courts and then to the Court in order to assert Vincent Lambert's fundamental rights under Articles 2 and 3 which he himself was unable to assert and which his wife could not invoke either since she had accepted the medical decision in issue.

(c) The individual third-party interveners

85. Rachel Lambert, Vincent Lambert's wife, submitted that the applicants did not have standing to act on behalf of Vincent Lambert. She pointed out that the Court had been prepared to recognise the standing of a relative either when the complaints raised an issue of general interest

pertaining to "respect for human rights" and the person concerned, as heir, had a legitimate interest in pursuing the application, or on the basis of the direct effect on the applicant's own rights. However, in the case of *Sanles Sanles v. Spain* ((dec.), no. 48335/99, ECHR 2000-XI), the Court had found that the rights asserted by the applicant under Articles 2, 3, 5 and 8 of the Convention belonged to the category of non-transferable rights and had held that the applicant, who was the sister-in-law and legitimate heir of the deceased, could not claim to be the victim of a violation on her late brother-in-law's behalf.

86. On the issue of representation, she observed that it was essential for representatives to demonstrate that they had received specific and explicit instructions from the alleged victim. This was not the case of the applicants, who had received no specific and explicit instructions from Vincent Lambert, whereas the examination of the case by the *Conseil d'État* had highlighted the fact that she herself had been taken into her husband's confidence and informed of his wishes, as corroborated by statements produced before the domestic courts.

87. François Lambert and Marie-Geneviève Lambert, Vincent Lambert's nephew and half-sister, submitted that the applicants lacked standing to act on his behalf. Firstly, the violations of Articles 2, 3 and 8 of the Convention alleged by the applicants concerned non-transferable rights to which they could not lay claim on their own behalf; secondly, the applicants were not the legal representatives of Vincent Lambert, who was an adult born in 1976; thirdly, their application contravened Vincent Lambert's freedom of conscience and his own right to life and infringed his privacy. François Lambert and Marie-Geneviève Lambert observed that, although the Court had, by way of an exception, accepted that parents might act on behalf and in the place of a victim in arguing a breach of Article 3 of the Convention, this was only in the case of the victim's disappearance or death and in certain specific circumstances. Those conditions were not met in the present case, making the application inadmissible. They argued that the Court had had occasion to reaffirm this inadmissibility in end-of-life cases similar to the present one (they referred to *Sanles Sanles*, cited above, and *Ada Rossi and Others v. Italy* (dec.), no. 55185/08, 16 December 2008).

88. Lastly, they argued that the applicants could not in fact "legitimately" challenge the *Conseil d'État*'s judgment, since the position they defended was directly opposed to Vincent Lambert's beliefs. The doctors and the judges had taken account of the latter's wishes, which he had confided to his wife – with whom he had had a very close relationship – in full knowledge of the facts, in view of his professional experience as a nurse.

2. The Court's assessment

(a) Recapitulation of the principles

89. In the recent cases of *Nencheva and Others v. Bulgaria* (no. 48609/06, 18 June 2013) and *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* ([GC], no. 47848/08, ECHR 2014), the Court reiterated the following principles.

In order to rely on Article 34 of the Convention, an applicant must be able to claim to be a victim of a violation of the Convention. According to the Court's established case-law, the concept of "victim" must be interpreted autonomously and irrespective of domestic concepts such as those concerning an interest or capacity to act (see *Nencheva and Others*, cited above, § 88). The individual concerned must be able to show that he or she was "directly affected" by the measure complained of (see *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 96, with further references).

90. An exception is made to this principle where the alleged violation or violations of the Convention are closely linked to a death or disappearance in circumstances allegedly engaging the responsibility of the State. In such cases the Court has recognised the standing of the victim's next-of-kin to submit an application (see *Nencheva and Others*, cited above, § 89, and *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, §§ 98-99, with further references).

91. Where the application is not lodged by the victims themselves, Rule 45 § 3 of the Rules of Court requires a written authority to act, duly signed, to be produced. It is essential for representatives to demonstrate that they have received specific and explicit instructions from the alleged victim on whose behalf they purport to act before the Court (see *Post v. the Netherlands* (dec.), no. 21727/08, 20 January 2009; *Nencheva and Others*, cited above, § 83; and *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 102). However, the Convention institutions have held that special considerations may arise in the case of victims of alleged breaches of Articles 2, 3 and 8 of the Convention at the hands of the national authorities. Applications lodged by individuals on behalf of the victim or victims, even though no valid form of authority was presented, have thus been declared admissible (see *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 103).

92. Particular consideration has been shown with regard to the victims' vulnerability on account of their age, sex or disability, which rendered them unable to lodge a complaint on the matter with the Court, due regard also being paid to the connections between the person lodging the application and the victim (ibid.).

93. For instance, in the case of *S.P., D.P. and A.T. v. the United Kingdom* (no. 23715/94, Commission decision of 20 May 1996), which

concerned, *inter alia*, Article 8 of the Convention, the Commission declared admissible an application lodged by a solicitor on behalf of children whom he had represented in the domestic proceedings, in which he had been instructed by the guardian *ad litem*, after noting in particular that their mother had displayed no interest, that the local authorities had been criticised in the application and that there was no conflict of interests between the solicitor and the children.

In the case of *İlhan v. Turkey* ([GC], no. 22277/93, §§ 54-55, ECHR 2000-VII), where the direct victim, Abdüllatif İlhan, had suffered severe injuries as a result of ill-treatment at the hands of the security forces, the Court held that his brother could be regarded as having validly introduced the application, based on Articles 2 and 3 of the Convention, since it was clear from the facts that Abdüllatif İlhan had consented to the proceedings, there was no conflict of interests between himself and his brother, who had been closely concerned with the incident, and he was in a particularly vulnerable position because of his injuries.

In the case of *Y.F. v. Turkey* (no. 24209/94, § 31, ECHR 2003-IX), in which a husband alleged under Article 8 of the Convention that his wife had been forced to undergo a gynaecological examination following her detention in police custody, the Court found that it was open to the applicant, as a close relative of the victim, to make a complaint concerning allegations by her of violations of the Convention, in particular having regard to her vulnerable position in the special circumstances of the case.

94. Still in the context of Article 8 of the Convention, the Court has also accepted on several occasions that parents who did not have parental rights could apply to it on behalf of their minor children (see, in particular, *Scozzari and Giunta v. Italy* [GC], nos. 39221/98 and 41963/98, §§ 138-139, ECHR 2000-VIII; *Šneersone and Kampanella v. Italy*, no. 14737/09, § 61, 12 July 2011; *Diamante and Pelliccioni v. San Marino*, no. 32250/08, §§ 146-47, 27 September 2011; *A.K. and L. v. Croatia*, no. 37956/11, §§ 48-50, 8 January 2013; and *Raw and Others v. France*, no. 10131/11, §§ 51-52, 7 March 2013). The key criterion for the Court in these cases was the risk that some of the children's interests might not be brought to its attention and that they would be denied effective protection of their Convention rights.

95. Lastly, the Court recently adopted a similar approach in the case of *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, concerning a young man of Roma origin, seriously disabled and HIV positive, who died in hospital before the application was lodged and had no known next-of-kin and no State-appointed representative. In view of the exceptional circumstances of the case and the seriousness of the allegations, the Court recognised that the Centre for Legal Resources had standing to represent Valentin Câmpeanu. The Court emphasised that to find otherwise

would amount to preventing such serious allegations of a violation of the Convention from being examined at an international level (§ 112).

(b) Application to the present case

96. The applicants alleged on Vincent Lambert's behalf a violation of Articles 2, 3 and 8 of the Convention (see paragraph 80 above).

97. The Court considers at the outset that the case-law concerning applications lodged on behalf of deceased persons is not applicable in the present case, since Vincent Lambert is not dead but is in a state described by the medical expert report as vegetative (see paragraph 40 above). The Court must therefore ascertain whether circumstances apply of the kind in which it has previously held that an application could be lodged in the name and on behalf of a vulnerable person without the latter having issued either a valid authority to act or instructions to the person purporting to act for him or her (see paragraphs 93-95 above).

98. It notes that none of the cases in which it has accepted, by way of an exception, that an individual may act on behalf of another is comparable to the present case. The case of *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, is to be distinguished from the present case in so far as the direct victim was dead and had no one to represent him. In the present case, while the direct victim is unable to express his wishes, several members of his close family wish to express themselves on his behalf, while defending diametrically opposed points of view. The applicants mainly invoke the right to life protected by Article 2, the "sanctity" of which was stressed by the Court in *Pretty v. the United Kingdom* (no. 2346/02, § 65, ECHR 2002-III), whereas the individual third-party interveners (Rachel Lambert, François Lambert and Marie-Geneviève Lambert) rely on the right to respect for private life and in particular the right of each individual, encompassed in the notion of personal autonomy (see *Pretty*, cited above, § 61), to decide in which way and at which time his or her life should end (ibid., § 67; see also *Haas v. Switzerland*, no. 31322/07, § 51, ECHR 2011, and *Koch*, cited above, § 52).

99. The applicants propose that the Court should apply the criteria set forth in *Koch* (cited above, § 44), which, in their submission, they satisfy on account of their close family ties, the fact that they have a sufficient personal or legal interest in the outcome of the proceedings and the fact that they have previously expressed an interest in the case.

100. However, the Court observes that in *Koch*, cited above, the applicant argued that his wife's suffering and the circumstances of her death had affected him to the extent of constituting a violation *of his own rights* under Article 8 of the Convention (§ 43). Thus, it was on that point that the Court was required to rule, and it was against that background that it considered that account should also be taken of the criteria developed in its

case-law allowing a relative or heir to bring an action before it on the deceased person's behalf (§ 44).

101. In the Court's view, these criteria are not applicable in the present case since Vincent Lambert is not dead and the applicants are seeking to raise complaints *on his behalf*.

102. A review of the cases in which the Convention institutions have accepted that a third party may, in exceptional circumstances, act in the name and on behalf of a vulnerable person (see paragraphs 93-95 above) reveals the following two main criteria: the risk that the direct victim will be deprived of effective protection of his or her rights, and the absence of a conflict of interests between the victim and the applicant.

103. Applying these criteria to the present case, the Court does not discern any risk, firstly, that Vincent Lambert will be deprived of effective protection of his rights since, in accordance with its consistent case-law (see paragraphs 90 above and 115 below), it is open to the applicants, as Vincent Lambert's close relatives, to invoke before the Court on their own behalf the right to life protected by Article 2.

104. As regards the second criterion, the Court must next ascertain whether there is a convergence of interests between the applicants and Vincent Lambert. In that connection it notes that one of the key aspects of the domestic proceedings consisted precisely in determining Vincent Lambert's wishes, given that Dr Kariger's decision of 11 January 2014 was based on the certainty that Vincent Lambert "had not wished, before his accident, to live under such conditions" (see paragraph 22 above). In its judgment of 24 June 2014 the *Conseil d'État* found, in the light of the testimony of Vincent Lambert's wife and one of his brothers and the statements of several of his other siblings, that in basing his decision on that ground, Dr Kariger "[could not] be regarded as having incorrectly interpreted the wishes expressed by the patient before his accident" (see paragraph 50 above). Accordingly, the Court does not consider it established that there is a convergence of interests between the applicants' assertions and what Vincent Lambert would have wished.

105. The Court concludes that the applicants do not have standing to raise the complaints under Articles 2, 3 and 8 of the Convention in the name and on behalf of Vincent Lambert.

106. It follows that these complaints are incompatible *ratione personae* with the provisions of the Convention within the meaning of Article 35 § 3 (a) and must be rejected pursuant to Article 35 § 4.

B. Rachel Lambert's standing to act in the name and on behalf of Vincent Lambert

1. The parties' submissions

107. In a letter from her lawyer dated 9 July 2014, Rachel Lambert requested leave to represent her husband Vincent Lambert as a third-party intervener in the procedure. In support of her request she furnished a judgment of the Châlons-en-Champagne guardianship judge, dated 17 December 2008, giving her authority to represent her husband in matters arising out of their matrimonial property arrangements, as well as two statements from a sister and half-brother of Vincent Lambert. According to those statements, Vincent Lambert would not have wished a decision in his case to be taken by his parents, from whom he was morally and physically estranged, but rather by his wife, who was the person in whom he placed his trust. She also produced a statement by her stepmother, who said that she had accompanied Rachel Lambert in July 2012 to a consultation with a professor of medicine at Liège University Hospital which was also attended by the first two applicants. During the consultation she and Rachel Lambert had stated Vincent Lambert's wish not to live in an incapacitated state if such a situation should arise, and the second applicant had reportedly said that, if the question of euthanasia should arise, she would leave the decision to Rachel Lambert. In her observations, Rachel Lambert submitted that, since she was informed of her husband's wishes, as corroborated by the statements she had produced, she alone had legal standing to act on behalf of Vincent Lambert and to represent him.

108. The Government did not make any submissions on this point.

109. The applicants submitted that the ruling of the guardianship judge produced by Rachel Lambert did not give her general authority to represent her husband, but merely authority to represent him in property-related matters. She could not therefore claim to be the only person to represent her husband before the Court. The applicants further maintained that the statements she had produced had no legal value; they also disputed the content of the statement by Rachel Lambert's stepmother. They noted that Vincent Lambert had not designated a person of trust, and concluded that, as French law currently stood and in the absence of a full or partial guardianship order, Vincent Lambert was not represented by anyone in proceedings concerning him personally.

2. The Court's assessment

110. The Court notes that no provision of the Convention permits a third-party intervener to represent another person before the Court. Furthermore, according to Rule 44 § 3 (a) of the Rules of Court, a third-party intervener is any person concerned "who is not the applicant".

111. Accordingly, the Court cannot but refuse Rachel Lambert's request.

C. Conclusion

112. The Court has found that the applicants lacked standing to allege a violation of Articles 2, 3 and 8 of the Convention in the name and on behalf of Vincent Lambert (see paragraphs 105-06 above), and has also rejected Rachel Lambert's request to represent her husband as a third-party intervener (see paragraphs 110-11 above).

Nevertheless, the Court emphasises that, notwithstanding the findings it has just made regarding admissibility, it will examine below all the substantive issues arising in the present case under Article 2 of the Convention, given that they were raised by the applicants on their own behalf.

II. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

113. The applicants submitted that the withdrawal of Vincent Lambert's artificial nutrition and hydration would be in breach of the State's obligations under Article 2 of the Convention. They maintained that the Act of 22 April 2005 lacked clarity and precision, and complained of the process culminating in the doctor's decision of 11 January 2014.

114. The Government contested that argument.

A. Admissibility

115. The Court reiterates its case-law to the effect that the next-of-kin of a person whose death allegedly engages the responsibility of the State may claim to be victims of a violation of Article 2 of the Convention (see paragraph 90 above). Although Vincent Lambert is still alive, there is no doubt that if artificial nutrition and hydration were withdrawn, his death would occur within a short time. Accordingly, even if the violation is a potential or future one (see *Tauira and 18 Others v. France*, no. 28204/95, Commission decision of 4 December 1995, Decisions and Reports (DR) 83-B, p. 131), the Court considers that the applicants, in their capacity as Vincent Lambert's close relatives, may rely on Article 2.

116. The Court notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention. It further notes that it is not inadmissible on any other grounds. The complaint must therefore be declared admissible.

B. Merits

1. The applicable rule

117. The Court reiterates that the first sentence of Article 2, which ranks as one of the most fundamental provisions in the Convention and enshrines one of the basic values of the democratic societies making up the Council of Europe (see *McCann and Others v. the United Kingdom*, 27 September 1995, §§ 146-47, Series A no. 324), enjoins the State not only to refrain from the "intentional" taking of life (negative obligations), but also to take appropriate steps to safeguard the lives of those within its jurisdiction (positive obligations) (see *L.C.B. v. the United Kingdom*, 9 June 1998, § 36, *Reports of Judgments and Decisions* 1998-III).

118. The Court will address these two aspects in turn and will begin by examining whether the present case involves the State's negative obligations under Article 2.

119. While the applicants acknowledged that the withdrawal of nutrition and hydration might be legitimate in cases of unreasonable obstinacy, and accepted that a legitimate distinction existed between, on the one hand, euthanasia and assisted suicide and, on the other hand, "therapeutic abstention", consisting in withdrawing or withholding treatment that had become unreasonable, they nevertheless argued repeatedly in their observations that, since these criteria were not met in their view, the present case concerned the intentional taking of life; they referred in this regard to the notion of "euthanasia".

120. The Government stressed that the aim of the medical decision was not to put an end to life, but to discontinue a form of treatment which had been refused by the patient or – where the patient was unable to express his or her wishes – which constituted, in the doctor's view based on medical and non-medical factors, unreasonable obstinacy. They quoted the public rapporteur before the *Conseil d'État*, who in his submissions of 20 June 2014 had noted that, in discontinuing treatment, a doctor was not taking the patient's life but was resolving to withdraw when there was nothing more to be done (see paragraph 45 above).

121. The Court observes that the Act of 22 April 2005 does not authorise either euthanasia or assisted suicide. It allows doctors, in accordance with a prescribed procedure, to discontinue treatment only if continuing it demonstrates unreasonable obstinacy. In its observations to the *Conseil d'État* the National Medical Academy reiterated the fundamental prohibition barring doctors from deliberately taking another's life, which formed the basis for the relationship of trust between doctor and patient. That prohibition is laid down in Article R. 4127-38 of the Public Health Code, which states that doctors may not take life intentionally (see paragraph 55 above).

122. At the hearing of 14 February 2014 before the *Conseil d'État*, the public rapporteur cited the remarks made by the Minister of Health to the members of the Senate examining the bill known as the Leonetti bill:

> "While the act of withdrawing treatment ... results in death, the intention behind the act [is not to kill; it is] to allow death to resume its natural course and to relieve suffering. This is particularly important for care staff, whose role is not to take life."

123. In the case of *Glass v. the United Kingdom* ((dec.), no. 61827/00, 18 March 2003), the applicants complained under Article 2 of the Convention about the administering of a potentially lethal dose of diamorphine to their son, without their consent, by doctors in the hospital where he was being treated. The Court noted that the doctors had not deliberately sought to kill the child or to hasten his death, and examined the parents' complaints from the standpoint of the authorities' positive obligations (see also *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V).

124. The Court notes that both the applicants and the Government make a distinction between the intentional taking of life and "therapeutic abstention" (see paragraphs 119-20 above), and stresses the importance of that distinction. In the context of the French legislation, which prohibits the intentional taking of life and permits life-sustaining treatment to be withdrawn or withheld only in certain specific circumstances, the Court considers that the present case does not involve the State's negative obligations under Article 2, and will examine the applicants' complaints solely from the standpoint of the State's positive obligations.

2. Whether the State complied with its positive obligations

(a) The submissions of the parties and the third-party interveners

(i) The applicants

125. The applicants submitted first of all that the Act of 22 April 2005 was not applicable to Vincent Lambert, who, in their view, was neither sick nor at the end of life, but was severely disabled. They complained of the "confusion" arising from the Act on the following points: the notion of unreasonable obstinacy (and in particular the criterion concerning treatment having "no other effect than to sustain life artificially", which they considered to be extremely imprecise), and the classification of artificial nutrition and hydration as treatment rather than care. In their submission, Vincent Lambert's enteral feeding was not a form of treatment that could be withdrawn, and the notion of unreasonable obstinacy did not apply to his medical situation.

126. They argued that the process leading to the doctor's decision of 11 January 2014 was incompatible with the State's obligations flowing from Article 2 of the Convention. In their view, the procedure was not truly

collective as it involved seeking opinions on a purely consultative basis, with the doctor alone taking the decision. They maintained that alternative systems were possible which would allow other doctors or the members of the family, in the absence of a person of trust, to participate in the decision-making process. Lastly, they argued that the legislation should take into account the possibility of disagreement between family members and make provision at the very least for mediation.

(ii) The Government

127. The Government submitted that the Act of 22 April 2005 struck a balance between the right to respect for life and patients' right to consent to or refuse treatment. The definition of unreasonable obstinacy was based on the ethical principles of beneficence and non-maleficence reiterated in the Council of Europe's "Guide on the decision-making process regarding medical treatment in end-of-life situations". In accordance with those principles, health care professionals had an obligation to deliver only appropriate treatment and had to be guided solely by the benefit to the patient, which was to be assessed in overall terms. In that regard both medical and non-medical factors, and in particular the patient's wishes, were to be taken into account. They pointed out that when the bill had been debated in Parliament, an amendment seeking to exclude artificial nutrition and hydration from the scope of treatment had been rejected. They stressed that treatment also encompassed methods and interventions responding to a functional deficiency in the patient and involving the use of intrusive medical techniques.

128. The Government emphasised that the French legislation provided for a number of procedural safeguards: consideration of the patient's wishes and of the views of the person of trust, the family or those close to the patient and implementation of a collective procedure in which the family and those close to the patient were involved. Lastly, the doctor's decision was subject to review by a judge.

(iii) The third-party interveners

(α) Rachel Lambert

129. Rachel Lambert submitted that the Act of 22 April 2005 subjected the doctor's decision to numerous safeguards and balanced each individual's right to receive the most suitable care with the right not to undergo treatment in circumstances amounting to unreasonable obstinacy. She stressed that the legislature had not sought to limit the recognition of patients' previously expressed wishes to cases in which they had designated a person of trust or drawn up advance directives; where this was not the case, the views of the family were sought in order, first and foremost, to establish what the patient would have wanted.

130. Referring to the collective procedure implemented in the present case, she pointed out that Dr Kariger had consulted six doctors (three of them from outside the hospital), had convened a meeting with virtually all the care staff and all the doctors and had held two meetings with the family. His decision had been reasoned at length and bore witness to the professionalism of his approach.

(β) François Lambert and Marie-Geneviève Lambert

131. François Lambert and Marie-Geneviève Lambert submitted that the doctor's decision had been taken in accordance with the Act of 22 April 2005, referred to above, the provisions of which they recapitulated. They stressed that the data emerging from the medical expert report ordered by the *Conseil d'État* were fully consistent with the notion of treatment serving solely to sustain life artificially, observing that it was Vincent Lambert's inability to eat and drink by himself, without medical assistance in the form of enteral nutrition and hydration, that would cause his death.

132. They submitted that the decision-making process in the present case had been particularly lengthy, meticulous and respectful of the rights of all concerned, the medical and paramedical opinions sought and the views of the family members who had been invited to participate (especially the applicants, who had been assisted by a doctor of their choosing throughout the process) and who had been kept fully informed at every stage. In their view, the final decision had been taken in accordance with the process required by law and by the Convention, as set out in the Council of Europe's "Guide on the decision-making process regarding medical treatment in end-of-life situations".

(γ) UNAFTC (National Union of Associations of Head Injury and Brain Damage Victims' Families)

133. UNAFTC echoed the concerns of the families and establishments it represented, and argued that patients in a chronic vegetative or minimally conscious state were not in an end-of-life situation and were not being kept alive artificially, and that where a person's condition was not life-threatening, artificial feeding and hydration could not be deemed to constitute treatment that could be withdrawn. UNAFTC submitted that a patient's wishes could not be established on the basis of spoken remarks reported by some of the family members, and that the doubt must always work in favour of life. At all events, in the absence of advance directives and of a person of trust, no decision to withdraw treatment could be taken in the absence of consensus within the family.

(δ) Amréso-Bethel

134. The association Amréso-Bethel, which runs a care unit for patients in a minimally conscious or chronic vegetative state, provided details of the care dispensed to its patients.

(ε) Human Rights Clinic

135. In view of the multitude of approaches across the world to end-of-life issues and the differences regarding the circumstances in which passive euthanasia was permitted, the Human Rights Clinic submitted that States should be allowed a margin of appreciation in striking a balance between patients' personal autonomy and the protection of their lives.

(b) The Court's assessment

(i) General considerations

(α) Existing case-law

136. The Court has never ruled on the question which is the subject of the present application, but it has examined a number of cases concerning related issues.

137. In a first group of cases the applicants or their relatives invoked the right to die, relying on various Articles of the Convention.

In the case of *Sanles Sanles*, cited above, the applicant asserted, on behalf of her brother-in-law, who was tetraplegic and wished to end his life with the assistance of third parties and who died before the application was lodged, the right to die with dignity, relying on Articles 2, 3, 5, 6, 8, 9 and 14 of the Convention. The Court rejected the application as being incompatible *ratione personae* with the provisions of the Convention.

In the case of *Pretty*, cited above, the applicant was in the terminal stages of an incurable neurodegenerative disease and complained, relying on Articles 2, 3, 8, 9 and 14 of the Convention, that her husband could not help her to commit suicide without facing prosecution by the United Kingdom authorities. The Court found no violation of the provisions in question.

The cases of *Haas* and *Koch*, cited above, concerned assisted suicide, and the applicants relied on Article 8 of the Convention. In *Haas*, the applicant, who had been suffering for a long time from a serious bipolar affective disorder, wished to end his life and complained of being unable to obtain the lethal substance required for that purpose without a medical prescription; the Court held that there had been no violation of Article 8. In *Koch*, the applicant alleged that the refusal to allow his wife (who was paralysed and needed artificial ventilation) to acquire a lethal dose of medication so that she could take her own life had breached her right, and his, to respect for their private and family life. He also complained of the

domestic courts' refusal to examine his complaints on the merits, and the Court found a violation of Article 8 on that point only.

138. In a second group of cases the applicants took issue with the administering or withdrawal of treatment.

In *Glass*, cited above, the applicants complained of the administering of diamorphine to their sick child by hospital doctors without their consent, and of the "do not resuscitate" order entered in his medical notes. In its decision of 18 March 2003, cited above, the Court found that their complaint under Article 2 of the Convention was manifestly ill-founded; in its judgment of 9 March 2004 it held that there had been no violation of Article 8 of the Convention.

In the case of *Burke v. the United Kingdom* ((dec.), no. 19807/06, 11 July 2006), the applicant suffered from an incurable degenerative brain condition and feared that the guidance applicable in the United Kingdom could lead in due course to the withdrawal of his artificial nutrition and hydration. The Court declared his application, lodged under Articles 2, 3 and 8 of the Convention, inadmissible as being manifestly ill-founded.

Lastly, in its decision in *Ada Rossi and Others*, cited above, the Court declared incompatible *ratione personae* an application lodged by individuals and associations complaining, under Articles 2 and 3 of the Convention, of the potentially adverse effects for them of execution of a judgment of the Italian Court of Cassation authorising the discontinuation of the artificial nutrition and hydration of a young girl in a vegetative state.

139. The Court observes that, with the exception of the procedural violation of Article 8 in *Koch*, cited above (see paragraph 137 above), it did not find a violation of the Convention in any of these cases.

(β) The context

140. Article 2 requires the State to take appropriate steps to safeguard the lives of those within its jurisdiction (see *L.C.B.*, cited above, § 36, and the decision in *Powell*, cited above); in the public-health sphere, these positive obligations require States to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives (see *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 49, ECHR 2002-I; the *Glass* decision, cited above; *Vo v. France* [GC], no. 53924/00, § 89, ECHR 2004-VIII; and *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 130).

141. The Court stresses that the issue before it in the present case is not that of euthanasia, but rather the withdrawal of life-sustaining treatment (see paragraph 124 above).

142. In *Haas*, cited above (§ 54), the Court reiterated that the Convention had to be read as a whole (see, *mutatis mutandis*, *Verein gegen Tierfabriken Schweiz (VgT) v. Switzerland (no. 2)* [GC], no. 32772/02, § 83, ECHR 2009). In *Haas* the Court considered that it was appropriate, in the

context of examining a possible violation of Article 8, to refer to Article 2 of the Convention (ibid.). The Court considers that the converse also applies: in a case such as the present one reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses. In *Pretty* (§ 67) the Court was not prepared to exclude that preventing the applicant by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life constituted an interference with her right to respect for private life as guaranteed under Article 8 § 1 of the Convention. In *Haas*, cited above (§ 51), it asserted that an individual's right to decide in which way and at which time his or her life should end was one of the aspects of the right to respect for private life.

The Court refers in particular to paragraphs 63 and 65 of the *Pretty* judgment, where it stated as follows:

> "... In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention. As recognised in domestic case-law, a person may claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his life ..."

> "The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."

143. The Court will take these considerations into account in examining whether the State complied with its positive obligations flowing from Article 2. It further observes that, in addressing the question of the administering or withdrawal of medical treatment in the cases of *Glass* and *Burke*, cited above, it took into account the following factors:

- the existence in domestic law and practice of a regulatory framework compatible with the requirements of Article 2 (*Glass*, cited above);

- whether account had been taken of the applicant's previously expressed wishes and those of the persons close to him, as well as the opinions of other medical personnel (*Burke*, cited above);

- the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interests (ibid.).

The Court will take these factors into consideration in examining the present case. It will also take account of the criteria laid down in the Council of Europe's "Guide on the decision-making process regarding medical treatment in end-of-life situations" (see paragraphs 60-68 above).

(γ) The margin of appreciation

144. The Court reiterates that Article 2 ranks as one of the most fundamental provisions in the Convention, one which, in peace time, admits of no derogation under Article 15, and that it construes strictly the exceptions defined therein (see, among other authorities, *Giuliani and Gaggio v. Italy* [GC], no. 23458/02, §§ 174-77, ECHR 2011 (extracts)). However, in the context of the State's positive obligations, when addressing complex scientific, legal and ethical issues concerning in particular the beginning or the end of life, and in the absence of consensus among the member States, the Court has recognised that the latter have a certain margin of appreciation.

First of all the Court observes that in the case of *Vo*, cited above (which concerned the acquittal on a charge of unintentional homicide of the doctor responsible for the death of the applicant's unborn child), in examining the point at which life begins from the standpoint of Article 2 of the Convention, it concluded that this matter came within the States' margin of appreciation in this sphere. It took into consideration the absence of a common approach among the Contracting States and of a European consensus on the scientific and legal definition of the beginning of life (§ 82).

The Court reiterated this approach in, *inter alia*, *Evans v. the United Kingdom* ([GC], no. 6339/05, §§ 54-56, ECHR 2007-I, concerning the fact that domestic law permitted the applicant's former partner to withdraw his consent to the storage and use of embryos created jointly by them) and in *A, B and C v. Ireland* ([GC], no. 25579/05, § 237, ECHR 2010, in which the applicants essentially complained under Article 8 of the Convention of the prohibition on abortion in Ireland for health and well-being reasons).

145. On the question of assisted suicide the Court noted, in the context of Article 8 of the Convention, that there was no consensus among the member States of the Council of Europe as to an individual's right to decide in which way and at which time his or her life should end, and therefore concluded that the States' margin of appreciation in this area was "considerable" (see *Haas*, cited above, § 55, and *Koch*, cited above, § 70).

146. The Court also stated, in general terms, in the case of *Ciechońska v. Poland* (no. 19776/04, § 65, 14 June 2011), concerning the authorities' responsibility for the accidental death of the applicant's husband, that the choice of means for ensuring the positive obligations under Article 2 was in principle a matter that fell within the State's margin of appreciation.

147. The Court notes that no consensus exists among the Council of Europe member States in favour of permitting the withdrawal of artificial life-sustaining treatment, although the majority of States appear to allow it. While the detailed arrangements governing the withdrawal of treatment vary from one country to another, there is nevertheless consensus as to the

paramount importance of the patient's wishes in the decision-making process, however those wishes are expressed (see paragraphs 74-75 above).

148. Accordingly, the Court considers that in this sphere concerning the end of life, as in that concerning the beginning of life, States must be afforded a margin of appreciation, not just as to whether or not to permit the withdrawal of artificial life-sustaining treatment and the detailed arrangements governing such withdrawal, but also as regards the means of striking a balance between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy (see, *mutatis mutandis*, *A, B and C*, cited above, § 237). However, this margin of appreciation is not unlimited (ibid., § 238) and the Court reserves the power to review whether or not the State has complied with its obligations under Article 2.

(ii) Application to the present case

149. The applicants alleged that the Act of 22 April 2005 lacked clarity and precision, and complained of the process culminating in the doctor's decision of 11 January 2014. In their view, these shortcomings were the result of the national authorities' failure to fulfil their duty of protection under Article 2 of the Convention.

(α) The legislative framework

150. The applicants complained of a lack of precision and clarity in the legislation, which, in their submission, was not applicable to the case of Vincent Lambert, who was neither sick nor at the end of his life. They further maintained that the legislation did not define with sufficient precision the concepts of unreasonable obstinacy and treatment that could be withdrawn.

151. The Court has regard to the legislative framework established by the Public Health Code (hereinafter "the Code") as amended by the Act of 22 April 2005 (see paragraphs 52-54 above). It further reiterates that interpretation is inherent in the work of the judiciary (see, among other authorities, *Nejdet Şahin and Perihan Şahin v. Turkey* [GC], no. 13279/05, § 85, 20 October 2011). It observes that, prior to the rulings given in the present case, the French courts had never been called upon to interpret the provisions of the Act of 22 April 2005, although it had been in force for nine years. In the present case the *Conseil d'État* had the task of clarifying the scope of application of the Act and defining the concepts of "treatment" and "unreasonable obstinacy" (see below).

- *The scope of application of the Act*

152. In its ruling of 14 February 2014 the *Conseil d'État* determined the scope of application of the Act. It held that it was clear from the very wording of the applicable provisions, and from the parliamentary

proceedings prior to enactment of the legislation, that the provisions in question were general in scope and were applicable to all users of the health system, whether or not the patient was in an end-of-life situation (see paragraph 33 above).

153. The Court notes that in his observations to the *Conseil d'État* Mr Jean Leonetti, the rapporteur for the Act of 22 April 2005, stated in his capacity as *amicus curiae* that the Act was applicable to patients who had brain damage and thus suffered from a serious condition that was incurable in the advanced stages, but who were not necessarily "at the end of life". For that reason the legislature, in the title of the Act, had referred to "patients' rights *and* end-of-life issues" rather than "patients' rights *in* end-of-life situations" (see, to similar effect, the observations of the National Medical Academy at paragraph 44 above).

- *The concept of treatment*

154. The *Conseil d'État*, in its ruling of 14 February 2014, interpreted the concept of treatment that could be withdrawn or limited. It held, in the light of Articles L. 1110-5 and 1111-4 of the Code, cited above, and of the parliamentary proceedings, that the legislature had intended to include among such forms of treatment all acts aimed at maintaining the patient's vital functions artificially, and that artificial nutrition and hydration fell into that category of acts. The *amicus curiae* submissions to the *Conseil d'État* agreed on this point.

155. The Court notes that the Council of Europe "Guide on the decision-making process regarding medical treatment in end-of-life situations" addresses these issues. The Guide specifies that treatment covers not only interventions whose aim is to improve a patient's state of health by acting on the causes of the illness, but also interventions which have a bearing only on the symptoms and not on the aetiology of the illness, or which are responses to an organ dysfunction. According to the Guide, artificial nutrition and hydration are given to a patient following a medical indication and imply choices concerning medical procedures and devices (perfusion, feeding tubes). The Guide observes that differences in approach exist between countries. Some regard artificial nutrition and hydration as a form of treatment that may be limited or withdrawn in the circumstances and in accordance with the guarantees provided for in domestic law. The considerations to be taken into account in this regard are the patient's wishes and whether or not the treatment is appropriate in the situation in question. In other countries they are regarded as a form of care meeting the individual's basic needs which cannot be withdrawn unless the patient, in the terminal phase of an end-of-life situation, has expressed a wish to that effect (see paragraph 61 above).

- *The concept of unreasonable obstinacy*

156. Under the terms of Article L. 1110-5 of the Code, treatment will amount to unreasonable obstinacy if it is futile or disproportionate or has "no other effect than to sustain life artificially" (see paragraph 53 above). It is this last criterion which was applied in the present case and which the applicants consider to be imprecise.

157. In his observations to the *Conseil d'État* in an *amicus curiae* capacity, Mr Leonetti stated that this wording, which was stricter than the wording originally envisaged (treatment "which prolongs life artificially") was more restrictive and referred to artificially sustaining life "in the purely biological sense, in circumstances where, firstly, the patient has major irreversible brain damage and, secondly, his or her condition offers no prospect of a return to awareness of self or relationships with others" (see paragraph 44 above). In the same vein, the National Medical Council emphasised the importance of the notion of temporality, observing that where a pathological condition had become chronic, resulting in the person's physiological deterioration and the loss of his or her cognitive and relational faculties, obstinacy in administering treatment could be regarded as unreasonable if no signs of improvement were apparent (ibid.)

158. In its judgment of 24 June 2014 the *Conseil d'État* detailed the factors to be taken into account by the doctor in assessing whether the criteria for unreasonable obstinacy were met, while making clear that each situation had to be considered on its own merits. These were: the medical factors (which had to cover a sufficiently long period, be assessed collectively and relate in particular to the patient's current condition, the change in that condition, his or her degree of suffering and the clinical prognosis) and the non-medical factors, namely the patient's wishes, however expressed, to which the doctor had to "attach particular importance", and the views of the person of trust, the family or those close to the patient.

159. The Court notes that the *Conseil d'État* established two important safeguards in that judgment. Firstly, it stated that "the sole fact that a person is in an irreversible state of unconsciousness or, *a fortiori*, has lost his or her autonomy irreversibly and is thus dependent on such a form of nutrition and hydration, does not by itself amount to a situation in which the continuation of treatment would appear unjustified on grounds of unreasonable obstinacy". Secondly, it stressed that where a patient's wishes were not known, they could not be assumed to consist in a refusal to be kept alive (see paragraph 48 above).

160. On the basis of this analysis, the Court cannot subscribe to the applicants' arguments. It considers that the provisions of the Act of 22 April 2005, as interpreted by the *Conseil d'État*, constitute a legal framework which is sufficiently clear, for the purposes of Article 2 of the Convention, to regulate with precision the decisions taken by doctors in

situations such as that in the present case. The Court therefore concludes that the State put in place a regulatory framework apt to ensure the protection of patients' lives (see paragraph 140 above).

(β) The decision-making process

161. The applicants complained of the decision-making process, which, in their view, should have been genuinely collective or at the very least have provided for mediation in the event of disagreement.

162. The Court notes at the outset that neither Article 2 nor its case-law can be interpreted as imposing any requirements as to the procedure to be followed with a view to securing a possible agreement. It points out that in the case of *Burke*, cited above, it found the procedure consisting in determining the patient's wishes and consulting those close to him or her as well as other medical personnel to be compatible with Article 2 (see paragraph 143 above).

163. The Court observes that, although the procedure under French law is described as "collective" and includes several consultation phases (with the care team, at least one other doctor, the person of trust, the family or those close to the patient), it is the doctor in charge of the patient who alone takes the decision. The patient's wishes must be taken into account and the decision itself must be accompanied by reasons and is added to the patient's medical file.

164. In his observations as *amicus curiae*, Mr Jean Leonetti pointed out that the Act gave the doctor sole responsibility for the decision to withdraw treatment and that it had been decided not to pass that responsibility on to the family, in order to avoid any feelings of guilt and to ensure that the person who took the decision was identified.

165. It is clear from the comparative-law materials available to the Court that in those countries which authorise the withdrawal of treatment, and where the patient has not drawn up any advance directives, there exists a great variety of arrangements governing the taking of the final decision to withdraw treatment. It may be taken by the doctor (this is the most common situation), jointly by the doctor and the family, by the family or legal representative, or by the courts (see paragraph 75 above).

166. The Court observes that the collective procedure in the present case lasted from September 2013 to January 2014 and that, at every stage of its implementation, it exceeded the requirements laid down by law. Whereas the procedure provides for the consultation of one other doctor and, where appropriate, a second one, Dr Kariger consulted six doctors, one of whom was designated by the applicants. He convened a meeting of virtually the entire care team and held two meetings with the family which were attended by Vincent Lambert's wife, his parents and his eight siblings. Following those meetings Vincent Lambert's wife and six of his brothers and sisters argued in favour of withdrawing treatment, as did five of the six doctors

consulted, while the applicants opposed such a move. The doctor also held discussions with François Lambert, Vincent Lambert's nephew. His decision, which ran to thirteen pages (and an abridged seven-page version of which was read out to the family) provided very detailed reasons. The *Conseil d'État* held in its judgment of 24 June 2014 that it was not tainted by any irregularity (see paragraph 50 above).

167. The *Conseil d'État* found that the doctor had complied with the requirement to consult the family and that it had been lawful for him to take his decision in the absence of unanimity among the family members. The Court notes that French law as it currently stands provides for the family to be consulted (and not for it to participate in taking the decision), but does not make provision for mediation in the event of disagreement between family members. Likewise, it does not specify the order in which family members' views should be taken into account, unlike in some other countries.

168. The Court notes the absence of consensus on this subject (see paragraph 165 above) and considers that the organisation of the decision-making process, including the designation of the person who takes the final decision to withdraw treatment and the detailed arrangements for the taking of the decision, fall within the State's margin of appreciation. It notes that the procedure in the present case was lengthy and meticulous, exceeding the requirements laid down by the law, and considers that, although the applicants disagree with the outcome, that procedure satisfied the requirements flowing from Article 2 of the Convention (see paragraph 143 above).

(γ) Judicial remedies

169. Lastly, the Court will examine the remedies that were available to the applicants in the present case. It observes that the *Conseil d'État*, called upon for the first time to rule on an appeal against a decision to withdraw treatment under the Act of 22 April 2005, provided some important clarifications in its rulings of 14 February and 24 June 2014 concerning the scope of the review carried out by the urgent-applications judge of the administrative court in cases such as the present one.

170. The applicants had lodged an urgent application with the administrative court for protection of a fundamental freedom under Article L. 521-2 of the Administrative Courts Code. This Article provides that the judge, "when hearing an application of this kind justified by particular urgency, may order any measures necessary to safeguard a fundamental freedom allegedly breached in a serious and manifestly unlawful manner by an administrative authority". When dealing with an application on this basis, the urgent-applications judge of the administrative court normally rules alone and as a matter of urgency, and may order

interim measures on the basis of a "plain and obvious" test (*manifest* unlawfulness).

171. The Court notes that, as defined by the *Conseil d'État* (see paragraph 32 above), the role of the urgent-applications judge entails the power not only to suspend implementation of the doctor's decision but also to conduct a full review of its lawfulness (and not just apply the test of manifest unlawfulness), if necessary sitting as a member of a bench of judges and, if needs be, after ordering an expert medical report and seeking the opinions of persons acting in an *amicus curiae* capacity.

172. The *Conseil d'État* also specified in its judgment of 24 June 2014 that the particular role of the judge in such cases meant that he or she had to examine - in addition to the arguments alleging that the decision in question was unlawful - any arguments to the effect that the legislative provisions that had been applied were incompatible with the Convention.

173. The Court notes that the *Conseil d'État* examined the case sitting as a full court (the seventeen-member Judicial Assembly), which is highly unusual in injunction proceedings. In its ruling of 14 February 2014 it stated that the assessment carried out at Liège University Hospital dated back two and a half years, and considered it necessary to have the fullest information possible on Vincent Lambert's state of health. It therefore ordered an expert medical report which it entrusted to three recognised specialists in neuroscience. Furthermore, in view of the scale and difficulty of the issues raised by the case, it requested the National Medical Academy, the National Ethics Advisory Committee, the National Medical Council and Mr Jean Leonetti to submit general observations to it as *amici curiae*, in order to clarify in particular the concepts of unreasonable obstinacy and sustaining life artificially.

174. The Court notes that the expert report was prepared in great depth. The experts examined Vincent Lambert on nine occasions, conducted a series of tests and familiarised themselves with the entire medical file and with all the items in the judicial file of relevance for their report. Between 24 March and 23 April 2014 they also met all the parties concerned (the family, the medical and care team, the medical consultants and representatives of UNAFTC and the hospital).

175. In its judgment of 24 June 2014 the *Conseil d'État* began by examining the compatibility of the relevant provisions of the Public Health Code with Articles 2, 8, 6 and 7 of the Convention (see paragraph 47 above), before assessing the conformity of Dr Kariger's decision with the provisions of the Code (see paragraphs 48-50 above). Its review encompassed the lawfulness of the collective procedure and compliance with the substantive conditions laid down by law, which it considered – particularly in the light of the findings of the expert report – to have been satisfied. It noted in particular that it was clear from the experts' findings that Vincent Lambert's clinical condition corresponded to a chronic

vegetative state, that he had sustained serious and extensive damage whose severity, coupled with the period of five and a half years that had passed since the accident, led to the conclusion that it was irreversible and that there was a "poor clinical prognosis". In the view of the *Conseil d'État*, these findings confirmed those made by Dr Kariger.

176. The Court further observes that the *Conseil d'État*, after stressing "the particular importance" which the doctor must attach to the patient's wishes (see paragraph 48 above), sought to ascertain what Vincent Lambert's wishes had been. As the latter had not drawn up any advance directives or designated a person of trust, the *Conseil d'État* took into consideration the testimony of his wife, Rachel Lambert. It noted that she and her husband, who were both nurses with experience of patients in resuscitation and those with multiple disabilities, had often discussed their professional experiences and that on several such occasions Vincent Lambert had voiced the wish not to be kept alive artificially in a highly dependent state (see paragraph 50 above). The *Conseil d'État* found that those remarks – the tenor of which was confirmed by one of Vincent Lambert's brothers – had been reported by Rachel Lambert in precise detail and with the corresponding dates. It also took account of the fact that several of Vincent Lambert's other siblings had stated that these remarks were in keeping with their brother's personality, past experience and views, and noted that the applicants did not claim that he would have expressed remarks to the contrary. The *Conseil d'État* observed, lastly, that the consultation of the family, prescribed by law, had taken place (ibid.).

177. The applicants submitted, relying on Article 8 of the Convention, that the *Conseil d'État* should not have taken into consideration Vincent Lambert's spoken remarks, which they considered to be too general.

178. The Court points out first of all that it is the patient who is the principal party in the decision-making process and whose consent must remain at its centre; this is true even where the patient is unable to express his or her wishes. The Council of Europe's "Guide on the decision-making process regarding medical treatment in end-of-life situations" recommends that the patient should be involved in the decision-making process by means of any previously expressed wishes, which may have been confided orally to a family member or close friend (see paragraph 63 above).

179. The Court also observes that, according to the comparative-law materials available to it, in the absence of advance directives or of a "living will", a number of countries require that efforts be made to ascertain the patient's presumed wishes, by a variety of means (statements of the legal representative or the family, other factors testifying to the patient's personality and beliefs, and so forth).

180. Lastly, the Court points out that in its judgment in *Pretty*, cited above (§ 63), it recognised the right of each individual to decline to consent to treatment which might have the effect of prolonging his or her life.

Accordingly, it takes the view that the *Conseil d'État* was entitled to consider that the testimony submitted to it was sufficiently precise to establish what Vincent Lambert's wishes had been with regard to the withdrawal or continuation of his treatment.

(δ) Final considerations

181. The Court is keenly aware of the importance of the issues raised by the present case, which concerns extremely complex medical, legal and ethical matters. In the circumstances of the case, the Court reiterates that it was primarily for the domestic authorities to verify whether the decision to withdraw treatment was compatible with the domestic legislation and the Convention, and to establish the patient's wishes in accordance with national law. The Court's role consisted in ascertaining whether the State had fulfilled its positive obligations under Article 2 of the Convention.

On the basis of that approach, the Court has found both the legislative framework laid down by domestic law, as interpreted by the *Conseil d'État*, and the decision-making process, which was conducted in meticulous fashion in the present case, to be compatible with the requirements of Article 2. As to the judicial remedies that were available to the applicants, the Court has reached the conclusion that the present case was the subject of an in-depth examination in the course of which all points of view could be expressed and all aspects were carefully considered, in the light of both a detailed expert medical report and general observations from the highest-ranking medical and ethical bodies.

Consequently, the Court concludes that the domestic authorities complied with their positive obligations flowing from Article 2 of the Convention, in view of the margin of appreciation left to them in the present case.

(ε) Conclusion

182. It follows that there would be no violation of Article 2 of the Convention in the event of implementation of the *Conseil d'État* judgment of 24 June 2014.

III. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

183. The applicants maintained that they were potentially victims of a violation of their right to respect for their family life with their son and brother, in breach of Article 8 of the Convention.

184. The Court is of the view that this complaint is absorbed by those raised by the applicants under Article 2 of the Convention. In view of its finding concerning that Article (see paragraph 182 above), the Court considers that it is not necessary to rule separately on this complaint.

IV. ALLEGED VIOLATION OF ARTICLE 6 OF THE CONVENTION

185. The applicants further complained that the doctor who took the decision of 11 January 2014 was not impartial, as he had previously taken the same decision, and that the expert medical report ordered by the *Conseil d'État* had not been fully adversarial.

They relied on Article 6 § 1 of the Convention, the relevant parts of which provide:

> "In the determination of his civil rights and obligations ... everyone is entitled to a fair ... hearing ... by an independent and impartial tribunal established by law."

186. Even assuming Article 6 § 1 to be applicable to the procedure resulting in the doctor's decision of 11 January 2014, the Court considers that these complaints, to the extent that they have not been dealt with already under Article 2 of the Convention (see paragraphs 150-181 above), are manifestly ill-founded.

187. It follows that this aspect of the application must be rejected pursuant to Article 35 §§ 3 (a) and 4 of the Convention.

FOR THESE REASONS, THE COURT

1. *Declares*, unanimously, the application admissible as regards the applicants' complaint raised under Article 2 on their own behalf;

2. *Declares*, by twelve votes to five, the remainder of the application inadmissible;

3. *Rejects*, unanimously, Rachel Lambert's request to represent Vincent Lambert as a third-party intervener;

4. *Holds*, by twelve votes to five, that there would be no violation of Article 2 of the Convention in the event of implementation of the *Conseil d'État* judgment of 24 June 2014;

5. *Holds*, by twelve votes to five, that it is not necessary to rule separately on the complaint under Article 8 of the Convention.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 5 June 2015, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Erik Fribergh	Dean Spielmann
Registrar	President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the separate opinion of Judge Hajiyev, Šikuta, Tsotsoria, De Gaetano and Griţco is annexed to this judgment.

D.S.
E.F.

JOINT PARTLY DISSENTING OPINION OF JUDGES HAJIYEV, ŠIKUTA, TSOTSORIA, DE GAETANO AND GRIȚCO

1. We regret that we have to dissociate ourselves from the majority's view expressed in points 2, 4 and 5 of the operative provisions of the judgment in this case. After considerable reflection, we believe that once all is said and written in this judgment, after all the subtle legal distinctions are made and all the fine hairs split, what is being proposed is nothing more and nothing less than that a severely disabled person *who is unable to communicate his wishes about his present condition* may, on the basis of a number of questionable assumptions, be deprived of two basic life-sustaining necessities, namely food and water, and moreover that the Convention is impotent in the face of this reality. We find that conclusion not only frightening but – and we very much regret having to say this – tantamount to a retrograde step in the degree of protection which the Convention and the Court have hitherto afforded to vulnerable people.

2. In reaching the conclusion in paragraph 112 of the judgment, the majority proceed to review the existing cases in which the Convention institutions have accepted that a third party may, in exceptional circumstances, act in the name and on behalf of a vulnerable person, even if the latter has not expressly stated his or her wish to submit an application. The majority deduce from that case-law two main criteria to be applied in such cases: the risk that the direct victim will be deprived of effective protection of his or her rights, and the absence of a conflict of interests between the victim and the applicant (see paragraph 102 of the judgment). While we agree with these two criteria as such, we completely disagree with the way in which the majority apply them in the particular circumstances of the present case.

With regard to the first criterion, it is true that the applicants can, and did, invoke Article 2 on their own behalf. However, now that the Court has recognised the *locus standi* of a non-governmental organisation to represent a deceased person (see *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania*, [GC] no. 47848/08, ECHR 2014), we do not see any valid reason not to follow the same approach in respect of the applicants in the instant case. In fact, as close relatives of Vincent Lambert, they have, *a fortiori*, even stronger justification for acting on his behalf before the Court.

As regards the second criterion, the majority consider that, since the impugned domestic decisions were based on the certainty that Vincent Lambert would not have wished to be kept alive under the conditions in which he now finds himself, it is not "established that there is a convergence

of interests between the applicants' assertions and what Vincent Lambert would have wished" (see paragraph 104 of the judgment). This statement would be correct only if – and in so far as – the applicants alleged a violation of Vincent Lambert's right to personal autonomy under Article 8 of the Convention, which, according to our Court's case-law, comprises the individual's right to decide in which way and at which time his or her life should end (see *Haas v. Switzerland*, no. 31322/07, § 51, ECHR 2011). However, although the applicants do invoke Article 8, they do so in a completely different context; it is Vincent Lambert's physical integrity, and not his personal autonomy, that they seek to defend before the Court. Their main complaints raised on behalf of Vincent Lambert are based on Articles 2 and 3 of the Convention. Unlike Article 8, which protects an extremely wide panoply of human actions based on personal choices and going in various directions, Articles 2 and 3 of the Convention are clearly unidirectional in that they do not involve any negative aspect. Article 2 protects the right to life but not the right to die (see *Pretty v. the United Kingdom*, no. 2346/02, §§ 39-40, ECHR 2002 III). Likewise, Article 3 guarantees a positive right not to be subjected to ill-treatment, but no "right" whatsoever to waive this right and to be, for example, beaten, tortured or starved to death. To put it simply, both Article 2 and Article 3 are "one-way avenues". The right not to be starved to death being the only right that Vincent Lambert himself could have validly claimed under Articles 2 and 3, we fail to see how it is logically possible to find any lack of "convergence of interests" between him and the applicants in the present case, or even entertain the slightest doubt on this point.

In these circumstances, we are convinced that the applicants did have standing to act in the name and on behalf of Vincent Lambert, and that their respective complaints should have been declared compatible *ratione personae* with the provisions of the Convention.

3. We would like to make it clear from the outset that had this been a case where the person in question – Vincent Lambert in this case – had clearly expressed his wish not to be allowed to continue to live because of his severe physical disability and the pain associated therewith, or, in view of that situation, had clearly refused food and water, we would have found no objection to hydration and feeding being turned off or withheld if domestic legislation provided for that (and save always the right of members of the medical profession to refuse to be party to that procedure on grounds of conscientious objection). One may not agree with such a law, but in such a situation two Convention rights are, as it were, pitted against each other: the right to life (with the corresponding duty of the State to protect life) on the one hand – Article 2 – and the right to personal autonomy which is subsumed under Article 8. In such a contest one can

agree that "respect for human dignity and human freedom" (underlined in *Pretty*, cited above, § 65) may prevail. But that is not Vincent Lambert's situation.

4. Vincent Lambert is, according to the available evidence, in a persistent vegetative state, with minimal, if any, consciousness. He is not, however, brain dead – there is a failure of function at one level of the brain but not at all levels. In fact, he can breathe on his own (without the aid of a life-support machine) and can digest food (the gastro-intestinal tract is intact and functioning), but has difficulty in swallowing, in moving solid food down the oesophagus. More critically, there is no evidence, cogent or otherwise, that he is in pain (as distinguished from the evident discomfort of being constantly in bed or in a wheelchair). We are particularly struck by a submission made by the applicants before this Court in their observations of 16 October 2014 on the admissibility and merits (see paragraphs 51 and 52), and which has not really been contested by the Government, to the following effect:

> "The Court must realise that, like any person in a state of severely diminished consciousness, Mr Lambert can be got out of bed, dressed, put in a wheelchair and taken out of his room. Many patients in a condition comparable to his reside in a specialised nursing home and are able to spend weekends and some holidays with their families ... and it is precisely the enteral method used to feed them that makes this form of autonomy possible.
>
> In September 2012 Doctor Kariger agreed to let Vincent Lambert's parents take him on holiday to the south of France. That was six months before the first decision to stop feeding him was taken ... and there had been no change in his condition in the interim."

From the evidence submitted before this Court, enteral feeding involves minimal physical invasion, causes the patient no pain, and, with minimal training, such feeding can continue to be administered by the family or relatives of Mr Lambert (and the applicants have offered to do so) – although the food mixture to be administered is still something that has to be prepared in a clinic or hospital. In this sense enteral feeding and hydration (irrespective for the moment of whether this is termed "treatment" or "care" or just "feeding") is entirely *proportionate* to the situation in which Vincent Lambert finds himself. In this context we are none the wiser, even after having heard oral submissions in this case, as to why the transfer of Vincent Lambert to a specialised clinic – the Bethel[1] nursing home – where he can be cared for (thereby relieving the Reims University Hospital of that duty) has been blocked by the authorities.

In other words, Vincent Lambert *is alive* and being cared for. He is also being fed – and food and water are two basic life-sustaining necessities, and

[1] See the observations of the third-party intervener association Amréso-Bethel.

are intimately linked to human dignity. This intimate link has been repeatedly stated in numerous international documents[2] What, we therefore ask, can justify a State in allowing a doctor – Dr Kariger or, since he has resigned and left Reims University Hospital[3], some other doctor – in this case not so much to "pull the plug" (Lambert is not on any life-support machine) *as to withdraw or discontinue feeding and hydration so as to, in effect, starve Vincent Lambert to death*? What is the overriding reason, in the circumstances of the present case, justifying the State in not intervening *to protect life*? Is it financial considerations? None has been advanced in this case. Is it because the person is in considerable pain? There is no evidence to that effect. Is it because the person is of no further use or importance to society, indeed is no longer a person and has only "biological life"?

5. As has already been pointed out, there is no clear or certain indication of what Vincent Lambert's wishes really are (or even were) regarding the continuance or otherwise of his feeding and hydration in the situation that he now finds himself in. Although he was a member of the nursing profession before the accident which reduced him to his present state, he never formulated any "advance directives" nor appointed "a person of trust" for the purpose of the various provisions of the Public Health Code. The *Conseil d'Etat*, in its decision of 24 June 2014, made much of the evidently casual conversations that Vincent Lambert had had with his wife (and apparently on one occasion also with his brother Joseph Lambert) and came to the conclusion that "Dr Kariger [could not] be regarded as having incorrectly interpreted the wishes expressed by the patient before the accident"[4]. In matters of such gravity nothing short of absolute certainty should have sufficed. "Interpreting" *ex post facto* what people may or may not have said years before (and when in perfect health) in casual conversations clearly exposes the system to grave abuse. Even if, for the sake of argument, Vincent Lambert had indeed expressed the view that he would have refused to be kept in a state of great dependency, such a statement does not in our view offer a sufficient degree of certainty regarding his desire to be deprived of food and water. As the applicants note in paragraphs 153 and 154 of their observations – something which again has not been denied or contradicted by the respondent Government –

> "If Mr Vincent Lambert had really wanted his life to end, if he had really 'given up' psychologically, if he had really and truly wanted to die [he] would already be dead by now. He would not have survived for 31 days without food (between the first time

[2] Suffice it to refer to General Comment no. 12 and General Comment no. 15 adopted by the UN Committee on Economic, Social and Cultural Rights at its twentieth and twenty-ninth sessions respectively.
[3] See the applicants' observations, § 164.
[4] See the seventh paragraph of that decision as reproduced in paragraph 50 of the judgment.

> his nutrition was stopped on 10 April 2013 and the first order of the Châlons-en-Champagne Administrative Court, of 11 May 2013 ordering the resumption of his nutrition) if something inside him, an inner force, had not made him fight to stay alive. No one knows what this force of life is. Perhaps, unconsciously, it is the fact that he is a father, and the desire to see his daughter? Perhaps it is something else. What is undeniable is that by his actions Mr Vincent Lambert has shown a will to live that it would be wrong to ignore.
>
> Conversely, any person who works with patients in a state of impaired consciousness will tell you that a person in his condition who gives up on life dies within ten days. In the instant case, Mr Lambert survived for 31 days with no food and only 500 ml of liquid per day."

However, all this emphasis on the presumed wishes or intentions of Vincent Lambert detracts from another important issue, namely the fact that under the French law applicable in the instant case, where a patient is unconscious and has made no advance directives, his wishes and the views or wishes of his family only *complement* the analysis of what the doctor in charge of the patient perceives to be a medical reality. In other words, the patient's wishes are, in such a situation, *in no way determinative of the final outcome*. The three criteria set out in Article L. 1110-5 of the Public Health Code – futility, disproportion and sustaining life artificially – are the only relevant criteria. As the *Conseil d'Etat* has stated, account must be taken of any wishes expressed by the patient and particular importance must be attached to those wishes (see paragraphs 47 and 48 of the judgment), but those wishes are never decisive. In other words, once the doctor in charge has, as in the instant case, decided that the third criterion applies, the die is cast and the collective procedure is essentially a mere formality.

6. By no stretch of the imagination can Vincent Lambert be deemed to be in an "end-of-life" situation. Regrettably, he will be in that situation soon, after feeding and hydration are withdrawn or withheld. Persons in an even worse plight than Vincent Lambert are *not in an imminently terminal condition* (provided there is no other concurrent pathology). Their nutrition – regardless of whether it is considered as treatment or as care – is serving a life-sustaining purpose. It therefore remains an *ordinary* means of sustaining life and should, in principle, be continued.

7. Questions relative to the supplying of nutrition and hydration are often qualified by the term "artificial", and this, as has happened in this case, leads to unnecessary confusion. Every form of feeding – whether it is placing a feeding bottle in a baby's mouth, or using cutlery in the refectory to put food in one's mouth – is, to some extent, artificial, as the ingestion of the food is being mediated. But when it comes to a patient in Vincent Lambert's condition, the real question that must be asked (in the context of the concepts of proportionality and reasonableness that underpin the notion of the State's positive obligations under Article 2) is this: is the hydration

and nutrition of benefit to the person without causing any undue burden of pain or suffering or excessive expenditure of resources? If the answer is yes, then there is a positive obligation to preserve life. If the burdens surpass the benefits, then the State's obligation may, in appropriate cases, cease. In this context we would add, moreover, that a State's margin of appreciation, referred to in paragraph 148, is not unlimited, and, broad as it may be, must always be viewed in the light of the values underpinning the Convention, chief among which is the value of life. The Court has often stated that the Convention must be read as a whole (a principle referred to in paragraph 142) and interpreted (and we would say also applied) in such a way as to promote internal consistency and harmony between its various provisions and the various values enshrined therein (see, albeit in different contexts, *Stec and Others v. the United Kingdom* (dec.) [GC], nos. 65731/01 and 65900/01, § 48, ECHR 2005 X, and *Austin and Others v. the United Kingdom* [GC], nos. 39692/09, 40713/09 and 41008/09, § 54, ECHR 2012). In assessing this margin of appreciation in the circumstances of the instant case, and the method chosen by the French authorities to "balance" any competing interests, the Court should therefore have given more weight to the value of life. It should also be recalled that we are not in a situation here where one can legitimately say that there may be some doubt as to whether or not there is life or "human life" (such as in cases dealing with fertility and human embryos – the "when does human life begin?" question). Nor is it a case where there is any doubt as to whether or not Vincent Lambert is alive. To our mind, a person in Vincent Lambert's condition is a person with fundamental human dignity and must therefore, in accordance with the principles underpinning Article 2, receive ordinary and proportionate care or treatment which includes the administration of water and food.

8. We agree with the applicants that the law in question lacks clarity[5]: on what is ordinary and extraordinary treatment, on what amounts to unreasonable obstinacy, and, more critically, on what amounts to prolonging (or sustaining) life *artificially*. It is true that it is primarily for the domestic courts to interpret and apply the law, but it is also clear to us that the *Conseil d'Etat*, in its judgment of 24 June 2014, adopted uncritically the interpretation given by Mr Leonetti, and moreover disposed in a perfunctory way of the issue of the compatibility of domestic law with Articles 2 and 8 of the Convention (see paragraph 47 of the judgment), attaching importance only to the fact that the "procedure had been observed". It is true that this Court should not act as a fourth-instance court and that the principle of subsidiarity must be respected, but not to the point of refraining from affirming the value of life and the inherent dignity even

[5] There is also a hint of this in paragraph 56.

of persons who are in a vegetative state, severely paralysed and who cannot communicate their wishes to others.

9. We agree that, conceptually, there is a legitimate distinction between euthanasia and assisted suicide on the one hand, and therapeutic abstention on the other. However, because of the manner in which domestic law has been interpreted and the way it has been applied to the facts of the case under examination, we strongly disagree with what is stated in paragraph 141 of the judgment. The case before this Court is one of euthanasia, even if under a different name. In principle it is never advisable to use strong adjectives or adverbs in judicial documents, but in the instant case it certainly is utterly contradictory for the respondent Government to insist that French law prohibits euthanasia and that therefore euthanasia does not enter into the equation in this case. We cannot hold otherwise when it is clear that the criteria of the Leonetti Act, as interpreted by the highest administrative court, when applied to a person who is unconscious and undergoing "treatment" which is not really therapeutic but simply a matter of nursing care, actually results in precipitating death *which would not otherwise result in the foreseeable future*.

10. The public rapporteur before the *Conseil d'Etat* is reported (in paragraphs 31 and 122 of the judgment) as having said (citing the Minister of Health while the Leonetti bill was being piloted in the Senate) that "While the act of withdrawing treatment ... results in death, the intention behind the act [is not to kill; it is] to allow death to resume its natural course and to relieve suffering. This is particularly important for care staff, whose role is not to take life." Much has been made of this statement both by the *Conseil d'Etat* and by this Court. We beg to differ. Apart from the fact that, as we have already said, there is no evidence in the instant case that Mr Lambert is suffering in any way, that statement would be correct if, and only if, a proper distinction were made between ordinary care (or treatment) and extraordinary care (or treatment). Feeding a person, even if enterally, is an act of ordinary care, and by withholding or withdrawing food and water death inevitably follows (which would not otherwise follow in the foreseeable future). One may not will the death of the subject in question, but by willing the act or omission which one knows will in all likelihood lead to that death, one actually intends to kill that subject nonetheless. This is, after all, the whole notion of positive *indirect* intent as one of the two limbs of the notion of *dolus* in criminal law.

11. In 2010, to mark its fiftieth anniversary, the Court accepted the title of *The Conscience of Europe* when publishing a book with that very title. Assuming, for the sake of argument, that an institution, as opposed to the individuals who make up that institution, can have a conscience, such a

conscience must not only be well informed but must also be underpinned by high moral or ethical values. These values should always be the guiding light, irrespective of all the legal chaff that may be tossed about in the course of analysing a case. It is not sufficient to acknowledge, as is done in paragraph 181 of the judgment, that a case "concerns complex medical, legal and ethical matters"; it is of the very essence of a conscience, based on *recta ratio*, that ethical matters should be allowed to shape and guide the legal reasoning to its proper final destination. That is what conscience is all about. We regret that the Court has, with this judgment, forfeited the above-mentioned title.