MERCY KILLING, EUTHANASIA AND AIDING AND ABETTING SUICIDE, ETC., UNDER DANISH LAW

BY

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INTRODUCTION

A constantly recurring subject which is both ethical and relevant to criminal law concerns the right to kill the terminally ill, people in great pain, etc., and the question of complicity in suicide. In the not-too-distant past, the debate was often sparked off by particularly notable cases, for example where a mother had killed her mentally defective child. More recently, the starting point has often been people's indignation over physicians' preserving an inhumane form of life even in cases where, a few years earlier, the patients concerned would have been sure of a quick death.

In what follows, I will attempt to sketch the legal position in Scandinavia, and in particular in Denmark, partly on the basis of recent judgments. As will appear, there exist differing points of view in Scandinavian law in this domain. I will try to bring out these differences when they are important, but I do not claim to cover more than Danish law.

I distinguish between the following categories: "active euthanasia", omitting to implement life-saving treatment, the breaking-off of treatment that has been begun, and aiding and abetting suicide. From the medical side it has been maintained that these are only linguistic distinctions. It is possible that from a biological point of view this is a reasonable criticism, but it is quite clear that there are today very important differences in the legal assessment of these situations. The fact that the boundaries are hazy and difficult to define does not necessarily mean that the distinctions should be abandoned. The basic situations are clearly different and they can without difficulty be ascribed different legal consequences; and in my opinion, they ought to be.

ACTIVE KILLING

According to the general opinion in Scandinavia the motive of a person who kills should not be given such weight that he can escape liability for this reason alone. In very extreme cases, however, freedom from liability can, to all intents and purposes, be the result when the *prosecuting*

authority does not prosecute on the basis that the prosecution would serve no useful public interest. A case can be cited from Swedish practice in which two aviators crashed. One was unhurt; the other, who was lying fatally injured and in terrible pain, begged his companion to kill him. The uninjured aviator then shot his companion to death. No case was brought against him. In Norway, a few years ago, no prosecution was brought against an elderly man who killed his mentally-ill daughter because he could not bear the thought of what would happen to her when he died. In general, in Denmark no prosecution is brought in suicide-pact cases, where A and B agree to die together—A turns on the gas and they both lie down on the bed, and B dies but A survives because outside help comes.

A condition of liability for (completed) homicide is obviously that the victim must have been *alive*. While, from a biological point of view, death is a process which happens over a period of time, to a lawyer it must in principle be attributable to an exact time. Under Danish law, a person is dead when cerebral activity, breathing and heartbeat have stopped. It is immaterial whether the person who has been killed lacked the capacity to live, e.g. because of premature birth, accident, illness or old age. It is also immaterial that the patient is being treated, for example, in a respirator and is unable to breathe without its help. This is also true of a patient who is suffering from "brain death". There is, however, a noticeable development in the direction of recognition of one form or another of brain death; Finland and Norway have already recognized this criterion for death. First, such a criterion is desirable from the point of view of making donors available for transplant purposes; secondly, it is desirable with a view to a more rational use of the limited technical means of treatment at the disposal of most hospitals.

Another condition for criminal liability is, of course, that there be a *causal connection* between the act of the accused and death. In Nordic law, a wide concept of causation is used. An act may be a considered cause even when it cannot naturally be characterized as the main cause. If a doctor gives an injection of morphine or some other pain-suppressing drug in order to relieve or reduce a patient's suffering, the consequence can be the so-called "double effect" whereby the patient dies at an earlier time than would probably have been the case had he not been given the drug. In such a case, the injection is, from a legal viewpoint, regarded as being one of the causes of death. It is, however, in general accepted that, in spite of this, there is no question of criminal homicide; the act is so atypical in relation to the normal scope of the homicide provisions that a natural understanding of the provisions leads to the conclusion that it is not covered; in other words, it is not illegal. If, on the other hand, the injection

leads to the patient's immediate death, the usual homicide provisions will apply, even when death would anyway have been expected very soon.

In court practice, homicide is the only felony which may result in imprisonment for life, though in Denmark this only occurs about once a year. In the great majority of cases, the court will pass a fixed sentence of imprisonment between eight and sixteen years. If the case concerns an actual mercy killing, however, or if there are other quite special circumstances, such a severe punishment would be Draconian. The Danish Penal Code therefore has a special provision on "homicide at the request of the victim" in sec. 239:

> Any person who kills some other person at the explicit request of the latter shall be liable to imprisonment for any term not exceeding three years or to simple detention for not less than sixty days.

There are corresponding provisions in the Icelandic Penal Code, sec. 213, and the Finnish Penal Code, ch. 21, sec. 3.

Sec. 239 implies that simple consent cannot be a basis for acquittal. Indeed, it cannot even justify a level of punishment under the normal minimum of five years' imprisonment (in contrast to sec. 235 of the Norwegian Penal Code). The difference between ordinary consent and an express request is that ordinary consent also covers situations where the victim simply accepts an act without directly wanting it to be taken. A request must be unambiguous, but it need not have been expressed in words. According to practice attempted suicide, however, is not in itself sufficient to prove that there was an actual request.

> In 1955 UfR 551 (High Court, Western Division), a woman had attempted to commit suicide by taking an overdose of sleeping pills. She was admitted unconscious to hospital. In the evening, her husband had the chance to be alone with her. He injected tetrapon (morphine) into a tube through which glucose was being fed into her arm. Five days later she died of pneumonia which had arisen as a result of the condition brought about by the poisoning from the sleeping pills and the morphine. *Retslægerådet* (the Medico-Legal Council) was of the opinion that she would probably have died as a result of the overdose of sleeping pills alone. As it was therefore questionable whether death could be regarded as having been caused by the injection of morphine, the husband was sentenced to four years' imprisonment for attempted homicide (under the normal homicide provision).

The provision is not of great practical importance if one looks at the figures in the criminal statistics, but it can cover some of the situations

which are often brought into the debate on euthanasia. Some examples can be given from recent court practice:

> City Court judgment, December 20, 1971. A woman had, over a period of more than 20 years, repeatedly been admitted into hospital because of a progressive and extremely painful illness of the joints. In the final year, she had been bedridden, as she was unable to walk. She was given daily pain-killing injections. Several times she had asked, definitely, for help to die. One day she took an overdose of sleeping pills and said goodbye to her family. Before the tablets had taken effect, however, she was admitted to hospital. Three days later, the family was informed that she would not survive another twenty-four hours, despite highly intensive treatment. It was obvious that she was in great suffering. Twelve hours later, her adult children killed her. They were sentenced to three months' suspended imprisonment for homicide upon request.
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> Judgment of the Supreme Court of Sweden, December 28, 1979. A forty-four-year-old man was found dead in his flat in a centre for handicapped persons. He had been suffering from disseminary sclerosis and recently he had only been able to move his right arm "a little", so that he had to be fed. Fourteen days before he was found dead he had, on his own initiative, got in touch with a woman who was active in the pressure group "The Right to Your Death". The patient was determined to die before he became so ill that he would have to be admitted to a "long-term hospital". The woman promised to help him. A week after their first contact, she gave him twenty-five tablets. A doctor had informed her that thirty-five was a fatal dose. She put ten tablets at a time onto a spoon and fed them into the patient's mouth. She then gave him something to wash them down with. During the following days, they tried different tablets and greater quantities, but the patient was only made ill by them. She got from the doctor more tablets, syringes and some insulin. She then gave him seventy tablets of barbituric acid, which he swallowed with the help of lemonade. Immediately afterwards the woman injected six hundred units of fast-acting insulin into his arm. In the District Court, the woman and the doctor were sentenced to eight months' imprisonment. The doctor then committed suicide. The Court of Appeal increased her sentence to one year's imprisonment, and this was affirmed by the Supreme Court. (In Denmark, there would probably have been an equivalent result through the use of sec. 239 of the Danish Penal Code.)

The person making the request must be in full possession of his senses and of sufficient age to understand the full import of his or her request. For this, it is presumably necessary to have attained the age of eighteen. He must not be under the influence of alcohol, drugs or medicine to such an extent that he is unable to take a decision in a responsible manner. The request can be rescinded at any time, and it automatically lapses after a certain period of time.

From this, it also follows that the so-called "Living Will" has no relevance in this connection under the present law. Only if the "Living Will" is made

in direct association with the particular situation in question—for example before an operation which will make it possible to give a safe diagnosis—can it possibly fulfil the demand in sec. 239 for an unequivocable request. However, as mentioned, the presence of such a "Living Will" only grants a lower level of punishment than in the case of ordinary homicide.

If the person was not able or willing to ask to be killed, then sec. 237 on ordinary homicide must be used. Homicide carries a level of punishment ranging from a minimum of five years up to a maximum of life imprisonment. However, the punishment can often be reduced in accordance with sec. 85:

> The penalty may be reduced when a punishable act has been committed under the influence of great mental agitation, or when there is other special information concerning the offender's mental state or the circumstances of the act, and these facts militate towards a penalty less severe than that which otherwise would apply. In particularly mitigating circumstances, the penalty may be remitted.

Some judgments where this section has been applied can be cited from court practice. Here, as with the other judgments that have been cited, it should be noticed that the level of punishment for most crimes of the type in question is today lower than it was in the past. A judgment need not be particularly old before it is valueless as a safe precedent with respect to the level of punishment.

> 1934 UfR 371 (High Court, Eastern Division). A mother killed her three-year-old child by giving it veronal. The child was suffering severely from water on the brain. It had been examined by a consultant at a pediatric hospital who had told the mother that the child's chances of survival must be regarded as extremely slim. The child was significantly backward for its age, its head was like a fifteen-year-old's and it screamed constantly because of its headaches. Result: three years' imprisonment, suspended.
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> 1949 RÅ 122 (Lower Court). A mother killed her seventeen-year-old son with gas after giving him phenemal. He had been placed in an institution since the age of seven, as he was severely mentally defective. It was her firm belief that, psychologically and physically, he suffered the most severe anguish because of, among other things, his confinement and convulsions. In the opinion of the Medico-Legal Council, the mother was suffering from a pronounced neurosis, etc., and was not a suitable case for punishment. Result: two years' imprisonment, suspended.
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> 1973 UfR 733 (Lower Court). A fifty-two-year-old man shot his wife after many years' marriage. She suffered from a cirrhosis of the liver and diabetes, and was so confused that it was impossible to hold a conversation with her. She

> was unhygienic and had several times eaten her own faeces. Her doctor said that the illness could only get worse. She refused to go into a nursing home. Result: two years' imprisonment, of which 237 days had been served while he was remanded in custody.

Under Norwegian law, a special provision on euthanasia can be found in sec. 235(2):

> Where a person is, with his or her consent, killed or is inflicted serious injury to body or health, or where a person has, out of compassion, taken the life of a hopelessly ill person or assisted therein, the penalty may be reduced either to below what would otherwise be the minimum penalty or to a milder form of penalty.

When the present Danish Penal Code of 1930 was being prepared, the inclusion of a similar provision was considered. This idea was abandoned, however, one of the reasons being, as was said at that time, that those taken ill should not have to fear for their lives or be frightened of their best friends. In practice, the courts have, as can be seen from the cited cases, reached an almost equivalent result on the basis of the ordinary provisions on the level of punishment. Stephan Hurwitz[1] has used this as a conclusive argument against introducing a special rule on euthanasia in the Penal Code. But, on the other hand, it has been said that it is not just a question of saving from a punishment a person who, out of compassion, has delivered a person from great suffering, but also of saving him from the mark of Cain.

The cited judgments do not apply to doctors. Criminal lawyers do not agree completely as to whether exactly the same rules apply to doctors and laymen alike. In my opinion, there is no reason to believe that doctors will be treated differently. A doctor who gives an immediately fatal injection to a cancer patient suffering from excruciating pain must be convicted of homicide, even though death would have occurred anyway in only a short time. For obvious reasons, it is impossible to say how widespread is such assistance to the dying. However, it has in fact been shown that it does happen to a limited extent. From a legal point of view it should be noticed that the position of the doctor is different from the situation that arises in the case of homicide by members of the family or by friends. In the private situation, a suspended sentence can have the effect of being a substitute for acquittal. This is not the case with doctors, who come up against the problem again and again.

[1] Stephan Hurwitz was Professor of Criminal Law in the University of Copenhagen. He became, in addition, Denmark's first Ombudsman.

THE OMISSION OF TREATMENT

The usual homicide provision covers, by its wording, only positive acts: "kills". It can, in addition, be applied to certain particularly serious omissions, when these can legally be compared with acts: one prerequisite being, of course, that the person in question has the requisite intent to kill. A mother who lets her infant die of hunger commits ordinary homicide even though the child is, for example, only one month old and seriously deformed.

However, the typical cases within this problematic area do not constitute homicide. The provisions dealing directly with omissions will apply instead. The most usual one is found in sec. 253 of the Penal Code:

> Any person who, though he could do so without particular danger or sacrifice to himself or others, fails
> (1) to the best of his power to help any person who is in evident danger of his life; or
> (2) to take such action as is required by the circumstances to rescue any person who seems to be lifeless, or as is ordered for the care of persons who have been victims of a shipwreck or any other similar accident;
> shall be liable to a fine or to simple detention for any term not exceeding three months.

In Denmark provisions of this kind have long existed: for example, there have been provisions on the drowning since 1796 and on those who are apparently dead from hanging, since 1819.

Under Danish and Norwegian law, the decisive argument was expressed in 1942 by Johannes Andenæs[2] in the following way: "If I stand by the seashore and see a drowning man struggling for his life, and I can rescue him by throwing out a lifebelt, basic social values say that I must not stay passive. A human life on the one hand, a movement of the arm demanded on the other. When, however, one finds that this duty to help a person in mortal danger is omitted in many older penal codes, this can only be viewed as the result of doctrinaire application of principle regarding the rights of the individual." An example of such an older penal code was, at that time, the Swedish Penal Code of 1864. The new Swedish Penal Code of 1962, however, introduced no change on this point. The argument in Sweden has particularly centred on the fact that the need in practice is satisfied by special provisions—for example on leaving the scene of traffic accidents—and that there is no reason to believe that people who will not,

[2] Johs. Andenæs, *Straffbar unnlatelse* (Criminal Omissions), Oslo 1942, p. 30. Johs. Andenæs is Professor of Criminal Law in the University of Oslo.

of their own accord, try to rescue a person in distress will do so for fear of criminal liability.

While it appears to us quite obvious that there ought to be a duty to intervene when a person, e.g. through an accident, is in mortal danger, it is not unquestionable that the same should apply when the person has himself brought about the danger or wishes to put himself in danger. Under Danish law, however, it is immaterial how the danger has arisen. The central point of sec. 253 has always been the duty to cut down hanged persons. The problem arises in practice when a person who has taken an overdose of sleeping pills *forbids* the family to call a doctor or an ambulance, or when persons who are suffering from a potentially fatal illness do not want medical investigation or *treatment*. In legal writing, there has been a certain disagreement concerning the evaluation of such situations. On the other hand, it is established by court practice that sec. 253 does not cover a situation where a man, in accordance with his wife's wishes, fails to call a doctor even though she was seriously ill. In this case (1963 UfR 195 (Supreme Court)) he had called an ambulance when she fell unconscious, but by that time it was too late. He was acquitted of a breach of sec. 253. It is not quite certain if this would also apply where the dangerous situation, by its nature, develops quickly. Theory is divided.

Neither does the section cover passivity in the face of another person's preparations for suicide. Perhaps pill-taking or cutting of arteries should be looked upon in the same way. It is assumed that the person is not unconscious or irresponsible. The mere fact that the person wants to die is insufficient to lead to a conclusion that he is irresponsible.

A corresponding rule applies with respect to physicians (sec. 7 of the Act on Physicians):

> Every physician is under a duty, upon request, to give the first necessary medical aid when speedy medical aid must, according to the information available, be regarded as urgently necessary, such as in the event of poisoning, serious bleeding, fits of choking and births where a midwife's help cannot be obtained or where the midwife herself summons the physician ...

Children are, from a legal point of view, always irresponsible. Therefore they cannot refuse medical help; nor can their parents or guardians do so on their behalf. This means, in practice, that doctors always have a duty to give children blood transfusions or other life-saving treatment, even where the parents refuse it on religious grounds.

If a situation is highly dangerous because of illness or acts of attempted suicide, it is the doctor's duty to tell the patient of the dangers if treatment is omitted, but he cannot go further than this. If members of the family,

ambulance men or doctors forcibly admit or forcibly treat a person, they are in breach of sec. 260 of the Penal Code:

> Any person who—
> (1) by violence ... forces any person to do, allow or omit to do anything ... shall be guilty of unlawful coercion and liable to a fine or to simple detention or to imprisonment for any term not exceeding two years.

The motive behind the act can, as mentioned above, not lead to non-liability but only to a more lenient punishment.

If the person is *unconscious* or *irresponsible,* or if he becomes so in time, there arises a situation to which sec. 253 of the Penal Code applies. This can lead to the absurd result that the doctor is not allowed to give treatment while the patient is conscious and there are still good chances of recovery, but that he has a duty to do so when the condition has developed so far that the chances of recovery are very small and unconsciousness or dizziness has occurred; nevertheless, in all probability, this is the position under Danish law today.

From an ethical point of view, it is difficult to justify intervention at a point where the man can no longer protest, when, up till then, his unequivocable opposition to treatment has been respected. This, at any rate, is one area where it would be justifiable to attach relevance to the "Living Will".

As an example, we can take a case from a Danish hospital. A workman was admitted. His injury was not highly dangerous provided blood transfusions could be given in the treatment. For religious reasons he refused such treatment. The doctors made sure, in many conversations with him, that he and his family were quite clear that if he did not have a transfusion, he would die. This did not change their position and, after more than a week in hospital, he died. In my opinion, it would unquestionably have been unethical to use his final state of unconsciousness to save his life by means of blood transfusions. On the other hand, it is far from certain that this ethical opinion accords with Danish criminal law.

The doctors and the others are in a very difficult position. If they omit to treat, because they wrongly think that the person is responsible, they are, objectively guilty of a breach of sec. 253. If they wrongly think that the person is responsible but nevertheless intervene, they are, subjectively, in breach of sec. 260. The most unreasonable results are excluded by the fact that the first-mentioned misunderstandings exclude intent and there is therefore no liability. In the latter, there is strictly speaking an attempt, but a prosecution would hardly be brought. There is also reason to believe

that a border area exists where there will neither be punishment under sec. 253, nor under sec. 260, regardless of whether one treats or not.

In the foregoing, there has often been mention of *the family or the doctor.* In many cases, however, precisely these persons will have to carry a greater responsibility. Sec. 250 of the Penal Code says:

> Any person who reduces some other person to a helpless condition or abandons, in such a condition, any person entrusted to his care shall be liable to imprisonment which, where the act results in death or grievous bodily harm and in other aggravating circumstances, may be increased to eight years.

A person is helpless when he is unable to help himself and there is no outside help that he can expect to get, so that his life and health are at the mercy of chance. It is immaterial whether the helpless condition is lasting or temporary. It is also immaterial whether the helplessness is accidental or self-inflicted. Custody, in the second alternative in the section, can result from a special position in general or a particular one in relation to the distressed person. It can be a sociolegal position (e.g. a physician), one pertaining to public law (e.g. hospital staff) or a special contract relationship (e.g. mountain guides); the special position can also be created by a particular connection with the cause of the emergency situation. The word "abandons" does not have any special import; if the person in question remains completely passive in the same room as the person who is helpless, he has "abandoned" the victim. There must also be intent. In an older case, it was accepted that a physician's failure to admit a patient was not covered by this section. The physician did not think the patient could be saved. Therefore he did not know that he was exposing the patient's life to danger by his refusal to admit him.

From what has been said up till now, it has more or less been understood that treatment would, probably, result in the person in question having a reasonably long life in a fairly normal state of health. The situation is different if it can be assumed that the patient will die in the very near future, irrespective of what is done: for example, where a doctor fails to use fluids treatment on a very old and weak patient. The means of prolonging life today are so great that in many cases it becomes pure caricature if they are applied without discrimination. The result may be that the human being is treated worse than we would treat our animals.[3] Or as

[3] As it was put by Bjørn Ibsen in *Causeri om alvorligt emne* (Causerie on a Serious Topic), Copenhagen 1969, p. 40. Bjørn Ibsen is anaesthetist and consultant physician in Copenhagen.

Werner Schöllgen has said:[4] Every human being has the right to die without being exposed to *"den verzerrenden Möglichkeiten einer medizinischen Technik"*. One must also assume that this is in accordance with Danish law. As long as the doctor stays within the area which his colleagues in the Medico-Legal Council find acceptable, it is unthinkable that in Denmark responsibility will be imposed under the Penal Code for failing to treat the dying. The same is probably true if the patient could have a very long life, but only, for example, with very severe brain injuries. And even where the boundaries of this area are exceeded, the sanction will, in general, be the very limited one which follows from the Physicians Act. It should be emphasized that under Danish law the physician is not liable for huge damages on the scale which can occur, for example, in the USA. Not only is the quantity of damages much smaller, but more is demanded before they are imposed.

It must also be emphasized that patients must, to a reasonable extent, be treated alike. However, a doctor has no duty to fly a patient from the wilderness of Greenland to the Copenhagen University Hospital in order to stave off inevitable death by fourteen days; but if the patient is already in the University Hospital, the doctors there must not fail to apply the usual treatment. Here too, in all practical cases, any responsibility arising will be incurred under the Physicians Act rather than under the Penal Code.

The focal point of discussion has always been whether criminal responsibility can be imposed on the physician for failure to treat or for direct homicide. No prosecution has ever been brought against a physician for unduly prolonging his treatment of a patient. The practical consequence of this is that any physician who is worried about incurring liability in one form or another can continue his treatment until what can be a very bitter end for the patient. The question has been raised in theory as to whether there is, or ought to be, a prohibition against "cruel and unusual treatment". When the doctor in question goes much further than is usual in medical practice, under the present legislation liability may—at least theoretically—arise under the Physicians Act and under the coercion section of the Penal Code. On the other hand, there is no question of responsibility under the rules of the Penal Code on causing bodily harm.

[4] See Werner Schöllgen in Gerhard Simson and Friedrich Geerds, *Straftaten gegen die Person und Sittlichkeitsdelikte in rechtsvergleichender Sicht* (Offences against the Person and Sexual Offences from a Comparative Law Perspective), Munich 1969, p. 63.

THE DISCONTINUANCE OF TREATMENT

If life-saving treatment is discontinued, the situation is different. If the patient is conscious, it follows from what has been said above that it is a question either of homicide or of requested homicide.

> City Court judgment, February 2, 1974. A nurse had, at the direct request of a totally paralysed patient who was suffering from poliomyelitis, given him a morphine-based injection and—after he had become unconscious—removed the tube of his respirator. She was sentenced to one year's imprisonment, suspended, for requested homicide.

However, if the effect of the discontinuance of the treatment does not occur immediately, it is in principle the patient's own responsibility—if a diabetic patient ceases to follow his diet or stops taking insulin, etc., then that is his own responsibility, whereas the doctor is responsible if he has refused to prescribe medicine.

If the patient is not conscious, and death occurs (almost) immediately, it will usually be a case of ordinary homicide.

> In a Swedish case (1965 SvJT 77) a consultant doctor had discontinued the supply of fluids, by agreement with the patient's family. The case concerned an eighty-year-old woman who had been admitted on December 8 with a brain hemorrhage. The treatment was discontinued on February 13 and she died six days later. During the case, an expert opinion was given in which it was stated: "... recovery must be regarded as having been unthinkable. Regaining of consciousness, although there would still have been serious disablement, cannot completely be discounted, although it would have been extremely unlikely." The doctor could have been accused of homicide, but was only prosecuted for failing to fulfil his official duties. He was acquitted of this because the court found that continued treatment would have had "no medical or human duty to fulfil". The Swedish Director of Public Prosecutions has said that he does not consider this judgment to be a decisive precedent.

In a Danish radio broadcast in 1974, a consultant from Copenhagen made certain statements which could be understood to mean that he had given "active death help". The Health Authority requested a police investigation into the circumstances. The case ended with the Health Authority publishing a press release in which it was stated that no basis had been found for supposing that the consultant had acted in breach of the written or unwritten rules. At the same time, the Authority stated how it interpreted the applicable law. In this connection it said, among other things:

> If treatment of a patient is futile because it would only prolong a death process that is occurring, in the opinion of the Health Authority it is not inconsistent with ... generally recognized principles of medical conduct to decide to omit to begin or continue measures which can only postpone the moment of death.

The Swedish National Board of Health and Welfare published a similar statement in 1969.

The starting question, here, is when a death process can be said to be "occurring".

It is questionable enough what the general practice is among doctors in Denmark. In the newspaper debate, there have been statements by doctors in both directions. According to one physician: "Of course one stops treatment. It would be quite unethical to continue with fresh, meaningless treatment, such as with antibiotics." But according to another physician: "It is not futile to continue to the last, even though the situation seems quite hopeless." In this debate, a nurse stated that it sometimes happened that young doctors put back drips after they had been discontinued by a consultant, and that this could prolong the suffering of the patient for weeks. In conversations with doctors, I have heard of a case where the appointment of an anaesthetist with a different religious attitude from that of his predecessor resulted in a complete change in the practice of a hospital ward. In this area, too, it must be made clear that legal actions would be out of the question if what was done was within the scope of what the Medico-Legal Council would characterize as ordinary practice.

In principle, from a legal point of view it is irrelevant whether the discontinuance takes place in order to release limited manpower and material resources so as to save other, or more, patients. On the other hand, it is legally permissible to pay regard to such matters *before* the treatment is begun. This means, among other things, that it is wrong to turn off a respirator, even if it is urgently needed for other patients. This is the case even when respirator treatment had started at a time when there was still reason to think that the condition of the patient was significantly better than is now the case. The opposite is the case in Norway.[5] However, from a legal point of view, it does not count as discontinuation of treatment that has been started when a surgeon—after opening up a stomach—abandons a planned operation because the cancer has progressed too far.

AIDING AND ABETTING SUICIDE

It is many years since suicide was decriminalized in Scandinavia. In Sweden, it has as a logical consequence been accepted that it is also not illegal to help a person to kill himself. In Denmark, on the other hand, such conduct is illegal by virtue of the special provision in sec. 240 of the Penal Code:

[5] Anders Bratholm, *Strafferett og Samfunn* (Criminal Law and the Society), Oslo 1980, p. 164. Anders Bratholm is Professor of Criminal Law in the University of Oslo.

> Any person who assists some other person in committing suicide shall be liable to a fine or to simple detention. If such an act of assistance is committed for reasons of personal interest, the penalty shall be imprisonment for any term not exceeding three years.

There are corresponding provisions in sec. 236 of the Norwegian Penal Code and sec. 214 of the Icelandic Penal Code.

A recent example from practice is 1978 UfR 868 (Eastern High Court):

> *T*, aged 38, gave his 43-year-old friend, who was under the influence of alcohol, a revolver loaded with one bullet, even though *T* knew, or certainly must have suspected, that the friend, who was neurotic and deeply depressed, would use the gun to take his own life. Immediately afterwards, the friend shot himself. *T* was sentenced to 14 days' imprisonment for breach of sec. 240, and of sec. 254 of the Penal Code concerning the handing over of weapons to intoxicated persons, and for breach of the Weapons Act.

Under Danish law, a very wide concept of complicity is used. However, this cannot apply with regard to sec. 240; here, a concept of physical or mental complicity of a more qualified kind must be applied.

> Lower Court judgment, January 9, 1980. *S* tried to commit suicide by taking an overdose of sleeping pills. Her cohabitee, *T*, got her into hospital. After her stomach had been pumped, etc., she told the hospital psychiatrist that she would commit suicide as soon as she was discharged; but he could find no legal reason to keep her in hospital by force since she was not mentally ill, etc. Two days after she was discharged, *S* said that she wanted to go to a certain house sixteen storeys high and jump off. *T* accompanied her to the house in a taxi, which he had ordered, and she jumped. *T* was acquitted in a prosecution under sec. 240 because "the assistance which the accused ... has yielded in the preparation and carrying out of ... suicide is found to have been of such relatively minor importance that the accused cannot be regarded as having been an accomplice in her suicide".

The decisive difference between sec. 239 on requested homicide and sec. 240 on aiding and abetting suicide is that in the latter case it is the person wishing to die who takes the conclusive act himself. At times it may be difficult to decide which of the two has taken this act. A clearly borderline case was the one which came before the Swedish Supreme Court on December 28, 1979, and which has been discussed above. Considering that it is decisive for liability itself in Sweden and for whether a considerably milder provision is to be used in Denmark, the borderline is, of course, important. If the person aiding or abetting suicide knows his law, he will not give the patient the injection leading to death himself, but give the

syringe to the patient and let him inject himself. It is difficult to accept the consequence that people who are so paralysed that they cannot commit suicide, cannot instead do it with the help of another without the latter being guilty under the more severe provision.