The bioethical dilemmas of legalizing 'active aid in dying' in France

Los dilemas bioéticos de la legalización de la 'ayuda activa a morir' en Francia

Maroun BADR*
Facoltà di Bioetica, Ateneo Pontificio Regina Apostolorum,
Rome, Italy

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Abstract

Euthanasia and assisted suicide are prohibited by French law. The Citizens' Convention on the End of Life, created in December 2022, was tasked with evaluating the framework for end-of-life care. Its final report shows that most of the members of the Convention are in favor of evolving of the law towards "active aid in dying". This conclusion forms the basis of a draft law to be considered before the summer of 2024. This article analyzes the main bioethical dilemmas at stake if the law is adopted.

Keywords: end of life, dignity, medicine, autonomy, palliative care.

* PhD candidate in bioethics, Facoltà di Bioetica, Ateneo Pontificio Regina Apostolo-rum, Rome, Italy. Email: contact@marounbadr.fr
https://orcid.org/0000-0001-9378-6273
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Introduction

A few days after abortion was enshrined as a fundamental freedom in the French Constitution (1), on March 10, 2024, French President Emmanuel Macron announced a draft law for an "active aid in dying" (AAD) (2). While this term is, in the words of the President, "simple and humane" and avoids any reference to the concepts of euthanasia or assisted suicide, its official definition is as follows:

> The term 'active aid in dying' refers to any act intended to bring about a death of person, at his or her request, who is suffering from a serious and incurable illness that in an advanced or terminal stage. The term may refer to both euthanasia and assisted suicide. Depending on the legislation concerned, it may refer to both concepts or to one or the other (3, p. 5).

This announcement echoes the meeting that took place on Monday, April 4, 2023 between the President and the members of the Citizens' Convention on the End of Life[1] (4). In his speech, he made it clear that he wanted a law in favor of AAD "by the end of the summer" in order to have a "French model for the end of life" (5). He did not fail to cite Opinion No. 139 of the National Ethics Council [*Conseil consultatif national d'éthique* (CCNE)] of September 13, 2022, which considers "that there is a way forward for the ethical application of active aid in dying" (6, pp. 4, 34). In fact, after 27 days of debate spread over 9 sessions (between December 2022 and April 2023), the Citizens' Convention delivered its favorable opinion on Sunday, April 2, 2023, to authorize assisted suicide and euthanasia. According to the final report, 76% of the members of the Convention voted in favor of opening up the ADD; 74.7% voted in favor

[1] The Citizens' Convention on the End of Life is an assembly of 185 citizens set up by the *Conseil économique, social et environnemental* (Cese) in December 2022. Its aim is to examine end-of-life issues in greater depth, and to issue a report on its work, organized into 9 sessions.

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of assisted suicide and 70.1% voted in favor of euthanasia, as "a solution included in the framework of a global path of accompaniment and care, to be coordinated in particular with the path of Palliative Care" (7, pp. 53, 120). The report presents 7 reasons in favor of the AAD and 5 against[2] (7, pp. 40-48). What would be the ethical-legal [1] and ethical-medical [2] stakes if the government adopted the Convention's opinion and legalized the AAD?

1. Ethical-legal issues

Although euthanasia and/or assisted suicide have been legalized in some countries (such as Belgium, Canada, Colombia, Switzerland, the Netherlands, Luxembourg, and some states in the United States), ethical and legal questions persist because of the contradictions in the laws [1.1] that affect the very purpose of the Law [1.2] and the principle of democracy [1.3].

1.1. Legal paradoxes

An analysis of several articles in the Civil Code and the Penal Code highlights the ethical issues surrounding the values and principles associated with the fundamental value of life.

On the one hand, article (art.) 16 of the Civil Code (CC) states that "the law guarantees the primacy of the person, prohibits any

[2] Arguments in favor: Active aid in dying 1) responds to situations of suffering poorly covered by the current support framework; 2) is complementary to palliative care; 3) fills the limitations of deep and continuous sedation until death; 4) respects the freedom of choice of individuals; 5) puts an end to hypocrisy; 6) helps to reassure people at the end of life; 7) enables an accompanied end of life.
Arguments against: 1) The current Claeys-Leonetti law is not fully known or applied; 2) Active assistance in dying represents a risk for vulnerable people; 3) Legalizing assisted suicide and euthanasia represents a danger for our healthcare system; 4) Active assistance in dying undermines our model of society and the spirit of solidarity; 5) The framework of an eventual law on active assistance in dying will be difficult to respect.

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attack on his dignity and guarantees respect for the human being from the beginning of his life". Art. 16-1 goes on to say that "everyone has the right to respect for his or her body. The human body is inviolable. The human body, its elements and its products cannot be the subject of any right of ownership". Art. 16-9 reinforces the provisions of the previous two articles by confirming that they are of public order. These articles can be summarized together under the principle of "the unavailability of the human body".

What's more, the constitutional principle of July 27, 1994, of "safeguarding protect the dignity of the human person against all forms of enslavement and degradation" (8) reinforces these two articles of the Civil Code. Does not AAD therefore constitute an attack on the human body and the human person? If articles 16 and 16-1 of the CC are a matter of public order, is not the AAD a violation of this order, according to article 6 of the same code which states that "no derogation may be made by special conventions, from the laws which relating to public order and morality"?

Such a principle clashes with another: personal autonomy, which was upheld by the European Court of Human Rights in Pretty v. the United Kingdom (9). Personal autonomy includes the right to control one's own body, as a bodily freedom that is part of individual freedom. Could we, in the name of autonomy, invoke Art. 16 of the French Civil Code (*et seq*.) and the constitutional principle of safeguarding the dignity of the individual? Does not a voluntary AAD, as a concrete expression of individual freedom, constitute an attack on the inviolability of the body?

On the other hand, the questions we have just raised are in competition with criminal law, which punishes an attack on life. Article 2-1 of the European Convention on Human Rights clearly states that "no one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law". This article obliges States to punish any intentional act of inflicting death, but also to protect life. In this case, assisted suicide and euthanasia legally meet

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the conditions of murder and assassination as defined also by the French Penal Code (PC). Art. 221-1 states that "the act of intentionally causing the death of another person constitutes murder". Art. 221-3 states that "murder committed with premeditation or ambush constitutes assassination". For its part, art. 221-5 states that "the act of endangering the life of another person by the use or administration of substances likely to cause death constitutes poisoning. Poisoning is punishable by thirty years' imprisonment". Furthermore, even if one has the right to commit suicide, incitement to suicide is prohibited by law under articles 223-13 to 223-15-1 of the PC. The AAD also fulfills the conditions of such an offense, whether it involves inciting others to commit suicide, or propagandizing or advertising products as a means of killing oneself. Opening the door to the AAD also means opening the door to fundamental changes in the laws deemed necessary for the proper organization of society. Whatever the form of the act committed, whatever the intention, whatever the wording of the legal texts, the act of AAD must not be trivialized when, in its very essence, it remains murder.

1.2. The purpose of Law

This raises the question of the role of Law in organizing of public life. Where there is no ethical consensus on delicate issues such as assisted suicide and euthanasia, it is legitimate to ask about the vocation of the Law. Since these questions concern an individual singularity that involves the person and each person, can we generalize these singularities through a law that should normally protect the interests of each citizen? Thus, Professor Emmanuel Hirsch asks: "Is it the role of the Law to respond with detailed recommendations 'to the various situations encountered', as if the journey to the end of life were devoid of any singularity and could be the subject of generalizable regulatory procedures?" (10, p. 46).

In fact, the Law is not meant to respond to individual desires or casuistic situations. Its primary vocation is to establish public order

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to regulate relations between individuals themselves, and between individuals and authority.

1.3. The principle of democracy

Dealing with a delicate issue such as the end of life in a multi-person discussion seems to be complicated by the diversity of opinions, ideologies, currents of thought, etc., as in the case of the Citizens' Convention, which underlines the importance of democracy within the group. But it seems that this democracy has been curtailed. Patrick Hetzel, deputy for the Bas-Rhin and vice-president of *Les Républicains* in the French National Assembly, points out that the members of the Convention were, perhaps unwittingly, subjected to a "procession of evidence of their manipulation". Patrick Hetzel gives a long list of examples that should raise questions for all of us:

> The opacity of the criteria for the selection of speakers, the exclusion of works hostile to the legalization of euthanasia from the bibliography available to the members of the Convention, the interventions of the proponents of the Belgian and Swiss systems from the beginning of the process, the absence of a contradictory debate with the proponents of foreign legislation legalizing euthanasia (Belgium, Quebec, Switzerland), systematic use of the term 'active euthanasia' during the debates, discussion limited to one hour and fifteen minutes during 27 days of deliberation between the proponents and opponents of euthanasia, exclusion of philosophers and ethicists with reservations about the legalization of euthanasia, limitation of the doctors' voice to a single morning, refusal to organize on-site visits to palliative care units (11).

The same goes to the methodology of the Convention:

> Closed questions, very short time allowed for answering questions (fifteen seconds at the eighth session), dysfunctional voting

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> on essential issues, organization of trend votes in the presence of the press without a quorum, even before the participants had taken a position on the framework for euthanasia and assisted suicide. When it came to deciding on the scope of euthanasia, participants had no choice but to vote for euthanasia for adults, adults and minors, or to abstain, without the possibility of voting against. This is a far cry from the ethical requirements of an objective debate that creates the conditions for a mature and deliberative vote, which is what this convention should have been (11).

Is this a true democracy? Is this Convention truly representative of the voice of all citizens? Is it based on objective reflection, accepting opposing views? To the announcement of such a draft law and to these questions, a collective of caregivers from several associations replied on March 11, 2024 that the "democratic path" is blinded by having ignored "the word of the caregivers who have not been consulted since last September" (12).

2. Ethical-medical dilemmas

In addition to ethical and legal issues, there are also ethical-medical issues, mainly those concerning patient autonomy and his consent [2.1], the notion of dignity [2.2] and the vocation of Medicine [2.3].

2.1. Patient autonomy and his consent

This autonomy, on which the report of the Citizens' Convention insists on respecting the patient's choice and will, is given concrete expression by consent. For consent to be valid, it must be free from error, fraud and violence. The person giving consent must be in full possession of his or her mental and intellectual faculties (art. 1145-1150 of the CC), which implies the freedom of the individual. Any

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contract or consent that does not respect these conditions is considered null and void. The Convention states that "the capacity of discernment must be assessed as a criterion for access to active assistance in dying, since it is linked to a free and informed will" (7, p. 49). Intrinsically linked, autonomy and consent can be approached in different ways, according to two main visions: pro-end-of-life (2.1.1) and pro-life (2.1.2).

2.1.1. Pro-end-of-life approach

The pro-end-of-life approach is based, particularly, on the four principles of North American bioethics known as "principalism" (beneficence, non-maleficence, autonomy and justice). Autonomy is a fundamental principle which breaks with the paternalistic approach to medicine and empowers the patient. Regarding end-of-life issues, autonomy can have two meanings, favoring AAD: "informed consent" and "self-definition" (13, pp. 2, 4) or self-determination which means everyone has the right to define one's own existence and to control it. In this case, AAD, particularly assisted suicide, "should not be understood as a medical intervention but rather as an autonomous action that does not invoke traditional medical principles such as beneficence" (14, p. 500)irremediable suffering from a medical condition is a legal requirement for access to assisted dying. According to the expressivist objection, allowing assisted dying for a specific group of persons, such as those with irremediable medical conditions, expresses the judgment that their lives are not worth living. While the expressivist objection has often been used to argue that assisted dying should not be legalised, I show that there is an alternative solution available to its proponents. An autonomy-based approach to assisted suicide regards the provision of assisted suicide (but not euthanasia.

As medical ethics in France is based on the North American bioethics model, the legislation also relies on it, emphasizing the principle of autonomy, especially when it comes to "informed consent"

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and refuting treatments. For example, Decision No. 2017-632 clearly states:

> Everyone has the right to refuse or not to receive treatment. However, the care of the patient remains the responsibility of the physician, especially palliative care.

The physician is obliged to respect the patient's wishes after informing him of the consequences of his choice and their seriousness (15).

Consequently, the Citizens' Convention supporting the AAD mentions: the "decision-making model is based on the principle of respect for the individual and his or her autonomy" that relies in informed consent (7, p. 170). Formulated differently, this autonomy is the expression of a choice to die and to choose the means to do so (16, pp. 55-60).

2.1.2. Pro-life approach

The pro-life approach begins with a fundamental question: are we free to make such a decision with infallible informed consent when we are suffering? Friedrich Nietzsche said:

> The time of death itself, the position on the bed of agony, is almost irrelevant. The exhaustion of a declining life, especially in the case of old people, the irregular and inadequate nourishment of the brain during this last period, the sometimes very violent nature of the pain, the novelty of this sickly state of which one has no experience, and all too often an outbreak of fear, a return to superstitious impulses, as if death were of great importance and bridges of a terrible kind had to be crossed-all this makes it impossible to use death as a testimony to life. On the contrary, almost everyone is driven by the solemnity of those around him, by sentimental outpourings, by tears either held back or shed, to a comedy of vanity, sometimes conscious, sometimes unconscious (17).

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Denial and anger in illness limit the informed exercise of freedom, and the person requesting the AAD could be acting under the influence of a vice of consent governed by two moral constraints: one is internal, with the feeling of being a burden on those around him, not to mention the psychological state one can go through during a serious illness; the other is external, expressed by the pressure of those around him: family, medical and socio-political (18, pp. 54-55).

The Citizens' Convention states that this consent will be obtained through Advance Directives (ADs) or through a trusted support person. The drafting of ADs to request AAD presupposes that one is in "good health" and that no suffering requires such a request. ADs that explicitly recognize a right to die run the risk of being transformed and implicitly implemented into a duty to die. Legislating such statements has a deeper social significance: "Allowing euthanasia would not only grant a right to a few, but would irrevocably change the way our whole society views death" (19). We could then see death as an intentional act. In this way, the ontological fear of death, a legitimate fear, that is part of the human condition loses all meaning, and humanity is dehumanized in the name of a duty to die. The only paradigms that come into play with such an open door of social duty are those of utilitarianism, cunning eudemonism, false risk-benefit calculations, and even eugenics.

2.2. The concept of dignity

The concept of dignity is present in bioethical discussions, in this case in end-of-life issues, where we speak of "dying with dignity". Here are four different references to texts in which the word "dignity" is used:

a) In the pro-euthanasia Manifesto of July 1974, we read the following. We believe in the value and dignity of the human person. This requires that they be treated with respect and, consequently, that they be allowed the freedom to make reasonable decisions about their own fate. [It is cruel and barbaric to

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demand that a person be kept alive against his will by denying him the liberation he desires, when his life has lost everything: dignity, beauty, meaning, prospects for the future. Unnecessary suffering is an evil to be avoided in civilized societies[3] (20).

b) Art. 1 of the Universal Declaration of Human Rights states that "all human beings are born free and equal in dignity and rights" (21);
c) In its decision of July 27, 1994, the French Constitutional Council established the constitutional principle of safeguarding human dignity against all forms of enslavement and degradation (8);
d) Article 1 of the Charter of Fundamental Rights of the European Union states that "human dignity is inviolable. It shall be respected and protected" (22).

What dignity are we talking about? Can dignity be lost? Can we dispossess or be dispossessed of dignity? Is there such a thing as true dignity in dying? Clearly, nowhere does the Law define dignity, even though it evokes it in several ethical contexts. And claims for the "right to die with dignity" are based on abstract legal concepts. Without going into the ethical-philosophical history of this notion and since the dignity's concepts "constantly evolve throughout the patient's end of life journey" (23, p. e123), we can say that dignity has three dimensions (24, pp. 7-14). The first two provide a basis for argumentation for pro-end-of-life approach (2.2.1) and the third one is a fundamental principle of the pro-life approach (2.2.2).

2.2.1. Pro-end-of-life approach

The first is subjective dignity. This is the dignity felt by the subject. It is based on feelings experienced through personal and social

[3] J. Monod, L. Pauling and G. Thomson (and around forty renowned scientists worldwide), Manifesto in favor of euthanasia, The Humanist, July-August 1974; translation. Le Figaro, July 1, 1974. Quoted by M.J. Thiel (20).

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perception. It derives its character from interpersonal relations. In other words, it is the subject's sense of self. A patient who requests euthanasia is someone who is suffering, in agony, with a subjective view of his or her dignity; he or she believes that his or her condition is not "worthy" of life. In this case, the patient thinks "that continued life in a suffering or incapacitated state is an indignity" or a "loss of dignity", as observed in Germany, United States and Canada (18, pp. 50, 117, 135, 170, 204, 363, 365, 457). It is the same argument given by the Citizen's Convention, which affirms that some people have a sense of "indignity and of being a burden on their loved ones or on society as a whole" (7, p. 45).

The second is objective dignity. It "denotes the effective exercise of freedom as it can be grasped by ethical discernment in its demand for objectivity" (24, p. 13). This translates into actions based on values such as peace, justice, respect, defense of life, etc. Pro-end-of-life supporters claim that the act of AAD is part of such objective dignity, based on the feeling of compassion, to help the others to be relieved from their suffering, as observed in Belgium, Germany and United States, (18, pp. 58, 270-271, 303, 366-372). In this context, the Citizens' Convention uses the expression "compassionate euthanasia", which could include children (7, p. 65).

2.2.2. Pro-life approach

The third is ontological dignity. It is inseparable from the person, body and soul, in their uni-totality (25, p. 124). In this sense, the body alone, with all its weakness, cannot define the person, nor can it alone represent the dignity of the person. Since the person is not limited to his biological dimension alone but must also be approached through his psychological and spiritual dimensions, ontological dignity becomes the foundation of all the rights and duties of every human being. Therefore, no one can take away this dignity, which is rooted in the very being of every human being (18, pp. 38-40). It is a dignity that cannot be proved; it is not an object of possession or right. "Ontological dignity is indelible and remains valid beyond any

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circumstances in which the person may find themselves" (26, § 7). This is why this type of dignity is the cornerstone of any medical act that cares for the person and does not end life. Such an act violates not only the dignity of the patient, but also that of the person who commits it, as Hanna Arendt put it::

> To put it bluntly, she suggests that when they refused to commit murder, it wasn't so much that they wanted to obey the commandment 'Thou shalt not kill,' but that they were unwilling to live with a murderer: their own person (27, p. 102).

Subjective dignity and objective dignity are also called existential dignity "which is the type of dignity implied in the ever-increasing discussion about a 'dignified' life and one that is 'not dignified'". This is how, in the case of an illness, some people get to "to experience their life conditions as 'undignified' vis-à-vis their perception of that ontological dignity that can never be obscured" (26, § 8) or their life could be judged by others as 'undignified'. However, justifying ADD on the basis of such types of dignity is to trivialize the human being as he or she is, to hide behind sentimentality in order to escape a responsibility linked to solidarity and true "*com*-passion" (suffering with). The sick person is a mirror that reveals what the other is. The confrontation with the suffering body of another reminds us of our own vulnerability. It reveals our weaknesses and incapacities.

This is why, the mere recourse to subjective and objective dimensions alone only promotes what we call "eugenic dignity". In the name of alleviation from suffering and compassion, patients, their families and society find themselves "forced" by a law that implicitly calls for the elimination of the most fragile, those who are economically costly, those who are a burden to their loved ones, in short of the human beings.

2.3. The vocation of Medicine

How is the AAD a medical procedure? Is it medically necessary? What is the role of the physician? These are the questions that the

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French National Council of the Order of Doctors [*Conseil national de l'Ordre des médecins* (CNOM)] addressed, directly or indirectly, on April 1, 2023, on the eve of the final report of the Citizens' Convention.

Indeed, the first and fundamental vocation of Medicine is to care. By virtue of this vocation, it diagnoses, treats and sometimes predicts, but death is not part of its identity. For the physician, Art. 38 of the French Code of Medical Ethics recommends that:

> He or she must accompany the dying person in his or her last moments, ensuring the quality of the life that is coming to an end through appropriate care and measures, preserving the dignity of the patient and comforting those around him or her. The physician does not have the right to deliberately provoke death.

To do otherwise is to violate the Hippocratic Oath and the universal medical ethic: "Thou shalt not kill". Whereas Hippocratic ethics constitute an "art" of care and an ideal of the medical profession (28, p. 14), AAD raises the question of whether it is medically necessary. Art. 16-3 of the CC states that "the integrity of the human body may be violated only in cases of medical necessity for the person concerned or, exceptionally, in the therapeutic interest of others". Specifically, medical necessity is that which is expressed by the interpretation of the case according to the doctor's judgment and must serve a therapeutic purpose and not to procure death. Violation of the integrity of the body concerns specific medical acts such as surgery, removal of a tumor, or even organ donation.

In this context, Cardinal and bioethicist Elio Sgreccia is clear when he affirms that the medical act can only be carried out with respect for the principle of the inviolability of life. For him, the therapeutic principle that allows harming the integrity of the human body requires four conditions: 1) intervention on the part of the body that is diseased or that directly causes the harm; 2) that there are no other means of curing the disease; 3) that the proportion of

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success of the intervention is good or proportionally high in relation to the harm; 4) that the patient consents (25, pp. 168-169). These conditions, which avoid any therapeutic relentlessness, as requested by the Congregation for the Doctrine of the Faith (29), are in line with what is clearly expressed in the 2016 Claeys-Leonetti law (30) which frames all practices related to the end of life. The only point of divergence between the Claeys-Leonetti law and the principles of Elio Sgreccia and the Magisterium of the Church concerns artificial nutrition and hydration. While the Claeys-Leonetti law considers them to be treatments that can be stopped, E. Sgreccia (25, pp. 779-781) and the Magisterium of the Church (31,32,29) consider them to be vital needs (normal cures) that should only be stopped only under one condition: the body is no longer able to absorb or metabolize them. Can we say that AAM is an appropriate therapeutic medical act? Can we say that it is a medical act that does not violate life and that is therapeutic and proportional? The answer of the CNOM is clear and categorical. It:

> Considers it imperative to ensure a better application of the Claeys Leonetti law and to equip itself with all the means necessary for the law to be fully effective: to make arrangements in medical and medico-social institutions and at home efficient throughout the country, to facilitate medical and medico-social support for patients at the end of life and their families, to promote the training of medical and paramedical professionals, to free up time for attending physicians to support their patients, to promote greater knowledge among physicians about the care of patients at the end of life. […] If the law were to change in order to legalize active assistance in dying (euthanasia and/or assisted suicide), the [CNOM] would like to make it clear from the outset that it would be unfavorable for a doctor to participate in a process leading to euthanasia, since the doctor cannot deliberately provoke death by administering a lethal product (33).

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On this basis, in the event of ADD legislation, the CNOM will:

> would demand a specific conscience clause that would guarantee the independence of the doctor, including in health care institutions, and that could be invoked at any stage of the procedure. The doctor should be able to continue treating the patient even after invoking this clause. If the physician no longer wishes to treat the patient, he or she should refer the patient to a physician who is able to do so (33).

In this context, it is clear that the vision of health professionals is diametrically opposed to the political vision of the French President.

Conclusion

The "right to die" cannot be a corollary of the "right to life". To die with dignity is first and foremost to preserve and defend the human person. Hence the following conclusions:

a) The use of the term "active aid in dying" is nothing more than a form of linguistic manipulation, since in practice all the acts considered for this possible law are the same as those associated with euthanasia and assisted suicide. Such manipulation diminishes and trivializes the seriousness of the problem and trivializes it. Freedom and autonomy cannot be authentic unless they are linked to the truth, in this case to the truths hidden by a mediocre lexicon.
b) President Emmanuel Macron describes the draft as a "law of fraternity, a law that reconciles the autonomy of the individual with the solidarity of nations" (2). Such a statement not only shows contempt for the work of the caregivers who serve patients (12), but also opens the way to unimaginable abuses such as "the administration of the lethal substance by a close relative" (12). Fraternity must be based on the following two principles/duties (25, pp. 170-172). The first is the

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principle of sociality, which is an individual duty. Sociality takes the form of active participation in the "realization of the good of others", through the promotion of life and health; through close accompaniment of patients and their families; through a respectful presence in the face of the mystery of death. It is legitimate not to suffer, it is legitimate to feel powerless in the face of suffering, but it is not legitimate to throw oneself into a paroxysm of individualism by choosing one's own death. This is the responsibility of a society that, in the name of personal freedom, is increasingly pushing people to become desperate individuals rather than people surrounded by others, The second is the principle of subsidiarity, which is a communal duty. It calls on society and the state to "provide more help where it is most needed". For patients at the end of life, this means increasing the number of palliative care units that provide patients with the necessary treatment in a human context where the ontological dignity of the person is respected and preserved. Instead of debating the question of "dying with dignity", we insist on the need to multiply the efforts to "caring with dignity"; patients have the right to be relieved of their suffering and to have a dignified end of life until their last breath. In the name of this principle that the CNOM calls on the State to take concrete measures to ensure a better application of the Claeys-Leonetti law:

Improve the efficiency of medical, medico-social and home-care facilities throughout the country, facilitate medical and medico-social support for patients and their families at the end of life, promote the training of medical and paramedical professionals, free up time for attending physicians to support their patients, promote better knowledge among physicians on how to care for patients at the end of life (33).

c) As the bioethicist Gonzalo Miranda (34), has pointed out, it is important to do everything possible to restore the patient's

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health and keep him alive, to do only what is possible, avoiding what is useless and harmful, while remaining at the service of the person, and to do the best possible to ensure a good quality of adapted care respecting the dignity of each patient at the end of life.

d) The bioethical values and principles that apply in this French context are the same that must be applied internationally, for four reasons. Firstly, whatever the geographical and/or socio-political context, procuring death or helping someone to procure it remains an act that runs counter to the universal principle "thou shalt not kill", which also includes "thou shalt not kill thyself". Life is a universal value that must be protected and promoted. Secondly, the diversity of approaches and the lack of international consensus on the definition of key concepts in the end-of-life context, particularly autonomy and dignity, must invite those with decision-making and legislative power to resort to the principle of prudence. The reason for this is that, in order to guarantee public order, the Law's vocation is to protect the Common Good, in this case, life, not individual desires. Thirdly, while it is legitimate and necessary to combat and alleviate suffering, Medicine cannot choose death as the means to do so. At the end-of-life, relieving pain and taking suffering into account are two fundamental pillars of medical care. Fourthly, while the question of suffering is universal and existential, contemporary individualism encourages fragile people to isolate themselves in order to deal with it solely through biomedical, psychological and/or socio-political considerations. However, ending life can never be the answer to such a question.

It seems that the "culture of death" denounced by John Paul II (35, § 87, 95, 100) is increasingly taking precedence over the "culture of life". There is an urgent need to form the consciences of the young people so that future generations do not fall into a dehumanization that would be irreversible.

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