

UNIVERSITY OF TARTU

SCHOOL OF LAW

Department of Public Law

Triin Hüva

EUTHANASIA AS A PROBLEM OF HUMAN RIGHTS

Master's Thesis

Supervisor

Prof. Dr. iur. Lauri Mälksoo

Tallinn

2023

TABLE OF CONTENTS

INTRODUCTION	2
1. LEGAL STATUS OF EUTHANASIA AND ITS IMPACT ON HUMAN RIGHTS	6
1.1. Legal Classification	6
1.1.1. Voluntary Euthanasia	7
1.1.2. Non-Voluntary Euthanasia	9
1.1.3. Involuntary Euthanasia	11
1.1.4. Physician-Assisted Suicide (PAS)	11
1.2. Legal Frameworks in the World	12
1.3. Regulation of Euthanasia Under International and European Union Law	19
1.3.1. Euthanasia in the context of ICCPR	19
1.3.2. Euthanasia in the context of European Union law	22
II. RIGHT TO LIFE VS RIGHT TO DIE: THE DEBATE IN PRACTICE	25
2.1. Assisted Dying in the Practice of the European Court of Human Rights: Challenges, Controversies, and the Way Forward	25
2.1.1. <i>Pretty v. The United Kingdom</i>	25
2.1.2. <i>Haas v. Switzerland</i>	27
2.1.3. <i>Gross v. Switzerland</i>	28
2.1.4. <i>Lambert and Others v. France</i>	29
2.1.5. <i>Sanles Sanles v. Spain</i>	30
2.1.6. Future Steps	30
2.2. <i>Mortier v. Belgium</i> : A Landmark Case for Euthanasia	32
2.3. The Slippery-Slope Argument: Legitimate or Sought Justification	35
III. “HEAVEN OVER HOSPITAL” VS “CARE, NOT KILL”: HEALTHCARE PROVIDERS, INSTITUTIONS, AND THE IMPLEMENTATION OF EUTHANASIA	40
3.1. Balancing Ethics and Legal Responsibilities	40
3.2. Patient Autonomy and the Hippocratic Oath—Ongoing Ethical Dilemma	43
3.3. The Rule of Double Effect in End-of-Life Care	47
IV. ENSURING HUMAN RIGHTS IN EUTHANASIA: ETHICAL AND MORAL CONSIDERATIONS	51
4.1. Navigating Cultural and Religious Beliefs: The Influence on Views of Euthanasia and Human Rights	51
4.2. Voices from the Margins	55
CONCLUSION	59
KOKKUVÕTE	63
BIBLIOGRAPHY	67

INTRODUCTION

Everyone has the right to live a full life, and this is a universal human right enjoyed by all people simply because they are human beings. These moral rights cannot be taken away from anyone, and this must be very well justified in the case of an interference with them. In order for States to guarantee their citizens all their rights and freedoms, there are human rights mechanisms that essentially create injunctions to protect fundamental rights. These mechanisms include, for instance, the Universal Declaration of Human Rights (UDHR),¹ the European Convention on Human Rights (hereinafter the ECHR and the Convention),² the International Covenant on Civil and Political Rights (ICCPR)³ and the Charter of Fundamental Rights of the European Union.⁴ The central point of all these treaties is the right of every human being to life⁵, since all other rights and freedoms are dependent on it, and without the right to life it would be impossible to enjoy them.

The human rights law has been repetitively adapted and updated over time to meet the needs of society and individuals. In order to achieve a balance in constantly developing world, new dimensions of human rights have been introduced (such as freedom of expression and the right to privacy). One area that is currently developing by storm and with which the Human Rights Act must also keep pace is medicine. Medical advances have changed many of the ascetics of human life: vaccines treat diseases that were once incurable, and machines support dysfunctional organs. The outlook on the principles of medicine has also changed, as the focus on saving and preserving human lives at all costs has begun to shift towards quality of life.⁶ The most significant norms to protect a person's interests and avoid violations in bioethics have already been established on the basis of rights –the right to dignity, the right to autonomy and self-determination, the right to informed consent, the right to refuse treatment, the right to relief of suffering according to the current state of knowledge, the right to know and not to know, the

¹ Universal Declaration of Human Rights. United Nations General Assembly. Paris, 10.12.1948.

² European Convention on Human Rights. Council of Europe. 04.04.1950.

³ International Covenant on Civil and Political Rights. United Nations General Assembly. New York, 16.12.1966.

⁴ Charter of Fundamental Rights of the European Union. Council of Ministers, European Parliament, European Commission. European Convention, 07.12.2000.

⁵ For example, the right to life is regulated in Article 3 of UCHR, Article 2 of ECHR and Article 6 of ICCPR.

⁶ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 1.

right to access to health, and the right to both mental and physical identity.⁷ This means that a new term called “right to die” has come into question, which includes the right of a person to decide for himself when and in what way to die.

Despite the exponential development of medicine, the implementation of new effective measures and, as a result, a noticeable increase in life expectancy, the patient may find himself in a situation where his quality of life has dropped drastically due to a final and incurable disease, and recovery is very unlikely or impossible. Today, the main causes of death are cancer, cardiovascular conditions and chronic respiratory diseases, which in most cases leave a person to torment his condition for a long time and wait for death. In this situation, the patient may prefer an earlier death in order to maintain dignity at the end of life and ignore an unbearable condition that is excessively burdensome for him.⁸ In order to determine the limits of respect for personal autonomy, it is necessary to balance it with competing interests.

This research focuses on euthanasia and general end-of-life care, which includes assisting the patient in his dying (hereinafter AID), thus author analyses the nature of euthanasia, its regulation, as well as its impact on the individuals affected. The main mechanism of human rights on which the work is based is the ECHR. In addition, the work looks at the relationship of euthanasia with human rights, namely the right to life, freedom from torture or cruel, inhuman or degrading treatment,⁹ right to self-determination and personal autonomy, or punishment, right to respect for private and family life,¹⁰ right to medical treatment, right to protection from discrimination.¹¹ Supporters of assisted dying, including euthanasia, argue that the right to choose the time, place, and manner of their death is a matter of the right of self-determination, which refers to the legal right of people to determine their own destiny in the international order, including the right to make decisions regarding one's own body and health, such as the decision to end one's life if suffering from a terminal illness or unbearable pain. The right to self-determination of peoples is a fundamental principle, originating from customary international law but also acknowledged as a general legal principle and enshrined

⁷ Beširevic, V. The Discourses of Autonomy in the International Human Rights Law: Has the Age of a Right to Die Arrived? *Cuadernos Constitucionales de la Cátedra Fadrique Furió Ceriol* n° 62/63, pp. 19-34. 2008.

⁸ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 1.

⁹ Arguments for both proponents and opponents of AID.

¹⁰ Arguments for proponents of AID.

¹¹ Arguments for opponents of AID.

in a number of international treaties. The United Nations Charter and the International Covenant on Civil and Political Rights protect self-determination as a right of "all peoples".¹²

This thesis consists of four major chapters, which the author has structured on the central question of his work - what are the biggest challenges facing the modern world in legalizing euthanasia and what is the prospect for it in Europe in the near future? To find the answer to this question, the author gives an overview of current legal frameworks and policies (different models) in different countries (first chapter) and analyse how legal and policy perspectives influence the implementation of euthanasia and therefore human rights (second chapter). The author emphasizes that since it is the duty of the legislator to ensure the protection of the rights of all people, all affected persons must be included in the decision-making, so that their voices and opinions are heard in the legislative process. Therefore, it is also necessary to look at the ethical side in order to understand the perception and point of view of those affected. To cover this, the work also discusses how cultural and religious beliefs shape views on euthanasia and human rights and the impact of these beliefs on legal frameworks and policies (forth chapter); it provides an overview of the role of healthcare providers and institutions in implementing euthanasia, a discussion of the ethical and legal responsibilities of healthcare providers and institutions, and an analysis of potential challenges and limitations in implementing euthanasia that respects and protects human rights (third chapter). In order to decipher her central question and focus the content of his work, the author proceeded from the following research questions:

1. What is the current legal status of euthanasia in different countries and how does it impact human rights?
2. How do cultural and religious beliefs influence views on euthanasia and the protection of human rights in this context?
3. How does the debate over euthanasia intersect with the broader discourse on end-of-life care and the right to die with dignity?

¹² Saul, M. The Normative Status of Self-Determination in International Law: A Formula for Uncertainty in the Scope and Content of the Right? Oxford University Press. Human Rights Law Review. Vol.11, No.4. 2011. pp 610-612.

4. How do patient autonomy and the right to self-determination intersect with the right to life in the context of euthanasia?
5. What role do healthcare providers and institutions play in shaping the debate over euthanasia and human rights?
6. How do the experiences of marginalized populations, such as those with disabilities or terminal illnesses, impact discussions of euthanasia and human rights?
7. What can be done to ensure that euthanasia is implemented in a way that respects and protects the human rights of all individuals involved?

The author's main sources for writing thesis are Derya Nur Kayacan's study "The Right to Die with Dignity: How Far Do Human Rights Extend? " (2022); case-law of the European Court of Human Rights (hereinafter ECtHR and the Court), international and European treaties, directives and regulations; academic articles (from academic journals) and previous BA, MA, PhD studies. This master's thesis uses data collection and data processing methods, as a result of which the collected source data has been worked out and systematized and passed on in all parts of the work. In terms of content, historical, chronological, systemic, analytical and comparative research methods have been used. The author introduces the relevant terminology (sub-chapter 1.1.) that must be distinguished when analyzing euthanasia. The terminology on euthanasia is still extremely variable in the literature, and their common feature is at times the fact that there is no common terminology. To the extent that the purpose of this work is to study euthanasia as a form of assisted death and its regulation, it hereinafter refers to euthanasia as assisted dying and a form of AID. AID and assisted dying may also apply to physician-assisted suicide in a more general definition when it comes to addressing assisted dying on a broad scale (for example, chapters 3 and 4).

1. LEGAL STATUS OF EUTHANASIA AND ITS IMPACT ON HUMAN RIGHTS

1.1. Legal Classification

The ancient Greeks and Romans did not believe that life needed to be preserved at any cost and were, in consequence, tolerant of suicide when no relief could be offered to a dying person or, in the case of the Stoics and Epicureans, when a person no longer cared for his life. The frantic development of medicine and technology, skilled medical professionals and many other instruments make it possible to live life more fully, healthier and longer than ever before.¹³ There are almost countless ways to maintain, restore, and treat a person's health. However, serious illnesses that only make life painful, costly and burdensome have not disappeared, resulting in the patient no longer having any life value.¹⁴

Individuals with terminal illnesses or incurable conditions may end their lives by euthanasia, affectionately also called "good death". This act is also known as "mercy killing", which is when someone who cannot survive due to their painful condition, ends their life in an inexplicable way. The death occurs gently, peacefully, and without pain. There is a basic reason behind it to cause a terminally ill patient or disabled person to die and aims for person's right to die with dignity in the most proportionate way. Euthanasia is thus practiced so that a person can live as well as die with dignity.

The main aspect of euthanasia is to relieve suffering of person who is in lot of pain due to his persistent illness.¹⁵ Euthanasia legal regulations arise from a number of formal factors: local laws, physical and mental health, personal beliefs and wishes. Different types of euthanasia emerge variety of factors, individuals outlook and his level of consciousness. Euthanasia is categorized into three main forms: voluntary (active and passive form), non-voluntary and involuntary.¹⁶

¹³ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. 2016. p 3.

¹⁴ Reichstein, A. A Dignified Death for All- How a Relational Conceptualisation of Dignity Strengthens the Case for the Legalisation of Assisted Dying in England and Wales. Human Rights Law Review. Vol.19. No.4. 2019. p 1-2.

¹⁵ Olsson, J. A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law. Malmö University. 2019. p 6.

¹⁶ Engström, A. A Human Right to Die?: The Legality of Euthanasia Under the European Convention on Human Rights. Örebro University. *Juridicum*. 2020. pp 3-4.

The distinction between suicide and any other form of euthanasia deserves attention. An individual commits suicide by stabbing, poisoning, or any other means. It is an act of intentionally killing oneself due to depression or other reasons (e.g., martyrdom). On the other hand, euthanasia is an action of a person to bring to an end the life of another person. Separate form of suicide is (physician-)assisted suicide. Assisted suicide is an act which intentionally helps another to commit suicide, e.g., by providing the means to do so. When it is a doctor who helps a patient kill himself by providing a prescription for lethal medication, it is a physician assisted suicide (PAS).¹⁷ But nevertheless, even if these two types of assisted dying distinguish a difference in the degree of physicians' involvement, the purpose and end result of euthanasia and PAS is the same: to assist the patient in his or her death. Therefore, terms "assisted dying" and AID has also been used in this work, referring to both voluntary active euthanasia and physician-assisted death.

In most legal systems, there is no specific provision for it and therefore it is usually referred to as either suicide (if committed by the patient) or murder (if committed by another). It is legal for physicians to decide not to prolong life in cases of extreme suffering, and they may prescribe drugs to relieve pain even if they shorten the patient's life.¹⁸

1.1.1. Voluntary Euthanasia

As previously noted in the work, euthanasia can be categorized into three main categories, with the aim of narrowing the formal definition of euthanasia and simplifying its regulation in national legislation. Voluntary euthanasia is in simple terms dealing with cases where a patient explicitly expresses a wish to die while suffering unbearably. This method is supported by two values- autonomy and individual well-being. In doing so, the individual's self-determination and support of individuals right to decide about life-sustaining treatment is guaranteed.¹⁹ Voluntary euthanasia is legal in some States of Australia, Belgium, Canada, Columbia, Luxembourg, the Netherlands, Spain and New Zealand.²⁰ Competent persons have observed in practice that the conditions necessary for candidacy for voluntary euthanasia, in which case

¹⁷ JD., Mueller, P.S., Sulmasy, L.S. Ethics and Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. *Annals of Internal Medicine*. Vol.167, No. 8. 2017. p 580.

¹⁸ Zannoni, D. Right or Duty to Live? Euthanasia and Assisted Suicide from the Perspective of European Convention on Human Rights. *European Journal of Legal Studies*. Vol.12, No. 2. 2020. pp 182-185.

¹⁹ Olsson, J. A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law. Malmö University. 2019. p 8.

²⁰ World Federation of Right to Die Societies. World Map. Available here: <https://wfrtds.org/worldmap/>

then there should be legal and medical provision to facilitate being allowed to die or assisted to die, are following:

- a. The patient is suffering from a terminal illness;
- b. The patient is unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy;
- c. The patient is, as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome (e.g., because the illness has to be treated in ways that lead to her being unacceptably dependent on others or on technological means of life support);
- d. The patient has an enduring, voluntary and informed consent to die (or has, prior to losing the competence to do so, expressed a wish to be assisted to die in the event that conditions (a)-(c) are satisfied); and
- e. The patient is unable without assistance to end her life.²¹

Active form of voluntary euthanasia (hereinafter VAE), also known as “right to die”, refers to conscious and rational patients’ request and the process is carried out by doctor through lethal injection (the affirmative act causing death). It is sometimes called as “aggressive” euthanasia. However, some consider active form of euthanasia to be faster and "cleaner" insofar as it is an effective and least painful or morally better method.²²

Voluntary assisted dying (VAD) is known as passive voluntary euthanasia is the withdrawal or withholding of life-sustaining medical interventions and is widely accepted as both ethical and legal. In this case, it is not necessary for the doctor to intervene to carry out the euthanasia process using a lethal dose of a sedative.²³ The term “passive euthanasia” is misleading: the range of actions subject to such a label includes some that are not passive (e.g., removal of a medical device) as well as many that are not properly called “euthanasia” (i.e., they do not seek

²¹ Engström, A. A Human Right to Die? The Legality of Euthanasia Under the European Convention on Human Rights. Örebro University. *Juridicum*. 2020. pp 5-6.

²² Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. p 10.

²³ Engström, A. A Human Right to Die? The Legality of Euthanasia Under the European Convention on Human Rights. Örebro University. *Juridicum*. 2020. p 6.

a “good death”).²⁴ Therefore, "passive euthanasia" as a concept is not very widespread and is rather referred to as "refusal of treatment" and is often regulated by law in countries that have legalized or decriminalized euthanasia. The desire for this type of euthanasia usually arises when the used measures neither improve the patient's condition nor promise a longer life with an acceptable quality of life. The decision as to which quality of life is still acceptable is up to the patient himself. The methods of passive euthanasia, for example, can be:

- a) switching off life-support machines
- b) disconnecting a feeding tube
- c) not carrying out a life-extending operation
- d) not giving life-extending drugs.

Indirect form of euthanasia is considered also as end-of-life treatment. This treatment, which is used to reduce the ailments associated with dying, usually involves therapies that shorten the patient's life. Such ways include, for example, the use of large quantities of painkillers, the effect of which becomes almost toxic to the patient, as well as the shutdown of consciousness. Shortening the life of a dying person in this way is indirect euthanasia. In cases where the suffering of a dying patient cannot be alleviated by other measures and means, indirect euthanasia may be an inevitable part of end-of-life care. Although, there are some who do not consider this method as a legal form of euthanasia but palliative care, which is known to provide patients dying by nature with the most comfortable conditions possible at end of their life.²⁵

1.1.2. Non-Voluntary Euthanasia

Passive non-voluntary euthanasia is known as withholding or withdrawing life-sustaining measures without the consent of the patient. Proponents of legalized euthanasia are mostly

²⁴ Giebel, H. Double Effect and Ethical End-of-Life Care: Assessing the Benefits and Burdens of Lethal Treatment (or Lack Thereof). *Solidarity: The Journal of Catholic Social Thought and Secular Ethics*. Vol.6, Iss.1. 2016. pp 5-6.

²⁵ *Riigikogu Kantselei Õigus- ja Analüüsiosakond. Eutanaasia Seadustamine Euroopa Riikides*. (Legalization of Euthanasia in European Countries). 20.09.2020. p. 1.

fighting to legalize voluntary euthanasia - meaning their petition contrasts with taking of life without the subject's knowledge or consent, or non-voluntary euthanasia.²⁶ Still, there are some exceptions- situations when it is impossible to ask patients opinion and let them express their own opinion. Non-voluntary euthanasia is possible when a living being is unable to understand the decision between life and death, then euthanasia would not be voluntary, since it has no ability to grasp the decision. ²⁷The person cannot make a decision or cannot make their wishes known in cases where:

- a) the person is in coma;
- b) the person is too young (e.g., a very young baby) or too old;
- c) the person is senile;
- d) the person is mentally retarded to a very severe extent;
- e) the person is severely brain damaged;
- f) the person with dementia;
- g) the person is mentally disturbed in such a way that they should be protected from themselves.

The prerequisites for non-voluntary active euthanasia are the same as for voluntary euthanasia, except that the patient is unable to give informed consent and there is at least one of the aforementioned reasons why the person cannot make a decision or express their wishes, and the doctor intentionally administers a lethal dose of sedative to the patient. All nations prohibit non-voluntary active euthanasia because it has been determined to be misleading and ineffective. In the Netherlands, non-voluntary active euthanasia of neonates is lawful under an agreement between physicians and district attorneys.

²⁶ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 7-8.

²⁷ Olsson, J. *A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law*. Malmö University. 2019. p 8.

The prerequisites for non-voluntary passive euthanasia are the same as for voluntary euthanasia, except that the patient is unable to give informed consent and there is at least one of the aforementioned reasons why the individual cannot make a decision or express their wishes, and expects the withdrawal of life-sustaining medical interventions. Passive euthanasia must be distinguished from futile medical care because futile medical care does not hasten or hasten the advent of natural death. In the case of non-voluntary (passive) euthanasia, a patient is unable to make a decision, and a third-party act as a proxy to make the decision in the patient's best interests. In hospitals in England, non-voluntary passive euthanasia is lawful in many countries, including India, Albania, and large portions of the United States.²⁸

1.1.3. Involuntary Euthanasia

Involuntary euthanasia involves a patient who does not or resists such measures. It means that a person is able to agree to their death but does not do so because they are either not asked or because they are asked but still want to live so patient is considered rational. This includes a situation where patient has not recognized the future suffering that would have awaited him and the other person just wanted to protect him from his own suffering. One official aspect of unintentional euthanasia is the killing of a person who did not want to die through euthanasia.²⁹ Thus, it makes perfect sense that involuntary euthanasia, both active or passive, is illegal all countries of the world and is considered as murder. For example, leaving patient to die (passive involuntary euthanasia) would be negligent homicide in those cases.³⁰

1.1.4. Physician-Assisted Suicide (PAS)

Euthanasia must be distinguished from assisted suicide, in which case the person suffering from a serious illness causing death ceases to live his own life using outside help. Extraneous assistance may consist in prescribing or serving a lethal amount of medicine by a doctor at the patient's request (PAS). In this case, the patient injects the medicine himself, knowing that it

²⁸ Varelius, J. Mental Illness, Naturel Death, and Non-Voluntary Passive Euthanasia. *Ethical Theory and Moral Practice*. Vol.19. 2016. pp 635-637.

²⁹ Allen, M.L. Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia. *Brooklyn Law School. Brooklyn Journal of International Law*. Vol.31, Iss.2, Art.5. pp 541-542.

³⁰ Australian Human Rights Commission. *Euthanasia, Human Rights and the Law*. 2016. pp 3.

will cause his death.³¹ In PAS the individual who wishes to die commits the final act, while in voluntary active euthanasia, because that individual is unable to pose the last act, a proxy acts on his or her behalf. The difference is about the person who acts last. PAS (for some countries under conditions) is legal in Austria, Belgium, Canada, Germany, Luxembourg, the Netherlands, New Zealand, Spain, Switzerland and many American States.³²

1.2. Legal Frameworks in the World

In order to create an understanding of the European region's assisted dying legislation, it is necessary to look at relevant approaches in the form of different countries. Although it is mainly European countries that come under scrutiny, the Netherlands, Belgium and Switzerland, a slight insight into Canada's attitude is also created, as Canada, with its distinctive approach to the methodology of euthanasia and ending life, is a great influence to many countries around the world.³³

In the context of ECHR, the right to die is about establishing a balance between Article 2's right to life and Article 8's right to privacy. Given that they have pledged to protect the vulnerable, Member States can decide for themselves whether or not it is a good idea to give people the freedom to end their own lives as a sign of personal autonomy. Due to the highly sensitive nature of this subject, the margin of error is currently rather substantial. The case law of the European Court of Human Rights (discussed in subchapter 2.1 below) makes it frequently transparent that article 8 contains the right to choose when and how to die, and that whatever limitations on this right must be justified, even if this justification is simple because of the margin of appreciation. As part of its positive obligation under Article 2 of the Convention, any Member State that legalizes assisted dying procedures additionally has to implement the appropriate measures to guarantee the safety of others. The States must also make clear the legal limits of their policies on assisted suicide.³⁴

³¹ JD., Mueller, P.S., Sulmasy, L.S. Ethics and Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. *Annals of Internal Medicine*. Vol.167, No. 8. 2017. pp 580-581.

³² Halloran, K. Ethics of Euthanasia and Physician Assisted Suicide. Merrimack College. 2022. pp 2-7.

³³ International euthanasia, assisted suicide, refusal of treatment and palliative care regulating policies can be seen here (provided by World Federation of Right to Die Societies (WFRtDS))

https://docs.google.com/spreadsheets/d/1DtRLRUCVzTuE2y2arQEhVXID30DuWyXFmk_jMSiPD_E/edit#gid=1248995596

³⁴ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* Springer. 2022. p 219.

The Netherlands was the first country to legalize the assisted dying model in 2002, when the Termination of Life on Request and Assisted Suicide Act (2001) was implemented. The right to cease treatment arises from Articles 10³⁵ and 11³⁶ of the country's constitution. The law developed in parallel with the long case and the doctor-patient relationship, and it was health professionals and judges who played a particularly important role in the creation of the law. More than two decades of practicing assisted dying procedures can be clearly seen in the annual growth in this demand, and therefore it is extremely important to conduct thorough research, apply various supervisory mechanisms, and develop already existing laws and regulations on an ongoing basis³⁷. Dutch AID regulatory laws have been repeatedly prescribed by supervisory bodies (most recently in 2019). According to the annual report presented in April 2023, the number of people seeking assisted death increased by 13.7% in 2022 compared to 2021, i.e., the total number of people who wanted it was 8720 (5.1% of the total number of people who died in Netherlands).³⁸ The Netherlands, as in Belgium (see below), is an influential guide among other (European) countries that may be planning or considering legalizing end-of-life procedures. Since this is a very risky and still taboo subject (one could say that the patient renounces his fundamental right to life), it is necessary to ensure that policies and regulations do not conflict with the rest of the ECHR. If surveillance reports or other studies indicate a possible slippery slope that could arise in a situation where the right to die can be interpreted too broadly, Article 2 of the ECHR would require the State to implement additional safeguards to ensure an orderly balance between the right to life and the right to death. The Termination of Life on Request and Assisted Suicide Act establishes the rules and requirements that must be met to use euthanasia or assisted suicide. This legal text assumes that a patient seeking assisted dying suffers from unbearable physical or mental difficulties and that the probability of recovery is close to deficient (however, the patient does not have to be considered terminally ill). AID can be applied for by patients from the age of 12 with the consent of the parent or guardian. For a patient aged 16-17 years, parental consent is no longer required, but their presence and involvement at each stage of the procedure do. Doctors have an obligation to ensure (including to identify) that the patient is thoroughly informed about the procedure, that other alternative options (such as palliative care) have been shared with him or her, and that

³⁵ The Constitution of the Kingdom of the Netherlands. 24.08.1815. Article 10, Right to Privacy,

³⁶ The Constitution of the Kingdom of the Netherlands. 24.08.1815. Article 11, Right to Inviolability of Person.

³⁷ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. p 22.

³⁸ Regional Euthanasia Committee. Annual Report. 2023.

the patient's consent is fully voluntary and well-thought-out. It is also necessary to confirm from another doctor (medical opinion) that the doctor conducting euthanasia or PAS has met all the criteria. After the procedure, a review procedure is carried out. Both the doctor and the patient have the right to refuse the procedure throughout the process³⁹. However, almost 2/3 of the doctors give up during the AID process, mainly because of their personal beliefs.⁴⁰

Belgium became the second EU Member State to legalize euthanasia in its 2002 Belgian Act on Euthanasia. In addition to euthanasia, Belgium also regulates PAS (Article 422bis of Penal Code), palliative care (Law on Palliative Care, 2002) and refusal of treatment (Patient Rights Act, 2002). In 2014, Belgium became the first country in the world to allow euthanasia for children as well. According to the Euthanasia Act, a doctor has the right to allow euthanasia in a patient who is competent and knowledgeable at the time of the application and does not experience any external pressures and influences.⁴¹ As in the Netherlands, assisted dying is aimed at people, who are suffering from a "medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident." The patient's application must also be approved by another independent doctor. Before euthanasia is performed, the patient undergoes a month-long reflection period. The euthanasia procedure is supervised by the *de Federale Controle- en Evaluatiecommissie Euthanasie* (the Belgian federal oversight body) (FCEE).⁴² Such legal guidelines have also been endorsed by the European Court of Human Rights in the very first euthanasia case, *Mortier v. Belgium* (2022) (detailed analysis below, sub-chapter 2.2.), in which the Court held that Belgian euthanasia regulations did not infringe the right to life under the ECHR Article 2. A peculiar fact about Belgium's euthanasia laws is that it does not regulate PAS. There has also been repeated criticism of Article 14.4 of the Belgian Euthanasia Act, which essentially prohibits health authorities from adopting euthanasia-free policies in their internal regulations. This clearly restricts the freedom of religion under Article 9 of the ECHR, inasmuch as, for example, a Catholic hospital should therefore lose its "Catholic" title, which does not allow the practice of end-of-life procedures.⁴³ In March 2023, the FCEE submitted its 2022 annual report, according to which 2966 applications were

³⁹ Halloran, K. Ethics of Euthanasia and Physician Assisted Suicide. Merrimack College. 2022. pp 5-7.

⁴⁰ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? Springer. 2022. pp 51-83.

⁴¹ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. p 23.

⁴² UN Human Rights Blog. *Mortier v. Belgium: A Landmark Decision on Euthanasia in the Case of Mental Illness*. 2022.

⁴³ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 208.

submitted for euthanasia (an increase of 9.85% compared to 2021). The main reasons for assisted dying were (cancer) tumours (59.9%) and various chronic and incurable diseases (19.6%). Of the patients, 69.9% were over 70 years of age and 42.2% were over 80 years of age and the number of cases under 40 years of age remained very limited (1.2%).⁴⁴

In Switzerland, euthanasia is criminally punishable. At the same time, it is not a crime to help commit suicide if there are no motives for doing so for self-interest. This is enshrined in Article 115 of the Swiss Criminal Code (1994). PAS is not regulated by law in Switzerland. This legal practice is based on the absence of a penalty, the interpretation of medical and pharmaceutical legislation, the guidelines of the relevant organizations and case law.⁴⁵ In Switzerland, a medical professional does not have to be a suicide assistant, a hawk can check the mental state of a person required to commit assisted suicide and only a doctor can prescribe a lethal substance. Derya Nur Kayacan, a legal expert of international law and human rights, has analyzed deeply assisted dying regulations in the Netherland in her study “The Right to Die with Dignity: How Far Do Human Rights Extend?”, and found that the only source of direction, the Swiss Academy of Medical Sciences (SAMS) Guidelines, are neither legally binding nor sufficiently explicit. For example, SAMS Guideline 18 requires a previous connection and numerous conversations between the physician and patient for the request for assisted suicide to be comprehensible. Yet, almost all of the tourists who travel to Switzerland for AID die shortly after getting there, and they usually meet with the prescribing physician only once. Undoubtedly, this circumstance does not comply with the requirements of Guideline 18, so the additional safeguards are crucial. It is inconsistent to cite the SAMS Guidelines for clarification while failing to superintend the activity in accordance with their standards. It does not fulfil the State's responsibility to protect life, particularly the lives of the vulnerable, to leave the control of assisted suicide to the prescription requirement and the police investigation, which is frequently a formality, after death has occurred. Given the highly active and liberal role that assisted suicide organizations play in Swiss practice and their lack of transparency, it is questionable whether the minimal methods of supervision Switzerland requires in order to fulfil a patient's desire to die with dignity satisfy the State's obligation under Article 2 of ECHR to protect the lives of individuals.⁴⁶ Most assisted suicides are committed with the help

⁴⁴ The Federal Commission for Control and Evaluation of Euthanasia. Annual Report. 2023.

⁴⁵ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. p 23.

⁴⁶ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 13-51; 217.

of two non-profit organizations, one of which (Dignitas) allows suicide assistance to foreigners, which has led to suicide tourism to Switzerland.⁴⁷ In March 2023, Dignitas submitted a 2022 report on PAS procedures performed in Switzerland, which revealed that the “last human right” was used by 206 people.⁴⁸

In Canada, there have been two similar cases in 22 years apart concerning the legalization and availability of AID. What is significant about these cases is the change of position and the two extremely different approaches to extremely similar cases. This distinction and change of views serve as an example for the whole world, illustrating how different people can have different perspectives on the same problems and how respect for individual autonomy has become increasingly important over time.⁴⁹ In 2015, an Act Respecting End-of-Life Care (bill 52) came into force in Canada, which established rules and criteria for continuous palliative sedation and medical aid in dying (hereinafter MAID). The sphere of influence of this legislation includes euthanasia, PAS, refusal of treatment and palliative care. Its central goal, bearing in mind the dignity and anatomy of a person, is to recognize the primacy of freely and clearly expressed desires associated with the termination of life. According to this document, the right to apply for MAID is granted to insured patients suffering from unbearable physical or mental pain, whose disease is final and advanced, due to which a person's capabilities are significantly and irreversibly reduced. As in previously analysed practices, the criterion for MAID is reflection (10 days).⁵⁰ The patient can appoint a substitute decision-maker who will make health care decisions on their behalf if they themselves become incompetent. Compared to the other jurisdictions described above, Canada's law and safeguards are stricter⁵¹. In order to report MAID cases, the institutions must develop a specific practice and report these cases to the board of directors. The main reasons for getting MAID are cancer (~69%), cardiovascular conditions (~14%), chronic respiratory diseases (~11%), and neurological conditions (~10%).⁵²

⁴⁷ *Riigikogu Kantselei Õigus- ja Analüüsisiosakond. Eutanaasia Seadustamine Euroopa Riikides. (Legalization of Euthanasia in European Countries). 23.09. 2020. p 3.*

⁴⁸ Dignitas. Review of the Year 2022 and Outlook for 2023. Zurich-Forch, 01.03.2023.

⁴⁹ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 218.

⁵⁰ Halloran, K. Ethics of Euthanasia and Physician Assisted Suicide. Merrimack College. 2022. pp 7-8.

⁵¹ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. pp 9; 24-25.

⁵² Halloran, K. Ethics of Euthanasia and Physician Assisted Suicide. Merrimack College. 2022. pp 7-8.

Below is a visual overview of the regulation of assisted death in the world. As can be seen from the maps, most countries have not yet addressed assisted dying in their laws, but this situation is likely to change very soon. Negotiations and petitions are already under way in many countries, as people's self-awareness and desire to exercise the right to self-determination in their home countries is raising increasing debate in government agencies with a view to changing the existing jurisdiction. The material below is from The World Federation of Right to Die Societies (WFRtDS) website. WFRtDS is an international non-profit organization of associations which advocate a self-determined and dignified end of life and promote euthanasia. The principle of this organization is that all people, regardless of their nationality, cultural and religious origin, social status, economic outlook, beliefs and values (etc.), have the right to die with dignity, peace and without burdensome torment, choosing for themselves the time and manner of their death, supported by a safe environment.⁵³

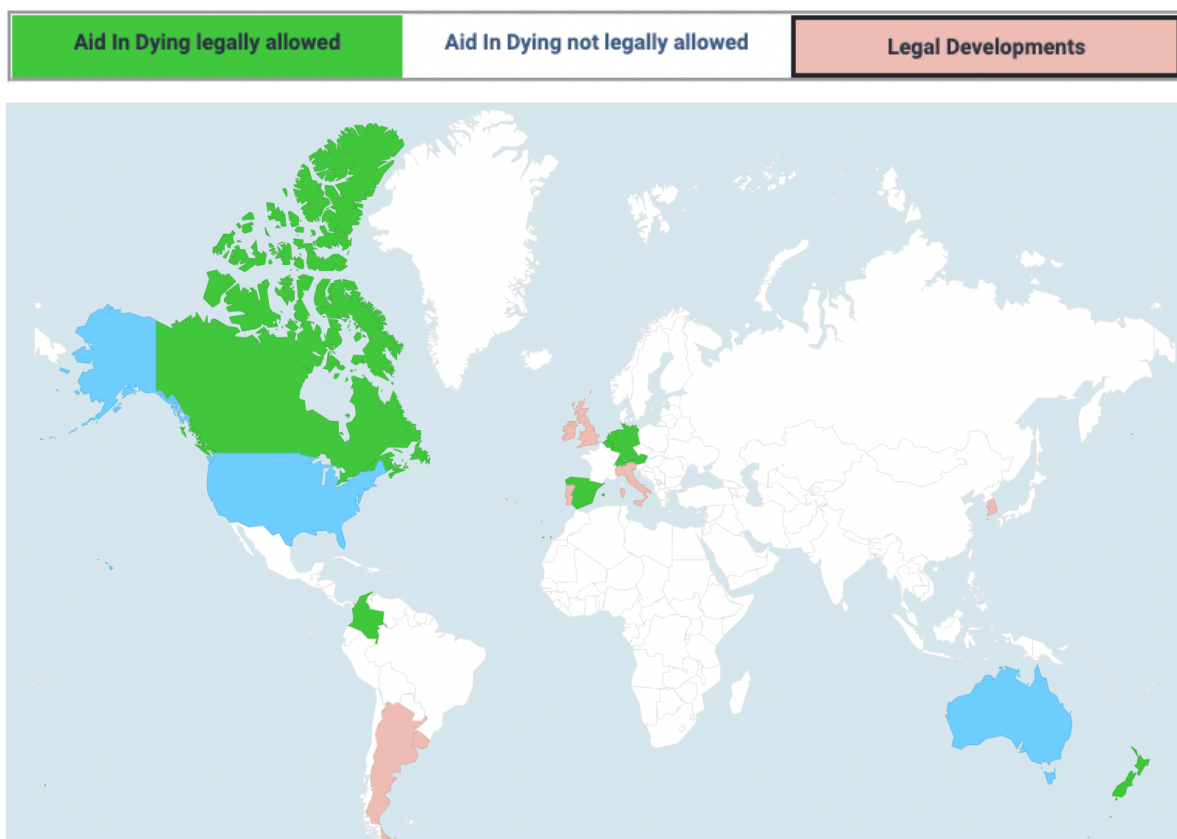


Illustration 1. An overview of the regulations in the world. Blue representing partial regulation.

Source: World Federation of Right to Die Societies. <https://wfrtds.org/worldmap/>

⁵³ Statutes. The World Federation of Right to Die Societies. Geneva, 01.04.2015. §§ 1; 3.

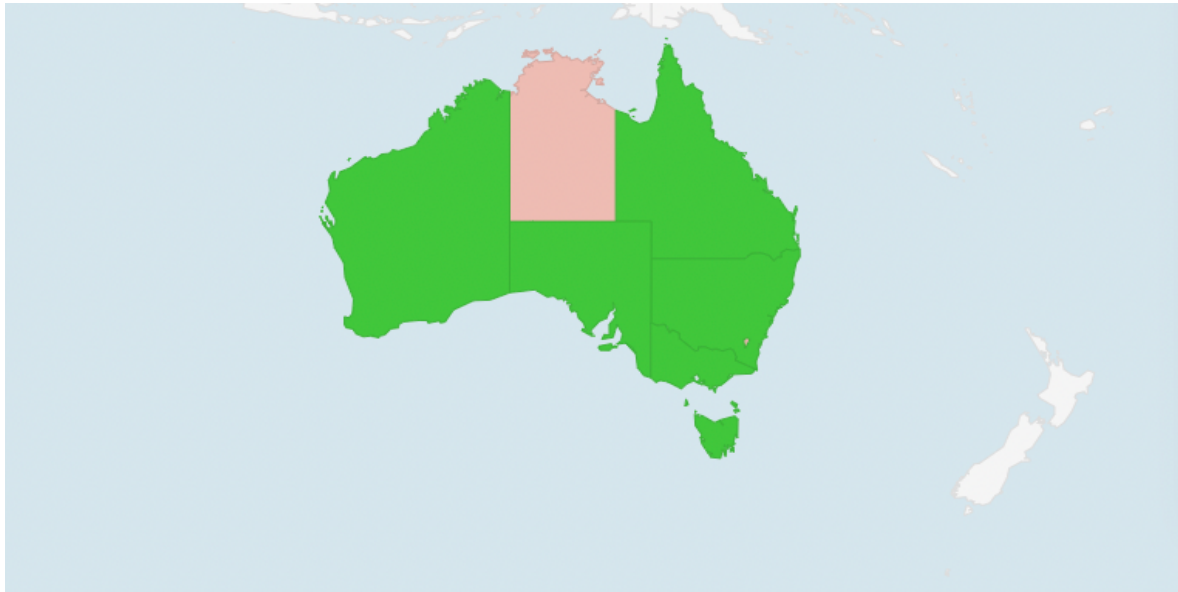


Illustration 2. An overview of the regulations in Australia. *Source: World Federation of Right to Die Societies. <https://wfrtds.org/worldmap/australia/>*

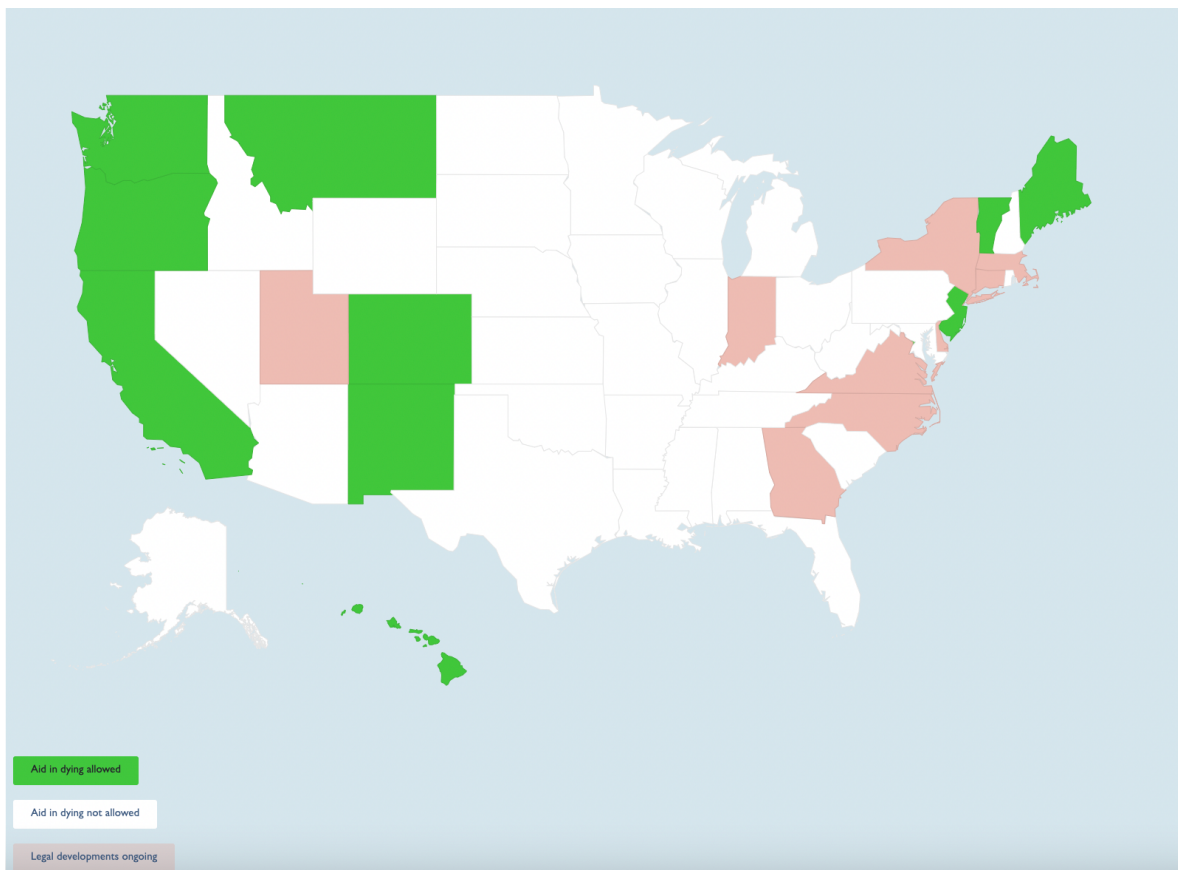


Illustration 3. An overview of the regulations in the U.S. *Source: World Federation of Right to Die Societies. <https://wfrtds.org/worldmap/united-States/>*

1.3.Regulation of Euthanasia Under International and European Union Law

1.3.1. Euthanasia in the context of ICCPR

For the purposes of this thesis, author considers the European Convention on Human Rights as the main source of law in the analysis of the legalization of euthanasia and the right to die with dignity, it is also necessary to examine the scope of the International Covenant on Civil and Political Rights (hereinafter ICCPR) in this research issue, since this document concerns all the countries outlined in the work and serves as a significant guide in the development of legislation in countries. ICCPR article 2 details three obligations that State Parties are required to adhere to. First, they must ensure that anyone whose recognized rights or freedoms have been violated, even by government officials, has access to a remedy. Second, a claimant's right to such a remedy must be determined by competent authorities, and the State must develop judicial remedy options. Finally, competent authorities must enforce granted remedies.⁵⁴ The right to die is governed by four articles in the ICCPR: right to life (Article 6), freedom to cruel, inhuman or degrading treatment (article 7), right to respect for private life (article 17), and freedom of thought, conscience and religion (article 18- discussed below, in sub-chapter 4.1.).

The right to life, like Article 2 of the ECHR (confirmed by the ECtHR), does not contain the right to die, but is not necessarily considered to be incompatible with the terms of the treaty. On the contrary, that right contains the positive obligations which the Member States have as regards respect for and determination of the patient's anatomy. In this case, the patient must not be subjected to undue pressure as the addressee of the right, and States have a responsibility to implement all possible guidelines and measures to ensure that the misuse of assisted death is protected. The Human Rights Committee is the body of independent experts that monitors implementation of ICCPR by its State parties. Its works promotes the enjoyment of civil and political rights, resulting in numerous changes of law, policy and practice.⁵⁵ In its General Comment No. 36, the Human Rights Committee reiterated the State's positive obligation to adopt measures for the protection of life, and in relation to assist dying, stated:

⁵⁴ International Covenant on Civil and Political Rights. United Nations General Assembly. New York, 16.12.1966. § 2.

⁵⁵ United Nations Treaty Bodies. Human Rights Committee.

*While acknowledging the central importance to human dignity of personal autonomy, States should take adequate measures, without violating their other Covenant obligations, to prevent suicides, especially among individuals in particularly vulnerable situations, including individuals deprived of their liberty. States parties that allow medical professionals to provide medical treatment or the medical means in order to facilitate the termination of life of afflicted adults, such as the terminally ill, who experience severe physical or mental pain and suffering and wish to die with dignity, must ensure that existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and, unambitious decision of their patients, with a view to protecting patients from pressure and abuse.*⁵⁶

Concerning the specific practices in the chosen liberal jurisdictions in Switzerland (2017) and the Netherlands (last 2019), the Human Rights Committee recommends stricter measures to defend the right to life under Article 6 of the ICCPR. The Committee strongly advocates for legislative modifications to guarantee that requests for AID are autonomous and argumentative, and has proposed stronger a priori procedures to prevent the abuse. Surprisingly the Committee has not commented on Belgium's laws concerning assisted dying and, after 2015, has not included Canada's Medical Assistance in Dying (MAID) law on its list of concerns. It has Stated that to want to end one's own life requires autonomy, reflection, and knowledge, hence, an a priori process is the most suitable for this aim. Also, the Committee recognizes the risk of a slippery slope and is concerned about the normalization of assisted suicide.⁵⁷

Article 7 The ICCPR protects all persons (including terminally ill and suffering patients) from cruel, inhuman and degrading treatment or punishment. It can be interpreted here that not allowing to someone VAE forces the patient to endure such condition (unreasonable pain and suffering) and therefore violates the principle of this article. However, it is not clear whether the State is obliged to allow or decriminalize euthanasia in this regard. ECtHR found in the case of *Pretty v. the UK* (more details below, sub-chapter 2.1.1.) in its 2002 ruling that Article 3 of the ECHR (analogue to Article 7 of the ICCPR) does not require the State to do so. Yet, State's prohibition on passive voluntary euthanasia (consensual withdrawal of life-sustaining

⁵⁶ UN Human Rights Committee. General Comment No. 36: Article 6: Right to Life. § 9.

⁵⁷ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 209-212.

treatment) could potentially infringe Article 7 of the ICCPR if it requires physicians to carry out treatment against the patient's requests. Article 7 aims at maintaining a person's physical integrity, which could be compromised if they are administered medical treatment without their consent. On the other hand, article 7 of the ICCPR does not protect against all interferences with physical integrity, thus, medical treatment, even if administered without consent, must reach a certain level of severity before it violates article 7.⁵⁸

Interferences with personal (including physical) integrity that are not severe enough to contravene article 7 may violate article 17's right to privacy, which protects that particular area of individual existence, physical and mental integrity, and autonomy that does not touch upon the sphere of liberty and privacy of others.⁵⁹ It is especially important to consider this article when it comes to the treatment to be provided to the patient (including its continuation and termination) and the end-of-life decision. Interference with this article, that is to say, interference by the State with respect to the integrity of the person, is permissible only in circumstances where it is lawful, serves a legitimate purpose and is well founded. Article 7 ICCPR (similar to Article 8 ECHR, but not fully analogous) is the relevant statutory provision in the case of voluntary euthanasia. In the aforementioned *Pretty v. the UK* case, the ECtHR found that the fact that the applicant was not in a position by law to exercise her choice to avoid what he considered an unworthy and troubling end to her life constituted an interference with the applicant's right to privacy. However, the Court noted that the general prohibition of assisted suicide, including the interference with Article 8 ECHR, that is to say, interference with private life by the State, is justified in a democratic society in order to protect the interests and rights of others. The Court has since confirmed that privacy also includes “an individual’s right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence”⁶⁰ (*Haas v. Switzerland*- more details below, sub-chapter 2.1.2) and “the right of each individual to decline to consent to treatment which might have the effect of prolonging his or her life”⁶¹ (*Lambert and Others v. France*- more details below, sub-chapter 2.1.4.).⁶²

⁵⁸ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. pp 29-30.

⁵⁹ Nowak, M. UN Covenant on Civil and Political Rights: CCPR Commentary. 2nd Edition. N.P. Engel. 2005. p 385.

⁶⁰ ECtHR 31322/07, *Haas v. Switzerland*. 20.06.2011. § 142

⁶¹ ECtHR, 46043/14, *Lambert and Others v. France*. 05.06.2015. § 180.

⁶² Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. pp 30-32.

The analysis of international human rights law surrounding AID lacks a transparent practical resolution. Rather, a balance of rights must be accomplished, with the State's obligation to safeguard life balanced against the right to personal autonomy and self-determination. In order to be justifiable, laws prohibiting voluntary euthanasia and other forms of assisted dying must not infringe on the right to respect for private life. Therefore, if a State legalizes voluntary euthanasia, there must be strict safeguards against abuse at work. No recognized right requires or prohibits the legalization of euthanasia, so long as adequate safeguards are in place to prevent arbitrary deprivations of life.

1.3.2. Euthanasia in the context of European Union law

Despite the fact that end-of-life decision-making laws vary among European Union (hereinafter the EU) Member States, similar issues dominate EU debates on euthanasia. Primarily, such conflicts involve striking a balance between respecting one's autonomy, protecting those who are vulnerable, and maintaining societal principles. At the core of this discussion is a dispute over recognizing an individual's desire to control their own life course and fears of potential abuse, manipulation, or discrimination against marginalized groups such as the elderly, people with disabilities, or those with psychological disorders.⁶³

The right of an individual to die with dignity, including through euthanasia or other forms of AID, has not been regulated by the European Union in its current legislation, and therefore there is no obligation on Member States to offer and legitimize (including decriminalize) such an opportunity to their citizens and patients. Nevertheless, a situation has arisen in which some countries in the European region, including the European Union, have legalized euthanasia and PAS. Such permissive regulations inevitably support so-called "suicide tourism," also referred to as "the world's saddest type of tourism." Reports from Belgium, where both euthanasia and PAS have been allowed by law since 2002 (including minors since 2014) (see the previous chapter), show that the interest of tourists coming from France, for example, in the euthanasia procedure has increased greatly and is still increasing, despite the fact that in Belgium one of the prerequisites for euthanasia is the long-term relationship between a doctor and a patient. In addition to Belgium, the Netherlands (since 2002) and Luxembourg (since 2009) also allow

⁶³ *Ibid.*

non-citizens and non-residents to receive euthanasia or help for suicide in their country.⁶⁴ On 19 April 2023, Luxembourg's National Commission for Control and Evaluation published a biennial report, which shows that since 2009 there have been a total of 170 cases of euthanasia in Luxembourg, most of which were by lethal injection, and four of them were assisted suicide cases by oral ingestion of a drug. Euthanasia may be contracted by a person suffering from a serious, incurable and irreversible disease who suffers unbearable physical or mental pain. There was a total of 24 cases in Luxembourg in 2021 and 34 cases in 2022, which together give a rise of 41.6% compared to the previous report.⁶⁵ Given also the simplified and convenient travel within the EU, it is extremely easy for citizens of EU Member States to travel to a country that has legalized euthanasia in order to get the desired result. Furthermore, Switzerland, which is not an EU Member State, has been decriminalized PAS since 1942, where tourists are also allowed to use the help of non-for-profit right-to-die organizations for assisted suicide.⁶⁶

Although there is no direct right to euthanasia and assisted suicide in EU legislation, this right could be interpreted from Article 56 of the Treaty on the Functioning of the European Union (hereinafter TFEU).⁶⁷ This provision protects the right of citizens of EU Member States to use and receive services in another Member State. Although AID is not aimed at making a profit, but according to Article 57 TFEU, the remuneration for the services must be provided, the cost-covering fee qualifies it as a service under Article 56. Furthermore, the European Court of Justice (hereinafter the CJEU) has confirmed in its previous case-law⁶⁸ that medical services which comply with national law fall within the scope of Article 56 TFEU. Thus, every citizen of an EU Member State has the right to travel to the Member State where euthanasia is legalized, in so far as a refusal to grant an AID would infringe Article 7 of the EU Charter of Fundamental Rights (respect for private and family life)⁶⁹ (Article 8 ECHR) and Article 56 TFEU. There is a different debate regarding a third party whose help the patient may need when travelling to a Member State. On the one hand, the third party should be held criminally

⁶⁴ Information on Requesting Euthanasia or Assisted Suicide. 2012. See here: <https://guichet.public.lu/en/citoyens/famille/euthanasie-soins-palliatifs/fin-de-vie/euthanasie-assistance-suicide.html>

⁶⁵ World Federation of Right to Die Societies. Luxembourg's Biennial Report. 2023.

⁶⁶ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 212-214.

⁶⁷ European Union. The Treaty on the Functioning of the European Union. 1957.

⁶⁸ CJEU C-159/90, The Society for the Protection of Unborn Children Ireland Ltd v. Stephen Grogan and Others, ECLI:EU:C:1991:378.

⁶⁹ European Commission. EU Charter of Fundamental Rights.2000.

liable, on the other hand, if the assistance of a third party was absolutely necessary for the patient to use and receive the service, the impact of the Article 56 TFEU should also extend to him. However, States have discretion in determining the right to die, and any restriction on this freedom must pass a proportionality test. The European Court of Justice is likely to take a conservative stance similar to that of the European Court of Human Rights in this contentious area of law.⁷⁰

⁷⁰ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 212-214.

II. RIGHT TO LIFE VS RIGHT TO DIE: THE DEBATE IN PRACTICE

2.1. Assisted Dying in the Practice of the European Court of Human Rights: Challenges, Controversies, and the Way Forward

Death remains an elusive subject, yet it is one of life's few objective facts. The European Court of Human Rights (hereinafter ECtHR) has been at the forefront of devising legal frameworks in Europe regarding euthanasia and assisted dying. However, every new ECtHR ruling on assisted dying and euthanasia issues generates controversy and debate. Some argue that legalizing assisted dying in any form would give individuals more control over their own lives, while others are concerned about the potential for abuse or coercion. As more countries consider legalizing assisted death, the ECtHR's case law will continue to have a substantial impact on shaping the discourse and ensuring that end-of-life decisions are consistent with human rights principles.⁷¹

In the following, the author gives examples of the most relevant and important case law of the ECtHR in order to illustrate the Court's position and, consequently, its guidance on the legislation of European countries and the correct interpretation of the European Convention on Human Rights. The chosen case law deals with assisted dying in the form of assisted suicide, since euthanasia in isolation has been only marginally concerned by the Court in its work. However, it is important to note that although the selected court cases deal with assisted suicide, it is a representation of the foundation of assisted dying through jurisprudence and are therefore analogous to the formulation of euthanasia as a process.

2.1.1. *Pretty v. The United Kingdom*⁷²

Over time, the precedents established by the ECtHR on this issue have evolved. Recent court decisions have increasingly acknowledged that individuals have the right to die with dignity. *Pretty v. The United Kingdom* (hereinafter "the Pretty Case") is a landmark case that exemplifies this transition. In this specific case, the applicant Diane Pretty was dying from motor neuron disease, an incurable degenerative disorder of the muscles. Given that the final phases of the disease are distressing and demeaning, she desired to have control over her death-

⁷¹ Zannoni, D. Right or Duty to Live? Euthanasia and Assisted Suicide from the Perspective of European Convention on Human Rights. *European Journal of Legal Studies*. Vol.12, No. 2. 2020. pp 182-185.

⁷² ECtHR 2346/02, *Pretty v. the United Kingdom*. 29.04.2002.

how and when she died. The applicant could not commit suicide without her husband's assistance due to her condition. However, while suicide was not a violation under the UK's law, assisting a suicide was. As the authorities denied the request, the applicant complained that her husband had not been assured immunity from prosecution if he assisted her in her death.⁷³ In July 2002, the Court ruled in its judgement that there had been no violation of Article 2 (right to life) of the Convention, which did not only require State “to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction,” establishing that the right to life could not be interpreted as conferring the completely contradictory right, such as the right to die, without a distortion of language.⁷⁴ The Court also determined that there had been no violation of Article 3 of the Convention (prohibition of cruel or inhumane treatment).⁷⁵ Even if the State could not enable but only sympathize with the applicant's fear that without the choice to end her life, she suffered a disturbing death which could diminish her dignity, the positive obligation on the part of the State that had been invoked would require the State to sanction actions intended to end life- an obligation that could not be derived from Article 3.⁷⁶ Although the Court showed most liberal approach analysing article 8 (right to respect for private life) ⁷⁷ and declared that even though a right to self-determination concerning the end of life had not been previously established under Article 8,⁷⁸ it considered personal autonomy as “an important principle underlying the interpretation of its guarantees,⁷⁹ the State’s aim to protect the weak and vulnerable justified the interference with applicants’ personal autonomy. ⁸⁰ In light of the above, the Court ultimately ruled that Article 8, and therefore Article 9 (freedom of conscience) and Article 14 (prohibition of discrimination) of the Convention had not been violated.⁸¹ Furthermore, subsequent cases have shown a higher respect for individual autonomy in matters regarding to mortality and dying under certain conditions, such as incurable diseases or intolerable pain.

⁷³ European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights.

⁷⁴ ECtHR 2346/02, *Pretty v. the United Kingdom*. 29.04.2002. §§ 38-39

⁷⁵ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 173.

⁷⁶ ECtHR 2346/02, *Pretty v. the United Kingdom*. 29.04.2002. § 55.

⁷⁷ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 177.

⁷⁸ European Court of Human Rights. Guide on Article 8 of the European Convention on Human Rights: Right to Respect for Private and Family Life, Home and Correspondence. 2022.

⁷⁹ ECtHR 2346/02, *Pretty v. the United Kingdom*. 29.04.2002. § 61.

⁸⁰ *Ibid.* §76.

⁸¹ Olsson, J. *A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law*. Malmö University. 2019. pp 19-23.

2.1.2. *Haas v. Switzerland*⁸²

In January 2011, the ECtHR delivered a judgement in case *Haas v. Switzerland*. The Haas Case raised the issue of whether, by virtue of the right to respect for private life, the State should have ensured that a sick person wishing to commit suicide could obtain a lethal substance sodium pentobarbital (hereinafter NaP) without a prescription, by way of derogation from the law, so as to be able to end their life without pain and with no risk of failure.⁸³ The applicant, member of Dignitas, the assisted suicide organization, who had been suffering from a serious bipolar affective disorder for around twenty years and had attempted suicide twice, argued that his right to end his life in a safe and dignified manner had been violated in Switzerland as a result of the conditions that had to be met – and which he had not met – in order to be able to obtain the substance in question.⁸⁴ Mr. Haas reasoned his request stating that his illness was difficult to treat and “made it impossible for him to live with dignity”.⁸⁵ Similar to *Pretty Case*, the Court found no violation of Article 8 (right to respect for private life) of the ECHR, finding that, even assuming that States had a positive obligation to take measures to facilitate suicide in dignity, the Swiss authorities had not breached that obligation in the applicant’s case.⁸⁶ Notably, the Court stated that the Member States of the Council of Europe had not yet reached a consensus regarding the right of an individual to choose how and when to terminate their life. Whereas assistance in suicide had been decriminalized, at least to some extent, in some Member States, the great majority appeared to place a higher emphasis on the protection of the individual's life than on his right to end his life. The Court determined that States had broad discretion (margin of appreciation) in these kinds of cases.⁸⁷ Although the Court further accepted that the applicant might have wished to commit suicide in a safe and dignified manner and without unnecessary pain, it nevertheless considered that the requirement under Swiss law for a medical prescription in order to obtain NaP had a legitimate aim, namely to protect people

⁸² ECtHR 31322/07, *Haas v. Switzerland*. 20.06.2011.

⁸³ European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights.

⁸⁴ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022.. pp178.

⁸⁵ ECtHR 31322/07, *Haas v. Switzerland*. 20.06.2011. § 7

⁸⁶ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022.. p 182.

⁸⁷ Olsson, J. *A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law*. Malmö University. 2019.

from taking hasty decisions and to prevent abuse, the risks of which should not be underestimated in a system that facilitated access to assisted suicide.⁸⁸

2.1.3. *Gross v. Switzerland*⁸⁹

The mankind is still debating how to ensure a dignified death. It is questionable whether the conditions of death or the ability to choose when to die should be protected.⁹⁰ *Gross v. Switzerland* (2014) involved the complaint of an elderly woman who desired to end her life but was not suffering from a clinical illness and was unable to obtain permission from Swiss authorities to be given a lethal dose of a drug in order to commit suicide. The applicant alleged that the Swiss authorities had violated Article 8 (right to respect for private and family life) of the ECHR by denying her the right to choose how and when she would terminate her life.⁹¹ The ECtHR ruled on May 14, 2013 that the current assisted suicide law in Switzerland lacked sufficient clarity. The Chamber found that Article 8 of the ECHR was violated when it was not determined whether a person who was not terminally ill could access the necessary medication (NaP). The Court suggested to remove impediments to obtaining lethal prescriptions by insisting on clearer laws, though it did not go far enough by failing to recognize an affirmative right to assisted suicide.⁹² The matter was ultimately referred to the Grand Chamber at the Swiss government's request that informed the Court in January 2014 that the applicant had died in November 2011. In its Grand Chamber judgment of 30 September 2014, the Court declared the application inadmissible by a majority vote. It was determined that the applicant had intended to mislead the Court on an issue that was central to her complaint. She had taken special precautions to prevent her death from being disclosed to her attorney and, by extension, the Court, in order to prevent the latter from halting the proceedings in her case. Therefore, the Court determined that her actions comprised an abuse of the right to an individual application (Articles 35.3.a. and 35.4. of the Convention). As a consequence of this ruling, the findings of the unimplemented Chamber judgment of 14 May 2013 are no longer legally binding.⁹³ Despite

⁸⁸ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 182-183.

⁸⁹ ECtHR 67810/10, *Gross v. Switzerland*. 30.09.2014.

⁹⁰ UNECLAC. *The Right to End-of-Life Palliative Care and a Dignified Death*. 2017.

⁹¹ Hendriks, A.C. *End-of-Life Decisions*. Recent Jurisprudence of the European Court of Human Rights. Academy of European Law. 2018.

⁹² Interian, J. *Gross v. Switzerland: A Deadly Dose for Personal Autonomy*. Boston College International & Corporative Law Review. 2015. pp 16-29.

⁹³ European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights.

this development, the 2013 decision sheds light on the Court's likely future analysis of assisted suicide for individuals without a terminal condition.

2.1.4. *Lambert and Others v. France*⁹⁴

The Lambert Case involved Vincent Lamber, a French citizen who had been in a vegetative state since 2008. On 24 June 2014, the French *Conseil d'État* declared lawful the decision taken on 11 January 2014, by the doctor treating Mr. Lambert, to discontinue his artificial nutrition and hydration.⁹⁵ The applicants submitted that the withdrawal of M. Lambert's artificial nutrition and hydration would be in breach of the State's obligations under ECHR Article 2 (right to life) and Article 8 (right to physical integrity), that depriving him of nutrition and hydration would constitute ill-treatment amounting to torture under Article 3, and that under Article 6.1. (right to a fair hearing) the doctor who had taken the decision had not been impartial, and that the expert medical report ordered by the *Conseil d'État* had not been fully adversarial.⁹⁶ Applicants stated that the withdrawal of treatment would amount to the intentional taking of life, namely involuntary passive euthanasia.⁹⁷ The Court determined that there would be no breach of Article 2 (right to life) of the ECHR if the *Conseil d'État's* judgment were implemented. Based on the Committee on Bioethics of the Council of Europe's "Guide on the Decision-Making Process Regarding Medical Treatment in End-of-Life Situations"⁹⁸ (2014), there was no consensus among the Member States of the Council of Europe in allowing the discontinuation of life-sustaining treatment and States enjoy the margin of appreciation in this question. The Court was also keenly aware of the significance of the case's concerns, which involved highly difficult medical, legal, and ethical issues. Under the circumstances, the Court held that since it was primarily the responsibility of the domestic authorities to determine whether the decision to withdraw treatment was compatible with domestic law and the ECHR, and to establish the patient's preferences in accordance with national law, its function was to review whether the State complied with the positive

⁹⁴ ECtHR, 46043/14, *Lambert and Others v. France*. 05.06.2015.

⁹⁵ European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights.

⁹⁶ English, R. Withdrawal of Nutrition and Hydration Would Not Offend Right to Life. Strasbourg Court, UK Human Rights Blog 2015.

⁹⁷ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 198.

⁹⁸ Council of Europe. Guide on the Decision-Making Process Regarding Medical Treatment in End-of-Life Situation. 2014.

obligations arising from Article 2 of the Convention.⁹⁹ The Court concluded that the legislative framework established by domestic law, as interpreted by the *Conseil d'État*, and the decision-making procedure, which had been meticulously carried out, were compatible with the requirements of Article 2 of the ECHR.¹⁰⁰ The Court also brought out the fact that previously (before the patient was unconscious) expressed wishes, e.g., not to be kept alive artificially, could be ascertained from previous statements made to a family member or close friend.¹⁰¹

2.1.5. *Sanles Sanles v. Spain*¹⁰²

The Court received the first application on the matter of assisted suicide in 2000 and declared it inadmissible *ratione personae*.¹⁰³ Mr. Sampedro, who was tetraplegic, committed suicide with the assistance of a third party in January 1998, while his claim to have the right to a dignified death approved was unresolved. In the *Sanles Sanles* case, the applicant was the heir legally appointed by her brother-in-law, Mr. Sampedro, to continue the proceedings he had initiated while he was still alive. She cited Articles 2 (right to life), 3 (prohibition of inhuman and cruel treatment), 5 (right to liberty and security), 6 (right to a fair trial), 9 (freedom of conscience), and 14 (prohibition of discrimination) of the ECHR in seeking recognition of the right to a dignified life or death, or to non-interference with her brother-in-law's desire to end his life. The Court ruled that because the applicant was not directly affected by the alleged violations of the Convention, she could not claim to be a victim of them (Article 34 of the ECHR). In more recent cases, like *Koch v. Germany*,¹⁰⁴ the Court has repeatedly cited this case to assert that Article 8 ECHR rights cannot be transmitted to the victim's relatives or successors.

2.1.6. Future Steps

Regarding the Convention, determining the right to die involves balancing Article 2's right to life with Article 8's right to privacy. Member States have discretion in deciding whether

⁹⁹ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 199.

¹⁰⁰ ECtHR, 46043/14, *Lambert and Others v. France*. 05.6.2015. §§149-175

¹⁰¹ ECtHR, 46043/14, *Lambert and Others v. France*. 05.06.2015. §§ 177-180

¹⁰² ECtHR, 48335/99, *Sanles Sanles v. Spain*. 26.10.2000.

¹⁰³ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 166.

¹⁰⁴ ECtHR, 497/09, *Kock v. Germany*.

allowing individual autonomy regarding ending one's own life aligns with their obligation to protect vulnerable individuals. Due to the extremely delicate topic at hand, this margin of appreciation is currently quite wide. European Court of Human Rights case law states that the right to decide when and how one dies is a component of Article 8, and any restriction on this must be justified, though justification can be relatively straightforward due to the margin of appreciation.¹⁰⁵ If Member States permit assisted suicide as part of their positive obligation under Article 2, they must also implement sufficient measures and safeguards for others' safety. Additionally, these States must provide clear information about the legal boundaries of their assisted suicide practices.¹⁰⁶

The common emphasis on autonomy as a premise for legislative change regarding assisted dying is insufficient to carry the debate forward. Autonomy is not just a subject to impairment and loss, but it also has flaws when used as the sole counterargument to the sanctity of life. For instance, the legislation must impose regulations on the autonomous choice of wishing to die. Dignity, on the contrary, provides a much stronger foundation for the necessity of legislative change. Respecting the individual nature of the quality of life and recognizing the concept of dignity as a relational concept, implies that individuals should have the right to choose the time and manner of their death. Dignity is most prominent as a personal value- what one person considers a dignified existence may be considered undignified by another. Nevertheless, it is primarily a relational concept. Individuals require others to respect their dignity and the boundaries it establishes, in addition to practical measures to ensure their dignity is recognized. Respecting a person's dignity necessitates that if they require assistance to terminate what, from their perspective, has become an undignified existence, the assistance must be legalized.¹⁰⁷

The European Court of Human Rights has enacted legal measures that facilitate the decriminalization of euthanasia and the provision of palliative care, despite not yet recognizing a right to assisted dying. These policies indicate development toward greater autonomy in

¹⁰⁵ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 218-219.

¹⁰⁶ Olsson, J. *A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law.* Malmö University. 2019. pp. 20-22.

¹⁰⁷ Reichstein, A. *A Dignified Death for All- How a Relational Conceptualisation of Dignity Strengthens the Case for the Legalisation of Assisted Dying in England and Wales.* *Human Rights Law Review.* Vol.19, No.4. 2019. p 1-2.

healthcare decision-making without explicitly addressing assisted death.¹⁰⁸ Using the ECtHR's rulings can help to strike a balance between individual autonomy and societal interests in end-of-life care policymaking. The Court has ruled that individuals have the right to determine how they wish to die without suffering or State intervention. However, this liberty is not unrestricted and must be measured against other human rights concerns, such as the protection of vulnerable individuals from coercion or mistreatment. As long as policymakers remain dedicated to upholding the values of dignity and autonomy - fundamental human rights values - we can hope for compassionately respectful solutions that allow terminally ill individuals to exercise autonomy over their final moments of life.¹⁰⁹ When analysing the euthanasia debate, the primary arguments are divided into two opposing principles, namely the assurance of personal autonomy against the protection of the human dignity of all individuals. By taking into consideration the reasoning for and against the lawfulness of euthanasia as well as the discretion given to the Member States, it is impossible to institute a universal standard regarding euthanasia within the Europe at the present time.¹¹⁰

2.2. *Mortier v. Belgium*: A Landmark Case for Euthanasia¹¹¹

When analysing the euthanasia debate, the primary arguments are divided into two opposing principles, namely the assurance of personal autonomy against the protection of the human dignity of all individuals. By taking into consideration the reasoning for and against the lawfulness of euthanasia as well as the discretion given to the Member States, it is impossible to institute a universal standard regarding euthanasia in Europe at the present time. Nevertheless, an examination of the recent judgement of *Mortier v. Belgium* could change the existing situation.

Before October 2022, the Court had dealt with assisted suicide (see previous cases) and withdrawal of life-sustaining treatment, but not with euthanasia. There had been no case from any of the European States where euthanasia has been legalized, like the Netherlands, Belgium,

¹⁰⁸ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 206.

¹⁰⁹ Hendriks, A.C. *End-of-Life Decisions. Recent Jurisprudence of the European Court of Human Rights.* Academy of European Law. 2018.

¹¹⁰ Engström, A. *A Human Right to Die? The Legality of Euthanasia Under the European Convention on Human Rights.* Örebro University. *Juridicum.* 2020. p 30.

¹¹¹ ECtHR, 78017/17, *Mortier v. Belgium.* 04.10.2022.

or Luxembourg. However, that changed when Mr. Tom Mortier (the applicant)¹¹², son of Mrs. Troyer who was suffering from chronic “incurable” depression and therefore ended her life through euthanasia in 2012, brought the landmark case before the Court on 6 November 2017.¹¹³ The applicant claimed that Belgium authorities failed to fulfil their positive obligation raised from the Article 2 of the ECHR, to protect the life of his mother, since the statutory procedure for euthanasia had allegedly not been followed in her case. Additionally, because of violating the Article 2 of the ECHR, there was, allegedly, a breach of the provision from the Article 8 of the Convention. Mr. Mortier also complained about the lack of an in-depth and effective investigation into the matters raised by him, referring to the Article 13 (the right to an effective remedy) of the ECHR.¹¹⁴

Analysing the scope of Article 2 of the ECHR, the Court stated that the central question of the particular case concerned the compatibility of the performed euthanasia-act itself with the ECHR and not the right to euthanasia regulated by Belgium Euthanasia Act (2002).¹¹⁵ The applicant’s complaints were examined from the perspective of the State’s positive obligations to protect the right to life, taking account of the legislative framework concerning acts prior to euthanasia, its compliance in present case and the post-euthanasia review.¹¹⁶ The Court found that the Belgian legislative framework governing the pre-euthanasia acts and procedure carried out in the current case complied with Article 2 of the ECHR and consequently Article 8 of the ECHR was not infringed,¹¹⁷ stating that the statutory provisions on euthanasia constituted in principle a legislative framework that specifically ensured the protection of the right to life of the patients as required by Article 2 of the ECHR¹¹⁸. Moreover, in regard to the right of the applicant to accompany his mother throughout the process and the patient’s right to autonomy the Court struck the balance in favour of the latter interest.¹¹⁹ Nonetheless, the Court determined that there had been a violation of Article 2 of the Convention due to the post-euthanasia review procedure in the present case, concluding that the State had failed to meet its procedural positive obligation due to the lack of independence of the Federal Board for the

¹¹² See the application (27.09.2015) here: <https://adfllegal.blob.core.windows.net/international-content/docs/default-source/default-document-library/resources/media-resources/europe/mortier-v-belgium.pdf>

¹¹³ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend?* (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 204-205.

¹¹⁴ European Court of Human Rights. Press Release: Court Finds Procedural Defects in Subsequent Review of Death by Euthanasia of Applicant’s Mother. 2022.

¹¹⁵ The Belgian Act on Euthanasia of May, 28th 2002.

¹¹⁶ European Court of Human Rights. Press Release: Court Finds Procedural Defects in Subsequent Review of Death by Euthanasia of Applicant’s Mother. 2022.

¹¹⁷ ECtHR, 78017/17, *Mortier v. Belgium*. 04.10.2022. § 203.

¹¹⁸ European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights.

¹¹⁹ ECtHR, 78017/17, *Mortier v. Belgium*. 04.10.2022. §§ 204-207.

Review and Assessment of Euthanasia and the length of the criminal investigation.¹²⁰ As demonstrated by the circumstances of this case, the process for obtaining approval for euthanasia for patients with mental illnesses can become extremely complicated due to the nature of the disease. Judge María Elósegui (Spain) noted in her dissenting opinion (p.22) that it is not easy to determine if a chronic psychopathology, in this instance chronic depression, is incurable.¹²¹

On 14 October 2022, the Belgian Federal Control and Evaluation Commission on Euthanasia (hereinafter FCEE) provided a response¹²² to the ECtHR ruling in the *Mortier* Case. In it, the FCEE confirmed that they had taken note of the decision, including in so far as the Chamber agrees with the principles of decriminalizing euthanasia, but pays attention to the inadequacy of the follow-up, the post-euthanasia review procedure. The Chamber explained that the procedure laid down in Article 8 of the Belgian Euthanasia Act does not prevent the doctor who carried out the euthanasia from voting in the commission on whether his actions comply with the material and procedural requirements of national law, and thus the independence of the Commission is not guaranteed.¹²³ The FCEE notes that while the Commission says the solution can only be to lift the anonymity of the registration document, this is not possible without a change in the law that is the sole responsibility of the legislature.

As healthcare improves around the globe, people are living longer, but they frequently must contend with debilitating and incurable painful conditions or maladies. Advocates contend that people with terminal illnesses should not be forced to undergo medical procedures they do not want or to suffer in silence when they do not have to. Others, again, strongly criticize the ECtHR's position concerning the *Mortier* Case, arguing that refusing to find the State guilty in the present case would effectively mean turning a blind eye to abuses, despite the many warnings of the "slippery slope" down which Belgium is progressing¹²⁴. This particular decision improved human rights by establishing clear guidelines for end-of-life care, but it also sparked debate over whether assisted dying should be lawful everywhere in the world.¹²⁵ There

¹²⁰ European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights.

¹²¹ UN Human Rights Blog. *Mortier v. Belgium: A Landmark Decision on Euthanasia in the Case of Mental Illness*. 2022.

¹²²FCEE. *Persbericht van de Federale Controle- en Evaluatiecommissie Euthanasie*.2022.

¹²³ ECtHR, 78017/17, *Mortier v. Belgium*. 04.10.2022. §§ 177-178.

¹²⁴ Europe's Top Human Rights Court Rules: Belgium Violated Right to Life in Euthanasia Case. ADF International. 2022.

¹²⁵ European Centre for Law & Justice. Written Observations Submitted to the European Court of Human Rights in the Case of *Mortier v. Belgium*. 2019.

are two methods to evaluate the significance of this verdict. First, it recognizes that individuals have the right to make decisions regarding their existence, including decisions regarding death. Second, it emphasizes the significance of striking a balance between individual liberties and the requirements of the community, particularly when it comes to delicate topics such as euthanasia. The Mortier Case will highlight some important precedents set for the future of healthcare ethics in a world where bioethics are receiving more attention than ever before: it affects the dedication of healthcare professionals to protecting their patients, the willingness of family members to accept such life-altering decisions, and, most importantly, it establishes moral standards for voluntary euthanasia in the present day.¹²⁶ As a society, we continue to face difficult issues relating to medical ethics and human rights as time passes. Even though the case of *Mortier v. Belgium* sheds some light on these issues, there is still a great deal of work to be done.

2.3. The Slippery-Slope Argument: Legitimate or Sought Justification

Article 2 of the Convention safeguards the right to life, which is "one of the most fundamental provisions of the Convention." Article 2 of the ECHR imposes a positive obligation on Member States, requiring them to "take appropriate measures that protect the lives of those within its jurisdiction" in addition to a negative obligation prohibiting the deliberate taking of human life. This obligation applies to the medical field and ensures that sufficient precautions are taken to protect the lives of patients under the care of the medical profession. Together with right-to-life debate, the positive obligation of the State to protect life, notably the lives of the most vulnerable, would be broken down into two branches of argumentation. First, the right to die is incompatible with the sanctity of life and should not be recognized under any circumstances. Second, assuming such a right were to be recognized, its application should not be permitted due to the inherent risk of abuse, also known as the "slippery slope."¹²⁷

The slippery slope argument argues that legalizing any form of assisted dying (e.g., euthanasia) would lead us down a difficult and dangerous path. Once the assisted dying Pandora's box is

¹²⁶ De Hert, M., Loos, S., Van Assche, K. The Belgian Euthanasia Law Under Scrutiny of the Highest Courts. *The Lancet Regional Health-Europe*. Vol.24. 2022.

¹²⁷ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 2-3.

unlocked, it may be impossible to regulate or control it adequately.¹²⁸ While advocates of euthanasia think that allowing people to choose the time and manner of their death is the matter of self-determination, right to dignity and private life and prohibition of discrimination, opposers of euthanasia theorize that legalization would lead to the involuntary euthanasia of vulnerable people, such as disabled and elderly patients that seem burdensome and expensive by society.¹²⁹ In addition, this raises ethical concerns about the role of doctors in end-of-life decision - making and the chance for prejudice and bias in these actions. How can we assure that physicians only act in the best interests of their patients considering that they have the authority to determine their life and death? What if some ethnic or socioeconomic group members are disproportionately prone to engage in euthanasia? When does the agony reach the level at which the existence becomes intolerable? What characteristics define a dignified death for a person? According to what conditions would one consider his or her existence to have lost its dignity? We cannot overlook the benefits of providing terminally ill individuals autonomy over their bodies, matter of fact, we must be extra diligent against mistreatment and ensure that all stakeholders are kept safe by adequate safeguards if this is decided. Then again, what laws and policies can be implemented to prevent the possibility of abuse?¹³⁰ Despite the fact that these determinations are highly subjective and dependent on a variety of personal circumstances, it is also necessary to take into account vital societal interests.¹³¹ The strongest argument against the right to die is protection of life, and since the issue entails life and death, the stakes could not be higher.

The slippery slope argument is referring to "a proposal that is made to embrace **something** that is not morally unacceptable, but it should be turned down because it would result in **consequence** that is morally unacceptable." In this line of reasoning, it is claimed that recognizing and legislating the right to die will inevitably lead to a slippery slope, either logical or practical or both, in which the practice will either intentionally or unintentionally reach above its initial boundaries. The "logical slippery slope" refers to the use of justifications in favour of the right to die to support other morally unacceptable actions. Using comparison as an illustration, if one supports the right to die for terminally ill patients awaiting death in pain,

¹²⁸ JD., Mueller, P.S., Sulmasy, L.S. Ethics and Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. *Annals of Internal Medicine*. Vol.167, No. 8. 2017. p 584-585.

¹²⁹ Aznar, J. The Slippery Slope of Euthanasia. *Medicina e Morale*. Vol. 70, No. 1. 2021. pp 112-114.

¹³⁰ Battin., M.P. Physician-Assisted Dying and the Slippery Slope: The Challenge of Empirical Evidence. 2008. *Willamette Law Review*. Vol.25, No.1. 2008. pp 128-131.

¹³¹ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 2.

one additionally has to embrace the right to die for patients who are not terminally ill but suffer from extreme agony. Over time, it will become acceptable to terminate the lives of mentally incompetent individuals who endure excruciating pain, leading to the conclusion that such lives are "unworthy." Likewise, if one argues that the right to die is based solely on respect for personal autonomy, he must be prepared to abolish all practical requirements other than the person's autonomous request and permit death on desire. The "practical slippery slope" is described by concerns regarding the inadequacy of safeguards, such as physician errors, false determination of capacity, and excessively broad interpretation of the rules. These considerations also include the concern that public normalcy of the right-to-die practice will lead to the ultimate approval of more problematic practices.¹³²

When determining whether the authorities should approve euthanasia, the pros and cons of such policies must be examined. Whether or not the implementation of the right to die will send the practice down a slippery slope is a central issue in the debate that will establish the tipping point. It raises ethical concerns addressing the way doctors' function and the potential for bias or discrimination against individuals. The answer relies significantly on the collection of extremely detailed information from existing States with permissive laws. Unfortunately, this kind of information cannot be obtained in a sufficient amount.¹³³ While proponents state that strict rules and regulations could avoid this, critics point to research demonstrating that "the Netherlands is an empirical example of the Slippery Slope in action." It shows that the adoption of euthanasia for terminally ill patients, who are facing both emotional and physical misery, as well as involuntary cases,¹³⁴ resulted from the increasing popularity of assisted dying to multiple groups of patients. After euthanasia is legalized, such developments raised scepticism about the successful implementation of any law to prevent additional issues. Critics have fears that legalization will unavoidably end in a situation in which vulnerable patients will be targeted without their consent. When patients are unable to express adequate consent or are lacking mental capacity, this argument becomes a lot more persuasive.¹³⁵ Personnel in healthcare organizations might feel obligated to reach decisions dependent on personal preferences rather than objective medical criteria, causing them to act against patients' preferences or best interests. In addition, this raises ethical challenges for healthcare workers,

¹³² Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 3-4.

¹³³ *Ibid.* pp 217.

¹³⁴ Aznar, J. The Slippery Slope of Euthanasia. *Medicina e Morale*. Vol. 70, No. 1. 2021. p 116.

¹³⁵ Hendin, H. The Slippery Slope: The Dutch Example. *Duquesne Law Review*. Vol.35:427.

as it conflicts with their duty to preserve life while respecting individuals' autonomy and dignity during end-of-life care.¹³⁶ Thereby, we face a critical need for specific regulations regarding how healthcare providers should manage end-of-life decision-making, including strict procedures for assessing capability and receiving informed consent from all involved parties.¹³⁷ Nonetheless, it must be kept in mind that even if a slippery slope is identified in one of the permissive jurisdictions, this risk may not be equally frightening for other States that have regulated or wish to regulate the right to die, as a number of different factors, including their respective medical, sociological, cultural, and historical contexts, will play a significant role in its application.¹³⁸ This is evident when examining the selected jurisdictions that illustrate the various routes taken toward the right to die.¹³⁹

In addition, there is no unanimity regarding the existence of a slippery slope, and a number of alternative explanations have been offered for the rise in assisted dying seekers¹⁴⁰. It is necessary to carry out additional empirical research on the practices of assisted dying in the Netherlands and Belgium, as they serve as significant examples of countries that could look into legalizing assisted dying.¹⁴¹ The decision should be treated as part of the State's obligation under Article 2 of the Convention, and both the Netherlands and Belgium could be in violation of the Convention if the necessary measures are not taken (look at previous analysis of the case of *Mortier v. Belgium*). If investigations provide a slippery slope, which includes the growth of the right-to-die practice beyond the limits of the respective legal framework as an outcome of generous interpretation, Article 2 of the ECHR would require the authorities to adopt additional safeguards to ensure the balance between the right to die and the right to life.¹⁴²

In conclusion, the slippery slope argument raises concerns regarding physician bias during end-of-life decision-making procedures. Therefore, we must ensure that effective safeguards exist for this complex topic, while always respecting the autonomy and dignity of the patient. The

¹³⁶ Keown, J. Euthanasia in the Netherlands: Sliding Down the Slippery Slope? *Notre Dame Journal of Law, Ethics & Public Policy*. Vol.9. 1995. page 437-447.

¹³⁷ UNECLAC. *The Right to End-of-Life Palliative Care and a Dignified Death*. 2017.

¹³⁸ Peters, A.L., *Euthanasia and Consensual Harm: Evaluating the Moral and Legal Asymmetry of Self- and Other-Regarding Acts*. *Inquires Journal*. Vol.13, No.10. 2021.

¹³⁹ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 217.

¹⁴⁰ Peters, A.L., *Euthanasia and Consensual Harm: Evaluating the Moral and Legal Asymmetry of Self- and Other-Regarding Acts*. *Inquires Journal*. Vol.13, No.10. 2021.

¹⁴¹ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 218.

¹⁴² *Ibid.* p 208.

issue of euthanasia's slippery slope remains. Yet, its accuracy shouldn't jeopardize vital conversations surrounding patient autonomy in end-of-life care. It is essential to strike a balance between individual rights and societal protections so that all parties involved are benefited without endangering the well-being or autonomy of others.¹⁴³

¹⁴³ Warwick, J. A Delicate Balance: Rethinking the Physician's Role in Physician Aid-in-Dying. UC Irvine Law Review. Vol.12. 2022. pp. 1432-1433.

III. “HEAVEN OVER HOSPITAL” VS “CARE, NOT KILL”: HEALTHCARE PROVIDERS, INSTITUTIONS, AND THE IMPLEMENTATION OF EUTHANASIA

3.1. Balancing Ethics and Legal Responsibilities

Despite significant advances, there comes a time when medicine can no longer deliver patients effective solutions to their problems. In September 2022, the World Health Organization (WHO) published research about noncommunicable diseases (NCDs), that gave an overview about the most common cause of death nowadays that is chronic conditions such as cancer, diabetes, Alzheimer's, or heart disease. NCDs kill annually 41 million people, which is equivalent to 74% of all deaths globally.¹⁴⁴ Although it is possible to control the symptoms of slow-progressing chronic illnesses, total recovery is frequently not possible. This is one reason why dying has increasingly become a medical event that takes place in healthcare facilities surrounded by machines. While symptoms can be managed and life can be prolonged, it is not always possible to assure the patient a satisfactory quality of life.¹⁴⁵

Accompanied by the closing notes of the previous chapter, it makes sense to examine here the rights and responsibilities of healthcare institutes and their personnel, and the risks and privileges that are passed on to these subjects when euthanasia (and other forms of assisted dying) are legitimized. The implementation of euthanasia legislation requires the collaboration of healthcare professionals and institutions. Their position represents substantial authority, as they are responsible for making ethical and legal decisions that can have a major effect on the lives of others. Hence, all pertinent procedural aspects must be clearly defined in order to grant adequate direction to healthcare providers and patients. While legislators are in charge of establishing the legal framework, healthcare organizations have a stronger ability to develop guidelines that address specifics requiring expert knowledge, such as the dosage of medication to be used for euthanasia and the determination of when an illness is terminal. This can be seen in the role of healthcare institutions in Dutch practice. Still, it should not be neglected that

¹⁴⁴ WHO. Noncommunicable diseases. 2022.

¹⁴⁵ Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 2.

healthcare organizations are not legislators, and they should not be tasked with establishing the scope of assisted dying or functioning as the practice's guardians.¹⁴⁶ Regarding euthanasia and human rights, the way in which physicians carry out these roles influences the subject matter. A major issue with enforcing euthanasia is guaranteeing that human rights are upheld throughout the entire process. Healthcare personnel and institutions must undergo adequate training in order to make informed choices concerning end-of-life care. It is arguable whether or not euthanasia violates human rights. Nevertheless, proponents maintain that allowing patients to choose how they die is a crucial aspect of personal autonomy. By permitting individuals with terminal illnesses to determine when and how they will end their lives, we respect their self-determination.¹⁴⁷ It is essential to specify the steps that must be taken to make certain that healthcare workers obtain adequate training before undertaking such positions. Undoubtedly, education programs for healthcare professionals on euthanasia ethics are necessary to overcome certain implementation challenges.¹⁴⁸ These programs could encompass discussions regarding the legal frameworks governing assisted dying in various jurisdictions as well as awareness-raising campaigns aimed at educating stakeholders on patients' rights in addition to other crucial areas such as the palliative care options available to those with life-threatening diseases.¹⁴⁹ Additionally, psychological support should be made available, or compulsory, to the healthcare personnel participating in assisted dying procedures.¹⁵⁰ Despite the benefits, implementing euthanasia is not without challenges. As such, it is vital that healthcare providers undergo extensive education and sufficient training to complete their duties effectively so that individuals' civil liberties remain unscathed.

In today's healthcare system, the application of euthanasia to reduce the distress of terminally ill patients is an issue of debate. Despite it being generally accepted that this practice must be approached with care, there remain a number of ethical and legal concerns that must be resolved before it becomes widespread. The moral and legal considerations connected to healthcare providers and organizations entrusted with euthanasia are complex and require careful analysis. The issue that comes up is whether doctors should end a patient's life or they

¹⁴⁶ *Ibid.* 219.

¹⁴⁷ Alhazmi, F. The Ethical Challenge of Conflicts of Interest in Healthcare, Duquesne University. 2019. pp 119-134.

¹⁴⁸ JD., Mueller, P.S., Sulmasy, L.S. Ethics and Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. *Annals of Internal Medicine*. Vol.167, No. 8. 2017. 584-586..

¹⁴⁹ American Nurses Association (ANA). Position Statement; the Nurse's Role When a Patient Requests Medical Aid in Dying. 2019.

¹⁵⁰ Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022. pp 220.

should do everything possible to preserve it. Some healthcare providers argue that euthanasia infringes the Hippocratic Oath (see next sub-chapter), which requires physicians to abstain from causing harm and preserve life at all costs, whereas others view it as an act of mercy that allows patients with terminal illnesses or unbearable pain to end their lives with dignity.¹⁵¹ Institutions have also taken definitive positions on this matter. For instance, Catholic hospitals refuse categorically any involvement in physician-assisted suicide or euthanasia procedures because they are guided by religious beliefs. This institutional stance could impact patient choice when seeking assisted dying options if they were not previously aware. This could let theorize that if the State is indeed legalizing euthanasia, should the regulations and policies prohibit every healthcare institution from adopting non-euthanasia policies within their premises (practiced in Belgium under the Belgian Euthanasia Act section 14.4.) to avoid the situation described above, where the patient could be, without knowing, affected by healthcare institutions religious beliefs and therefore misses the chance for assisted dying? Then again, if, for example, the same Catholic hospital were to lose its "Catholic" title because its healthcare professionals were practicing euthanasia and assisted suicide, since this was required by domestic law, this could raise a question of infringement of the healthcare institution's freedom of religion under article 9.¹⁵² Additionally, there are apprehensions about potential misuse or coercion by relatives or stakeholders who may have vested interests in hurrying up an individual's death for their advantage. These dilemmas shed light on the complex nature of this issue from both ethical as well as legislative viewpoints.

Although euthanasia remains a challenging moral question filled with emotional intensity, a proper preparation through education and training can significantly mitigate risks associated with its application while safeguarding human rights. The States that are on the way legalizing euthanasia or are thinking about it, must also provide sufficient clarity as to the legal boundaries of their assisted dying practices. Doing so, they have to highlight the significance of defining the procedural elements of assisted dying. This includes establishing legal frameworks and guidelines endorsed by healthcare institutions, the need for psychiatric evaluation to assess the patient's decision-making capacity and reasons for requesting assisted dying, as well as providing palliative care options. Although patients cannot be forced to choose other

¹⁵¹ Warwick, J. A Delicate Balance: Rethinking the Physician's Role in Physician Aid-in-Dying. *UC Irvine Law Review*. Vol.12. 2022. pp. 1421-1426.

¹⁵² Kayacan, D. N. *The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World)*. Vol. 6. 1st ed. Springer International Publishing AG. 2022. p 206.

alternatives, they must be nevertheless informed of all available options. To inform the patient properly, the physician should consult a palliative care specialist. To ensure transparency and prevent potential abuses, an efficient supervisory system must be established and regular research should be conducted to analyse statistics and examine any increase in assisted dying requests. Procedural regulations should also take into account the patient's morale and provide psychological support for healthcare personnel.¹⁵³

3.2. Patient Autonomy and the Hippocratic Oath—Ongoing Ethical Dilemma

The Hippocratic Oath (hereinafter the Oath) is an ancient medical code that has long served as a guiding principle for medical professionals around the world. It states: “*I will keep [the sick] from harm and injustice. /.../ I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect*”. Despite the fact that the Hippocratic Oath is not a legally binding document and its provisions are not directly incorporated into the law, physicians have for centuries been guided by the Hippocratic Oath, which prohibits them from intentionally ending an individual's life.¹⁵⁴ This age-old rule has endured the test of time and has gone through numerous modifications to reflect the beliefs of each era. The Hippocratic Oath has been adjusted over the centuries, yet it continues to adhere to its fundamental values.¹⁵⁵ When it comes to euthanasia, a modern-day practice, some proponents argue that euthanasia provides humane relief for terminally ill patients and those in intolerable agony, whereas opponents insist that it violates core medical principles. While some preferred providing palliative care or hospice support rather than assisting dying patients, others struggled with the concept of "doing harm" when interacting with those who request assistance to die with dignity. Consequently, whereas the Hippocratic Oath remains an essential guideline for modern medical practice, its interpretation within society's constantly changing moral framework is essential.

The Hippocratic Oath says that physicians will always consider that, at times, “warmth, sympathy, and understanding” can aid more than standard medical practice may be able to

¹⁵³ The College of Family Physicians of Canada. A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia. 2015. pp 4-9.

¹⁵⁴ Hulkower, R. The History of the Hippocratic Oath: Outdated, Inauthentic, and Yet Still Relevant. The Einstein Journal of Biology and Medicine. Vol.25, No 1. 2016. pp 41.44.

¹⁵⁵ Neal, M. How Relevant is the Hippocratic Oath in Guiding Physicians' Views on Physician-Assisted Suicide. University of Nebraska-Lincoln. 2020. pp 8-11.

achieve.¹⁵⁶ The supporters claim that euthanasia and other forms of end-of-life care are sympathetic options for terminally ill patients enduring unbearable suffering. They argue that interpreting the Hippocratic Oath allows for such liberties, physicians are obligated to "first do no harm," and allowing individuals in distress to continue living could be considered harmful. In addition, the advocates of the right-to-die movement believe that everyone should have autonomy over their own bodies and must not undergo unnecessary suffering. Opponents, on the other hand, argue that euthanasia violates the ethical standards and personal dignity of human life. They assert that physicians have a vital obligation to preserve life at all costs while providing palliative care to alleviate symptoms without hastening death. The critics use the Oath as evidence against assisted dying practices on moral grounds. There are additional disagreements regarding the definition of "intolerable" suffering.¹⁵⁷

Traditionally, the Hippocratic Oath has emphasized the principle of non-maleficence, which by its very nature means that all medical personnel must avoid harming the patient, and obliges doctors to prioritize the patient's well-being. At this point, however, it could be debated whether the forced prolongation of a substandard end-of-life (e.g., in the case of palliative care) meets Oath's core values.¹⁵⁸ Is the desperate retention of a terminally ill person, although he does not want it himself, but because the Hippocratic Oath demands it, sufficient justification for violating a person's fundamental right, the right to self-determination? Isn't this a clear cause of harm, which the Oath itself forbids? The right to self-determination, as repeatedly noted in the work before, emphasizes the patient's right to make independent decisions about his health and well-being. At this point, the duty of the doctor and the right of the patient are confronted. Which of them occupies a higher place in the hierarchical pyramid? Both elements are clearly separate and independent, and have no direct legal connection, but their purpose is common: the well-being of the patient, and so both concepts are appropriate when discussing the ethical and legal issues surrounding end-of-life care. Here again, the question arises that if both the patient and the doctor have a different vision of "well-being" (the doctor's primary duty to keep the patient alive, regardless of whether the patient wants it, and the patient's right to self-determination), is it at all appropriate to proceed from the Hippocratic Oath as "legally non-binding guidelines", if it is compared to a person's universal right to self-determination.

¹⁵⁶ Kasman, N.M. Ethics and Euthanasia. Augustana College. 2018. pp 3-4.

¹⁵⁷ Neal, M. How Relevant is the Hippocratic Oath in Guiding Physicians' Views on Physician-Assisted Suicide. University of Nebraska-Lincoln. 2020. pp 13-20.

¹⁵⁸ Halloran, K. Ethics of Euthanasia and Physician Assisted Suicide. Merrimack College. 2022. pp 13-15.

Medical ethics and medicine in general have evolved since Hippocrates' time. Currently, there is much focus on the development of palliative medicine. Several programs aimed at preserving the quality of life for patients with terminal illnesses are currently being developed. Such efforts will enable these individuals to live to their natural end without enduring excruciating pain. Nevertheless, not all agony can be relieved and released. It is true that the margin for error is thin, but it should be always kept in mind that no one has the right to establish what kind of suffering is tolerable while other ones are not. Therefore, the legalized euthanasia is recommended, and the corresponding legislation allowing euthanasia is enforced, while following the example of States which already have these kinds of regulations.¹⁵⁹

The “do no harm” obligation of doctors should also be placed under significant consideration. This principle can be interpreted, among other things, as meaning that the prolongation of a patient's life if he suffers unbearably, he is terminally ill, his quality of life no longer corresponds to a full and liveable life, or he has been "predicted" only a certain amount of time, which he has to wait for when suffering, without the possibility of avoiding this agony (including the use of assisted methods of dying), can be considered harmful, since it can cause unnecessary physical or emotional suffering to the patient. The principle of non-malice does not only derive from the Hippocratic Oath, but this fundamental ethical principle is also regulated and recognized by a number of (European) laws and regulations. For example, the right to the integrity of the person is recognized and the use of treatment without the informed consent of the patient is prohibited, as well as by prohibiting any form of excruciating and inhuman treatment in Article 3 of the ECHR.¹⁶⁰ The EU Medical Device Regulation¹⁶¹ and the EU Clinical Trials Regulation¹⁶² establish requirements for the safety and performance of medical devices and clinical investigations, with the aim of ensuring that they do not harm patients. They also include provisions on conduct, safety oversight, side effects and informed consent. It can also be interpreted in such a way that if the treatment does not produce a result, the patient's interests and autonomy could be seen in order to stop keeping him alive. The obligation not to harm patients is also regulated, for example, by the European Convention on

¹⁵⁹ Alhazmi, F. *The Ethical Challenge of Conflicts of Interest in Healthcare*, Duquesne University. 2019. p 153.

¹⁶⁰ See the Guide on Article 3 of European Convention on Human Rights: Prohibition of Torture by European Court of Human Rights (2022) here: https://www.echr.coe.int/Documents/Guide_Art_3_ENG.pdf

¹⁶¹ Regulation (EU) No 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices. The European Union Medical Device Regulation.

¹⁶² Regulation (EU) No 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use. The European Union Clinical Trials Regulation.

Human Rights and Biomedicine¹⁶³ (requirements for privacy, protection of confidentiality, respect for human dignity) and is the main objective and focus of work on, for example, the European Agency for Treatment (EMA) and the European Union Network for Patient Safety and Quality of Care (PaSQ). Those who interpret the Hippocratic Oath as being consistent with euthanasia argue that the primary duty of the physician is to relieve the suffering of the patient, and that if all other options have been exhausted and the patient is still experiencing unbearable suffering, then euthanasia may be the most compassionate course of action. They also argue that the principle of autonomy, which is emphasized in modern medical ethics, requires that patients be allowed to make decisions about their own medical care, including the decision to end their own life.

This interpretation, that physicians' basic duty of "do no harm" could extend to euthanasia laws that would make assisted dying more accessible to patients, has been heavily criticized by opponents. The argument they make (see, for example, the case of *Glucksberg*¹⁶⁴ and *Gonzales v. Oregon*¹⁶⁵) relies on the traditional conception of medicine and the fear that physician participation in assisted dying could jeopardize the medical purpose of healing. It must be emphasized, meanwhile, that physicians' understanding of "do no harm" has evolved over time. The 1964 version of the Hippocratic Oath¹⁶⁶ does not contain the original language prohibiting physicians from prescribing lethal medications. Instead, it states, "*If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness.*" The argument they make (see, for example, the case of *Glucksberg and Gonzales*) relies on the traditional conception of medicine and the fear that physician participation in assisted dying could jeopardize the medical purpose of healing. It must be emphasized, meanwhile, that physicians' understanding of "do no harm" has evolved over time. The 1964 version of the Hippocratic Oath does not contain the original language prohibiting physicians from prescribing lethal medications. Instead, the Oath states, "*All gratitude if I am able to save a life. It may also be within my power to end a life; I must approach this immense responsibility with great humility.*" The amendments to the Hippocratic Oath reflect a recurring concept: the evolution of the purpose and scope of medicine, as well as the physician's function, as time and technology improves. These modifications raise even

¹⁶³ Convention on Human Rights and Biomedicine. Council of Europe. Oviedo, 04.04.1997.

¹⁶⁴ *Washington v. Glucksberg*. 521 U.S. 702.1997.

¹⁶⁵ *Gonzales v. Oregon*. 546 U.S. 243. 2006.

¹⁶⁶ Different Physician Oaths can be found here: <https://www.aapsonline.org/ethics/oaths.htm#lasagna>

more concerns regarding the appropriate scope of the medical profession. Concerns that are relevant to the aid in dying (hereinafter AID) discussion. A major improvement to the Hippocratic Oath, for instance, is the elimination of language prohibiting physicians from assisting in abortions.¹⁶⁷ The original Oath pledged not to "give a woman a pessary to procure an abortion," but this language has been completely removed from the modern version and substituted with language regarding life and death. The modern iteration of the Oath (1964) demonstrates how adjustments in public opinion and professional behaviour have led to the evolution of formal professional standards. Currently, public opinion and professional standards are shifting in regard to AID, and if the same pattern occurs as it did with abortion, professional standards regarding AID may soon change as well, mirroring the recent public practice to legalize AID.¹⁶⁸

3.3. The Rule of Double Effect in End-of-Life Care

Patients who have been diagnosed with an incurable or protracted condition or disease may feel the need to be able to control their pain and torment and coordinate the last time of their lives as tolerable as possible.¹⁶⁹ The rule of double effect, also known as the doctrine of double effect (hereinafter DDE) seeks to address situations where administering medication with the intent to relieve pain might lead to death, but allows for it under specific circumstances. The DDE provides guidelines for healthcare providers who administer drugs knowing full well that they may result in death while intending only palliative outcomes.¹⁷⁰ This doctrine, in any of its various formulations, establishes guidelines that dictate that harm (in an instance, the patient's death) could be permissibly caused as an unintended side-effect of a physician's voluntarily taken action, even though it would be wrong for the physician intending directly to cause that harm.¹⁷¹ The doctrine is used as an ethical guard, and its values mean that end-of-life sedation is permissible because it allows both the patient and the patient's family to authorize the final mode of care and manage and regulate the patient's pain while causing the

¹⁶⁷ The Oath was referred in the landmark case *Roe v. Wade* (case that legalized abortion in the U.S.) against the healthcare providers.

¹⁶⁸ Warwick, J. A Delicate Balance: Rethinking the Physician's Role in Physician Aid-in-Dying. *UC Irvine Law Review*. Vol.12. 2022. pp. 1420-1421.

¹⁶⁹ Alhazmi, F. The Ethical Challenge of Conflicts of Interest in Healthcare, Duquesne University. 2019. p 128.

¹⁷⁰ Thomson, B.A. Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom be Laid to Rest? *Vanderbilt Journal of Transnational Law*. Vol.33, Iss.4. 2000. pp. 1041-1044.

¹⁷¹ Latram, S.R. Aquinas and Morphine: Notes on Double Effect at the End of Life. *DePaul Journal of Health Care Law*. Vol.1, Iss.3.1997. p 627.

least amount of harm to the individual and their family.¹⁷² While this principle can provide helpful guidance when making challenging decisions about end-of-life care, applying it within the context of euthanasia remains debatable due to potential legal, ethical, and social implications-highlighting why one needs profound consideration before taking any action on this matter.¹⁷³

When examining the ethical implications of euthanasia, it is crucial to take into account specific moral guidelines. The rule of double effect can provide a workable solution in cases where ending one's life is being considered as it permits pain and suffering relief while still adhering to the ethical principle of non-maleficence. This doctrine validates an action that has both positive and negative outcomes if certain prerequisites are fulfilled:

- 1) Acceptable-end condition: The bad effect must not be intended as the end or goal of the act.
- 2) Acceptable-means condition: The bad effect must not be intended as a means to the good effect.
- 3) Acceptable-act condition: The act must not be bad in itself (independently of it causing the bad effect).
- 4) Proportionate-reason condition: The agent must have a proportionately serious moral reason for performing the act (i.e., at least as serious a reason to pursue the good act and/or effect as to avoid the bad effect).

As with other ethical principles, the principle of double effect is not a magic formula that simplifies all of the complex medical decisions. To adequately apply the principle, one must be competent and the particulars of the situation at hand must be fully analysed. As with several areas of life, decision-making at the end of life can be complex. This demonstrates the validity

¹⁷² Thomson, B.A. Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom be Laid to Rest? *Vanderbilt Journal of Transnational Law*. Vol.33, Iss.4. 2000. pp. 1041-1044.

¹⁷³ Alhazmi, F. *The Ethical Challenge of Conflicts of Interest in Healthcare*, Duquesne University. 2019. pp 128.

of Aristotle's dictum that acting well requires prudence.¹⁷⁴ Nonetheless, some critics oppose its implementation in scenarios involving euthanasia since such practices are deemed unprincipled because they involve causing harm or death intentionally even when motivated by compassion.

Imagine the only substance capable of easing the suffering of a dying patient caused his death an hour later. Would use this drug to alleviate a patient's distress be morally distinct from assisting their death? Intuitively, patients should be treated as they are looking for, given that the law, which protects all individuals, enables it. In this case, the doctrine has no influence on euthanasia. A physician does not commit a crime when she harms or helps the patient die for his benefit. If the patient determines that, the benefit outweighs the harm.¹⁷⁵ When contemplating euthanasia and the rule of double effect, understanding the concept of intention is crucial in navigating its complex ethical considerations. The intention plays a pivotal role in determining whether an action can be considered euthanasia or a legitimate use of the rule of double effect. Some have asserted that healthcare providers can avoid legal responsibility for death initiated by an end-of-life decision if they are in accordance with the double effect doctrine. Nonetheless, many legal scholars deny this interpretation of the law. They argue that intent is crucial in situations where the law requires a *Mens Rea*, or guilty mind. In homicide, for instance, it distinguishes between murder and manslaughter. In order to establish the former, the State must prove that the accused intended either death or serious bodily injury. If he did not, the less serious charge of manslaughter applies. This non-idiomatic legal concept of intent has evolved through case law.¹⁷⁶ As such, clear communication and ethical decision-making are essential when dealing with end-of-life care. Nevertheless, relying on subjective intentions can pose challenges that lead to harsh punishments due to institutions' all-or-nothing approaches towards these issues. When comparing DEE and euthanasia, the question inevitably arises as to whether such "indirect killing" is really more acceptable in society than carrying out euthanasia at the request of the patient. It seems ironic at times that when doctors are forbidden to end a patient's life as a medical aid, it's forbidden and less moral than the patient's death as a "side effect," so to speak, by allowing various treatments that alleviate the patient's symptoms but shorten life. It is contrary to the general interest to accept euthanasia and other

¹⁷⁴ Giebel, H. Double Effect and Ethical End-of-Life Care: Assessing the Benefits and Burdens of Lethal Treatment (or Lack Thereof). *Solidarity: The Journal of Catholic Social Thought and Secular Ethics*. Vol.6, Iss.1. 2016. pp 2-3.

¹⁷⁵ Shaw, A.B. Two Challenges to the Double Effect Doctrine: Euthanasia and Abortion. *Med Ethics*. 2002.

¹⁷⁶ Allmark, P., Cobb, M., Liddle, B.J., Tod, A. Is the Doctrine of Double Effect Irrelevant in End-of-Life Decision Making? Sheffield Hallam University. pp 5-6.

forms of assisted death, but this deprives the patient of benefits. Compared to euthanasia, the principles of doctrine do not allow for the deliberate termination of a patient's life, even if it is the patient's own central desire, and such an act would only be sympathetic. However, it allows for the use of all kinds of therapeutic measures that could potentially reduce the patient's pain in the short term but thereby accelerate death. Such an action inevitably seems selective and arbitrary. The ban on euthanasia stems from the belief that direct assistance to death is fundamentally wrong, but the desperate preservation of a substandard life is not. At this point, it would be morally and in accordance with human rights to let the patient choose his end-of-life treatment in accordance with his or her values and to allow the procedure. It is difficult for society to accept a change in customs based on moral principles. But perhaps the legislature should look at the experiential and pragmatic nature of a patient's end-of-life care rather than ethical beliefs.¹⁷⁷ This debate's intricate nature calls for careful consideration from various parties involved in end-of-life decisions: medical professionals, caregivers, patients, families and policymakers alike must work together closely.

¹⁷⁷ Shaw, A.B. Two Challenges to the Double Effect Doctrine: Euthanasia and Abortion. *Med Ethics*. Vol.28, No. 5. 2002. pp 102-104.

IV. ENSURING HUMAN RIGHTS IN EUTHANASIA: ETHICAL AND MORAL CONSIDERATIONS

4.1. Navigating Cultural and Religious Beliefs: The Influence on Views of Euthanasia and Human Rights

The right to hold a belief is absolute. This is regulated, for example, by the Charter of the European Union (Article 10), the ECHR (Article 9) and the ICCPR (Article 18). The State may not interfere with an individual's right to independently develop their beliefs and morals. But when religious belief is manifested or applied in action, it departs the realm of absolute protection and can be subject to legitimate limitations, because it may impact other individuals. Hence, the right to religious freedom does not always provide the right to act freely in accordance with one's religious beliefs (see *Pretty Case*).¹⁷⁸

Decisions at the end of life, such as euthanasia and human rights, are strongly influenced by cultural and religious beliefs. Such beliefs not only influence the views of individuals but also the legal frameworks and policies surrounding them. The interaction between diverse cultural and religious perspectives on euthanasia is extraordinarily complex, with various levels of impact relying on the particular faith. Respecting cultural diversity while protecting vulnerable groups is essential as we work to develop appropriate policies for this complicated issue.¹⁷⁹ Issues regarding the legalization of euthanasia frequently involve matters of personal faith, whether it is belief in the "sanctity of life" or belief in "personal autonomy" and one's freedom in selecting euthanasia or any other form of assisted dying. Consequently, recognizing diverse perspectives on medical options or palliative care from diverse backgrounds can aid healthcare providers in providing more effective interventions for patients who might experience challenging end-of-life decisions. It would be irresponsible to disregard the influence of cultural and religious beliefs on legal policies, given that they affect our perception of fundamental human rights issues. When drafting laws regulating euthanasia, it is necessary to take into account the fundamental right in question, so that people, faith and attitude towards the sanctity of life do not constitute an obstacle to participation in end-of-life processes, insofar

¹⁷⁸ Australian Human Rights Commission. *Euthanasia, Human Rights and the Law*. Issues Paper. 2016. pp 33-34.

¹⁷⁹ Religion and Human Rights. *Religious Impact on the Right to Life in Empirical Perspective*. 2016. p 2.

as it is a violation of this right. This situation mainly arises, for example, in the case of the personal convictions of medical personnel.¹⁸⁰

Some religions consider death as a natural consequence of existence that should not be interfered with. Others view it as a catastrophe that must be avoided at all costs. Regarding issues such as the value of life and suffering, religious beliefs vary. These opposing viewpoints illustrate how cultural norms and religious convictions substantially influence attitudes toward assisted suicide and euthanasia, among other end-of-life care practices.¹⁸¹ The author then discusses the beliefs of the major religious groups in relation to euthanasia and the right to die.

Buddhists place a high value on (human) life and have a deep reverence for life in general, regardless of its quality. Buddhism teaches that it is immoral to terminate human life, including one's own, even if that life is not lived in ideal physical or mental health, and that euthanasia would be a solution to alleviate suffering. Buddhists view death as an inevitable aspect of existence, which is also characterized by suffering. As far as the Buddhist principle "life must not be taken" prohibits euthanasia, Buddhists are opposed to the practice.¹⁸² It is believed that addressing euthanasia in end-of-life decisions results in bad karma.¹⁸³ However, it is believed that life does not need to be preserved at all costs by employing unreasonable and burdensome measures. A person who is ill, for instance, should not be treated recklessly. Buddhism places an emphasis on compassion and non-harm in every aspect of life.¹⁸⁴ This can be interpreted as meaning that although Buddhists should have access to all forms of treatment, their faith does not prohibit ceasing treatment if it becomes unreasonable. Furthermore, euthanasia in the context of Buddhism can be viewed as an empathetic method for relieving the suffering of a terminally ill and tormented person when its main goal is not to harm or kill the patient. The majority of Buddhists believe that euthanasia and AIDS ought to be applied as a last resort when alternatives (such as palliative care) have been proven to be insufficient. Additionally, the debate on the "right to self-determination versus religious beliefs" tends to favour the patient's own moral and spiritual beliefs. Therefore, the Buddhist position is, in basic terms,

¹⁸⁰ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. pp 33-34.

¹⁸¹ Religion and Human Rights. Religious Impact on the Right to Life in Empirical Perspective. 2016. 2.

¹⁸² Perrett, R.W. Buddhism, Euthanasia and the Sanctity of Life. Journal of Medical Ethics. Vol.22. 1996. pp 309-313.

¹⁸³ Borah, S. Euthanasia- Right to Die, a Buddhist Outlook. Philosophical Journal of JB College. 2023. pp 5-6.

¹⁸⁴ Phutchu, S. Euthanasia: the Buddhist Hermeneutics in the 21st Century. The Journal of International Buddhist Studies College. Vol.7. 2020. pp 108-109.

that there is no moral impediment to making end-of-life decisions so long as "life is not taken."¹⁸⁵

In any circumstance, the Catholic Church does not recognize euthanasia or any other form of assisted dying. Catholics believe that human life is most sacred and must be protected until its natural end, regardless of suffering and (fatal) diseases that can leave a person tormented for an extended period of time. Catholic teachings prohibit intentional killing and prioritize life because life is a gift from God and its end must also be determined by God.¹⁸⁶ To the extent that Catholics fear the end of life and do not want to deal with it, it may occur that terminally ill and aching patients are left alone by their families, causing them to feel hopelessness and loneliness, which can lead to a decision to end their lives. Catholicism prescribes that, in this case, the individual may utilize alternative therapies, such as palliative care or psychological therapy. However, Catholics concede that abandoning marginally life-prolonging emergency treatment measures may be morally permissible in certain circumstances (such as in the case of a dying individual).¹⁸⁷ Yet, this is only the case if the treatment does not offer a reasonable chance of physical or mental benefit, such as resuscitating a patient at the very end of their life. Catholic medical professionals may find it difficult to reconcile their religious principles with the wish to alleviate someone's suffering through euthanasia when faced with end-of-life decisions.¹⁸⁸

Hinduism is the world's third-largest religion and compared to Christianity, Islam and Buddhism, there is less discussion of and uniformity of beliefs on the morality. Their beliefs largely touch on the spiritual issues of life, rebirth, and continued existence. Hindus believe that life does not begin with birth or end with death, but the soul is in a constant and eternal cycle of birth, death and rebirth. In Hinduism, the prohibition of death plays an important role, insofar as the followers of this religion respect all living things.¹⁸⁹ Although euthanasia is not regulated in Hindu teachings, it is not acceptable according to the principles of Hinduism (karma, balance, justice, non-violence). Premature termination of life, according to these teachings, has a negative effect on karma. The concept of karma is based on the belief that all

¹⁸⁵ Pew Research Center. Religious Groups' Views on End-of-Life Issues. 2013. pp 1-2.

¹⁸⁶ United States Conference of Catholic Bishops. To Live Each Day with Dignity; A Statement on Physician-Assisted Suicide. 2011. p 1.

¹⁸⁷ Pew Research Center. Religious Groups' Views on End-of-Life Issues. 2013. pp 2-3.

¹⁸⁸ United States Conference of Catholic Bishops. Assisted Suicide and Euthanasia: Beyond Terminal Illness. 2012. pp 2-5.

¹⁸⁹ Best, M., Grove, G., Lovell, M. Perspectives of Major World Religions regarding Euthanasia and Assisted Suicide: A Comparative Analysis. Journal of Religion and Health. Griffith University. 2022. pp 18-20

the good and bad things in life are caused by actions done in previous lives, and the use of euthanasia would most likely lead to a lot of suffering in the next life, and postponing karma will increase suffering even more.¹⁹⁰ However, Hindu scripture can also be interpreted in such a way that very exceptional circumstances can justify speeding up death when it is necessary to preserve human dignity or minimize harm. For example, in a fatal illness, accelerating death through euthanasia can restore compassion. Nevertheless, modern Indian culture and its legal system are clear when criticizing AID.¹⁹¹

The Muslim scripture Qur'an and other sources are perhaps the strictest in terms of euthanasia and assisted dying, and these practices are not acceptable in any interpretation of the religion in question. The minimal discussion of AID includes passages on Allah's authority, human dignity, life, perseverance, death, and paradise, and these passages provide clear guidance on the interpretation of Islam, which is strongly aided against dying in every context, considering it a forbidden murder.¹⁹² According to Islamic teachings, life is sacred and comes from God, and therefore it is a sin to take life, insofar as God alone decides how long someone lives and when and in what way he dies. When it comes to suffering and torment, there is a perception that only God knows what is good for a person, and difficulties can also be useful in testing one's faith. Muslims also consider suffering a "purification" of their sins, which they must redeem before they come before God.¹⁹³ On the other hand, there is a general understanding among Islamic followers that the terminally ill do not have to use emergency means and technologies to delay dying, so the possibility of refusing treatment can be considered here.¹⁹⁴ This issue highlights the fundamental conflict between individual autonomy and societal values. The interaction between these factors and the legal restrictions surrounding euthanasia have sparked heated debates regarding human rights. Examining how various cultures perceive death can provide valuable insight into why some communities are more accepting of euthanasia than others. To bridge the cultural divide surrounding end-of-life care issues such as euthanasia, it is necessary to conduct awareness-raising campaigns intended at promoting understanding of diverse cultural and religious perspectives.

¹⁹⁰ Pew Research Center. Religious Groups' Views on End-of-Life Issues. 2013. p 4.

¹⁹¹ Best, M., Grove, G., Lovell, M. Perspectives of Major World Religions regarding Euthanasia and Assisted Suicide: A Comparative Analysis. Journal of Religion and Health. Griffith University. 2022. pp 18-20.

¹⁹² *Ibid.* pp 15-18.

¹⁹³ Pew Research Center. Religious Groups' Views on End-of-Life Issues. 2013. pp 4-5.

¹⁹⁴ Aramesh, K., Shadi, H. Euthanasia: An Islamic Ethical Perspective. Medical Ethics and History of Medicine Research Center. Vol.6, Suppl.5. 2007. pp 37-38.

4.2. Voices from the Margins

One of the biggest concerns of the State is certainly the protection of vulnerable populations from the abuse of AID. It is essential not to discriminate against individuals based on their physical or mental health status¹⁹⁵ at the end of life when providing healthcare. To fully comprehend how best to address these issues related to the rights of marginalized populations within the context of euthanasia debates, it is necessary to conduct an ethical analysis alongside the development of legitimate frameworks that guarantee everyone meets their needs without exception through the implementation of appropriate measures by societies, ultimately leading to the fair treatment of every citizen. The availability of high-quality end-of-life care services is frequently obstructed for these individuals by a variety of obstacles and challenges.¹⁹⁶ Critics argue that by legalizing euthanasia (and other forms of assisted dying) and making it available, the potential risk of pressuring and influencing the elderly, people with disabilities, and the poor in end-of-life situations is raised. Such an influence may be driven by the patient's desire to spare their loved ones and physicians the significant financial burdens of end-of-life healthcare costs, and not by the patient's genuine desire for autonomy in dying. In order to avoid such situation, it is necessary to clearly and strictly regulate the availability and the patient's suitability by proportional safeguards which must be effectively supervised by the State. In defence of their arguments, proponents of euthanasia have put forward the assumption that it is mostly likely that patients seeking euthanasia are primarily insured and educated, and therefore their decisions are more thoughtful, they are able to better understand their options and are less vulnerable to external influences. For example, financial pressure falls away if having health insurance. A study conducted in the US (“2020 Data Summary from Oregon”) analysed data reports on AID participants and the sources of influence of their end-of-life decision (see results table below). Although the main reason for assisted dying was the loss of autonomy among patients and a decrease in quality of life, as a result of which patients were no longer able to engage in activities that made their lives enjoyable, significant external influences, i.e., patients' fear of remaining a burden on their families and doctors, cannot be ignored. Based on the results of this investigation, it can be argued that the risk that the end-of-life decision made by patients is not unaffected by external influences is clearly present and

¹⁹⁵ See the Lambert Case above. ECtHR, 46043/14, *Lambert and Others v. France*.

¹⁹⁶ United Nations Network on Racial Discrimination and Protection of Minorities. Guidance Note on Intersectionality, Racial Discrimination & Protection of Minorities. 2022. p 20.

quite high.¹⁹⁷At this point, the question again arises: could such a fact, that the terminally ill and tormented patient does not wish to be burdensome to his loved ones and therefore end his life with the help of euthanasia, fall within the scope of human autonomy and the right to self-determination? From the point of view of the author, this question of interpretation should be answered in the affirmative, because although it is an external influence, the central part of this question is still the patient himself.

	Oregon	Washington
Availability of health insurance	100%	97%
Higher (College) Education	71,8%	76%
External sources of influence	53,1%	58,6%
Loss of autonomy	93,1%	89,6%
External sources of influence	94,3%	90,6%

Figure 1. The results of the 2020 data summary from Oregon about the participants of euthanasia and their influences. *Source: “Delicate Balance: Rethinking the Physician’s Role in Physician Aid-in-Dying” by J.A. Warwick.*

To describe this discussion at the legal level, the author now discusses one of the most important documents that protects the main marginalized group, people with disabilities. The Convention on the Rights of Persons with Disabilities¹⁹⁸(hereinafter CRPD) obliges Member States (including all countries with a primary focus of work) to ensure that persons with disabilities are allowed to enjoy all human rights, without discrimination of any kind. This means that States must take all necessary measures to protect the right of persons with disabilities to exercise their rights on an equal basis with others. Disability within the meaning of that convention refers to a person's impairment linked to various obstacles limiting a person's actual participation in society on an equal basis with others. There is no explicit definition of disability in this document, but it must be interpreted as meaning that persons with disabilities include those who have a long-term intellectual disability. When analysing the CRPD in the context of euthanasia, the most relevant provision is Article 25. It specifically prohibits Member States from discriminating against healthcare or health services or food and fluid on

¹⁹⁷ Warwick, J. A Delicate Balance: Rethinking the Physician’s Role in Physician Aid-in Dying. UC Irvine Law Review. Vol.12. 2022. pp 1427-1428.

¹⁹⁸ The Convention on the Rights of Persons with Disabilities. The United Nations General Assembly. New York, 13.12.2006.

the basis of disability. Article 10 of the CRPD determines the right to life of persons with disabilities (Article 2 ECHR). In the light of these provisions, States are obliged to ensure that national laws do not allow involuntary euthanasia for people with disabilities. The free and informed consent of the person concerned is essential for decisions concerning the physical and mental integrity of persons with disabilities. This mostly concerns the treatment provided, which people with disabilities must be able to use or even refuse if they so wish. The treatment of persons with disabilities without their consent, for example in the case of forced treatment, violates Articles 17 (protection of the integrity of the person), 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), 12 (equal recognition before the law) and 16 (prohibition of exploitation, violence and abuse) of the CRPD. The legislator must ensure that doctors respect the legal capacity of patients with disabilities in their decision-making in all circumstances. Also, patients must be provided with any information about their condition and available (alternative) services, receiving comprehensive support and advice if necessary.¹⁹⁹

While the concept of assisted dying may appear to be a compassionate measure, it can raise concerns about coercion and discrimination against vulnerable communities in our society. Individuals who face societal or financial challenges, for instance, may feel compelled to choose euthanasia due to an absence of resources or support mechanisms. In addition, there have been cases in which patients from minority groups have complained of experiencing discriminatory end-of-life care decisions based on cultural stereotypes or misconceptions.²⁰⁰ This entails requiring multiple independent reviews prior to validating requests for euthanasia in order to ensure that sufficient safeguards are in place to protect those who could be abused. It also involves promoting educational programs aimed at reflecting healthcare providers about any potential biases they might have toward specific patients.²⁰¹ Any public policy should prioritize avoiding the possibility of harm and ensure that no one's life is taken without their consent. Thus, it is crucial that legislators evaluating euthanasia regulations take into account the potential negative effects that these policies could have on disadvantaged groups while balancing individual autonomy over death with concerns regarding inequality and power dynamics in the society we live in. It is essential that euthanasia shall not be considered a

¹⁹⁹ Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. pp 32-33.

²⁰⁰ Battin., M.P. Physician-Assisted Dying and the Slippery Slope: The Challenge of Empirical Evidence. 2008. Willamette Law Review. Vol.25, No.1. 2008. p 104.

²⁰¹ *Ibid.* pp 128-131.

panacea, but instead as part of a broader discussion about end-of-life care for all members of society, regardless of their health or ability status. Enhanced education campaigns and consciousness-raising efforts could raise better understanding and empathy for those who face particular difficulties during their final stages of life, allowing them to receive equal treatment regardless of their social status. Moreover, access to high-quality end-of-life care should be a fundamental entitlement for all people, regardless of social status or health condition.²⁰²

²⁰² United Nations Network on Racial Discrimination and Protection of Minorities. Guidance Note on Intersectionality, Racial Discrimination & Protection of Minorities. 2022. p 20.

CONCLUSION

A person's right to die is still, and is likely to continue to be, a fiery, very heated contentious subject. This debate calls for the delimitation of personal autonomy in such a way that competing interests and personal autonomy and the right to self-determination are balanced with competing rights and interests. The need to regulate euthanasia is clearly visible among European countries, as the quality of human life is becoming the focus of medical ethics and practice. The Netherlands and Belgium are a great example to other countries in terms of their euthanasia laws. Nevertheless, this is a relatively new practice and therefore strict monitoring by the relevant bodies is essential to ensure that national laws are in line with the European Convention on Human Rights. In the context of the Convention and the ICCPR, the right of an individual to die is concerned with the balancing of the right to life as laid down in Article 2 of the Convention and the right to private and family life under Article 8 of the Convention. The Human Rights Committee recommends *a priori* procedure for this case, while stressing that it is of the utmost importance to avoid the possibility of slippery slopes and the normalization of assisted dying when drafting euthanasia laws.

It is still unclear whether assisted dying and accelerating and contributing to someone's death to ensure personal autonomy and the right to self-determination outweigh the interests of others. In order to answer this question, the European Court of Human Rights has remained quite formal. The Court has left Member States a fairly wide margin of appreciation as to whether the State has positive responsibilities to protect human life, can be balanced by the expression of a person's autonomy (by a decision to end one's life at a time and in a manner of one's choice). In one of the first cases, *Pretty v. the UK*, the ECtHR stipulated that Article 2 of the Convention (right to life) cannot be interpreted as a completely contradictory right (the right to die). The State must criminalize the illegal taking of life, whilst applying effective and necessary measures to protect the lives of vulnerable people. Nevertheless, the Court confirmed that the right to choose the manner of death falls within the scope of Article 8 of the Convention, affirming the importance of personal autonomy and the right to self-determination. The right, therefore, must be guaranteed if it does not pose a threat to the interests of other (vulnerable) people. Although the Court did not uphold the violation of Article 8 (the right to choose how to die) by the State, inasmuch as it was, according to the circumstances of the case, "necessary in democratic society" to protect the rights of others, the

Court held that not allowing a physically incapable terminally ill patient to choose the manner of her death was discriminatory and therefore violated Article 14 of the Convention. The latter argument was also upheld by the Court in the case of *Haas v. Switzerland*, in which it held that the issuance of a lethal substance without a prescription as an exception was not justified, since the positive obligation of the State to protect life must, because of its sensitive subject, adopt and comply with strict protective measures. Such rulings are important to prevent possible slippery slopes and abuse of AID. Subsequent court cases show greater respect for personal autonomy. The right to die with dignity was affirmed by the Court in its judgment in the *Gross Case*, adding that this right is supplemented by the right to desire and receive assistance. In the case of *Lambert and Others v. France* set a significant precedent for the Court to withdrawal of treatment. He confirmed that the right of refusal of treatment (a form of euthanasia) is the matter of personal autonomy and right to dignity, even in cases where the patient is not able to communicate their wishes. All these cases are important for shaping the methods of interpretation for Member States, especially those that allow or decriminalize euthanasia, in the creation and regulation of legislation on euthanasia and PAS.

The very first judgment on euthanasia was delivered in 2022 in the case of *Mortier v. Belgium*. As a result, the Belgian Euthanasia Act and the procedure for conducting euthanasia were approved, thereby confirming that euthanasia and other forms of assisted dying are not contrary to Article 2 of the Convention (right to die) provided that adequate safeguards have been applied. This particular decision, despite criticism from opponents of euthanasia, that this decision turns a blind eye to Belgian abuses (slippery slope argument), establishing clear guidelines for end-of-life care and sparked a debate about whether euthanasia should be legalized anywhere in the world.

In its case-law, the Court has not affirmed the right to die as a general fundamental right under the Convention, but it has nevertheless confirmed that legalization and decriminalization euthanasia and assisted of dying are not contrary to the Convention, provided that adequate safeguards have been put in place during the euthanasia process and that national law excludes the abuse of AID (*Mortier v. Belgium*). The ECtHR has put in place legal measures that facilitate the regulation of euthanasia and strike a balance between personal autonomy and societal interests, while still leaving Member States a wide margin of discretion. Although there is no universal standard for euthanasia in Europe, it can be seen that policies are evolving towards greater autonomy in health decision-making.

However, when implementing and amending the law relating to euthanasia, it is necessary to take into account, among other things, the historical, institutional, political, cultural and social environment. Furthermore, it is not enough just to have a general assessment of society and a political opinion, but it is also important to identify and take into account the opinions of those who would perform euthanasia. Therefore, it is extremely important to pay attention to the current and also past medical ethics, including the content and requirements of the Hippocratic Oath, which is common among doctors. Nevertheless, doctors' understanding of the concept of "do no harm" has changed over time, and the recent version of the Hippocratic Oath (1964) does not contain the original language prohibiting doctors from prescribing lethal drugs or implementing therapeutic measures that accelerate death (the rule of double effect). Also, an important improvement in the Hippocratic Oath is the abolition of the ban on abortion. It is difficult for society to accept a change in customs based on moral principles, but nevertheless, legislators have begun to look at the experiential and pragmatic nature of patient end-of-life care (e.g., palliative care) rather than ethical beliefs.

When establishing laws on euthanasia, it is very important to take into account the interests of each group of society, and the legislator has an obligation to ensure that national laws reflect the beliefs of the respective cultural space. Therefore, it is imperative that marginalized groups are involved in the decision-making process so that there is no discrimination. The beliefs of religious groups also play a role in shaping the law, and article 9 of the Convention, which guarantees freedom of thought, conscience and religion, must be taken into account. Respect for cultural diversity, while protecting vulnerable groups, is essential for the development of appropriate policies. It would be irresponsible to ignore the influence of cultural and religious beliefs on legal policy, given that they affect the understanding of fundamental human rights issues. Different cultures, such as Buddhism, Catholicism, Hinduism and Islam, perceive death very differently, and this understandably creates conflict in the discussion surrounding euthanasia. In order to resolve this conflict, it is necessary to conduct awareness-raising campaigns.

While the concept of assisted dying may seem like a compassionate measure, it can raise concerns about coercion and discrimination against vulnerable communities in society. When introducing euthanasia laws, the legislator must prevent harm from occurring and negative impacts on disadvantaged groups, such as the disabled, the elderly and the poor. When

formulating euthanasia policies, it is of the utmost importance to balance individual autonomy over death with concerns about inequalities and power dynamics in society in order to avoid the violation of Article 14 of the Convention (prohibition of discrimination). Access to quality end-of-life care should be guaranteed for all people, regardless of their social status or health status.

The right to life does not (as a corollary) include a right to choose to die. But nor does it require a State to ensure that a person's life is protected when this is against the express wishes of that person. It cannot be talked about the fundamental "right to die", rather it is all about balancing of rights, the appropriate balance of which may be subject to competing views. The aforementioned problems are the biggest challenges facing the modern world in legalizing euthanasia. But what is the prospect for it in Europe in the near future? It is unlikely that the ECtHR would deviate from the procedural approach in the near future and introduce the right to die in enforcement jurisdictions where it has not yet been implemented in practice. Euthanasia is not yet gaining the value of a human right so soon (if ever, considering cultural differences, fear of slippery slope and the responsibility of medical personnel), but evolving medicine, technology and self-awareness will give a great impetus to the greater spread of euthanasia in Europe. Its predecessor can be considered, for example, the spread of the right to abortion, which is increasingly tolerated in Europe and has become an important right in the field of medicine and human rights. Effective and developed educational campaigns and programmes, awareness-raising efforts, the involvement of all social groups in decision-making processes, the implementation of strict protective measures, the creation of monitoring bodies are a way of ensuring the protection of society's values and the balance of competing interests in the implementation of euthanasia laws.

KOKKUVÕTE

Isiku õigus surra on endiselt ja tõenäoliselt jätkab olemist tuline väga tuline vaidlusalune teema. See arutelu nõuab isikliku autonoomia piiritlemist nii, et konkureerivad huvid ning isiklik autonoomia ja õigus enesemääramisele oleksid tasakaalus konkureerivate õiguste ja huvidega. Euroopa riikide seas on selgelt näha eutanaasia reguleerimise vajadust, kuivõrd inimelu kvaliteet on muutumas meditsiinieetika ja -praktika keskpunkti poole. Holland ja Belgia on oma eutanaasiaseaduste koha pealt teistele riikidele suureks eeskujuks. Sellegipoolest on tegemist küllaltki uue praktikaga ning seetõttu on range järelevalve relevantsete organite poolt ülimalt vajalik, et tagada siseriiklike seaduste kooskõla Euroopa inimõiguste ja põhivabaduste konventsiooniga. (EIÕK) Konventsiooni ja Kodaniku- ja poliitiliste õiguste rahvusvahelise pakti kontekstis puudutab isiku õigus surra õiguse elule, mis on sätestatud artiklis 2, ja õiguse privaat- ja eraelule, mis tuleneb konventsiooni artiklist 8, tasakaalustamist. Inimõiguste Komitee soovib selleks juhiks *a priori* menetlust, rõhutades seejuures, et eutanaasiaseaduste väljatöötamisel on äärmiselt oluline vältida „libeda tee“ tekkimise võimalikkust ning abistatud suremise normaliseerumist.

Endiselt on ebaselge, kas assisteeritud suremine ning seejuures kellegi surma kiirendamine ja sellele kaasa aitamine isikliku autonoomia ja õiguse enesemääramise tagamiseks kaaluvad üles teiste huvid. Sellele küsimusele vastuse andmiseks on Euroopa Inimõiguste Kohus (EIK) jäänud küllaltki formaalseks. Kohus on jättnud liikmesriikidele küllaltki laia kaalutusruumi, kas riigil lasuvad positiivsed kohustused inimelu kaitsta, on võimalik tasakaalustada isiku autonoomia väljendamisega (otsusega lõpetada oma elu vabalt valitud ajal ja viisil). Ühes esimeses kohtukaasuses *Pretty vs. Ühendkuningriik* sätestas EIK, et konventsiooni artiklit 2 (õigus elule) ei saa tõlgendada täiesti vastuolulise õigusena (õigus surra). Riik peab kriminaliseerima ebaseadusliku elu võtmise ning seejuures rakendama efektiivsed ja vajalikud meetmed haavatavate inimeste elu kaitseks. Sellegipoolest kinnitas kohus, et õigus valida oma surma viis kuulub konventsiooni artikli 8 ulatusse, kinnitades isikliku autonoomia ja õiguse enesemääramisele tähtsust, ning see peab olema tagatud, kui ei kujutata endast ohtu teiste (haavatavate) inimeste huvidele. Kuigi kohus ei kinnitanud artikli 8 (õigus valida kuidas surra) rikkumist riigi poolt, kuivõrd see oli kaasuse asjaolude kohaselt “demokraatlikus ühiskonnas vajalik” teiste inimeste õiguste kaitseks, otsustas kohus, et füüsiliselt võimetu lõplikult haigele patsiendile mittevõimaldamine valida oma surma viis, on diskrimineeriv ja rikub seega

konventsiooni artiklit 14. Viimast argumenti kinnitas kohus ka kaasuses *Haas v. Šveits*, kus EIK otsustas, et erandina surmava aine väljastamine ilma retseptita ei ole põhjendatud, kuivõrd riigi positiivne kohustus kaitsta elu peab oma tundliku teema tõttu võtma kasutusele ranged kaitsemeetmeid ja neid ka järgima. Sellised lahendid on olulised, et vältida võimalikku „libedat nõlva“ ning eutanaasia ja muuda assisteeritud suremise vormide kuritarvitamist. Järgnevad kohtukaasused näitavad seejuures isikliku autonoomia suhtes suuremat austust. Õigust väärilt surra kinnitas kohus oma kohtuotsuses *Gross* Kaasuses, täiendades, et seda õigust täiendab õigus soovida ja saada assisteerimist. Kaasuses *Lambert jt vs Prantsusmaa* tegi kohus märkimisväärse pretsedendi ravist loobumise teemal. Ta kinnitas, et õigus ravi katkestada (eutanaasia vorm) on isikliku autonoomia ja õiguse väärrikusele küsimus isegi juhul, kui patsient ei ole võimeline oma soove edastama. Kõik need kaasused on olulised liikmesriikidele, eriti eutanaasia dekriminaliseerinud ja lubanud riikidele, tõlgendamismeetodeid eutanaasia ja assisteeritud enesetappu puudutava seadusandluse loomel ning selle reguleerimisel.

Kõige esimene eutanaasiat puudutav kohtuotsus tehti 2022.aastal asjas *Mortier vs Belgia*. Selle tulemusena kiideti heaks Belgia Eutanaasia Seadus ning eutanaasia läbiviimise protseduur, kinnitades seejuures, et eutanaasia ega muud assisteeritud suremise vormid ei ole vastuolus konventsiooni artikliga 2 (õigus surra), kui on kohaldatud piisavad kaitsemeetmed. See konkreetne otsus, vaatamata eutanaasia oponentide kriitikale, et see otsus pigistab Belgia kuritarvitamiste suhtes silma kinni („libeda nõlva“ argument), kehtestades selged suunised elulõpu hoolduse kohta ning tekitas arutelu kas eutanaasia peaks olema legaliseeritud kõikjal maailmas.

Kohus ei ole oma praktikas jaatanud õigust surra kui konventsioonist tulenevat üldist põhiõigust, kuid sellegipoolest on ta kinnitanud, et eutanaasia ja assisteeritud suremise dekriminaliseerimine ei ole konventsiooniga vastuolus, kui eutanaasia protsessi vältel on kasutatud piisavaid kaitsemeetmeid ning siseriiklikud seadused välistavad eutanaasia ja assisteeritud suremise meetodite kuritarvitamise (*Mortier vs Belgia*). EIK on kehtestanud õiguslikud meetmed, mis hõlbustavad eutanaasia reguleerimist ning loob tasakaalu isikliku autonoomia ja ühiskondlike huvide vahel, jättes endiselt liikmesriikidele laia kaalutlusruumi. Kuigi Euroopas ei ole eutanaasia suhtes universaalset standardit, on näha, et poliitikad arenevad suurema autonoomia suunas tervishoiualaste otsuste tegemisel.

Eutanaasiaseaduste ja -regulatsioonide väljatöötamisel mängivad märkimisväärsed rolli nii ajaloolised, kultuurilised, institutsionaalsed, poliitilised, kui ka sotsiaalsed argumendid. Ei piisa vaid ühiskonna üldisest seisukohast ja poliitilistest hinnangutest, vaid oluline on kaasata otsustusprotsessidesse ka spetsialistid, kes potentsiaalselt hakkaksid eutanaasiat läbi viima arstid. Seetõttu on äärmiselt oluline pöörata tähelepanu praegusele ja ka varasemale meditsiinieetikale, sealhulgas arstide seas levinud Hippokratese vande sisule ja nõuetele. Sellegipoolest on arstide arusaam „ära tee kahju“ kontseptsioonist aja jooksul muutunud ning Hippokratese vande hiljutine versioon (1964) ei sisalda algkeelt, mis keelaks arstidel surmavaid ravimeid välja kirjutada või rakendada ravimeetmeid, mis kiirendavad surma (topeltagajärje doktriin). Samuti on Hippokratese vande oluline edasiminekuks abordi keelustamisest loobumine. Ühiskonnal on raske aktsepteerida moraalsetel põhimõtetel põhinevat tavade muutust, kuid sellegipoolest on hakanud seadusandjad vaatama pigem patsiendi elulõpuhoolduse kogemuslikku ja pragmaatilist olemust (nt palliatiivne ravi) kui eetilisi tõekspidamisi.

Eutanaasiaseaduste kehtestamisel on väga oluline võtta arvesse ühiskonna iga grupi huve ning seadusandjal on kohustus tagada, et siseriiklikud seadused kajastaksid vastava kultuuriruumi tõekspidamisi. Seetõttu tuleb otsustusprotsessi kaasata kindlasti ka marginaliseeritud grupid, et tagada ei esineks diskrimineerimist. Seaduste kujundamisel mängivad rolli ka religioonigruppide tõekspidamised ning arvestada tuleb konventsiooni artikliga 9, mis tagab inimese mõtte-, südametunnistuse- ja usuvabaduse. Kultuurilise mitmekesisuse austamine, kaitstes samal ajal haavatavaid rühmi, on oluline asjakohase poliitika väljatöötamisel. Oleks vastutustundetu jätta tähelepanuta kultuuriliste ja usuliste veendumuste mõju õiguspoliitikale, arvestades, et need mõjutavad arusaama põhilistest inimõiguste küsimustest. Erinevad kultuurid, näiteks budism, kristlus, hinduism ja islam, tajuvad surma väga erinevalt ning see tekitab arusaadavalt konflikti eutanaasiat ümbritsevas diskussioonis. Et seda konflikti lahendada, on vaja läbi viia teadlikkuse tõstmise kampaaniaid.

Kuigi assisteeritud suremise mõiste võib tunduda kaastundliku meetmena, võib see tekitada muret ühiskonna haavatavate kogukondade sunni ja diskrimineerimise pärast. Seadusandjal tuleb eutanaasiaseadusi kehtestades vältida kahju tekkimist ning negatiivse mõju avaldumist ebasoodsas olukorras olevatele rühmadele, näiteks puuetega inimesed, vanurid ja vaesed. Eutanaasiapoliitikat kujundades on ülimalt oluline tasakaalustada individuaalset autonoomiat surma üle murega ebavõrduse ja võimudünaamika pärast ühiskonnas, et vältida konventsiooni

artikli 14 (diskrimineerimisekeeld) riivet. Juurdepääs kvaliteetsele elulõpuhooldusele peaks olema garanteeritud kõigile inimestele, olenemata nende sotsiaalsest staatuses või tervislikust seisundist.

Õigus elule ei hõlma (sellest tulenevalt) õigust valida, kas surra. Kuid samuti ei nõua see, et riik tagaks inimese elu kaitse, kui see on vastuolus tema selgesõnaliste soovidega. Seetõttu ei saa rääkida põhiõigusest "surra", pigem on see seotud õiguste tasakaalustamisega, mille sobiv tasakaal võib sõltuda konkureerivatest vaadetest. Eelmainitud probleemid on suurimad väljakutsed, millega tänapäeva maailm eutanaasia legaliseerimisel silmitsi seisab. Kuid millised on selle väljavaated Euroopas lähitulevikus? On ebatõenäoline, et EIK võiks lähitulevikus kalduda kõrvale menetluslikust lähenemisest ning kehtestada õiguse surra rakendamise jurisdiktsioonides, kus seda veel praktikas rakendatud ei ole. Eutanaasia ei omanda veel niipea inimõiguse väärtust (kui üldse, arvestades kultuurilisi erinevusi, „libeda kalde“-hirmu ja meditsiinitöötajate vastutust), kuid arenev meditsiin, tehnoloogia ja eneseteadvus annavad suure tõuke eutanaasia suuremale levikule Euroopas. Selle eelkäijaks võib lugeda näiteks abordiõiguse levikut, mis on Euroopas aina enam tolereeritud ning muutunud üheks oluliseks õiguseks meditsiini- ja inimõiguste valdkonnas. Tõhusad ja arendatud hariduskampaaniad ja -programmid, jõupingutused teadlikkuse tõstmiseks, kõigi ühiskonnagruppide kaasamine otsustusprotsessidesse, rangete kaitsemeetmete rakendamine, järelevalveorganite loomine on viis, kuidas kindlustada eutanaasiaseaduste kehtestamisel ühiskonna väärtushinnangute kaitse ning konkureerivate huvide tasakaal.

BIBLIOGRAPHY

1. Allen, M.L. Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia. Brooklyn Law School. Brooklyn Journal of International Law. Vol.31, Iss.2, Art.5. pp 541-542. Retrieved from: (last visited 24.04.2023)
<https://core.ac.uk/download/pdf/228601912.pdf>
2. Allmark, P., Cobb, M., Liddle, B.J., Tod, A. Is the Doctrine of Double Effect Irrelevant in End-of-Life Decision Making? Sheffield Hallam University. Retrieved from: (last visited 22.04.2023) http://shura.shu.ac.uk/2341/2/NP_Resubmission_DDE_%232.pdf
3. Alhazmi, F. The Ethical Challenge of Conflicts of Interest in Healthcare, Duquesene University. 2019. Retrieved from: (last visited 20.04.2023)
<https://dsc.duq.edu/cgi/viewcontent.cgi?article=2768&context=etd>
4. American Nurses Association (ANA). Position Statement; the Nurse's Role When a Patient Requests Medical Aid in Dying. 2019. Retrieved from: (last visited 20.04.2023)
<https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-Statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf>
5. Aramesh, K., Shadi, H. Euthanasia: An Islamic Ethical Perspective. Medical Ethics and History of Medicine Research Centre. 2007. Retrieved from: (last visited 23.04.2023)
https://www.academia.edu/399232/Euthanasia_An_Islamic_Ethical_Perspective
6. Aznar, J. The Slippery Slope of Euthanasia. *Medicina e Morale*. Vol. 70, No. 1. 2021. Retrieved from: (last visited 22.04.2023) <https://www.observatoriobioetica.org/wp-content/uploads/2021/04/The-slippery-slope-of-euthanasia.pdf>
7. Australian Human Rights Commission. Euthanasia, Human Rights and the Law. Issues Paper. 2016. Retrieved from: (last visited 22.04.2023) <https://humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law>

8. Battin., M.P. Physician-Assisted Dying and the Slippery Slope: The Challenge of Empirical Evidence. 2008. Willamette Law Review. Vol.25, No.1. 2008. Retrieved from: (last visited 19.04.2023) <https://willamette.edu/law/resources/journals/review/pdf/volume-45/wlr45-1-battin-11-8-08.pdf>
9. Best, M., Grove, G., Lovell, M. Perspectives of Major World Religions regarding Euthanasia and Assisted Suicide: A Comparative Analysis. Journal of Religion and Health. Griffith University. 2022. Retrieved from: (last visited 23.04.2023) <https://research-repository.griffith.edu.au/bitstream/handle/10072/417874/Grove864714-Published.pdf?sequence=2>
10. Beširevic, V. The Discourses of Autonomy in the International Human Rights Law: Has the Age of a Right to Die Arrived? *Cuadernos Constitucionales de la Cátedra Fadrique Furió Ceriol* n° 62/63. 2008. Retrieved from: (last visited 22.04.2023) <https://www.corteidh.or.cr/tablas/r26747.pdf>
11. Borah, S. Euthanasia- Right to Die, a Buddhist Outlook. Philosophical Journal of JB College. 2023. Retrieved from: (last visited 23.04.2023) https://www.academia.edu/98333518/EUTHANASIA_RIGHT_TO_DIE_A_BUDDHIST_OUTLOOK
12. Council of Europe. Guide on the Decision-Making Process Regarding Medical Treatment in End-of-Life Situation. 2014. Retrieved from: (last visited 16.04.2023) <https://saocamilo-sp.br/assets/artigo/bioethikos/155563/A11.pdf>
13. Dignitas. Review of the Year 2022 and Outlook for 2023. Zurich-Forch, 01.03.2023. Retrieved from: (last visited 23.04.2023) <https://wfrtds.org/swtizerland-dignitas-publishes-report-on-2022-and-outlook-for-2023/>
14. De Hert, M., Loos, S., Van Assche, K. The Belgian Euthanasia Law Under Scrutiny of the Highest Courts. The Lancet Regional Health-Europe. Vol.24. 2022. Retrieved from: (last visited 16.04.2023) [https://www.thelancet.com/pdfs/journals/lanepi/PIIS2666-7762\(22\)00245-9.pdf](https://www.thelancet.com/pdfs/journals/lanepi/PIIS2666-7762(22)00245-9.pdf)

15. English, R. Withdrawal of Nutrition and Hydration Would Not Offend Right to Life. Strasbourg Court, UK Human Rights Blog 2015. Retrieved from: (last visited 22.04.2023) <https://ukhumanrightsblog.com/2015/06/16/withdrawal-of-nutrition-and-hydration-would-not-offend-right-to-life-strasbourg-court/>
16. Engström, A. A Human Right to Die? The Legality of Euthanasia Under the European Convention on Human Rights. Örebro University. *Juridicum*. 2020. Retrieved from: (last visited 22.04.2023) <https://www.diva-portal.org/smash/get/diva2:1476405/FULLTEXT01.pdf>
17. Europe's Top Human Rights Court Rules: Belgium Violated Right to Life in Euthanasia Case. ADF International. 2022. Retrieved from: (last visited 16.04.2023) <https://adfinternational.org/tom-mortier-ruling/>
18. European Centre for Law & Justice. Written Observations Submitted to the European Court of Human Rights in the Case of *Mortier v. Belgium*. 2019. Retrieved from: (last visited 16.04.2023) <http://media.aclj.org/pdf/Written-Observations,-Mortier-v.-Belgium,-9-March-2019.pdf>
19. European Court of Human Rights. Factsheet: End of Life and the European Convention on Human Rights. Retrieved from: (last visited 22.04.2023) https://www.echr.coe.int/documents/fs_euthanasia_eng.pdf
20. European Court of Human Rights. Guide on Article 8 of the European Convention on Human Rights: Right to Respect for Private and Family Life, Home and Correspondence. 2022. Retrieved from: (last visited 16.04.2023) https://www.echr.coe.int/documents/guide_art_8_eng.pdf
21. European Court of Human Rights. Press Release: Court Finds Procedural Defects in Subsequent Review of Death by Euthanasia of Applicant's Mother. 2022. Retrieved from: (last visited 22.04.2023) <https://www.politico.eu/wp-content/uploads/2022/10/04/Judgment-Mortier-v.-Belgium-Death-by-euthanasia-of-the-applicants-mother-without-his-being-informed-1.pdf>

22. FCEE. *Persbericht van de Federale Controle- en Evaluatiecommissie Euthanasie*. (Press Release of the Federal Commission for Control and Evaluation of Euthanasia). 2022. Retrieved from: (last visited 18.04.2023) <https://wfrtds.org/wp-content/uploads/2022/10/FCEE-reactie-CEHRM-221014.pdf>
23. Giebel, H. Double Effect and Ethical End-of-Life Care: Assessing the Benefits and Burdens of Lethal Treatment (or Lack Thereof). *Solidarity: The Journal of Catholic Social Thought and Secular Ethics*. Vol.6, Iss.1. 2016. Retrieved from: (last visited 22.04.2023) <https://philarchive.org/archive/HEIDEA-3>
24. Halloran, K. *Ethics of Euthanasia and Physician Assisted Suicide*. Merrimack College. 2022. Retrieved from: (last visited 22.04.2023) https://scholarworks.merrimack.edu/cgi/viewcontent.cgi?article=1061&context=honors_c_apstones
25. Hendriks, A.C. *End-of-Life Decisions. Recent Jurisprudence of the European Court of Human Rights*. *Academy of European Law*. 2018. Retrieved from: (last visited 16.04.2023) <https://scholarlypublications.universiteitleiden.nl/access/item%3A2907069/download>
26. Hendin, H. The Slippery Slope: The Dutch Example. *Duquesne Law Review*. Vol.35:427. Retrieved from: (last visited 22.04.2023) <https://dsc.duq.edu/cgi/viewcontent.cgi?article=3098&context=dlr>
27. Hulkower, R. The History of the Hippocratic Oath: Outdated, Inauthentic, and Yet Still Relevant. *The Einstein Journal of Biology and Medicine*. Vol.25, No1. 2016. Retrieved from: (last visited 20.04.2023) https://www.einsteinmed.edu/uploadedFiles/EJBM/page41_page44.pdf
28. Interian, J. *Gross v. Switzerland: A Deadly Dose for Personal Autonomy*. *Boston College International & Corporative Law Review*. 2015. Retrieved from: (last visited 22.04.2023) <https://lira.bc.edu/work/ns/a6a89eed-c275-4f78-af4e-5d08993a7d99>
29. JD., Mueller, P.S., Sulmasy, L.S. *Ethics and Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*. *Annals of Internal Medicine*. Vol.167,

- No. 8. 2017. Retrieved from: (last visited 22.04.2023)
http://www.medicinainterna.net.pe/sites/default/files/ARTICULO_DE_ETICA_DEL_MES_LEGALIZACION_DEL_SUICIDIO_ASISTIDO.pdf
30. Kasman, N.M. Ethics and Euthanasia. Augustana College. 2018. Retrieved from: (last visited 19.04.2023)
<https://digitalcommons.augustana.edu/cgi/viewcontent.cgi?article=1025&context=biolstudent>
31. Kayacan, D. N. The Right to Die with Dignity: How Far Do Human Rights Extend? (European Union and its Neighbours in a Globalized World). Vol. 6. 1st ed. Springer International Publishing AG. 2022.
32. Keown, J. Euthanasia in the Netherlands: Sliding Down the Slippery Slope? Notre Dame Journal of Law, Ethics & Public Policy. Vol.9. 1995. Retrieved from: (last visited 19.04.2023)
<https://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1427&context=ndjlepp>
33. Latram, S.R. Aquinas and Morphine: Notes on Double Effect at the End of Life. DePaul Journal of Health Care Law. Vol.1, Iss.3.1997. Retrieved from: (last visited 22.04.2023)
<https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1303&context=jhcl>
34. Neal, M. How Relevant is the Hippocratic Oath in Guiding Physicians' Views on Physician-Assisted Suicide. University of Nebraska-Lincoln. 2020. Retrieved from: (last visited 19.04.2023)
<https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1252&context=honorstheses>
35. Nowak, M. UN Covenant on Civil and Political Rights: CCPR Commentary. 2nd Edition. N.P. Engel. 2005.
36. Olsson, J. A European Right to Assisted Suicide? Moral Justifications of the ECtHR Case Law. Malmö University. 2019. Retrieved from: (last visited 17.04.2023) <https://www.diva-portal.org/smash/get/diva2:1483141/FULLTEXT01.pdf>

37. Perrett, R.W. Buddhism, Euthanasia and the Sanctity of Life. *Journal of Medical Ethics*. Vol.22. 1996. Retrieved from: (last visited 23.04.2023)
https://www.academia.edu/38275416/Buddhism_euthanasia_and_the_sanctity_of_life
38. Peters, A.L., Euthanasia and Consensual Harm: Evaluating the Moral and Legal Asymmetry of Self- and Other-Regarding Acts. *Inquires Journal*. Vol.13, No.10. 2021. Retrieved from: (last visited 19.04.2023)
<http://www.inquiriesjournal.com/articles/1918/euthanasia-and-consensual-harm-evaluating-the-moral-and-legal-asymmetry-of-self-and-other-regarding-acts>
39. Pew Research Center. Religious Groups Views on End-of-Life Issues. 2013. Retrieved from: (last visited 23.04.2023)
<https://www.pewresearch.org/religion/2013/11/21/religious-groups-views-on-end-of-life-issues/>
40. Phutchu, S. Euthanasia: the Buddhist Hermeneutics in the 21st Century. *The Journal of International Buddhist Studies College*. Vol.7. Retrieved from: (last visited 23.04.2023)
<https://so03.tci-thaijo.org/index.php/ibsc/article/download/234913/169538/905814>
41. Regional Euthanasia Committee. Annual Report. 2023. Retrieved from: (last visited 23.04.2023) <https://wfrtds.org/dutch-euthanasia-review-committees-published-report-on-2022/>
42. Reichstein, A. A Dignified Death for All- How a Relational Conceptualisation of Dignity Strengthens the Case for the Legalisation of Assisted Dying in England and Wales. *Human Rights Law Review*. Vol.19, No.4. 2019. Retrieved from: (last visited 19.04.2023)
https://ueaeprints.uea.ac.uk/id/eprint/71770/1/Accepted_Manuscript.pdf
43. Religion and Human Rights. Religious Impact on the Right to Life in Empirical Perspective. 2016. Retrieved from: (last visited 23.04.2023) https://www.theologie.uni-wuerzburg.de/fileadmin/01040400/Religion_and_Human_Rights/members_only/conference_2016/Booklet_ABSTRACTS.pdf

44. Riigikogu Kantselei Õigus- ja Analüüsisiosakond. *Eutanaasia Seadustamine Euroopa Riikides*. (Legalization of Euthanasia in European Countries). 23.09.2020. Retrieved from: (last visited 23.04.2023) <https://www.riigikogu.ee/wpcms/wp-content/uploads/2020/09/Teemaleht-10-Eutanaasia.pdf>
45. Saul, M. *The Normative Status of Self-Determination in International Law: A Formula for Uncertainty in the Scope and Content of the Right?* Oxford University Press. *Human Rights Law Review*. Vol.11, No.4. 2011. Retrieved from: (last visited 24.04.2023) https://www.researchgate.net/publication/228152058_The_Normative_Status_of_Self-Determination_in_International_Law_A_Formula_for_Uncertainty_in_the_Scope_and_Content_of_the_Right
46. Shaw, A.B. Two Challenges to the Double Effect Doctrine: Euthanasia and Abortion. *Med Ethics*. Vol. 28, No 5. 2002. Retrieved from: (last visited 22.04.2023) <https://jme.bmj.com/content/medethics/28/2/102.full.pdf>
47. Zannoni, D. Right or Duty to Live? Euthanasia and Assisted Suicide from the Perspective of European Convention on Human Rights. *European Journal of Legal Studies*. Vol.12, No. 2. 2020. Retrieved from: (last visited 19.04.2023) https://www.echr.coe.int/LibraryDocs/COHEN-2018-A_human_rights_approach_to_end_of_life.pdf
48. The College of Family Physicians of Canada. *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia*. 2015. Retrieved from: (last visited 22.04.2023) https://www.cfpc.ca/CFPC/media/Resources/Health-Policy/Guidefor-Euthanasia_EN_FInal.pdf
49. The Federal Commission for Control and Evaluation of Euthanasia. *Annual Report*. 2023. Retrieved from: (last visited 23.04.2023) <https://wfrtds.org/belgium-euthanasia-in-2022/>
50. Thomson, B.A. Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom be Laid to Rest? *Vanderbilt Journal of Transnational Law*. Vol.33, Iss.4. 2000. Retrieved from: (last visited 22.04.2023) <https://scholarship.law.vanderbilt.edu/cgi/viewcontent.cgi?article=1741&context=vjtl>

51. UN Human Rights Blog. Mortier v. Belgium: A Landmark Decision on Euthanasia in the Case of Mental Illness. 2022. Retrieved from: (last visited 22.04.2023)
<https://ukhumanrightsblog.com/2022/10/24/mortier-v-belgium-a-landmark-decision-on-euthanasia-in-the-case-of-mental-illness/>
52. UN Human Rights Committee. General Comment No. 36: Article 6: Right to Life. § 9. Retrieved from: (last visited 22.04.2023) <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/261/15/PDF/G1926115.pdf?OpenElement>
53. UNECLAC. The Right to End-of-Life Palliative Care and a Dignified Death. 2017. Retrieved from: (last visited 18.04.2023)
<https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2017/11/ECLAC-contribution.pdf>
54. United Nations Network on Racial Discrimination and Protection of Minorities. Guidance Note on Intersectionality, Racial Discrimination & Protection of Minorities. 2022. Retrieved from: (last visited 23.04.2023)
<https://www.ohchr.org/sites/default/files/documents/issues/minorities/30th-anniversary/2022-09-22/GuidanceNoteonIntersectionality.pdf>
55. United Nations Treaty Bodies. Human Rights Committee. Retrieved from: (last visited 22.04.2023) <https://www.ohchr.org/en/treaty-bodies/ccpr>
56. United States Conference of Catholic Bishops. Assisted Suicide and Euthanasia: Beyond Terminal Illness. 2012. Retrieved from: (last visited 23.04.2023)
<https://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/SuicideNonterminal2018.pdf>
57. United States Conference of Catholic Bishops. To Live Each Day with Dignity; A Statement on Physician-Assisted Suicide. 2011. Retrieved from: (last visited 23.04.2023)
<https://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/bishops-Statement-physician-assisted-suicide-to-live-each-day.pdf>

58. Varelius, J. Mental Illness, Naturel Death, and Non-Voluntary Passive Euthanasia. *Ethical Theory and Moral Practice*. Vol.19. 2016. pp 635-637. Retrieved from: (last visited 23.04.2023) <https://link.springer.com/article/10.1007/s10677-015-9664-7>
59. Warwick, J. A Delicate Balance: Rethinking the Physician’s Role in Physician Aid-in-Dying. *UC Irvine Law Review*. Vol.12. 2022. Retrieved from: (last visited 22.04.2023) <https://scholarship.law.uci.edu/ucilr/vol12/iss4/11/>
60. WHO. Noncommunicable diseases. 2022. Retrieved from: (last visited 20.04.2023) <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>
61. World Federation of Right to Die Societies (WFRtDS). Luxembourg’s Biennial Report. 2023. Retrieved from: (last visited 22.04.2023) <https://wfrtds.org/luxembourgs-national-commission-for-control-and-evaluation-publishes-biennial-report/>

Cases (chronological order by courts):

1. CJEU C-159/90, *The Society for the Protection of Unborn Children Ireland Ltd v. Stephen Grogan and Others*, ECLI:EU:C:1991:378.
2. ECtHR, 26.10.2000, *Sanles Sanles v. Spain*. Application No 48335/99.
3. ECtHR, 29.04.2002, *Pretty v. the United Kingdom*. Application No 2346/02.
4. ECtHR, 20.06.2011, *Haas v. Switzerland*. Application No 31322/07.
5. ECtHR, 17.12.2012, *Kock v. Germany*. Application No 497/09.
6. ECtHR, 30.09.2014, *Gross v. Switzerland*. Application No 67810/10.
7. ECtHR, 05.06.2015, *Lambert and Others v. France*. Application No 46043/14.

8. ECtHR, 04.10.2022, *Mortier v. Belgium*. Application No 78017/17.
9. U.S. Supreme Court, *Washington v. Glucksberg*. 521 U.S. 702.1997.
10. U.S. Supreme Court, *Gonzales v. Oregon*. 546 U.S. 243. 2006.

Official documents:

1. Charter of Fundamental Rights of the European Union. Council of Ministers, European Parliament, European Commission. European Convention, 07.12.2000.
2. Charter of the United Nations. San Francisco, 26.06.1945.
3. Convention on Human Rights and Biomedicine. Council of Europe. Oviedo, 04.04.1997.
4. European Convention on Human Rights. Council of Europe. Rome, 04.11.1950.
5. International Covenant on Civil and Political Rights. United Nations General Assembly. New York, 16.12.1966.
6. Regulation (EU) No 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use. The European Union Clinical Trials Regulation.
7. Regulation (EU) No 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices. The European Union Medical Device Regulation.
8. Statutes. The World Federation of Right to Die Societies. Geneva, 01.04.2015.
9. The Belgian Act on Euthanasia of May, 28th 2002.
10. The Constitution of the Kingdom of the Netherlands. 24.08.1815.

11. The Convention on the Rights of Persons with Disabilities. The United Nations General Assembly. New York, 13.12.2006.
12. The Treaty on the Functioning of the European Union. Rome, 25.03.1957.
13. Universal Declaration of Human Rights. United Nations General Assembly. Paris, 10.12.1948.