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in a Globalized World 6

Derya Nur Kayacan

The Right to Die with Dignity

How Far Do Human Rights Extend?

Springer

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March 2022

Derya Nur Kayacan

Contents

List of Abbreviations

ACB	Belgian Advisory Committee on Bioethics
ADMD	*Association pour le droit de mourir dans la dignité* (Association for the Right to Die with Dignity)
AGEAS	*Arbeitsgemeinschaft Evangelischer Ärztinnen und Ärzte der Schweiz* (The Association of Protestant Physicians of Switzerland)
AJP/PJA	*Aktuelle Juristische Praxis/Pratique Juridique Actuelle*
ALfA	*Aktions Lebensrecht für Alle e V* (Right to Life for All Action)
Alta L Rev	Alberta Law Review
Am J Sociol	American Journal of Sociology
Annals Health L	Annals of Health Law
Arch Intern Med	Archives of Internal Medicine
Arch Pediatr Adolesc Med	Archives of Pediatrics & Adolescent Medicine
Ariz L Rev	Arizona Law Review
B C Int'l & Comp L Rev	Boston College International and Comparative Law Review
BCCA	British Columbia Court of Appeal
BCCLA	British Columbia Civil Liberties Association
BCSC	British Columbia Supreme Court
Berk J Int L	Berkeley Journal of International Law
BGer	*Bundesgericht* (Swiss Federal Supreme Court)
BMA	British Medical Association
BMC Health Serv Res	BMC Health Services Research
BMJ	British Medical Journal
Br Med Bull	British Medical Bulletin
BR-Dr	*Bundesrats-Drucksache* (Printed Documents of the German Federal Council)

BT-Dr	*Bundestags-Drucksache* (Printed Documents of the German Federal Parliament)
BVerfG	*Bundesverfassungsgericht* (German Federal Constitutional Court)
BVerwG	*Bundesverwaltungsgericht* (German Federal Administrative Court)
CA	Court of Appeal
Camb Q Healthc Ethics	Cambridge Quarterly of Healthcare Ethics
CD&V	*Christen-Democratisch en Vlaams* (Christian Democratic and Flemish)
CDA	Christian Democratic Appeal Party
CEC	Central Ethics Committee of SAMS
CFCEE	*Commission fédérale de contrôle et d'évaluation de l'euthanasie* (Federal Commission for Control and Evaluation of Euthanasia)
CHF	Swiss franc
CJ	Chief Justice
col	column
cols	columns
Comm L World Rev	Common Law World Review
CPS	Crown Prosecution Service
Crit Care	Critical Care
D66	Democrats 66
Dalhousie L J	Dalhousie Law Journal
DAS	Demedicalized assisted suicide
DPP	Director of Public Prosecutions
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ERAS	*Echtes Recht auf Selbstbestimmung* (Association for Real Right of Self-Determination)
EU	European Union
Eur J Health L	European Journal of Health Law
Eur J Public Health	European Journal of Public Health
EXIT ADMD	EXIT – Association pour le Droit de mourir dans la Dignité/Suisse Romande
EXIT	EXIT – *Deutsche Schweiz*
Fam Prac	Family Practice
FDHA	Federal Department of Home Affairs
FDJP	Federal Department of Justice and Police
FDP	*Freie Demokratische Partei* (Free Democratic Party)
FMH	*Foederatio Medicorum Helveticorum* (Swiss Medical Association)
FPZV	*Federatie Palliatieve Zorg Vlaanderen* (Flemish Palliative Care Federation)

Front Psychol	Frontiers in Psychology
GC	Grand Chamber
GesG-Aargau	*Gesundheitsgesetz des Kantons Aargau* (Aargau Cantonal Health Act)
GesG-Zürich	*Gesundheitsgesetz des Kantons Zürich* (Zurich Cantonal Health Act)
GH	*Gerechtshof* (Court of Appeal – the Netherlands)
GMC	General Medical Council
Hastings Cent Rep	Hastings Center Report
HC	House of Commons
HL	House of Lords
HR	*Hoge Raad* (Supreme Court of the Netherlands)
ICCPR	International Covenant on Civil and Political Rights
Issues L & Med	Issues in Law & Medicine
J Am Med Dir Assoc	Journal of the American Medical Directors Association
J Hosp Tour Res	Journal of Hospitality & Tourism Research
J Med Ethics	Journal of Medical Ethics
J Med Philos	Journal of Medicine and Philosophy
J Neurol	Journal of Neurology
J Pain Symptom Manage	Journal of Pain and Symptom Management
J Palliat Med	Journal of Palliative Medicine
J Soc Christ Ethics	Journal of the Society of Christian Ethics
J	Justice
JAMA Intern Med	JAMA Internal Medicine
KNMG	*De Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst* (Royal Dutch Medical Association)
LEIF	*LevensEinde InformatieForum* (End of Life Information Forum)
MAID	Medical assistance in dying
MDEL	Medical decisions at the end of life
Med L Rev	Medical Law Review
Med Law	Medicine and Law
Mich St U J Med & L	Michigan State University Journal of Medicine and Law
Minn L Rev	Minnesota Law Review
Mod L Rev	Modern Law Review
MP	Member of Parliament
MschKrim	*Monatsschrift für Kriminologie und Strafrechtsreform*
N Eng J Med	New England Journal of Medicine
NaP	Sodium Pentobarbital

NarcA	812.121 Swiss Federal Act on Narcotics and Psychotropic Substances of 3 October 1951 (1 February 2020)/Narcotics Act
NCE	Swiss National Advisory Commission on Biomedical Ethics
NHS	National Health Service
NJB	Nederlands Juristenblad
NRP 67	National Research Programme 'End of Life'
NVK	*Nederlandse Vereniging voor Kindergeneeskunde* (Dutch Association for Pediatrics)
NVVE	*Nederlandse Vereniging voor een Vrijwillig Levenseinde* (Dutch Association for Voluntary End of Life)
NVvP	*Nederlandse Vereniging voor Psychiatrie* (Dutch Association for Psychiatry)
Ordomedic	Ordre des médecins (Order of Physicians)
Ottawa L R	Ottawa Law Review
Oxf J Leg Stud	Oxford Journal of Legal Studies
Parl	Parliament
PAS	Physician-assisted suicide
PvdA	*Partij van de Arbeid* (Labour Party)
QIL	Questions of International Law
Queen's L J	Queen's Law Journal
QUT L Rev	QUT Law Review
RB	*Rechtbank* (Court of first instance)
RCP	Royal College of Physicians
Rev Esp Sanid Penit	*Revista Española de Sanidad Penitenciaria*
RTE	Regional Euthanasia Review Committees
RWS	*Recht op Waardig Sterven* (Right to Die with Dignity)
SAMS	Swiss Academy of Medical Science
SCC	Supreme Court of Canada
SCEN	*Steun en Consultatie bij Euthanasie in Nederland* (Support and Consultation on Euthanasia in the Netherlands)
Schweiz Ärzteztg	*Schweizerische Ärztezeitung*
sec	section
sess	session
Singapore Med J	Singapore Medical Journal
Statut Law Rev	Statute Law Review
Swiss Med Wkly	Swiss Medical Weekly
Swissmedic	Swiss Agency for Therapeutic Products
TPA	812.21 Swiss Federal Act on Medicinal Products and Medical Devices of 15 December 2000 (1 August 2020)/Therapeutic Products Act

UKSC	Supreme Court of the United Kingdom
Vill L Rev	Villanova Law Review
vol	volume
VVD	*Volkspartij voor Vrijheid* (People's Party for Freedom and Democracy)
VVP	*Vlaamse Vereniging voor Psychiatrie* (Flemish Association for Psychiatry)

Chapter 1
Introduction

Throughout time, the law has adapted itself to society's and individual's needs, aiming to achieve a balance for harmony. A need to recalibrate this balance most often occurs after introducing an innovation that affects the lives of all humankind. The Internet, one of the greatest inventions of the twentieth century, presented several new aspects of social life that required the attention of the legislatures, such as data protection and cyber-security. It has also introduced new dimensions of human rights, especially in freedom of expression and the right to privacy. It has been for the law to reconcile the conflicting interests of individuals with each other and with society. Another area in need of recalibration has emerged due to medical advancements.

Over the past century, and mainly since the 1950s, medicine has gone through tremendous developments that have changed many aspects of human life.[1] The capabilities of medicine are enhancing. Vaccines cure once-incurable diseases, and machines support failing organs that can also be replaced by transplantation. Constant research is being done to find new ways to respond to diseases. Developments in medical science and technology transformed life expectancies and the outlook on death. Medicine, which has concentrated solely on saving lives, has started to perceive death as a sign of failure that ran against its raison d'être.[2] However, over time, the focus has shifted from preserving life at all costs to the quality of life that includes more considerations of the patient's expectations from his or her own life. The once paternalistic approach of medicine, where the physician was perceived as 'the guardian who uses his specialised knowledge and training to benefit patients, including deciding unilaterally what constitutes benefit', has been challenged.[3] In light of the greater significance given to patients' wishes, the physician-patient

[1] Player (2018), p. 121.

[2] Ball (2017), p. 15.

[3] Chin (2002), p. 152; See also Glick (1992), pp. 17–18; Meulenbergs and Schotsmans (2005), pp. 125–126.

D. N. Kayacan, *The Right to Die with Dignity*, European Union and its Neighbours in a Globalized World 6, https://doi.org/10.1007/978-3-031-04516-5_1

relationship has been and continues to be redefined as personal autonomy moves towards the center of medical decision-making.[4] One can see this shift in the development of patients' rights, for example, the concept of informed consent or the right to refuse treatment.[5]

Despite the significant developments, there comes the point where medicine can no longer provide satisfying solutions to the patient's problems. Nowadays, the most common cause of death is chronic conditions such as cancer, diabetes, Alzheimer's, or heart disease.[6] While the symptoms of chronic illnesses, which have slower progress, can be managed, a complete recovery is often not achievable. That is why death has become a medical event, which takes place in healthcare institutions surrounded by machines more often than ever.[7] While symptoms can be managed and life can be prolonged, it is not always possible to guarantee a quality of life acceptable to the patient.

On some occasions, despite all the capabilities of medicine, some patients might find themselves in a situation where they are no longer satisfied with their quality of life and would prefer an earlier death. Several reasons could motivate such a preference. There could be a medical condition that causes severe suffering, making life unbearable. Alternatively, a prognosis might indicate a painful end that one would rather wish to avoid, or perhaps it could feel like life has been stripped of its dignity and is no longer worth living. Whatever the reason might be, some patients ask their physicians to help end their lives. With the enhancement of medicine on the one hand and the growing emphasis on personal autonomy on the other hand, whether such a wish from a patient ought to be granted is a question with great complexity. Which decisions can be made at the end of one's life and to what extent one could demand these decisions to be respected has been one of the most controversial debates over the past few decades. With several intertwined aspects of ethics, law, medicine, psychology, and sociology, the question is: Does one have the right to choose the time and manner of one's own death? Is there a right to a dignified death? Does the respect for personal autonomy, namely the right to self-determination, gain sufficient weight to grant a request to end one's life at one's discretion?

This topic is surrounded by subjective notions. When does the suffering reach a point where life becomes unbearable? What qualifies a good death to a specific individual? Under what circumstances would one define one's life to have lost its dignity? Even though these determinations are highly personal and dependent on many subjective circumstances, there are highly critical societal interests that must

[4] Nessa and Malterud (1998), p. 394; Tan (2002), p. 149.

[5] Channick (1999), pp. 586–587.

[6] Chronic illnesses cause %71 of all deaths globally. (2018) Noncommunicable Diseases. In: World Health Organization. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.

[7] Warraich (2017), pp. 51–66; Whiting (2002), pp. 11–12; Otlowski (1997), p. 1; For an interesting approach to the difficulties of expressing personal autonomy at the end of life and how death has become a medicalized event, see Simmons (2017), pp. 95ff.

be considered as well. Protection of life is the strongest argument that stands against the right to die.

The right to life is protected under Article 2 of the European Convention on Human Rights (ECHR or the Convention)[8] and is 'one of the most fundamental provisions in the Convention'.[9] In addition to a negative obligation imposed on the member States not to deliberately take an individual's life, Article 2 also imposes a positive obligation that requires States 'to take appropriate steps to safeguard the lives of those within its jurisdiction'.[10] This positive obligation applies to the medical sphere and assures that appropriate measures and safeguards are adopted to protect patients' lives, who are under the care of the medical profession.[11] Within the right to die debate, the State's positive obligation to protect life, especially of the vulnerable, embedded within the right to life can be divided into two lines of argument. First, the right to die is contrary to the sanctity of life and, therefore, should not be acknowledged at all. Second, even if such a right were to be acknowledged, its practice should not be allowed due to the risk of abuse inherent in its application, namely the 'slippery slope'.

The slippery slope argument is described as the case when 'a proposal is made to accept A, which is not agreed to be morally objectionable, it should nevertheless be rejected because it would lead to B, which is agreed to be morally objectionable'.[12] Within this line of argument, it is suggested that acknowledging and regulating the right to die will ultimately cause a logical or practical slippery slope or both, where the practice will either intentionally or unintentionally extend beyond its initially drawn lines. The logical slippery slope refers to the arguments in favor of the right to die being used to support other morally unacceptable practices. For example, if one defends the right to die for patients with terminal illnesses awaiting death in agony based on reasons of compassion, one must also accept the right to die for patients who are not terminally ill but suffer under extreme pain. In time, one will eventually start approving ending the lives of mentally incompetent patients, who suffer unbearably, which can ultimately cause considering such lives 'unworthy'. Alternatively, if one argues that the right to die stems from the mere respect for personal autonomy, one must be willing to eliminate all other requirements in practice except for the person's autonomous request and allow death on demand. The practical slippery slope focuses on concerns over the insufficiency of safeguards, for example, physician errors, incorrect determination of capacity, or overly broad interpretation of the rules. These concerns also include the fear of societal normalization of the

[8] Council of Europe, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos 11 and 14, 4 November 1950, ETS 5 (ECHR).

[9] *McCann and Others v the United Kingdom* 27 September 1995 Ser A no 324, [147].

[10] Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania [GC] App no 47848/08 ECHR 2014 [130].

[11] *Calvelli and Ciglio v Italy* [GC] App no 32967/96 ECHR 2002-I [49].

[12] Keown (2018), p. 68.

right to die practice, eventually leading to the acceptance of more questionable practices.[13]

The debate on the right to die is a search for reconciliation between personal interests, which are based on the right to self-determination, and societal interests, which are embedded in the right to life and find expression as the State's duty to protect the vulnerable. Notions of human dignity, personal autonomy, and sanctity of life seek a refreshed interpretation. These notions also shape the boundaries of medical ethics, determining to which extent the involvement of the medical profession in end-of-life decisions is appropriate. Despite the common understanding of the importance of these notions, their role in the right-to-die debate depends on their interpretation, reflecting elements from society's legal and historical, cultural, and religious backgrounds. How did the European Court of Human Rights (ECtHR or the Court), which has 47 member States with various backgrounds, interpret these notions within the right-to-die context?

After a short description of the terminology, the exemplary jurisdictions of Switzerland, the Netherlands, and Belgium will be examined to understand how and in which manner the right to die has evolved. The ever-increasing respect for personal autonomy and its expanding boundaries will be analyzed by further examining the United Kingdom, Germany, and Canada. Afterward, a study of the Court's case law will present the development of the right to die under the realm of the Convention. In the concluding remarks, an answer will be sought to the question, what is to be expected from the future of this controversial right?

References

(2018) Noncommunicable Diseases. In: World Health Organization. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

Ball H (2017) The right to die: a reference handbook. ABC-CLIO, Santa Barbara, CA

Channick SA (1999) The myth of autonomy at the end-of-life: questioning the paradigm of rights. Vill L Rev 44(4):577–642

Chin J (2002) Doctor-patient relationship: from medical paternalism to enhanced autonomy. Singapore Med J 43(3):152–155

Glick HR (1992) The right to die: policy innovation and its consequences. Columbia University Press, New York

Kamisar Y (1958) Some non-religious views against proposed mercy-killing legislation. Minn L Rev 42(6):969–1042

Keown J (2018) Euthanasia, ethics and public policy: an argument against legalisation, 2nd edn. Cambridge University Press, Cambridge

Meulenbergs T, Schotsmans P (2005) The sanctity of autonomy? Transcending the opposition between a quality of life and a sanctity of life ethic. In: Schotsmans P, Meulenbergs T (eds) Euthanasia and palliative care in the low countries. Peeters, Leuven

Nessa J, Malterud K (1998) Tell me what's wrong with me: a discourse analysis approach to the concept of patient autonomy. J Med Ethics 24:394–400. https://doi.org/10.1136/jme.24.6.394

[13] Keown (2018), pp. 71–88; Rachels (1986), pp. 173–174; See also Kamisar (1958), pp. 969ff.

Otlowski M (1997) Voluntary euthanasia and the common law. Oxford University Press, New York
Player CT (2018) Death with dignity and mental disorder. Ariz L Rev 60:115–161
Rachels J (1986) The end of life: euthanasia and morality. Oxford University Press, New York
Simmons J (2017) The continental perspective on assisted suicide and euthanasia. In: Cholbi MJ (ed) Euthanasia and assisted suicide: global views on choosing to end life. Praeger, Santa Barbara, CA, pp 95–120
Tan NHSS (2002) Deconstructing paternalism – what serves the patient best? Singapore Med J 43(3):148–151
Warraich H (2017) Modern death: how medicine changed the end of life. St Martin's Press, New York
Whiting R (2002) A natural right to die: twenty-three centuries of debate. Greenwood Press, Westport, CT

Chapter 2
Definitions

Euthanasia is derived from the Greek words *εὐ* (good) and *θάνατος* (death), and refers to a 'gentle and easy death'.[1] There are several descriptions of euthanasia in the literature, and the only element common to all is the fact that there is no consistency.

Euthanasia has been divided into subcategories: active/passive euthanasia and voluntary/involuntary/non-voluntary euthanasia. Active euthanasia entails a deliberate action that causes death, whereas, in passive euthanasia, death results from a deliberate omission. The omission of an act that defines passive euthanasia translates to withdrawing or withholding life-sustaining or possibly life-saving treatment.[2] Although the decision to withhold or withdraw treatment could be based on several different reasons (the patient's wishes or if the patient is not able to communicate his or her wishes, medical futility, or the best interest of the patient), what is often required for this omission to qualify as 'passive euthanasia' is the intent to hasten death.[3] The presence of a request to die is the differential element for the second group of subcategories. If euthanasia is carried out upon the autonomous request of the person killed, this is called voluntary euthanasia.[4] Involuntary euthanasia is when the person has not consented to the termination of his or her life, although he or she *was* competent to do so at the time of the killing. If the person *was not* competent to make such a request, this is referred to as non-voluntary euthanasia.[5] Another distinction made in the literature is direct and indirect euthanasia. Direct euthanasia refers to an action carried out with the express intention to terminate life. In contrast, indirect euthanasia is used for cases when causing death is not the intention but

[1] Focarelli (2020), para. 1.

[2] Lewis (2007), p. 5.

[3] Otlowski (1997), p. 5.

[4] Singer (2011), p. 157; Focarelli (2020), para. 7.

[5] Singer (2011), p. 158; Focarelli (2020), para. 7.

D. N. Kayacan, *The Right to Die with Dignity*, European Union and its Neighbours in a Globalized World 6, https://doi.org/10.1007/978-3-031-04516-5_2

occurs as a known side effect (administering pain medication in increasing dosages to relieve suffering).[6]

Euthanasia has been used as a general term to refer to medical decisions that have the effect of shortening life. However, subcategorizing euthanasia has been recently considered to be 'outdated',[7] confusing, and unnecessary.[8] For the purposes of this study, which focuses on the right to die based on the notion of personal autonomy, euthanasia is the act of terminating the life of a person upon that person's explicit and autonomous request. Other forms described in the previous paragraph that fall outside this definition will not be referred to as euthanasia. Admittedly, the right to refuse treatment and withdrawing or withholding life-sustaining treatment are crucial topics that represent a big part of end-of-life decisions and require a detailed analysis of their own. However, these medical decisions, whether made by the patient or by third parties when the patient is not competent to make such a decision, fall outside the scope of the present study, which focuses on active termination of life.[9] The fact that an explicit and autonomous request to die is an integral component of the euthanasia definition renders the subcategories based on voluntariness substantially flawed. Additionally, death is the primary goal of euthanasia, which makes the direct and indirect classification irrational. Therefore, such adjectives (active, passive, voluntary, involuntary, non-voluntary, direct, indirect) will not be used unless necessary for emphasis.

While being in a terminal phase or the existence of an incurable illness or unbearable suffering has been included in some definitions,[10] it is better to place these concepts as prerequisites for the practice of euthanasia and not as part of its definition. The person requesting euthanasia only makes such a request if he or she has concluded that death is the better option under his or her own specific circumstances. This side of the scale is the realization of personal autonomy. To what extent a euthanasia request ought to be granted, if at all, is determined against the other side of the scale, which holds concerns like respect for human life, medical ethics, and the protection of the vulnerable. Prerequisites such as incurable illness or unbearable suffering answer the question, 'under which circumstances will both sides of the

[6] Focarelli (2020), para. 9.

[7] Griffiths et al. (2008), p. 76.

[8] Lewis (2007), p. 5; Radbruch et al. (2016), p. 108; According to Leenen, some life-shortening medical decisions, which can be referred to as a form of euthanasia, such as termination of medically futile treatment, administration of pain medication, or decisions based on the patient's right to refuse treatment are 'distorted silhouettes of euthanasia'. Leenen (1984), pp. 335–337.

[9] The Lambert Case, which will be analysed under Sect. 4.1.7 'The Lambert Case', will touch upon the ECtHR's approach to withdrawal of treatment. However, the inclusion of this judgment in this study does not aim to capture or comment on the legal issues surrounding these topics. It only aims to complement the analysis of the member States' positive obligation under Article 2 of the Convention regarding the process of end-of-life decision-making.

[10] Beauchamp and Davidson's definition requires the person asking to be killed to be in a state of 'acute suffering or irreversibly comatoseness' in order for the act to qualify as euthanasia. Beauchamp and Davidson (1979), p. 304; Editors of Encyclopaedia Britannica (2021) Euthanasia. In: Encyclopædia Britannica. https://www.britannica.com/topic/euthanasia.

scale find balance?' They are tools to identify the limits of personal autonomy and justify *the practice of euthanasia* rather than defining *the act of euthanasia*.

Furthermore, whether someone is terminally ill or whether an illness is truly incurable are medical considerations that cannot always be precisely determined. On the other hand, unbearable suffering is a subjective state that could mean different things to each person. Including these concepts in the definition of euthanasia carries the disputes on its justifiability to its definition.[11]

Assisted suicide takes place when a person ends his or her own life with another person's assistance, and when a physician acting in a professional capacity provides this assistance, it is specified as physician-assisted suicide.[12] What differentiates assisted suicide from euthanasia is by whom the final act is performed. In assisted suicide, the person wishing to die performs the final act that causes death. However, in euthanasia, the final act is performed by another person. It will be seen in Chapter C that assistance is commonly provided in the form of prescribing lethal medication. Some people prefer to avoid using the word 'suicide' in this context due to the negative connotation it entails and choose to call it assisted dying instead. This argument is usually based on the moral stigma attached to the term 'suicide', which is considered a preventable incident often committed in a mentally unstable state. Suicide in this sense is different from what is referred to as 'assisted suicide' because, in the context of the right to die as discussed here, the person wishing to end his or her life has come to this decision for different reasons.[13] Such phrases like 'death with dignity' or 'aid in dying' have also been preferred by proponents of the right to die.[14] Although recognizing the reasons behind the choice to use words free from negative implications that the word 'suicide' might carry, it will be more practical to use the phrase 'assisted-suicide' for this study. Furthermore, the phrase 'assisted dying' will cover both practices of euthanasia and assisted suicide.

[11] Leenen (1984), p. 334.

[12] Radbruch et al. (2016), pp. 108–109.

[13] Friesen evaluates the grounds to avoid using the term 'suicide' when talking about assisted dying and concludes that there is more harm than good in concentrating on the differences between the two terms. Friesen (2020), pp. 32ff.

[14] Death with Dignity National Center, which is a nonprofit organization in the USA that promotes legislation for assisted dying, considers the use of 'assisted suicide' within the context of the right to die to be 'politicized language deployed with the intent of reducing support for the issue' and recommend using 'value-neutral language' such as death with dignity, assisted dying or aid in dying. Death with Dignity, Terminology of Assisted Dying. https://www.deathwithdignity.org/terminology/; Compassion & Choices, which is also a nonprofit organization working for the promotion of end-of-life choices in the USA, prefers the term 'medical aid in dying'. Compassion & Choices, Understanding Medical Aid in Dying. https://compassionandchoices.org/end-of-life-planning/learn/understanding-medical-aid-dying/; However, Feltz's study results indicate that there is only a minor decrease in acceptability when the term 'physician-assisted suicide' is used instead of 'assisted dying'. The negative connotation of the word 'suicide' might not have the impact one thinks it does. Feltz (2015), pp. 217ff.

References

Beauchamp TL, Davidson AI (1979) The definition of euthanasia. J Med Philos 4(3):294–312
Compassion & Choices, Understanding Medical Aid in Dying. https://compassionandchoices.org/end-of-life-planning/learn/understanding-medical-aid-dying/
Death with Dignity, Terminology of Assisted Dying. https://www.deathwithdignity.org/terminology/
Editors of Encyclopaedia Britannica (2021) Euthanasia. In: Encyclopædia Britannica. https://www.britannica.com/topic/euthanasia
Feltz A (2015) Everyday attitudes about euthanasia and the slippery slope argument. In: Cholbi M, Varelius J (eds) New directions in the ethics of assisted suicide and euthanasia. Springer, Cham
Focarelli C (2020) Euthanasia. Max Planck Encyclopedia of Public International Law. https://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e793?prd=EPIL
Friesen P (2020) Medically assisted dying and suicide: how are they different, and how are they similar? Hastings Cent Rep 50(1):32–43
Griffiths J, Weyers H, Adams M (2008) Euthanasia and law in Europe. Hart Publishing, Oxford
Leenen HJJ (1984) The definition of euthanasia. Med Law 3(4):333–338
Lewis P (2007) Assisted dying and legal change. Oxford University Press, Oxford
Otlowski M (1997) Voluntary euthanasia and the common law. Oxford University Press, New York
Radbruch L, Leget C, Bahr P et al (2016) Euthanasia and physician-assisted suicide: a White Paper from the European Association for Palliative Care. Palliative Medicine 30(2):104–116. https://doi.org/10.1177/0269216315616524
Singer P (2011) Practical ethics, 3rd edn. Cambridge University Press, New York

Chapter 3
The Right to Die in Practice

Personal autonomy in end-of-life decisions is perceived differently worldwide and receives various levels of interpretation depending on the jurisdiction. The weight given to personal autonomy reflects elements from society's historical, cultural, religious, and legal backgrounds. Today, several jurisdictions interpret personal autonomy in a permissive way of the decision to end one's own life, namely the right to die. Although sharing some common features, the right to die is practiced in various ways. While some only allow physician-assisted suicide, others have chosen to legalize euthanasia. The requirements for assisted dying might be different as well.

Several non-European States have regulated the right to die. The Constitutional Court of Colombia had accepted the right to die with dignity in 1997, and the Ministry of Health and Social Protection adopted a Resolution providing guidelines for the practice of euthanasia in 2015.[1] In 2018, Colombia became the third ever State, after the Netherlands and Belgium, to regulate euthanasia for minors subject to strict requirements.[2] The State of Victoria, Australia, passed a bill in 2017 that legalized assisted dying for terminal patients as of 19 June 2019.[3] Western

[1] In 1997, the Constitutional Court of Colombia had ruled that 'denying a terminal patient the right to die with dignity violated equality and imposed a discriminatory burden against those seriously ill or impaired.' The Government did not take any steps to regulate the right to die until 2015, and the Court's decision did not find any implementation. Upon another judgment from the Constitutional Court in 2014, the Ministry of Health adopted a resolution in 2015 that provided guidelines for the practice euthanasia. The choice is only available for terminal patients with unbearable suffering and who are competent to make a decision to end their life. Only a physician is authorized to carry out the procedure. [1997] Colombian Constitutional Court Decision C-239/1997; [2014] Colombian Constitutional Court Decision T-970/2014; See also Palomino (2017), pp. 51ff.

[2] [2017] Colombian Constitutional Court Decision T-544/2017; Triviño (2018) Colombia Has Regulated Euthanasia for Children and Adolescents. In: LatinAmerican Post. https://latinamericanpost.com/20090-colombia-has-regulated-euthanasia-for-children-and-adolescents.

[3] The physician will administer the medication only if the patient is not physically capable of doing so himself or herself. Therefore, the rule is physician-assisted suicide with an exception for

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Australia passed a similar bill in December 2019 that has come into effect on 1st of July, 2021 after an 18-month implementation period.[4] In a referendum held in October 2020, 65.1% of the New Zealanders voted in favour of the assisted dying legislation, which came into force on 7 November 2020.[5] Oregon was the first State to legalize physician-assisted suicide in the United States in 1997. Since then, Montana, Washington, Vermont, California, Colorado, the District of Columbia, Hawaii, New Jersey, and Maine have followed Oregon's example. Physician-assisted dying is legal in Canada, following the Supreme Court's ruling in the Carter Case in 2015. The Council of Europe member States of Switzerland, the Netherlands, Belgium, and Luxembourg have legal systems permissive to assisted dying.

This chapter aims to bring a factual perspective. The most crucial argument, which stands against the right to die, is the protection of life. More accurately, the State must protect its citizens from unwarranted third-party interventions. Within the right-to-die debate, this duty formulates as the protection of the vulnerable. Apart from weakening the value of human life, what is most feared is the possibility of ending one's life without that person's honest and sincere request, meaning that assisted dying will open a door that puts the lives of vulnerable people in danger. Based on the State's duty to protect the vulnerable, any argument made favouring the right to die must be balanced against the risk of abuse. Whether such a risk exists will remain a theoretical question unless one analyses the States that have already permitted assisted dying. How was the legalization of assisted dying enacted in these permissive jurisdictions? What was the path taken and points discussed along the way? As it has been stated, 'the best guide to what *could* happen is what *has* happened'.[6] Famous for its assisted suicide organizations, Switzerland will be analysed first. Following will be an examination of the Dutch and Belgian experiences with their respective legislation on euthanasia. Some crucial developments from the United Kingdom and Germany will be mentioned for comparison. Finally, two landmark cases from the Canadian Supreme Court will contribute by portraying a change of perspective over time.

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euthanasia only when the circumstances do not allow otherwise. Victoria, Australia, Voluntary Assisted Dying Act 2017, No 61 of 2017 (19 June 2020).

[4] Western Australia, Australia, Voluntary Assisted Dying Act 2019, No 027 of 2019 (19 December 2019).

[5] New Zealand, End of Life Choice Act 2019, 2019 No 67 (7 November 2020); Official Referendum Results Released. In: Electoral Commission. https://elections.nz/media-and-news/2020/official-referendum-results-released/.

[6] Jones et al. (2017), p. 1.