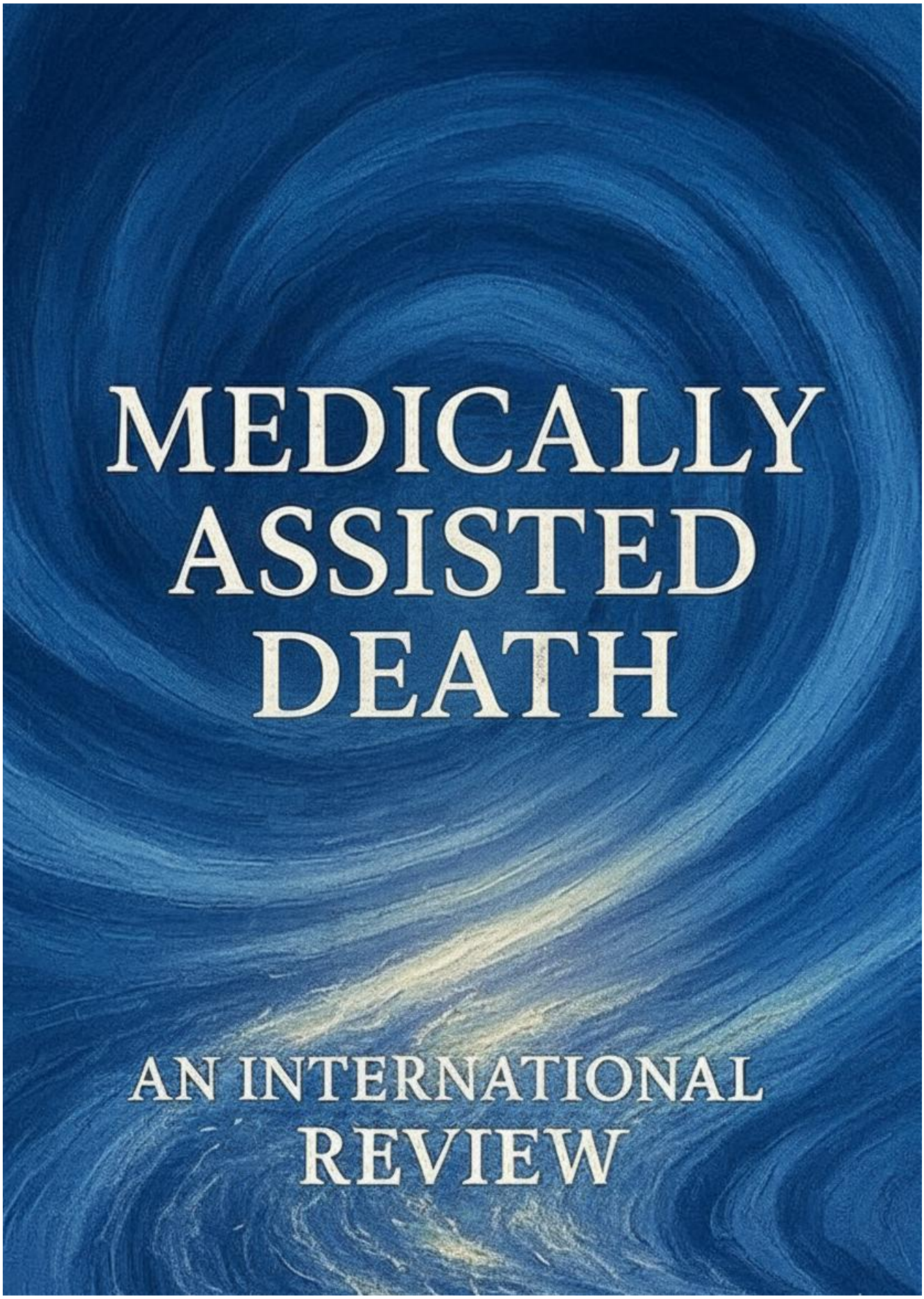
MEDICALLY
ASSISTED
DEATH
AN INTERNATIONAL
REVIEW

Department of Bioethics and Philosophical Approach to Law

E-book

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An International Review

Editors
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Introduction

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The issue of medically assisted death, in the form of assisted suicide and, even more so, euthanasia, has been at the forefront of the most sensitive and controversial issues at the centre of the bioethical and bio-legal debate.

The issue has received increasing attention, internationally, in the broader context of reflection on questions raised by other end-of-life interventions, such as the non-activation and withholding of life-sustaining treatments refused by the patient or deemed clinically inappropriate, and the use of deep palliative sedation.

The latter are end-of-life interventions that differ from assisted suicide and euthanasia and should not be improperly equated with them. Nevertheless, not unlike acts of active assistance in dying, they must be contextualized within the profound changes in death scenarios that have emerged in recent decades, at least in developed areas of the world.

Indeed, in these areas, thanks to the extraordinary progress made since the mid-20th century, medicine has constantly increased its power to control death, modulating its timing and modes, and has allowed, as never before, the prolonging of survival, even in the presence of diseases for which there is still no possibility of cure, and perhaps there will not be in the future. Nevertheless, the prolonging of survival is often accompanied by acute physical and mental suffering, in the face of which it has become increasingly common to consider it not only justified, but necessary, to research and develop strategies to alleviate patients when they consider their suffering to be unbearable.

It should also be emphasized that, despite continuing differences in different national and cultural contexts, a rethinking of long-established traditional medical ethics, with its paternalistic and vitalistic approach, has begun.

There is now widespread recognition of the patient's right to have a say in decisions related to their care, expressing their consent or dissent and, therefore, refusing treatment, including that on which their survival may depend, after receiving adequate information.

In this context, legal provisions have been introduced in countries that, in addition to recognizing the right to refuse life-saving treatment and to receive deep palliative sedation, were the first to legalize assisted suicide.

This is the path taken in several states in the United States, including Oregon since 1994, and in Latin America, starting with Colombia in 1997. In Europe, this path was followed by the Netherlands in 2001, Belgium in 2003, and Luxembourg in 2009. Switzerland, while maintaining its ban on euthanasia, has excluded the punishability of compassionate assistance to a suffering person who wishes to end their life through assisted suicide.

In many other countries, despite the recognition of the right to self-determination, resistance to active assistance in dying has not disappeared, and euthanasia, like assisted suicide, has remained a criminal offense in many legal systems.

In recent years, nevertheless, there has been renewed attention to the issue of medically assisted dying, not only at the theoretical level, but also at the institutional level.

This has led to the entry into force of new laws on the subject, such as those introduced in Spain in 2021 and Portugal in 2023, while a country such as Colombia has completed with legislative action the process of full legalization of voluntary assisted death, which, as already noted, began in 1997. On the other hand, in important countries, such as France and Great Britain, the process of passing a law on medically assisted death has not yet been completed, although it has already reached a decisive stage, with approval by the National Assembly in May 2025 and the House of Commons in June 2025, respectively. Finally, it is worth mentioning the situation in Italy. Here, the Constitutional Court laid the groundwork, for transforming the regulatory framework on end-of-life related issues, with ruling No. 242/2019, which declared the prohibition of assisted suicide, established by Article 580 of the Criminal Code, unconstitutional, if provided to persons with terminal illnesses and suffering severe pain.

Nearly six years after ruling no. 242/2019, Italy still does not have the legislative framework required by the Constitutional Court and desired by a large part of the Italian population. Nevertheless, against the background of increasing requests for assisted suicide, prompted by the conditions set by the Constitutional Court, a composite scenario of institutional initiatives and interventions has emerged. This allows us to speak of a ‘work in progress’ that could be completed, despite strong resistance, if we continue in the direction already outlined and learn from the virtuous examples of regulations introduced in other countries, including those culturally close to Italy, such as Spain and Portugal.

The significant changes in the regulatory framework on end-of-life related issues, which have already affected or may soon affect several countries, deserve attention and further study in the most qualified contexts for bioethical and bio-legal reflection, such as the International Chair of Bioethics.

With the aim of stimulating such reflection, the Department of Bioethics and Philosophical Approach to Law, with the support of the Italian Unit of the International Chair of Bioethics, has developed a book project which, in line with previous ICB publications, will bring together papers from ICB

scholars representing different geographical and cultural contexts on the subject of medically assisted death.

The aim of the book is to offer an up-to-date overview of the regulatory treatment of the last and most problematic end-of-life intervention in different contexts, on the one hand, highlighting the reasons that have supported and continue to support the legalization of assisted dying, and, on the other, examining the validity of the arguments put forward in contexts where medically assisted death continues to be considered a crime.

In the first version being presented to readers, the e-book contains eight contributions, three of which (by Patrizia Borsellino, Lorena Forni, and Federico Pizzetti) are related to the Italian situation; two (by José-Antonio Seoane and María Tormo, with Pilar Pinto Pastor and Benjamin Herreros) are related to Spain; one (by Karina M. Elmir) is about the situation in Latin America; one (by Igor Milinković) is about Bosnia and Herzegovina; and one (by Margareth Vetis Zaganelli) is about the situation in Germany.

The intention, however, is to shape the collection as an open book, susceptible to being enriched by further papers, which we hope will be stimulated by the discussion and comparison that the 17th Conference on "Bioethics, Medical Ethics, and Health Law," to be held in Ljubljana, will offer as its first important opportunity.

A Difficult Path to the Approval of a New Italian Law on Medical Assisted Death

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Abstract: The paper offers an overview of the current Italian regulatory framework on medically assisted death, starting from ruling No. 242/2019, which represented a turning point. In particular, the analysis emphasises that, in the Italian context, the legal regulation on this matter is a work in progress. Indeed, despite the continuing absence of the legislative framework called for by the Constitutional Court, further judicial decisions and regulatory initiatives have been taken at regional level. Thanks to these, some pillars have been established (e.g., the criteria for access to relevant procedures and the role of the National Health Service), which should be incorporated into national legislation in Italy, despite persisting opposition.

Key words: Medical Assisted Death, End of Life Issues, Constitutional Court Decisions, Legal Regulation, Italy

Summary: 1. Judgment No. 242/2019. A turning point in Italian law on end-of-life issues. 2. Changed scenarios of dying brought to the attention of the Constitutional Court. 3. The regulatory framework as the starting point for the Court's argument. 4. The need for a step forward. 5. Criteria for access to medically assisted death. 6. Continuing preclusion of euthanasia. 7. Misunderstandings about palliative care. – 8. Institutional roles and procedures as a condition for the protection of rights. – 9. A backward-looking draft and the hope of finding the path to a good law.

1. Judgment No. 242/2019. A turning point in Italian law on end-of-life issues

In the Italian context, active assistance, provided to people suffering from incurable diseases and intolerable pain, to end their lives according to their wishes, has repeatedly been at the centre of bioethical and bio-legal reflection. Nevertheless, it has for a long time remained on the margins of public debate, mainly, but not only, due to strong opposition from Catholic culture and associations, not so much against a single act, as against any form of legal recognition of the lawfulness of assisted dying, even if subject to strict limits and conditions. However, in recent years, this issue has drawn increasing attention both at institutional and theoretical level, following the ruling of the Constitutional Court, which declared Article 580 (Incitement or assistance to suicide) of the Criminal Code unconstitutional, "*where it does not exclude the punishment of those who ... facilitate the execution of the intention to commit suicide, formed independently and freely, of a person kept alive by life-sustaining treatment and suffering from an irreversible condition that causes physical or psychological suffering that they consider intolerable, but who is entirely capable of making free and*

informed decisions, provided that these conditions and the manner of execution have been verified by the National health service, after consultation with the local ethics committee concerned".
This decision was to mark a turning point in Italian end-of-life law, made by the Constitutional Court on the basis of a solid background of factual and normative considerations.

2. Changed scenarios of dying brought to the attention of the Constitutional Court

The factual considerations concerned the profound changes in the scenarios of dying due to increased medical intervention efficacy.
These changes consisted in removing the event of death from the realm of "chance and necessity", and subjecting it to increasing control, relating not to the "if" (given that death will remain inevitable for human beings, as for all living beings), but rather to "when" and "how", i.e. the timing and manner in which the event will occur.
Indeed, for a long period of human history, the time lapse between the onset of diseases or the occurrence of accidental events, leading to death death, was very short, due to the inability of medicine to offer effective responses to pathological conditions. In just a few decades, and specifically starting from the second half of the twentieth century, the increasing availability of therapeutic strategies and methods, with varying degrees of technological sophistication, has, instead, - at least in the developed areas of the world - created the conditions for prolonged survival that has nothing "natural" about it, but depends exclusevely on medical intervention. This has meant that death, as the outcome of a more or less long "dying process", has, in turn, lost its connotation of naturality.
The scenarios of dying, transformed by the increased capacity of medical intervention, are, for example, those in which death occurs as a result of chronic degenerative, oncological, neurological or other diseases, the evolution of which is accompanied by quality of life deterioration and growing suffering. Or those in which individuals, belonging to an increasingly long-lived population, spend the final part of their lives in a worsening condition of multiple pathologies, often associated with cognitive decline, which precludes any relational dimension. Or, again, those in which, due to very serious injuries resulting from accidents, people, often still young, escape death, thanks to resuscitation techniques and life-sustaining treatments. Nevertheless, they find themselves in situations of actual suspension between life and death, such as permanent vegetative state. In other cases they do not suffer impairment of their cognitive faculties, but experience a condition of motor and sensory deprivation, as well as exposure to suffering, of such severity that the continuation of life appears to them as an unbearable imprisonment.

These scenarios of prolonged survival, characterised by the implementation of medical interventions capable of modulating the process of dying, but not to reverse it, by removing the causes of the pathologies, were, precisely, referred to by the Constitutional Court when, in judgment no. 242/2019, it spoke of "unimaginable situations" at the time when Article 580 was introduced into the Italian Criminal Code in 1930. These are situations affecting all individuals whom "medical science has become capable of rescuing from death, without, nevertheless, being able to restore sufficient vital functions"[1].

Focusing its attention on the peculiar condition of these individuals, the Court recognised that, the assistance provided by third parties to end their lives, cannot be brought within the scope of Article 580, in the name of the need to protect weak and vulnerable individuals, but must, instead, be assessed in the light of the rules and principles governing therapeutic decisions and end-of-life interventions, which are already well established in the Italian legal system.

3. The regulatory framework as the starting point for the Court's argument

Moving on to the regulatory framework on which the Constitutional Court based its decision, we must consider the context of the rules and principles outlined, over a period of several decades (from the late 1970s onwards) by legislative measures and judicial decisions that anticipated, and paved the way, for a strong rethinking of the traditional concept of care relationships and the mandate of medicine. All the above led to Law No. 219/2017 "Provisions on informed consent and advance treatment dispositions".

In repeatedly referring to this law as a cornerstone, the Court emphasised the provisions that established the ultimate overcoming of the paternalistic model of the doctor-patient relationship, based on the idea of attributing exclusively to doctors all decisions relating to medical treatments. On the other hand, outlined a care paradigm in which the response to patient suffering takes on the role of indispensable guiding criterion for care practice, for a long time attributed to maintenance of survival at any cost.

These provisions clearly define a set of rights, as a prerogative recognised by positive law, which have always been denied to sick individuals.

Firstly, the right to have the final say on all treatments, whether to be implemented or already in place and intended to continue over time. This right derives from Article 1 of Law 219/2017. This article grants autonomy to all treatment recipients. Defined as "decision-making", it belongs to them alone and cannot be placed on the same level as the autonomy granted to healthcare professionals. The latter

[1] Judgement by Constitutional Court No. 242/2019. The expression had already been used by the Constitutional Court in Order no. 207/2018, paragraph 8.

autonomy justified by professional know-how makes doctors responsible for identifying and proposing, but certainly not imposing, the appropriate courses of treatment for patients.

Secondly, and relatedly, the patient's rights - also established in Article 1 - to refuse any diagnostic investigation and/or healthcare treatment, including artificial hydration and nutrition, after having been adequately informed, in the case of life-saving treatment, of the consequences of refusal. Under applicable law, healthcare professionals are required to respect this right, while explicitly exempted from civil and criminal liability.

Thirdly, the right, established in the second article, to be relieved from suffering, even in the event of refusal of the treatment indicated by the doctor, receiving appropriate pain therapy and palliative care, including the last frontier of treatment, namely deep palliative sedation. Moreover, in the case of conditions with poor prognosis and imminence of death, the right not to prolong the dying process with useless and disproportionate treatments.

4. The need for a step forward

What are the implications of the above-mentioned provisions on "unimaginable situations" of prolonging survival accompanied by unbearable suffering?

The Court points out that, with the regulations on treatment decision making and end-of-life interventions, that have become part of the Italian legal system, the legal guarantee of an effective therapeutic response to situations of extreme suffering, has already been strengthened, including through the use of deep palliative sedation. In addition, the recognition has been consolidated that every sick individual has the right to withdraw from survival prolongation in seriously compromised conditions, that have become unbearable for them, by requesting the interruption of life-sustaining treatment and the simultaneous administration of sedation.

However, the Court also affirms that, once every individual has been recognised as having the right to refuse life-saving treatment, we can no longer neglect the wide range of situations of suffering, to which the solution, deemed appropriate by the people concerned, could not be offered by the above mentioned measures already available under the current law.

Hence the need for further steps at the regulatory level, and the possibility of offering the sick help to die (in the form of assisted suicide), as a further feasible path, going beyond Law No. 219/2017. A necessary step not to deprive sick and suffering people of the only way in which they can be freed from the prison of their unbearable condition.

In breaking the absolute ban on helping to die people in conditions of persistent, intolerable and, in their own opinion, irremediable physical and mental suffering, the Constitutional Court had to address issues of primary importance in relation to assisted dying, defining the criteria for identifying the

group of individuals who can avail themselves of it, as well as the roles of the institutional and health authorities involved. At the same time, however, it has repeatedly prompted law-makers to enforce a new law, in order to provide the most appropriate context for a precise and detailed regulation of procedures, preventing any form of abuse, and best guaranteeing both those assisted in ending their lives and those who carry out the acts of assistance.

Almost six years after Judgment No. 242/2019, however, Italy does not have the legislative regulation, called for by the Constitutional Court and desired by a large part of the Italian population, yet.

Against the backdrop of increased requests for assistance in dying, prompted by the conditions set by the Constitutional Court, a composite scenario of institutional initiatives and interventions has emerged. While difficult to fully illustrate, it highlights that, in the Italian context, there are still issues to be solved and steps to be taken to achieve the goal of a law that guarantees the right to end their life with dignity to every irremediably suffering individual.

5. Criteria for access to medically assisted death

The first fundamental issue to be solved in relation to medically assisted death is the definition of the requirements that legitimise a request for help to die.

As already mentioned, these requirements have been identified by the Constitutional Court as the presence of irreversible conditions, the persistence of physical and psychological suffering, judged as unbearable by the person concerned, and the ability of the person, requesting assistance in dying, to make free and informed decisions. The Court also include the additional requirement of dependence on life-sustaining treatment. However, this fourth requirement has been widely considered misleading and potentially discriminatory and has been the subject of legal action[2].

Following these, the Constitutional Court, called upon again to rule, first in judgment No. 135/2024 and subsequently in judgment No. 66/2025, on the one hand, did not find that last requirement unconstitutional, but, on the other hand, proposed its broader interpretation: namely, life-sustaining treatment means a wide range of procedures, even if only envisaged and not already implemented, necessary to prolong survival (including evacuation manoeuvres, the insertion of catheters, and the

[2] Both, the first and second rulings of the Constitutional Court were based on two judgments in criminal proceedings against Marco Cappato and others investigated for the crime of "assisted suicide", under Article 580 of the Italian Criminal Code, for accompanying in Switzerland two individuals, suffering from an irreversible terminal illness and in severe pain, but not dependent on life-sustaining treatment in the strict sense. First, the preliminary investigation judge of the Court of Florence and, subsequently, that of the Court of Milan, raised the question of the constitutional legitimacy of Article 580 of the Criminal Code, as reformed after judgment no. 242/2019, precisely with regard to the requirement of dependence on life support as a criterion for access to assisted suicide.

aspiration of mucus from the bronchial tubes, to limit ourselves to the examples given by the Court itself).

It must be acknowledged that the broader interpretation proposed by the Court is undoubtedly the concept of life-sustaining treatment that deserves to be adopted[3], and the one likely to reduce the discriminatory impact that emerged in the wake of judgment No. 142/2019. On the other hand, however, it should be emphasised that, although this concept ends up including in "life support" all treatments (and acts of care) that accompany the survival of the patient, making it a redundant requirement, its maintenance among the requirements for access to medically assisted death may, nevertheless, fuel uncertainty and give rise to unjustified differences in treatment.

Emblematic examples of this are provided by the cases of two women, both suffering from advanced multiple sclerosis and in perfectly comparable clinical conditions of unbearable suffering, only one of whom was recognised by the Health Service as meeting the fourth requirement and being eligible for assistance in dying[4].

Dependence on life support, therefore, appears, on closer inspection, as a requirement likely to maintain unjustified inequalities between equally suffering individuals and, as such, as a requirement that should be eliminated from the regulations, in line with the legislation already introduced in countries such as Spain and Portugal, and which is expected to be introduced in France and Great Britain[5].

6. Continuing preclusion of euthanasia

There is, however, a further aspect about the guarantee of equality that cannot be overlooked in the legal regulation of medically assisted death, requiring further significant steps towards the establishment of rights at the end of life, as marked by the decisions of the Constitutional Court.

In other words, the prohibition of euthanasia must be overcome, whose heterogeneity/discontinuity with respect to assisted suicide is emphasised.

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[3] In anticipation of the same perspective, see P. Borsellino, *Limitation of the therapeutic effort: ethical and legal justification for withholding and/or withdrawing life sustaining treatments*, in «Multidisciplinary Respiratory Medicine», 10, 5, 2015.

[4] The first of the two women, Laura Santi, was granted access to assisted suicide and died at her home in Perugia, surrounded by her loved ones. The second, Martina Oppelli, repeatedly requested recognition of the requirements to end her life of suffering in the same way, but had to travel to Switzerland to carry out her wishes, as her application was rejected three times.

[5] In Spain and Portugal, laws legalising assisted suicide and euthanasia were, respectively, enacted in 2021 and 2023. In Great Britain and France, important steps towards legalisation, although not yet definitive, were taken, respectively, with the approval of bills regulating them by the House of Commons in June 2025 and the National Assembly in May 2025. For an analysis of the regulation in Spain, see, in this book, the contribution on *The Regulation of Euthanasia in Spain* by María Tormo, Pilar Pinto Pastor, Benjamín Herreros (ASISA Bioethics and Health Law Committee).

In limiting its judgment to assistance in suicide, as it was called upon to do[6], the Court made no reference to individuals who, due to physical incapacity or psychological difficulties, cannot by themselves initiate the process leading to death by suicide, but require the euthanasia intervention of third parties.

The question of the active intervention of a third party and, therefore, of the inclusion of euthanasia in medical assistance procedures in dying, without criminal liability, was covered again[7] by the Constitutional Court in a further ruling, No. 132 of 25 July 2025. In this case, the Court was called upon to rule on the constitutionality of Article 579 of the Criminal Code (murder of a consenting person), in the part in which it does not exclude the punishment of those who, where the conditions for access to medically assisted suicide exist, materially carry out the will of the sick person who, due to physical impossibility and the absence of suitable instruments, cannot proceed independently.

The question was raised during proceedings before the Court of Florence by a person suffering from multiple sclerosis who, finding himself in the conditions indicated in judgment No. 242 of 2019 for access to medically assisted suicide, as verified by the local health authority concerned, was nevertheless unable to self-administer the lethal drug. He was unable to use his limbs, due to the progression of the disease, and could not obtain the equipment necessary for the independent implementation of assisted suicide, i.e. an infusion pump that could be activated by voice command or by means of the mouth or eyes, the only methods permitted by the current stage of progression of the disease.

The Court would have been expected to take the opportunity of this judgment to reduce the heterogeneity/discontinuity of assistance in dying in the form of euthanasia, compared to assisted suicide. It could have done so, first of all, on the basis of the argument that, in both procedures, the doctor is invested with a decisive "assistance" role. The only difference being that, in the case of euthanasia, the form of assistance appropriate to situations, in which the patient is unable to perform any act, is provided and, as such, is more complete. As in other rulings, it could have also stressed the principle of equality established in Article 3 of the Italian Constitution. This article, in delegitimising unequal treatment of citizens (and all individuals) on the basis of "personal conditions", including, first and foremost, health conditions, provides the first strong legal, as well as

[6] Indeed, the question of the constitutional legitimacy of Article 580 of the Italian Criminal Code, on which the Constitutional Court ruled in judgment no. 242/2019, was raised during the court proceeding against Marco Cappato, the activist who accompanied to Switzerland Fabiano Antoniani (D.J. Fabo) supporting his wish to be assisterd in suicide.

[7] Having already done so in judgment No. 50 of 15 February 2022, in which it declared inadmissible the request for a popular referendum for the partial repeal of Article 579 (murder of a consenting person) of the Criminal Code. See, in this regard, P. Borsellino, *Diponibilità e indisponibilità della vita* (Availability and unavailability of life)**,** in *Forum, Bio-Law Journal - Rivista di BioDiritto*, no. 2/2022, 55-59. *www.biodiritto.org.*

ethical, reason for guaranteeing the right to a dignified death even to those who, precisely because of their clinical condition, might not see it recognised.

Nevertheless, this was not the path taken by the Constitutional Court. While considering the request of the person unable to self-administer the drug worthy of protection, it ruled against the admissibility[8] of questions of constitutional legitimacy on the possible active intervention of a third party, due to a lack of evidence on the availability of devices suitable for overcoming the limits that prevent self-administration.

In other words, the Court held that, thanks to adequate activation, which is the responsibility of the Health Service, it is always possible to allow access to assisted suicide to persons who meet the requirements established by judgment No. 242/2019, and subsequent judgments No.135/2024 and No. 66/2025, implicitly suggesting that the available technical solutions actually make the reasons for resorting to euthanasia meaningless.

This could be described as a technical-procedural *trick*, whereby the Court avoids addressing the question of principle of whether it is justified to maintain the prohibition on euthanasia, considering that also assisted suicide involves the collaboration and supervision of a doctor and other health professionals, responsible for preparing the drug and determining the method of administration, has been highlighted.

This is an important issue, which can hopefully be solved in the direction already taken by countries culturally close to Italy, such as Spain, and Portugal.

7. Misunderstandings about palliative care

Equally important are the requirements on the clinical and care preconditions for access to medically assisted death and the procedural steps and methods of implementation of the interventions.

When I refer to preconditions of a clinical and care nature, I am referring to the provision, already contained in judgment No. 242/2019, that the patient requesting assistance in dying must have been "involved" in a palliative care programme. The conditions and modalities of this involvement must be clearly defined so as not to misinterpret the guidelines provided by the Constitutional Court.

Now, if we consider that palliative care has brought about a paradigm shift in practice and, even before that, in medical ethics, which is destined to have a decisive impact on the relief of suffering for many patients with incurable diseases and a poor prognosis[9], we cannot but agree, in line with the Constitutional Court, on the thesis that it is not only desirable but necessary to provide uniform and

[8] Not against the validity of the question of legitimacy on the merits.

[9] See, in this regard, P. Borsellino, *Biorights at the end of life. Achievements and Open Questions in Italian Context*, in J.A. Seoane, O. Vergara, eds, *The Discourse of Bioright. European Perspectives*, *The International Library of Bioethics*, 109, Springer, 2024, pp. 303-318.

enhanced palliative care throughout the country and in all care settings, without excluding the patient's home, as well as to extend it - well beyond the field of oncological diseases, to which it was initially (and for a long time) limited - to all life-threatening diseases.

If this is true, it is also true that the best provision and delivery of palliative care (which is still far from being achieved in our country) could reduce, but certainly not eliminate, situations of persistent suffering, which are considered unbearable by sick people, even with adequate control of painful symptoms. It is, indeed, the loss of future planning, very often in contexts of increasing motor, sensory and relational deprivation, that makes the continuation of life to most patients appear as an unbearable imprisonment, from which palliative care alone cannot free them. On the other hand, it should not be forgotten that, like any other intervention or treatment, palliative care requires the consent of the patient in order to be implemented.

This makes it necessary to distance ourselves from the illusion or, perhaps better, the mystification of "palliative omnipotence", i.e. the thesis that therapeutic approaches, in which palliative care is substantiated, can always and in all cases offer an adequate response to the physical and mental suffering of patients with a terminal prognosis and/or in irremediably debilitating conditions, thus depriving the request for help in dying of any justification.

It also follows that, in defining the path to access medical assistance aimed at ending the life of a patient who meets the requirements, the requesting patient must be ascertained to have been informed about palliative care and placed in a position to actually avail themselves of it. Instead, it does not appear justified to present them as a sort of "obligatory path" that the applicant is necessarily required to take.

On the other hand, these are the guidelines on palliative care and the correct way of understanding its relationship with medically assisted death, adopted by the representative bodies of palliative care in Italy, such as the Italian Society for Palliative care (SICP) and the Italian Federation of Palliative Care[10]. These are the same guidelines adopted by the documents aimed at defining - within the framework of the above-mentioned judgments of the Constitutional Court - organisational arrangements and procedures in matters of medically assisted death, as already implemented by

[10] See the Memorandum presented at the hearing before the Justice Committee and the Social Affairs, Health, Public and Private Employment, and Social Security Committee of the Italian Senate. on 28 May 2024. Available on the website: https://www.fedcp.org/news/audizione-fcp-sicp-in-tema-disposizioni-in-materia-di-morte-volontaria-medicalmente-assistita.

administrative measures in some Italian Regions[11] and, in the case of Tuscany and Sardinia, by regional laws, promulgated, on 14 of March 2025 and on 17 of September 2025[12], respectively.

8. Institutional roles and procedures as a condition for the protection of rights

Following a ruling such as No. 242/2019, which marked a turning point in Italian law on end-of-life issues, it became clear that terminally ill patients, in conditions of unbearable suffering, would not be able to have their expectation of being helped to die fulfilled, without the establishment of procedures that can be easily followed, from the moment the request for intervention is made until its implementation, thanks to the clear identification of the care facilities and medical professionals involved, the bodies responsible for assessing requests and the existence of the requirements, and contexts in which the interventions can be carried out.

This has been confirmed by the resistance and slowness of healthcare Services in responding to requests from individuals suffering unbearably, for some of whom assisted suicide in a private facility in Switzerland has ended up appearing as the only way forward in order not to prolong suffering that they consider unbearable.

While waiting for legislative regulations to be adopted, that can define the precise procedural steps to be followed in the event of requests for medically assisted death, the regional initiatives, mentioned at the end of the previous paragraph, have upheld the guidelines, already provided by the Constitutional Court in its ruling no. 242/2019, regarding both the role to be recognised to the National Health Service structures in verifying the conditions and procedures for implementing medically assisted death, and the involvement of the local ethics committee concerned, with a qualified ethical advisory role. to protect the person making the request. However, important steps forward have been taken, in specifying decisive aspects to make the path indicated by the Constitutional Court viable: from the formulation of requests to the establishment and functioning of assessment bodies within healthcare facilities and, above all, the planned timelines for assessing the requirements for access to procedures and for their implementation.

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[11] The administrative measure was adopted by the Emilia-Romagna Region, which, in February 2024, issued "Technical and operational instructions for verifying the requirements set out in Constitutional Court ruling no. 242/2019, and the procedures for its application, by the Directorate-General for Personal Care, Health and Welfare". The Lombardy Region has also set up a technical Committee to draw up 'procedural guidelines for the regional health system on medically assisted death'. However, these have not been formalised.

[12] The path of regional legislation was instead taken by Tuscany, which, on 14 March 2025, enacted the law 'Organisational procedures for the implementation of Constitutional Court rulings No. 242/2019 and No. 135/2024'. However, this law was challenged before the Constitutional Court by the Italian Government, which contested the Region's competence in the matter. Subsequently, the Sardinian Region also approved Bill No. 59, entitled '*Procedures and timelines for regional healthcare assistance for medically assisted suicide pursuant to and by effect of Constitutional Court ruling No. 242/2019*'.

Without prejudice to differences, that only a national law will be able to overcome, the prevailing view is that the body, with ethical competence and an advisory function, to be involved in the assessment process, should not be identified in the territorially ethics committees concerned, currently responsible in Italy for the assessment of research and clinical trials, but rather in specific multidisciplinary bodies, with expertise in the most problematic areas of clinical practice, known as Clinical Ethics Committees.

Finally, it appeared indisputable that, once the requirements for access to medically assisted death have been met, the National Health Service[13] has the responsibility to implement the procedures, providing the location, medication and equipment, without any financial burden on the applicant. Moreover, the voluntary nature of the assistance provided by healthcare personnel and the limitation of assistance in dying to the method of self-administration, which is characteristic of assisted suicide, were reaffirmed, once again, in line with the ruling of the Constitutional Court.

9. A backward-looking draft and the hope of finding the path to a good law

The above considerations allow us to affirm that the right to be helped to die, when dramatic situations arise, in which such help becomes a condition for ending life with dignity, is still, in Italy, a sort of "right in the balance". The situation is, in other words, that of a "work in progress". This has been started but not yet fully achieved, and may be completed if - as repeatedly requested by the Constitutional Court and hoped for by a large part of the Italian population - a law will be finally enacted, suitable of providing solid guarantees to sick people and, at the same time, clear guidelines for healthcare professionals, following the examples of regulations already introduced or in the process of being approved in other European countries.

On the other hand, it should be emphasised that the groundwork for good legal regulation of medically assisted death has already been laid in Italy by judicial rulings, especially by the Constitutional Court, and by regional institutional initiatives, as well as by the extensive work carried out by parliamentary committees, over the last five years[14].

There are, certainly, still outstanding questions, but some firm points have been established, first and foremost that of assigning to the National Health Service the tasks of assessment and implementation related to medically assisted death procedures, against a backdrop of significant awareness.

The justification for acts of assistance in dying does not lie in the denial of the value of the life of those who are terminally ill and/or in conditions of irremediable disability. Rather, it is based on the

[13] On the role of the National Health Service, see, in this book, the contribution by Lorena Forni, *Medically Assisted Suicide and the Crisis of the National Healthcare System: A Brief Bioethical Analysis of the Italian Case*.

[14] The hearings, held until last autumn, can be consulted on the website of the Senate of the Republic. Available at: https://webtv.senato.it/webtv/commissioni/disposizioni-materia-di-morte-volontaria-medicalmente-assistita-2.

conviction that it is precisely the value to be recognised in the life - in its biographical and not only biological significance, - of every human being, that requires us to go beyond the paralysing dichotomy of the unavailability/availability of life, and to pursue all paths that allow us to protect dignity, including the path, however painful it may be, of granting them the right to die, when, in their opinion, there is no other way out of a condition that has become unbearable.

Contrary to these trends, the political forces currently in government in Italy presented a draft law, last July, entitled "Executive provisions of the Constitutional Court ruling No. 242 of 22 November 2019".

This draft law, in line with the wishes of mainly Catholic and *pro-life* associations, which are firmly opposed to assisted dying and its regulation by law, far from implementing it, places itself completely outside the perimeter marked by judgment No. 242/019 and by further rulings of the Court.

Indeed, it introduces provisions aimed not at regulating, but rather at making access to medically assisted death impossible, on the assumption of the inviolability of the right to life, which, on closer inspection, translates into the duty to live at all costs.

It does so by making palliative care mandatory, assigning the assessment of the requirements to an *ad hoc* committee appointed by the government, with timelines that are not compatible with the conditions of extreme suffering of the sick, and by proposing, with the exclusion of the National Health Service and the privatisation of procedures, unequal treatment, based on the economic condition of the sick.

This is a draft law with strong ideological connotations, whose provisions, already widely criticised, would be open to challenges of unconstitutionality, if translated into law, as has already happened in Italy in the case of the ideologically charged Law No. 40/2004, on medically assisted procreation, which was subsequently dismantled by the Constitutional Court in its most restrictive provisions.

It is to be hoped that we stop in time, and that Parliament will find its way back to a good law on medically assisted death, the basic lines of which have already been outlined in a significant way.

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The End -of-Life Decision-Making Law in Italy: a "Transitional" Model

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Abstract: The essay presents an analysis of the existing legal framework about end-of-life decision-making in Italy with a specific focus on the withdrawal and withholding of life-sustaining treatment.

Key words: End-of-Life; Decision-Making; Life-Sustaining Treatment; Italian Act no. 219/2017.

Summary: 1. Overview. 2. The Constitutional framework of the right to die in Italy. 3. The patient's right to refuse life-supporting medical treatments under current statutory law: Act no. 219/2017. 4. The patient's right to be medically aided in dying by the NHS under certain clinical circumstances: Art. 580 of the Criminal Code according to the case-law of the Constitutional Court. 5. Further scenarios concerning end-of-life decision-making law in Italy: "*en attendant…"* Parliament.

1. Overview

The current Italian system of end-of-life decision-making law should be appreciated, on one hand, as a result of legislative and judicial drives, and, on the other hand, as a transitional model between those States that do (*only*) recognize the right to withdraw or withhold life-sustaining medical treatments and those States that (*also*) include the right to euthanasia.

In fact, as for the legal "drivers", it should be highlighted that the right of the patient to refuse all medical procedures — life-support *included*, with no exemptions — has been initially founded in the "penumbra" of the Constitution, by an interpretative approach adopted by the Court of Cassation[1].

Following that judicial interpretation of constitutional provisions, the Parliament, at the end of the XVII session, passed the Act 22nd December 2017, n° 219 on "Informed consent and advance disposition of treatment" ("*Consenso informato e disposizioni anticipate di trattamento*")[2], which sets out in detail, at the statutory level, the conditions and the procedures according to which that *right to die*, understood as the *right to refuse medical treatments*, might be exercised by the individual[3].

Analogously, the other dimension of the *right to die*, intended as the *right to obtain medical assistance in self-administering a lethal dose under some strict and tailored requirements*, has been initially

[1] Cass. Ct. 21748/2007. *See infra*, §2.
[2] *See infra* §3.
[3] *See infra* §3.

founded in the "penumbra" of the Constitution by virtue of an interpretation adopted by the Constitutional Court[4], and it is now awaiting detailed legislative implementation[5].

As for the legal "classification" of the current model on end-of-life decision-making, Italy has gone beyond merely recognizing the right to refuse medical treatment, extending also to the admission of medical aid in dying, while remaining far from contemplating euthanasia.

In fact, Italian law recognizes the right to withhold or withdraw life-sustaining medical treatment[6].

At the same time, it no longer punishes medical aid in dying — defined as the prescription by a physician of a lethal substance, on the basis of the patient's free and informed will and for self-administration — but only where (among other conditions) the patient suffers from an irreversible illness and is dependent on life-sustaining treatments that he or she has refused[7].

From this perspective, while Italy acknowledges that the National Health Service (NHS) has a legal obligation to assist patients in self-administering the lethal substance, it is not a euthanasic State.

Indeed, Italy does not allow a physician to deliberately administer a lethal substance in order to cause the death of a patient with decision-making capacity at the patient's voluntary request; nor does it admit that a physician may deliberately enable a patient to end his or her life by prescribing or providing medical substances with the intent to bring about death[8] *outside* the framework of dependence on irreversible life-sustaining treatments that have been refused (a framework where the same medical aid consists solely of anticipating a *natural death* that would, in any case, ensue within a short period of time owing to the same refusal of medical support indispensable for survival).

2. The Constitutional framework of the right to die in Italy

The constitutional grounds of the Italian "*right to die*", *intended as the right to refuse medical treatments that support life*, can be traced back to Articles 2 and 32 of the Constitution[9].

The Constitutional Court and the Court of Cassation[10] have affirmed that although the right to life is not explicitly stated in the constitutional text, it is implicitly recognized and guaranteed as one of the inviolable "rights of human person" included in Article 2 Const. Consequently, the Republic is under

[4] Const. Ct. 242/2019. *See infra* §2.
[5] *See infra*, §4 and §5.
[6] *See infra* §4.
[7] *See infra*, §4.
[8] *Cf*. the definitions adopted in the World Medical Association, *Declaration on euthanasia and physician-assisted suicide*, 2019.
[9] *Cf*. P. Veronesi, *Uno statuto costituzionale del corpo*, in *Trattato di biodiritto-Il governo del corpo*, Giuffrè, 2011, 137-172; U. Adamo, *Costituzione e fine vita. Disposizioni anticipate di trattamento ed eutanasia*, Cedam, 2018.
[10] Cass. Ct. 21748/2007 and Const. Ct. 242/2019, 135/2024, 66/2025.

a constitutional duty to protect every human life, without exception, through the laws and the actions of public authorities.

At the same time, the State has *no* constitutional obligation, under Article 2 Const., to recognize and implement what may be termed the "negative dimension" of the right to life (*i.e.*, the right to death at individual will with the assistance or intervention of the State itself or any other third party).

As a consequence, any hypothetical legal framework that would render lawful — *solely* on the basis of the individual's mere will — the conduct of a third party causing death, *irrespective* of the circumstances under which the intention was formed, the identity or motives of the persons involved, and without taking into account the manner in which consent is expressed, or the means used to bring about death, would be constitutionally void[11].

However, Article 32 Const. affirms, in parallel, the fundamental principle of voluntary medical treatment by stating that no one shall be compelled to undergo a specific medical intervention unless it is mandated by law and respects the inviolable limits of human dignity. Consequently, individuals possess a general right to determine what occurs (and what *does not*) "to" and "within" their own bodies[12]. Therefore, in the absence of a statutory provision that mandates a medical treatment, individuals have the right to accept or decline any medical intervention, even if such intervention is essential for their survival[13].

If the right to self-determination regarding medical treatment is valued as fundamental, then this right should also be extended to individuals who are deemed incapable of making medical decisions[14]. Otherwise, such a stance would create an intolerable discrimination — impermissible under Article 3 of the Constitution — among individuals in their exercise of a fundamental right inherent to human dignity, based solely on a personal condition: whether or not the pathology affecting the individual has resulted in legal incapacity[15].

Therefore, it is essential to recognize, alongside the right to consent to or refuse medical treatment in the *present*, the right to plan medical interventions in *advance*[16].

The recognition of a patient's constitutional right to refuse medical treatment — including life-saving or life-sustaining interventions — prevents the legislature from enacting measures of "compulsory" medical treatment aimed *solely* at protecting the individual's health, *unless* there is *also* a significant impact on public health.

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[11] Const. Ct. 242/2019, 50/2022, 135/2024.

[12] Const. Ct. 135/2024.

[13] Cass. Ct. 21748/2007.

[14] Cass. Ct. 21748/2007.

[15] *Cf.* F.G. Pizzetti, *Alle frontiere della vita: il testamento biologico tra valori costituzionali e promozione della persona*, Giuffrè, 2008.

[16] *See infra* §4.

The only acceptable exception to this principle is when an ill individual requires treatment to save her life or psycho-physical health and is unable to make informed medical decisions (due to a mental illness[17]), or has *not* expressed her wishes through advance care planning to guide medical decisions in the event of subsequent mental incapacity.

In fact, allowing additional exceptions for "compulsory" (or even "forcibly administered") treatments would risk opening the door to potential limitations on an individual's therapeutic autonomy, based solely on a "*paternalistic* view" — adopted by society or by physicians — of what is deemed to be in the "best interest" of the individual[18].

Furthermore, because every patient possesses the constitutional right to refuse any form of medical treatment, including treatment necessary to sustain life, it has been held unreasonable — and thus constitutionally impermissible — to penalize the mere material assistance in accelerating death through the prescription of a lethal substance by physicians in circumstances where patients — competent and irreversibly ill — already have the means of ending their lives by freely declining the treatment essential to their survival[19].

Preventing such a patient — incurable and reliant upon life-sustaining medical support — from realizing her fully informed and genuinely voluntary wish to further shorten that interval — which, for the individual, may amount to nothing more than a period of sheer "agony" — through the medically assisted self-administration of a lethal dose (rather than simply awaiting death following the withdrawal of life-sustaining measures) amounts to compelling that patient to undergo death by means of a more prolonged and gradual process that is wholly irreconcilable with her personal conception of dignity in dying.

Such a situation accordingly constitutes an unacceptable restriction on the patient's freedom of self-determination in matters of medical treatment, including those aimed at relieving pain, as enshrined in Articles 2 and 32 of the Constitution[20].

Therefore, in these curtailed circumstances, from the "right to die", understood as the right to renounce life-saving treatments, there also derives the "right to die" conceived as the *patient's right to receive assistance, from a willing physician, in the self-administration of a lethal dose to hasten death* ("*medical aid in dying*")[21].

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[17] Const. Ct. 76/2025.

[18] *Cf.* P. Borsellino, *Il concetto di dignità umana nella riflessione bioetica e biogiuridica italiana. Le buone ragioni di una definizione condivisa*, in *Quaderni di diritto e politica ecclesiastica*, 2024, 35-56.

[19] Const. Ct. 242/2019.

[20] Const. Ct. 242/2019, 135/2024.

[21] *See infra* §4.

At the same time, due to the obligation to guarantee life under Article 2 Const., the legislature *cannot* abdicate its duty to provide safeguards in relation to personal choices involving assisted suicide or consensual killing.

A "*minimum*" protection of the value of life — *constitutionally irreducible* — must be established through necessary substantive and procedural guarantees, ensuring that the decision to cease living is made by a competent individual, of sound mind, with informed awareness, a sense of self-responsibility, and in the absence of any errors or abuse (such as misdiagnosis, prognostic faults, or malicious suggestions by third parties aimed at distorting one's will by exploiting her vulnerability, *etc.*) [22].

The State also has a constitutional obligation to ensure adequate forms of social support, medical care, and continuous home-based health and social assistance, since the availability or absence of such services may significantly affect the decisions of the individual facing illness and disability, potentially determining the difference between a choice to live and a request to die[23].

3. The patient's right to refuse life-supporting medical treatments under current statutory law: Act no. 219/2017

Developing the abovementioned constitutional framework[24], Article 1 of the Act n° 219/2017[25] affirms that anyone has the right to life, health, dignity, and self-determination, and that no medical treatment may be initiated or prolonged without the free and informed consent of the patient, except in cases of compulsory treatments expressly foreseen by statutory law.

Regarding life-sustaining supports, Art. 1(5) provides that any competent individual has the right to refuse any treatment, either wholly or partially. Additionally, a patient retains the right to revoke any previously granted consent, even if such revocation leads to the suspension of treatment. This dissent may be communicated in any suitable manner that accommodates the patient's condition. For individuals with disabilities, options such as video recordings or other communicative devices are permitted. It is essential that this dissent be documented in writing and included in the patient's medical records and electronic health file.

When a patient indicates their intent to refuse or forgo necessary medical treatment, the attending physician is obligated to inform the patient — and, with the patient's consent, their family members

[22] Const. Ct. 50/2022, 135/2024.

[23] Const. Ct. 66/2025.

[24] *See supra* §2.

[25] *Cf.* C. Casonato, S. Penasa, M. Ridolfi, *Consenso informato e DAT: tutte le novità*, Giuffrè, 2018; M. De Filippis, *Biotestamento e fine vita. Nuove regole nel rapporto medico-paziente: informazioni, diritti, autodeterminazione*, Giuffrè, 2018; M. G. Di Pentima, *Il consenso informato e le disposizioni anticipate di trattamento*, Giuffrè, 2018.

— about the implications of that decision and any available alternatives. The physician must also take all appropriate measures to support the patient, including providing access to psychological support services when needed. Additionally, Art. 1(5) affirms the patient's right to modify her decision at any time. This provision suggests an implicit requirement for a time interval between the patient's decision to refuse treatment and the implementation of her will, allowing for the possibility of an eventual change of mind. All expressions of acceptance, revocation, or refusal must be properly documented in the patient's medical and electronic health records.

It is important to emphasize that, according to Art. 1(6), physicians must respect a patient's decision to refuse treatment without incurring civil or criminal liability. This obligation to honor the patient's wishes, along with the exemption from any kind of liability, is upheld even if the natural death results from the expressed dissent.

In such cases, Act n° 219/2017 correctly presumes that the individual's choice does *not artificially* hasten death; rather, death occurs *naturally* once life-support is withdrawn or withheld, pursuant to an autonomous and informed decision by a legally capable patient. Thus, the protection of the right to life is adequately maintained in a coherent and constitutional balance with the right to self-determination. Here, the individual's autonomy is *not aimed* at *disposing* of the *right to natural life* by demanding *a lethal substance*; instead, it seeks to achieve a *natural death* by forgoing *artificial life-sustaining medical support* (a choice firmly rooted in the individual's freedom to decide about her healthcare)[26].

Article 1(3) provides that a competent patient has the right to refuse, either wholly or partially, to receive pertinent information or to appoint family members or a "person of trust" ("*fiduciario*") to receive this information and to provide "express consent" on her behalf. Consequently, it can be argued that the same family member or trusted representative — designated by the competent patient — may also have the authority to refuse or revoke consent for life-sustaining treatments. This point presents a complex legal question. On one hand, Act n° 219/2017 does not explicitly provide exceptions in Art. 1(3) and (5) regarding the representative's power to make decisions about life-supporting procedures. On the other hand, since the decision to consent or dissent here concerns life-saving support, the right involved is fundamentally personal — *i.e.,* the right to life — because the refusal made by the healthcare proxy could result in the patient's natural death. Thus, it is debatable whether, in the absence of specific instructions, the family member or designated person of trust could decide to cease life-sustaining treatments on the patient's behalf. However, it can be reasonably argued that, because the patient is capable of understanding and articulating her own wishes, any

[26] *See supra* §2.

decision made by her representative to discontinue life-sustaining treatment could easily be overridden by the patient's immediate and opposing desire — to continue such treatment — given that the patient still possesses the legal (and practical) capacity to express that wish.

Another important point to be elucidated here is the interpretation of the formula "life-sustaining medical treatment" adopted by the lawmakers.

Plainly, it should be evaluated as a medical treatment of life-support that the patient *has* the right to refuse the so-called "artificial hydration and nutrition", as expressly mentioned as a "medical treatment" by Art. 1(5). The same Article 1(5) defines this kind of treatment as the administration of nutrients via medical devices, based on a medical prescription.

Beyond this specification, the lawmakers have not provided any further "examples" of life-supporting medical treatment to clarify, orient or circumscribe the application of the right to waive life-sustaining medical practices.

However, the Constitutional Court delivered a persuasive interpretation of that statutory wording in a case concerning an end-of-life decision. According to that Court, the patient holds the fundamental right to refuse any medical treatment administered to her body, regardless of the treatment's technical complexity or invasiveness. Therefore, life-sustaining medical treatments encompass procedures typically performed by healthcare professionals, as well as those that, while requiring specialized skills acquired through training, may also be undertaken by family members or caregivers who take on the responsibility of assisting the patient. Thus, if such measures are necessary to ensure the performance of vital bodily functions — such that their omission or withdrawal would likely lead to the patient's death within a short period of time — then they must indeed be categorized as life-sustaining treatments[27].

In accordance with the provisions outlined in Article 2 of Act n° 219/2017, a patient who has chosen to exercise her right to die remains entitled to receive palliative relief and pain management. The right to palliative care and pain management is broadly recognized under Act n° 38/2010 — expressly mentioned in Article 2 — and also includes the option for terminal sedation, provided that such a request is duly documented in the clinical records.

That same Article 2(2) establishes the limits of what a patient may lawfully request from attending physicians in end-of-life clinical situations, even in cases where the patient voluntarily seeks the administration of such treatments.

[27] Const. Ct. 135/2024.

While individuals retain the right to refuse life-saving medical treatment, they are equally entitled to give informed consent to life-sustaining interventions, as well as to any other medically indicated therapy.

However, where a patient is affected by a *medically certified short-term terminal prognosis* or is *in a state of imminent death*, physicians are under a legal duty to *refrain* from any form of *unreasonable therapeutic persistence*, including the administration of treatments deemed *clinically futile* or *disproportionate*.

The legislature did *not* establish any detailed definitions for these parameters, which could — interpretively — encompass situations in which death is from 24 hours to 3 months and the treatments lack clinical efficacy or present risks that outweigh the benefits concerning the quality of life in such a limited time remaining before the patient's death.

The right to withdraw or withhold life-supporting therapies, as well as the right to decide whether to receive those treatments — insofar as they become futile or disproportionate and therefore forbidden under Article 2 — is also recognized for incompetent patients who had previously planned their healthcare.

Furthermore, Article 4 of Act n° 219/2017 serves as the legal basis for *advance directives* (*living wills*), known in Italian as "*disposizioni anticipate di trattamento*" (DAT) [or "*advance health-care dispositions*" (AHD)][28].

Every individual of legal age and sound mind has the right to articulate her preferences regarding medical treatments in the event of future incapacity. To make informed decisions, individuals must receive "adequate medical information about the consequences of their choices." Although the law does not explicitly mandate consultation with an attending physician, it requires that individuals do not rely exclusively on personal beliefs or ideas. Instead, they must obtain, at a *minimum*, medical information from qualified professionals. Sources of information deemed acceptable include medical personnel, professional associations, or reputable websites, provided that the information comes from named experts with verified expertise and is scientifically sound.

According to Art. 4, individuals have the right to express their consent or refusal regarding diagnostic and therapeutic treatments *in advance*, without any *exception*. This also means that individuals can indicate their refusal of *life-saving measures* — including artificial nutrition and hydration — in advance by drafting and signing their AHD.

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[28] *Cf.* A. Sirotti Gaudenzi, *Il biotestamento*, Maggioli, 2019; F.G. Pizzetti, *Il diritto alla pianificazione anticipata delle cure: fondamenti costituzionali e attuazione nella legge n. 219/2017*, in E. Calò (a cura di), *Consenso informato e disposizioni anticipate*, ESI, 2019, 203-257.

A valid AHD must be a public document executed before a notary, a private document authenticated (just for the identity of the person and the date of the signature) by a notary or another public official, or a private document (completely handwritten, signed, and dated by the individual) officially filed with the civil registrar in the municipality of residence. For individuals with disabilities, alternatives such as videotaping or assistive communication devices are acceptable. The AHD is submitted to a National Database and can be renewed, modified, or revoked following the same procedures. In emergencies, an AHD can be revoked with an oral statement, which must be documented by the physician in the presence of two witnesses.

In addition to expressing her previous wishes regarding healthcare, within the same AHD the individual may also designate a "trusted person", who must be a competent adult. This person of trust must accept the appointment by signing the same document or through a separate formal act of agreement. Additionally, the "trusted person" may terminate the appointment at any time without the need to provide a reason; similarly, the person who appointed the "trusted person" may also revoke the designation at any time, without explanation.

According to Art. 4, any AHD made by the patient, once the same patient has become incompetent, is binding unless the attending physician and the designated "trusted person" agree that: the AHD is manifestly inconsistent (for instance, due to illogical reasoning, inadequate medical information, or an intent that does not align with the provision of advance health care); is not in harmony with the clinical condition of the incompetent patient; or is outdated (there are new therapies that were unforeseen at the time the advance health directives were signed, which could provide a realistic opportunity for improved living conditions for the patient).

While Article 4(7) of Act n° 219/2017 left it to the Regions the possibility of establishing local registers, a national electronic database for advance healthcare directives was established by the Ministry of Health (Ministerial Decree n° 1689/2019), as provided for in Act n° 205/2017.

Act n° 219/2017 introduces an additional legal tool for future healthcare planning.

According to Article 5, an individual diagnosed with a "*chronic illness*" or a "*progressively worsening disease with a poor prognosis*" (*not* in other clinical conditions) may arrange, with the attending physician, a "*shared care planning*" ("*pianificazione condivisa delle cure*"). The individual must receive comprehensive information regarding prognosis, life circumstances, treatment options, and palliative care. The shared health-care plan allows for the consideration of *present* and *future* healthcare decisions, even in the event that the *person becomes incompetent*. The Article 5 permits the planning of end-of-life care, including the refusal of life-support measures — nutrition and hydration considered — and the request for palliative therapies or terminal sedation. Additionally,

pursuant to the same Article 5, the individual may designate a "trusted person". This "trusted person" will represent the patient, acting on her behalf, in case of loss of legal capacity.

The shared care plan must be documented in writing and signed by both the patient and the physician. It may be modified by the patient and the attending physician as circumstances change.

Since the plan is drawn up by the same attending physician (in accordance with the patient) based on present diagnosis, prognosis, and clinical needs (and not, as with the AHD, for a future, hypothetical condition of illness and incapacity), it is binding for the healthcare team.

Lastly, Act n° 219/2017 sets out provisions governing health care decisions in cases involving minors or incapacitated adults, who have not expressed their will through advance healthcare dispositions, or shared care planning.

According to Article 3, the parents, legal guardian ("*tutore*"), or judicial "support administrators" ("*amministratore di sostegno*") are recognized as the authorized representatives of the minor, the incapacitated adult ("*interdetto*"), or the beneficiary adult ("*beneficiario*") under a "support administration" ("*amministrazione di sostegno*": Article 404 *et seq.* of the Civil Code). As such, informed consent (or refusal) is provided by these legal representatives on behalf of the patient.

However, the presence of a legal representative does not absolve the physician of the responsibility to actively involve the patient in the information process. This applies even when the patient, due to the absence of full legal capacity, is unable to give direct consent or dissent. For minors and individuals supported by an administrator, their opinions hold increasing importance and relevance, even if they do not carry direct legal weight, in accordance with their age and developing ability to make informed decisions.

It is important to note that Article 3 outlines several guiding principles for the legal representative in exercising decision-making authority. It stipulates that they must either consent to or refuse the treatments proposed by the physician, with the aim of safeguarding the individual's physical and mental health and preserving their life, all while fully respecting the person's dignity.

At first glance, it may be quite challenging to legally permit an end-of-life decision made by parents, guardians, or "support administrators".

In fact, if their actions must prioritize the preservation of the life of a minor or an incompetent adult, it could be deemed unlawful to decide to withhold or withdraw a life-supporting device, except in cases where the treatment is considered futile: but in this peculiar scenario, the same treatment would be simply prohibited by Article 2, which mandates that physicians refrain from any form of therapeutic obstinacy.

However, the phrase "*while fully respecting the dignity*" of the incompetent patient — explicitly set forth in Article 3 — may lead to an interpretation in which legal representatives *are* permitted to *refuse* life-sustaining care.

Of course, from a legal perspective, every human life is inherently endowed with dignity, regardless of the specific circumstances in which it unfolds. Therefore, *no* assessment of a person's dignity — whether they are a minor, an incapacitated individual, or a patient facing a serious illness — should be made by a legal representative solely based on the severity of the medical condition, life expectancy, or degree of cognitive impairment. Consequently, it is *not* admissible, under any circumstance, that there may exist lives which are objectively "*unworthy*" of being lived[29]. Therefore, from this perspective, it shall not be legally justifiable, in any way, for a legal representative to decide to refuse (or request the withdrawal of) life-sustaining treatments, except in those specific circumstances set out in Article 2, where death is imminent and the physician is under a legal duty to abstain from administering any treatment deemed futile or disproportionate.

However, the notion of "*dignity of the person*", which must be fully respected, may also take into account the *same individual's identity.* Under this angle, it has been considered a matter of dignity to preserve (also) the patient's perception of self and her existential interest in preserving a particular image facing a medical-sustained life[30].

In other words, in safeguarding the "dignity of the person" who lacks capacity as the aim imposed on legal representatives of incompetent patients, by Article 3, one cannot disregard the *individual's conception* of the dignity of a life sustained by medical treatments. Therefore, in singular and specific cases, the legal representative might even refuse life-sustaining treatments deemed *fundamentally incompatible* with the *patient's subjective view of the dignity* of an existence when *artificially maintained* by medical powers.

In the absence of a living will or shared care plan, a legal representative would need to carefully reconstruct the patient's understanding of dignity based solely on clear, unambiguous, and compelling evidence.

Where this effort to reconstruct the presumed will of the incapacitated person — in the absence of advance directives — does not yield a sufficiently well-founded conclusion that the patient would have refused life-sustaining treatment as incompatible with her deeply personal conception of the dignity of existence, the legal representative's duty under Article 3 to safeguard the life of the incapacitated person shall prevail. Accordingly, any refusal by the legal representative to initiate or continue life-sustaining therapies shall be considered invalid.

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[29] Const. Ct. 135/2024.

[30] *Cf.* P. Borsellino, *Bioetica tra morali e diritto*, Raffaello Cortina, 2018, pp. 481-502.

Furthermore, if the patient — notwithstanding her condition of lack of legal capacity — does possess a minimal but sufficient level of discernment to express her actual wish in favor of life-sustaining treatment, the legal representative cannot lawfully refuse such treatments, due to the legal duty to protect the individual's life under Article 3.

4. The patient's right to be medically aided in dying by the NHS under certain clinical circumstances: Art. 580 of the Criminal Code according to the case-law of the Constitutional Court

Following the constitutional framework outlined above[31], the legal ban on materially assisting suicide, codified in Article 580 of the Criminal Code, has been partially struck down by the Constitutional Court as inconsistent with the patient's constitutional right to self-determination in therapeutic choices[32] — including those aimed at relieving suffering — enshrined in Articles 2 and 32(2) of the Constitution[33].

As a consequence of this partial annulment of Article 580 of the Criminal Code, and pending comprehensive legislative regulation of medical assistance in dying, the legal framework resulting from the Constitutional Court's decision provides that a medical practitioner may, on their own initiative, comply with a patient's request to prescribe a lethal substance for self-administration, provided that strict requirements are satisfied and essential procedures are observed[34].

In particular, according to the Court ruling, the patient must be affected by an irreversible medical condition that results in physical or psychological suffering perceived, by the same individual, as absolutely intolerable; must be kept alive through life-sustaining treatments — proposed or effective — that have been refused according to Article 1 of Act n° 219/2017[35]; must be offered palliative care according to Article 2 of Act n° 219/2017[36]; must retain full capacity to make autonomous, free and informed decisions, and all those conditions must be verified by a medical board of the NHS, with the favorable opinion of the clinical ethics committee.

In this situation the individual's choice *artificially* hastens the moment of death, but in a condition where (natural) death shortly occurs in any case, due to the patient's decision to withdraw or withheld life-supporting therapy. In such a way, the decision to request the "medical aid in dying" is intertwined with the same decision to refuse life-supporting medical treatment. Consequently, the

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[31] *See supra*, §2.

[32] Const. Ct. 242/2019.

[33] *Cf.* S. Canestrari, *Ferite dell'anima e corpi prigionieri. Suicidio e aiuto al suicidio nella prospettiva di un diritto liberale e solidale*, Bononia University Press, 2021.

[34] *See supra* §2.

[35] *See supra* §3.

[36] *See supra* §3.

protection of the right to life is adequately maintained in a coherent and constitutional balance with the right to self-determination[37].

Importantly, following the constitutional case-law, patients have an enforceable right against the NHS to be medically assisted during the implementation of the aid-in-dying procedure even if doctors are not legally bound by any duty to assist the patient in this process (they are simply not subject to criminal prosecution if they voluntarily choose to do so)[38].

This is the reason why the Constitutional Court has determined that a constitutional provision for "conscientious objection" on the part of physicians is unnecessary: in fact, doctors are not legally bound to any duty to cooperate[39].

5. Further scenarios concerning end-of-life decision-making law in Italy: "en attendant…" Parliament

In Italy, the legal framework governing end-of-life decision-making rights is currently navigating through a pivotal "transition" phase.

In particular the evolving frontier in Italy of the right to die is represented by the implementation of legislation that allows medical assistance in dying following the case-law of the Constitutional Court, which has contoured the constitutional perimeter of a possible legislation on the matter[40].

As for a brief example, a possible future statute will have to decide how a local NHS authority might fulfill its legal duty to provide medical aid-in-dying if, hypothetically, *no* NHS-employed physician is willing to participate as is legally entitled to do. From this perspective, a future statute might introduce a legal obligation for the NHS medical personnel to cooperate in clinically assisted suicide — a potential development that would significantly impact the medical profession — allowing for "conscientious objection" for those doctors who do not wish to partake.

Additionally, potential legislative intervention in the end-of-life decision-making system could tackle the issue of identifying the clinical ethics committee responsible for issuing opinions on patients' requests for assisted suicide. The ethics committees established under Act n° 3/2018 and Health Ministerial Decrees of 1.2.2022 and 26-30.1.2023 primarily focus on evaluating clinical trials rather than conducting ethical reviews of medical assistance in suicide. Legislators may also choose to establish multiple ethical committees at the regional level, or a single national committee tasked with the ethical evaluation of all requests for medical assistance in suicide across the country. Moreover,

[37] *See supra* §2.
[38] Const. Ct. 132/2025.
[39] Const. Ct. 135/2024.
[40] Const. Ct. 242/2019, 50/2022, 135/2024, 66/2025, 132/2025.

statutory intervention should ensure that these committees are composed so as to reflect the essential autonomy and impartiality of their members, along with their expertise in medical, scientific, bioethical, and legal matters, thereby instilling confidence in the decision-making process.

Furthermore, the legislative intervention could also delineate a comprehensive procedure — with a specified timeline for each phase — that, upon the patient's request, guarantees a thorough verification of eligibility requirements for medical aid in dying by the local branch of the NHS; then ensure the issuance of the opinion from the clinical ethics committee; and finally enforce the mandatory provision of medical devices (and assistance in their use) for the self-administration of the lethal substance by the eligible applicant.

The legislative process for the approval of comprehensive legislation regarding medically assisted suicide is currently underway in Parliament[41].

As a consequence, showing any content of this proposed legislation makes perfect sense only once the bill has been formally passed at least in the form of a draft text approved by one of the two Chambers involved in the Italian legislative process. While this approval is currently remote, any further information or suggestion about that possible regulation under debate is beyond the scope of this essay[42].

Legislators may, furthermore, go beyond the mere implementation of medical aid in dying [43].

In fact, it is important to note that the Constitutional Court has affirmed that legislators have broad discretion in shaping end-of-life laws, provided that they ensure a "*minimum*" protection of the constitutional value of life, as outlined above (primarily in terms of legal and social safeguards against abuses targeting vulnerable individuals)[44].

If lawmakers wish to further expand individual rights concerning end-of-life choices, while respecting that minimum protection, additional legal issues would need to be addressed. These include recognizing the right to request and obtain medically assisted suicide outside of situations involving dependence on life support — which would require amending the current criminal ban in such cases (Article 580 of the Criminal Code, still in force) — or amending the current criminal ban on euthanasia and consensual homicide (Article 579 of the Criminal Code, in force), so as to enable the

[41] Bill n° S. 65.

[42] Meanwhile, the Tuscany Region has enacted the Regional Act n° 16/2025, that enables the regional health service to implement requests for medically assisted suicide, in accordance with the case law established by the Constitutional Court. However, the national Government has contested this regional legislation before the Constitutional Court, arguing that it constitutes an unconstitutional overreach into the national legislative authority on the matter (Article 117 Const.). The Court's decision is currently far to be pronounced.

[43] Const. Ct. 242/2019, 135/2024, 66/2025, 132/2025.

[44] Const. Ct. 50/2022, 66/2025. *See supra*, §2.

direct administration of the lethal dose by the physician in cases where patients are unable to self-administer it.

It is also important to emphasize that, alongside the legislative implementation of "*medical aid in dying*", there are certain crucial aspects of the existing legal framework — specifically set out in Act n° 219 of 2017 — that warrant careful consideration and a possible systematic fine-tuning (potentially through legislative amendment).

Firstly, the significance of the "*caregiver*" role, particularly when it comes to supporting older adults, could be more effectively recognized and appreciated within the framework of Act n° 219 of 2017.

In fact, Article 39 of Legislative Decree n° 29 of 2024 defines a "*caregiver*" as a family member who, motivated by altruism and commitment, provides care and assistance to an individual within the home, in social situations, and with mobility, as well as in both basic and instrumental activities of daily living. This unpaid role highlights the selfless dedication of caregivers and their interactions with social services, social-health, and healthcare professionals.

While Legislative Decree n° 29/2024, concerning persons lacking self-sufficiency and elderly individuals, recognizes the pivotal role of the caregiver in healthcare, it is important to note that the figure of the "caregiver" is *not* explicitly contemplated by Act n° 219/2017.

Such exclusion implies that caregivers who have not been formally appointed as guardians or "support administrators", pursuant to Article 3 of Act n° 219/2017, are not empowered to make healthcare decisions on behalf of the persons they assist.

This situation, far from optimal, calls for a legislative revision of Act n° 219/2017 in order to ensure the inclusion of caregivers in healthcare decision-making processes.

In this context, the role and powers of the "trusted representative" — the individual appointed by a competent patient to represent her in relations with healthcare facilities and professionals (Article 1 of Act n° 219/2017) — should also be clarified.

In fact, this "trusted representative" can be particularly valuable in contexts of fragility and vulnerability, where the patient, though still *competent*, may require personal support — similar to the role played by the caregiver — in interactions with physicians and healthcare institutions.

Secondly, it may be useful — though not strictly necessary — to amend Act n° 219 of 2017 by introducing provisions that more clearly set out the judicial procedure to be followed in the scenarios envisaged in Article 4(5) and Article 3(5). This concerns, in particular, situations where there is a disagreement between the attending physicians of an incapacitated patient and the patient's legal

representative, whether a court-appointed guardian or a healthcare proxy duly designated pursuant to the same Act.[45]

As currently framed, the Act merely provides that the decision shall be referred to the guardianship judge upon petition by the parties identified in Articles 406 *et seq.* of the Civil Code, by the attending physician, or by the legal representative of the healthcare facility, without laying down the procedural rules that the judge must follow in reaching their decision.

It is true that, by way of interpretation, the guardianship judge must apply the procedural provisions contained in Article 407 or Article 412 of the Civil Code, which govern the proceedings for the appointment or removal of a "support administrator".

However, these provisions require adaptation to the distinct procedural context of a dispute not relating to the appointment or removal of a "support administrator", but rather to a significant and potentially complex disagreement between an already appointed legal representative and the treating physicians concerning a therapeutic decision.

A clearer delineation of the powers of the guardianship judge — whether exercised *ex officio* or upon petition — would be beneficial, particularly to emphasize the necessity of a structured fact-finding phase in such proceedings.

This phase is essential to ensure a thorough and comprehensive understanding of the case and should include, among other elements, a personal hearing of the incapacitated individual (where they retain a residual but sufficient capacity for interaction) and the conduct of appropriate medical assessments to inform the court's judgment.

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[45] *See supra* §3.

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Medically Assisted Suicide and the Crisis of the National Healthcare System: A Brief Bioethical Analysis of the Italian Case

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Abstract: This paper investigates the intersection between medically assisted suicide (MAS) and the structural crisis of Italy's National Health Service (SSN). Triggered by recent Constitutional Court rulings, which both confirm strict eligibility criteria and stress the importance of procedural safeguards within the SSN, the analysis explores how systemic deficiencies - staff shortages, organizational inefficiencies, and limited access to palliative care - impair the practical realization of MAS. These shortcomings, the paper argues, point to a broader erosion of biomedical ethics, increasingly replaced by market-oriented logics within both public and private healthcare. In the absence of national legislation on MAS, this ethical and institutional gap highlights the urgency of reform to ensure equitable end-of-life care and uphold patient self-determination.

Key-words: Medically Assisted Suicide (MAS); National Healthcare Service (NHS); Principles of Bioethics; Bioethical Crisis; End-of-Life- Issues.

Summary: 1. Medically Assisted Suicide and the National Health Service in Italy: initial framework. 2. The crisis of the National Health Service is not merely a crisis of resources. 3. What value does the principle of Autonomy still hold in End-of-Life ethics? 4. Concluding remarks.

1. Medically Assisted Suicide and the National Health Service in Italy: initial framework.

In Italy, medically assisted suicide (hereafter, MAS) is not yet regulated by national legislation. However, since 2019[1], it has been permitted under specific conditions established by the Constitutional Court. According to the Court, a request for MAS must meet strict requirements: it must come from a competent adult suffering from an irreversible illness with a poor prognosis, causing intolerable physical or psychological suffering, and dependent on life-sustaining treatment. Furthermore, the request must be submitted to a facility within the National Health Service (hereafter, NHS), following a mandatory, though non-binding, opinion from the territorially competent Ethics Committee. In line with its prior rulings, the Court has affirmed that both the request and its implementation must occur within the public healthcare system. Nevertheless, it has also reiterated that the lethal medication must be self-administered by the patient, thereby excluding the non-punishability of third parties who assist in the administration process.

The Constitutional Court has also emphasized that MAS constitutes a «protected individual legal position»[2] albeit one that is heavily conditioned. It constitutes a highly limited subjective right, whose

[1] See the rulings of the Italian Constitutional Court, Nos. 242/2019, 135/2024, 66/2025, and 132/2025, available at: https://cortecostituzionale.it/actionPronuncia.do (last accessed: July 28, 2025).

[2] See the third-to-last paragraph of section 3.1 of the *Considerato in diritto*, ruling No. 132/2025.

practical exercise depends on very stringent personal conditions of the requesting patients and involves still heterogeneous and complex procedural steps, to be fulfilled in public facilities, in the absence of specific legislation on the matter.

On the one hand, the Court considers the rigorous conditions it outlined to be necessary to prevent abuses against vulnerable individuals and to counteract societal or cultural trends that might pressure seriously ill persons into suicidal choices, despite the possibility that - if adequately supported by their familial, social, and institutional networks - hey might find reasons to continue living. On the other hand, these same conditions underscore the seriousness of the issue of medically assisted death as currently configured in Italy.

Reflecting on the numerous conditions that hinder the approval of MAS requests, the Constitutional Court has highlighted the complex and strained relationship between the (actual) provision of MAS and the current state of the NHS. The Court reminded that the Republic has a constitutional obligation to ensure «adequate forms of social support, as well as continuous health and social care at home, as the availability or lack of such services may decisively influence a patient's choices and serve as the dividing line between opting for life or requesting death»[3].

In this regard, the Court has noted that, even today, universal and equitable access to palliative care is not guaranteed across all care settings, whether at home or in hospitals. Patients often face long waiting lists, a shortage of adequately trained personnel, significant geographical disparities in service provision, and, in some cases, insufficient inclusion in the healthcare system. More specifically, the Court explicitly renewed its «urgent appeal to the legislator to promote the development of palliative care networks and the effective integration of patients within the healthcare and social-health systems, in order to prevent the inappropriate resort to assisted suicide»[4].

Furthermore, the Court strongly reaffirmed its hope that «both the legislator and the National Health Service act promptly to ensure concrete and timely implementation of what was established in ruling No. 242 of 2019, while preserving the legislator's discretion to adopt different rules, provided they remain consistent with the principles reiterated in this decision»[5].

The Constitutional Court's interventions reflect a clear intention: for several years, it has called for national legislation to govern MAS and address current shortcomings. The issue is twofold: on one side, there is clear *political reluctance to legislate on this matter*[6]; on the other, the absence of

[3] See the final paragraph of section 7.2 of the *Considerato in diritto,* ruling No. 66/2025.

[4] See section 7.3, final paragraph of the *Considerato in diritto*, ruling No. 66/2025.

[5] See section 8 of the *Considerato in diritto*, ruling No. 66/2025.

[6] At present, the national government has filed legal challenges against certain regional initiatives, including those of Emilia-Romagna and Tuscany. In February 2024, the Emilia-Romagna Region, through Resolution No. 44/2024, adopted an operational procedure for evaluating requests for medically assisted suicide (MAS) and for establishing clear timelines and procedures for providing assistance in the event of approval. However, litigation is currently pending before the

overarching legal regulation has led to *inconsistent and fragmented practices*, both in terms of procedures (timelines, handling of requests, etc.) and in the actual guarantees afforded to all involved parties, including patients and healthcare workers.

This situation complicates the professional ability to implement appropriate measures for patients who meet the legal requirements for MAS. It also exacerbates the suffering of requesting patients by delaying access to what should, in principle, be a legally recognized option. Often, MAS cases have been carried out following ad hoc procedures developed by individual facilities rather than based on unified, standardized protocols.

Within this context, the Court's rulings have introduced an innovative element: for the first time, the Constitutional Court has clearly defined the role of the National Health Service in MAS, identifying it - under Article 117 of the Italian Constitution[7] and Law No. 833/1978[8] - as the primary institution responsible for managing health services. This reference is not incidental. The fundamental right to health (Article 32 of the Constitution) demands tangible, responsive systems to address new and emerging needs, such as those posed by MAS. Simultaneously, the Court has not hesitated to highlight the structural crisis facing the NHS. Indeed, the Court has stated that eligible patients have «the right to be accompanied by the National Health Service throughout the MAS process, a right that, according to the principles governing the NHS, includes the provision of appropriate devices, where available, and assistance in their use»[9].

This paper, therefore,will focus on *several bioethical concerns* associated with the current condition of the Italian NHS. Although these elements might not seem especially pronounced at first glance, they are, in fact, particularly when discussing medically assisted death[10], highly relevant as they

Regional Administrative Court (TAR), initiated by members of the regional opposition, which has suspended the implementation of the resolution. The full text of the resolution is available at the following address: file:///C:/Users/Ospite/Downloads/BURERT%20n.44%20del%2013.02.2024%20(P2)%20PDFA.firmato.pdf (last accessed: July 28, 2025). In addition, the Italian government has lodged an appeal before the Constitutional Court against Tuscany's Law No. 16/2025, titled *Organizational Guidelines for the Implementation of Constitutional Court Judgments Nos. 242/2019 and 135/2024*. The full text is available at:https://raccoltanormativa.consiglio.regione.toscana.it/articolo?urndoc=urn:nir:regione.toscana:legge:2025-03-14;16 (last accessed: July 28, 2025). Details of the pending appeal, awaiting a ruling by the Court, are available at: https://www.cortecostituzionale.it/ricorsi.do?operazione=ricerca_avanzata (last accessed: July 28, 2025).

[7] The constitutional provision establishes the exclusive competence of the State (and not the Regions) in matters of health. The full text is available at the following address: https://www.senato.it/istituzione/la-costituzione/parte-ii/titolo-v/articolo-117 (last accessed July 28, 2025).

[8] The complete text of Law No. 833/1978 is available at: https://presidenza.goverNo.it/USRI/ufficio_studi/normativa/Legge%2023%20dicembre%201978,%20n.%20833.pdf (last accessed July 28, 2025).

[9] See the third-to-last paragraph, point 3.2, of the *Considerato in diritto,* ruling No. 132/2025.

[10] F. G. Pizzetti, *L'autodeterminazione alla fine della vita: punti di riferimento costituzionali, disciplina legislativa e applicazioni giurisprudenziali*, in M. G. Salvadori (eds.), *Scelte e cure di fine vita: profili giuridici, etici, clinici. Scenari europei a confronto*, Giappichelli, Torino, 2024, pp. 3-38.

reveal the direct connection between the difficulties in requesting and receiving MAS and the deteriorating state of the public healthcare system.

2. The crisis of the National Health Service is not merely a crisis of resources.

The Italian National Health Service (NHS) is currently facing a profound and enduring crisis, both economic and managerial in nature. This has long resulted in a shortage of timely and efficient healthcare services[11]. However, even a preliminary analysis reveals that this is not the sole issue: the NHS is also undergoing a *bioethical crisis*. This represents the most serious challenge to the core values of biomedical ethics - namely, beneficence, non-maleficence, justice, and autonomy[12] - since the NHS's inception in 1978[13]. The effects are even more pronounced in cases that require specialized forms of care, such as those involving MAS.

This phenomenon is complex, but it must be noted that, as a result of specific health policy choices made over the past two decades[14], the NHS has been forced into harsh competition with private healthcare providers[15].

As previously mentioned, this situation raises also serious ethical and bioethical concerns. Within a system of healthcare services that is on the brink of collapse and barely able - often with worsened quality and delays compared to the pre-pandemic era[16] - to offer (insufficient) responses to patients, it becomes difficult to argue that ethical action is being upheld.

In terms of biomedical ethics, this means a breach of the principles of non-maleficence, beneficence, justice, and autonomy. Patients' health choices are undermined; delayed service delivery causes harm; the best interests of patients are not promoted; and equitable access to even basic healthcare services is not ensured[17].

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[11] N. Dirindin, *La sanità italiana tra crisi ed eccellenza*, in *il Mulino*, n. 3/2020, pp. 408-4141; N. Formisani, S.Grassi, I. Pineda Daudinot, *Salute in Italia: ancora un diritto per tutti? Un confronto col sistema sanitario cubano*, in *BioLaw Journal - Rivista di Biodiritto*, No. 4/2021, pp. 75-89; A. Bruscia, N. Costalunga, *Diritto alla salute nell'Italia post-pandemica: tra fragilità strutturali e retorica politica*, in *Heteroglossia. Quaderni di Linguaggi e Interdisciplinarità*, No. 19/2023, pp. 39-71.

[12] T. L. Beauchamp, J. F. Childress, *Principles of Biomedical Ethics,* 7th Edition, Oxford University Press, Oxford, 2015.

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[14] R. Tarricone, V. D. Tozzi, *Le lezioni incomprese della pandemia,* in *eco. Mensile di economia diretto da Tito Boeri,* No. 3/2024, p. 39

[15] R. Tarricone, V. D. Tozzi, *Le lezioni incomprese della pandemia,* op. cit., p. 39.

[16] See more on special issue: *BioLaw Journal – Rivista di Biodiritto*, n. 2/2019. Specifically, see, I. Ciolli, *La salute come diritto in movimento. Eguaglianza, universalismo ed equità nel sistema sanitario nazionale, oggi*, in *BioLaw Journal-Rivista di Biodiritto*, No. 2/2019 pp. 13-33; B. Pezzini, *Il diritto alla salute a quarant'anni dall'istituzione del servizio sanitario nazionale: le criticità strutturali di un diritto sociale*, in *BioLawJournal Rivista di Biodiritto*, No. 2/2019 pp. 117-146.

[17] The bioethical crisis is not limited to the Italian context; for further insight, see H. Ten Have, *The challenges of global bioethics,* in *Global Bioethics,* No. 1/2022, pp. 41-44; I. Cambra-Badii, E. Busquets-Alibés, N. Terribas-Sala, J.-E. Baños,

In short, the crisis of the NHS is a *crisis of principles*. It does not concern individual healthcare professionals, but rather the qualification of the NHS itself as a structure that should merit constant and priority ethical-political and legal-ethical attention. At both national and regional levels, the NHS is no longer perceived as a necessary and vital institution to be protected and supported in order to uphold the fundamental right to health, with which it is intimately connected and interdependent.

The collapse of biomedical ethics within the NHS affects all services, but it becomes particularly acute in MAS-related cases. As previously discussed, public healthcare institutions lack clear ethical and regulatory frameworks for establishing shared, standardized procedures that respect patients' rights and ensure the implementation of MAS within a reasonable timeframe.

This reality exacerbates access barriers to specific forms of care for already deeply suffering individuals. It inflicts further unjust harm upon those who request MAS, as it prolongs suffering that should, by principle, be avoided, especially when a request for MAS has been approved and could be promptly executed through qualified healthcare support.

Labeling MAS as a healthcare service might seem counterintuitive. However, beyond the ideological rhetoric of vitalism, the suicide under discussion is *medically assisted*. It is not an ordinary suicide, but a specific, regulated act, carried out with the essential and active involvement of healthcare professionals within NHS facilities. Therefore, the more inequities plague general access to the NHS, the greater the barriers to the effective implementation of healthcare support for patients requesting MAS. *Medically assisted* are the two words that denote the specificity of the request for assisted suicide, which, although the final act is performed by the patient, involves a comprehensive process that precedes it. This process encompasses the involvement of the healthcare system (SSN), including doctors, nurses, and psychologists engaged in the patient's assessment, the territorially competent ethics committee, the procurement of medication, equipment, and machinery, as well as the selection of the appropriate setting for medically assisted suicide (MAS). All these stages are strictly relevant to the healthcare context in general. Furthermore, the administration carried out by the patient on themselves is not an arbitrary lethal substance, but rather one or more specific drugs that have required a medical prescription. Currently, only the final administration must be carried out by the requesting patient. Within this framework, the active role of the healthcare system and healthcare professionals is indispensable. Although it is true that the healthcare system entered a particularly critical phase during the 2020 pandemic[18], it is equally true that in the post-pandemic period, the NHS has neither

(Eds.), *Bioethics: Foundations, Applications and Future Challenges*, (1st ed.), CRC Press, Boca Raton, Florida, USA, 2023. https://doi.org/10.1201/9781003269885 (last accessed July 28, 2025).

[18] L. Dell'Atti, G. Naglieri, *Le fonti della crisi: fra esigenze unitarie e garanzie costituzionali nel governo dell'emergenza da CoViD-19*, in *BioLaw Journal – Rivista di BioDiritto*, n.1/2020, pp. 135-143; C. Ciardo, *Il Servizio Sanitario Nazionale alla prova dell'emergenza CoViD-19: il rischio di una sanità diseguale,* in *BioLaw Journal – Rivista di BioDiritto*, No. 1/2020, pp. 227-238.

received adequate investment nor recovered. On the contrary, it has deteriorated further, and political or regulatory interventions have failed to bring about meaningful or productive change[19].

In this climate of institutional silence - and in the absence of a strong, unified front among intellectuals, jurists, healthcare workers, bioethicists, philosophers, economists, or academics - the ethical dimension of healthcare has become increasingly *Americanized*[20]. In the vacuum left by the public system, private health insurance policies have multiplied, leading to increased reliance on private institutions for health services[21]. This reflects the growing embrace of a neoliberal consumerist model of health, where the so-called *freedom of choice* is, in practice, a rhetorical expression used to justify a system in which health is more readily guaranteed the more one is able to pay for it.

We are witnessing the gradual dismantling of the public health model and the systematic erosion of the binding character of Article 32 of the Constitution, as well as Articles 2 and 3 of the Italian Charter. This erosion contributes to growing socioeconomic disparities, which effectively restrict the exercise of the fundamental right to health and, by extension, the freedoms and equality of citizens[22].

This aspect is particularly problematic in the ethics of end-of-life care. In the absence of proper institutional support, the necessary medications, equipment, and tools for MAS have not been provided by public health facilities. Especially in the early MAS cases in Italy, if private non-profit associations had not intervened to supply personnel, equipment, and cover the costs of medications and machinery[23], patients would not have been able to carry out their final, autonomous decision.

The phenomenon of so-called *suicide tourism*[24] is also not new in this context. Patients, driven by the impossibility of obtaining timely access to MAS in their own country, have turned to foreign healthcare providers, often at great financial cost, to exercise their end-of-life choices.

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[19] L. Lamberti, *Considerazioni in tema di vincoli di bilancio e tutela del diritto alla salute*, in amministrativ@mente, Rivista scientifica trimestrale di diritto amministrativo, No.2/2022, https://www.amministrativamente.com/index.php/formez/issue/view/837 (ultimo accesso 28 luglio 2025).

[20] G. R: Gristina, *Diritto alla salute e alla sua tutela: principi fondamentali del sistema sanitario universalistico*, in *Recenti Progressi in Medicina,* No. 10/2023, pp. 581-589; G. Carboni, *Il potere degli stati per la tutela della salute pubblica*, in *Diritto Pubblico Comparato ed Europeo – DPEC,* No. 1/201201, pp. 3-30.

[21] M. Geddes da Filicaia, C Giorgi, *L'espansione del privato in sanità: il caso italiano nel contesto globale*, in *Politiche Sociali*, No. 3/2023, pp. 425-444, especcially pp. 428-432.

[22] G. Costa, C. Di Girolamo, *Salute disuguale: un metro per valutare l'impatto dei cambiamenti*, in *Politiche Sociali*, No. 3/2023, pp. 445-467.

[23] The first case of MAS in Italy was made possible thanks to the medical, legal, administrative, and financial support provided to the requesting patient by the *Luca Coscioni Association*. This association fully addressed numerous gaps and managed the many practical difficulties involved in carrying out adequate assistance for suicide. The details of the case are documented at the following link: https://www.associazionelucacoscioni.it/notizie/comunicati/suicidio-assistito-mario-asur-marche-decide-farmaco?_gl=1*1v22bt8*_up*MQ..*_ga*MTgxOTcxODg2Ny4xNzUyMDY3ODk2*_ga_QQMZLR1HRV*czE3NTIwNjc4OTYkbzEkZzAkdDE3NTIwNjc5NDUkajExJGwwJGg2MDcyMjMzNDU (last accessed July 28, 2025).

[24] R. Girani, *La disciplina del suicidio assistito nell'ordinamento elvetico: il fenomeno del cd "suicide tourism" dall'Italia alla Svizzera*. in BioLaw Journal – Rivista di Biodiritto, n.3/2023, pp. 165-190; C. A. Prokopis, *Suicide*

3. What value does the principle of Autonomy still hold in End-of-Life ethics?

From a bioethical standpoint, the principle most severely impacted within the NHS, particularly in end-of-life matters, is the principle of autonomy.

The healthcare shift underway since 2020[25] has not directly overturned the recognition of health as a fundamental right, which remains protected under Article 32 of the Constitution. However, in practice, this right is increasingly weakened, especially in the context of end-of-life decisions. This erosion becomes even more evident when autonomous choices regarding one's health involve deeply personal and morally controversial issues, such as the decision to pursue MAS.

In such cases, the hyper-liberal public ethic that now dominates general health discourse in Italy often gives way to renewed expressions of paternalism and vitalism. There remains an entrenched institutional resistance - manifested through targeted legal challenges - against regional legislative or procedural initiatives aimed at offering patients reliable timelines and procedures in the event their MAS request is approved.

This resistance can largely be understood as an *ethical refusal* to recognize the legitimacy of competent adults' autonomous decisions when they seek to plan their own death through assisted suicide. It is otherwise difficult to justify, on other grounds, the legislator's persistent inaction, especially considering the repeated and urgent calls from the Constitutional Court in recent years for comprehensive regulation of medically assisted dying (including, but not limited to, MAS).

In this context, the Constitutional Court has reminded political decision-makers of *their duty to provide appropriate care and assistance* at the end of life. However, the duty to offer such care does not imply a duty on the part of the patient to accept it, whether in the form of active treatments or palliative care. Providing appropriate therapies and services, in a timely manner and suitable to the patient's condition, is a responsibility of the NHS. Conversely, the freedom to choose among available therapeutic options is a fundamental individual right, rooted in the broader right to self-determination concerning bodily integrity and medical treatment, as derived directly from the right to health (Article 32 of the Constitution). This has been recognized in numerous prior rulings of the Court[26].

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tourism: Leiper's tourism system theoretical perspective, in *Tourism: An International Interdisciplinary Journal,* No. 2/2021, pp. 300-304.

[25] This revolution has also profoundly impacted end-of-life ethics in the Italian context: *"A profound cultural revolution has taken place regarding end-of-life matters, one that has changed ethical attitudes toward voluntary death."* See M. Mori, *L'Italia in testa anche sull'etica del fine vita: è il primo paese di grandi dimensioni ad ammettere il suicidio medicalmente assistito.* in *Iride. Filosofia e Discussione pubblica*, No. 2/2020, pp. 329–336, especially the conclusions, pp. 335–336.

[26] See the rulings of the Italian Constitutional Court, No. 438/2008, avaiable at: https://www.cortecostituzionale.it/actionPronuncia.do. (ultimo accesso 28 luglio 2025).

Importantly, this freedom does not entail any obligation to live at all costs, nor does it imply a duty to undergo treatment. Likewise, the obligation to offer adequate services and care does not, on ethical or legal grounds, justify making specific medical pathways mandatory or requiring patients to accept certain therapies as a precondition for accessing MAS—as is controversially suggested in the current government-sponsored draft bill on the subject, under discussion in Parliament since July 17, 2025[27].
In short, even in these highly controversial end-of-life matters, we are witnessing a subtle but significant shift—from the exercise of rights to the concession of privileges. While the principle of autonomy remains formally recognized, in practice it increasingly functions as a *façade*, behind which economic logics operate and structural inequalities are reinforced.
This has particularly grave implications for individuals in fragile conditions or facing irreversible suffering—such as patients requesting MAS. If access to healthcare services is neither universal nor equitable—whether in home settings or in hospitals; if waiting lists are impenetrable; if there is a shortage of properly trained staff and an inadequate, uneven distribution of palliative care services; and if the system fails to effectively include and support patients whose health is already severely compromised—then we must acknowledge the extraordinary ethical and bioethical burden such patients face in attempting to carry out a final autonomous act regarding their own body, especially when that act expresses a sincere will to die.

4. Concluding remarks.

This analysis of the complex relationship between requests for medically assisted suicide (MAS) and the ongoing crisis of the Italian National Health Service (NHS) allows for several concluding reflections.
First, it is evident that fundamental bioethical principles are being consistently violated. This is a troubling sign of *a new ethical paradigm*[28], marked by a *neoliberal orientation*, that is displacing or severely compromising traditional biomedical ethics. As a result, the NHS is being transformed in ways that increasingly obstruct access for patients seeking MAS.

[27] The text of the draft law, which is strongly vitalist and illiberal in its orientation, presents numerous controversial aspects and, contrary to what is stated in its title— *Disposizioni esecutive della sentenza della Corte costituzionale. n. 242/19*—does not actually implement what the Court has indicated for several years now. The text is available at the following address: https://www.quotidianosanita.it/governo-e-parlamento/articolo.php?articolo_id=130696 (last accessed July 17, 2025). Among the many critical voices, reference can be made to the position taken by the Consulta di Bioetica Onlus, whose press release can be consulted at the following address: https://www.consultadibioetica.org/osservazioni-della-consulta-di-bioetica-onlus-sul-ddl-disposizioni-esecutive-della-sentenza-della-c-c-n-242-19/ (last accessed July 17, 2025), as well as to A. Massaro, *Il nuovo disegno di legge in materia di suicidio medicalmente assistito: come può uno scoglio arginare il mare?*, in *Giurisprudenza penale*, No. 7-8/2025, pp. 1-10.
[28] A. Belli, *L'insopprimibile incongruità dei diritti sociali. Un'analisi giuridico-filosofica*, in *Rivista di filosofia del diritto*, n. 2/2023, pp. 397-418

Second, the Constitutional Court has played a proactive and prominent role in shaping the national discourse on end-of-life issues, and MAS in particular. However, two distinct orientations can be discerned within its jurisprudence. One is more conservative, rooted in an ontological-personalist and paternalistic framework[29]. It holds that life must be preserved until its natural end and views palliative care as the only legitimate form of end-of-life health support, aimed at offering a dignified death and ultimately preventing, or greatly reducing, the number of MAS requests.

Alongside this, however, a second, more liberal and secular approach has emerged, particularly evident in the Court's most recent rulings, Nos. 66/2025 and 132/2025. This orientation emphasizes the responsibility of political actors and the NHS to ensure the *public provision of real and effective healthcare services*. Rather than taking a stance on the ethical merits of palliative care, other treatments, or MAS, the Court instead insists that public institutions must offer appropriate responses, in accordance with constitutional values and principles, and in light of the existing legal framework. The Court highlights the necessity of ensuring that any legitimate health request, especially from gravely suffering individuals, is neither rendered unreasonably burdensome nor ignored altogether. Parliament and the NHS are thus urged to «ensure the concrete and timely implementation of what was established in Judgment No. 242 of 2019»[30], meaning they must enable citizens to make constitutionally valid choices regarding their own death. This call represents a clear ethical-legal commitment to protecting diverse end-of-life options available to each citizen-patient, reaffirming the legitimacy of MAS requests under the precise conditions set forth by the Court. This is a call to reconcile public health policies and ethical norms with the most deeply personal of decisions, a call to recognize and regulate end-of-life practices, including MAS, in a way that balances public responsibility with individual autonomy.

Lastly, if «the Italian system is suspended between the risk of an accelerated decline, increasingly resembling a collapse, and the opportunities for its revival»[31], we can imagine a *bitter, cynical ethical prospect*, according to which MAS will become less opposed institutionally, and the complex issues of medically assisted death will become the subject of legislative regulation when some private economic actor, interested in this segment of healthcare activity, without encountering particular institutional difficulties, considers it economically advantageous and makes it a *core business* to be offered on the health market.

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[29] P. Borsellino, *Bioetica tra "morali" e diritto,* Cortina, Milano, 2018, pp. 89 ff.

[30] See point No. 8 of the *Considerato in diritto* of Constitutional Court ruling No. 66/2025.

[31] S. Neri, *Il Servizio Sanitario Nazionale e la riforma dell'assistenza territoriale: tra collasso e rilancio*, in *Autonomie locali e servizi sociali*, No.1/2023, pp. 3-17, especially pp. 3-5.

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The Regulation of Euthanasia in Spain

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Abstract: This paper examines the Spanish Law on euthanasia, which has been in force since June 25, 2021 and grants the same legal status to euthanasia and medically assisted suicide. The law incorporates the right of medically assisted suicide into the portfolio of services offered by the Spanish National Health System, making it available in both public and private healthcare facilities as well as in patients' homes. The first available data shows that since its enforcement to December 31,2023 697 procedures were carried out, representing 46% of the requests submitted. These figures are lower than both the legislator's initial estimates and the numbers reported in other countries during the early years of comparable legislation.

Keywords: Law regulating euthanasia; Legal requirements; Process; EvaluationConscientious objection

Summary: 1. Introduction. 2. Requirements for accessing assisted dying. 3. Process for accessing assisted dying. 4. Oversight and Evaluation Commission. 4.1 Evaluation of assisted dying in Spain. 4.2 Data related to the procedure. 4.3 Information on applicants. 4.4 Complaints to the Oversight and Evaluation Commission (CGE). 4.5 Applicants who subsequently became organ donors. 5. Conscientious objection by healthcare professionals. 5.1 Nature of conscientious objection. 6. Report of the Spanish Bioethics Committee.

1. Introduction

The Organic Law Regulating Euthanasia, Organic Law 3/2021 (LORE), was published in Spain on March 25, 2021, and has been in force since June 25, 2021. Once approved, LORE incorporated the provision of assistance in dying into the portfolio of services offered by the Spanish National Health System, making it available in both public and private healthcare facilities.

The Spanish Parliament passed the law with 198 votes in favor, 138 against, and 2 abstentions.

The decision to request assisted dying must be autonomous, understood as one made by the patient based on an informed understanding of their medical condition, following appropriate information and guidance from the responsible healthcare team. The provision of assisted dying refers to the act of making the necessary means available to a person who meets the legal requirements and has expressed the wish to die. This provision may take two forms:

- The direct administration of a substance to the patient by a qualified healthcare professional; i.e., the practice of euthanasia.
- The prescription or supply of a substance to the patient by a healthcare professional, enabling the patient to self-administer it in order to cause their own death; i.e., medically assisted suicide.

2. Requirements for accessing assisted dying

Eligibility for the procedure in Spain is determined by the following

criteria. General Criteria:

- The individual must be of legal age (18 years or older).
- The individual must hold Spanish nationality, legal residency in Spain, or a certificate of registration (known locally as: *empadronamiento*) demonstrating residence in Spanish territory for at least 12 months.
- The individual must have the capacity to act and make decisions. The applicant must be deemed competent to make healthcare decisions.

Clinical Criteria:

- The individual must be suffering from a serious, chronic, and incapacitating condition, defined in the law as: "a condition involving substantial limitations to physical autonomy and essential daily functioning, resulting in an inability to care for oneself, along with significant impairments in communication and interpersonal engagement. These limitations are associated with constant and intolerable physical or psychological suffering, with certainty or a high probability that they will persist over time without the possibility of cure or significant improvement. In some cases, this may involve complete dependence on technological support."
- The individual must be suffering from a serious and incurable illness, defined in the law as:
- "one which, by its nature, causes constant and unbearable physical or psychological suffering, with no possibility of relief that the person considers tolerable, and with a limited life expectancy, in a context of progressive frailty."

3. Process for accessing assisted dying

The process begins with an initial request, which must be voluntary, informed, and submitted in writing. It must be signed and dated by both the applicant and the Attending Physician (AP). From that point onward, the AP becomes the patient's primary point of contact. First, the AP must verify whether the legal requirements for requesting the procedure are met. If they are not, the AP must inform the applicant in writing and submit an unfavorable report to the Oversight and Evaluation Commission (CGE), before which the applicant may file a complaint within 15 days.

If the requirements are met, the AP initiates a deliberative process with the patient, providing information on the diagnosis, treatment options, alternatives to assisted dying, available palliative care, and any applicable social support services. This information must be provided verbally, and also in writing within a maximum of 5 days.

At least 15 days after the initial request, the patient must submit a second request, signed in the presence of the AP. Two days later, the deliberative process resumes to allow the AP to address

any remaining questions from the applicant. This deliberation phase may last a maximum of 5 days. After 24 hours have passed since the end of the deliberative process, the patient confirms their decision by signing the informed consent form.

Once informed consent has been signed, the AP must consult a Consulting Physician (CP), who must specialize in the illness affecting the applicant and be independent from the AP's team. The CP will evaluate the case, examine the patient if deemed necessary, and issue a favorable or unfavorable report within 10 days. If the report is unfavorable, the applicant may file a complaint with the CGE.

If the report is favorable, the AP must forward the case within 3 days to the CGE, which will verify whether the legal criteria for the procedure are met. The president of the CGE will appoint a review team – one physician and one legal expert—to ensure compliance with legal requirements. This pair must issue a report within 7 days and submit it to the CGE president. If the review results in a favorable decision, authorization is granted, and the decision is communicated to both the AP and the applicant. From that point, the applicant and the AP agree on the location (hospital or home), the method (euthanasia or medically assisted suicide), and the date for carrying out the procedure. The applicant has up to two months to proceed, within which time they must agree with the AP on the specific date.

Following the completion of the procedure and the patient's death, the AP must submit two documents to the CGE within five working days for verification purposes:

Document 1: Personal information of the patient and identification details of the AP and CP, including their professional license numbers.

Document 2: Anonymized and detailed information about the process (patient's age and sex, date and place of death, underlying condition, etc.). This second document is used to verify that the procedure was carried out correctly.

The applicant may withdraw from the procedure at any time. Furthermore, once the procedure has been approved, they may request to postpone it for a maximum period of six months. If, after this period, the patient has not requested that the procedure be carried out, it is understood that they have chosen to withdraw.

Additionally, if an unfavorable report is issued at any stage (by the AP, CP, or CGE), the applicant may submit a complaint to the CGE for review. If the unfavorable decision is upheld, the patient may appeal before the contentious-administrative court.

Through an Advance Directive (AD), any adult who is capable and acting voluntarily may express their wishes in advance, to be honored in the event they are unable to express them personally in

the future. The person granting the advance directive may also designate a representative to act as their intermediary with the responsible physician and care team, should the situation arise. The assisted dying procedure may also be requested through an Advance Directive, provided it has been registered in accordance with current legislation. When the process begins via an AD, the first and second written requests and the informed consent are not required. Instead, the physician directly issues a favorable or unfavorable report, and the same steps described above are followed. As a result of the entry into force of LORE, the Ministry of Health is currently processing a modification of Royal Decree 124/2007, of February 2, which regulates the National Register of Advance Directives and its corresponding automated personal data file. The aim is to update the minimum information that regional governments must transmit to the National Register of Advance Directives.

Table 1. Application process for administering assisted dying.

Step 1	**Initial Request:** Submitted to the Attending Physician (AP) and signed by both the physician and the patient. ● Assessment of whether the legal requirements are met. ● Within 2 days: Deliberative process regarding the patient's diagnosis, therapeutic options and expected outcomes, information on palliative care, and available support for dependency. ● Within 5 days: The patient receives the above information in writing.

Step 2	**Second Request:** Submitted to the Attending Physician. Must be presented at least 15 days after the first request, except in cases where delay is not possible due to the risk of the patient losing decision-making capacity. ● Within 2-5 days of submission: A new deliberative process is carried out. ● 24 hours after the deliberative process concludes, if the patient reaffirms their request the Attending Physician informs the care team (especially, nursing staff), the patient's family (if the patient so requests), and collects the signed informed consent document. ● If the applicant withdraws the request, this is also communicated to the care team.
Step 3	The Attending Physician informs the **Consulting Physician**, who will ● Conduct an interview with the applicant.. ● Review the applicant's medical history. ● Within a maximum of 10 days: issue a report confirming if the legal requirements are met. ● Communicate the conclusions of the report to the patient.
Step 4	The Attending Physician informs the **President of the CGE** of the consultant's favorable report. ● Maximum 3 days.
Step 5	The president of the CGE: **Appoints two members** of the Oversight and Evaluation Commission—one physician and one legal expert—to verify whether the legal requirements are met. ● Maximum 2 days.
Step 6	**Both members of the CGE**: ● Review the documentation and, if deemed necessary, conduct interviews with the Responsible Physician, the healthcare team, and/or the applicant. ● Within a maximum of 7 days: issue a report assessing whether the legal requirements are met. If the assessment is favorable, the procedure is authorized. ● Maximum 2 days: the decision is communicated to the President of the CGE.
Step 7	**President of the CGE:** Informs the Attending Physician.

Step 8	**Procedure Approval**: ● The applicant sets a date. ● The applicant choose a method ● The presence and support of healthcare professionals is provided. ● The applicant retains the right to withdraw from/ or postpone the procedure at any time.
Step 9	**After the procedure**: ● Within a maximum of 5 days: The Attending Physician submits the following to the CGE: - Document One: Personal data of the applicant, the Attending Physician, and the Consulting Physician. If an advance directive exists, the applicant's representative is also included. - Document Two: Clinical data of the applicant, confirmation of compliance with legal requirements, and a detailed description of the performance of assisted dying. ● Within a maximum of 2 months: inform the doctor in charge; the CGE oversees whether the procedure has been carried out legally.

CGE: **Oversight and Evaluation Commission**

4. Oversight and Evaluation Commission

An Oversight and Evaluation Commission (CGE) will be established in each of the Autonomous Communities, as well as in the cities of Ceuta and Melilla. Each commission shall be composed of a multidisciplinary team of no fewer than seven members, medical professional, nursing staff and legal experts.

The Oversight and Evaluation Commissions will address complaints filed by individuals whose requests for assisted dying have been denied by the Attending Physician. They will also resolve conflicts of interest that may arise during the process and adjudicate any disagreements among designated members that prevent the formulation of either a favorable or unfavorable report by the CGE. Additionally, the commissions will be responsible for identifying potential compliance issues, addressing questions that arise during the application of the law, and will serve as an advisory body within their specific territorial jurisdiction.

4.1 Evaluation of assisted dying in Spain

To date, statistical data is available for the first six months of 2021 (the law came into effect on

June 25, 2021) and for the years 2022 and 2023.

4.2 Data related to the procedure

In 2021, 173 requests were received, compared to 576 in 2022 and 766 in 2023. However, out of all requests received in 2021, 75 procedures were carried out, while 288 were performed in 2022 and 334 in 2023. These figures are summarized in Table 2. In some cases, the evaluation process could not be completed because the patient died during the assessment.

Table 2. Requests and assisted dying procedures since the law came into effect.

Year	Received Requests	Performed Procedure	% of Procedures Completed Relative to Requests
2021*	173	75	43,4%
2022	576	288	50,0%
2023	766	334	43,6%
Total	**1515**	**697**	**46,0%**

Of all the assisted dying procedures carried out during this period, euthanasia was the method chosen in the majority of cases, with medically assisted suicide (MAS) representing a minority option, as shown in Table 3.

Table 3. Type of procedures (euthanasia vs MAS) performed in Spain each year.

Year	Performed Procedure	Euthanasia	MAS
2021*	75	72	3
2022	288	236	11
2023	334	316	18

When considering the place where assisted dying was performed and whether it took place in the public or private sector, it can be concluded that between 2021 and 2023, the provision of assisted dying in Spain showed a stable trend both in location and type of setting.

Regarding the place of the procedure, in 2021, 34 cases were carried out at home, 30 in hospitals, and only 5 in long-term care facilities. In 2022, 148 procedures took place at the patient's home, 112 in hospitals, and 9 in long-term care centers. The type of facility was unknown in 19 cases. Finally, in 2023, the number of procedures performed in hospitals exceeded those at home, with 159 in hospitals and 147 at home. Additionally, 19 procedures took place in long-term care institutions, and the type of facility was unknown in 9 cases.

Regarding the sector in which the procedure was carried out, there was a clear predominance of

the public sector over the private sector every year. In 2021, out of 75 procedures performed, only one (1.33%) was carried out in a private facility. In 2022 (with a total of 288 procedures), 91.3% (n=284) were performed in the public sector, compared to 1.3% (n=4) in the private sector. This proportion increased in 2023 (total 334), with 91.62% in the public sector and 8.38% (n=28) in the private sector.

The average time from the initial request to the performance of assisted dying over these three years was 60 days in 2021, 75 days in 2022, and 67 days in 2023.

Requests that did not result in the procedure being performed were due to not meeting the eligibility criteria, the patient revoking the request, or the patient passing away during the evaluation process. Table 4 provides a comparative overview of the reasons for non-performance each year.

Table 4. Reasons why assisted dying was not provided.

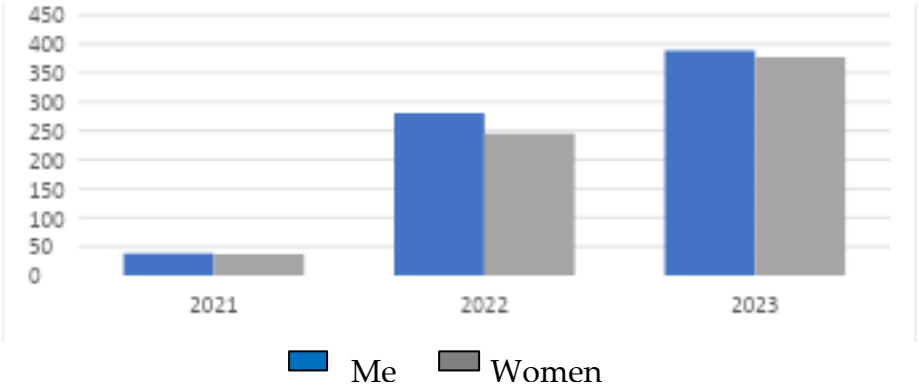
Year	Procedures Not Carried Out	Withdrawal Without Revocation	Denied	Withdrawal	Died during evaluation	Postponement
2021*	98	28	25	7	32	6
2022	288	8	105	1	152	22
2023	432	0	188	21	190	33
Total	818	36	318	29	374	61

In 2023, data were collected on the conditions that caused patients to pass away before receiving the assisted dying procedure: in 121 cases (63.68%), the cause was an oncological disease; in 37 cases (19.47%), a neurological condition; in 11 cases (5.78%), a respiratory illness; and in 8 cases (4.21%),the cause was multi-pathological. In 13 cases, the cause of death was due to other conditions not specified in detail.

4.3 Information on applicants

Over the three years analyzed, the gender distribution has remained balanced, as shown in the following chart, which also illustrates the annual increase in requests for assisted dying.

Sex of individuals requesting assisted dying



Regarding age, the majority of applicants are elderly. In 2021, the most common age range was between 60 and 79 years. In 2022, most requests came from individuals aged between 60 and 80. In 2023, the most represented age group was 70 to 79 years (28% of the total), reinforcing the pattern of requests primarily coming from older adults.

Concerning whether the procedure was initiated entirely by the patient or required the use of advance directives, it is notable that although most requests begin through the ordinary procedure (first and second written requests), each year there have also been requests initiated through advance directives (AD). Specifically, in 2021, only 3 requests were initiated via AD; in 2022, this number rose to 14; and in 2023, 22 requests were submitted through AD. This indicates a gradual increase in the use of advance directives as a valid pathway to access the procedure, although it remains in the minority.

Professional Data: Attending Physician (AP) and Consulting Physician (CP)

Table 5 shows the statistical comparisons by specialty for both AP and CP who participated in the end-of-life care process.

Table 5. Specialties of doctors involved in the assisted dying process.

	2021		2022		2023	
Speciality	MC	MR	MC	MR	MC	MR
Family Medicine	43	10	354	57	457	74
Neurology	17	22	40	123	52	143
Oncology	6	12	28	58	46	64
Geriatrics	0	1	17	0	29	174
Internal Medicine	9	5	13	34	25	33
Not recorded/other	0	25	76	256	90	93

4.4 Complaints to the Oversight and Evaluation Commission (CGE)

In cases where the procedure is denied—whether by the Attending Physician (AP), the Consulting Physician (CP), or the Oversight and Evaluation Commission (CGE)—the applicant may file a complaint with the CGE requesting a reassessment of their case. If the denial is upheld, the applicant may subsequently file a legal appeal through the administrative court system. Over the three years the law has been in effect, the following data on appeals have been recorded: In 2021, 15 requests were submitted to the CGE for case review, of which 3 (20%) were resolved in favor of the applicant. There is no record of any judicial appeals filed in the administrative courts that year.In 2022, the number of appeals to the CGE rose to 61, of which 23 (37.7%) were resolved favorably. That same year, two judicial appeals were filed, with one resulting in a favorable outcome for the applicant. Finally, in 2023, out of 188 denials, 78 appeals were submitted, and 32 of these (41%) were resolved in favor of the applicant by the CGE. That year saw a significant increase in judicial appeals, with 21 cases filed. However, all were resolved against the applicant, upholding the CGE's decisions. 4.5 Applicants who subsequently became organ donors

Finally, it is worth noting that in some cases, individuals who requested medical assistance in dying went on to become organ donors following the procedure. Specifically, there were 7 such cases in 2021, 42 in 2022, and 42 in 2023. Table 6 presents a comparative summary of all transplant procedures carried out subsequent to the provision of medical assistance in dying.

Table 6. Transplants performed following Medical Assistance in Dying

	2021	2022	2023
Nº of donors	7	42	42
Nº organs removed	28	164	172
Nº organs transplanted	27	137	141
Nº of transplant patients	22	113	115

5. Conscientious objection by healthcare professionals

5.1 Nature of conscientious objection

The exercise of the right to conscientious objection ensures legal certainty and respects the freedom of conscience of healthcare professionals directly involved in the provision of medical assistance in dying. The LORE (Organic Law Regulating Euthanasia) defines conscientious

objection in Article 3, paragraph (f), as: *"The individual right of healthcare professionals to refuse to perform those medical acts regulated under this Law that conflict with their personal convictions."*

Furthermore, Article 16 of the LORE states:

"Healthcare professionals directly involved in the provision of medical assistance in dying may exercise their right to conscientious objection. The refusal to carry out the procedure on grounds of conscience is an individual decision of the healthcare professional directly involved, which must be expressed in advance and in writing.

Health authorities shall establish a registry of healthcare professionals who declare themselves conscientious objectors to participating in the performance of medical assistance in dying. This registry will record written declarations of objection and serve to provide the necessary information for health administrations to ensure proper management of the service of medical assistance in dying. The registry shall be subject to strict confidentiality and comply with applicable personal data protection regulations."

Accordingly, healthcare professionals directly involved in the provision of medical assistance in dying may exercise their right to conscientious objection. Refusal to perform the procedure or assist in it on grounds of conscience is a personal decision that must be declared in advance and submitted in writing. Health authorities are required to maintain a registry of healthcare professionals who declare such objections. This registry must adhere to strict confidentiality and comply with personal data protection regulations.

5.2 Recommendations Regarding Conscientious Objection under the Framework of LORE

In accordance with current Spanish legislation and the guidance documents issued by the Ministry of Health (such as the *Manual of Good Practices in Euthanasia*), the following recommendations are made concerning the exercise of conscientious objection.

Public healthcare services, within the scope of their respective responsibilities, shall adopt the necessary measures to guarantee the right to medical assistance in dying under the conditions and requirements set out in the LORE. Among these measures, the creation of "support and advisory teams" may be considered.

Conscientious objection is an individual right, not a collective one. It is inherently personal and, therefore, cannot be exercised by institutions, healthcare centres, departments, or units.

Objection must be specific and refer exclusively to actions directly related to the performance of the procedure. It may not be extended to routine care or other medical services the patient may

require as part of their standard treatment.

The objection is therefore concrete and narrowly defined. Regarding its scope, the Ministry of Health's manual limits it to the actions and procedures outlined in:

Article 8. Procedure to be followed by the attending physician when a request for medical assistance in dying. This article details the actions that are part of the preliminary procedural steps necessary for the lawful provision of medical assistance in dying. These include confirming the patient's clear, firm, and informed decision to proceed with the request for medical assistance in dying, based on repeated and consistent expressions of such a wish, or alternatively, noting any withdrawal of that decision.

Article 11. Performance of the procedure of Medical Assistance in Dying. This article covers the final stage, which includes prescribing, preparing, administering, or supplying the medication, along with providing observation and support until the patient's death.

Both the preliminary and final stages form part of the unified legal process for the provision of medical assistance in dying.

Under Article 16.1 of the LORE, healthcare professionals may exercise conscientious objection only if they are directly involved in necessary and immediate actions either preceding or occurring during the performance of the procedure without which the process could not take place.

This includes not only physicians and nurses responsible for prescribing or administering the medication but also: Attending and consulting physicians. Clinical psychologists, if their involvement is formally required. Pharmacists, when compounding medications or preparing the kits used for the procedure.

A healthcare professional who is a conscientious objector and receives a request for medical assistance in dying must inform the patient of their objection and is obligated to refer the request to a supervisor or another designated professional, in accordance with the protocol established in their autonomous community.

Subsequent objection (i.e. a change in position after an earlier declaration) and reversibility of objection are both permitted, acknowledging that beliefs and personal convictions may evolve over time, even if a general written objection had previously been submitted.

Professionals may register or withdraw their declaration of objection from the official registry at any time.

Healthcare facility administrators must be aware of which professionals have declared conscientious objection in order to plan service provision accordingly. This information must always be handled with strict confidentiality and used solely for the purpose of managing the provision of medical assistance in dying.

The Registry of Healthcare Professionals Declaring Conscientious Objection may be structured by the autonomous communities within their respective areas of authority, either as a single, centralised system or in a decentralised manner within the healthcare area management offices. In all cases, the autonomous administration shall remain solely responsible for the registry. The registry must comply with the principle of strict confidentiality and the current regulations on personal data protection.

A genuine conscientious objection requires consistency across the professional's clinical practice. It is ethically inappropriate to claim conscientious objection within the public healthcare system but not in the private sector or vice versa as the objection ceases to be authentic if it is motivated by technical, legal, employment-related, or other considerations unrelated to one's personal moral convictions

No healthcare professional who has declared a conscientious objection may be discriminated against. No requirements may be imposed, no negative consequences applied, and no incentives offered with the aim of persuading professionals to withdraw or forgo their objection. Institutions and clinical teams must refrain from exerting any form of pressure either to encourage or discourage the exercise of the right to conscientious objection as defined under the LORE

Health authorities are responsible for ensuring and facilitating access to medical assistance in dying. The legitimate exercise of conscientious objection must not restrict, delay, or otherwise interfere with a patient's request for the procedure.

Healthcare administrations must also inform patients of the nature and scope of the right to conscientious objection. The exercise of this right by healthcare professionals must not compromise the quality or continuity of patient care.

Healthcare professionals are entitled to clear information regarding the structure and functioning of the conscientious objection registry within their autonomous community, particularly with respect to the use and protection of their personal data.

Importantly, conscientious objection specific to the provision of medical assistance in dying does not extend to other aspects of care. This includes clinical duties, palliative care, routine treatment, administrative responsibilities, communication with patients and families, psychosocial support, and inter-facility transfers.

6. Report of the Spanish Bioethics Committee

The Spanish Bioethics Committee identifies three specific stages of the procedure during which healthcare professionals may exercise conscientious objection. According to the Committee's interpretation, this right does not take effect until the deliberative process has been completed.

The Committee also raises concerns about whether legal entities (i.e., institutions) can claim the right to conscientious objection, arguing that such objection could in theory extend beyond individuals. However, Spanish law does not support this interpretation, as it explicitly refers only to "the individual decision of the healthcare professional directly involved" in the process.

The Committee further emphasizes a broad interpretation of the term "healthcare professional", extending beyond physicians and nurses to include pharmacists and auxiliary staff. In the Committee's view, pharmacists may also invoke conscientious objection. This position is particularly relevant in the context of assisted suicide, where there is both a prescribing physician and a pharmacist who is responsible for providing the required medication to carry out the act.

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End-of-Life Decisions and Scenarios in Spain

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Abstract: End-of-life decisions and scenarios in Spain are the result of the transformation of ethical and social values, the changes in doctor-patient relationship and the definition of the goals of medicine, as well as the evolution of legislation and case law since the restoration of democracy in 1975. The paper describes the different historical stages that lead to the current end-of-life framework and explains its main features.

Keywords: Autonomy; Euthanasia; Palliative care; Refusal of treatment; Sedation; Withholding and Withdrawal of Treatment.

Summary: 1. Introduction. 2. Historical perspective. 2.1. Introduction, acknowledgment and guarantee of patient autonomy. 2.2. Consolidation and development of patient autonomy at and for the end-of-life. 2.3. Deepening autonomy and legally defining end-of-life scenarios. 2.4. Strengthening of patient autonomy and enlargement of end-of-life scenarios. 3. Systematic perspective. 3.1. End-of-life legal features. 3.2. End-of-life scenarios. 4. Conclusion.

1. Introduction

The recent enactment of the Organic Law 3/2021, 24 March, regulating euthanasia has expanded and redefined the possibilities for decision-making and agency by patients at the end of life in Spain. However, the decriminalisation and regulation of euthanasia is a further step in shaping the end-of-life scenarios that have emerged through a long evolution since 1975, when democracy was restored in this country.

In order to correctly understand the current end-of-life scenarios in Spain, this paper will adopt a dual perspective, historical and systematic. The legal consolidation of patient's rights and autonomous decision-making in end-of-life care is the result of the evolution of legislation and case law since the 1978 Spanish Constitution, and has happened along with the transformation of ethical and social values and relevant changes in healthcare field, mainly new ways of getting sick and dying and new definitions of the goals of medicine –including the relief of pain and suffering, the care of those who cannot be cured, and the pursuit of a peaceful death–, and a shift in doctor-patient relationship guided by the rehabilitation of trust and mainly the respect for patient autonomy.

2. Historical perspective

The evolution of end-of-life decisions and scenarios is closely intertwined with that of patient autonomy and rights as well as of the professional due care. Departing from Spanish Constitution,

the legal framework stems from a legislative regulation that has been pushed forward and updated by case law. This evolution can be organised into four stages.

2.1. Introduction, acknowledgment and guarantee of patient autonomy

The standpoint is the Spanish Constitution (1978), mainly its article 15. On the one side, it protects life by stating that "[e]veryone has the right to life and to physical and moral, and under no circumstances may be subjected to torture or to inhuman or degrading punishment or treatment." (art. 15.1). On the other, it does not include neither a right to autonomous decision nor a general right to liberty/freedom, but autonomous decisions are considered an expression of and based on the fundamental right to physical and moral integrity (art. 15.1). Furthermore, the Spanish Constitution includes a catalogue of fundamental rights and liberties which supports and develops patient autonomy to make and implement decisions about his/her life and health: human dignity and free development of personality (art. 10.1), the freedom of conscience – ideological and religious freedom– (art. 16), the right to freedom –of movement– and security (art. 17), the right to privacy (art. 18.1) and other rights such as the right to health protection (art. 43).

The first significant legislative development was the General Health Act (Act 14/1986, 25 April), a state legal norm that has acknowledged the right to informed consent, including proxy decisions for incompetent persons (art. 10.1, 10.5 and 10.6). In contrast to the pre-constitutional legal provisions, the aforementioned Act did also recognise a genuine right of the patient to autonomous decision-making, but with notable restrictions. This was the case of the refusal of treatment (art. 10.9), requiring in order to be recognised the simultaneous request for voluntary medical discharge (art. 10.9 and art. 11.4), and establishing three exceptional circumstances in which it was not necessary to obtain the prior written consent of the patient (art. 10.6): a) a risk to public health, b) decision-making incompetence; c) an emergency situation that could cause irreversible injury or danger of death. Public health (art. 10.6.a) was a reasonable limit, but the other two limits were not. To make the right to refuse a treatment conditional on the request for medical discharge –whose voluntary nature was questionable– was disproportionate and unbalanced, and the exceptions of incompetence (art. 10.6.b) and emergency (art. 10.6.c) were conceptually defective and poorly formulated, covering a kind of paternalism.

In this first stage, among other relevant legislative provisions regarding end-of-life issues can be mentioned the Act 30/1979, 27 October, that regulate the requirements for a lawful organ donation, and a brand new Criminal Code (Organic Law 10/1995, 23 November) where, for the first time, was reduced the penalty in cases of cooperation or assistance in suicide in euthanasia context (art. 143.4).

Finally, it is worth mentioning the most remarkable judicial decision in Constitutional case law, indeed the first leading case in this field: the Spanish Constitutional Court judgment 120/1990, 27 June, confirming the right not to receive treatments against the patient's will, supported by the fundamental right to physical and moral integrity (art. 15.1 Spanish Constitution), while asserting that did not mean to recognise a right to die.

2.2. Consolidation and development of patient autonomy at and for the end-of-life

The second stage departed from what can be deemed as a bioethical Constitution: Council of Europe's Convention, 4 April 1997, for the protection of human rights and dignity of the human with regard to the applications of biology and medicine (Convention on human rights and biomedicine), ratified by Spain on by Document of 23 July 1999 and in force since 1 January 2000. Its most eminent legislative development is Act 41/2002, of 14 November, basic regulating patient autonomy, and rights and obligations regarding clinical information and documentation, still in force and remaining the legal reference for patient's rights. This Act is the most influential legislative contribution of this second stage and reflects the evolution and consolidation of patient autonomy, albeit at an uneven pace and scope in the different dimensions of autonomy –decisional, informational and executive.

The Convention on human rights and biomedicine showed the increasing international influence on setting up the Spanish biolegal field, outlined the informed consent process (arts. 5 ff.) and introduced advance directives into our legal system for the first time (art. 9: "previously expressed wishes"). Nonetheless, the most significant and deep marks belong to Act 41/2002: a more balanced regulation of the right to clinical or health information (arts. 2, 3, 4, 5, 6, 10, 12 and 13); the consolidation of the right to informed consent and free choice (arts. 2, 3 and 8 ff.), expressly affirming a broad right to refuse treatment without the former restrictions (art. 2.4); the regulation of the singular situation of mature minors, recognising a kind of healthcare legal age at 16 (art. 9); and the extension *ad futurum* of decision-making autonomy through advance directives (art. 11).

The decisive role of regional legislation deserves a mention, because the Autonomous Communities —Spanish regions— regulations preceded the national Act 41/2002, being pioneer in this regard Catalonia (Act 21/2000, 29 December), immediately followed by Galicia, Navarre and others. Moreover, other national legal provisions completed the legal landscape, i. a., the Act 16/2003, 28 May, on cohesion and quality in the National Health System, which updated and developed structural and organisational aspects addressing autonomy's institutional dimension and considering respect for rights and autonomy as a criterion of quality; the Act 44/2003, 21 November, on the regulation of healthcare professions, which included references to the dignity and self-determination of the patient among the general principles of relations between healthcare professionals and patients (art. 5.1), as

also did the Act 55/2003, 16 December, on the framework statute for statutory healthcare personnel (art. 19.i), j).

Ordinary and constitutional case law have also played an important role. The evolution of the former culminated in Supreme Court (First Chamber) ruling of 12 January 2001, hyperbolically considering informed as a "fundamental human right". Most important was the Spanish Constitutional Court case law through the judgment 154/2002, 18 July, confirming that the rights to autonomous decision-making and to refuse treatments were in accordance with the Constitution in the case of minors and proxy decisions too, supported by the fundamental rights to physical and moral integrity (art. 15 Spanish Constitution) and freedom of conscience and religion (art. 16 Spanish Constitution).

2.3. Deepening autonomy and legally defining end-of-life scenarios

The twofold starting point of the third stage expresses its international dimension. The first regulatory pillar is the Charter of Fundamental Rights of the European Union (2000), which has acquired legal validity and binding force in Spain thanks to article 6.1 of the Treaty of Lisbon (2007). The Charter confirmed the growing importance of the three dimensions of patient autonomy throughout its text, in particular by explicitly including the requirement to respect the free and informed consent of the individual in the field of medicine and biology (art. 3.2.a) within the regulation of the right to the integrity of the person (art. 3), and the right to the protection of personal data, based on the consent of the person concerned (art. 8), which has also been enshrined in the Treaty on the Functioning of the European Union (Article 16). The second pillar is the Convention on the Rights of Persons with Disabilities (2006), the first international human rights treaty of the 21st century, which provides the normative framework for executive autonomy and the necessary modifications in the characterisation, interpretation and application of the other two dimensions of autonomy, especially the decisional one, placing first the individual autonomy of persons with disabilities, and not proxy decisions, including freedom to make decisions, independence and full and effective participation (above all arts. 3 and 12).

The internationalization is also shown with the appeal to the European Court of Human Rights case law (cases Haas v. Switzerland, 2011; Koch v. Germany, 2012; Gross v. Switzerland, 2013 and 2014; Lambert and Others v. France, 2015; Gard and Others v. The United Kingdom, preceded by the case Pretty v. the United Kingdom, 2002) as an interpretative element in the constitutional case law, along with the regulatory work of the European Union, through its Constitution, Directives, Regulations and other provisions, along with an intense Soft Law contribution of other bodies and institutions, such as the United Nations and, above all, UNESCO, due to its special dedication to bioethics and

the ethics of science and technology, translated into regulations such as the Universal Declaration on Bioethics and Human Rights (2005).

Regarding domestic law, the most significant contribution in the third stage came from the Autonomous Communities, passing several legal regulations on the dignity in the end-of-life process since 2010 (Andalusia, Navarre, Aragon, etc.). These norms have legally defined concepts and clinical situations in order to provide greater legal and clinical certainty for patients and professionals, establishing the lawful and unlawful end-of-life scenarios (refusal of treatment, withholding and withdrawal of life sustaining treatments, palliative care, palliative and terminal sedation, informed consent or advance directives among the former, being therapeutic obstinacy one of the latter), strengthening patient's rights and autonomy in the process of dying, and clarifying healthcare professional's duties and healthcare system's institutional guarantees.

Once again, the Spanish Constitutional Court reinforced patient's autonomy and rights through its judgment 37/2011, 28 March, stressing the constitutional link of the right to informed consent with the fundamental right to physical and moral integrity (art. 15 Spanish Constitution) and stating that respecting patients' autonomy is a guarantee for professional good practice. Moreover, the Supreme Court case law broadened the scope of healthcare standard of due care and good practice (*lex artis* in Spanish case law), demanding not only technical competence and correctness but also to respect patient's informed consent and confidentiality.

2.4. Strengthening of patient autonomy and enlargement of end-of-life scenarios

The fourth and last stage is characterized by the enlargement of the end-of-life scenarios with the addition of euthanasia after the organic law 3/2021, 24 March, on the regulation of euthanasia, was passed. This state legal norm decriminalises euthanasia —modifying the article 143 of the Spanish Criminal Code— and acknowledges a right to request help in assisted dying through direct administration or the prescription and supply of drugs by a healthcare professional. Nonetheless, it should be noted that this law does not acknowledge a right to die, but a right of self-determination to decide how and when to die in accordance with the requirements and procedure legally established.

As it has just been stated, the legal response is twofold: decriminalisation and regulation of assisted dying. Regarding to the former, the wording of paragraph 4 is amended and a paragraph 5 is added to article 143 of the Spanish Criminal Code; therefore, human life continues to be a legal right worthy of protection, so that conduct that harms it is unlawful and punishable (arts. 138 ff. Spanish Criminal Code), except those that comply with the conditions set out in the organic law 3/2021 (art 143.5 Spanish Criminal Code). Secondly, this law regulates in detail the conditions and requirements that

exempt from criminal liability and make lawful the actions of those who participate in the process of medically assistance in dying.

A second relevant legislative feature concerns the decisional autonomy of persons with disability. The Act 8/2021, 2 June, reforming civil and procedural legislation to support persons with disabilities in the exercise of their legal capacity, has adapted the Convention on the rights of persons with disability in order to guarantee equal recognition before the law and ensure all the measures related to the exercise of their legal capacity respect the rights, will and preferences of the person and foster his/her decisional autonomy, promoting self-determination, even with supported measures, and reducing the decisional role of representatives to the most severe and exceptional situations.

Case law has played again a significant role in this last stage. On the one hand, two judgments of the Spanish Constitutional Court (judgment 19/2023, 22 March, and judgment 94/2023, 12 September) have confirmed that the legal conditions for euthanasia as set out in the organic law 3/2021 are in accordance with Spanish Constitution. On the other, European Court of Human Rights case Mortier v. Belgique (2022) has been a significant legal support for the aforementioned Spanish Constitutional Court judgments, since the case has been used as a lawful standard for assessing the legal regulation of medical assisted dying. Along with it, other cases such as Daniel Kársai v. Hungary (2024) and Pindo Mulla v. Spain (2024) have completed the judicial doctrine of decisional autonomy in the end-of-life field and confirmed the influence of international legal answers in shaping the issue.

3. Systematic perspective

The legal evolution towards the current end-of-life decisions and scenarios in Spanish legal system can be systematically ordered by selecting the most relevant legislative and judicial contributions, describing firstly the main legal features and then defining the lawful end-of-life scenarios.

3.1. End-of-life legal features

The right to life (art. 15.1 Spanish Constitution) is a legal guarantee for the individual and a source of negative and positive obligations for the State. This negative and positive duty to protect life is not absolute, and has been relaxed by means of the organic law 3/2001, 24 March, regulating euthanasia. Moreover, the protection of individual life does not take precedence over the right to physical and moral integrity (art. 15.1 Spanish Constitution; e. g. Spanish Constitutional Court judgments 120/1990; 37/2011) and the right to freedom of religion and conscience (art. 16 Spanish Constitution; Spanish Constitutional Court judgment 154/2002). Therefore, treatment without consent and coercive medical assistance are unlawful actions –and even criminal offences– that infringe the right to physical and moral integrity (art. 15.1 Spanish Constitution) and other legislative provisions (above

all Act 41/002, 14 November). Moreover, to care and to assist the patient are lawful and enforceable even if a cure is not possible; otherwise, it constitutes ill-treatment.

Along with this delimitation of the scope of patient autonomy, it should be underlined the broadening of the concept of the medical due care or *lex artis*, which is no longer limited to comply with the technical requirements or to improve health condition, but includes also ethical requirements such as respect for patient's informed consent and confidentiality, and even an efficient management of resources (art. 2.6 Act 41/2002; Supreme Court judgements; Spanish Constitutional Court judgment 37/2011).

There is no a legal duty to live. The protection of life must be connected to the will of the individual (Spanish Constitutional Court judgment 19/2023, legal ground 6.C.b.iv). There is not a right to euthanasia, but there is a right to request and receive assistance in dying understood as a public subjective right (legal grounds 5.b; 6.B.a; cf. as well arts. 13 and 14 organic law 3/2021). Citizens are entitled with a "right to self-determination with regard to one's own death in euthanasia contexts' (legal grounds 6.C.d; 6.D.b.i) or a "right to self-determination with regard to one's own death in contexts of extreme suffering" (legal ground 6.D.a). This right is more than just a generic or factual freedom (*agere licere*) or area free from the law, which was the former constitutional doctrine established by the Spanish Constitution Court judgment 120/1990. This is a vital decision of self-determination protected by fundamental rights and constitutional principles (Spanish Constitution Court judgment legal ground 6.C.d.ii). From the constitutional and legal perspective, instead as a fundamental right as such, it is better and more accurately understood as a constitutional right of legal configuration (Spanish Constitutional Court judgment 94/2023, legal ground 6.B.b).

Therefore, assistance in dying is lawful subject to certain conditions established in organic law 3/2021, 24 March, regulating euthanasia, and meets the requirements established by the European Court of Human Rights in the Mortier case (2022, §§ 135-141). Although there is no a right to die covered by article 2 of the European Convention on Human Rights, there is a right to decide when and how to end one's life as an aspect of the right to respect for private life (art. 8 Convention). Furthermore, the right to life acknowledged in article 2 does not prohibit the conditional decriminalisation when is accompanied by adequate and sufficient legal and institutional safeguards to prevent abuse and ensure respect for the right to life. The conditions for the lawfulness of the decriminalisation of euthanasia are the following (§ 141): 1) existence of a prior legislative framework that respects the requirements of art. 2 of the Convention, in particular positive –material and procedural– obligations of the State to protect life; 2) respect for the legislative framework in the case analysed; 3) existence of *a posteriori* control offering guarantees.

As the Spanish Constitutional Court has stated, the legislative decriminalisation and regulation of euthanasia by means of organic law 3/2021 offers a framework of substantive and procedural guarantees that satisfies the State's duties to protect the fundamental rights at stake, including life, against third parties (Spanish Constitutional Court judgment 19/2023, legal ground 6.D.c.i), reinforcing these guarantees even further with the *a priori* or *ex ante* controls (arts. 8 and 10 organic law 3/2021) that supplements the usual *a posteriori* o *ex post* control.

3.2. End-of-life scenarios

As it has been described, euthanasia is just one of the end-of-life decisions, and not the most common one, where the patient can be, either following his/her decision, or the professional judgment: Considering the aforementioned characteristics, the main lawful end-of-life scenarios in Spain are the following:

1) Refusal of treatment is an informed decision made by a patient for withholding or withdrawing a treatment, even if this decision could lead to his/her death, that has to be put in writing (art. 2.4 Act 41/2002). The patient can make this decision through his/her informed consent (arts. 8-10 Act 41/2002), when remains competent at the time of implementing the decision, or an advance directives document (art. 11 Act 41/2002), when he/she is currently incompetent but has made his/her decision beforehand anticipating a future lack of competence, being recommended that such a document should be the result of a process of a shared care planning.

2) Withholding and withdrawal of life-sustaining treatment, i.e, not starting or stopping a treatment that has the potential to sustain the life of a patient, are two ways of adaptation of therapeutic effort. This decision is made by the healthcare professionals and is considered ethically and legally correct when it aims to avoid keeping the patient alive through disproportionate and futile treatments, being reinforced by the Autonomous Communities legal provisions that established a professional duty to avoid therapeutic obstinacy.

The expression “passive euthanasia” for this scenario is not accurate and should be avoided in order to prevent misunderstandings.

3) Palliative care is a comprehensive approach provided at any stage of patient’s illness that addresses the physical, psychological, spiritual, and social needs of the patient and his/her family in order to achieve the best quality of life available to the patient by relieving suffering, controlling pain and distressing symptoms.

4) Palliative sedation is the process of inducing and maintaining deep sleep to relieve refractory symptoms in the palliative care setting —or even in terminal stages: terminal sedation—, having previously obtained the patient’s consent or, if incompetent, his/her representative’s consent.

The expression “indirect euthanasia” for this scenario is not accurate and misguiding and thus should be avoided in order to prevent misunderstandings.

5) The assistance in dying, usually known as euthanasia, consists of providing the necessary means to a person who suffers a serious and incurable disease or a serious, chronic and incapacitating illness that causes him/her an unbearable and continuous physical or psychological suffering that cannot be alleviated, and who has expressed his/her previous and informed request to die, either through the direct administration of a substance to him/her by a healthcare professional, or the prescription or supply to him/her by the healthcare professional of a substance, so that it can be self-administered to cause his/her own death. The organic law 3/2021 uses the term “euthanasia” only in its preamble and a couple of incidental mentions in the main body but avoids to use them for describing the lawful conducts (arts. 3.g) 1st and 2nd), not mentioning anywhere the expression “medically assisted suicide”.

4. Conclusion

Spanish legal answer to the end-of-life decision-making and scenarios is the outcome of long and complex political, ethical, clinical and legal processes that have led to the current situation. Firstly, as a typical Roman-German legal system, it stands out the legislative regulation, currently ended by organic law 3/2021, but accompanied by an increasing contribution of case law, mainly that of Constitutional Court and of European Court of Human Rights.

This feature leads and explains a second relevant factor, stemming from the two trends that have transformed contemporary political and legal systems since the end of the Second World War: on the one hand, constitutionalisation, evidenced through the normative superior hierarchy of Constitution and constitutional jurisdiction, together with the omnipresence of fundamental rights; on the other, law is going beyond the boundaries of the State, both supra-, through European and international regulations, and infra-, through the regulations of the Autonomous Communities. A glance at the historical context shows that each stage of the end-of-life evolution is supported by a “constitutional” foundation and developed further through national and regional legislation and then either strengthen or confirmed by ordinary and constitutional case law.

Thirdly, how the professional relationships between the doctor and the patient have left behind paternalism and embraced the contemporary goals of medicine towards a deliberative model through two complementary perspectives: that of the patient, with a growing recognition of his/her autonomy and rights, and that of the healthcare professionals, in line with the evolution of professional duties and the standards of due care, both within the institutional context provided by the healthcare and social care system.

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Legal Framework of Medically Assisted Dying in Bosnia and Herzegovina

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Abstract: Respect for patients' autonomy (human dignity) obliges medical professionals to honor competent patients' informed and voluntary decisions regarding their medical treatment. Among the most complex legal and ethical dilemmas in this context are end-of-life decisions, particularly the questions of whether a patient should be entitled to request that a physician actively end their life through the administration of a lethal substance (active euthanasia), or to provide the means for the patient to do so independently (physician-assisted suicide). This paper examines the legal framework governing medically assisted dying in Bosnia and Herzegovina (BiH) (its entities: the Republic of Srpska and the Federation of Bosnia and Herzegovina), with a focus on the legal status of active euthanasia, assisted suicide, and the prospects for introducing advance directives within the BiH legal order.
Euthanasia is prohibited under the criminal laws of all BiH jurisdictions. However, the regulatory frameworks of the Republic of Srpska, the Federation of Bosnia and Herzegovina, and the Brcko District differ with regard to the patient's right to refuse life-sustaining treatment. These provisions are analyzed in detail, and possible legislative changes are suggested. The paper also addresses the ethical and legal aspects of advance directives introduction, outlining their conceptual foundations and ethical justifications. Although BiH ratified the Convention on Human Rights and Biomedicine in 2007, which requires that previously expressed wishes regarding medical interventions be taken into account, it has yet to adopt legislation regulating living wills. The divergent entity-level provisions on refusal of life-sustaining treatment further complicate the potential introduction of this instrument. Drawing on comparative experiences from other national legislations, the paper evaluates possible directions for reform, emphasizing the need for a coherent legal framework that balances respect for patient autonomy with safeguards for vulnerable individuals in end-of-life decision-making.

Keywords: Active Euthanasia; Assisted Suicide; Passive Euthanasia; Advance Directives; Autonomy; Dignity; Bosnia and Herzegovina.

Summary: 1. Introduction. 2. Legal Framework of Medically Assisted Dying in BiH. 2.1 Legal Regulation of Medically Assisted Dying in the Republic of Srpska. 2.2 The Legal Framework on Medically Assisted Dying in the Federation of BiH. 2.3 Medically Assisted Dying in the Legal Framework of the Brčko Distrikt. 3. The Regulation of Advance Directives in BiH. 3.1 Concept and Ethical Relevance of Advance Directives. 3.2 International and European Standards of Advance Directives. 3.3 Legal Framework of Advance Directives in BiH. 3.4 Legal Consequences of the Living Will Application in BiH. 4. Conclusion

1. Introduction

Respect for patient autonomy (human dignity) obliges medical professionals to honor the competent patients' informed and voluntary decisions about their medical treatment. Patients' right to participate in treatment decision-making has been justified by reference to values of autonomy and self-determination, which are closely related to the concept of human dignity. However, dignity cannot be reduced to autonomy. Every autonomous act of an individual will not necessarily be in accordance with the value of human dignity. Among the issues that raise complex ethical dilemmas are the decisions concerning the end of life. In this paper, some of the ethical and legal controversies

surrounding end-of-life decisions will be explored. Special attention will be given to the legal framework of the end-of-life decision-making in BiH (its entities: the Republic of Srpska (RS) and the Federation of Bosnia and Herzegovina (FBiH), as well as in the Brcko District (BD)).

The right of patients to participate in decisions concerning their medical treatment has become a universally recognized right, grounded in the principle of respect for autonomy and self-determination. Since Kant, personal autonomy has often been recognized as the foundation of human dignity. In Kant's own account of dignity, and in the work of many authors that follow him, "there is a close association between dignity and something we might call autonomy[1], (understood as a capacity to determine one's ends, and make authentic choices[2]). To deprive a person of the possibility of autonomous action means to dehumanize him/her, to reduce him/her to the mere object of action, to attack and violate his/her fundamental dignity (this is the essence of the Kant's second formulation of the categorical imperative). Applied to the context of physician-patient relations, if the patient cannot influence the course of his/her medical treatment, if his/ her wishes are ignored, or even deliberately contravened, then his/her dignity is undermined. Against this backdrop, the persistence of paternalism in medicine appears increasingly problematic. Defined as "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced"[3], paternalism reflects the traditional image of the physician as a father-like figure entrusted to decide what serves the patient's best interests. Such an approach treats patients as incapable of making rational and adequate decisions, thereby denying them their autonomy and, consequently, undermining their dignity. Respect for informed consent ensures the protection of human dignity, for if patients are unable to influence the course of their medical treatment, or if their wishes are ignored or deliberately contravened, their dignity would be seriously compromised. However, dignity cannot be reduced to autonomy. Every autonomous act of an individual will not necessarily be in accordance with the value of human dignity. One of the issues that arouse complex ethical dilemmas are the decisions concerning the end of life. The question arises: does the right to autonomous decision-making extend to choices concerning the termination of a patient's life, and does it legitimize requests for physician assistance in bringing about the death of the patient?

Euthanasia is one of the most controversial subjects in bioethics and biolaw. The word *euthanasia* is derived from the Greek words: *eu* (good) and *thanatos* (death). According to Humphry, it may be

[1] Andrew Brennan, Yeuk-Sze Lo, "Two Conceptions of Dignity: Honour and Self-Determination", in *Perspectives on Human Dignity. A Conversation*, eds. Jeff Malpas, Norelle Lickiss (Springer, 2007), 50.

[2] *Ibid.*

[3] Gerald Dworkin, "Paternalism", *Monist* 56 (January 1972), 65; Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press), 10.

defined as *help with a good death*[4]. Euthanasia can be categorized into several distinct forms, depending on the presence or absence of patient consent and on the means by which death is brought about. Voluntary euthanasia occurs when the termination of life takes place at the explicit request of the person who undergoes it. Non-voluntary euthanasia refers to cases in which the patient is not capable of making, or is unable to express, a request either for or against the termination of life (e.g. cases involving infants or adults who have permanently lost consciousness). Involuntary euthanasia, by contrast, involves ending the life of a patient who is capable of expressing a view but has not made such a request.[5] Another distinction concerns the manner in which death is brought about: active euthanasia involves direct interventions intended to hasten death, whereas passive euthanasia occurs when life-sustaining treatment or nourishment is withheld or withdrawn with the intention of hastening death.[6]

Proponents of euthanasia legalization commonly invoke the right to a dignified death. However, the dignity argument is used by the euthanasia opponents as well (in their case to defend the inviolability of human life). This dual invocation underscores the Janus-faced nature of human dignity, a feature especially pronounced in the context of euthanasia debates. In their influential analysis of the concept, Beyleveld and Brownsword seek to systematize the diverse meanings of dignity by distinguishing between "dignity as empowerment" and "dignity as constraint". According to the authors, the conception of "dignity as empowerment" implies that "the function of human dignity is to reinforce claims to self-determination rather than to limit free choice".[7] It represents "a conception of individual empowerment rather than of social or collective constraint".[8] Under this understanding, dignity provides a basis for respecting a patient's wishes concerning the end of life. However, the restrictive or constraining dimension of dignity ("dignity as constraint") also plays an important role in discussions on the ethical justifiability of euthanasia. This conception of human dignity acts as "a constraint on free choice"[9]. It can be used to control or prohibit even those activities to which one freely consents and which seem to harm no one else. Thus, the notion of dignity as constraint is often invoked by opponents of euthanasia to argue that certain end-of-life decisions, regardless of their autonomous character, may nevertheless be ethically impermissible.

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[4] Derek Humphry, *Final Exit. The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (New York: Delta Trade Paperback, 2002), 1.

[5] Michael Tooley, "Euthanasia and Assisted Suicide", in *A Companion to Applied Ethics*, eds. R.G. Frey, Christopher Heath Wellman (Blackwell Publishing Ltd, 2003), 326.

[6] Jessica E. Young, Janine Winters, Chrystal Jaye, Richard Egan, "Patients' views on end-of-life practices that hasten death: a qualitative study exploring ethical distinctions", *Annals of palliative medicine* 10(3) (2021), 3564.

[7] Deryck Beyleveld, Roger Brownsword, *Human Dignity in Bioethics and Biolaw* (Oxford – New York: Oxford University Press, 2001), 28.

[8] *Ibid.*

[9] *Ibid*, 11.

According to Lee and George, who represent the anti-euthanasia position, all human beings possess a personal dignity, derived from the natural human capacity for conceptual thought, deliberation, and free choice, which grounds the universal moral obligation not to kill them.[10] A similar stance is advanced by Sulmasy, who distinguishes between three senses of dignity: intrinsic, inflorescent, and attributed. The intrinsic dignity, which denotes the value human beings possess simply by virtue of their humanity, is considered a fundamental form of dignity.[11] Sulmasy connects the concept of intrinsic dignity to a categorical rejection of euthanasia and assisted suicide. As Sulmasy argues, intrinsic dignity is the inherent worth that every human being possesses by virtue of their humanity, a value that remains inalienable regardless of illness, disability, or loss of autonomy. While disease and dying may erode an individual's attributed dignity, these losses can never diminish his/her intrinsic dignity. Accordingly, healthcare professionals have a moral duty to preserve and support attributed dignities through palliative care and compassionate support, but never by intentionally destroying the life of the person who possesses intrinsic dignity. On this account, euthanasia and assisted suicide fail to respect the most fundamental form of dignity and are therefore ethically impermissible.[12]

Harris, by contrast, emphasizes the moral relevance of persons (individuals capable of valuing their own existence) and respecting their autonomous choices rather than human life as such, arguing that to deny an individual control over the circumstances of their death constitutes a form of tyranny. This view, though Harris does not explicitly use the term dignity, corresponds to the conception of "dignity as empowerment".[13] Ronald Dworkin defends the right of rational individuals to be the author of their own life, while simultaneously affirming the "sacredness" and "inviolability" of life, insisting that each human life has intrinsic value and deserves respect. In *Life's Dominion*, he defines dignity as the moral right (and responsibility) of an individual to decide independently on fundamental questions about the meaning and value of his/ her own life, answering to his/her own conscience and convictions.[14] Respecting autonomy means more than allowing people to pursue pleasure or avoid pain. It means allowing them to live, and die, in accordance with the values that make their life meaningful. Dworkin argues that decisions about the timing and manner of death belong to the realm of an individual's critical interests, those interests that give meaning and integrity to life as a whole, beyond mere experiential pleasures or pains. Denying a person the ability to decides about manner

[10] Patrick Lee, Robert P. George, "The nature and basis of human dignity", *Ratio Juris* 21.2 (2008), 173.
[11] Daniel P. Sulmasy, "Human Dignity and Human Worth", in *Perspectives on Human Dignity: A Conversation*, eds. Jeff Malpas, Norelle Lickiss (Springer, 2007), 12.
[12] Daniel P. Sulmasy, "Death, dignity, and the theory of value", *Ethical Perspectives* 9.2 (2002).
[13] Beyleveld, Brownsword, *Human Dignity in Bioethics and Biolaw*, 237-239.
[14] Ronald Dworkin, *Life's Dominion* (New York: Vintage Books, 1994), 166.

his/her life will end risks forcing them to live in ways that contradict their critical interests, thereby undermining their dignity.[15]

If rationality and free choice are regarded as the *differentia specifica* of humankind, the principle of patient self-determination would appear to prevail. Nevertheless, the responsibility dimension of a dignified death cannot be overlooked. Sulmasy's concept of inflorescent dignity, understood as human flourishing and living in ways consistent with one's intrinsic dignity, provides a framework for reconciling autonomy with responsibility.[16] In this sense, to avoid confronting one's medical condition could be regarded not only as irresponsible but also as undignified. The European Court of Human Rights (ECtHR) has contributed to this debate by recognizing that the right to choose the time and manner of one's death falls within the scope of the right to private life (Article 8 of the European Convention on Human Rights (ECHR)), even though it has refrained from acknowledging a general "right to die".

2. Legal Framework of Medically Assisted Dying in BiH

BiH is a complex state comprised of two entities: the Republic of Srpska (RS) and the Federation of Bosnia and Herzegovina (FBiH) (the Brcko District (BD) is a third territorial unit; the BD is a small subnational unit that enjoys broad legislative autonomy). The distribution of competences between BiH and the entities is determined by the Constitution of BiH in such a way that BiH is assigned the competences for regulating issues that are expressly stated in the Constitution of BiH, while all other issues are solely the responsibility of the entities.[17] The BiH entities and the BD are responsible for regulating health protection (in the FBiH, which is itself structured as a federal entity, health protection constitutes a shared competence between the federal level and its ten constituent federal units – the cantons). The criminal offences against life are also regulated by the entity and the BD criminal legislation.

2.1 Legal Regulation of Medically Assisted Dying in the Republic of Srpska

Under the criminal legislation of the RS, active euthanasia is legally classified as murder, punishable by imprisonment ranging from five to twenty years (Article 124(1) of the RS' Criminal Code)[18].

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[15] See: *Ibid.*

[16] Daniel P. Sulmasy, "The varieties of human dignity: a logical and conceptual analysis", *Medicine, Health Care and Philosophy,* Vol. 16, Issue 4 (2013), 938.

[17] Article III(1) and Article III(3) of the Constitution of BiH; Available at: https://www.ustavnisud.ba/uploads/documents/constitution-of-bih_ 1625734692.pdf (Accessed: 19.06.2025)

[18] Official Gazette of the Republic of Srpska, no. 64/2017, 104/2018 (Const. Ct. Decision), 15/2021, 89/2021, 73/2023; Official Gazette of Bosnia and Herzegovina, no. 9/2024 (Const. Ct. BiH Decision); Official Gazette of the Republic of Srpska, no. 105/2024 (Const. Ct. Decision), 19/2025; Official Gazette of Bosnia and Herzegovina, no. 14/2025 (Const. Ct. BiH Decision).

However, Article 124(2) stipulates that: "If a murder is committed under particularly mitigating circumstances, the offender shall be punished by imprisonment from one to eight years." This provision makes it possible for cases of euthanasia to be treated as murder committed under particularly mitigating circumstances, thereby allowing for the imposition of a more lenient sentence, a possibility that has been confirmed in judicial practice. In contrast to the legislation of neighboring countries, however, the Criminal Code of the RS does not recognize "mercy killing" or "murder upon request" as separate criminal offences.[19]

In examining the provisions relevant to the legal treatment of physician-assisted suicide, the offence of "Incitement to Suicide and Aiding in Suicide" holds particular importance. Article 129(1) of the RS Criminal Code provides: "Whoever incites another to commit suicide or aids in the commission of suicide, and the act is committed or attempted, shall be punished by imprisonment of six months to five years." Furthermore, if the act of aiding suicide is committed under particularly mitigating circumstances, the offender may be punished either with a monetary fine or with imprisonment of up to three years.

The legal system of the RS thus provides for criminal liability in cases of both active euthanasia and physician-assisted suicide. This, in turn, raises the question of the regulatory framework governing passive euthanasia, understood as the omission to initiate life-sustaining treatment or the withdrawal of such measures. An examination of the relevant health law provisions leads to the conclusion that passive euthanasia in the RS is legally permissible.

The RS Health Protection Law[20] explicitly guarantees the patient's right to make autonomous decisions regarding medical treatment, even when such decisions may jeopardize the patient's own life. Article 39(1) provides: "A patient has the right to make free decisions regarding his/her health, unless this would directly endanger the life and health of other people." Moreover, Article 43(1) explicitly states that: *"*A patient has the right to refuse a medical procedure, even in cases of necessary life-saving or life-prolonging medical treatments." While Article 39(2) specifies that the patient's right to make free decisions regarding his/her health does not encompass a right to euthanasia, an interpretation of the cited provisions suggests that this limitation does not apply to passive euthanasia.

[19] This criminal offence is recognized in the legislation of several countries in the region. According to Article 117 of the Criminal Code of Serbia: "Whoever deprives of life an adult person out of compassion, due to the person's severe medical condition, and at that person's serious and explicit request, shall be punished by imprisonment of six months to five years" (Official Gazette of the Republic of Serbia, no. 85/2005, 88/2005 – corr, 107/2005 – corr, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016, 35/2019, 94/2024); Criminal Code of Croatia, in Article 112(3), stipulates: "Whoever kills another person at his or her explicit and serious request, out of compassion for the person's severe medical condition, shall be punished by imprisonment for up to three years" (Official Gazette of the Republic of Croatia, no. 125/11, 144/12, 56/15, 61/15, 101/17, 118/18, 126/19, 84/21, 114/22, 114/23, 36/24).

[20] Official Gazette of the Republic of Srpska, no. 57/2022, 62/2025.

The Code of Medical Ethics and Deontology of the RS Medical Doctors' Chamber also contains provisions relevant to patients' decisions concerning the end of life. According to Article IV.2 of the Code: "The wish of a well-informed patient, suffering from an incurable disease, regarding the artificial prolongation or suspension of his/her life, when clearly expressed while fully conscious, should be respected."[21]

2.2 The Legal Framework on Medically Assisted Dying in the Federation of BiH

The criminal legislation of the FBiH also treats euthanasia as murder. Unlike the legislation of the RS, compassion for the victim's deteriorated condition does not constitute grounds for a more lenient punishment. The Criminal Code of the FBiH[22] does not recognize "particularly mitigating circumstances" as a basis for imposing a reduced sanction, thereby excluding the possibility of more lenient sentencing in cases of so-called "mercy killing" (Article 166 of the FBiH Criminal Code). Furthermore, the Code does not provide for the possibility of imposing a lesser sanction for the criminal offence of "Incitement to Suicide and Aiding in Suicide" in situations involving particularly mitigating circumstances, which also stands in contrast to the RS Criminal Code. Consequently, the possibility of more lenient punishment is excluded both in cases of active euthanasia and in istances of assisted suicide.

A more restrictive approach to patient autonomy in end of life decision-making is also evident in the health legislation of the FBiH. Although the Law on the Rights, Duties, and Responsibilities of Patients of the FBiH[23] affirms that a patient has the right to make free decisions regarding his or her life and health, provided that such decisions do not endanger the life and health of others, it explicitly stipulates that: "The patient has the right to refuse a proposed medical measure, except in cases where it serves to save or preserve his or her life, or where failure to undertake such a measure would endanger the life or health of other persons." This blanket prohibition on patient refusal of life-sustaining measures is particularly controversial when considered in light of the relevant jurisprudence of the ECtHR, and it leads to the conclusion that, in the legal framework of FBiH, not only active but also passive euthanasia is prohibited.

[21] Available at: https://www.komoradoktorars.org/index.php/2018-11-26-17-31-48/s-l/d-s-dicins-i-i-d-n-l-gi (Accessed: 17.06.2025)

[22] Official Gazette of the Federation of Bosnia and Herzegovina, no. 36/2003, 21/2004 – corr., 69/2004, 18/2005, 42/2010, 42/2011, 59/2014, 76/2014, 46/2016, 75/2017, 31/2023, and 58/2025

[23] Official Gazette of the Federation of Bosnia and Herzegovina, no. 40/2010

2.3 Medically Assisted Dying in the Legal Framework of the Brčko Distrikt

In the BD legislation, a mixed approach has been adopted, which partially diverges from the solutions contained in the legislation of the RS and the FBiH. In the field of criminal law, the BD Criminal Act mirrors the approach adopted in the FBiH (Article 163 of the BD Criminal Code)[24]. Euthanasia is classified as homicide, with no possibility of imposing a reduced sanction even in cases involving particularly significant mitigating circumstances (as such circumstances are not legally recognized as grounds for a lesser penalty in relation to this criminal offence). Likewise, Article 167 of the same Code, which criminalizes "Incitement to Suicide and Assistance in Suicide," contains no provision for more lenient punishment in cases involving mitigating circumstances.

By contrast, the Law on Health Protection in BD BiH[25], consistent with the legislation of the RS, does not preclude the refusal of life-sustaining treatment. Article 32(1) expressly affirms the patient's right to decline a proposed medical intervention, even when such treatment would preserve or prolong his or her life, with the sole exception of persons suffering from mental illness. Consequently, while the BD criminal legislation equates euthanasia with ordinary homicide, excluding the possibility of lesser penalties for both active euthanasia and assisted suicide, the provisions of the Law on Health Protection in BD implicitly recognize the permissibility of passive euthanasia.

3. The Regulation of Advance Directives in BiH

3.1 Concept and Ethical Relevance of Advance Directives

The ethical and legal dilemmas relating to the advance directives application in BiH will also be examined within this paper. Advance directives enable people to exercise their autonomy in advance, by documenting their wishes for medical care in the event of future incompetence. They represent „oral or written statements in which people declare their treatment preferences in the event that they lose decision-making capacity".[26] The ethical basis of advance directives is the same as in the case of informed consent. As the informed consent given in advance, advance directives are primarily associated with the conception of "dignity as empowerment".

However, this concept also possesses a responsibility dimension. To think and plan ahead and make an investment in the future, is an essential feature of living the moral life. According to Barilan, we cannot apply the concept of autonomy to unruly persons, whose life is a chaotic chain of "local acts,"

[24] Official Gazette of the Brčko District of BiH, no. 19/2020 – consolidated text, 3/2024, and 14/2024

[25] Official Gazette of the Brčko District of BiH, no. 5/2023 – consolidated text, 7/2023, and 31/2024

[26] Gary S. Fischer, James A. Tulsky, Robert M. Arnold, "Advance directives and advance care planning", in *Encyclopedia of Bioethics*, Volume 1, ed. Stephen Garrard Post (Macmillan, 2004), 74.

none of which seems to bear any rational connection to another.[27] Deciding in advance about possible medical decisions (and their consistency with one's own "critical interests") is certainly a part of morally responsible behavior and consistent with living a morally responsible/dignified life.

Proponents of advance directives typically adopt some version of the "Extension View" of precedent autonomy. As Davies formulates it, the "Extension View" holds that individuals possess the same moral authority over their future affairs as they do over their present ones, with this authority simply projected forward in time[28]. Among the most prominent advocates of this perspective are Ronald Dworkin and Nancy Rhoden.

On the other hand, critics of advance directives, most prominently Rebecca Dresser and John Robertson, argue that an individual's preferences and interests do not survive the loss of decision-making capacity. On this view, physicians ought to base their decisions on the patient's present condition and act in accordance with the current best interests of the now-incompetent patient.[29]

Advance directives are commonly divided into two categories: proxy directives and instructional directives, both of which apply only when the patient has lost decision-making capacity. Proxy directives (durable powers of attorney for healthcare) authorize another person to make medical decisions on the patient's behalf. They are simple to create and easy to understand, but do not, on their own, reflect the patient's values or treatment preferences. Instructional directives (living wills) address this limitation by specifying circumstances in which the patient would or would not wish to receive particular treatments (e.g., refusing resuscitation in cases of permanent unconsciousness or terminal illness). The scope and specificity of such documents vary.[30]

3.2 International and European Standards of Advance Directives

A substantial number of international and regional instruments contain provisions on advance directives, either regulating them in general or addressing their application in specific areas of healthcare (such as mental health care).[31] In Europe, the Council of Europe Convention on Human

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[27] Yechiel Michael Barilan, "Respect for Personal Autonomy, Human Dignity, and the Problems of Self-Directedness and Botched Autonomy", Journal of Medicine and Philosophy, Vol. 36, No. 5 (2011), 2

[28] John K. Davis, "Precedent Autonomy, Advance Directives, and End-of-Life Care", in *The Oxford Handbook of Bioethics,* ed. Bonnie Steinbock (Oxford University Press, 2007), 350.

[29] *Ibid*., 351.

[30] Fischer, Tulsky, Arnold, "Advance directives and advance care planning", 75-76.

[31] See, for example: United Nations Convention on the Rights of Persons with Disabilities, 2006; WHO Guidance on Mental Health, Human Rights, and Legislation (2005, 2021); Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo Convention), 1997; Recommendation CM/Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder; Recommendation (2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity; Resolution 1859: Protecting human rights and dignity by taking into account previously expressed wishes of patients, 2012;

Rights and Biomedicine (Oviedo Convention), adopted in 1997, contains the most significant and widely recognized provisions on advance directives. According to Article 9 of the Convention: "The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."[32] This seems to indicate that advance directives are not binding. This line of interpretation is confirmed by the Explanatory Report, which states that "taking previously expressed wishes into account does not mean that previously expressed wishes should necessarily be followed".[33] Moreover, the Convention's article provides no details on the way in which wishes should be expressed or how the physician should ascertain those wishes. So, what are the consequences of the Oviedo Convention ratification on the legal status of advance directives in the State Party? There is a general agreement that Article 9 of the Convention is directly applicable.[34] Accordingly, there is an obligation for states that have ratified the Oviedo Convention to recognize at least the indicative value of previously expressed wishes of patients. Although the ECHR does not contain specific provisions regarding advance directives and the ECtHR has so far not addressed advance directives directly, "the case-law of the European Court of Human Rights forms a vital source for describing the legal status of advance directives in Europe"[35]. The relevant provisions of the ECHR are contained in Article 8 of the ECHR, which provides: "Everyone has the right to respect for his private and family life, his home and his correspondence." One of the relatively recent cases that should be mentioned is *Lambert and Others v. France*. Although the Court was not dealing with advance directives, the circumstances of the case emphasized the relevance of these legal instruments (the normative legitimacy of advance directives was more recently implicitly reinforced in *Karsai v. Hungary*). In *Lambert*, the Court also made several references to Guide on the decision-making process regarding medical treatment in end-of-life situations, which stresses the importance of advance directives.

3.3 Legal Framework of Advance Directives in BiH

In BiH, there is no specific legislation regulating advance directives. However the health legislation of the BiH entities provides for the possibility of proxy designation. According to the RS Health Protection Law, a patient has the right to designate, in writing, a person who will give consent on his/her behalf or who will be informed about the provision of healthcare services in his/her place

[32] Available at: https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=164 (Accessed: 05.07.2025)
[33] Available at: https://rm.coe.int/1680a8e4d0 (Accessed: 07.05.2025)
[34] Herman Nys, et al., *Rights, autonomy and dignity of people with dementia* (King Baudouin Foundation, 2013), 79.
[35] Tom Goffin, "Advance Directives as an Instrument in an Ageing Europe", *European Journal of Health Law* 19 (2012), 132.

(Article 42.2). While this provision establishes a mechanism for proxy consent, it does not amount to a comprehensive regulation of this form of advance directives, since it fails to specify who may act as a proxy, the formal requirements for such designation, and the precise scope of the surrogate decision-maker's authority.

For that reason, it is necessary to establish the appropriate safeguards in order to prevent abuses of this legal instrument. A more adequate solution, for example, would be the introduction of combined directives, particularly in situations involving the withdrawal or withholding of life-sustaining treatment, where a proxy's decision may directly result in the patient's death. An example of good practice can be found in Germany. The German Civil Code stipulates that if there is a justified risk that the represented person may die or suffer serious and long-term harm to health as a result of a medical measure, a proxy may consent to such a measure, or decide to forego it, only if the power of attorney expressly includes such authority and is granted in writing; otherwise, approval by a guardianship court is required (sec. 1904 of the BGB).[36]

A similar solution has been adopted in the FBiH. According to the Law on the Rights, Duties and Responsibilities of Patients of the FBiH, a patient is entitled to designate a healthcare surrogate who may provide consent to treatment on the patient's behalf, or, in cases where the patient is unable to decide on consent, be informed of the healthcare measures to be undertaken (Article 18(6)). The scope of this provision in the context of end-of-life decision-making is, however, limited, since the patient is not permitted to refuse life-sustaining treatment. Consequently, a surrogate decision-maker is also precluded from exercising such an option.

In the BD, legislation similarly provides that a patient may designate another person who will either consent to treatment on the patient's behalf or be informed about the healthcare measures to be performed. Such a designation must be given in written form (Article 30(4) of the BD Health Protection Law).

3.4 Legal Consequences of the Living Will Application in BiH

A previously expressed refusal of life-saving or life-prolonging treatment may be classified as passive euthanasia. In BiH, as noted above, active euthanasia is criminalized as murder, though the RS adopts a somewhat more lenient approach by allowing it to be classified as murder committed under particularly mitigating circumstances. The legal status of passive euthanasia, however, remains less settled and varies across jurisdictions. It may be argued that, under certain conditions, passive euthanasia is permissible in the RS, with a comparable position in the BD. This conclusion applies to

[36] Available at: https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html#p7251 (Accessed: 01.07.2025)

decisions made by competent patients. Yet more complex issues arise when a patient has, in advance, refused the artificial prolongation of life. What legal consequences would follow if a physician were to act in accordance with the living will of a terminally ill patient? Conversely, what implications might arise if a physician were to decline to implement a patient's advance wishes formally expressed in notarial form?

In 2007, BiH ratified the Convention on Human Rights and Biomedicine (Oviedo Convention). However, direct application of international conventions is not common among courts in BiH. According to Article 3.b. of the BiH Constitution: "The general principles of international law shall be an integral part of the law of Bosnia and Herzegovina and the Entities." One of the general principles of the international law is *pacta sunt servanda*, and, according to the BiH Constitution, which obliges the responsibile authorities to follow it. Consequently, it would be acceptable for courts to base their decision on the one of the ratified conventions (such as Oviedo Convention), or at the very least to take its provisions into account when adjudicating relevant cases.

Even if the Oviedo Convention could not be directly applied, alternative legal grounds exist for the acquittal of a physician charged with implementing a living will. In particular, the ECHR occupies a distinctive constitutional status within BiH. The ECHR was incorporated into the BiH legal system through the Constitution of BiH (Annex IV of the General Framework Agreement for Peace in BiH). According to Article II (2) of the BH Constitution: "The rights and freedoms set forth in the European Convention for the Protection of Human Rights and Fundamental Freedoms and its Protocols shall apply directly in Bosnia and Herzegovina. These shall have priority over all other law." Although the ECHR doesn't contain provisions related to advance directives, its underlying principles speak in favor of advance directives acknowledgment. Appellate jurisdiction of the BH Constitutional Court (relevance of the the European Court of Human Rights' Case Law). Moreover, the Constitutional Court of BiH exercises appellate jurisdiction over constitutional issues arising from decisions of any other court in BiH, and in performing this role it draws extensively on the jurisprudence of the ECtHR. Accordingly, there is a strong constitutional and jurisprudential basis for acquitting a physician who withdraws or withholds treatment from a terminal patient pursuant to an advance request executed in notarial form (at least in the RS and the BD, where the legal possibility of refusing life-sustaining treatment is expressly recognized).

4. Conclusion

Arguments based on the principles of human dignity and individual autonomy support a more liberal approach to issues concerning the right to die. Against this background, the provision of the Law on the Rights, Duties, and Responsibilities of Patients of the FBiH, which establishes a blanket

prohibition on the refusal of life-sustaining treatment, appears particularly controversial. This, in turn, raises the question of how a potential legal challenge before the courts to such a provision would be adjudicated within the judicial system of Bosnia and Herzegovina, and especially by the Constitutional Court of BiH, given the special constitutional status of the ECHR within the BiH legal order and, consequently, the strong influence of the jurisprudence of the ECtHR. These considerations also highlights the necessity of an informed and inclusive public debate on the legal status of euthanasia.

With regard to the criminal legislation of the entities and the BD, a justified reform would consist in the introduction of "mercy killing" or "murder upon request" as distinct criminal offenses. Such an approach would allow for the imposition of more lenient sanctions in these cases within the FBiH and BD, while in the RS it would enhance the consistency of judicial practice and strengthen legal certainty, given that the possibility of imposing a reduced sentence by invoking particularly mitigating circumstances already exists in the RS criminal legislation. Although there are currently no official initiatives aimed at the legalization of euthanasia within the entity-level legislation, it would nevertheless be reasonable to initiate a public debate on this matter. The fact that in some countries of the region physician-assisted suicide has already been legalized (Slovenia), while in others legislative initiatives toward its legalization have been launched (e.g., the Draft Civil Code of Serbia), underscores both the continuing relevance of the issue and the need to inform the public about the arguments for and against the legalization of this legal institute.

The arguments from dignity and autonomy also support the recognition of patients' previously expressed wishes, including those concerning end-of-life decisions. For that reason, the introduction and appropriate regulation of advance directives have a special importance.

In the RS, a legal framework for the living wills development already exists (even for terminal patients). The analysis above leads us to the conclusion that a court willing to interpret national law in the light of accepted international obligations, could acquit a physician accused of killing on request if the latter withdrew/withheld treatment from a terminal patient upon his advance request expressed in a notarial form. There is a necessity of defining appropriate form for the application of this legal instrument. Also, there is a need for more specific provisions regarding the health-care proxy designation. It is necessary to define more appropriately the scope of the proxy powers (the combined directives are a more adequate solution; this form is particularly important regarding the refusal of life-saving treatment). In the FBiH, practical effects of living wills introduction are limited (considering the fact that patients cannot refuse life-saving treatments).

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Medically Assisted Death in Germany: the Judgment of the Federal Constitutional Court of 26 February, 2020 (BVerfGE 153, 182)

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Abstract: This article analyzes the thematic of assisted dying in Germany, particularly with regard to the recent decision by the Federal Constitutional Court declaring Section 217 of the German Criminal Code unconstitutional. It then provides a historical overview of the issue and discusses the bills currently under consideration in the country. Finally, it addresses the right to self-determination as one form of expression of individual autonomy, highlighting the dilemma between protecting life and respecting individual freedom.

Keywords: Medically Assisted Death; Germany BVerfGE 153, 182; Autonomy of Will; Federal Constitutional Court.

Summary: 1. Introduction. 2. The legal discipline on assisted suicide in Germany before 2020. 3. The Judgment of the Federal Constitutional Court (BVerfGE 153, 182). 4. The failure of legislative initiatives on medically assisted death. 5. Conclusion.

1. Introduction

Medically assisted death is a complex issue that involves ethical, philosophical, and legal dimensions and refers to the autonomous act by which life is ended in a voluntary, dignified, and conscious manner, with the support and under the control of health services.

Voluntary medically assisted death is an expression used to include the two procedures that translate into the help of health professionals to accelerate the death of a person who is in physical or psychological suffering, or afflicted by a serious and incurable illness: active euthanasia and assisted suicide.

Considered by many to be a way to ensure patient dignity, medically assisted death is a differently regulated practice in various countries, with some jurisdictions allowing it while others restricting or prohibiting it.

In Germany, at least in recent decades, medically assisted death has been the subject of intense legal and political debates, and since 2020, it has been possible to receive assisted suicide in this country, as long as the decision-making process is adopted freely and independently.

In a historic 2020 manifestation, the Federal Constitutional Court ruled that the prohibition of assisted suicide services, provided for in Section 217 of the Penal Code (*Strafgesetzbuch*),[1] is

[1]GERMANY. Strafgesetzbuch (StGB), of May 15, 1871. Available at: https://www.gesetze-im-internet.de/stgb/. Accessed on: June 23, 2025.

unconstitutional and that every individual has the right to self-determination in the choice to take his or her own existence and request help to do so, as long as the decision is autonomous and responsible. In fact, the freedom to take one's own life also includes the possibility of requesting help from others.

Before addressing the content of the fundamental pronouncement in the Judgment of February 26, 2020 (BVerfGE 153, 182), it is necessary to briefly set out the panorama of assisted suicide in Germany that preceded the intervention of the Federal Constitutional Court, which will be dealt with in the following paragraphs.

2. The legal discipline on assisted suicide in Germany before 2020

Initially a provisional document aimed at establishing a democratic government after the end of World War II and the Nazi experience, the Constitution of Germany, also known as the Basic Law (*Grundgesetz*),[2] eventually became the country's permanent constitution and marked the beginning of the Federal Republic of Germany (West Germany), having been adopted on May 23, 1949.

It is important to mention that the German Constitution enshrines three very pertinent principles related to the theme of euthanasia and assisted suicide:

- The inviolability of human dignity, with the inherent duty of the State to respect and protect it (Article 1, n.1);
- The right to the free development of personality (Article 2, n.1);
- The right to life and physical integrity (Article 2, n. 2).

This set of principles inserted in the Basic Law has been interpreted as attributing to the individual the right to be treated as a human being, whatever his state of health, the right to the protection of his biological and mental existence, and the right to put an end to his own existence, considering that freedom of action is understood in a broad sense.

As far as it is concerned, the German Criminal Code (*Strafgesetzbuch*)[3], in accordance with the aforementioned constitutional principles related to the subject of euthanasia and of assisted suicide, provides for active euthanasia as a crime in its own right, punishing it under Article 216, with a prison sentence of 6 months to 5 years.

It is a requirement for the fulfillment of this legal type of crime that the victim has formulated an express and serious request to have his or her life suppressed, because, if the request does not exist, the perpetrator may be accused of committing simple homicide, provided for and punished by

[2]GERMANY. Basic Law of the Federal Republic of Germany (Grundgesetz). Available at: https://www.btg-bestellservice.de/pdf/80208000.pdf. Accessed on: June 23, 2025.

[3]GERMANY. Strafgesetzbuch (StGB), of May 15, 1871. Available at: https://www.gesetze-im-internet.de/stgb/. Accessed on: June 23, 2025.

Article 212 of the same *Codex*, and the criminal sanction in this case is between 5 years and life imprisonment, provided for the most serious cases. It should be noted that the attempt at active euthanasia is also punishable conduct.

In 2015, the German Bundestag (*Bundestag*)[4], passed a law with the introduction of the Penal Code (*Strafgesetzbuch* – StGB), § 217, which went on to criminalize "commercial aid and complicity in suicide" (*Geschäftsmäßige Förderung der Selbsttötung*). Thus, after extensive debates, for the first time in Germany, the conduct of assisted suicide was criminalized, unlike the murder of the consenting person, punishable by § 216 StGB. That provision was worded as follows[5]:

> "(1) Anyone who, with the intention of encouraging the suicide of another, offers or obtains the opportunity to do so in a commercial way or carries out intermediate activities for that purpose, shall be punished with imprisonment of up to three years or a fine.
> (2) Anyone who has acted in a non-commercial manner shall not be punishable as aiding and abetting a crime and is a relative or relative of the person referred to in the first paragraph".

For the purpose of punishment, § 217 StGB imposed the requirement of "commercialism" (*Geschäftmäßigkeit*). That is something other than the purpose of profit (*Gewerbsmäßigkeit*). A person who acts "in a commercial manner" is someone who acts with "the intent to exercise repeatedly and continuously the conduct provided for in the case", which is why the expression is sometimes also translated as "professional help" or "organized". The ban was therefore primarily aimed at assisted suicide associations, which collected money from their members.

The legislation approved in October 2017 promoted an amendment to the Penal Code and criminalized the promotion of suicide in a commercial way. Section 217 of the Criminal Code provides for a term of imprisonment of up to 3 years for anyone who, with the intention of encouraging another to commit suicide, obtains or negotiates an opportunity to commit it.

The ground for exclusion of the unlawful act being that the person does not have the commercial intention and is a relative or close to the person seeking to end their existence. However, § 217 of the Criminal Code was declared unconstitutional by a decision of the Federal Constitutional Court of February 26, 2020.

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[4]GERMANY. German Bundestag. Available at: https://www.bundestag.de/en. Accessed on: July 20, 2025.

[5]Original text: «(1) Wer in der Absicht, die Selbsttötung eines anderen zu fördern, diesem hierzu geschäftsmäßig die Gelegenheit gewährt, verschafft oder vermittelt, wird mit Freiheitsstrafe bis zu drei Jahren oder mit Geldstrafe bestraft; (2) Als Teilnehmer bleibt straffrei, wer selbst nicht geschäftsmäßig handelt und entweder Angehöriger des in Absatz 1 genannten anderen ist oder diesem nahesteht».

With the judgment of the Federal Constitutional Court, (BVerfGE 153,182), the regulatory framework on assisted suicide has been fundamentally changed, which will be set out in detail in the following paragraphs.

3. The Judgment of the Federal Constitutional Court (BVerfGE 153,182)

The German Federal Constitutional Court – *Bundesverfassungsgericht (*BVerfGE) was established in 1949 with the enactment of the Basic Law (*Grundgesetz*) and came into operation in 1951. Its importance lies in being the guardian of the German Constitution, ensuring that all state powers are subordinate to the fundamental rights set out therein. The BVerfGE consists of two chambers or senates (*Senaten*), each composed of eight members, making a total of sixteen judges.

In 2020, in a groundbreaking decision, the Federal Constitutional Court (BVerfGE) admitted assisted suicide (*Sterbehilfe-Urteil*). Under the rapporteurship of Judge Sibylle Kessal-Wulf, the BVerfGE recognized that the general right of personality, an expression of the autonomy of the individual, includes the right to determine one's own death and seek help from third parties.

It is a freedom of the individual, constitutionally protected, which must be respected by the State and society as an act of determination based on the free, informed, permanent and definitive will to put an end to one's own existence. According to the Court, the Legislator must regulate the matter carefully, aiming to prevent the commercialization of suicide.

The decision of the German Constitutional Court of February 26, 2020 was motivated by a case from 2017 in which a patient traveled to Switzerland to perform assisted suicide because her husband was denied medication that would shorten her life.

Subsequently, patients, doctors and assisted death associations filed an appeal and motivated the decision of the German Constitutional Court that considers unconstitutional §217 of the Criminal Code, instituted in 2015 with the aim of curbing the commercial promotion of suicide.

The Court therefore ruled: the general right of personality (Article 2.1 together with Article 1.1 of the Basic Law) includes a right to self-determined death. This right includes the freedom to take one's own life and to seek the voluntary assistance of others to do so. The decision made by the individual in the exercise of this right to end his or her life in accordance with his or her understanding of the quality of life and the meaning of his or her own existence must be respected as an act of autonomous self-determination by the State and society.

The judges also reiterated that the respect and protection granted to human dignity are fundamental principles of the constitutional order. However, they make the reservation that the social concern regarding the possibility of trivialization and normalization of the practice of suicide is legitimate.

It is stated that, although the numbers of assisted deaths have increased in neighboring countries that allow the practice, this does not show the trivialization of assisted suicide and can be explained in the light of greater acceptance and information on the subject. That said, they assert that a restriction on the freedom of self-determination is plausible only if the degree of burden on the individual is still reasonably proportional to the benefits accruing to the general public. In addition, "the State must ensure the necessary protection of fundamental rights in accordance with Article 1.3 of the Basic Law within its own legal system."

Another important justification is noted: the aspects of the protection of third parties are not adequate to justify the restriction of individual self-determination that emanates from § 217 StGB. It is true that the individual must endure these barriers to freedom under the fundamental rights which the legislator attracts in order to maintain and promote social coexistence within the limits of what is generally reasonable in the given circumstances.

However, the independence of the individual must be preserved. Concerns about the protection of others, such as avoiding imitation effects, do not justify the individual having to accept the de facto deprivation of the right to suicide.

They also emphasized that third parties must also be able to legally carry out their willingness to assist suicide. In addition, it is up to the legislator to provide for the way to carry out suicide care, establishing guidelines such as procedural guarantees, legal obligation to provide information regarding the act, requirement to guarantee the reliability of the services provided, and prohibition of extreme or dangerous forms of assisted suicide.

Finally, they highlighted that, depending on the case, different markers can be established in order to attest to the patient’s sense of consciousness and his ability to perform the act.

In the Ruling, the Federal Constitutional Court did not restrict the right to assisted suicide to a specific group, reserved only for people with terminal illnesses or unbearable pain, opening the possibility also for those suffering from psychiatric illnesses.

4. The failure of legislative initiatives on medically assisted death

As analyzed, the German Constitutional Court ("*Bundesverfassungsgericht*") decriminalized the practice of assisted suicide in February 2020, declaring unconstitutional Section 217 of the German Criminal Code ("*Strafgesetzbuch*"), which punished a person who assisted another person taking his or her own life, due to concerns about the potential commercialization of assisted suicide.

In its ruling, the Court concluded that § 217 violated personality rights, provided for in Articles 1 and 2 of the German Constitution (GERMANY, 2020).[6] To that effect, Paragraph 217 provided that:

> "(1) Whoever, with the intent to promote the suicide of another person, commercially provides, obtains, or arranges for that person the opportunity to do so, shall be punished with imprisonment for a term not exceeding three years or with a fine [...]" (GERMANY, 1871, p. 114).

In the Ruling, the possibility of doctors providing terminal patients with the necessary drugs to carry out assisted death was determined, but there is not exactly a right of patients to do so, nor an obligation of doctors to consent or provide the means to do so. Even so, nine hundred and seventy-seven cases of assisted suicide were recorded in Germany in 2024 (IHU, 2025)[7].

Although the Constitutional Court's decision on assisted suicide contains an implicit invitation to the legislature to intervene with "procedural guidelines", so far the *Bundestag* has not approved any draft law on the subject. Thus, there is still no clear legal regulation that specifically defines how this right should be exercised.

In recent years, the number of people who have decided to resort to assisted suicide in Germany has increased and more than 400 people resorted to assisted suicide in 2023, according to the *Deutsche Gesellschaft für Humanes Sterben*[8]. However, some cases of doctors sentenced to prison terms for helping patients, such as those in Berlin[9] and Essen[10], raise important legal questions about who truly holds the right to assisted suicide and under what conditions it is possible to adopt this procedure.

On July 6, 2023, two bills dealing with assisted dying were rejected by the *Bundestag,* in a free vote with a wide margin of *votes.* The first of these, led by Lars Castellucci and Ansgar Heveling

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[6]GERMANY. Bundesverfassungsgericht. Criminalisation of assisted suicide services unconstitutional, February 26, 2020. Available at: https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/EN/2020/bvg20-012.html. Accessed on: June 23, 2025.

[7]INSTITUTO HUMANITAS UNISINOS (IHU). Um panorama da legislação sobre eutanásia na Europa, May 28, 2025. Available at: https://www.ihu.unisinos.br/categorias/652647-um-panorama-da-legislacao-sobre-eutanasia-na-europa. Accessed on: June 23, 2025.

[8]DGHS. Deutsche Gesellschaft für Humanes Sterben. Home. Available at: https://www.dghs.de/. Accessed on: July 20, 2025.

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[10]SCHLÄFER, Eva. For the first time, a German doctor is imprisoned for assisted suicide. Frankfurter Allgemeine, July 10, 025. Available at: https://www.faz.net/aktuell/gesellschaft/kriminalitaet/suizidhilfe-erstmals-tritt-ein-deutscher-arzt-eine-haftstrafe-an-110581949.html. Accessed on: July 20,. 2025.

(GERMANY, 2022), [11]would legalize the prescription of lethal drugs between three weeks and three months after the patient has undergone a mandatory counseling procedure. The proposal was rejected with 304 votes in favor, 363 against and 23 abstentions.

The second bill, led by Katrin Helling-Plahr and Renate Künast (GERMANY, 2023), [12]would determine the permission for assisted suicide, if the patient undergoes two consultations with a minimum interval of three months between them with a psychiatrist and the professional confirms that the person's desire would be of a "voluntary, serious and permanent" nature. It aimed to make euthanasia no longer an object of Criminal Law, and it was rejected with 287 votes in favor, 375 against and 20 abstentions (ZEEMAN, 2023).[13]

As a condition, it would stipulate that (i) suicide could not be requested by an individual suffering from mental illness that impaired their decision-making capacity; and (ii) that counseling should be done by a second physician, separately (VAN MAREN, 2023).[14]

The main differences between the two bills, therefore, concerned the characteristics of the sessions required as a requirement for the prescription of lethal drugs and whether or not assisted suicide practices should be penalized (ITALY, 2024, p. 134)[15].

Finally, it can be said that the biggest impasse related to the regulation of assisted dying in Germany revolves around the fine line between the need to respect individual autonomy and the concern with the trivialization of suicide.

It is important to note that in Germany there is the figure of the German Society for Humanitarian Death (DGHS), an organization that aims to provide protection and assistance to patients seeking a humanitarian death. For them, the central criterion in this discussion should be the right to self-determination (HÄNEL; GOLDENBERG, 2023)[16].

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[11]GERMANY. Drucksache 20/904. Berlin: Deutscher Bundestag, 2022. Available at: https://dserver.bundestag.de/btd/20/009/2000904.pdf. Accessed on: June 28, 2025.

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5. Conclusion

In February 2020, in a historic decision, the German Federal Constitutional Court (BVerfG) lifted the ban on physician-assisted suicide. The Court ruled that any doctor who provides aid to an individual who has chosen to seek the end of his or her life cannot be held criminally liable. The decision marked a significant shift in the approach to end-of-life choices in Germany, giving people the ability to seek assistance to end their lives in specific circumstances.

This change in the legal landscape allowed doctors to prescribe lethal drugs to patients who could perform the act on their own. This practice differs from active euthanasia, which is prohibited in Germany and involves intentionally causing the death of a patient, usually by performing an action with the express purpose of ending his or her life. The issue of euthanasia is very sensitive in Germany, especially because of the hundreds of thousands of people with disabilities killed by the Nazis in the Holocaust. Therefore, the theme used by the Germans is the *"Sterbehilfe",* which means “help to die” (ZEEMAN, 2023).

In Germany, unlike in other countries, the right to assisted suicide is not reserved exclusively for people with terminal illnesses or unbearable pain. The Federal Constitutional Court did not restrict this right to a specific group, opening the possibility also to those suffering from psychiatric illnesses. This choice, aimed at avoiding discrimination, has, however, caused many difficulties for doctors, family members and the country’s courts. Assessing the autonomic ability to make this final decision is complex, especially for those suffering from depression or schizophrenia.

According to the Federal Constitutional Court, the desire to die should not be the result of a spontaneous impulse, but of thoughtful and rational reflection. And yet, it is necessary to protect those who may not be able to make a responsible decision due to psychiatric illnesses or psychological crises. This raises another question, about how people with mental disorders can make their own end-of-life decision.

While the BVerfGE’s decision has allowed doctors to better support patients who wish to undergo assisted suicide, it has also put doctors in a difficult situation, who are now faced with the difficulty of balancing their professional obligations and respect for patient autonomy.

The change that occurred with the 2020 BVerfGE decision introduced complexities and challenges for health professionals in the ethical, legal, and practical aspects of assisted suicide. The absence of clear guidelines has left doctors in a state of uncertainty, with difficulty in interpreting and applying the assisted dying process consistently.

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Assisted death in Latin America: firm steps towards obtaining a right that is increasingly within reach

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Abstract: This article aims to present a legal and ethical landscape emerging in different Latin American countries with regard to the recognition of the right to decide one´s own death. It highlights the role of the Constitutional Court as both an ally in this process and an impetus for other nations that have not yet managed to enshrine respect for human dignity and the right to self-determination over our lives in law.

Keywords: Medically Assisted Death; Euthanasia; Assisted Suicide; Latin America – Argentina.

Summary: 1. By way of introduction: the possibility of deciding how we want to die. 2.The Latin American scenario regarding death as a fundamental right. 3. Colombia: the role of the Constitutional Court in Latin America. 4. Uruguay: on the path to guaranteeing a dignified death. 5. Argentina and its outstanding issues: political influences, religious opposition, low citizen participation in decision-making. 6. Conclusion.

"Our intelligence, so bold, so active, has hardly concerned itself with death."

1. By way of introduction: the possibility of deciding how we want to die

The idea of being able to decide about our own death has always been a utopia in Latin America.

The possibility of disposing of our bodies in accordance with the most fundamental principle that we humans have for determining what we want, namely autonomy, the cornerstone of bioethics, has been and continues to be challenged by deeply rooted dogmatic positions in popular thinking about what dying means for each person.

It is difficult to conceive of dying as an essential part of life itself and to understand that each person must plan their own end according to their beliefs.

Death remains as a social taboo, often confined to hospitals, hidden from public view and not talked about, particularly with the dying.

This prohibition highlights the most pressing shortcomings of the contemporary notion of autonomy, namely its claim that, in their deliberations on death, individuals can escape a network of socially established beliefs. It is presented as a fundamental ingredient of cultural issues that have accompanied the process of dying in society. Thus, it provokes different reactions, ranging from relegating agony and death to the private sphere to reducing it to hospital institutions.

Death is therefore understood as an individual act administered by those believed to be qualified to do so: medical and hospital staff.

The way people die has changed radically in recent generations. Death and dying have moved from a family and community setting to being primarily the domain of health systems. Futile (useless) or potentially inappropriate (non-therapeutic obstinacy) treatment may continue until the last hours of life.

The process of dying has become economically unbalanced in high-income countries and, increasingly, in low- and middle-income countries; there is an excessive focus on clinical interventions at the end of the life cycle. Rebalancing death and dying will depend on many factors: social, cultural, economic, religious, and political, which determine how death is interpreted, experienced, and felt in society.

Ultimately, death remains the only inevitable event.

2. The Latin American scenario regarding death as a fundamental right

The devastating passage of the COVID-19 pandemic in 2020 has redefined the concept of dying and its protocols. Latin America has suffered dramatically from the scarcity of resources available to the population, the lack or excessive cost of vaccines, health policy decisions, and deaths as a spectacle in public spaces. It has forever changed the interpretation of the end of life. Patiens often daid in solitude, far from the family environment, accompained only by healthcare personnel wearing protective masks for company. Technology has replaced hugs and prepared us for a different kind of farewell ceremony.

Health systems thus became the custodians of a medicalized death, where individuals die not as they wish, but as institutional conditions allow.

Latin America has always shown a late and poor recognition of the enjoyment of rights and the development of capacities related mainly to the fundamental powers of the individual. This is because there are still great inequalities and structural challenges. Inequality is a common denominator when it comes to accessing basic and internationally recognised rights. Strengthening public systems, caring for vulnerable populations and citizen participation are key factors in guaranteeing the exercise of this fundamental right in the region.

Medically assisted death—which includes voluntary euthanasia and medically assisted suicide—raises a profound debate in Latin America that intertwines ethics, law, medicine, and culture. From a bioethical perspective, this phenomenon requires a rigorous evaluation of the principles of autonomy, beneficence, non-maleficence, and justice, while also considering the historical and socio-legal particularities of this part of the world.

Its legal treatment varies among different states and continues to be subject to intense cultural, religious, and legal debate.

From a bioethical perspective, the analysis starts from the aforementioned principle of autonomy, which recognises the right of every person to decide about their own body and the end of their life, especially in contexts of irreversible suffering. This principle must be harmonised with beneficence (acting in the best interests of the patient), non-maleficence (avoiding harm) and justice (ensuring equality in access and protection of rights).

Contemporary bioethics in the region advocates for a robust regulatory framework, with safeguards to ensure voluntariness, full information and the absence of coercion. This includes interdisciplinary committees, evaluation of palliative alternatives, and clear protocols for action. Rather than focusing on an absolute 'yes' or 'no,' the debate should focus on how to ensure that, if offered, medically assisted death is an ethically justified, legally protected, and humanely dignified act.

Analysing the Latin American context, we must mention additional challenges that influence the political and social decision-making process on such a large scale, such as the right to express how we want to die: cultural and religious factors that exert great social pressure and prioritise the preservation of life as an absolute value; inequalities in healthcare that fuel fears that assisted death will become an escape from inadequate, costly and deficient healthcare systems; the lack of legislation makes the situation an oasis of legal uncertainty, exposing healthcare professionals to great uncertainty regarding their potential actions; conscientious objection as a prerogative of healthcare providers, allowing them to refuse to perform acts contrary to their convictions, as opposed to the patient's right to choose according to their last wishes.

From a medical point of view, in recent years in Latin America, there has been a virtually seamless transition from a paternalistic model in which the doctor was at the centre of the system and did not allow patients to refuse or suspend treatment, however ineffective it might be, to a highly medicalised model in which, in theory, the patient is at the centre and in which any medical action must be governed by the principle of autonomy, by the patient's right to information, by their participation in the decision-making process and by the possibility of giving their consent for any intervention to be carried out.

Healthcare culture, fear of litigation leading to a new paradigm of "judgement-based medicine", and financial incentives contribute to overtreatment at the end of life, further fuelling institutional deaths and the perception that healthcare professionals are the managers of death.

The concept that man has of the 'right to die with dignity' has dominated the contemporary bioethical debate related to the end of human life. Those who advocate for the right to a 'dignified death' understand that this includes the right to dispose of one's own life through euthanasia or medically

assisted suicide, based on respect for the individual freedom or autonomy of the patient (Toboada, 2000)[1].

3. Colombia: the role of the Constitutional Court in Latin America

Latin America is a common cultural space in many respects, but at the same time it is a heterogeneous reality. This applies both to the institutional level and to the development of constitutional justice in this region. In most countries, there is a constitutional justice system with a specialised body that is expressly called a Constitutional Court or Tribunal. The most significant difference is that some constitutions place these institutions within the structure of the judicial branch (Bolivia and Colombia), while others configure them as autonomous bodies or external to the classic structure of the branches of government (Chile, Ecuador, Guatemala, Peru, and the Dominican Republic). However, this does not mean that in states that do not have a body called a constitutional court or tribunal, there is no constitutional justice system or institution responsible for concentrated constitutional review. On the contrary, in countries where there is no specialised body, control is exercised by a chamber, a section or the full bench of the Supreme Court or Tribunal. This is the case in Argentina, Brazil, Costa Rica, El Salvador, Honduras, Mexico, Nicaragua, Paraguay, Uruguay and Venezuela.

Colombia is a leading country in the Latin American region in terms of active euthanasia. It is currently the only Latin American country that has decriminalised and regulated it, based on Constitutional Court rulings, thus establishing it as a regional benchmark. In other countries, such as Mexico, Chile, and Argentina, there are legislative projects or public debates underway, but the legal framework still limits or prohibits these practices. The Colombian Constitutional Court, through ruling C-239 of 1997, stated that access to active euthanasia is a right of terminally ill patients. The same Court established the guidelines that make this possible, through certain requirements such as verification of the patient's state of health, maturity of judgement and willingness to die. As a result, no criminal charges could be brought against a health professional who assists in the assisted death procedure.

In its ruling, it also declared Article 326 of the Colombian Penal Code, on mercy killing in cases of terminally ill patients, to be constitutional, expressly establishing criminal justification for doctors who assist in active euthanasia, and called on Congress to determine guidelines for regulating dignified death as soon as possible.

[1] Toboada P., The right to the die with dignity. Acta bioeth. http://www.scielo.cl/cielo.php?script=sci_arttext&amp,pid=S1726-569X20000007&lng=es

Furthermore, with the aim of adequately regulating the procedure for dignified death for all its citizens, Colombia, through Resolution No. 825-2018 of 9 March 2018 issued by the Ministry of Health, regulated the procedure for enforcing the right to die with dignity for children and adolescents, and establishes that children over the age of 12 will be able to make decisions about their early death, except in cases where children between the ages of 6 and 12 demonstrate psychological development equivalent to that of a child over the age of 12 (Colombian Ministry of Health, 2015).

Along the same lines of thinking, the Constitutional Court of Colombia, in its ruling C-164-22 of 11 May 2022, declared the crime of inducing or assisting suicide to be unenforceable, stating in its considerations that 'The right to die with dignity is a multidimensional right that grants a set of powers that allow a person to have control over the process of their death and to impose limits on third parties with regard to decisions made in the context of healthcare' (Jaramillo Salazar, 2022)[2].

The Plenary Chamber of the Constitutional Court of Colombia establishes a series of requirements for practising active euthanasia and medically assisted death without criminal penalty, which Jaramillo Salazar (2022). Summarises appropriately as follows: granting of free, informed and unequivocal consent; the subject must have a clearly diagnosed bodily injury or serious and incurable illness; due to this condition, the subject must be suffering physical and mental pain that is incompatible with their own dignity; assistance in causing death must be provided by a medical professional.

The Colombian Constitutional Court has recognised dignified death as a fundamental multidimensional right that can be realised in different ways: palliative care, adaptation of therapeutic efforts, euthanasia and medically assisted suicide. Colombia is one of the few countries that has fought to obtain this right.[3]

4. Uruguay: on the path to guaranteeing a dignified death

Uruguay has taken the first legislative step in South America towards legalising euthanasia and assisted suicide. If successful, it will become the third country in the Americas, after Canada and Colombia, to legislate in favour of it.

The bill has been submitted to parliament through the House of Representatives' Public Health and Social Welfare Committee and consists of 13 articles. The design is based on the recognition of the right of the individual to die with dignity in accordance with the expression of their valid will, provided that the requirements set out in the law are met, with the establishment of a system of

[2] Jaramillo Salazar, C. Five keys to understanding ruling C-164 of 2022 on medical assistance for suicide in Colombia. Colombia: DescLab, 2022

[3] Constitutional Court of Colombia, Judgment C-124 of 11 may 2022 (2022) Retrieved from http://www.corteconstitucional.gov.co/relatoria/2022/c-164-22

controls and guarantees for all those involved, in order to avoid suffering that is perceived as unbearable by each individual.

Likewise, the text of this bill establishes specific guarantees for patients, doctors and other actors involved in the care process. In this way, it seeks to ensure freedom, dignity, the absence of pressure of any kind, clarity and equality in procedures, and legal certainty.

The explanatory memorandum accompanying the bill makes explicit reference to the international instruments that have served as the basis for the drafting of this law. One of the pillars is the American Convention on Human Rights, Pact of San José, Costa Rica, signed in the city of San José, Costa Rica, on 22 November 1969 and ratified by Law No. 15,737 (of 8 March 1985), which establishes, among other rights, the right to personal integrity, enshrined in Article 5.1, which states that: 'Every person has the right to have their physical, mental and moral integrity respected.' Article 11 of the Inter-American Convention on the Protection of Human Dignity and Human Rights provides in paragraph 1 that every person has the right to respect for their honour and recognition of their dignity. The Constitution of Uruguay establishes in Article 7 that all inhabitants of the Republic have the right to be protected in the enjoyment of their life, honour and liberty.

5. Argentina and its outstanding issues: political influences, religious opposition, low citizen participation in decision-making

In the Argentine legal context, every person has the right to voluntarily refuse surgical procedures, artificial resuscitation, or life-sustaining measures that they consider extraordinary, disproportionate, or that cause them undue suffering (Law 26.742, 2012)[4]. The National Law No. 26,529,[5] known as the Law on Patient Rights in relation to healthcare professionals and institutions, which has been in force in argentina since 2009, establishes a comprehensive framework for patient rights, medical records and informed consent. This public regulation, which is generally applicable, was amended in 2012 by the enactment of the aforementioned Law No. 26,742, commonly known as the Dignified Death Law.

The amendment introduced changes to Articles 2, 5, 6, 10 and 11 of Law 26,529, in addition to incorporating Article 11 bis and an additional paragraph to Article 7. The main objective of the current legislation, together with its regulatory decree 1089/12, is to guarantee the dignity of patients in the final stage of life, respecting their autonomy and wishes. In this way, it recognises the right of terminally ill persons to accept or refuse medical interventions such as surgical procedures, hydration,

[4] Law N° 26742, Public Helth Law. https://www.argentina.gob.ar/normativa/nacional/ley-26742-197859/texto

[5] Ley N°26.529: sancionada el 21de octubre de 2009, promulgada el 19 de noviembre de 2009 y publicada en el Boletín Oficial el 20 de noviembre de 2009.

feeding and artificial resuscitation, especially when these are extraordinary or disproportionate in relation to the chances of recovery and cause excessive suffering.

In line with this legal framework, in early 2011 the National Executive Branch established a Commission to draft the Bill for the Reform, Updating and Unification of the Civil and Commercial Codes of the Nation. To this end, all previous comprehensive bills were taken into account. The new Code, now called the Civil and Commercial Code, significantly reduces the number of articles compared to the one in force prior to its publication and unifies the two pre-existing codes, with the support of legal doctrine.

This code attaches transcendental importance to personal rights, making special mention of both physical and spiritual integrity and the dignity of the person. The issue of personal rights has a compelling force that allows for the asylum and protection of the human person in the face of the violation or vulnerability of their essential or fundamental rights. Personal acts: these are acts that have self-referential bioethical conduct: acts related to one's own body (Art. 56 CC and C); research on human beings (Art. 58); informed consent for medical acts and research (Art. 59); advance medical directives (Art. 60); use of one's own corpse for research.

In this way, essential concepts are incorporated into the law and the disposition of one's own body, also from this Code, establishing the attributes of personality and the so-called highly personal rights.

With regard to medically assisted death in Argentina, there are currently four bills before parliament that propose to address euthanasia and assisted suicide: the Good Death Regulation of Euthanasia Bill (April 2023); the Alfonso Bill. Medically Assisted Good Death (May 2024); Bill on Medically Assisted Voluntary Death (May 2024); Bill on the Legal Regime for Assistance in Ending One's Own Life (June 2024). Despite their differences and nuances, they all agree on limiting the practice to cases of serious and incurable illness or serious, chronic, disabling suffering, as certified by a health professional. All the proposed laws emphasise the right to die with dignity.

Among the theories opposed to the application of the right to decide how to die, it is plausible to argue that the inclusion of serious, chronic and disabling conditions as a sufficient requirement in existing draft regulations runs the risk of suggesting that a particular disability is sufficient in itself to explain the intolerable nature of the experience of life.

6. Conclusion

Medical assisted dying in Latin America is is not just a legal or medical dilemma: it is a mirror that reflects our conception of suffering, dignity, and freedom. The bioethical challenge is to design systems that respect life while recognizing the right to die with autonomy and without pain, within the framework of a pluralistic society that respects its diversity.

However, euthanasia and assisted suicide are prohibited in Brazil, and although there have been discussions on the subject, the law does not allow these practices (Sousa Da Silva, 2018).

There is a diverse landscape that demonstrates different ethical, cultural, and religious perspectives that have an impact on the regulation of assisted death in this part of the world. Some countries have recognised the right to decide on one's own end of life in particular situations, while others have chosen and continue to do so today to maintain broader prohibitions, based on deep ethical values that seem to be rooted in their societies. The debate will continue evolving in Latin America, influenced by political change, social and cultural transformation. Legislation and public perception of these practices could be affected by growing awareness of individual rights and demands for more patient-centred healthcare.

Medically assisted death becomes a component of universal healthcare. It should be available not only to those who are considered to be near the end of their lives, but also for all people with unbearable suffering who wish to end it.

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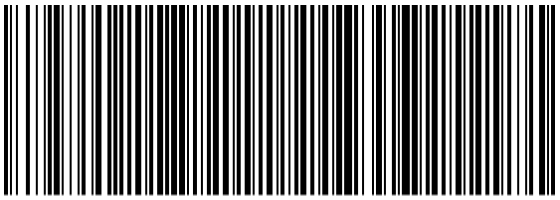
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