The Right to Die: Autonomy at the Limits

DOI: 10.52214/vib.v11i.13787

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Abstract

This paper examines whether the autonomous self can give rise to a right to die in the form of a right to physician-assisted death (PAD) with a geographic focus on Europe. The paper questions whether a patient's request for PAD can be justified as an expression of true autonomy or whether autonomy itself must be understood as inherently relational. The paper further explores case-law concerning human rights and the incompatibility of a right to die with the right to life, which serves as the foundation for human rights protections. The paper argues that neither patient autonomy nor the right to life provides a sufficient basis for establishing a right to die. Rather, autonomy should be viewed within an interdependent ethical framework that recognizes human vulnerability and mutual responsibility. The paper concludes that legitimizing PAD risks altering the meaning of care and eroding societal and medical commitments to preserving life.

Keywords: Autonomy, Right to Die, End-of-Life, Physician-Assisted Death, UK, Europe

Introduction

This paper examines whether autonomy justifies a right to die in the form of physician-assisted death (PAD) and explores the possible implications of this right in the European countries where PAD is legal. The paper begins by analysing autonomy in the context of end-of-life care, through the lens of the patient-doctor relationship and the decision-making process. The issue is whether a patient's request for PAD can be seen not only as justifiable but also as necessarily grounded in the patient's autonomous decision-making capacity. The paper then delves into the legal implications of a putative right to die, exploring its incompatibility with the right to life, which is a cornerstone of protecting all human rights. The paper also investigates the conditions under which PAD might nevertheless be legally permissible, e.g., under European Law. Finally, the paper concludes that neither patient autonomy nor the right to life provides a solid foundation for a right to die. It argues that patient autonomy should be understood as inherently relational, emphasizing that individual decisions impact society at large, and that autonomy as a purely individualistic concept is ultimately illusory. Moreover, the theoretical foundation of the self is shown to depend on its relation to others, which implies that the act of killing is not only an act against the other but also against the self.

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Background

In Europe, six countries – Switzerland, the Netherlands, Belgium, Luxembourg, Spain, and Austria – have legalized some form of assisted dying, while others, including England and Wales, are in the process of doing so. In addition, Colombia, Canada, New Zealand, ten states in the US and six states in Australia allow assisted dying. In some countries, patients can access assisted dying only in case of terminal illness, while in others the requirement can be 'severe suffering' from a 'chronic disease,' which may encompass mental health conditions. Generally speaking, the legislative safeguards which place conditions on access to PAD raise concerns over equal access.[1] Yet the safeguards are meant to protect against uses of PAD that legislatures have not approved and to make sure that citizens requesting PAD are doing so freely and without any form of coercion and external pressure.

The Concept of the Autonomous Self in End-of-Life Care and Its Implications

Autonomy is a central concept in Beauchamp and Childress's four principles of biomedical ethics, often seen as the cornerstone of medical ethics. To these authors, respecting autonomy means recognising a person's right to make choices based on their values and beliefs, not just by avoiding interference but by actively supporting their ability to decide freely.[2] Beauchamp and Childress's conceptualization of autonomy explains the paradigm shift of the past half century from the 'doctor knows best' tendency towards a more balanced doctor-patient approach where patients are seen as active protagonists with their own opinions, desires, and, above all, a right to know about and consent to medical treatment. Patients' autonomous choices may not always align with what doctors consider to be in their best interests, as seen in refusals of life-saving treatments that their medical practitioners deem essential. And, patients cannot force doctors to administer medical treatments that they do not consider optimal. These two assumptions create tension when it comes to life-and-death decisions and whether the patient's autonomous choice can stretch to the point of choosing when and how to die. The questions, therefore, are whether a legitimate request for PAD can stem from autonomy. According to Beauchamp and Childress, public policies on PAD should prevent abuse but should not undermine its moral justification: "A favourable response by a physician to a request for assistance in facilitating death by *hastening* it through prescribing lethal medication is not relevantly different from a favourable response to requests for assistance in facilitating death by *easing* it through removal of life-prolonging technology or use of coma-inducing medication."[3] On this view, the principle of autonomy (the 'patient's perspective') and the principle of beneficence (the 'clinicians' perspective', i.e., a positive obligation to contribute to the welfare of others) do not necessarily conflict ethically, although competing principles should be balanced on a case-by-case basis. Countries where some forms of PAD are legal offer an example of how these principles need some kind of 'support' to avoid exploitation.

An Autonomy-Based Argument for PAD

The expressivist objection to assisted dying claims that allowing PAD for a specific group of persons *expresses* a negative judgment on whether their life is worth living. Some argue that an autonomy-based approach is the only way to address this objection. For example, Esther Braun claims that policies permitting assisted dying to all autonomously

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[1] See R. McDougall, B. Pratt, 'Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation,' *BMC Medical Ethics,* 2020, 21 (38), at 2. https://doi.org/10.1186/s12910-020-00483-5

[2] TL. Beauchamp, JF. Childress, *Principles of Medical Bioethics. Seventh Edition*. New York: Oxford University Press (2009), 106-107.

[3] Beauchamp and Childress, 185.

choosing it avoid the expressivist objection.[4] To Braun, the autonomy-based approach is the way forward since "assisted suicide should not be understood as a medical procedure that can be 'indicated' but rather as an autonomous action that can be carried out for all sort of reasons that should not be judged by others."[5] Consequently, PAD should not be considered a medical practice because, as such, it would fall under the umbrella of *indicated* treatments under certain circumstances (such as irremediable suffering) where the patient would benefit.[6] Second, intentionally terminating the life of a patient can lead to a harmful division within the clinician's medical and social role. Instead, "the judgment of whether her [the patient]'s life is worth living is strictly the patient's."[7] According to Braun, assisted suicide should be removed from the realm of beneficence relevant to all medical procedures and confined to the autonomous self who has full power over his or her fate. Braun's autonomy-based position is that it would be legal to provide PAD to anyone who makes an autonomous request regardless of their medical condition, thus circumventing the principle of beneficence. To her, restrictions would be needed only to ensure that the patients' decision to end their own life is taken autonomously (so the patient has decision-making capacity, the decision is informed and voluntary). This avoids depicting any group as less worthy of living. However, Braun refrains from delving into the practical implications of this kind of autonomy-based approach to PAD.

Given the fact that people are situated in social contexts, the question is whether this decisional power stemming from the *autonomous self*, in particular in circumstances of vulnerability, can be seen as entirely beginning and ending in the individual – as Braun maintains – or can be the subject of external influences.

"Desperation and a feeling of being superfluous"[8] form the context in which individuals exercise self-determination.[9] This creates a fragile foundation for both autonomy and decision making. Therefore, Ole Hartling defines autonomy when it comes to deciding about one's own death as a "prison of freedom."[10] The idea of deciding autonomously – understood as acting independently not only of other people's influence but also of any duress (physical or psychological) may seem like an illusion. End-of-life decisions are undoubtedly grounded in the concept of autonomy, but not in the individualistic sense that views human beings as isolated entities. Rather, these decisions reflect that people are deeply embedded in the fabric of society, which shapes their identities in both positive and negative ways.

Autonomy needs to be considered in the context of the wider ethical framework of medicine and society.[11] It is not just a matter of individual will, but it is relational: when patients express their desire to die due to suffering, clinicians should look beyond autonomy and focus on relieving the suffering, not ending the life of the sufferer. Patient choices are not an isolated exercise of will and can also affect others both directly and indirectly – to such an extent, for

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[4] E. Braun, 'An autonomy-based approach to assisted suicide: a way to avoid the expressivist objection against assisted dying law,' *Journal of Medical Ethics*, 2023, 49, at 498 https://doi.org/10.1136/jme-2022-108375

[5] Braun, 500.

[6] Braun, 499-500.

[7] Braun, 499.

[8] O. Hartling, 'Euthanasia and assisted dying: the illusion of autonomy,' *BMJ* 2021, 374, at n2135 https://doi.org/10.1136/bmj.n2135

[9] Hartling.

[10] Hartling.

[11] D.P. Sulmasy, et al. 'Physician-Assisted Suicide: Why Neutrality by Organized Medicine is Neither Neutral Nor Appropriate,' *Journal of General Internal Medicine*. 2018, 33 (8), at 1395. https://doi.org/10.1007/s11606-018-4424-8

instance, that in countries where PAD is legal, it has increased at a steady pace in the years immediately following its legalization, likely due to rising public acceptance.[12] Unassisted suicide has also increased in jurisdictions where PAD is legal.[13]

PAD and A Duty of Care

PAD is not a "neutral" act but has profound implications not only for the patient but for the clinicians' *duty of care* embedded in their professional ethos, since this becomes the umbrella under which PAD falls. In this regard, the American Medical Association Code of Medical Ethics is clear: "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[14] Some assert that doctors' role in PAD undermines the moral integrity of their profession in a way that is similar to doctors' refusal to help their patients during their end-of-life stage.[15]

As mentioned above, doctors are not obligated to do everything in their power to prolong a patient's life. Patients can refuse treatment and doctors can prescribe palliative drugs whose side effects may include some shortening of life. "But while patient autonomy gives us a right to refuse procedures, it does not give us a right to demand them; it is a shield, not a sword."[16] In fact, "[p]atient autonomy yields to the inviolability of life."[17]

Does the Right to Life Encompass the Right to Die? A Legal Overview

Human rights laws protect individuals from undue interference with the rights and liberties considered pillars of human dignity and its preservation. The right to life is the first and foremost right protected by the European Convention on Human Rights (ECHR) since its deprivation prevents the protection of any subsequent rights. The right to life is an absolute right that may be derogated only "(a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."[18] The state has both a positive duty to ensure that "[e]veryone's right to life shall be protected by law"[19] and a negative duty not to deprive citizens of their life unless the exceptional cases stated above apply. This right must also be protected without discrimination on any ground.[20] When it comes to

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[12] See A.D. Colombo, G. Dalla-Zuanna, 'Data and Trends in Assisted Suicide and Euthanasia, and Some Related Demographic Issues,' *Population and Development Review*, 2024, 50 (1): 233-257. https://doi.org/10.1111/padr.12605

[13] D. Paton, S. Girma , 'Assisted suicide laws increase suicide rates, especially among women,' 2022https://cepr.org/voxeu/columns/assisted-suicide-laws-increase-suicide-rates-especially-among-women

[14] American Medical Association (AMA), 'Physician Assisted Suicide AMA Policies. Council on Ethical and Judicial Affair, 2009, https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide

[15] CL. Sprung, et al., 'Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective,' *Journal of Palliative Care*, 2018, 33 (4): at 200. https://doi.org/10.1177/0825859718777325

[16] E. Jackson, J. Keown, *Debating Euthanasia*, Oxford: Hart Publishing (2012), 91.

[17] Jackson, and Keown.

[18] Art. 2 ECHR.

[19] Art. 2 ECHR.

[20] Art. 14 ECHR. "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

healthcare provisions, Article 2 is often read in conjunction with Article 8 (right to respect for private and family life):[21] "Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life."[22]

Pretty v. The United Kingdom (2002) clearly established that Article 2 cannot be stretched to include the opposite right, namely, the right to die.[23] This statement has been reiterated in cases concerning euthanasia and/or assisted suicide that underwent scrutiny by the European Court of Human Rights (ECtHR), also referred to as the Court of Strasbourg. This does not imply that contracting States cannot allow PAD because when there is no general agreement on such sensitive matters, the European Court of Human Rights (ECtHR) affords States a margin of appreciation. In fact, States must guarantee safeguards (they have positive obligations) to protect their citizens from coercion and make sure their decision is made autonomously. As the Court recently stressed in *Daniel Karsai v. Hungary* (2024), "Article 2 does not prevent the national authorities from allowing or providing PAD, subject to the condition that the latter is accompanied by appropriate and sufficient safeguards to prevent abuse and thus secure respect for the right to life."[24] This would mean that the right to life is not seen as *a priori* contrary to provisions of euthanasia or PAD.

In *Mortier v. Belgium* (2022),[25] the Court addressed the State's positive obligations relating to euthanasia and PAD. The issues were "whether the Euthanasia Act, as in force at the relevant time, offered an effective safeguard for protecting vulnerable individuals' right to life and whether the euthanasia of the applicant's mother was performed under the conditions compliant with Article 2 of the Convention."[26] The Court of Strasbourg found the Belgian law on euthanasia compliant with Article 2 ECHR with the requirement to provide material safeguards while in breach of the right to life in relation to procedural safeguards applicable once the patient has died.

As the Court of Strasbourg highlighted in *Mortier*, "the legislative framework governing pre-euthanasia procedures must ensure that an individual's decision to end his or her life has been taken freely and with full understanding of

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[21] Art. 8,2 ECHR. "There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of thee rights and freedoms of others."

[22] *Case of Pretty v. The United Kingdom*, App. No. 2346/02 (29 July 2002), §39.

[23] Ibid, §40. ("The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention.")

[24] *Daniel Karsai v. Hungary*, App. No. 32312/23 (13 June 2024), §145. The case concerns Mr Karsai, a 47-year-old human rights lawyer affected by amyotrophic lateral sclerosis. The applicant argues that the prohibition on seeking assisted dying under Hungarian law breaches his right to private life (art. 8 ECHR) alone and in conjunction with his right not to be discriminated against (art. 14 ECHR) because terminally ill patients dependent on invasive medical treatments have the option to refuse them at any point. The Court found no violation of the applicant's rights on either ground.

[25] *Mortier v Belgium*, App. No. 78017/17 (4 January 2023). The case concerns the applicant's mother – a Belgian citizen in her 60's suffering from chronic severe depression – who has been euthanised under the Belgian Act on Euthanasia (2002) without having properly informed her adult children. The applicant, her son, claimed that the government failed to protect his mother's right to life (art. 2 ECHR) and her right to respect for private and family life (art. 8 ECHR). The Court of Strasbourg unanimously found Belgium in breach of art. 2 ECHR in regard to the *a posteriori* procedure to investigate deaths caused by euthanasia.

[26] Mortier v. Belgium, §144.

what is involved."[27] As stated in *Haas v. Switzerland* (2011),[28] the national authorities have the duty "to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved."[29] The Court is particularly mindful that the risk of abuse in the provision of assisted dying is directly proportional to the ease and speed of access to such provision. Since the *Mortier* case concerns mental and not physical suffering, the Court expects "enhanced safeguards in the euthanasia decision-making process."[30] The Court found that the legislative framework in place in Belgium did sufficiently protect patients seeking euthanasia for mental illness. Article 2 ECHR requires *independence* among medical practitioners consulted by patients to obtain the green light for euthanasia: independence both in terms of institutional connections (*formal* independence) and *de facto* independence. While the former can be considered in terms of hierarchical connections (such as a junior-senior work relationship) the latter is vaguer. It is not clear what degree of acquaintance would negate independence. In the *Mortier* case, the majority of judges did not view the doctors' shared affiliation with the Life End Information Forum (LEIF), which advocates for dignified death for all, as sufficient evidence of a lack of independence.[31] Medical practitioners' independence also concerns the *post-euthanasia* procedural safeguards where an independent judicial system needs to establish that no suspicious circumstances led to the patient's death. The Belgian Euthanasia Act established an independent board of 16 members nominated by a legislative assembly of qualified doctors, lawyers, and professionals expert in end-of-life issues to review each case. However, the law did not prevent doctors who actively participate in the case under review from voting on whether their own acts complied with the law.[32] In *Mortier,* a doctor was involved in both the case and its review. This is one of the reasons (alongside the undue length of the criminal investigation) that the Court found the *a posteriori* safeguarding process in breach of Article 2 ECHR.

There is a significant grey area surrounding the compatibility of PAD provisions and the Article 2 ECHR. In fact, the State's positive obligations may extend to National Health Service (NHS) medical practitioners since the NHS is government-owned and directed and publicly funded (primarily through taxation)[33]: "[T]he negative obligation prohibits the State from conducting euthanasia and assisted suicide itself, even as part of a well-regulated scheme with appropriate safeguards. This means, under the Convention, States may allow/tolerate private parties from conducting euthanasia/assisted suicide with appropriate safeguards but the State itself cannot conduct them."[34] NHS medical practitioners can be considered State employees. If assisted dying were implemented in England and Wales,

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[27] *Mortier v. Belgium*, §146.

[28] *Case of Haas v. Switzerland*, App. No. 31322/07 (20 June 2011). The case concerns Mr Haas, a 58-year-old who had been suffering from serious bipolar affective disorder for the past twenty years and had been denied assisted suicide by Dignitas. For these reasons, he contacted, with no success, various bodies seeking permission to obtain sodium pentobarbital (a lethal substance) without prescription from a pharmacy. The applicant contended that his right to respect for his private life (art. 8 ECHR) has been unlawfully restricted, while the Court of Strasbourg reached the opposite conclusion.

[29] *Case of Haas v. Switzerland*, §54.

[30] *Mortier v. Belgium*, §147.

[31] *Mortier v. Belgium*, §162.

[32] Mortier v. Belgium, §§177-178.

[33] The Government, more specifically the Department of Health and Social Care, provides the overall direction of the NHS system and also sets its objectives/framework of practice. Since the Health and Social Care Act 2012 entered into force private healthcare companies (governmental approved and compensated) can run some NHS services.

[34] R. Shah, 'Assisted Suicide on the NHS would breach the ECHR,' *UK Human Rights Blog,* 2024. https://ukhumanrightsblog.com/2024/11/01/guest-post-assisted-suicide-on-the-nhs-would-breach-the-echr/

medical practitioners in charge of assisting patients through the process would likely be NHS-funded; therefore, a plausible case can be made that a law of this kind is incompatible with the ECHR.[35] However, the ECtHR has not yet addressed cases specifically concerning the role of state-funded doctors in PAD.

Hence, the fact that other European countries already permit physicians employed by the state or state-run healthcare system to perform PAD does not, *per se*, resolve the issue. The Court of Strasbourg addresses only those cases brought by individuals who are directly affected and only after all national remedies have been exhausted. Yet, in *Mortier* dissenting opinion Judge Serghides argued that euthanasia has no legal basis within the Convention and that if the drafters had wanted to insert PAD provisions they would have included a separate protocol (as it happened when, first, protocol no. 6 and then protocol 13 entered into force to abolish the death penalty in both wartime and peacetime). Moreover, if the State's positive obligations to protect human life are not read together with the State's negative obligations not to act against human life (obligations in place "regardless of whether the threat comes from State agents using lethal force or from State organs applying euthanasia procedures and practices"[36]) there would be no room for the negative obligations to protect the right to life effectively.

The right to life is considered an absolute right. The right to life does not inherently include a right to die, as such an interpretation contradicts the fundamental principles of the right to life. However, it remains possible in law to enact legislation permitting the active hastening of death, provided there is a robust framework in place to protect citizens from potential abuses of their right to life (positive obligations).[37] Hence, "the devil is in the detail"[38] in terms of whether PAD, assessed case-by-case and in terms of procedure, violates Article 2. Yet, when it comes to State negative obligations in relation to Article 2, they can become blurred in particular since they fall under the 'margin of appreciation' umbrella. In *Karsai* the ECtHR reiterated that criteria for PAD such as terminal illness should not be perceived as attaching less value to the lives of people meeting them, instead "these criteria can be viewed as reflecting the delicate balance to be struck between respect for human dignity and the right to self-determination on the part of patients with full mental capacity who wish to die, and the risks involved in allowing PAD beyond a narrowly defined scope."[39] However, this position – likely rooted in the principle that competent patients can refuse life-sustaining treatments even if this hastens death – risks conflating cases that are apparently similar but are instead fundamentally different. This surely further muddies the waters.

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[35] R. Shah, 'Rejoinder to Deb and Graham: Yes, the ECHR prohibits States from euthanising people,' *UK Human Rights Blog*, 2024https://ukhumanrightsblog.com/2024/11/19/rejoinder-to-deb-and-graham-yes-the-echr-prohibits-states-from-euthanising-people-by-rajiv-shah/

[36] *Mortier v. Belgium – Separate Opinions – Partly Dissenting Opinion of Judge Serghides*, §6.

[37] *Mortier v. Belgium*, §139.

[38] N. Papadopoulou, L. Wicks, 'Taking 'the right to life' seriously: Addressing the role of 'the right to life' in the context of assisted dying,' *Medical Law International*, 2025, 25 (2), at 97.

[39] *Daniel Karsai v Hungary*, §148.

Relational Autonomy and the Impossibility of a Right to Die

In recent weeks, the Terminally Ill Adults (End of Life) Bill,[40] proposed by Labour MP Kim Leadbeater, which seeks to legalise PAD for terminally ill, competent adults in England and Wales, has been the subject of extensive discussion.[41] While proponents of the Bill stressed the value of the patient's autonomy, which they argue should encompass when and how the patient would die, opponents emphasised the need to invest in the palliative care system and the risk that the law could pose to vulnerable people and society at large if medical boundaries are stretched and the doctor-patient relationship is indelibly compromised.

The path to accessing PAD begins with a preliminary discussion with a registered medical practitioner. Eligible individuals must be terminally ill, mentally competent adults with a life expectancy of no more than six months, registered with a GP in England and Wales, and ordinarily residing in England and Wales for at least the past year. Doctors have no obligation to initiate a conversation about PAD. However, a doctor is permitted to raise the subject proactively with an adult patient. If a doctor declines to discuss PAD and a patient expresses interest, the doctor must offer the patient the relevant information to allow the patient to seek PAD elsewhere. The preliminary discussion must be followed by a first declaration signed by both a 'coordinating doctor' and another person. Following the initial assessment, a seven-day reflection period begins. Then, a second doctor independently evaluates the patient to confirm the findings of the initial assessment. It may also be necessary to obtain a further assessment if the previous doctor is not satisfied that the patient meets the required criteria. Then, the first declaration and the two medical assessments are sent to the Voluntary Assisted Dying Commissioner, appointed by the Prime Minister, and forwarded to a multidisciplinary three-person Assisted Dying Panel.

After that, the patient needs to make a second declaration, which must be witnessed by both the coordinating doctor and another person. Then a second reflection period begins, typically lasting fourteen days. At this point, once all conditions are met, the coordinating doctor can provide the patient with the lethal substance to be self-administered. The coordinating doctor (or another authorized medical practitioner) must be available to the patient until the end of the process, though not necessarily in the same room.

During the parliamentary discussion that led to the approval of the Bill at its second reading in the House of Commons, the Bill's proponent, Kim Leadbeater MP, stated: "I struggle to see how it is fair or just to deny anyone the autonomy, dignity and personal choice of taking control of their final weeks. And the right to choose does not take away the right not to choose. Giving the choice of an assisted death to those who want it would of course not stop anyone who is terminally ill from choosing not to make that choice."[42] In contrast, Barry Gardiner MP's concern is that Leadbeater "has focused today on the individual and the individual choice, but we are here to legislate for society as a whole. […] Rather than simply focusing on the individual suffering, which we all recognise is acute, we must broaden the debate to the impact that the legislation will have on society as a whole."[43]

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[40] Latest version of the Bill as approved by the House of Commons on 20th June 2025, https://bills.parliament.uk/publications/61635/documents/6734

[41] At the time of writing, the Terminally Ill Adults (End of Life) Bill has passed its third reading at the House of Commons (313 votes in favour, 291 against and 39 abstentions) and it is at its second reading at the House of Lords.

[42] House of Commons, Terminally Ill Adults (End of Life) Bill, Volume 757, Debated 29 November 2024. https://hansard.parliament.uk/commons/2024-11-29/debates/796D6D96-3FCB-4B39-BD89-67B2B61086E6/TerminallyIllAdults(EndOfLife)Bill

[43] House of Commons, Terminally Ill Adults (End of Life) Bill

This discussion, emblematic of the current debate on PAD, appears polarized between two opposing views: one emphasizing the patient's autonomy in an individualistic way – the right to choose and, therefore, the right to die – and the other advocating that this kind of autonomy must be tempered by recognition of a shared social bond. According to the latter perspective, an individual's decision to end their life through PAD could disrupt the psycho-emotional equilibrium of others in society and fundamentally undermine the doctor-patient relationship. However, this polarisation fails to see something crucial that can revolutionize the concept of individual autonomy, now seen as relational and not individualistic. Human beings are, in their essence, vulnerable, and for this reason, other human beings are essential to them.[44] Human vulnerability exposes the self as fundamentally anchored in and developed through another self. Vulnerability also creates a responsibility towards others, which means letting oneself be exposed in front of others and having the capacity to suffer with the sufferer and alleviate their suffering by all adequate means. Imagine someone standing on the edge of a bridge, ready to jump into freezing water, believing it will put an end to their suffering. Someone witnessing this would not push the person, even if they requested it, to overcome their possible hesitation. Instead, they would offer a helping hand in various ways, such as by contacting the appropriate authorities or engaging in conversation to provide support. This is not because people do not care about neighbours' suffering, but because ultimately, they know that death cannot be the proper answer to their cry for help. The experience of death is solely that of witnessing someone else's death; the death witnessed is never one's own. Thus, encountering another's death always reflects back on the self. However, if death has been artificially induced, it signifies a deliberate disengagement from one's inner responsibility to others, like pushing someone standing on the edge of a bridge. This disengagement becomes violence, since it assumes that the other can be fully understood and hence fully 'possessed,' while "[t]o be in relation with the other face to face – is to be unable to kill."[45]

Conclusion

The autonomous self does not give rise to a right to die. Moreover, the notion of an autonomous self, fully capable of deciding to bring about one's own death, and the clinician's supposed duty to assist in such a decision, is based on an illusory conception of autonomy – one that disregards the deeply relational nature of human existence, which carries significant social and ethical consequences. More fundamentally, this perspective fails to acknowledge that human beings are inherently interconnected, existing in relationships with others. Recognizing this relational dimension is crucial to understanding the untenability of a right to die, as such a right would neglect two essential aspects of the human condition: intrinsic vulnerability and ethical responsibility toward others. Human existence is marked by interdependence, where each individual is not only shaped by but also responsible for those around them. Within this framework, autonomy cannot be reduced to isolated self-determination, but must be understood in relation to the broader ethical and social fabric in which decisions are made. Furthermore, the principle of responsibility, which underpins human coexistence, restrains acts that constitute an ultimate usurpation of another's existence – killing. If the right to die were to be legitimized as an extension of personal autonomy, it would not only risk eroding the moral and legal foundations that protect human life but also shift the understanding of care from an ethic of 'support, palliate and accompany' to one that may, under certain circumstances, justify the active termination of life. This shift would have profound implications for the medical profession, the doctor-patient relationship, and society's perception of suffering, dependency, and aging. Ultimately, the argument against a supposed right to die is deeply ethical and ontological. It challenges the very foundation of what it means to be human: to exist in relation to others, to be vulnerable, and to bear responsibility for one another in ways that preclude acts of harm, even when framed as autonomy or compassion. The fact that the ECtHR legitimizes assisted suicide and/or euthanasia but refrains from

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[44] See E. Levinas, *Humanism of the Other*, Chicago: University of Illinois Press (2006).

[45] E. Levinas, *Entre Nous. Thinking-of-the-Other*, New York: Columbia University Press (1998), 10.

explicitly enshrining a right to die is symptomatic of an uneasiness regarding this possible *new right*. The right to life is an absolute right which cannot be restricted or limited unless in prescribed circumstances. However, as the analysis above has shown, the Court of Strasbourg has allowed PAD and/or euthanasia provisions to fall under article 2 ECHR positive obligations – meaning the practice can be lawful, as long as appropriate safeguards are in place to protect, at least, nominally citizens' right to life, thereby leaving legal space for the active termination of life.

Patients' autonomy, understood as a bulwark against unwanted medical treatments, should not be equated with the idea of patients' autonomy to choose PAD. The former remains relational, involving care and the possibility of reversing the decision if the patient later chooses to resume treatment. The latter, by contrast, treats autonomy as a tool to reject care altogether and embrace killing.