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La CEDU sul divieto di suicidio assistito in Ungheria
(CEDU, sez. I, sent. 13 giugno 2024, ric. n. 32312/23)

La Corte Edu si pronuncia sul caso di un cittadino ungherese, affetto da sclerosi laterale amiotrofica (SLA) in stadio avanzato, non curabile, il quale rivendica il diritto di decidere quando e come porre fine alla propria vita, prima che la malattia raggiunga uno stadio che egli reputa intollerabile. A tal fine, avrebbe bisogno di assistenza al suicidio, ma chiunque prestasse tale aiuto rischierebbe di essere perseguito penalmente, anche se il fatto si consumasse in un paese che permette la morte medicalmente assistita. Per tali motivi, il ricorrente ha lamentato l'impossibilità di porre fine alla propria vita con l'aiuto di altri e la sua discriminazione rispetto ai malati terminali tenuti in vita da trattamenti di sostegno vitale, che possono chiedere la sospensione delle cure ed accelerare il momento della propria morte.

I Giudici di Strasburgo hanno, innanzitutto, osservato che la prestazione di servizi di morte medicalmente assistita comporta implicazioni sociali estremamente ampie e rischi di errori e abusi tali per cui, nonostante una tendenza crescente verso la legalizzazione, la maggior parte degli Stati membri del Consiglio d'Europa continua a vietare sia il suicidio medicalmente assistito che l'eutanasia. In tale ambito, pertanto, lo Stato dispone di un ampio potere discrezionale e le autorità ungheresi avrebbero trovato un giusto equilibrio tra gli interessi concorrenti in gioco, senza oltrepassare tale potere discrezionale.

Per quanto riguarda la presunta discriminazione, la Corte ha ritenuto il rifiuto o la revoca delle cure in situazioni di fine vita – consentito nella maggior parte degli Stati membri- intrinsecamente legato al diritto al consenso libero e informato, piuttosto che al diritto ad essere aiutato a morire, come ampiamente riconosciuto nell'ambito della professione medica e stabilito anche nella Convenzione di Oviedo del Consiglio d'Europa. La Corte, pertanto - sottolineata l'importanza della garanzia delle cure palliative per una morte serena e dignitosa – ha ritenuto l'asserita differenza di trattamento delle due categorie di malati oggettivamente e ragionevolmente giustificata.

Nessuna violazione, dunque, del diritto al rispetto della vita privata e familiare (art.8), né del divieto di discriminazioni (art.14).

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EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIRST SECTION

CASE OF XXXXX v. HUNGARY

(Application no.32312/23)

JUDGMENT

STRASBOURG

13 June 2024

This judgment will become final in the circumstances set out in Article 44 § 2 of the Convention. It may be subject to editorial revision.

In the case of XXXXX v. Hungary,

The European Court of Human Rights (First Section), sitting as a Chamber composed of:
Alena Poláčková, *President*,
Marko Bošnjak,
Krzysztof Wojtyczek,
Gilberto Felici,
Ivana Jelić,
Erik Wennerström,
Raffaele Sabato, *judges*,
and Liv Tigerstedt, *Deputy Section Registrar*,

Having deliberated in private on 14 May 2024,

Delivers the following judgment, which was adopted on that date:

INTRODUCTION

1. The case concerns the right, asserted by the applicant, who is suffering from amyotrophic lateral sclerosis, to be assisted in dying.

PROCEDURE

2. The case originated in an application (no. 32312/23) against Hungary lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Hungarian national, Mr Dániel András Karsai ("the applicant"), on 10 August 2023.

3. The applicant was represented by Ms E. Frank and Mr P. Stánicz, lawyers practising in Budapest. The Hungarian Government ("the Government") were represented by their Agent, Mr Z. Tallódi, of the Ministry of Justice.

4. The application was allocated to the First Section of the Court (Rule 52 § 1 of the Rules of Court). Given that Péter Paczolay, the judge elected in respect of Hungary, was unable to sit in the case (Rule 28), the President of the Chamber decided to appoint Marko Bošnjak to sit as an *ad hoc* judge (Rule 29).

5. On 26 September 2023 the application was communicated to the Government. On the same day the Chamber decided to grant priority to the application, in accordance with Rule 41 of the

Rules of Court, and to hold a public hearing on the admissibility and merits of the case under Rule 54 § 5.

6. The Chamber also decided, of its own motion, to hear evidence from experts (Rule A1 of the Annex to the Rules of Court), namely Professor Régis Aubry and Professor Judit Sándor, *in camera*.

7. The President of the Chamber directed that verbatim records of both hearings were to be made, pursuant to Rule 70 of the Rules of Court and Rule 8 of the Annex to the Rules of Court, and instructed the Registrar accordingly.

8. Both parties filed observations on the admissibility and merits. In addition, third-party comments were received from the Italian Government, the European Centre for Law and Justice, the Alliance Defending Freedom International and the Care Not Killing Alliance, the Hungarian Civil Liberties Union and from Dignitas (Article 36 § 2 of the Convention).

9. On 27 November 2023 the Chamber held a fact-finding hearing and heard evidence from the experts in the presence of the parties' representatives, *in camera*, in the Human Rights Building, Strasbourg.

10. A public hearing took place in the Human Rights Building, Strasbourg, on 28 November 2023.

There appeared before the Court:

(a) *for the Government*

Mr Zoltán Tallódi, Agent,
Ms Mónika Weller, Co-Agent,
Mr Csaba Óváry, General Director of the Bajcsy-Zsilinszky Hospital in Budapest,
Mr Dávid Oravecz, Advisors;
Mr Zoltán Turai,
Ms Bíbor Hochmann, Deputies to the Permanent Representative;
Mr Olivér Varga, Trainee.

(b) *for the applicant*

Mr Dániel A. Karsai, Applicant,
Mr Péter Stánicz,
Ms Evelyn Frank, Counsels;
Mr Balázs Tóth,
Mr Viktor Kazai,
Mr Tibor Sepsi, Advisers;
Ms Fanni Antreter,
Mr Erik Budai,
Ms Dominika Péter
Ms Kata Gelencsér, Co-advisers.

The Court heard addresses by the applicant, Mr Stánicz, Mr Tallódi and Mr Óváry, as well as their replies to questions put by judges.

THE FACTS

11. The applicant was born in 1977 and lives in Budapest. He is a prominent human-rights lawyer in Hungary.

12. He was diagnosed with amyotrophic lateral sclerosis (ALS) in August 2022 and is currently in an advanced stage of that disease. ALS is an uncurable progressive neurodegenerative disease (a form of motor neuron disease), with an invariably fatal outcome. It consists in the gradual loss of motor neuron function, and hence of the voluntary control of muscles. At the end-stage of ALS, most of the muscles responsible for volitional motion are paralysed; moreover, speech, unaided breathing and swallowing becomes very difficult and ultimately impossible. Sensory and cognitive abilities may stay largely intact, and patients generally maintain their intellectual functions and consciousness throughout the progression of the disease. No therapy offers a substantial clinical benefit for patients with ALS. The main care for patients with ALS is timely intervention to manage symptoms, including use of nasogastric feeding, the prevention of aspiration and provision of ventilatory support. Typically, death due to respiratory paralysis occurs in three to five years.[1]

13. The applicant first experienced the symptoms of ALS in July 2021. Since then, he has been losing dexterity in his hands and lower limbs. His swallowing is deteriorating, and he has experienced episodes of choking. He requires daily assistance, and has regular sessions with a physiotherapist, a speech and language therapist and a psychiatrist.

14. The applicant maintains that he will soon be completely paralysed and will be unable to communicate; he will be "imprisoned in his own body without any prospect of release apart from death" and his existence will consist almost exclusively of pain and suffering. He wishes to end, or shorten to a minimum, this phase of his disease by availing himself of some form of physician-assisted dying; however, neither euthanasia nor assisted suicide are legal in Hungary. In this connection, the applicant submits, essentially, as follows: in order to maintain his physical and mental integrity, the applicant must commit suicide while he still can, if he wishes to end his life before his illness results in a condition that he considers to be unbearable. Once his illness reaches the stage where his mobility is so severely reduced that he cannot end his own life, he will have to wait until he eventually requires life-sustaining treatment which, in his case will occur only – if ever – directly before his death.

RELEVANT LEGAL AND OTHER MATERIAL

I. DOMESTIC LEGAL FRAMEWORK AND STANDARDS OF ETHICAL CONDUCT

A. The Criminal Code and the explanatory memorandum thereto

15. The relevant parts of Act C of 2012 on the Criminal Code read as follows:

Section 3

"(1) Hungarian criminal law shall apply to

(a) criminal offences committed in Hungary,

...

(c) acts committed by Hungarian nationals abroad if the act constitutes a criminal offence under Hungarian law.

(2) Hungarian criminal law shall apply to

(a) acts committed by persons other than Hungarian nationals abroad if the act:

(aa) constitutes a criminal offence under Hungarian law and is also punishable under the law of the place where it was committed,

...

(b) acts committed by persons other than Hungarian nationals abroad against a Hungarian national, or a legal person ... which are punishable under Hungarian law.

(3) In the cases specified in paragraph (2), the criminal proceedings shall be initiated by the Attorney General.

..."

Homicide
Section 160

"(1) Any person who kills another human being is guilty of a felony that is punishable by imprisonment for five to fifteen years.

(2) The penalty shall be imprisonment for ten to twenty years, or life imprisonment, where the homicide was committed:

(a) deliberately with premeditation;

...

(k) against a person whose ability to defend himself or herself is diminished due to old age or disability;

...

(3) Any person who engages in preparations to commit homicide shall be punished by imprisonment for one to five years.

(4) Any person who commits negligent homicide is guilty of a misdemeanour punishable by imprisonment for one to five years.

(5) Any person who persuades another to commit suicide shall be punished in accordance with subsection (1) if such person is under the age of fourteen years or is unable to express his or her will, and if suicide is in fact committed."

Voluntary Manslaughter
Section 161

"Any person who commits homicide as a result of provocation or in the heat of passion is guilty of a felony, punishable by imprisonment for two to eight years."

Aiding and Abetting Suicide
Section 162

"(1) A person who induces or provides assistance for another person to commit suicide is guilty of a felony and shall be punished by imprisonment for one to five years if suicide is in fact attempted or committed.

(2) Any person over the age of eighteen years who persuades another person under the age of eighteen years to commit suicide, or who provides assistance in committing suicide, shall be punished by imprisonment for two to eight years, if suicide is in fact attempted or committed."

16. With regard to the extraterritorial jurisdiction of the Hungarian Criminal Code, the explanatory memorandum to the Bill on the Criminal Code explained that, as a general rule, an act committed abroad by a non-Hungarian citizen continued to be punishable only in the event of double incrimination. The Bill makes three exceptions to this rule: in the case of crimes against the State; in cases of crimes against humanity, war crimes, or other crimes, prosecution of which is required by an international treaty promulgated by law; and in the case of crimes committed against a Hungarian citizen. The memorandum explained this as follows:

"Among the jurisdictional provisions, the Bill prescribes the passive personality principle as a new feature, thus taking into account the trend appearing in international treaties. Based on the passive personality principle, Hungarian criminal jurisdiction also extends to acts committed by a non-Hungarian citizen abroad to the detriment of a Hungarian citizen or of a legal entity established under Hungarian law, or of another legal entity without legal personality. The condition for punishability is that the act is punishable under Hungarian law. The passive personality principle enables the criminal prosecution of non-Hungarian citizens who commit a crime abroad against a Hungarian citizen or legal person or other legal entity, where their act is not punishable under the law of the place where it was committed. So in this case, double incrimination is also not a condition for the exercise of jurisdiction.

In the case of crimes committed abroad by a non-Hungarian citizen, the Bill ties the actions of the Hungarian authorities to an additional condition (a decision by the Attorney General), since the prosecution of crimes committed by a foreign citizen or stateless person abroad by the Hungarian authorities may affect Hungary's international relations. It must therefore be subject to thorough consideration, covering all circumstances, as to whether the conditions for the efficient conduct of criminal proceedings in Hungary exist. In view of this, the Bill maintains the existing provision unchanged, to the effect that in such cases the Attorney General decides on whether to initiate criminal proceedings."

B. The Code of Criminal Procedure

17. Article 4 (1) of Act XC of 2017 on the Code of Criminal Procedure provides as follows:

"The prosecution service or investigating authority shall initiate criminal proceedings *ex officio* if it becomes aware of a criminal offence that is subject to public prosecution."

C. Healthcare Act

1. *Right to self-determination and to refuse treatment in the Act on Healthcare*

18. One of the declared purposes of Act CLIV of 1997 on Healthcare (hereinafter the "Healthcare Act") is to create conditions whereby all patients can preserve their human dignity, self-identity and right to self-determination, and whereby all of their other rights remain intact (section 1 point (c)).

19. Every patient has, in the event of a medical emergency, the right to receive life-saving care and treatment in order to prevent serious or permanent impairment to health, as well as to have his or her pain eased and suffering reduced (section 6). Life-saving intervention is defined by the Healthcare Act as "a medical activity aimed at saving the patient's life in the event of a medical emergency" (section 3 point (n)), while life-sustaining intervention is "a medical activity aimed at artificially maintaining the patient's life or at substituting certain vital life functions" (section 3 point (o)).

20. A patient's personal freedom and right to self-determination can only be restricted if this is justified by the patient's state of health, and only in the manner and circumstances specified by the Healthcare Act (section 2 (1)). In the context of the exercise of the right to self-determination, a patient can freely decide whether he or she wishes to use healthcare services, and which procedures to consent to or refuse in the course of using such services, having regard to the restrictions laid down in section 20 of that Act (section 15 (2)).

21. Sections 20-23 of the Healthcare Act, concerning the right to refuse medical care, provide:

The Right to Refuse Healthcare
Section 20

"(1) In accordance with the provisions set out in subsections (2)-(3) and with the exception of the cases defined in subsection (6), a patient with full legal capacity shall have the right to refuse healthcare, unless this would endanger the lives or physical safety of others.

(2) Where a patient refuses the provision of any care, and if its absence would be likely to result in serious or permanent impairment of his or her health, this must be done through a public deed or in a private deed with full probative value, or, where the patient is unable to write, in the joint presence of two witnesses. In the latter case, the refusal must be recorded in the patient's medical record and certified with the signatures of the witnesses.

(3) Life-sustaining or life-saving interventions may only be refused, thereby allowing the illness to follow its natural course, if the patient suffers from a serious illness which, according to the current state of medical science, will lead to death within a short period of time even with adequate healthcare, and is incurable. The refusal of life-sustaining or life-saving interventions must be made in keeping with the formal requirements set out in subsection (2).

(4) Refusal as defined in subsection (3) shall be valid only if a committee composed of three physicians has examined the patient and issued a unanimous written statement to the effect that the patient took his or her decision in full cognizance of its consequences; if the conditions defined in subsection (3) have been satisfied; and, furthermore, if on the third day after this statement by the medical committee the patient consistently declares his or her intention to refuse treatment in the presence of two witnesses. If the patient does not consent to an examination by the medical committee, his or her statement regarding refusal of medical treatment cannot be taken into consideration.

(5) The committee defined in subsection (4) shall be composed of: the patient's attending physician, one board-certified doctor who specialises in the field corresponding to the nature of the illness and is not involved in treating the patient, and one board-certified psychiatrist.

(6) A female patient may not refuse a life-sustaining or life-saving intervention if she is pregnant and is considered capable of carrying the pregnancy to term.

(7) In the event of refusal as defined in subsections (2) to (3), an attempt shall be made to identify the reasons underlying the patient's decision through personal interviews, and to alter the decision. During this process, in addition to the information defined in section 13, the patient shall be informed once again of the consequences of not carrying out the intervention.

(8) A patient may withdraw his or her statement regarding refusal at any time and without any restriction as to the form thereof."

Section 22

"(1) A person with legal capacity may – in anticipation of his or her subsequent incapacity to act, and subject to this being formally set out in a public deed – refuse:

(*a*) specific examinations [or] interventions provided for in section 20 (1);

(*b*) the interventions provided for in section 20 (3); and

(*c*) certain life-sustaining [or] life-saving procedures, if he or she suffers from an incurable disease and is unable to care for himself or herself physically as a result of such illness, and if his or her pain cannot be reduced even by appropriate medical treatment.

(2) In anticipation of his or her future incapacity, a person with legal capacity may designate a person with legal capacity, executed in an authentic instrument, to exercise his or her right under subsection (1) in his or her stead.

(3) The statement referred to in subsections (1)-(2) may be withdrawn by the patient at any time, regardless of his or her legal capacity, without formal requirements.

(4) As regards a statement indicating a refusal to accept the provision of care by a person with legal capacity as provided for in subsection (2) hereof, the committee referred to in section 20 (4) shall certify:

(*a*) the conditions set out in subsection (1) are satisfied, and

(*b*) the person referred to in subsection (2) made his or her decision in full awareness of the consequences thereof."

Section 23

"(1) An intervention referred to in section 20 (3) may be terminated or not carried out only if the patient's will to do so can be ascertained in a clear and convincing manner. In case of doubt, the patient's subsequent personal statement must be taken into account; in the absence thereof, consent for performing the life-sustaining or life-saving interventions must be assumed.

(2) If treatment is refused, the patient or the person referred to in section 22 (2) may not be forced to change his or her decision by any means whatsoever. If an intervention referred to in section 20 (3) is refused, the patient shall nevertheless be entitled to treatment aimed at reducing his or her suffering and alleviating pain."

22. The Healthcare Act does not authorise assisted suicide or euthanasia.

2. Palliative care

23. The relevant parts of the Healthcare Act read as follows:

End-of-Life Care of Terminal Patients
Section 99

"(1) The objective of end-of-life care for terminal patients (hereinafter: hospice care) shall be to provide physical and psychological nursing and care for a patient with a lengthy terminal illness, to improve his or her quality of life, to alleviate suffering, and to preserve the patient's human dignity all the way through until the end of life.

(2) To achieve the objective set out under subsection (1), the patient shall be entitled to palliative care to mitigate pain, alleviate physical symptoms and emotional suffering, and to have family members and other significant persons at his or her side.

(3) Whenever possible, hospice care shall be provided in the patient's home, with the patient surrounded by his or her family.

(4) Hospice care shall include assisting the terminally ill patient's family members in nursing the patient and providing emotional support to them throughout the duration of the illness and during the period of bereavement and mourning."

24. Hospice palliative care is further defined by Decree no. 60/2003. (X. 20.) of the Health Minister as a form of healthcare that aims to eliminate or reduce the pain and other distressing symptoms of patients in the final stages of an incurable terminal illness, to improve their quality of life, and to support family members and bereaved relatives, through the help of a multidisciplinary care team. In general, hospice palliative care is provided to patients with an expected survival period of no longer than a year. The multidisciplinary team consists of doctors, physiotherapists, nurses, dieticians, mental-health professionals and social workers. All forms of hospice palliative care are free of charge for the patient. Following an initial maximum 50 days of care, it can be prolonged twice, with the maximum period of care being capped at 150 days.

D. The Code of Ethics of the Hungarian Medical Chamber

25. The relevant part of the Code of Ethics of the Hungarian Medical Chamber states:

"(16) A breach of the legal provisions related to situations requiring special treatment - especially first aid, the treatment of terminally ill patients, organ and tissue transplantation, abortion and assisted reproduction procedures - is also considered an ethical offence.

- Euthanasia is [defined as] a deliberate action by a doctor when carrying out his or her profession, aimed at the premature death of an incurable, suffering patient, at the latter's request.
- Euthanasia moves the time of death to an earlier time than the natural end. Doctors take an oath and are authorised to heal and to alleviate the suffering of the patient, and not to take another person's life.

(17) Any action for the purpose of ending a person's life is incompatible both with the medical profession and with medical ethics, and is also a flagrantly serious ethical offence.

- The provision of palliative terminal medicine is justified for the care of terminally ill patients. Its essence is to reduce the physical and mental suffering of terminally ill patients who, in the current state of science, are incurable.
- Terminal palliative medicine is not the same as euthanasia. After careful consideration, the doctor recommends not to use therapy that is deemed to be ineffective and [instead] uses treatment that provides the necessary care, comfort, symptomatic treatment and spiritual support. Terminal palliative medicine can only be used with consent of the patient or his or her legal representative, given, if possible, in a written form.
- It is not considered to be euthanasia where the patient refuses life-sustaining treatment after receiving sufficient information – and under the conditions laid down in the legislation – because death thus occurs as a result of the natural course of the disease.
- It is not considered euthanasia if we administer the smallest effective dose of a drug to a suffering patient who has reached the end stage of the disease; and if the suffering increases, we gradually increase the dose, even to an extent that will probably bring the time of death closer, because our duty is to alleviate suffering and the intention is not to cause the patient's death."

II. RELEVANT DOMESTIC LEGAL PRACTICE

26. Between 1993 and 2001 the Hungarian Constitutional Court received several petitions concerning the right of patients with terminal illnesses to end their lives with dignity. On 28 April 2003 the Constitutional Court adopted a joint decision on all of them.

27. One of the main claims put forward by the petitioners was that the Healthcare Act restricted, in an unconstitutional manner, the right of terminally ill patients to self-determination, by not allowing them to end their lives with the aid of a physician. In their view, the right to life and human dignity enshrined in Article 54 (1) of the Constitution of 1949 entailed the right to end one's life with dignity. For the same reason, the petitioners also submitted that the legislature had acted unconstitutionally, by omission, in failing to harmonise Articles 166 to 168 of Act IV of 1978 on the Criminal Code (providing for the criminal offences of homicide and assistance in suicide) with Article 54 (1) of the Constitution of 1949. The petitioners complained, *inter alia*, that any medical aid in dying provided to a terminally ill person was punishable by law, although such acts ought to be deemed lawful on the basis of the patient's constitutional right, and that "mercy killing" was not properly distinguished from homicide. Furthermore, in the petitioners' view, although the Healthcare Act allowed terminally ill patients to refuse the medical care necessary for sustaining their lives, even this possibility was not granted widely enough and the rules regarding such a refusal unjustifiably restricted the right to self-determination of terminally ill patients.

28. The Constitutional Court began by reviewing the developments in the applicable domestic criminal and healthcare legislation. As regards criminal law, it noted that "since Act V of 1878,

the criminal-law statutes in force in Hungary have been consistent in that they punish homicide, even if perpetrated by a physician at the request or in the interest of a terminally ill patient"; as regards healthcare, it took note of the changes brought about the new Healthcare Act, in particular the strengthening of patients' rights in the course of medical care, by entitling them to decide whether they wish to receive medical care, and also to consent to or refuse interventions. It further analysed the international context and found that at the material time, only the Dutch, Belgian and Oregon legislation offered the option of active euthanasia. The Constitutional Court also reviewed the positions of various Council of Europe bodies as set out, amongst other sources, in the case of *Pretty v. the United Kingdom* (no. 2346/02, ECHR 2002-III), in the Parliamentary Assembly's Recommendation no. 1418 (1999) on the protection of the human rights and dignity of the terminally ill and the dying, and in the Convention on Human Rights and Biomedicine (see paragraphs 35-37 below).

29. The Constitutional Court found it appropriate to examine the questions raised in the petitions from the perspective of the right to life and the right to self-determination as an aspect of the right to human dignity, and held as follows:

> "6.1. The decision by a terminally ill patient not to live until the natural end of a life that is characterised by suffering is part of patient's right to self-determination and, as such, it falls within the scope of Article 54 (1) of the Constitution. The right to decide upon one's own death is to be enjoyed by all persons, irrespective of whether they are healthy or ill – whether terminally, as the art of medicine currently stands, or not. This is one of the reasons why modern systems of law, including that of Hungary, only prohibit assistance in suicide but not suicide itself, in contrast to former times, when suicide was penalised in many places: those who committed suicide had various sanctions imposed on them after death (for example, they were buried outside the cemetery, their property was confiscated, and so on).
>
> A legal system based on ideologically neutral constitutional foundations cannot reflect either support or condemnation for an individual's decision to end his or her life; this is a sphere where, as a general rule, the State has to refrain from interference. The role to be played by the State in this respect is limited to those absolutely necessary measures which result from its obligation to ensure institutional protection concerning the right to life.
>
> 6.2. In the view of the Constitutional Court, two conclusions follow from the above. Firstly, the decision by a terminally ill patient not to live until his or her natural death in order to shorten suffering and pain, or for any other reason, and the related refusal to grant consent to a medical intervention that is absolutely necessary to keep him alive, are part of his or her right to self-determination, the exercise of which may be restricted – but not prevented – by an Act of Parliament to the degree necessary for the protection of another fundamental right. ...
>
> Secondly, the wish of a terminally ill patient to have his or her life ended not merely by refusing a life-sustaining or life-saving medical intervention, but through the active aid of a physician, cannot be considered, from a constitutional perspective, as an integral part of his or her right to self-determination concerning one's own life or death that is not susceptible to limitation – or even total prohibition – by law, in the interest of protecting any other fundamental right. In such a scenario, another person becomes involved in the process as an active participant, namely, the physician attending the patient, when the patient decides to die

in a manner reconcilable with his or her dignity. The role of the physician is not limited to performing the patient's will; he or she is necessarily involved – often substantially – in forming the patient's decision, by informing the patient about the nature and the course of the illness, his or her life prospects, and the possibilities of controlling the pain and suffering resulting from the illness."

30. In the Constitutional Court's view, the right to die with dignity, in the constitutional context presented in the petitions, does not exist in harmony with the right to life, but on the contrary: the enforcement of either right may result in limiting the other. Therefore, the absolute nature of the right to human dignity, in unity with the right to life – as elaborated in earlier decisions of the Constitutional Court – does not extend to human dignity alone. The desire of a terminally ill patient to have his or her death induced by a physician, for example by supplying or administering an appropriate substance, is beyond that part of the patient's right to self-determination that is absolute, as in such cases death is actively induced by another person. In this connection, the Constitutional Court noted the following:

"In the opinion of the Constitutional Court, the fact that termination of life-sustaining medical intervention by a physician at the request of a terminally ill patient and the ending of a terminally ill patient's life by a physician at the patient's request were prohibited in almost all countries of the world until quite recently is undoubtedly due to the legislatures' conviction that the conditions for even partially easing the strict prohibitions formerly applied in order to protect the right to life have only emerged recently. Several rulings by the European Commission of Human Rights and the European Court of Human Rights can serve as examples of the fact that changing circumstances, including scientific developments, have rendered obsolete certain restrictions on human rights that were formerly deemed legitimate (for example, the case of *Sutherland v. the United Kingdom*, Commission Report of 1 July 1997; the case of *Goodwin v. the United Kingdom*, the Court's judgment of 3 July 2002).

The Constitutional Court holds that in the field of the statutory regulations pertaining to the enforcement of terminally ill patients' right to self-determination, there is no irreversibly determined boundary between unconstitutional and constitutional measures; the level of knowledge, the state of development (in other words, the advanced or underdeveloped nature) of State institutions, and a range of other factors may influence the evaluation of the constitutionality of this issue.

In the relevant Hungarian regulatory framework, too, the route has led from a long period of complete prohibition to the setting aside in 1997 of the provision of the [Healthcare] Act, which had required physicians to treat with maximum professional care even those patients whom they deemed to be terminally ill, and to the authorisation for terminally ill patients to refuse life-saving or life-sustaining interventions, that is, to exercise their right to self-determination – at least to this extent. In this way, the legislature has allowed patients to decide about having their lives ended in a manner reconcilable with their human dignity. At the same time, the legislature has enacted several provisions to guarantee that patients make an informed decision, being fully aware of its consequences [and] without any external influence."

31. As to whether the statutory prohibition on a physician actively inducing the death of a terminally ill patient, at the patient's request, – by supplying or administering a substance, or by any other means – is a necessary or proportionate restriction of the right to self-determination, the Constitutional Court stated as follows:

> "In this respect, the obligation on the State to protect life is [thus] to ensure that no external influences interfere with the complex process of the patient deciding whether or not to refuse a life-sustaining or life-saving intervention. The State's obligation ... must be enforced in respect of the protection of the life not only of patients choosing between life and death but also, in a broader sense, of everybody else who may face the same challenge in the future. This approach by the Constitutional Court is consistent with its [previous] position ..., according to which "it follows from the objective aspect of the right to life that the duty of the State goes beyond its obligation not to violate one's right to life and to employ its legislative and administrative measures to protect this right. This obligation is not limited to the protection of the life of individuals, but it also includes the protection of human life in general and the conditions of its existence. This latter duty is qualitatively different from the aggregate of the protection of the right to life of individuals, it is 'human life' in general, and thus human life as a value, that is the subject of protection." [Decision 64/1991 (XII. 17.) AB, ABH 1991, 297, 303]. Having regard to the petitions considered in this decision, the Constitutional Court supplements the above arguments with the importance of public confidence in medical services and institutions...
>
> ...
>
> The Constitutional Court points out that it was in 1997 that the legislature reached the conclusion that the total prohibition applied earlier in this field had become obsolete. Therefore, the [Healthcare Act] has allowed terminally ill patients whose illnesses are expected, according to the current state of the art of medicine, to lead to death within a short time, to refuse life-sustaining or life-saving interventions in order to choose a dignified way of ending their lives. ..."

32. The Constitutional Court found that, given the prominent constitutional value of the right to life, it had been justified to apply criminal sanctions against persons who acted against the prohibition on assisting in suicide or taking someone's life. The motives of persons involved in inducing the death of a terminally ill patient were to be evaluated by the court when imposing a sentence.

33. The Constitutional Court also examined the petitioners' claim about an allegedly unconstitutional restriction of patients' right to self-determination by the provisions of the Healthcare Act, given the fact that the refusal of life-saving or life-sustaining interventions by terminally ill patients was allowed only where certain conditions were fulfilled (see sections 20-23 of the Healthcare Act above). The Constitutional Court found that the special rules on how patients could exercise the right to self-determination with respect to life-sustaining and life-saving measures were justified by the State's obligation to ensure institutional protection concerning the right to life. As regards the petitioners' claim that the legislature unconstitutionally restricted the right to refuse life-sustaining or life-saving interventions of terminally ill patients whose illnesses were not expected to lead to death within a short period of time, the Constitutional Court held as follows:

"... the restriction [is] motivated by the reasonable intention to protect the right to life and is not therefore deemed to be of an arbitrary nature. Consequently, on the basis of the State's obligation to ensure institutional protection of human life ... the legislature's position on not allowing, at present, the refusal of life-saving or life-sustaining medical interventions by persons suffering from serious and – as the art of medicine currently stands – terminal illnesses, but who are likely, [again] as the art of medicine currently stands, to die only in the long term, is not considered unconstitutional."

34. The Constitutional Court also found that the examination by a committee of three physicians of the validity of the refusal to accept treatment could not be regarded as unnecessary or disproportionate, as the task of the committee was to verify that the statutory conditions for refusing treatment had been met.

III. INTERNATIONAL LEGAL TEXTS AND PROFESSIONAL STANDARDS

A. Council of Europe

1. *The Oviedo Convention*

35. The Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (CETS 164, the Oviedo Convention) was signed on 4 April 1997 and entered into force on 1 December 1999, and with respect to Hungary on 1 May 2002. Article 5, entitled "General rule", in Chapter II on Consent, provides as follows:

"An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time."

36. In so far as relevant, the Explanatory Report to the Oviedo Convention provides as follows in respect of Article 5:

"35. The patient's consent is considered to be free and informed if it is given on the basis of objective information from the responsible health care professional as to the nature and the potential consequences of the planned intervention or of its alternatives, in the absence of any pressure from anyone. Article 5, paragraph 2, mentions the most important aspects of the information which should precede the intervention but it is not an exhaustive list: informed consent may imply, according to the circumstances, additional elements. In order for their consent to be valid the persons in question must have been informed about the relevant facts regarding the intervention being contemplated. This information must include the purpose, nature and consequences of the intervention and the risks involved. Information on the risks involved in the intervention or in alternative courses of action must cover not only the risks inherent in the type of intervention contemplated, but also any risks related to the individual

characteristics of each patient, such as age or the existence of other pathologies. Requests for additional information made by patients must be adequately answered."

2. The Parliamentary Assembly's Recommendations and Resolutions

37. The Parliamentary Assembly of the Council of Europe has adopted the following texts, of pertinence to the present topic and reproduced in the relevant part:

(a) Recommendation 1418 (1999) of the Parliamentary Assembly on Protection of the human rights and dignity of the terminally ill and the dying

"...

9. The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects:

a. by recognising and protecting a terminally ill or dying person's right to comprehensive palliative care, while taking the necessary measures:

9.1.1. to ensure that palliative care is recognised as a legal entitlement of the individual in all member states;

9.1.2. to provide equitable access to appropriate palliative care for all terminally ill or dying persons;

...

9.1.7. to ensure that, unless the patient chooses otherwise, a terminally ill or dying person will receive adequate pain relief and palliative care, even if this treatment as a side-effect may contribute to the shortening of the individual's life;

...

b. by protecting the terminally ill or dying person's right to self-determination, while taking the necessary measures:

...

9.2.3. to ensure that no terminally ill or dying person is treated against his or her will while ensuring that he or she is neither influenced nor pressured by another person. Furthermore, safeguards are to be envisaged to ensure that their wishes are not formed under economic pressure;

9.2.4. to ensure that a currently incapacitated terminally ill or dying person's advance directive or living will refusing specific medical treatments is observed.... To ensure that surrogate decisions that rely on general value judgements present in society should not be admissible and that, in case of doubt, the decision must always be for life and the prolongation of life;

9.2.5. to ensure that – notwithstanding the physician's ultimate therapeutic responsibility – the expressed wishes of a terminally ill or dying person with regard to particular forms of treatment are taken into account, provided they do not violate human dignity;

...

c. by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

9.3.1. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";

9.3.2. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

9.3.3. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."

(b) Parliamentary Assembly Resolution 1649 (2009) on Palliative care: a model for innovative health and social policies

"...

5. The Assembly regards palliative care as a model for innovative health and social policies, as it takes account of the changes in our perceptions of health and illness and does not assume that curing diseases is the precondition for self-determination and participation in society. Autonomy is accordingly the requirement for a subjective form of "health", which includes people's freedom to decide for themselves how to deal with illness and death.

6. The Assembly notes that palliative care enables people who have serious illnesses, are suffering pain or are in a state of great despair, to exercise self-determination. The approach is not, therefore, just based on need, but contributes directly to human, civic and participation rights being asserted right up to death.

...

12. It recognises that the limits of any medical intervention are determined by the autonomy of the individual patients in so far as they express their will not to receive curative treatment or, regardless of any medical assessment of their state of health, have done so explicitly in a living will, for instance.

13. The Assembly hopes that palliative care also offers individuals who have given up hope the prospect of dying in dignity if they are allowed to turn down curative medicine but accept pain relief and social support.

14. It therefore regards palliative care as an essential component of appropriate health care based on a humane concept of human dignity, autonomy, human rights, civic rights, patient rights and a generally acknowledged perception of solidarity and social cohesion."

(c) Parliamentary Assembly Resolution 1859 (2012) on Protecting human rights and dignity by taking into account previously expressed wishes of patients

"1. There is a general consensus based on Article 8 of the European Convention on Human Rights (ETS No. 5) on the right to privacy, that there can be no intervention affecting a person without his or her consent. From this human right flow the principles of personal autonomy and the principle of consent. These principles hold that a capable adult patient must not be manipulated and that his or her will, when clearly expressed, must prevail even if it signifies refusal of treatment: no one can be compelled to undergo a medical treatment against his or her will.

...

5. This resolution is not intended to deal with the issues of euthanasia or assisted suicide. Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited."

7. The Assembly, recalling its Recommendation 1418 (1999) on the protection of the human rights and dignity of the terminally ill and the dying, recommends that national parliaments, when legislating in this field, respect the following principles, in addition to those enshrined in the Oviedo Convention and Committee of Ministers Recommendation CM/Rec(2009)11:

7.1. self-determination for capable adults in the event of their future incapacity, by means of advance directives, living wills and/or continuing powers of attorney, should be promoted and given priority over other measures of protection;

...

7.8. surrogate decisions that rely on general value judgments present in society should not be admissible and, in case of doubt, the decision must always be for life and the prolongation of life."

(d) Parliamentary Assembly Resolution 2249 (2018) on the provision of palliative care in Europe

"1. The Parliamentary Assembly recognises that palliative care is fundamental to human dignity and a component of the human right to health.

2. Building on the definition given by the World Health Organization, the Assembly notes that palliative care focuses on preventing and relieving suffering associated with a life-threatening or life-limiting condition through a holistic approach addressing physical, psychosocial and spiritual problems. The goal of palliative care is to improve the quality of life for patients and their families, and to uphold their dignity, by alleviating suffering in all its forms.

...

4. The Assembly deeply regrets that fifteen years after the adoption of Committee of Ministers Recommendation Rec(2003)24 on the organisation of palliative care, hundreds of thousands of people in Europe still do not have access to appropriate palliative-care services. The Assembly is particularly concerned about the lack of access to appropriate pain relief, leading to situations in which patients suffer for months and even years, and die in pain that could be prevented.

...

7. In view of the above, the Assembly calls on the Council of Europe member States to take the following measures with a view to strengthening palliative-care services and to ensuring access to quality palliative care for both adults and children who need it:

...

7.3. ensure access to pain treatment and management as a crucial component of palliative care, in particular:

7.3.1. remove legal and regulatory obstacles that restrict access to pain-relieving medication in the context of palliative care;

7.3.2. address educational and attitudinal barriers by raising awareness of appropriate and effective pain management, including opioid-based treatments, among health-care professionals and the general public;

..."

3. *Guide on the decision-making process regarding medical treatment in end-of-life situations*

38. In the course of its work on patients' rights and with the intention of facilitating the implementation of the principles enshrined in the Oviedo Convention, the Committee on Bioethics (DH-BIO) of the Council of Europe prepared a Guide on the decision-making process regarding medical treatment in end-of-life situations. It was adopted at the Committee's 4th plenary meeting (26-28 November 2013). The Guide concerns the decision-making process regarding medical treatment as it applies to end-of-life situations (including its implementation, modification, adaptation, limitation, or withdrawal). It does not address the issues of euthanasia or assisted suicide. The relevant parts of the Guide are set out in the Court's judgment in the case of *Lambert and Others v. France* ([GC], no. 46043/14, §§ 61-68, ECHR 2015 (extracts)).

39. Among the problematic issues, the Guide mentions the use of sedation for distress in the terminal phase of illness. It notes as follows:

"Sedation seeks, by means of appropriate medication, to reduce awareness to a degree which may extend to loss of consciousness. Its aims to alleviate or remove the patient's perception of an unbearable situation (such as unbearable pain or unappeasable suffering) when every available treatment adapted to this situation has been offered and/or dispensed but has failed to bring the expected relief. The aim of sedation is not, therefore, to shorten life.

Nonetheless, the debate focuses on two points:

- use of sedation not to relieve physical symptoms (such as dyspnoea), but to alleviate psychological or existential suffering

If a patient's symptoms seem to be under control, but he or she continues to maintain that the suffering is unbearable and that he or she would like to be given sedation, how should the team deal with this request? Continuous deep sedation can lead to a loss of consciousness which could be irreversible and prevent the person from communicating with his or her family and friends. This could raise ethical discussions within the care team and with family members.

- use of sedation with the secondary risk of shortening the time left to live

Even though this is not its purpose, sedation can have a side effect in certain cases of accelerating the process of dying. There is much debate about the use of continuous deep sedation in the terminal phase up to the person's death, if in addition it is in conjunction with the cessation of all treatment.

For some, this result in itself poses a problem, particularly if the person cannot participate in the decision-making process (for example, brain-damaged patients). For others, the decision

is acceptable provided that the main intention is not to hasten the onset of the end of life but to relieve suffering."

B. United Nations

40. On 30 October 2018 the United Nations Human Rights Committee adopted General Comment No. 36 on Article 6 (right to life) of the International Covenant on Civil and Political Rights, which replaced certain pervious general comments. It states, *inter alia*, as follows:

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

41. On 11 August 2000 the United Nation Committee on Economic Social and Cultural Rights (CESCR) adopted General Comment No. 14 on Article 12 (the Right to the Highest Attainable Standard of Health) of the International Covenant on Economic, Social and Cultural Rights in which it stated, *inter alia*, that the State Parties are under the legal obligation to "respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons ... to preventive, curative and palliative health services." With regard to the right to refuse treatment, the CESCR noted that the right to health includes the right to control one's health and body and "the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation".

C. Inter-American Convention on Protecting the Human Rights of Older Persons

42. The Inter-American Convention on Protecting the Human Rights of Older Persons was adopted on 15 June 2015 by the member States of the Organisation of American States. Article 6, titled "Right to life and dignity in old age", reads as follows:

"States Parties shall take steps to ensure that public and private institutions offer older persons access without discrimination to comprehensive care, including palliative care; avoid isolation; appropriately manage problems related to the fear of death of the terminally ill and pain; and prevent unnecessary suffering, and futile and useless procedures, in accordance with the right of older persons to express their informed consent."

D. Recommendations by the European Association of Palliative Care

43. The European Association of Palliative Care issued Revised recommendations on standards and norms for palliative care in Europe based on the revision between June 2020 and September 2022 of the 2009 recommended framework. The aim of the revised recommendations is to provide evidence and consensus-based guidance on palliative sedation for healthcare professionals involved in end-of-life care, for medical associations and health policy decision-makers. Certain of its final statements read as follows:

"1. Palliative sedation aims to relieve refractory suffering through the monitored proportional use of medications intended to reduce consciousness in patients with life-limiting disease. ...

2. Symptoms or a state of existential distress are considered to be refractory when there is a lack of methods likely to provide appropriate relief within an acceptable time frame and without unacceptable adverse effects.

3. ... Determining refractoriness is a joint decision between the physician (and/or the multi-professional team) and the patient or their legal representative/significant others.

4. Palliative sedation is used (i) For the management of refractory suffering; (ii) In emergency situations in case of imminent death; (iii) In end-of-life weaning from life sustaining support, when the occurrence of refractory suffering is foreseeable; and (iv) As temporary respite when treatment cannot achieve sufficient relief in an acceptable timeframe.

5. The aim of palliative sedation is to relieve refractory suffering, not to shorten life.

6. Palliative sedation in the management of refractory psychological symptoms and existential distress is different from other situations for some major reasons:

(1) The severity of the distress may be very dynamic and idiosyncratic, and psychological adaptation and coping may occur. Therefore, it is much more difficult to establish refractoriness;

(2) The pharmacological and non-pharmacological approaches have low adverse effects;

(3) The presence of this distress does not necessarily indicate a far advanced state of physiological deterioration.

7. Palliative sedation should be carefully considered because of the probable loss of the patient's ability to interact and of potential risks.

...

14. The designation of psychological symptoms and existential distress as refractory should only be done following comprehensive assessment by experts in palliative care, considering the psychological, social and spiritual components of suffering, with, if necessary, consultation with other professionals competent in one of these areas.

...

18. Apart from unanticipated emergency situations the aims, methods, benefits and risks of the proposed palliative sedation should be discussed with and approved by patients capable of making decisions by means of an informed consent. ...

...

22. Other than in emergency situations at the end of life, light sedation should generally be attempted first.

23. Intermittent palliative sedation can be indicated early in the patient's disease trajectory to provide temporary relief whilst waiting for treatment benefit from other therapeutic approaches (transient sedation) or to give the patient a break from the current burdensome situation (respite sedation) before regaining consciousness.

24. In the case of psychological symptoms or existential distress as the primary indication for palliative sedation, when palliative sedation is appropriate to the situation, intermittent sedation should be attempted first with planned downward titration after a pre-agreed interval.

25. Deeper palliative sedation should be considered when light sedation has been ineffective, or when it is clear that light sedation will not provide adequate relief in time or in an emergency situation (e. g. massive haemorrhage or asphyxia).

26. The option of continuous deep sedation should be considered when intermittent sedation or continuous light sedation have been insufficient to relieve suffering adequately.

...

32. For palliative sedation in the final stage of life, the goal of care is to ensure comfort until death and the only critical parameters for ongoing observation should be those pertaining to comfort.

...

37. Pharmacological and non-pharmacological measures that are either inconsistent with or irrelevant to the goal of patient comfort should be generally withdrawn."

IV. EVIDENCE FROM THE EXPERTS HEARD BY THE COURT

44. On 27 November 2023 the Court heard evidence from Professor Régis Aubry, who is a hospital-based doctor responsible for a palliative care unit at the Besançon Regional University Hospital and a member of the French National Ethics Advisory Committee. Professor Aubry was also a member of the group appointed to prepare a draft version of the Committee on Bioethics of the Council of Europe's guide on the decision-making process regarding medical treatment in end-of life situations (see paragraph 38 above). On the same day, the Court also heard evidence from Professor Judit Sándor, who is a professor at the Central European University in Vienna, a member of the Board of Governors of the World Association for Medical Law, and the director of the CEU Centre for Ethics and Law in Biomedicine in Budapest. Both experts replied to the questions posed by judges and representatives of both parties. The most relevant parts of their testimonies are summarised below.

A. Professor Régis Aubry

45. In describing the symptoms of and prognosis for ALS, Professor Aubry explained that this incurable disease typically progresses extremely quickly, with a gradual loss of physical faculties, often with full mental awareness on the part of the patient, whose cognitive capacities are likely to remain intact. Throughout the disease the patient requires palliative care and support, including analgesic treatments, occupational therapy, physiotherapy and social and psychological support. As the disease progresses the patient ultimately reaches the stage where he or she can no longer breath without assistance. In Professor Aubrey's opinion, an important dimension of palliative care was to

anticipate what was going to happen and how the patient would wish to respond to it, in particular whether he or she wished to refuse life-sustaining treatment (assisted artificial ventilation) in combination with deep and continuous sedation once he or she reached the stage of respiratory paralysis. This issue had to be discussed with the patient in advance, while of course allowing for any subsequent change in the patient's wishes.

46. Professor Aubry referred to the European Association for Palliative Care, whose recommendations on palliative sedation applied throughout Europe (see paragraph 43 above). Patients in France who were at a very advanced stage of the disease, with short-term life expectancy, were entitled to receive continued and deep sedation until death. Such sedation rendered the patient unconscious and placed him or her in a coma. It could be envisaged only for a period ranging from a few hours to a few days. It allowed the person to die tranquilly and did not mean actually bringing about death. While deep and continuous sedation might not be provided as a matter of a right in other countries, it was an option normally available to patients, and there was a duty – in medical terms – to ensure access to it. In reply to a question from the applicant's representative as to what would happen if an ALS patient refused deep sedation at that stage, Professor Aubry explained that this was a sort of apocalyptic scenario, in which the individual would suffocate while still conscious; a scenario which would in his view be inhumane. He also stated that none of his patients had expressed such a wish.

47. According to Professor Aubry, palliative sedation corresponded to a large extent to the wishes of patients who did not want to be assisted through artificial ventilation. Prior to that, palliative care and support for patients generally enabled them to transcend their suffering in some way and to find some meaning in being alive. However, there were, albeit rarely, situations when patients questioned the meaning of being kept sedated until they died or did not want to wait until the point when they could refuse treatments under deep sedation. Some ALS patients were faced with "existential suffering" and saw no meaning in their life. This suffering, which was quite characteristic of but not exclusive to ALS, was different from depression and physical suffering, and there were no medications to address it. The question of what meaning a patient could find in his or her life was not one that a doctor could decide. Those caring for the patient had to analyse this suffering, decode what might be amenable to treatment, and above all listen to the patient and support him or her; that was the duty of the medical profession, a duty of solidarity towards human suffering.

48. Asked to explain the essential concepts related to physician-assisted dying (hereinafter "PAD"), Professor Aubry clarified that PAD referred to the fact that a person's death was brought about by medical intervention. PAD covered the concepts of assisted suicide and euthanasia. Assisted suicide could take the form of medical assistance in suicide and medically assisted dying, where a fatal substance was prescribed following verification that the individual's situation came within a legally defined framework, but the individual himself or herself then took the substance. In the case of euthanasia, it was the physician who administered the fatal substance. The term passive euthanasia, which was tending to fall out of use, previously referred to the refusal or withdrawal of life-sustaining intervention (hereinafter "RWI"), ultimately leading to the patient's death.

49. With respect to PAD, Professor Aubry mentioned ethical tensions on the part of medical professionals, who were bound by the Hippocratic oath, and noted that these were particularly pronounced with regard to euthanasia, in which the caregivers assumed the role of active participants. Furthermore, in his opinion, PAD was associated with a risk of abuse in respect of persons who found themselves in a situation of great vulnerability. The main challenges in making decisions about PAD related to ascertaining fully the patient's desire to die, which had to be free from influences that were both internal (such as pain and discomfort) and external (such as pressure, the feeling of being a burden). There had to be a method, through a strict framework, for trying to decode what the source of the request for PAD might be and for considering how to address the core elements of such a request. This took time and a great deal of collective work. PAD could only be possible in a situation where vulnerable people felt valued and supported and where all other options – in particular, palliative care – had been exhausted. However, even when this was the case and patients were expressing a genuine wish to die, there was still the possibility that this wish could change. In the case of ALS, patients might express the desire to die at an early stage, while they could still communicate, from fear of not being able to express themselves later. However, as research had shown, there was often a certain degree of ambivalence, which grew as the disease progressed. What people wished at the beginning of the illness was not necessary the same as what they wished later. In this connection, Professor Aubry referred to data concerning the State of Oregon (United States), which was the most complete data available on the subject, due to annual reporting requirements. This showed that the incidence of assisted suicide had not increased following decriminalisation in 1997. Most interestingly, however, the data also showed that many of those who qualified for medically assisted suicide did not ultimately collect the life-ending drugs or did not take it. This, in Professor Aubry's interpretation, could be taken as ultimate evidence of ambivalence and hesitation on the part of people who had initially decided to have recourse to medically assisted suicide. In this respect, Professor Aubry referred to the difference with euthanasia, where the third party was convinced that the request corresponded to the patient's wish to die and the described patient's ambivalence could possibly not manifest itself.

50. Lastly, as regards safeguards against abuse, Professor Aubry stressed the need for transparency and for traceability of the arguments on which decisions concerning PAD were based. Furthermore, in his view, more research was needed on the experiences in those countries which had legalised PAD; at the moment, however, this was difficult in view of the limited data.

B. Professor Judit Sándor

51. Professor Sándor explained the background to the adoption in 1997 of the Healthcare Act in Hungary, which for the first time set out a list of patients' rights, including the right to information, to treatment (including pain relief), to refuse treatment (including, subject to certain conditions, life-sustaining interventions), to complain and make submissions to the Patients' Representative (*betegjogi képviselő*), and to make end-of-life decisions. It provided for respect for human dignity in the context of healthcare. There was, however, no provision addressing the situation of a terminally-ill patient who suffered greatly but could not terminate his or her life by way of RWI because, given the trajectory of the disease, he or she was not dependent on medical life support.

52. With regard to RWI, Professor Sándor explained that the procedure was complicated and that there was a shortcoming in that no register of end-of-life decisions (such as living wills) was kept. With regard to the palliative care available in Hungary, she noted that hospice care had been financed by the social-security system since 2005, but that there appeared to be insufficient capacity for all the patients who needed it.

53. Concerning criminal law, Professor Sándor confirmed that assisted suicide and euthanasia were both punishable under the 2012 Hungarian Criminal Code. Compared to similar laws in some countries, the criminal offence of assisted suicide was quite broad. It originated in the 1878 Criminal Code, which decriminalised suicide but criminalised the assistance for it. She pointed to the tension, observable also in other jurisdictions, whereby the laws on patients' rights had evolved in the 20th and 21st centuries, but the criminal laws on assisted suicide had remained unchanged.

54. Professor Sándor considered that the end of life had always been an important point in ethical discussion, touching as it did upon issues of self-determination, informed consent and the protection of vulnerable people and people with disabilities. While the primacy of human dignity was the starting point, approaches differed as to how it should be ensured. She pointed out that PAD ought not to be used as a "way out" for people in poverty or disenfranchisement. As a first step, palliative care should be improved, based on the relevant guidelines, which referred not only to physical but also psychological suffering, and to doctors' duties in this regard. Terminally ill patients who were left alone or to the care of their relatives were more likely to make radical decisions. While a terminally ill patient's wishes were to be respected, what constituted informed consent was a complex issue. There had to be a carefully developed procedure, advance planning and discussions of alternatives. However, such communications with patients required doctors' involvement, special skills, resources and time.

55. Different countries approached PAD through different avenues –legislative processes based on sociological and public surveys, or judicial intervention. There were doctors who had been actively involved in movements towards introducing PAD, but many doctors often found themselves in tension with their oath and their commitment to save lives. Transparency and honest input from the medical profession was important. Developments with regard to PAD were also influenced by cultural background, and its diversity was reflected in the European landscape of laws on end-of-life decisions. It seemed that the western and eastern parts of Europe had different attitudes to end-of-life decisions. There were societies where there was an open public discourse on this issue and there were those where this subject was still considered off-limits. It thus came as no surprise that the Oviedo Convention contained no provisions regarding PAD. However, the trend was that death was less and less taboo and people felt more empowered to make decisions about the final phase of their lives.

56. Professor Sándor emphasised the importance of the right to informed consent in bioethics. Consent was capable of transforming an illegal act into something legal. Patients could refuse care, but could not ask for something specific. She explained that the trend towards the recognition of end-of-life decisions sprung from this right, and initially resulted in a form of passive euthanasia. Issues then came to light regarding the distinction between patients who could end their suffering by RWI and those who were not dependent on active support. A similar

issue occurred with regard to the use of assisted suicide, which required that the final action be performed by the patient. Some patients at the advanced stages of their diseases were no longer able to perform the final action and could terminate their life only by way of euthanasia.

57. In Professor Sándor's opinion, the tendency which could be observed in Europe towards a broader acceptance of PAD had occurred in three stages. First, there was a chilling effect following the Second World War because of the Nazis' eugenic practices and euthanasia programmes. After 1980 a strong bioethics and patients' rights movement emerged, followed by legalisation of certain forms of PAD in the Benelux countries and the right to palliative sedation in France. The third wave came after the COVID-19 pandemic, when countries such as Portugal, Spain and, to a certain extent, Austria legalised PAD, sometimes through very detailed legislation. Whether this latest stage was in fact related to experience with the COVID-19 pandemic or represented a broader trend remained to be seen.

V. RELEVANT COMPARATIVE-LAW MATERIAL

A. Rules governing physician-assisted dying (PAD) and refusal or withdrawal of life-sustaining interventions (RWI)

58. The information available to the Court regarding the question of the legality of RWI and PAD includes a comparative-law survey covering forty-two member States of the Council of Europe, namely Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Cyprus, Estonia, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, North Macedonia, the Republic of Moldova, Monaco, Montenegro, the Netherlands, Norway, Poland, Portugal, Romania, Serbia, Spain, the Slovak Republic, Slovenia, Sweden, Switzerland, Türkiye, Ukraine, and the United Kingdom.

59. According to the information available to the Court, therapeutic withdrawal (discontinuation of life-sustaining treatment leading to natural death) is conditionally allowed in 27 member States.

60. Euthanasia and assisted suicide are lawful as forms of PAD in five member States: Belgium, Luxembourg, the Netherlands, and, more recently, Spain (PAD allowed since 2021) and Portugal (the law of 2023 has not yet entered into force, pending the adoption of the required regulations). PAD (including euthanasia) can be provided, under certain conditions, to emancipated minors or minors capable of understanding their actions in Belgium and Luxembourg. In seven member States (Austria, Finland, Germany, Italy, Lichtenstein, Sweden, and Switzerland) certain forms of assisted suicide are lawful, and are available in some of them as PAD, while euthanasia remains unlawful. This seems to be the case also in Scotland. In certain jurisdictions (for instance, Italy and Germany), where a certain form of assisted suicide has been decriminalised as a result of a court ruling (see paragraphs 71-76 and 77-79 below), legislation regulating a special procedure for the use of PAD has not so far been adopted. In other European jurisdictions, consultative processes with regard to PAD have been initiated, and there have been, or are at present, attempts to introduce legislation to allow PAD (for instance, France, and England and Wales).

61. PAD is criminally punishable in the majority of Council of Europe member States. The level of criminal sanctions in this respect varies greatly and depends on how this crime is defined in the

domestic law and on the mitigating/aggravating factors which may be applicable. In nearly every member State surveyed, criminal law appears to have, in principle, extraterritorial effect, in particular where the victim of the crime and/or the perpetrator are nationals of that State. However, in the absence of sufficient information it is not possible to determine whether assistance in suicide carried out abroad is commonly punishable in Europe.

62. As regards the United States, assisted suicide is legal in eleven jurisdictions (California, Colorado, Oregon, Washington, Vermont, New Jersey, New Mexico, Maine, Montana, Colorado, and Hawaii, as well as the District of Columbia). In recent years PAD has become legal and available in all Australian states and in New Zealand. In Canada, both euthanasia and assisted suicide were legalised following the Canadian Supreme Court's judgment in the case of *Carter v. Canada* (see paragraph 80 below).

63. In jurisdictions where PAD is legal, access to it is dependent on various substantive pre-conditions, such as decision-making capacity, voluntary and sustained/repeated requests over time and an eligible disease (for example, an incurable or terminal condition, maximum remaining life expectancy, and/or refractory suffering). The legislation often includes further restrictions, such as required minimum age and residency, and provide for procedural safeguards, aimed at preventing abuses or errors in the provision of PAD.

B. Selected case-law

1. England and Wales

64. On 29 November 2001 the House of Lords refused an appeal by Ms Pretty, a terminally ill woman with motor neurone disease who had unsuccessfully requested that the Director of Public Prosecutions give an undertaking not to prosecute her husband should he assist her to commit suicide in accordance with her wishes ([2001] UKHL 61). For details concerning the House of Lords' judgment, see *Pretty v. the United Kingdom*, no. 2346/02, § 14, ECHR 2002-III.

65. Several years later, the House of Lords was asked in *R (Purdy) v Director of Public Prosecutions* to decide whether the refusal by the Director of Public Prosecutions (hereinafter "DPP") to provide further guidance on the circumstances which would give rise to prosecution of aiding and abetting suicide complied with Article 8 of the Convention. The appellant in that case suffered from an incurable disease and wanted to travel to a country such as Switzerland where assisted suicide was lawful, should her continued existence become unbearable. She approached the DPP to request clarification in advance as to whether her husband would face prosecution if he assisted her to travel. The DPP refused to clarify the position. The House of Lords in its judgment of 30 July 2009 ([2009] UKHL 45) found that the Code for Crown Prosecutors was not sufficiently precise and accessible to allow individuals to understand and foresee whether or not they would be prosecuted for assisting a suicide and was therefore not compliant with Article 8 of the Convention.

66. Following the House of Lords' judgment, the Crown Prosecution Service's Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide was issued in February 2010 and updated in October 2014. It explains the factors which favour or mitigate against prosecution. Among the public-interest factors which mitigate against prosecution are the fact that the victim

had reached a voluntary, clear, settled and informed decision to commit suicide; that the suspect was wholly motivated by compassion; and that the actions of the suspect could be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide. Similar but separate guidance was issued with respect to "mercy killings", and has been regularly updated.

67. In the meantime, on 25 June 2014, the Supreme Court addressed appeals concerning claims related to assisting suicide by Mr Nicklinson, Mr Lamb, and a person known for the purpose of the proceedings as Martin (judgment [2014] UKSC 38). As regards the appeals brought by Mr Nicklinson and Mr Lamb, see *Nicklinson and Lamb v. the United Kingdom* ((dec.), nos. 2478/15 and 1787/15, 23 June 2015). Martin argued that there should be clearer guidance in the policy published by the DPP with regard to prosecuting those from whom he wished to obtain advice and assistance in connection with killing himself. The Supreme Court found that it was one thing for the court to order the DPP to provide a policy, but quite another for the court to dictate what should be in that policy. The exercise of judgment by the DPP, the variety of relevant factors, and the need to vary the weight to be attached to them according to the circumstances of each individual case were all proper and constitutionally necessary features of the system of prosecution in the public interest.

68. On 27 November 2018, in *Noel Conway v Secretary of State for Justice* ([2018] UKSC B1), the Supreme Court Appeal Panel (hereinafter "the Panel") considered an application for permission to appeal in relation to the assisted suicide ban. It refused permission to appeal to the appellant, who suffered from motor neurone disease and wanted to die with assistance. Whilst he had a right at common law to refuse consent to continue his non-invasive ventilation (hereinafter "NIV"), which was likely to have led to his death within a few minutes once he became dependent on NIV, he did not accept that the withdrawal of his NIV under heavy sedation would be a dignified death. He instead wanted a medical professional to prescribe him medication so that he could die at a time of his choosing. The Panel gave reasons, acknowledging that the case raised arguable points of law, and that the ban on assisting suicide was an interference with Article 8. It referred to the difference between letting someone die and taking active steps to bring about their death as being central to the common law for centuries. It further noted as follows:

> "... several justifications have been put forward to support a hard and fast rule – the protection of weak and vulnerable people from insidious pressures, respect for the sanctity of all human life, and the preservation of trust and confidence in the medical profession. The European Court has held, in *Nicklinson v United Kingdom* (2015) 61 EHRR 97, that whether an interference such as this is justified is for each Member State to decide. There is no European consensus on the matter."

69. The Panel went on to state as follows:

> "Under the United Kingdom's constitutional arrangements, only Parliament could change this law. But the Supreme Court could, if it thought right, make a declaration that the law was incompatible with the Convention rights, leaving it to Parliament to decide what, if anything, to do about it. The questions for the court would therefore be twofold: (1) Is the hard and fast rule banning all assistance to commit suicide a justified interference with the Convention rights

of those who wish for such assistance? (2) If it is not, should this court make a declaration to that effect? In particular, is it appropriate to make such a declaration in this case? These are questions upon which the considered opinions of conscientious judges may legitimately differ. Indeed, they differ amongst the members of this panel."

70. As a result of the above and noting some reluctance on the part of the Panel, it was concluded that the prospects of the case were not sufficient to justify granting permission to appeal.

2. Germany

71. Following the Court's judgment in *Koch v. Germany* (no. 497/09, 9 July 2012), the Federal Administrative Court, by way of an action for retrial of the case, considered the merits of the appeal on points of law lodged by Mr Koch, whose wife (referred to as Ms K.) had been denied authorisation to acquire a lethal dose of sodium pentobarbital to commit suicide by the Federal Institute of Drugs and Medical Device (hereinafter "the Federal Institute"). In its judgment of 2 March 2017 (BVerwG 3 C 19.15), the Federal Administrative Court partly upheld Mr Koch's appeal. It considered that the purpose of preventing abuses and protecting vulnerable persons from decisions taken hastily or without full mental capacity no longer justified the prohibition, with no exceptions, on acquiring sodium pentobarbital in order to commit suicide, if the acquirer was in a situation of extreme distress due to a severe and incurable disease. According to the Federal Administrative Court, such an exception had to be made if "– firstly – the severe and incurable disease [was] connected with grave physical suffering, in particular severe pain, which result[ed] in unbearable psychological strain for the affected person and could not be reduced sufficiently ...; – secondly – the affected person [was] able to take decisions and [had] made the free and earnest choice to end his or her life; and if he or she – thirdly – [did] not have any other reasonable option to carry out the wish to die". It further held as follows:

"34. Closer examination is required of the other possibility of giving effect to the wish to die in a reasonable manner. A possibility such as this can usually be assumed to exist if the affected person can end his or her life by abandoning life-sustaining or life-prolonging treatments whilst being provided with palliative care, for instance by switching off the ventilator or by terminating artificial nutrition. ... However, the ending of treatment only constitutes another reasonable possibility of giving effect to the wish to die if it is anticipated that this action will result in death in the foreseeable future, that is, if it does not merely lead to a further deterioration in health for an indefinite period of time, possibly combined with a loss of the ability to take decisions. ...

35. Physician-assisted suicide was not an option at the relevant time, nor is it currently.

...

37. ... The term "required medical care" in section 5 (1) no. 6 of the [Narcotic Drugs Act] means the use of narcotic drugs for therapeutic purposes. In a situation of extreme distress as described here, the use of a narcotic drug in order to commit suicide may in exceptional cases be considered to serve therapeutic purposes; [where] it is the only possibility of ending a situation of suffering caused by a disease which is unbearable for the affected person. ...

...

42. ... Based on the above, the refusal by the Federal Institute of 16 December 2004, in the form of the objection notice of 3 March 2005, was unlawful. The Federal Institute would have been obliged to examine whether Ms K. was in a situation of extreme distress that would have required it to grant the requested licence. This was within the realms of possibility in this case. Due to her advanced, almost complete paraplegia, Ms K. suffered from extremely severe physical impairments, which were irreversible, required constant medical assistance and care, and were associated with severe pain. In her application, she explained in detail that and why she experienced her condition as an unbearable situation of suffering. Based on her explanations, it was effectively not in doubt that she had autonomously and earnestly decided to wish to end her life. Under these circumstances, the Federal Institute was not entitled to refuse the requested licence without examining whether Ms K. had another reasonable possibility of giving effect to her wish to die. The Federal Institute could not assume this to be the case merely because Ms K. needed artificial ventilation. Although this led to the possibility that terminating the treatment, with medical palliative care, may have been an option, it was not clear whether switching off the ventilator would in her case have led to death in the foreseeable future..."

72. In its judgment of 26 February 2020 (2 BvR 2347/15 and others), the German Federal Constitutional Court held that the prohibition of professional assistance in suicide (Article 217 of the Criminal Code) violated the general right of personality, which encompassed the right to a self-determined death. It found that this right was not limited to the right to refuse, of one's own free will, life-sustaining treatments. It also concerned cases where individuals decided to actively take their own life, and this was irrespective of whether they were seriously or terminally ill. Furthermore, it also encompassed the freedom to seek and, if offered, utilise assistance provided by third parties for this purpose.

73. The Federal Constitutional Court found that Article 217 of the Criminal Code amounted to an interference with fundamental rights in relation to persons wishing to commit suicide. The interference was particularly serious and had to be measured against the standard of strict proportionality. The Federal Constitutional Court went on to find that the prohibition in question pursued the legitimate aim of protecting autonomy and life from, *inter alia*, risks related to a normalisation of suicide and social expectations which would pressurise individuals, especially elderly and ill persons, into taking their own life. Referring to domestic and foreign research, it noted that a frequent motive for seeking assistance in suicide was the desire not to burden relatives or third parties.

74. The Federal Constitutional Court observed that although Article 217 was limited to professional assisted-suicide services, that is, a specific form of suicide assistance, the fact remained that in many situations individuals would be left with no actual and reliable options to act upon a decision to commit suicide if assisted-suicide services were not available. It noted in this connection that in the absence of such services, individuals were largely dependent on the willingness of doctors to provide assistance, at least in the form of prescribing the substances necessary to commit suicide. However, the laws and codes governing the medical profession provided for prohibitions on assisted suicide in many regions of Germany and they largely excluded any real prospect of such assistance being rendered to the individual in need of it. Moreover, while improvements in palliative

care might help to reduce the number of cases where terminally ill patients wished to die, they could not compensate for the impugned restriction in cases where the decision to commit suicide was taken in pursuit of free self-determination. The Federal Constitutional Court also found that the State could not simply refer the individual to the option of using assisted suicide offered abroad, as fundamental rights should be ensured with the domestic legal order.

75. The Federal Constitutional Court found that the prohibition on professional assisted suicide services reduced the possibilities for assisted suicide to such an extent that there was *de facto* no scope for the individual to exercise their constitutionally protected freedom. This, in the Federal Constitutional Court's view, could not be justified by the protection of others. In the reasons supporting its decision, the Federal Constitutional Court also referred to the Court's case-law, especially to *Pretty*, cited above, and *Haas v. Switzerland* (no. 31322/07, ECHR 2011).

76. On 7 November 2023 the Federal Administrative Court upheld the lower court's finding that the Federal Institute was currently under no obligation to exceptionally authorise the acquisition of sodium pentobarbital for the purpose of committing suicide (judgment 3 C 8.22). It noted, *inter alia*, that the codes of medical ethics now allowed doctors to provide assistance in suicide, and some – albeit a few – doctors were willing to do so. Professional suicide services could be used to establish contact with such doctors, who were able to prescribe drugs other than sodium pentobarbital (for example, an orally administered combination of several drugs, or an injection of thiopental). While these options entailed several disadvantages and hurdles compared to the self-administered use of sodium pentobarbital, these constraints were considered proportionate and justified, taking into account the high risks involved in the distribution of sodium pentobarbital (such as misuse or abuse, including with regard to vulnerable persons).

3. Italy

77. In judgment no. 242 of 25 September 2019, the Italian Constitutional Court declared Article 580 of the Criminal Code, which provides for the criminal offence of inciting or assisting a person to commit suicide, unconstitutional, in so far as it did not exclude criminal liability for persons who facilitated the fulfilment of the free and informed intent to commit suicide of a person "who [was] being kept alive by life-sustaining treatments and [was] suffering from an irreversible condition that [was] a source of intolerable physical or mental suffering but who [was] fully capable of taking free and informed decisions, provided that those conditions and the procedures for implementation have been verified by a public entity within the national health service, following an opinion by the ethics committee with geographical jurisdiction".

78. The Constitutional Court acknowledged that the criminalisation of assisting suicide was not, in itself, contrary to the Constitution, in that it was intended to protect the right to life, especially of the most vulnerable persons, from external interference. Nevertheless, it considered that with regard to the situation before it (concerning certain patients who were dependent on life-sustaining treatment) such criminalisation was not compliant with the Constitution. It noted that the patients in question could already decide to allow death to take its natural course by requesting the interruption of life-sustaining treatment (including artificial hydration and nutrition) under continuous heavy sedation. However, this might be a slower process, which

would also prolong the anguish of those close to them. Moreover, the Constitutional Court noted that, while the primary importance of the value of life did not rule out a duty to respect patients' decision to die by means of withdrawing treatments – even when this required an action by third parties (that is, by removing or turning off devices, and administering heavy and constant sedation and pain medication) – there was no reason for the same value to become an absolute obstacle, reinforced by criminal liability, to granting a patient's request for assistance in suicide, and thereby avoiding the slower decline resulting from the withdrawal of life-support devices. In the Constitutional Court's view, the criminal prohibition in question unreasonably restricted patients' freedom of self-determination with regard to the choice of treatments, including those designed to relieve suffering.

79. The Constitutional Court also held that merely decriminalising assisted suicide would open the way to various and serious risks, leaving the most vulnerable unprotected. Therefore, given the lack of action on the part of the legislature, and relying largely on the Law on Advanced Medical Directives, it set out the procedural requirements that had to be met for the exemption from punishment to apply.

4. Canada

80. In *Carter v. Canada (Attorney General)* (2016 SCC 4, [2016] 1 S.C.R. 13), the leading plaintiff was a woman diagnosed with ALS. The Canadian Supreme Court found that the legislative landscape on the issue of PAD had changed in the two decades since *Rodriguez v. British Columbia (Attorney General)* ([1993] 3 S.C.R. 519, see *Pretty*, cited above, § 66), referring to increasing recognition of PAD in foreign jurisdictions. It noted that these regimes had produced a body of evidence about the practical and legal workings of PAD and the efficacy of safeguards for the vulnerable. It framed the target of prohibition of PAD as "the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness." Having regard to the severe impact of the prohibition on affected individuals, the majority opinion of the Supreme Court concluded that the prohibition on PAD was overly broad and failed to be minimally impairing. In its view "the blanket prohibition sweeps conduct into its ambit that is unrelated to the law's objective." In this connection, it addressed the State's argument that the blanket prohibition was necessary in that there was no reliable way to identify those who were vulnerable and those who were not. It endorsed the trial judge's reasoning, which referred to the assessment processes in comparable end-of-life medical decision-making, in which concerns about decision-making capacity and vulnerability likewise arose. In the trial judge's view "[l]ogically speaking, there is no reason to think that the injured, ill, and disabled who have the option to refuse or to request withdrawal of life-saving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying." Therefore, it was concluded that the risks that the State described were already part of the existing medical system.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

81. The applicant complained about the fact that it was not possible for him, under Hungarian law, to end his life with assistance, in breach of his right to private life, enshrined in Article 8 of the Convention, which reads as follows:

"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. 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 the 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 the rights and freedoms of others."

A. Terminology used

82. The Court notes that the terms used to refer to assisted dying practices vary from country to country. For the purposes of this judgment, the Court will refer to the definition provided by Professor Aubry (see paragraph 48 above). Accordingly, "PAD" refers to physician-assisted dying, which covers assisted suicide and voluntary euthanasia, when such acts are performed in a regulated and medically supported setting. "RWI" refers to the refusal (by the patient) or withdrawal (at the patient's request) of life-sustaining or life-saving interventions, such as respiratory support, which ultimately lead to the affected patient's death.

B. Admissibility

83. The Government disputed that there was a right to self-determined death under the Convention, arguing that the cases referred to by the applicant, such as *Haas v. Switzerland* (no. 31322/07, ECHR 2011) and *Mortier v. Belgium* (no. 78017/17, 4 October 2022), concerned jurisdictions where the right to assisted dying was recognised under the domestic law. In those cases, the interference had concerned the questions of the foreseeability of the law and procedural guarantees. The Government further argued that Article 8 did not apply to the present case, because the question of the prosecution of third parties who might wish to assist the applicant did not touch upon the applicant's own interest. They disputed that an individual's claim, intended to secure the right for others to participate in ending that individual's life, could be an aspect of his or her "private life". They further wondered "how a decision requiring action (let alone criminal conduct) by others and not by oneself [could] be regarded as within one's personal autonomy".

84. The applicant argued that Article 8 applied to his case. Given the stage to which his disease had progressed, he was physically unable to take his own life, that is, to commit suicide, without assistance from others; the latter assistance was therefore a precondition for him to exercise his right to a self-determined death. He could have taken his own life unaided only in the early stage of his disease, but that would have meant dying prematurely, contrary to his wishes.

85. The Court considers that the applicant's interest in having access to PAD relates to core aspects of his right to respect for his private life enshrined in Article 8 of the Convention. It concerns respect for his autonomy, physical and mental integrity and for human dignity, which

is the very essence of the Convention (compare *Pretty v. the United Kingdom*, no. 2346/02, §§ 61 and 65, ECHR 2002-III; *Haas*, cited above, § 51; *Koch v. Germany*, no. 497/09, § 52, 19 July 2012; and *Mortier*, cited above, §§ 124 and 135).

86. The Court furthermore notes that it has not been disputed that, due to his physical incapacity, the applicant could end his life only with aid from other persons who would be willing to assist him. The Hungarian criminal law which prohibits those persons from freely assisting the applicant in committing suicide therefore restricts the applicant's enjoyment of his right to a self-determined death. The Court further notes that the existence of criminal liability for assisting in suicide has also been considered to be an issue affecting the rights of the persons wishing to commit suicide by the highest courts in certain national jurisdictions, including the Hungarian Constitutional Court (see paragraphs 27, 29-31, 64-68, 72-75, 78 and 80 above). Therefore, and having regard to the approach in *Pretty* (cited above), the Court sees no reason to dismiss the applicant's complaint on the ground raised by the Government that the impugned criminal law provisions apply to those who would seek to assist him in suicide, rather than to him directly (see paragraph 83 above). This conclusion is in line with the long-held principle that "[t]he Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective" (see *Airey v. Ireland*, 9 October 1979, § 24, Series A no. 32).

87. The Court therefore considers that the present complaint falls to be examined as concerning an aspect of the applicant's right to respect for his private life within the meaning of Article 8. As regards the question whether this Article goes so far as to require the respondent State to allow or provide the applicant a certain form of PAD, this is a matter which can be resolved only through an examination on the merits, with due regard to the conflicting considerations and the State's margin of appreciation.

88. Having regard to the foregoing the Court finds that the complaint is compatible *ratione materiae* with the Convention. Noting that it is not inadmissible on any other grounds listed in Article 35 of the Convention, the Court declares it admissible.

C. Merits

1. *The applicant's arguments*

89. The applicant argued that although he had full decision-making capacity, the regulatory framework in Hungary did not allow him to hasten his inevitably approaching death and thereby to shorten the unbearable suffering related to his incurable disease. He agreed with the submissions from the HCLU regarding the state of hospice-palliative care in Hungary (see paragraph 118 below), but disputed the Government's arguments and most of the arguments put forward by the Italian Government, the ECLJ, the ADF and the CNK (see paragraphs 114-116 below). In his view, the existence of the right to a self-determined death could not be contested. His case concerned only the question of the scope of this right, which was to be determined taking account of social changes and the particular circumstances of his case. He submitted that his case ought to be distinguished from that of *Pretty* (cited above), because (i) it also concerned the extraterritorial effect of the Hungarian ban on assisted suicide; (ii) prosecution of the offence of assisted suicide was mandatory; and (iii) the legal and social context in Europe had changed since the Court had adopted the judgment in *Pretty*,

and a trend had emerged towards legalisation of PAD. He submitted detailed arguments in support of his position, which can be summarised in the following manner.

(a) Nature of his condition and inadequacy of options currently available in Hungary to respond to them

90. The applicant argued that, given the nature and course of his disease, recourse to palliative care and the possibility of RWI (see paragraph 82 above) would leave him to endure intolerable suffering. As his disease progressed, he would become locked inside his body while being fully conscious over a prolonged period, thus awaiting death without any meaningful existence. The experience of existential dread resulting from this state could not be avoided or shortened to any significant degree by RWI.

91. In this connection he argued that an ALS patient would need life-sustaining interventions only at the very end stage of his disease, or would not need them at all. Furthermore, while palliative care could provide relief with respect to certain aspects of his physical suffering, it could not provide relief from the experience of existential dread. In this respect, he submitted that he would not want to be sedated, as this would deprive him of the only remaining part of his autonomy, namely his ability "to be in control of his own fate". In his submission, Hungarian law disregarded the area of quality of life as one aspect of end-of-life decision making and forced people to stay alive, even when that was unbearable.

92. In his pleadings submitted after the public hearing, the applicant clarified that if he wished to shorten his life, only two options were available to him: either to use PAD, or to discontinue life-sustaining treatment and then starve to death or suffocate.

(b) Criminal ban on PAD

93. The applicant submitted that he wished to have the option of dying by PAD in Hungary, referring to this as the ideal solution, reflecting his attachment to his home country. If that wish could not be met, he would at least want to be able to travel abroad for that purpose. However, leaving aside the financial implications, this option was not available to him because anyone assisting him in ending his life in Hungary, or outside that country, could face criminal charges in Hungary. He would not want to die knowing that doctors, friends or his family would risk prosecution in Hungary. He disputed the assertion that there was some discretion involved in the decision to prosecute assistance in suicide, which in his view distinguished his case from that of *Pretty* (cited above). The authorities were required to initiate criminal proceedings *ex officio* and there was a real risk that they would do so in his case, especially in view of the media interest generated by it. Referring to official statistics which showed that 483 offences allegedly committed abroad had been prosecuted by the Hungarian authorities in the period from January to October 2023, he submitted that prosecution of such crimes was not uncommon. Moreover, in the last ten years sixteen cases concerning assisted suicide had been registered in the official criminal statistics, with the criminal acts in question having been carried out, at least in part, in Hungary. However, no detailed criminal statistics concerning prosecutions of cases related to end-of-life decisions were available. In his view, the domestic legal framework which made it impossible for him to avail himself of PAD, either in Hungary or abroad, was unjustified.

94. The applicant also maintained that his case was not about the general right to PAD as an expression of self-determination and autonomy, but rather about the rights of terminally ill patients who wished to accelerate the inescapable trajectory of their disease, which exposed them to unbearable suffering. In the applicant's view, the Court was not called upon to impose any new positive obligation on the State in this regard, because he was asking only for a narrow exception to the absolute criminal ban on assisting suicide. However, he submitted that the right to a self-determined and dignified death imposed a positive obligation on the State to create a real and effective possibility for the exercise of this right. He further maintained that any form of assisted suicide would need to be regulated and the provision of PAD would require an appropriate legal framework and robust safeguards against abuse. He also acknowledged that a considerable margin of appreciation could be left to the member States in this respect. However, he believed that the lack of any possibility for him to decide to end his life, on his own terms, was disproportionate. In particular, in his view, an appropriate framework could be worked out. In fact RWI, which was allowed in Hungary, was already accompanied by safeguards, which were equally relevant to patients' decisions on PAD. The aim of preventing the misuse and abuse of PAD could therefore be achieved by means less restrictive than a blanket ban. The applicant also argued that the Government had provided no data in support of their allegations about the purported risks related to PAD, although it had been available for decades in other European countries.

95. The applicant disputed the Government's arguments concerning the relevance of "ableism" to the present case (see paragraph 103 below). He disapproved of imposing an external view about a person's quality of life and argued that the right for an incurably ill person to make an autonomous decision for himself or herself was to be respected. The concerns related to "ableism" would not arise if the relevant legislation contained certain objective criteria, such as the terminal stage of the disease, and safeguards to ensure that the decision was based on what the person himself or herself considered to be unbearable suffering. The applicant maintained that his decision to die ought to be respected, even if he were physically unable to enforce it, and argued that the Government's refusal to allow him to die was in fact rooted in ableism.

(c) Development of the Court's case-law and alleged international trend in support of PAD

96. The applicant pointed out that over twenty years had passed since the judgment in *Pretty* (cited above). Referring to the judgments in *Haas* and *Mortier* (both cited above), the applicant argued that the case-law of the Court had evolved, as had the legislation in many member States, which increasingly recognised the right to make end-of-life decisions. Referring to recent judgments in Italy, Germany, Austria and Canada, and to the legislation in the countries where assisting suicide had been decriminalised through a legislative process, the applicant argued that there was an emerging consensus in the Euro-Atlantic legal space on the disproportionate nature of the absolute ban on all forms of assisted suicide with respect to terminally ill patients who were fully mentally competent but unable to terminate their life without help. In his submission, the European consensus was reflected also in the attitude and acceptance of PAD by the general population and the medical profession. The applicant referred to the results of several opinion polls on the extent of public acceptance of PAD in Hungary.

(d) The alleged lack of legislative review of the possibility of decriminalisation of PAD

97. The applicant argued that the respondent State had failed to take his claim to a self-determined death seriously. Assistance in suicide had been forbidden by criminal law since 1878 and the Hungarian Parliament had included the prohibition, with identical wording, in each Criminal Code adopted since then. The legislation banning assistance in suicide in absolute terms had not been accompanied by any explanation as to its necessity. It was not subject to any impact assessment or mentioned in parliamentary debates or in any of the written materials produced by the committees or the plenary of the Hungarian Parliament. The applicant also argued that recent studies showed an increase in acceptance of euthanasia by the Hungarian population.

2. The Government's arguments

98. The Government were of the opinion that the present case did not call for a change of the Court's position as expressed in *Pretty* (cited above). They disputed the applicant's assertions and put forward the following arguments.

(a) Alleged limitations imposed by Articles 2 and 17 of the Convention

99. In the Government's view, there could be no positive obligation on the State to provide a lawful opportunity for any form of assisted dying. In this connection, they referred to the text of Article 2 of the Convention, in particular to the reference therein to "intentional" deprivation of life and to the exhaustive list of exceptions, which did not include PAD. They pointed out that Article 6 of the International Covenant on Civil and Political Rights – in contrast to Article 2 of the Convention – prohibited "arbitrary" deprivation of life. They argued that the judgment in *Mortier* (cited above) did not take account of the foregoing, nor of the positive obligations under Article 2 which stemmed from the Court's case-law. In their submission, the more the State, by regulating this field, was involved in PAD, the more likely the deprivation of life would be contrary to the negative obligations under Article 2. In their opinion, PAD could only be legalised by adding or amending a protocol to the Convention.

100. The Government further submitted that if the State's margin of appreciation could "extend [to] a derogation from the Convention" it should also extend to "respecting the right to life". In their submission, the Court ought not to "make derogations from Article 2 compulsory for the High Contracting States". The concept of individual autonomy could not provide a basis for PAD as this concept excluded the right to be killed, given the non-destruction clause in Article 17 of the Convention.

(b) Protection of the life of vulnerable persons and related ethical dilemmas

101. The Government referred to the judgment in *Pretty* (cited above) and submitted that there were clear risks of abuse in the provision of PAD. Moreover, they referred to the "slippery slope" argument and in this respect maintained that once PAD was allowed it would become difficult to restrict its use because of claims to equal treatment from persons in arguably analogous situations. They suggested that there was inconsistency in allowing PAD in the name of personal freedom and then limiting it only to terminally ill or physically disabled people.

Furthermore, the legalisation of PAD would require that eligible patients were informed of this option, which in turn might represent a form of pressure on persons who did not have religious objections to suicide, pushing them to end their life for practical purposes, such as avoiding the costs related to their care.

102. The Government also pointed out the irreversibility of PAD and submitted that the wishes of terminally ill people changed during palliative care as they learned how to cope with the difficulties that arose. An initial wish to use PAD could not reflect the change of attitude which would develop through this coping process.

103. The Government made extensive submissions, especially at the public hearing, on the relationship between "ableism", as discrimination against people with disabilities, and PAD. They argued that PAD, which was envisaged as being available to terminally ill or disabled persons as opposed to healthy individuals, was linked to assumptions about quality of life which were grounded in ableism and was thus in violation of Article 10 of the United Nation Convention on the Rights of Persons with Disabilities. These assumptions were related to the idea that the sick and disabled were a burden on society and that their lives carried less value. In the Government's opinion, the mere perception that it was reasonable for a patient to end his or her life through PAD was rooted in ableism.

104. The Government, referring to certain studies concerning jurisdictions which had legalised PAD, submitted that the relaxation of laws on PAD had a disproportionate effect on vulnerable groups. PAD was not an isolated act of individual autonomy but had far-reaching societal implications. The Hungarian ban on assisting suicide was intended to protect terminally ill and disabled people, who were vulnerable to real or perceived social perceptions and expectations, to their own feelings of dependency, uselessness and hopelessness, and who therefore required special protection regardless of their mental capacities. Hungarian society did not encourage the sick to seek death but sought instead to provide them with care and support.

(c) RWI and palliative care

105. The Government disputed the idea that PAD was the only way to die with dignity. They referred to the relief which could be provided to terminally ill patients by palliative care and to the possibilities of RWI. The latter option most commonly entailed a refusal of enteral feeding, parenteral nutrition and respiratory support. Refusal of such intervention could shorten the course of the illness, and the related suffering had to be alleviated or eliminated by all possible means, such as sedation or deep sedation. Suffering caused by breathlessness could be alleviated by using opiate derivatives, narcotics and analgesics. The Government maintained that the decisions on treatment, in contrast to PAD, could be revoked at any time, and argued that RWI was not meant to be a decision to end one's life but a decision to refuse futile treatment; it could not be considered as a form of euthanasia or assisted suicide.

106. The Government also explained that continuous deep sedation was not a legal term in Hungarian law and did not have a uniform definition. However, they considered it to refer to the final stage of palliative sedation, in which sense it fell within the patient's right to healthcare, which included alleviation of pain and palliative care (sections 6 and 99 of the Healthcare Act, see paragraphs 19, 23 and 24 above). Continuous deep sedation could be used when it was medically

justified. Any dispute in this connection could be resolved by changing the attending physician or by contacting the Patients' Representative and, if that were unsuccessful, resorting to litigation in court. The Government also maintained that continuous deep sedation was restricted to the terminal stage of the patient's life, when no other means of symptom control were available, and could not be applied over a prolonged period.

(d) Margin of appreciation

107. The Government were of the view that the prohibition on assisted suicide was generally consistent with the Convention. The number of States which had legalised any form of PAD had not increased significantly, and remained only a small fraction of the forty-six member States of the Council of Europe. Therefore, it could not be said that there was a European consensus on the matter. The States should enjoy a wide margin of appreciation in regulating this field and in choosing to protect the right to life of vulnerable persons, instead of facilitating the ending of their life.

108. The Government also argued that the national authorities were in a better position to evaluate their population's most fundamental collective moral and social values, and to decide whether it was necessary (and by what means) to protect the vulnerable from overt or covert pressure to kill themselves.

109. The Government also submitted that public opinion could not be a source of international law. With regard to the opinion polls referred to by the applicant, they submitted that the data did not suggest that there was sufficient support for PAD, and that in any event the data was not based on informed opinion which would consider the risks and consequences of such legislation, and perhaps reflected only the compassion of members of the public towards the affected patients.

(e) Criminal ban and its limitations

110. The Government argued that the passive personality principle did not have particular relevance in this case, as even in its absence, any persons helping the applicant to leave the territory of Hungary for the purposes of seeking PAD abroad, or Hungarian citizens assisting him in this respect abroad, would be liable to prosecution. The present case could not therefore be contrasted with *Pretty* (cited above).

111. As regards the criminal liability – under the passive personality jurisdiction – of foreign medical personnel assisting a Hungarian citizen in a country that allowed PAD, the Government submitted that the authorities of that country would in any case not be willing to cooperate with a prosecution. Such persons would not therefore be effectively threatened by prosecution in Hungary, even if preliminary proceedings were instituted in Hungary *ex officio*. In this connection, the Government also referred to the submissions by the third party Dignitas (see paragraphs 119-121 below) and noted that they did not indicate any such threat. Moreover, in reply to a question posed at the hearing, the Government also explained that if foreign citizens who had assisted a Hungarian citizen with PAD entered the territory of Hungary, they could invoke the fact that the action was lawful in their country. Under the applicable provisions of the Criminal Code, an issue would arise as to whether they were aware of the circumstances that

made their act a crime. The Government accordingly argued that the Hungarian criminal law did not prevent Hungarian citizens from availing themselves of PAD abroad (if those services were available to foreign nationals and foreign residents, which was a choice made by the host country) as long as they were able to access those services without assistance from Hungarian citizens or other persons inside the territory of Hungary. The Government also submitted that the applicant had not claimed that he was prevented from seeking PAD abroad while he was still able to travel without assistance.

112. The Government further argued that notwithstanding the above considerations, removal of the passive personality jurisdiction would strip Hungarian citizens of the protection of criminal law, including its preventive effect, in all circumstances. It was not reasonable for the State to encourage actions abroad which were deemed to be contrary to public order in Hungary. Furthermore, an option to travel would extend only to those who could afford the related costs, and would thus have a discriminatory effect on those who were financially worse off.

113. Lastly, the Government argued that any prior authorisation by their authorities for PAD to be performed abroad would be contrary to the requirements of Article 2 of the Convention. However, in their submission, there was sufficient flexibility in the prosecution and punishment of such crimes to allow for consideration of the motivation of the perpetrator, the suffering and wishes of the victim and the danger to society posed by the offence. Referring also to the 2003 decision by the Constitutional Court (see paragraphs 26-34 above) the Government argued that there was room for the sentence to be mitigated, and reduced to below the statutory minimum level if the circumstances so justified.

3. Third parties' submissions

(a) Italian Government

114. The Italian Government submitted that Article 8 enshrined a right to self-determination in therapeutic choices, including end-of-life choices, such as passive euthanasia. However, it did not include a right to PAD or a right to die, as this could conflict with the obligation to protect life under Article 2 of the Convention. In their view, the Court's case-law indicated that Article 8 gave rise only to a procedural protection attached to PAD. They moreover argued that the member States could not be required to adopt a "purely subjective concept of human dignity".

(b) European Centre for Law and Justice (ECLJ)

115. The ECLJ submitted that the Convention allowed for the refusal of disproportionate treatment but did not give rise to a right to PAD. In its view, the procedural protection under Article 8 extended only to situations where there was a material right to PAD under the domestic law. They also submitted that the Court had explicitly contradicted Article 2 of the Convention by allowing the use of euthanasia in *Mortier* (cited above).

(c) Alliance Defending Freedom (ADF) International and Care not Killing (CNK) Alliance

116. ADF International and the CNK Alliance argued that the Convention did not confer, nor support, a right to die. In particular, in their view, Article 2 was a *lex specialis* and therefore Articles

8 and 9 of the Convention could not be used to create a right which would be diametrically opposed to Article 2. They argued that the latter provision entailed a primary duty on the State to put in place a framework designed to provide effective deterrence against threats to the right to life. There were inherent risks of abuse in any system legalising PAD. In their submission, the normalisation of suicide or euthanasia could lead to a medical culture wherein PAD became a first-line response to intractable health, social and economic issues.

(d) Hungarian Civil Liberties Union (HCLU)

117. The HCLU argued that an incurably ill patient should be able to use PAD, provided that such decision was reached on the basis of careful consideration and that the law on PAD incorporated safeguards against potential abuse. It argued that the Hungarian Government had not evaluated whether the aim of protecting vulnerable people could be achieved through less restrictive means. With regard to the issue of ableism, they pointed out that a decision to use PAD reflected personal choices. The HCLU referred to a study conducted in the Netherlands and published in 2023 which showed that younger and more educated patients affected with ALS were more likely to use PAD, regardless of their satisfaction with palliative care. The HCLU further referred to the results of an online nationwide survey conducted in Hungary in 2023, involving 923 respondents aged 16-59, which indicated that the majority of respondents supported euthanasia under "specific conditions".

118. The HCLU criticised the operation and transparency of the existing system of end-of-of life decisions in Hungary, noting that information on advance directives taken by patients was scarce and that no records concerning decisions on RWI were kept by hospitals and ambulance services. They argued that several examples suggested that it was ultimately the medical staff who were making end-of-life decisions. Furthermore, the HCLU argued that palliative care in Hungary was in many aspects deficient, on account of insufficient resources, staffing shortages and regional disparities.

(e) Dignitas

119. Dignitas argued that the criminal ban on assisted suicide in Hungary was not an appropriate method for preventing suicide and suicide attempts. Individuals who suffered severely but did not have access to PAD were at risk of resorting to unguided self-made suicide attempts, which often failed, with negative consequence for the individuals as well as for their loved ones. In Dignitas's opinion, it was not acceptable to "force" individuals with mental capacity into remaining imprisoned in a state of suffering which they found inhumane and which they would have ended if they were able to do so through safe, painless physician-supported suicide.

120. In Dignitas's submission, the criminal ban on assisted suicide in Hungary left patients only with the option of travelling abroad for PAD, with the following consequences. Since any assistance (including that of an organisational nature) could lead to prosecution, they had to plan and leave earlier, when they were still able to travel alone, and to accept that they would die without their family members or other close persons being present. They also had to be able to afford the costs of using PAD abroad. The latter aspect, and the fact that these patients could not

commit suicide because of limitations on their physical abilities, amounted to discrimination. Moreover, the law discriminated between patients who needed life-sustaining treatment from the day of diagnosis and could die by refusing such treatment, and those who were affected with incurable diseases and endured suffering for months or years before they reached the point when they required life-sustaining care.

121. Dignitas submitted that Article 2 of the Convention did not impose an obligation to prohibit PAD and that a trend in favour of acceptance of PAD could be observed throughout Europe. Referring to *Haas* (cited above), *Gross v. Switzerland* (no. 67810/10, 14 May 2013) and *Lambert and Others v. France* ([GC], no. 46043/14, ECHR 2015 (extracts)), it argued that the criminal ban on PAD in Hungary could not be upheld.

4. The Court's assessment

(a) Relevant case-law

(i) Assisted suicide, including physician-assisted dying (PAD)

122. A blanket ban, under criminal law, on assisting suicide was at the centre of the *Pretty v. the United Kingdom* case (cited above). The applicant in that case was in an advanced stage of motor neurone disease and wanted to commit suicide to avoid what she considered an undignified and distressing end to her life. She was prevented from doing so by the law criminalising the provision of assistance in suicide, and the related risk of prosecution of her husband were he to provide her with such assistance. In its judgment, delivered in 2002, the Court observed that the criminal ban on assisted suicide in England and Wales was designed to safeguard life by protecting the weak and vulnerable and especially those who were not in a condition to take informed decisions against acts intended to end life or to assist in ending life. It noted that many terminally ill individuals were vulnerable, and it was the vulnerability of the class which provided the rationale for the law in question. The Court went on to find that clear risks of abuse existed and that it was primarily for the States to assess those risks and the likely incidence of abuse if the general prohibition on assisted suicide were relaxed or if exceptions were to be created (see *Pretty*, cited above, § 74). The Court did not therefore consider that the blanket nature of the ban on assisted suicide was disproportionate. In this connection it also referred to the Government's submissions regarding the flexibility that was provided for in individual cases by the fact that consent was needed from the Director of Public Prosecutions to bring a prosecution and by the fact that a maximum sentence was provided, allowing lesser penalties to be imposed as appropriate. It did not appear to the Court to be arbitrary for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allowed due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence (ibid., § 76).

123. Almost ten years later the Court, in *Haas v. Switzerland* (cited above), examined a complaint about the refusal to make sodium pentobarbital available to the applicant, who was suffering from a serious bipolar affective disorder, in order to assist him in committing suicide. In the context of examining a possible violation of Article 8, the Court found it appropriate to refer to Article 2 of the Convention, which imposes on the authorities a duty to protect vulnerable persons, even against

actions by which they endanger their own lives. In the Court's view, this latter provision obliged the national authorities to prevent an individual from taking his or her own life if the decision had not been taken freely and with full understanding of what was involved (ibid., § 54). The Court noted that in a system that facilitated access to assisted suicide, such as that in Switzerland, the right to life guaranteed by Article 2 of the Convention obliged the State to establish a procedure capable of ensuring that a decision to end one's life did indeed correspond to the free will of the individual concerned (ibid., § 58). The Court had regard to the fact that the member States of the Council of Europe were far from having reached a consensus with regard to an individual's right to decide how and when his or her life should end; to the need for appropriate implementing and preventive measures regarding access to PAD; and to the fact that it did not seem impossible for the applicant to find a specialist who would have been prepared to assist him. It concluded that even assuming that the States had a positive obligation to adopt measures to facilitate the act of suicide with dignity, the Swiss authorities had not failed to comply with this obligation in the applicant's case (ibid., §§ 57-61).

124. In *Koch v. Germany* (cited above), in which the applicant was the husband of a woman whose request for a lethal dose of sodium pentobarbital had been refused, the Court found that this and the subsequent domestic judicial decisions amounted to an interference with his right to respect for his private life (ibid. §§ 46-54). It went on to find a purely procedural violation of Article 8 because the domestic courts had refused to consider the merits of the applicant's complaint (ibid., §§ 65-72).

125. In April 2022 the Court delivered its judgment in *Lings v. Denmark* (no. 15136/20, 12 April 2022), which concerned a complaint under Article 10 of the Convention by a retired physician, and member of an association in favour of euthanasia, who had been convicted for attempted assistance in suicide and for assistance in suicide. The Court noted that it was not required to determine whether the criminalisation of assisted suicide was justified and referred to its previous case-law in which the individual's right to decide how and when his or her life should end was considered to fall within the scope of the right to respect for his or her private life (ibid., §§ 47-51). It went on to note that there was, however, no support in the Court's case-law for concluding that a right to assisted suicide existed under the Convention, including in the form of providing information about suicide or assistance that went beyond providing general information about suicide. Accordingly, as the applicant had been prosecuted for having assisted suicide through specific acts, the Court considered that the case was not about the applicant's right to provide information that others under the Convention had a right to receive (ibid., § 52). The Court also noted that several elements militated in favour of a wide margin of appreciation, namely the quality of the judicial review of the disputed measure and its application in the case, the fact that the subject of assisted suicide concerned matters of morals, and the fact that the member States of the Council of Europe were far from having reached a consensus on this issue. Therefore, and in view of the circumstances of the case, the Court considered that the reasons relied upon by the domestic courts were relevant and sufficient to establish that the interference complained of could be regarded as "necessary in a democratic society", proportionate to the aims pursued, namely the protection of health and morals and the rights of others, and that the authorities of the respondent State had acted within their margin of appreciation (ibid., §§ 53-61).

126. The most recent case concerning PAD is *Mortier v. Belgium* (cited above), which was delivered in October 2022. The applicant's mother, who had suffered from depression for about forty years, died of euthanasia authorised by law. The applicant essentially complained that the State had failed in its positive obligations to protect his mother's life and, in consequence, had also violated his right to respect for his private and family life. As regards the applicable margin of appreciation in the context of the positive limb of Article 2, the Court stated the following:

> "142. The area of end of life, and in particular euthanasia, raises complex legal, social, moral and ethical questions. Opinions and legal responses to these questions among States parties to the Convention are very diverse, and there is no consensus on the right of an individual to decide how and when their life should end (*Haas*, cited above, § 55, and *Koch v. Germany*, no. 497/09, § 70, July 19, 2012, regarding assisted suicide, and *Lambert and Others*, cited above, § 147, regarding the possibility of allowing or not the withdrawal of treatment artificially maintaining life; see also the comparative-law elements contained in the *Lings* judgment, cited above, §§ 26-32 and § 60).
>
> 143. Therefore, the Court considers that in this area which concerns the end of life and how to strike a balance between the protection of the right to life of a patient and of the right to respect for his private life and his personal autonomy, it is necessary to grant a margin of appreciation to States (see, *mutatis mutandis*, with regard to the possibility of allowing or not the withdrawal of treatment artificially maintaining life and its modalities of implementation, *Lambert and Others*, cited above, § 148). This margin of appreciation is however not unlimited, the Court retains the power to review the State's compliance with its obligations under Article 2 ... ."

127. The Court observed that the decriminalisation of euthanasia was intended to give individuals a free choice in order to avoid what, in their view, would be an undignified and distressing end to life. It noted that the right to life could not therefore be interpreted as *per se* prohibiting the conditional decriminalisation of this form of PAD. However, in order to be compatible with Article 2, such decriminalisation had to be accompanied by appropriate and sufficient safeguards to prevent abuse and thus secure respect for the right to life (ibid., §§ 137-39). In this connection, the Court set out the following three criteria (ibid., § 141):

> "– the existence in domestic law and practice of a legislative framework concerning acts prior to euthanasia in compliance with the requirements of Article 2 of the Convention;
>
> – compliance with the legislative framework established in the specific case;
>
> – the existence of *a posteriori* control offering all the guarantees required by Article 2 of the Convention."

128. The Court went on to find no violation of Article 2 under its substantive head, considering that the legislative framework governing the pre-euthanasia procedure had provided for sufficient substantive and procedural safeguards and that the act in question had been performed in compliance with the law (ibid., §§ 145-65). However, it found a violation of Article 2 under its procedural head, as a result of the lack of independence of a specialised review board and the excessive length of the criminal investigation (ibid., §§ 166-85). The Court also considered that neither the specific act of euthanasia nor the applicant's lack of involvement in the process had breached his Article 8 rights (ibid., §§ 200-09).

(ii) Refusal or withdrawal of life-saving or life-sustaining interventions

129. In *Pretty* the Court noted that, in the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention. The Court noted that, as recognised in domestic case-law, a person might claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his or her life (see *Pretty*, cited above, § 63).

130. The Court subsequently examined a number of applications concerning the withdrawal of life-sustaining interventions, in which the focus was on the State's positive obligations to take appropriate steps to safeguard the lives of those within its jurisdiction; in the public-health sphere these obligations require States to make regulations compelling hospitals to adopt appropriate measures for the protection of patients' lives (see *Lambert and Others*, cited above, § 140). In the context of the withdrawal of life-sustaining interventions the following factors were examined: the existence in domestic law and practice of a regulatory framework compatible with the requirements of Article 2; considerations of the applicant's previously expressed wishes and those of the persons close to him or her, as well as the opinions of other medical personnel; and the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interests (see *Lambert and Others*, cited above, § 143; see also *Gard and Others v. the United Kingdom* (dec.), no. 39793/17, §§ 80-98, 27 June 2017, and *Parfitt v. the United Kingdom*, (dec.) no. 18533/21, § 37, 20 April 2021).

131. In its case-law under Article 8, the Court has emphasised that a person's bodily integrity concerns the most intimate aspects of one's private life, and that compulsory medical intervention, even if it is of a minor importance, constitutes an interference with this right (see, for example, *Vavřička and Others v. the Czech Republic* [GC], no. 47621/13 and 5 others, § 276, 8 April 2021).

(b) The Court's assessment of the present case

(i) Scope of the examination

132. The Court notes, firstly, that the applicant's wish to control the timing of his death is intrinsically connected to the nature of his disease; that is, a degenerative and terminal disease which leads to physical incapacity and pain and may lead him to experience "existential dread". Instead of being condemned to a life of intolerable suffering until his natural death, the applicant wishes to be able to bring his life to a peaceful end at a time and in a manner of his own choosing (see paragraphs 89-91 above). Secondly, while the applicant was not very clear about the type of assistance that he would wish to have available to him, his submissions refer essentially to PAD (see paragraphs 89 and 94 above). Thirdly, the applicant submitted – and this has been confirmed by one of the experts – that his cognitive abilities will most probably remain intact as his disease advances and possibly up to his death. It is likely that he will continue to be fully capable of making his own decision about his life, although communicating any such decision might present a challenge at some point (see paragraphs 12, 45 and 49 above).

133. The Court considers that the applicant's complaint about being prevented from ending his life with the assistance of others and thereby exercising his right to self-determination in a matter of crucial importance to him ought to be examined in light of the above elements, which define the scope and the context of his complaint. It further notes that the applicant's complaint relates, on the one hand, to his inability to have recourse to PAD in Hungary and, on the other, to his inability to have recourse to PAD abroad (see paragraph 93 above). Both of these aspects will be examined below.

134. Finally, the Court notes that the applicant complained about the lack of availability of PAD, which encompasses both euthanasia and assisted suicide (see paragraphs 48 and 82 above). However, his complaint regarding the criminal prohibition essentially refers to the criminal offence of assisted suicide (see paragraphs 15, 89 and 93 above).

(ii) Whether the case involves the State's negative and/or positive obligations

135. The Court observes that anyone who provides assistance to suicide in Hungary, or to a Hungarian national abroad, can be punished under Hungarian criminal law (see paragraphs 15 and 16 above). The Government argued that in practice it would be difficult or impossible to prosecute persons, such as medical staff, who would assist the applicant with suicide outside the territory of Hungary (see paragraph 111 above). At the same time, however, they confirmed that anyone in Hungary who would assist the applicant in committing suicide, including by helping him to travel or make arrangements for PAD to be carried out abroad, could indeed be prosecuted (see paragraphs 110-112 above). Given the applicant's physical condition and the fact that he is in Hungary, this is effectively equivalent to denying him the possibility to end his life on his own terms, at home or abroad, thereby interfering with his right to respect for his private life.

136. This being stated, the Court notes that the applicant himself argued that the State should be under a positive obligation to secure the conditions for the effective exercise of the right to a self-determined and dignified death, and that the decriminalisation of certain forms of assisted suicide would require strict regulation and appropriate safeguards (see paragraph 94 above). In the case of PAD, this would also necessarily involve a positive provision of access to medical intervention, such as access to life-ending drugs (see paragraph 48 above, and also *Haas*, cited above, § 53). The applicant's complaint therefore goes beyond mere non-interference, engaging negative and positive obligations, which are intertwined. In this respect, the Court would reiterate that the boundaries between the State's positive and negative obligations under Article 8 do not always lend themselves to precise definition. However, the applicable principles are similar. In both contexts regard must be had to the fair balance that has to be struck between the competing interests.

(iii) Compliance with Article 8 of the Convention

137. An interference with the exercise of an Article 8 right will not be compatible with the second paragraph of this provision unless it is "in accordance with the law", has an aim that is legitimate under that paragraph and is "necessary in a democratic society". It has not been disputed in the present case that the criminal ban on assisted suicide complied with the Convention requirement of lawfulness. Furthermore, the Court has no doubt that the impugned criminal ban should be considered to pursue the legitimate aims of, *inter alia*, protecting the lives of vulnerable individuals

at risk of abuse, maintaining the medical profession's ethical integrity and also protecting the morals of society with regard to the meaning and value of human life.

138. The Court will now proceed to examine the central question in the present case, namely, whether a fair balance has been struck between the applicant's interest in being able to end his life by means of PAD, and the legitimate aims pursued by the legislation in question, regard being had also to the positive obligations entailed by decriminalisation of PAD (see paragraphs 135 and 136 above) and the State's margin of appreciation in this domain.

(α) The respondent State's margin of appreciation

139. The Court reiterates that in weighing up the different interests at stake, the States are in principle regarded as enjoying a certain margin of appreciation. This margin varies in accordance with the nature of the issues and the importance of the interests at stake (see *Haas*, cited above, § 53, and *Pretty*, cited above, § 70). A number of factors must be taken into account when determining the breadth of the margin of appreciation to be enjoyed by the State when deciding any case under Article 8 of the Convention. Where a particularly important facet of an individual's existence or identity is at stake, the margin allowed to the State will normally be restricted. Where, however, there is no consensus within the member States of the Council of Europe, either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises sensitive moral or ethical issues, the margin will be wider (see *S.H. and Others v. Austria* [GC], no. 57813/00, § 94, ECHR 2011).

140. The Court has already found that the applicant's interest in having access to PAD relates to core aspects of his right to respect for his private life (see paragraph 85 above). Moreover, it finds it incontestable that these values assume particular importance in the context of those terminally ill patients who see PAD as the only means of ending their suffering.

141. As regards the countervailing interests pursued by the absolute ban on assisted suicide and the resultant lack of availability of PAD in Hungary, the Court observes the following. In so far as these interests relate to matters of health-care policy, it has been already established by the Court that such matters fall in principle within the margin of appreciation enjoyed by the domestic authorities, who are best placed to assess priorities, use of resources and social needs (see, among many authorities, *Hristozov and Others v. Bulgaria*, nos. 47039/11 and 358/12, § 119, ECHR 2012 (extracts)). Moreover, the Court has consistently held that the Convention must be read as a whole (see *Haas*, cited above, § 54, and *Verein gegen Tierfabriken Schweiz (VgT) v. Switzerland (no. 2)* [GC], no. 32772/02, § 83, ECHR 2009). In consequence, it is appropriate to refer, in the context of examining a possible violation of Article 8, to Article 2 of the Convention, which creates for the authorities a duty to protect vulnerable persons, even against actions by which they endanger their own lives (see *Haas*, cited above, § 54). When determining the breadth of the margin of appreciation that should be granted to the States under Article 8 with respect to PAD, account must be had to the fact that the choice of the means that are appropriate in order to protect the right to life, and other relevant values affected by the sensitive issue in question, will need to be made in full appreciation of the local conditions and institutions in a given society. This is even more so where a positive provision of PAD is at issue.

142. The Court further reiterates that the Convention is a living instrument which must be interpreted in the light of present-day conditions and of the ideas prevailing in democratic States today. Since the Convention is first and foremost a system for the protection of human rights, the Court must have regard to the changing conditions in Contracting States and respond, for example, to any evolving convergence as to the standards to be achieved (see, among other authorities, *Fedotova and Others v. Russia* [GC], nos. 40792/10 and 2 others, § 167, 17 January 2023). In this connection, in examining previous cases concerning access to PAD the Court relied on the finding that the member States of the Council of Europe were far from having reached a consensus with regard to an individual's right to decide how and when his or her life should end (see *Lings*, cited above, § 60; *Mortier*, cited above, § 142; and *Haas*, cited above, § 55). However, it must be acknowledged that over the last few years important legal developments in favour of granting some form of access to PAD have occurred in certain European countries, such as Austria, Italy, Germany, Spain and Portugal (see paragraph 60 above). In some of these countries the decision to provide access to PAD emanated from the domestic courts' recognition that this was a necessary condition to ensure respect for individuals' right to self-determination (see, for instance, paragraphs 71-79 above); in others it resulted directly from the legislative process. In England and Wales, which continue to prohibit assisted suicide, special guidelines were developed in order to ensure transparency regarding factors which mitigate against prosecution of such cases (see paragraph 66 above).

143. Therefore, the Court cannot but note that a certain trend is currently emerging towards decriminalisation of medically assisted suicide, especially with regard to patients who are suffering from incurable conditions (see paragraph 63 above). Nevertheless, and even if access to PAD has recently been or is being deliberated in the parliaments of certain other member States (see paragraph 60 above), the majority of member States continue to prohibit and prosecute assistance in suicide, including PAD (see paragraph 61 above). Moreover, the Court notes that the relevant international instruments and reports (see paragraphs 35-41 above), including the Council of Europe's Oviedo Convention, provide no basis for concluding that the member States are thereby advised, let alone required, to provide access to PAD (contrast, *mutatis mutandis*, *Fedotova and Others*, cited above, §§ 175-77).

144. In view of the foregoing and noting that this subject continues to be one that raises extremely sensitive moral and ethical questions, and one on which opinions in democratic countries often profoundly differ (compare *A, B and C v. Ireland* [GC], no. 25579/05, § 233, ECHR 2010), the States must be granted a considerable margin of appreciation (see *Haas*, cited above, § 55). From the perspective of Article 8 this margin extends both to their decision to intervene in this area and, once they have intervened, to the detailed rules laid down in order to achieve a balance between the competing interests (see *Pejřilová v. the Czech Republic*, no. 14889/19, § 43, 8 December 2022, and *Evans v. the United Kingdom* [GC], no. 6339/05, § 82, ECHR 2007-I). Having said that, the Court would reiterate the long-established principle that even when the margin of appreciation is considerable it is not unlimited and is ultimately subject to the Court's scrutiny (see *Handyside v. the United Kingdom*, 7 December 1976, § 49, Series A no. 24; *A, B and C v. Ireland*, cited above, § 238, and *Verein Klimaseniorinnen Schweiz and Others v. Switzerland* [GC], no. 53600/20, §§ 450 and 541, 9 April 2024).

145. Having regard to the arguments raised by the Government and some of the third parties (see paragraphs 99-100, and 114-116 above), the Court finds it appropriate to point out that it has already found that 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 (see paragraphs 126 and 127 above). It is in the first place for the national authorities to assess whether PAD could be provided within their jurisdiction in compliance with this requirement.

146. The Court must now examine whether, in the context of Article 8 and the particular circumstances of the present case, the respondent State, by preventing the applicant from having recourse to any form of PAD, exceeded the margin of appreciation as defined above.

(β) Whether a fair balance has been struck in the present case

147. It has not been disputed in the present case that the applicant has full mental capacity and has formed a genuine wish to have access to PAD if his suffering becomes unbearable (compare *Pretty*, cited above, § 73). The Government's submissions do not focus on protecting the applicant from any self-harm entailed by the possibility he is seeking. Rather, they concern the implications that the requested relaxation of the impugned legislation would have on individuals in vulnerable situations and on society as a whole (see paragraphs 98-113 above).

– *The Government's arguments relating to PAD's alleged link to "ableism"*

148. In the Government's submission, PAD was not an acceptable option, as it was based on the assumption that people affected by illness or disability were a burden on society and that their lives were less worthy (see paragraph 103 above). The Court notes that while legalisation of PAD might have certain wider social implications (see paragraph 149 below), there is nothing to suggest that it is necessarily based on discrimination. In this connection, it notes that under the Healthcare Act only terminally ill people can refuse life-sustaining or life-saving treatment and, in consequence, die (see paragraph 21 above), yet the Government did not seem to consider this to be related to a lesser respect for the value of life of this category of patients. Indeed, the Court considers that criteria such as incurable or terminal illness, which often feature in national laws on PAD (see paragraph 63 above), should in no way be seen as attaching any less weight to the value of the lives of those patients who meet 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.

– *Social implications and risks of abuse*

149. The Government also argued that relaxation of the impugned legislation could expose vulnerable people to overt and covert pressure to end their lives, affect their sense of self-worth, undermine trust in the medical profession, and create the effect of a "slippery slope" (see paragraphs 101 and 104 above). The applicant questioned the evidential basis for these arguments (see paragraph 94 above). In this respect the Court notes that the lack of data in this field, which

was observed also by Professor Aubry (see paragraph 50 above), may not of itself suggest that the Government's arguments are without foundation. Be that as it may, the Court does not consider that all of the arguments put forward by the Government can be decided on the sole basis of statistical or other evidence. Many of the asserted wider social implications of legalisation of PAD may inevitably be sensitive to collective moral values; they may differ from society to society and may also evolve over time (see also paragraphs 54 and 55 above). However, these implications are unquestionably relevant and important. Furthermore, being sensitive to national conditions, they can only be properly appraised by the national authorities.

150. The Court notes, moreover, that any system of PAD – even one limited to terminally ill patients with refractory symptoms (see paragraph 94 above) – would require the development of a robust regulatory framework, capable of being effectively and safely applied in practice, and willingness to cooperate on the part of the medical profession. It notes in this connection that the safeguards which are already in place with respect to RWI in Hungary and some other contracting States might admittedly be of some relevance (see paragraphs 21, 77, 79, 94, above; compare also the criteria for compatibility with Article 2 of PAD and withdrawal of life-sustaining interventions, summarised in paragraphs 127 and 130 above). However, it cannot be overlooked that the provision of PAD in respect of patients who are not dependent on life support may give rise to further challenges and a risk of abuse (compare *Pretty*, cited above, § 74).

151. In this connection, the Court notes that both of the experts heard by the Court referred to the challenges in ensuring that a patient's decision to use PAD is genuine, free from any external influence and is not underpinned by concerns which should be effectively addressed by other means (see paragraphs 49 and 54 above). Furthermore, the process of communication with the patient must be capable of accommodating the real possibility that the patient will change his or her view on PAD as the disease progresses. Ensuring the ongoing validity of the request can be particularly difficult in the case of medical conditions, such as ALS, where patients might ultimately lose the ability to communicate (ibid., and paragraph 12 above). In any case, the Court understands from the expert evidence that effective communication with the patient requires special skills, time and significant commitment on the part of medical and other professionals, as does the provision of adequate palliative care, which both experts considered to be a necessary precondition for considering recourse to PAD (see paragraphs 49 and 54 above). The Court notes in this connection that the assessment and allocation of such resources is, in principle, a matter which falls within the margin of appreciation of the domestic authorities.

152. In view of the foregoing, the Court observes that the wider social implications and the risks of abuse and error entailed in the provision of PAD weigh heavily in the balance when assessing if and how to accommodate the interests of those who wish to be assisted in dying. Furthermore, as established above, the States enjoy a considerable margin of appreciation in deciding how that balance should be struck (see paragraph 144 above). The applicant did not in principle dispute this. He instead argued that the criminal prohibition on assisted suicide, to the extent that it did not provide for any exception to meet the particular circumstances of patients in his situation, was nonetheless unjustified. The Court will now examine the remaining arguments on which the applicant relied in this respect.

– *Alleged lack of alternative means to address the applicant's situation*

153. The applicant argued that, given the nature and course of his disease, palliative care and the possibility of RWI would still leave him to endure intolerable suffering over a prolonged period of time. During that time, however, he would not be dependent on life-sustaining interventions, which he could refuse under Hungarian law. In other words, he would not be able to hasten his death. In arguing for PAD, the applicant seems to rely heavily on this alleged lack of any alternative means of addressing his suffering (see paragraphs 90-92 above).

154. The Court considers that high-quality palliative care, including access to effective pain management, is in many situations – and no doubt in that of the applicant – essential to ensuring a dignified end of life (see for instance paragraphs 37, 41 and 43 above). It notes that, according to the expert evidence heard by the Court, the available options in palliative care, guided by the European Association of Palliative Care's Revised Recommendations, including the use of palliative sedation, are generally able to provide relief to patients in the applicant's situation and allow them to die peacefully (see paragraphs 43, 46 and 47 above). It further observes that despite certain concerns raised by one of the third parties (see paragraph 118 above), the applicant did not put forward any specific arguments to the effect that the palliative care available to him was inadequate or that he would not be able to receive, as part of the palliative services available in Hungary, palliative sedation to relieve refractory suffering. Equally, the applicant did not dispute that he would be able to hasten his own death by refusing to consent to assistance in breathing, or by requesting the withdrawal of such assistance, when it becomes necessary (see paragraphs 21 and 25 above). Nor did he allege that he would not receive adequate comfort care during the terminal phase when unaided breathing entails discomfort and distress. For their part, the Government affirmed that this option would be open to the applicant (see paragraphs 105 and 106 above, and also paragraphs 23, 24 and 25 above).

155. The applicant instead argued that he would refuse such a course of action, since, by being medically sedated, he would lose what is left of his autonomy (see paragraph 91 above; see also the concerns expressed by the German Federal Administrative Court, paragraph 71 above). The Court notes that this is a legitimate personal choice, and one of an undoubtedly crucial nature (see paragraph 46 above). However, it considers that a personal preference to forego otherwise appropriate and available procedures cannot in itself require the authorities to provide alternative solutions, let alone to legalise PAD. To hold otherwise would effectively mean that Article 8 could be interpreted as encompassing PAD as a right that is enforceable under the Convention, regardless of the available alternatives.

156. Furthermore, the applicant alleged that RWI, as described above, would in any case become available to him when it was too late – by that point he would have been "locked inside his body" for a prolonged period of time and exposed to unbearable "existential suffering" while remaining fully conscious (see paragraphs 90 and 91 above).

157. The Court notes that the existential suffering to which the applicant refers is not uncommon in patients with ALS, although not exclusive to them (see paragraph 47 above). It is fully aware that it may be particularly hard for patients with ALS to find hope or purpose in a life marked by successive and disabling physical losses, converging towards an unavoidable fatal outcome (see paragraphs 45 and 47 above). It further notes that existential suffering may be

refractory to medical treatment (see paragraph 47 above) and that the use of sedation to alleviate it might be contested or unwarranted in certain situations (see paragraphs 39 and 43 above).

158. The gravity of the applicant's suffering can in no way be underestimated. However, in the Court's opinion, it is part of the human condition that medical science will probably never be fully capable of eliminating all aspects of the suffering of individuals who are terminally ill. Moreover, although it amounts to genuine and severe anguish, existential suffering relates essentially to a personal experience, which may be susceptible to change and does not lend itself to a straightforward objective assessment (see, for instance, paragraph 43 above). It is not for the Court to determine the acceptable level of risk involved in PAD in such circumstances; it is enough to note that the difficulties in objectively appraising refractoriness and other relevant elements of existential suffering may further exacerbate the risks addressed above (see paragraphs 149-151). For this reason, the Court is unable to accept this argument as one which militates for an obligation under Article 8 of the Convention to legalise PAD. However, this heightened state of vulnerability warrants a fundamentally humane approach by the authorities to the management of these situations, an approach which must necessarily include palliative care that is guided by compassion and high medical standards. The applicant did not allege that such care would be unavailable to him (see paragraph 154 above), and the domestic authorities cannot therefore be regarded as falling foul of any positive obligation that might arise from Article 8 of the Convention in this regard.

– *Criminal prohibition on PAD and lack of flexibility as regards the prosecution of such offences*

159. The Court notes at the outset that the applicant's complaint that he was prevented from having recourse to PAD in Hungary because of the criminal-law prohibition on its use cannot be examined separately from the question of the positive provision of PAD, which it has already addressed. That is because, as explained previously (see paragraphs 135-136 above), the introduction of an exception to the impugned prohibition would inevitably require positive measures and regulation of PAD by the State. However, the applicant's complaint that this prohibition prevented him from seeking PAD abroad concerns an essentially negative obligation, that is, the obligation to refrain from interfering with his Article 8 rights (see paragraph 135 above). In this connection and having regard to the provisions of Hungarian law (see paragraphs 15-17 above), the Court observes that any non-Hungarians who would assist the applicant in committing suicide abroad could risk prosecution in Hungary. However, it is uncontested that the applicant, who is unable to move independently, would in any event require assistance already on the territory of Hungary, which could undoubtedly subject those assisting him in Hungary to prosecution (see paragraphs 15,17, 110-112 above).

160. The Court further notes that PAD continues to be not only legally unavailable but also punishable under criminal law in the majority of the Council of Europe's member States (see paragraph 61 above). It further finds that the criminal prohibition on assisted suicide is intended to deter life-endangering acts and to protect interests arising from considerations of a moral and ethical nature. As the comparative-law research confirms, there is nothing unusual or excessive in the fact that the State's prohibition applies also when the act of suicide is ultimately carried out abroad, especially if the victim of the crime and/or the perpetrator are nationals of that State (see paragraph 61 above).

161. The Court observes that ensuring that the applicant's wish to use PAD abroad is not penalised in Hungary would in effect require the respondent State to create an exception in the operation of its criminal law (see paragraphs 15-17 above). Moreover, it considers that although PAD could be carried out in compliance with Article 2 of the Convention in jurisdictions which provide appropriate safeguards (see paragraphs 126,127 and 145 above), issues related to the coherency of the domestic criminal-law system and the collective moral and ethical considerations underpinning the prohibition of assistance in suicide, which were raised by the Hungarian Government in the present case (see paragraphs 104 and 149 above), provide reasonable grounds for the Hungarian authorities' reluctance to introduce the type of exception sought by the applicant (compare and contrast *Baret and Caballero v. France*, nos. 22296/20 and 37138/20, §§ 84 and 85, 14 September 2023).

162. Lastly, the Court notes that, while the prosecution of offences of assisted suicide seems to be required by law (see paragraph 17 above), the Government have asserted that the motivation of the perpetrator, the victim's circumstances and the danger posed by the offence could be taken into account as mitigating factors, and that, where justified, the sentence imposed could be lower than the statutory minimum (see paragraph 113 above, and also the Constitutional Court's reference to mitigation in sentencing, paragraph 32 above; compare, *mutatis mutandis*, *Pretty*, cited above, § 76, and *Thörn v. Sweden*, no. 24547/18, § 58, 1 September 2022).

163. Having regard to the foregoing, and taking into account the State's considerable margin of appreciation (see paragraph 144 above), the Court does not consider that the criminal ban on assisted suicide, including its application to any person assisting the applicant to have recourse to PAD abroad, was disproportionate.

– *Allegedly insufficient review of the impugned measure by the domestic authorities*

164. Lastly, the Court notes the fact that the prohibition on assisted suicide in Hungary dates back to 1878, when the act of suicide itself was decriminalised (see paragraphs 28 and 53 above). In 2003 the Hungarian Constitutional Court found this prohibition, in spite of its absolute nature, to have remained compatible with the Constitution. It examined the issue of PAD from the perspective of the right to self-determination and acknowledged that the field in question was evolving and that boundaries could not be irreversibly determined. It noted that RWI had been conditionally permitted in Hungary only in 1997, after a long period of complete prohibition. Furthermore, several factors, such as the integrity of the medical profession and protection of human life in the broader sense, argued against further relaxation of the legislation in this field (see paragraphs 26-32 above).

165. The Court, in agreement with the Hungarian Constitutional Court, takes note of the evolving nature of the regulations governing PAD, which is confirmed by recent trends (see paragraphs 30 and 60 above). It also considers it understandable that the applicant wishes that the Hungarian legislature had reviewed the necessity of the absolute ban on suicide assistance in the light of the recent legal developments in other countries. Indeed, the Government did not dispute that, with the exception of the Constitutional Court's decision in 2003, the absolute ban on assistance in suicide has not been reviewed by the domestic authorities in any substantial way. However, the Court does not consider it appropriate to attach decisive weight to this element. In

this connection, it would again point out that the majority of the Council of Europe's member States continue to prohibit PAD. Furthermore, the Constitutional Court will have an opportunity to reassess this issue if it is approached by an affected petitioner who seeks to achieve the decriminalisation of PAD.

– *Conclusion*

166. The Court emphasises that the issue it has been asked to determine in the present case is not whether a different policy – such as one providing for PAD – might have been acceptable, but whether in striking the particular balance that they did between the competing interests, the Hungarian authorities remained within their considerable margin of appreciation (compare, for instance, *Hristozov and Others*, cited above, § 125). Against the above background, the Court does not find that the Hungarian authorities overstepped that margin. It thus follows that there has been no violation of Article 8 of the Convention.

167. That being said, the Court would reiterate that the Convention has to be interpreted and applied in the light of present-day conditions. The need for appropriate legal measures should therefore be kept under review, having regard to the developments in European societies and in the international standards on medical ethics in this sensitive domain (compare *S.H. and Others v. Austria*, cited above, § 118, and *Y v. France*, no. 76888/17, § 91, 31 January 2023).

II. ALLEGED VIOLATION OF ARTICLE 14 IN CONJUNCTION WITH ARTICLE 8 OF THE CONVENTION

168. The applicant complained that he was subjected to discrimination because the law did not provide him with an option to hasten his death, although it did provide such an option to terminally ill patients who were dependent on life-sustaining treatment. He relied on Article 14 in conjunction with Article 8 of the Convention. The former provision reads as follows:

> "The enjoyment of the rights and freedoms set forth in [the] 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."

A. Admissibility

169. The Court notes that this complaint is neither manifestly ill-founded nor inadmissible on any other grounds listed in Article 35 of the Convention. It must therefore be declared admissible.

B. Merits

1. *The parties' arguments*

170. The applicant submitted that Hungarian law accorded different treatment to those terminally ill persons with mental capacity who suffered from refractory symptoms but could hasten their death only by means of PAD, and those who could do so by having recourse to RWI. In this connection, he submitted that RWI could be used by patients in need of life-sustaining interventions

who were terminally ill, the latter concept not being defined in law. RWI was allowed even when it required active participation on the part of medical staff. The applicant did not require life-sustaining intervention and might never need it, or might need it only at the very late stage of his disease. In his view, denying him access to PAD, which was the only option that would enable him to implement his end-of-life decision, while allowing others in an analogous situation to have access to RWI, was not justified. He also argued that this type of discrimination was not addressed in *Pretty* (cited above).

171. The Government submitted that RWI and PAD were inherently different procedures. Referring to the Oviedo Convention (see paragraphs 35 and 36 above), they argued that, as a general rule, patients had a right to refuse medical treatment. With regard to life-sustaining treatment, this right was restricted because of the State's positive obligation to protect life. The right to RWI could be exercised by patients in terminal situations whose life was dependent on life-sustaining treatment and whose death was imminent, under certain conditions, which were meant to ensure that any decision concerning RWI was free from undue influence. The applicant, if he qualified as a terminally ill person, would be able to have recourse to RWI under the same conditions as anyone else. The Government argued that patients who were not in need of life-sustaining treatment were not in a comparable situation to those who were. As an illustration, the Government submitted that pneumonia could also have a fatal outcome if the patient refused antibiotics, but this did not mean that patients who were not suffering from pneumonia were discriminated against because they could not make an end-of-life decision by refusing antibiotics.

172. The Government further argued that RWI was not an intentional deprivation of life but simply an acceptance of the fact that the patient's life could not be saved and thereafter allowing death to occur naturally. In the case of PAD, death was intended to be actively and deliberately hastened by the intervention of the medical profession.

2. The Court's assessment

173. According to the Court's settled case-law, in order for an issue to arise under Article 14 there must be a difference in the treatment of persons in analogous or relevantly similar situations with regard to the enjoyment of the rights and freedoms safeguarded by the other substantive provisions of the Convention and the Protocols thereto. Such a difference of treatment is discriminatory if it has no objective and reasonable justification, in other words, if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. The Contracting State enjoys a margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment. The notion of discrimination within the meaning of Article 14 also includes cases where a person or group is treated, without proper justification, less favourably than another, even though the more favourable treatment is not called for by the Convention. As to the burden of proof in relation to Article 14 of the Convention, the Court has held that once the applicant has demonstrated a difference in treatment, it is for the Government to show that the difference was justified (see *Khamtokhu and Aksenchik v. Russia* [GC], nos. 60367/08 and 961/11, §§ 53, 64 and 65, 24 January 2017, and *Biao v. Denmark* [GC], no. 38590/10, §§ 88-90 and 92, 24 May 2016).

174. The Court takes note of the Government's argument that RWI and PAD are inherently different acts in terms of their causation and intent (see paragraph 172 above), and that the applicant cannot be compared to those persons whose lives depend on life-sustaining treatment (see paragraph 171 above). However, the Court is not required to determine these contested points as, in any event, the alleged difference in treatment has objective and reasonable justification. As a further preliminary point, it should be noted that the applicant also argued that terminal illness as the condition to have recourse to RWI was not defined in law (see paragraph 170 above). The Court notes that the Healthcare Act refers to a serious illness leading to death within a short period of time (see paragraph 21 above). While the Healthcare Act does not specify that period in further detail, the Court does not find this of particular importance, especially since the applicant's main argument is based on the fact that he is expected to need continuous life-sustaining treatment, if at all, only at the very end stage of his disease.

175. The Court notes that the right to refuse or request discontinuation of unwanted medical treatment is inherently connected to the right to free and informed consent to medical intervention, which is widely recognised and endorsed by the medical profession, and is also laid down in the Oviedo Convention (see paragraphs 35, 36, 41 and 56 above; see also *Mayboroda v. Ukraine*, no. 14709/07, § 52, 13 April 2023, and *Reyes Jimenez v. Spain*, no. 57020/18, §§ 29 and 30, 8 March 2022). This point has also been consistently reiterated by the Court with regard to situations where the refusal to accept a particular treatment might lead to a fatal outcome (see *Pretty*, cited above, § 63; *V.C. v. Slovakia*, no. 18968/07, § 105, ECHR 2011 (extracts); and *Jehovah's Witnesses of Moscow and Others v. Russia*, no. 302/02, § 135, 10 June 2010). It must be acknowledged that the refusal or withdrawal of treatment in end-of-life situations is the subject of particular consideration or regulation because of the need to safeguard, *inter alia*, the right to life (see paragraphs 37, 38, 130, and 171 above); however, such refusal or withdrawal is intrinsically linked to the right to free and informed consent, rather than to a right to be assisted in dying.

176. The Court further notes that it has found it justified for Hungary to maintain an absolute ban on assisted suicide, on account, among other aspects, of the risks of abuse involved in the provision of PAD, which may extend beyond those involved in RWI (see paragraph 150 above); the potential broader social implications of PAD (see paragraph 149 above); the policy choices involved in its provision (see paragraphs 151, 157 and 161 above); and the considerable margin of appreciation afforded to the States in this respect (see paragraph 144 above). Similar cogent reasons exist under Article 14 for justifying the allegedly different treatment of those terminally ill patients who are dependent on life-sustaining treatment and those patients who are not, and who in consequence cannot hasten their death by refusing such treatment. The Court would note in this connection that, in contrast to the situation with regard to PAD, the majority of the member States allow RWI (see paragraph 59 above). Furthermore, as mentioned above, the right to refuse or withdraw consent to interventions in the health field is recognised also in the Oviedo Convention, which, in contrast, does not safeguard any interests with regard to PAD (see paragraphs 35 and 36 above). The Court therefore considers that the alleged difference in treatment of the aforementioned two groups of terminally ill patients is objectively and reasonably justified.

177. It follows that there has been no violation of Article 14 taken in conjunction with Article 8 of the Convention.

III. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

178. Lastly, the applicant essentially reiterated the complaints made in the context of Article 8 under Articles 3 and 9, taken alone and in conjunction with Article 14 of the Convention. He complained that the lack of access to PAD exposed him to treatment contrary to Article 3 of the Convention, and further alleged under Article 9 that his lack of access to PAD prevented him from dying with dignity, which was a core element of his religious and philosophical beliefs.

179. In so far as the above complaints are not a mere restatement of the complaint raised under Article 8, taken alone and in conjunction with Article 14, the Court, having regard to its findings in *Pretty* (cited above, §§ 53-56 and §§ 82-83) and to the applicant's submissions in the present case, finds that they do not give rise to any appearance of a violation. It follows that these complaints are manifestly ill-founded and must be rejected in accordance with Article 35 §§ 3 (a) and 4 of the Convention.

FOR THESE REASONS, THE COURT

1. *Declares*, by a majority, the complaint under Article 8 alone and the complaint under Article 14 in conjunction with Article 8 admissible;
2. *Declares*, unanimously, the remainder of the application inadmissible;
3. *Holds*, by 6 votes to 1, that there has been no violation of Article 8 of the Convention taken alone;
4. *Holds*, by 6 votes to 1, that there has been no violation of Article 14 in conjunction with Article 8 of the Convention.

Done in English, and notified in writing on 13 June 2024, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Liv Tigerstedt
Deputy Registrar

Alena Poláčková
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

(a) partly concurring, partly dissenting opinion of Judge Wojtyczek;
(b) dissenting opinion of Judge Felici.

PARTLY CONCURRING, PARTLY DISSENTING OPINION OF JUDGE WOJTYCZEK

1. I respectfully disagree with the view that the instant application is admissible. Moreover, I have reservations about the reasoning of the judgment.

2. The applicant is in a very difficult personal situation; his disease is a source of profound suffering which calls for the utmost respect and sympathy. However, I am not persuaded by his arguments, for the reasons explained below.

3. Concerning the interpretation of the Convention, I fully agree with the views expressed by Judge Serghides in his very persuasive dissenting opinion appended to the judgment in the case of *Mortier v. Belgium* (no. 78017/17, 4 October 2022). In my view, his opinion sets out the correct interpretation of the Convention in respect of euthanasia and medically assisted suicide. Unlike many other substantive provisions of the Convention, Article 2 is couched in a specific manner, clearly displaying the intent to list, in an exhaustive manner, the exceptions to the obligation to protect human life. The second sentence of Article 2 § 1 of the Convention insists that no one shall be deprived of his life intentionally. At the same time, Article 2 §§ 1 and 2 list, in total, four exceptions to this prohibition. Euthanasia and medically assisted suicide are not mentioned as possible exceptions to the prohibition on depriving anyone of his life intentionally. Such wording of Article 2 of the Convention calls for a strict literal interpretation and excludes the insertion of additional exceptions by dynamic interpretation. It excludes, in particular, the decriminalisation of euthanasia and medically assisted suicide.

Article 2 of the Convention opens the catalogue of Convention rights, and this deliberate choice on the part of the drafters underlines the fundamental nature of the right to life. This sequence of rights indicates that the subsequent substantive provisions must be read and applied in the light of Article 2.

Both the letter of this provision and its place in the structure of the text as a whole reflect the underlying assumptions that human life is priceless and that is always has both an intrinsic and objective value and an intrinsic and objective sense, which do not depend on subjective feelings about the meaningfulness or meaninglessness of life. The Convention conveys a clear intent to ensure a particularly strong and unconditional protection of human life. If these fundamental assumptions are called into question, then the entire edifice of the Convention system starts to shatter.

Linguistic, systemic and functional methods of interpretation all point in one direction: the right to life is inalienable and cannot be waived by a request to obtain euthanasia or medically assisted suicide. Article 2 excludes any implicit "opt-out-of-life clause".

For that reason, I agree with the following view, expressed in paragraph 141 of the instant judgment:

> "In consequence, it is appropriate to refer, in the context of examining a possible violation of Article 8, to Article 2 of the Convention, which creates for the authorities a duty to protect vulnerable persons, even against actions by which the endanger their own lives ...".

I would add that this duty encompasses protection against assisted suicide and euthanasia. I further accept that Article 8 cannot "be interpreted as encompassing PAD as a right that is enforceable under the Convention, regardless of the available alternatives" (see paragraph 155 *in fine*), although I have some reservations concerning the reference to "the available alternatives". On the other hand, I respectfully disagree with the view expressed in paragraph 161 (see also paragraph 145) that "PAD could be carried out in compliance with Article 2 of the Convention in jurisdictions which provide appropriate safeguards".

4. Personal autonomy is a very precious freedom and an important pre-condition for a happy and self-fulfilling life, and must be effectively protected; however, given the clear letter of Article 2, its scope under the Convention cannot encompass decisions about one's own life and death. The very notion of "private life" – which first and foremost presupposes *life* – does not extend to the choice of death by means of medically assisted suicide or euthanasia.

I therefore respectfully disagree with the majority's views that "the applicant's interest in having access to PAD relates to core aspects of his right to respect to his private life enshrined in Article 8 of the Convention" (see paragraph 85) and that "the present complaint falls to be examined as concerning an aspect of the applicant's right to respect for his private life within the meaning of Article 8" (paragraph 87). Rather, the applicant's interest in having access to medically assisted suicide relates to core aspects of his right to life.

Paradoxically, this all-encompassing understanding of private life, including self-determination with regard to life and death, based upon the implicit assumption that the value and meaning of one's own life depends upon individual choices, in fact contributes to exacerbating the suffering that stems from a subjective feeling of the meaninglessness of life. The more death upon request becomes an option that is available in practice, the more difficult it is to preserve a sense of the meaningfulness of life. In the context of possible suggestions and pressures, as well as of real economic interests, overly wide personal autonomy may become a lure for all sorts of predators and could easily turn into an illusion of autonomy for vulnerable persons, in spite of all the legal guarantees and procedures. If the Convention is intended to guarantee a protection of private life that is not theoretical or illusory but practical and effective, then the scope of this protection must stay within some clearly drawn limits.

5. The majority refers to international instruments and reports and states as follows in paragraph 143:

> "Moreover, the Court notes that the relevant international instruments and reports (see paragraphs 35-41 above), including the Council of Europe's Oviedo Convention, provide no basis for concluding that the member States are thereby advised, let alone required, to provide access to PAD (contrast, *mutatis mutandis*, *Fedotova and Others*, cited above, §§ 175-77)."

In my view, the relevant international instruments and reports provide a basis for concluding that the member States are advised not to provide access to medically assisted suicide and euthanasia. I should like to note here several soft-law instruments.

Recommendation 779 (1976) *Rights of the sick and dying*, adopted by the Parliamentary Assembly of the Council of Europe on 29 January 1976 (and not referred to in the reasoning), states:

"7. Considering that the doctor must make every effort to alleviate suffering, and that he has no right, even in cases which appear to him to be desperate, intentionally to hasten the natural course of death."

Recommendation 1418 (1999) *Protection of the human rights and dignity of the terminally ill and the dying*, adopted by the Parliamentary Assembly of the Council of Europe on 25 June 1999 (see paragraph 37 of the instant judgment), contains the following recommendations:

"The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects:

...

by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

9.3.1. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";

9.3.2. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

9.3.3. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."

Resolution 1859 (2012) *Protecting human rights and dignity by taking into account previously expressed wishes of patients*, adopted by the Parliamentary Assembly of the Council of Europe on 25 January 2012 (see paragraph 37 of the instant judgment), contains the following recommendation:

"5. ... Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited."

6. The reasoning refers to the conception of the Convention as a living instrument (see paragraphs 142 and 167) and notes "a certain trend ... currently emerging towards the decriminalisation of medically assisted suicide" (see paragraph 143). Jurists may have divergent views about the extent to which the meaning of the Convention may be modified by case-law. I have expressed views in favour of a restrictive approach in this respect (see my dissenting opinion appended to the judgment in the case of *Fedotova and Others v. Russia* [GC], nos. 40792/10 and 2 others, 17 January 2023). Others have expressed different opinions on this question, advocating a more dynamic interpretation of the Convention. However, whatever the accepted scope of possible modifications by interpretation, an obligation to legalise euthanasia (envisaged implicitly in paragraph 167) would be a fundamental change of paradigm (that is, an essential modification of the treaty) going beyond any "living instrument" doctrine and would undermine not only the right to life enshrined in the Convention, but also the foundations of the entire Convention system.

Furthermore, I note in this context that the Convention itself was a reaction to certain marked international trends in the 1930s and 1940s in various parts of Europe and was conceived as a protection against such trends. A human-rights treaty which is not "trend-proof" but which can be adapted via interpretation to "currently emerging trends" or even to an emerging "European

consensus" is unable to ensure a truly effective protection of fundamental human rights. There is a risk that a "living instrument", so understood, which protects rights with a "variable geometry", may evolve into a dying instrument.

7. In conclusion, I note that irrespective of the correct interpretation of the Convention, it contains no right of access to medically assisted suicide or euthanasia. In any event, under the Court's settled case-law, the instant application should, in my opinion, have been rejected as manifestly ill-founded.

Moreover, if the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective, then it is difficult to accept that an effectively protected right to life can be reconciled with access to medically assisted suicide or euthanasia.

DISSENTING OPINION OF JUDGE FELICI

"Making someone die in a way that others approve,
but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."

Ronald Dworkin, Life's Dominion (1993)

1. With due respect to my colleagues in the majority, I am unable to concur with their conclusions regarding the absence of a violation of Article 8 and of Article 8 in conjunction with Article 14 of the Convention. The rationale behind this dissenting opinion is multifaceted. It encompasses both legal reasoning and a much-needed "progressive" interpretation of the Convention, in line with the "living instrument" doctrine, as well as a personal conviction which, although not decisive, compels me to take a clear stance on a case which, due to the rights at stake and the particular nuances involved, necessitates a different, and in my opinion, fairer outcome.

(i). Regarding the violation of Article 8 of the Convention

2. It is first necessary to analyse the indisputable factual situation in which the applicant finds himself and to highlight the specific elements that characterise it. Four elements are indicative of the applicant's condition:

(1) the prognosis of certain death was established once the illness afflicting him had been identified. The applicant was diagnosed with Amyotrophic lateral sclerosis, which is a degenerative disorder that is invariably and inexorably progressive;

(2) at the present time, and for the foreseeable future, there is no effective cure for this disease. ALS is incurable; for the moment, no concrete and immediate solutions have been identified by medical research and, according to medical experts, 70% of those affected die within three years;

(3) the disease imposes on the applicant unbearable suffering, both physical and mental;

(4) finally, the intellectual lucidity and mental presence that individuals afflicted with this disease generally retain until the end of their days is worthy of note.

These four elements permit a clear and unambiguous delineation of the state in which Mr Dániel Karsai found and continues to find himself, a situation that he describes as being "imprisoned in his own body without any prospect of release apart from death"(see paragraph 14 of the judgment).

3. Regarding the applicant's arguments: he made it clear that he wished to shorten his life, and that in order to do so only two options were available to him: either to use physician-assisted dying (PAD), to discontinue life-sustaining treatment and then starve to death or suffocate. The core of his pleadings was not, specifically and primarily, a general right to PAD as an expression of self-determination and autonomy, but rather the specific and circumstanced right of a terminally-ill patient who wishes to die to access a remedy responding to his desire to end his life.

From a legal standpoint, the applicant did not ask the Court to impose a new positive obligation, in that he was asking for an *exception* to the general ban on assisted suicide. At the same time, however, he specified that, in view of the right to self-determination and human dignity, a derived positive obligation is implicitly imposed on the State. Lastly, he acknowledged the need for a specific legislative framework in this area, in order to avoid the risk of abuse and to strike a balance between the State's margin of appreciation and the right of terminally-ill patients to choose to die.

4. In my opinion, both these arguments are valid, and there are no legal obstacles preventing the recognition of both a positive and a negative obligation on the State, for the reasons that will be specified below. In the light of the circumstances outlined above, which are specific to the present case, the Court would have had leeway to develop its case-law. There is no previous case that coincides perfectly and is substantially identical to this one. The case-law quoted in the judgment, namely *Pretty v. the United Kingdom*, no. 2346/02, ECHR 2002-III, *Haas v. Switzerland*, no. 31322/07, ECHR 2011, and *Mortier v. Belgium*, no. 78017/17, 4 October 2022, dealt with other aspects of end-of-life decision-making, access to end-of-life treatment and the criminalisation of assisted suicide. Although related, the cited case-law does not overlap with the present case, which, as noted above, has specific features; it would have been possible, and perhaps useful, to distinguish, more or less narrowly/broadly, between them. Equally, this case-law situation allows room to develop new principles, ones that are tailored to the specific case.

Nonetheless, I understand that a different decision, based on a finding of a violation of Article 8 of the Convention, could easily be open to criticism, in particular in so far as it could be read as imposing a positive obligation on the State under Article 8.

5. Nevertheless, there exist several well-founded arguments in favour of a different outcome. Firstly, Convention rights are endowed with an inherent content, which is independent of the States' legislation and is thus ontological in nature. It is evident that respect for private life encompasses the right to resist one's own physical suffering, even if this entails the termination of life. In fact, the right to personal freedom, including its intangible or moral aspect, is an inalienable human right which enables the individual to develop his or her personality and to follow his or her inclinations in line, as closely as possible, with his or personal conception of existence; this is true also in relation to one's death.

Secondly, it is imperative that the Court adhere to the very definition of respect for private life as set forth in Article 8 of the Convention. It is difficult to identify any intention or evidence of

consistency when States have a duty to afford protection against medical negligence (see *Nicolae Virgiliu Tănase v. Romania* [GC], no. 41720/13, § 127, 25 June 2019, with the further references therein), or even, to take a very emblematic example, for imposing a ban (under building rules applicable to private individuals) on installing a satellite on a house roof for television reception, which was found to be an infringement of privacy (see *Khurshid Mustafa and Tarzibachi v. Sweden*, no. 23883/06, 16 December 2008), yet no violation is found in instances where States fail to provide an effective action or instrument to address intolerable suffering, such as that complained of by the present applicant.

Thirdly, the European public order formula/doctrine is but one of several possible interpretations of the Convention. As the applicant correctly notes, it does not preclude the Court from considering not only the current state of the legislation in the various member States, but also the emerging trends on certain issues. When discussing developing trends, in this case pertaining to end-of-life legislation, it is necessary to consider the broader context of humanity. Here, it is accurate to state that the Court did not confine its analysis to a mere comparative examination of European legislation. Rather, it was required also to consider both European and non-European trends, as this issue is a global one, necessitating a comprehensive and transnational approach. Indeed, euthanasia and assisted suicide are lawful as forms of PAD in five member States: Belgium, Luxembourg, the Netherlands, Spain and Portugal (the law of 2023 has not yet entered into force, pending the adoption of the required regulations). In seven member States (Austria, Finland, Germany, Italy, Lichtenstein, Sweden and Switzerland) certain forms of assisted suicide are lawful, and are available in some of them as PAD. In other European jurisdictions, consultative processes with regard to PAD have been initiated, and there have been, or are at present, attempts to introduce legislation to allow PAD (for instance, in France, England and Wales). A referendum procedure on access to end-of-life treatment in the form of PAD is underway in Slovenia. If we take account of the considerable attention currently being paid to the issue of access to active end-of-life treatment in public debate, essentially at a global level, it is indisputable that the magnitude of a trend in favour of recognising at least some forms of PAD cannot be questioned.

6. In the light of the aforementioned considerations, it is my opinion that there are no insurmountable legal obstacles to affirming a positive obligation on the part of the State, having regard to all the characteristics of this case, in relation to the application of Article 8 of the Convention. It follows that the interference constituted by the fact of criminalising persons who assist with suicide, particularly if the act is extraterritorial, does not comply with the Convention.

Contrary to the reasoning and conclusions set out in paragraphs 162 and 163 of the judgment, it does not appear that the State can be granted any margin of appreciation in this situation. The criminal ban on PAD is something that exists, irrespective of any possibility of mitigating the punishment foreseen in the law. The mere fact of criminalising an act – irrespective of the likelihood that an investigation is instigated or a conviction issued, or the severity of the sentence imposed - represents an interference, because the mere risk of being accused of a crime is in itself an interference. In the absence of any margin of appreciation for the State, I do not believe that an assessment of proportionality is required in this case.

Furthermore, to return in abstract terms to the formula/doctrine of the European legal order, it does not even appear that the crime of assisting suicide carried out abroad it is generally punishable in Europe (see paragraph 61 of the judgment).

7. This Court is tasked with adjudicating concrete cases in accordance with the Convention and its own case-law, while striving to maintain the latter's coherence without being unduly influenced by it. In the present case, the Court has, debatably, succeeded in its very formal role as a constructor of case-law and – again debatably – attempted to ensure coherence with regard to the precepts of the Convention, rather than deciding Mr Karsai's case on its particular merits. Consequently, although the principles outlined in *Pretty v. United Kingdom* (cited above) are reinterpreted, the result appears to be a timid readjustment from which no tangible benefits are derived.

Even during the public hearing that the Section correctly organised, Mr Karsai presented his situation with courage, strength and vigour. He reminded the Court of its duty to rule on the specific case and in concrete terms, not merely *in abstracto*. The applicant's physical weakness was a striking counterpoint to the strength of his arguments. The impression is that the applicant's legitimate concerns were not taken into account, and that his legitimate request for help fell on deaf ears.

Furthermore, in their refusal to refer the case to the Grand Chamber, the majority failed to grant the Court's highest judicial body an opportunity to deliver a relevant ruling from a legal and, above all, a human-rights perspective.

8. It is now necessary to examine the arguments put forward by this Court and to identify which arguments are flawed. The Court, in assessing the legitimacy, proportionality and necessity of the Hungarian State's interference in denying a terminally-ill ALS patient access to PAD, argues that a different, more permissive legislation would be potentially open to abuse and would have significant social implications (see paragraph 150 of the judgment). In particular, the Court emphasises that any PAD system would require an appropriate and robust regulatory framework. Furthermore, even in the latter scenario, the specific condition of a terminally-ill person might not render their wishes genuine and free from external constraints. Consequently, the Court has determined that, in the light of the respondent State's margin of appreciation and the potential risks of abuse, State interference in the applicant's private life could be justified under Article 8 of the Convention.

It must be emphasised, however, that the risk of abuse of legal instruments does not in itself represent a legal argument. It is assumed that the State, understood as the guarantor of the protection of citizens and their fundamental rights, as established in various constitutional charters, must have the necessary tools to prevent any abuse. Conversely, given the private and intimate sphere in which disease develops, permeating and absorbing an individual's very existence, the absence of regulation could even encourage abuse.

From this point of view, it is necessary to emphasise the Court's role as guardian of the protection of human rights, including from a procedural point of view. The above-cited *Mortier v. Belgium* case established a purely procedural violation in the specific process that can lead to PAD, further highlighting the fact that State and international systems must have the strength to prevent, limit and remedy abuses. Furthermore, let it be said *incidenter tantum*, the *Mortier* ruling has clearly legitimised, as compatible with the Convention, a legal system which provides for fairly broad access to euthanasia practices in the strict sense: the Court has established that no violation of the

Convention can be inferred *per se* from the fact that a State has legislation which provides for euthanasia.

9. Another argument put forward by the Government and endorsed by this Court concerns the availability of high-quality palliative care, which also includes access to effective painkillers or pain-management techniques. The Court considers this essential to ensure a dignified end of life. Furthermore, this Court has determined that the availability of palliative care, including sedation, will provide relief to patients in the same condition as the applicant and allow for a peaceful death. I am, however, unable to adhere to this stance, particularly in view of the observations made by the experts consulted in the course of these proceedings.

It is assumed that palliative care can alleviate the unbearable suffering caused by an illness such as that from which the applicant suffers, making it 'tolerable'. However, the experts consulted have indicated that there is currently no medicinal treatment capable of alleviating existential suffering. This type of suffering, which is distinct from physical suffering, was described by the applicant as the experience of being "trapped in the body while being completely conscious for long periods of time...waiting for death without any meaningful existence". Although there is no agreed definition of this concept, the experts consulted stated that this "feeling" is linked to the belief that life has become meaningless and futile, for which there is no effective medical treatment. According to Professor Aubry "this suffering, which was quite characteristic but not exclusive to ALS, was different from depression and physical suffering, and there were no medications to address it" (see paragraph 47 of the judgment).

I further note that such suffering would become pertinent only in the context of an illness exhibiting all of the characteristics outlined in the preceding paragraph. Consequently, potential criticism of a different decision by the Court, on the basis that it might be a short-cut to the legalisation of euthanasia without strict conditions, is not viable, given that the issues raised here pertain solely to the condition in which the applicant finds himself and the specific questions that arise therefrom.

10. Lastly, I find it necessary to disagree with another argument of the Court, concerning the concept of human dignity. Whilst it is true that the *Haas v. Switzerland* case (cited above) concerned the dignity of an individual requesting access to assisted suicide, it is not clear how the Court could have been concerned in *Haas* with protecting the dignity of the life of a person requesting PAD and yet fail to apply the same lens and degree of sensitivity to the case at hand. The Court should have been even more concerned in the present case with the dignity of a person contemplating PAD.

Is it possible to qualify dignity as an inherent quality of the human being, regardless of the circumstances of their existence? In this regard, it is really worth remembering the words of John Stuart Mill, which still resonate with extraordinary relevance: "Over himself, over his own body and mind, the individual is sovereign" (On Liberty, 1859). Finally and in consequence, it should be remembered that each person is the best judge of his or her own dignity.

Thus, the principle of self-determination, which has been repeatedly reaffirmed by the Court in areas other than this one, is also relevant to the assessment of this case.

(ii) Regarding the violation of Article 14 in conjunction with Article 8 of the Convention:

11. The applicant complains that Hungarian law discriminates between terminally-ill patients who do not require life-saving treatment and therefore do not have access to PAD (such as ALS patients) and those who do require life-saving treatment and can therefore choose to end their suffering through RWI. The applicant is not, and may never be, in need of life-sustaining treatment, except in the very final stages of the disease, and this in fact puts him at a disadvantage compared to the other category of terminally-ill patients; in practice, he complains of unequal treatment between essentially homogeneous groups.

In both cases, we are dealing with terminally-ill people who have no chance of recovery, but for whom the specific characteristics of their conditions require differentiated treatment.

The Court, *de facto* endorsing the Government's position, argues that RWI and PAD are two procedures which are inherently different in terms of their causation and intent (see paragraph 175) and submits that there in fact exists an objective and reasonable justification for this difference. The justification was be based on arguments already made in relation to Article 8 of the Convention, namely the risk of abuse and the member States' margin of appreciation.

12. This position is incorrect, and misses the real focus of the issue, namely the concept of life-sustaining treatment, which should be examined more carefully. What are life-sustaining treatments and what do they involve? Although the concept of life-sustaining treatment is conceived in terms of dependence on machines, it can also include other forms of assistance which, although they do not take the form of essential respiratory aid, for example, nevertheless assume a role and a centrality that make them in fact comparable to life-sustaining treatment and, above all, indispensable for the patient's survival.

A fundamental question arises, namely whether a person such as Mr Karsai, who is in a condition in which he is unable to look after his basic physiological functions, feed himself, take care of his personal hygiene and move around, is not in fact already receiving life-saving treatment. In view of these aspects, but also in general terms, is it not artificial to say that a person in the applicant's condition cannot be compared to a person requiring life-saving treatment? They are, in fact, two people with a diagnosis of certain death, the only difference being that the latter – the terminally-ill person in need of life-saving treatment – can benefit from a treatment that may enable him to survive, whereas the former cannot. The paradox that obliges me to dissociate myself from the Court's decision is now obvious. In fact, the Court did not consider the two situations to be homogeneous and thus confirmed that the person who is biologically able to survive has the possibility of choosing not to do so by making use of RWI, whereas the person who is biologically unable to survive does not have the freedom to choose not to do so, except in the final stages of his illness.

13. I believe that subordination of the decision to take one's life to whether one is dependent on life-saving treatment represents an unnecessary reduction of the protection of the right to life and an interference in private life, understood as the individual's capacity for self-determination. Here too, the requirement of life-saving treatment appears to be a standard that is incapable of allowing a rational choice between similar situations, since it is inappropriate and disproportionate to the objective of the protection sought. The ability to choose to end one's life should be based on an

assessment of the illness and suffering faced by the patient, not on the type of treatment – that is, whether or not it is life-saving – that the illness requires.

(iii) Conclusion.

14. For these reasons, I consider that the Court should have found a violation of both Article 8 and of Article 14 in conjunction with Article 8. The Court's approach, although legally impeccable, is not adequate to respond to a legal gap and social demand which have not yet found a uniform and guaranteed response in the various member States, but which potentially affects us all.

As a final point, it is useful to repeat (see § 7 above) that the Court – in so far as it decided not to relinquish the case to the Grand Chamber – missed an extraordinary opportunity, which would have allowed a more up-to-date approach to the principles regarding end-of-life care and PAD, which, given the extreme importance of the subject, was certainly the task and responsibility of the Grand Chamber.