Dignity at the end of life and Decriminalization of Euthanasia

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LAFFERRIERE, JORGE NICOLÁS, "Dignity at the End of Life and Decriminalization of Euthanasia", en *Criminal Law and Morality in the Age of Consent*, Masferrer, Aniceto (Ed.), Cham, Springer International Publishing, 2020, p. 347-367. ISBN: 978-3-030-64162-7, ISBN electrónico: 978-3-030-64163-4

Abstract: This article will analyze the notion of euthanasia and the proposal to decriminalize it, presenting three views on dignity that underlie the euthanasia debate. To start with, I will consider the vision that highlights autonomy as the main meaning of dignity. I will identify its inconsistencies and the problems that such a perspective presents in connection with unconscious individuals, and I will discuss whether a right to die exists. Secondly, I will look into utilitarian arguments in favor of legalizing euthanasia in those cases where the quality of life is not dignified. This will entail addressing the slippery slope argument. Finally, I will examine the position that sustains dignity as a value, inherent in the person, that implies the respect for the inviolability of human life, and I will present the distinctions that need to be made when making decisions at the end of life.

I. Introduction

Powerful technologies, medical procedures, and drugs have extended human life.[1] This increase in life expectancy has had enormous benefits. But new legal issues arise concerning dignity at the end of life. Guaranteeing the dignity of the dying person is a widely recognized demand for justice. However, depending on the underlying conception of dignity, there will be very different answers that will not always respond to all the demands for justice.

In some cases, medical procedures, drugs, or biotechnologies applied to people with terminal illnesses imply little or no expectation of improvement, and the problem arises as to whether it is morally permissible to reject such therapies. In other cases, end-of-life suffering leads people to consider the possibility of deliberately ending their lives, either by taking their own lives or by asking someone else to do so. Other people would allow euthanasia for the most diverse reasons: from mental disorders to social conditions, or even fatigue.

The question then arises as to whether it is just to take the life of another person at their request or assist them in committing suicide.[2] Thus, although there have always been proposals to decriminalize or legalize euthanasia under certain circumstances, the

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[1] Global life expectancy at birth in 2015 was 71.4 years, and global average life expectancy increased by 5 years between 2000 and 2015, the fastest increase since the 1960s. Global Health Observatory (2016).

[2] Euthanasia is understood as the act of the physician who complies with a request from a patient to end their life. If the physician helps a patient to end their own life, this is known as assisted suicide. Although there are differences between euthanasia and assisted suicide, in this paper we will deal with them as having the same moral meaning of deliberately putting an end to someone's life.

issue now takes on new dimensions due to the emergence of drugs, procedures, and biotechnologies that extend human life.

The aim of this article[3] is to consider the arguments that are used in favor of decriminalizing or legalizing euthanasia as an exception to the law of murder.

The proposals in favor of legalizing euthanasia are linked to three views on dignity: dignity as autonomy, dignity from a utilitarian perspective of quality of life, and dignity as excellence in being (Part II). In Part III, I will analyze the view that maintains that there is a right to cause one's own death, either through euthanasia or assisted suicide, as a legitimate expression of personal autonomy. I will consider the inconsistencies of this conception of dignity and analyze the limits that it presents in relation to cases of unconscious people. Ultimately, the connection between dignity, autonomy and euthanasia involves answering the question whether there is a "right to die". In Part IV, I will consider the utilitarian arguments of those who contend that, when a deterioration in the quality of life makes life unworthy, it would be legitimate to take the life of the person in a terminal state. In this Part, I will approach the so-called slippery slope argument. Finally, I will study the view that posits human dignity as as a value, inherent in the person, in connection with human nature and its consequences in relation to the inviolability of life (Part V). This will also mean making distinctions in relation to making end-of-life decisions, excluding as unjust the action that deliberately takes the life of the patient but admitting as legitimate the renunciation of disproportionate treatments that do not provide prospects for improvement in the face of imminent death.

II. Three competing views on dignity at the end of life

Underlying the debate over euthanasia, I find three competing views on dignity at the end of life. A recent Draft of a General Comment on Article 6 of the International Covenant on Civil and Political Rights[4] that is under discussion in the United Nations Human Rights Committee gives a very good example of these underlying visions. The Draft proposes the following text in relation to end-of-life issues:

> 10. [While acknowledging the central importance to human dignity of personal autonomy, the Committee considers that States parties should recognize that individuals planning or attempting to commit suicide may be doing so because they are undergoing a momentary crisis which may affect their ability to make irreversible decisions, such as to terminate their life. Therefore,] States should take adequate measures, without violating their other Covenant obligations, to prevent suicides, especially among individuals in particularly vulnerable situations. At the same time, States parties [may allow] [should not prevent] medical professionals to provide medical treatment or the medical means in order to facilitate the termination of life of [catastrophically] afflicted adults, such as the mortally wounded or terminally ill, who experience severe physical or mental pain and suffering and wish to die with dignity. In such cases, States parties must ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and, unambiguous

[3] I would like to thank Mariela Santoro for helping me with the translation of this article.

[4] Article 6.1 of the International Covenant on Civil and Political Rights states: "Article 6. 1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life".

decision of their patients, with a view to protecting patients from pressure and abuse.[5]

This Draft attaches central importance to personal autonomy for human dignity. Hence, as an expression of this autonomy, the Draft advocates that physicians be allowed to apply euthanasia under certain circumstances. It also makes distinctions among individuals planning to commit suicide, expressing a stronger concern for those who are in vulnerable situations. There is an ambivalence surrounding suicide that reveals the limitations of the view that would connect dignity with autonomy.

The Draft also contains elements belonging to the utilitarian view, which connects dignity with quality of life. In fact, the text refers to the possibility of applying euthanasia in cases of catastrophically afflicted adults, such as the mortally wounded or terminally ill, who experience severe physical or mental pain and suffering. Thus, the Draft is making appraisals of life conditions, explaining that in such cases those individuals should be allowed to "die with dignity". Here what is underlying is the utilitarian logic that considers that under certain circumstances a life that fails to satisfy certain quality criteria is not dignified.

Finally, in the Draft there is also a connection between dignity and the inviolability of human life. Above all, it should be noted that this Draft is a general comment on Article 6, which deals with the right to life. In addition, the text mentions the duty of the States to prevent suicides, which implies a certain respect for the inviolability of life even against the will of the individuals themselves. Moreover, it highlights that individuals considering suicide may be undergoing a crisis that places them in a vulnerable situation, acknowledging the inherent value of life even in such cases. The importance of preventing situations of euthanasia under pressure or abuse also reveals that the question regarding the quality of life and autonomy are restricted by the inviolability of human life.

In this sense, throughout this article I will maintain that, if the debate over euthanasia adopts as a starting point the principle of autonomy as the only element of dignity, the arguments appear weak and insufficient to correctly place the debate on legal tracks which respond to fundamental questions brought out by biotechnologies applied to the end of life. If our starting point is the principle of autonomy, there are no consistent answers to the demands for justice. Nevertheless, I believe that if a view is adopted to link dignity with quality of life notions, based on a utilitarian criterion, we cannot either offer a coherent and robust answer to the various issues underlying end-of-life decision making. Instead, I believe that starting from the ontological dignity as an individual's intrinsic value, which includes inviolability of life as well as freedom for personal realization, we will be able to make significant distinctions that will allow us to respond to the problems that arise at the end of life, especially when terminally ill.

III. Autonomy and Euthanasia as a right to put an end to one's life

Discussion about the legal admissibility of euthanasia is at present rooted in arguments that seek to legitimate such conduct within the framework of personal autonomy.

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[5] Human Rights Committee, "General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights, on the right to life", Revised draft prepared by the Rapporteur, http://www.ohchr.org/Documents/HRBodies/CCPR/GCArticle6/GCArticle6_EN.pdf (bracketed matter in the original).

According to Diego Gracia, there are three stages in the history of euthanasia: (a) ritualized euthanasia, (b) medicalized euthanasia, and (c) autonomized euthanasia.[6] Unlike former times in which euthanasia was motivated by social, political, medical, and eugenic concerns,[7] today, as Gracia explains it, the question is whether it is ethically possible to give a positive answer to an individual who wishes to die and asks for help in doing so.[8]

On this view, taking one's life is a legitimate part of the exercise of personal autonomy. Therefore, as we have seen in the Draft mentioned in Part II, in general the discussion about euthanasia focuses on persons who are terminally ill or experiencing severe suffering. In this sense, in the following paragraphs, I will study the question of autonomy and euthanasia in individuals who are terminally ill or suffering beyond endurance, making a distinction between conscious and unconscious individuals. The case of unconscious persons introduces serious difficulties for the view in favor of legitimizing euthanasia on the grounds of autonomy, even when there are attempts to construct alternative or forced criteria for autonomy. In Part III.3, I will address what happens when the notion of autonomy is stretched to its ultimate consequences as implying a right to die or legitimacy in the decision to take one's life under any circumstances, and I will try to provide critical answers to these arguments since I understand that if euthanasia is legalized a person is deprived from an indefeasible good, with serious social consequences.

III.1. *Autonomy of persons in a conscious and terminal state or with unbearable suffering*

Euthanasia challenges the principle of respect for life that considers any conduct oriented to taking the life of another person or assisting them in their suicide to be unjust. The case for euthanasia has been made gradually and progressively, mainly after some very dramatic cases where the end-of-life decisions were at stake due to the expansion of biotechnologies. In other words, rather than invoke the right of any person to take their own life under any circumstances, it is alleged that such a right is a prerogative of persons who are terminally ill or severely suffering at the end of their lives.

The debate over euthanasia arose in cases related to terminally ill persons receiving vital assistance from medical procedures, drugs, or biotechnological support. The decision to remove vital support mechanisms as a consequence of the right of self-determination over one's body, even when there is a risk of death, meant the first step towards the normalization of euthanasia.

For example, Dworkin says that in a society marked by ethical individualism, one master idea is accepted: autonomy. And autonomy implies the right to make personality-defining or life-defining decisions for oneself.[9] He observes that, in the United States, the Supreme Court in *Cruzan v. Director, Missouri Department of Health*[10] has constitutionally accepted that the State has no power to forbid a physician from terminating life support even when death soon and inevitably follows.

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[6] Gracia (1996), 67-91. See also Vivanco Martínez (2014), 44–64.

[7] It is remarkable how, after the systematic elimination of persons through euthanasia in Nazi Germany, even with the collaboration of physicians, the movement for euthanasia soon recovers certain social legitimacy and is expanded, mainly after the 1960s. See Santos (2017), 781–82.

[8] Gracia (1996), 84.

[9] Solum, Dworkin, Finnis (1997), 1490.

[10] 497 U.S. 261 (1990).

As Gorsuch says, those who propose a right to assisted suicide "typically emphasize the dire medical condition of a particular patient, the unpleasantness of the hospital settings, and the compassion of individual physicians."[11] In Part V.2, I will address the problem with attempting to draw a distinction between euthanasia and renunciation of overzealous treatment. This problem was at the onset of the proposals in favor of legalizing euthanasia as an expression of personal autonomy. To anticipate, there is a decisive difference between conduct oriented to causing death, whether by action or omission, and the rejection of disproportionate treatments against the prospects for improvement when death soon and inevitably follows. Here I will present the reasons why I consider that the argument favoring euthanasia for persons who are terminally ill or suffering beyond endurance is unjust.

A first objection to this claimed right to put an end to one's life in cases of terminal illnesses or extremely severe suffering questions where to draw the dividing line. In his debate with Dworkin, Finnis asks about the right to die: "Where is the proposition specifying who has the right, to what acts, by which persons? Is it the right of terminally ill patients? (And what is terminal illness?) Or only those who are suffering? (And what sort and degree of suffering?)."[12] Dworkin considers that the line should be drawn so that only those who will die within a period of six months are eligible.[13] But the line is arbitrary, and no one can explain why we allow euthanasia in certain cases and not in others.

Another argument against euthanasia for the terminally ill says that if the law of murder were amended to legalize euthanasia, the ethics of doctors, nurses, and hospital administrators would change very rapidly, mainly because of the law of torts.[14] "Killing with intent becomes a routine management option."[15] Murphy talks about an obligation to kill that seems implicit in the rights language used by euthanasia and assisted suicide activists.[16] He asks what would happen if the drugs did not cause death as expected, and he thinks that there will be an obligation of attending physicians to take steps to ensure that the patient is "thoroughly killed."[17]

Along the same lines, the physician-patient relationship is denaturalized and affected by doubt and distrust, since a sensible patient might be afraid to express all their feelings and fears where this could be perceived as a request to die. Such fear will make a patient lonelier and more isolated, even from their family if their relatives have had an active role in the decisions involving unconscious patients.

Palliative care physicians are one of the specialties that are more deeply affected by the legalization of euthanasia, because they want to accompany patients through all the symptoms and stages of their disease, and euthanasia or assisted suicide betrays that purpose.[18] Even pharmacists are involved in euthanasia, as happened in Belgium, where in November 2005 parliament decriminalized the act of dispensing a lethal prescription.[19]

When we face extreme situations, such as a terminal illness or severe suffering, a powerful argument against euthanasia is that there is an actual risk that the decision may

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[11] Gorsuch (2000), 695.

[12] Finnis (1998), 1130.

[13] Solum, Dworkin, and Finnis (1997), 1500.

[14] Finnis (1998), 1133.

[15] Finnis (1998), 1133.

[16] Murphy (2017), 369–70.

[17] Murphy (2017), 372.

[18] Murphy (2017).

[19] Saad (2017), 198–99.

not be authentically autonomous, but rather guided by the pressure of guilt, depression, poor care, or economic worries.[20] These pressures may be explicit, implicit or even imposed by context, since the patient may think that her o his relatives expect her or him to decide on the application of euthanasia himself.[21]

An excessive individualism underlies such arguments justifying euthanasia, which conceive of a patient alone, existentially isolated and detached from their family and social bonds, providing a kind of atmosphere which is consistent with the play of interests alien to the patients themselves, or at least with their invisibilization in the discussion. This in fact damages the dignity of all parties involved and leads to a consequence: the isolation of the patient, who is alone in their autonomy. But it is possible to see other relational options in the subsidiary and joint interaction among the individual, their family, intermediary institutions, and the State.

In sum, the arguments linked to the legalization of euthanasia on grounds of autonomy for persons who are terminally ill or undergoing severe suffering have deficiencies and fail to provide convincing reasons to justify its legalization.

III.2. *Autonomy and euthanasia of unconscious or terminally ill persons*

The argument that proposes the legalization of euthanasia based on personal autonomy finds a limitation that is difficult to overcome in connection with cases of unconscious persons. In principle, euthanasia could not be applied to these persons since it would not be the result of an autonomous decision and, in general, there are opinion is uniform in considering that "involuntary" euthanasia is severely unjust and inadmissible. Paradoxically, it was thanks to highly publicized cases of persons in minimally conscious states that stronger pressure was exerted to make progress in legalizing a dignified death, and even euthanasia.

Once again, what is relevant here is the distinction between euthanasia and overzealous treatment, which will be analyzed in Part V. In this Part, I will exclusively refer to those arguments contending that it would be legitimate, as an expression of the patient's autonomy, to apply euthanasia even to unconscious persons.

Extolling personal autonomy has resulted in looking for criteria and procedures to anticipate or reconstruct a patient's will so as to determine whether to apply euthanasia. Thus, even in cases of unconscious persons who are terminally ill, it has been proposed to end their lives as a as a logical consequence deriving from the principle of autonomy.

A first argument to justify euthanasia in unconscious persons consists in resorting to anticipated directives, that is to say, written documents in which the person previously stated the medical decisions that the patient would wish to make in the event they become unconscious at the end of their lives.

The problem with these anticipated directives is that it proves impossible to foresee all the health circumstances and conditions that will surround the decision. In other words, when the time comes to apply such a directive, there may be unforeseen factors that materially change the judgment made in advance.

A second way to justify euthanasia in unconscious persons as an expression of autonomy consists in trying to reconstruct the patient's will (*substituted judgement*), or in the surrogate's constructing a preferential criterion (*constructive preference*), taking into

[20] Finnis (1998).
[21] Finnis (1998).

account both the substitution as well as the best interest criteria[22], or in the surrogate's giving testimony about the actual will of the patient.

Theoretically speaking, decisions may be made on behalf of an unconscious or incompetent patient by a physician[23] or a surrogate, generally someone appointed by the patient himself or by a family member, based on an order of preference that may be established by law or otherwise.[24] Others suggest a decision jointly made by the physician and the patient's family members.[25]

This proposal of euthanasia by decision of a surrogate has received sharp criticism. Among the negative remarks, it has been argued that testimony as to the patient's will may be based on a comment either casually or thoughtlessly made. The will may have been changeable, or may have been expressed in an emotional setting conditioning the patient's judgement, or may have been made without the information required for adequate discernment and consent. Cantor highlights that the courts in some states like Missouri and New York have ruled that in order for the surrogate's decision to be admitted, "clear and convincing" evidence should be left by the patient to demonstrate that the patient would have wanted such an action under the given circumstances.[26]

From the physician-patient relationship perspective, testimony as to a person's will does not constitute informed consent properly speaking, since giving information becomes irrelevant because the surrogate's role limits to give testimony.

A fundamental problem with the participation of relatives in a decision on euthanasia is the presence of potential financial incentives, differing religious or moral beliefs, or family conflicts.[27] It is interesting to note that although Article 12 of the UN Convention on the Rights of Persons with Disabilities refers to the wishes and preferences of the person in question, it also introduces the "conflict of interests" and "undue influence" criteria as restrictions on action by persons who help express the will of a person with disabilities.

From the logic of autonomous will, some authors wonder whether the order of priority fixed by law is the one that the incapacitated individual would have chosen.[28] In addition, there might be a conflict between the cultural perspectives of the patient and the surrogate Similarly, the surrogate may simply be wrong as regards the patient's wishes, or project her own's preferences onto the patient.

All in all, it becomes untenable to maintain that in such cases the decisions made regarding terminal illnesses may be considered to be autonomous. This autonomy is a reconstructed or a fictitious autonomy.

III.3. *Is there a right to die?*

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[22] Cantor (2001), 193.

[23] See Krupp (1998), 99-128 (demonstrating the ethical problems inherent in decisionmaking by surrogates or doctors, pointing to economic incentives and paternalism as potential issues).

[24] In *In re Quinlan*, 355 A.2d 647 (NJ 1976), the Supreme Court of New Jersey held that if Karen Ann Quinlan had been in a conscious state, she would have had the right to resist vital life support measures and that, given her incapacity, her right had to be exercised by a "guardian" or surrogate like her father. See Cantor (2001).

[25] Cai et al. (2015), 131-41.

[26] Cantor (2001), 190.

[27] Krupp (1998).

[28] Kohn, Blumenthal (2008), 979-1018.

The autonomy criterion is only consistent if we accept that a right to die may be advanced by any person at any time. But can that be justified?

When ending his debate with Finnis, Dworkin acknowledges: "it all comes down to this question of individual freedom ... there must also be a respect for the dignity of having control over your own life."[29] To Harris, preventing a person from making by themselves one of the most important decisions in their lives—as euthanasia undoubtedly is—is a form of tyranny.[30] Dworkin emphasizes how important it is for individuals to be able to control the timing and the manner in which they die.[31]

Several authors have responded very properly to this argument of making autonomous will so absolute a notion as to legitimize an act causing one's own death, either on one's own or with the assistance of someone else.

Arguing that there is a right to die puts at stake the view of life as a basic human good, which will be discussed in depth in Part V. In any case, I may say now that I understand it to be an indefeasible good and that, as explained by Massini Correas, the expression 'right to die' or 'right to death' "is self-contradictory, since one cannot have the right to the frustration of a human good, and especially for the perpetration of a human evil par excellence: the annihilation of life."[32]

Some others justify this right alleging that suicide is not a crime. Andorno reasons that "it is true that, generally, if someone wishes to commit suicide, they can do it. But it does not follow that there is a 'right' to die, that is to say, a right that may require of the State a support for such desire, let alone demanding other persons to take their lives. Death does not constitute a 'good that is owed' in terms of justice."[33] In addition, the State is not unconcerned about suicide, but it opts not to punish the perpetrator of suicide or attempted suicide since society believes that this act is generally carried out in circumstances that vitiate free will and, besides, a completed suicide is not amenable to typical punishments.[34] As regards the purported right to die, there is no foundation for such a right, that is to say, the objective human good rationally justifying the existence of such a right; and, more importantly, it threatens a basic human good—a person's life.[35]

Allegedly, the autonomy to take one's own life would be the realization of the principle that requires informed consent for any action affecting an individual's physical integrity. Keown refutes this argument, explaining that "the legal requirement of consent to medical treatment provides a shield against unwanted touching, not a sword to demand interventions. It does not follow from the fact that physicians may not treat patients without their consent that they can terminate them with their consent. Moreover, the killing of patients has never been regarded by the law as a medical treatment but as a serious crime (and by the medical profession as a whole as inconsistent with the physician's role as healer)."[36]

There are several rules "restricting" the autonomous will that are consistent with safeguarding life as a fundamental legal good. Let us just think about the rider's obligation to wear a helmet or the duty to fasten a seatbelt when driving an automobile. More important is the abolition of slavery, a practice which implies a radical form of disposing

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[29] Solum, Dworkin, Finnis (1997), 1505.

[30] Harris (2004), 47.

[31] Dworkin (1994), 273.

[32] Massini Correas (2003), 404.

[33] Andorno (2012), 166.

[34] Serrano (2006), 237.

[35] Massini Correas (2003), 404–5.

[36] Keown (2014), 1-41.

of your own life.[37] Nor is a person allowed to dispose of their organs when it amounts to committing suicide, and this does not constitute a violation of their autonomy.

The autonomy principle is insufficient grounds by itself to justify euthanasia because "it does not provide any reason to act; no one just acts to realize their autonomy, but to perform valuable conducts with freedom."[38] Although Mill is usually quoted as providing grounds for the legalization of euthanasia, one must recall that to Mill there is no freedom not to be free, and allowing individuals to alienate their autonomous will betrays their own autonomy.[39]

Gorsuch says that "there are autonomy interests on both sides of the assisted suicide issue: the interest of those persons who wish to control the timing of their deaths and the interest of those vulnerable individuals whose lives may be taken without their consent due to acts of mistake or abuse."[40] As the slippery slope argument demonstrates, if only those that have an "autonomous will" are granted legal protection, the most vulnerable are neglected.[41]

In sum, autonomy fails to justify euthanasia. Certainly, such explanations also require answers to the arguments about the quality of life of terminally ill patients, presenting a substantive development concerning the inviolability of human life.

IV. The utilitarian perspective in the end-of-life issues

IV.1. *Euthanasia and dignity as quality of life*

Along with the argument of autonomous will, another school of thought seeks to justify euthanasia from a utilitarian perspective. According to this view, dignity would require that a person be allowed to take their life because the life they lead while terminally ill or with severe suffering is no longer compatible with dignity and indeed amounts to an undignified condition.

One of the problems surrounding the application of the utilitarian logic at the end of life is how to calculate quality of life or determine what constitutes an undignified living condition. In reality, it is very difficult to weigh the state of being alive, against pain, economic problems, or other circumstances. Human life could never be weighed in the same way as other goods or ills.[42] "Weighing the liberty interest of the person seeking death against the right of persons to avoid being killed as a result of abuse or mistake is literally impossible due to the incommensurability of the goods being weighed."[43]

Within this utilitarian calculus, a widespread idea of "quality of life" is involved that ends up considering any illness or suffering condition to be "undignified". Zambrano emphasizes that "physical and emotional suffering does not only deprive life of any sense, but many times it is transformed in order to serve your fellows more intensively, and,

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[37] Ollero wisely addresses this argument surrounding euthanasia and the unrenounceable nature of freedom as well as the right to life. Ollero (2006), 205.

[38] Quintana (2011), 637.

[39] Faulconer (2016), 322. Quotation of the passage from the book by Mill *On Liberty*: "The principle of freedom cannot require that he should be free not to be free. It is not freedom, to be allowed to alienate his freedom."

[40] Gorsuch (2000), 660.

[41] Masferrer (2016), 251.

[42] Andorno (1997), 973–79.

[43] Gorsuch (2000), 679.

above all, that your fellow finds in the suffering life a reason to live."[44] Quintana adds that the concept of "quality of life" associated with euthanasia has discriminatory implications.[45] Along the same lines, Gormally explains that asserting that a patient lacks a life worthy of being lived is a justification incompatible with the acknowledgment of the patient's inalienable dignity and value.[46]

Pilar Zambrano gives a good explanation for the anthropological background underlying this issue: "If what is valued by Law is not human life in itself, but life as desired and wished by its own holder, the conclusion is evident: once the capability of valuing and loving yourself is lost, what is also lost is one's own condition to be valuable and desirable or susceptible to be beloved."[47]

The utilitarian criterion, in connection with dignity, entails classifying lives as worthy or unworthy of being lived. Unless doctors are permitted to kill anyone and everyone who makes a 'stable and competent' request for death, they are going to have to proceed on a classification of lives as 'worth living' or 'not worth living'.[48] "Legalization would require society's active participation in making comparative moral judgements about the value of different kinds of human lives. Unless we adopt the neutralist's position that assisted suicide should be open to all rational adults, an individual's request to die would not be honored without social ratification. Society would have to regulate which lives are worth living and which ones are not."[49]

In a study on factors of influence at the time of death in relation to the perception of dignity, Chochinov and his team confirmed that the most mentioned items regarding the potential loss of dignity were "not being supported by the community," "feeling unworthy or useless," "incapable of managing vital body functions", "not feeling that a long-lasting or significant contribution was made," "not having control over one's life," "feeling like a burden to others," and "not being treated with respect and understanding."[50] These findings cast a different light on the idea that any terminal situation implies an undignified condition, and they serve to draw attention to the significance of the relational dimension of a person, assistance to the patient and, above all, palliative care, which help overcome pain in almost every case, being an ethically acceptable alternative in view of the demands for legalizing euthanasia.

Finally, although it is impossible to develop this topic thoroughly in this Article, we should consider the underlying issue when the utilitarian calculation is further applied to other goods at stake, such as public health or hospital expenditure. These factors are never explicitly included in the debate, but they undoubtedly influence, and greatly, the issues surrounding end-of-life decisions. Finnis considers that the healthcare financial interests could push for the legalization of euthanasia, and those interests could influence physician's decisions at the bedside.[51] Gorsuch says that "given the laws of economics, the increasing availability of assisted suicide (a cheaper solution) might serve as a deterrent to the development and dissemination of (more expensive) palliative and hospice options."[52]

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[44] Zambrano (2005a).
[45] Quintana (2011), 638.
[46] Gormally (2004), 171.
[47] Zambrano (2005b), 265.
[48] Finnis (1998), 1144.
[49] Gorsuch (2000), 690.
[50] Chochinov et al. (2006), 666–72.
[51] Finnis (1998), 1139.
[52] Gorsuch (2007), 332.

Another complex problem that implies a conflict of interest is the connection between euthanasia and organ procurement. The need to have more organs available could lead to loosening the relevant controls and facilitating the application of euthanasia if the patient was an organ donor. In Belgium, organ donation after euthanasia is permissible under the law and there is an ongoing debate as to whether this situation might create situations of exploitation and coercion.[53]

IV.2. *The Slippery Slope Argument*

In general, legalization of euthanasia is initially introduced in exceptional cases, linked to patients facing imminent death. Nevertheless, experience has shown that then the dividing line drawn (for example, severely and terminally ill patients with a six-month life expectancy) becomes blurred and euthanasia is applied to other cases involving less terminally ill and less severe patients. This criticism of the legalization of euthanasia is known as the slippery slope argument[54], and there are four significant bases of the argument. First, from the most severe and dramatic cases of terminally ill persons, euthanasia started to be applied to other persons with curable illnesses or undergoing merely temporary situations. Second, and relatedly, the number of euthanasia cases has increased. Third, euthanasia is applied not only to conscious persons, but also to persons who are unconscious or incapable of giving their consent, such as children. Fourth, controls over the application of euthanasia are problematic due to the ambiguity inherent in diagnosis and the clinical situations involved.

The slippery slope argument is linked to the practical experience of the countries that have legalized euthanasia. In the Netherlands, the legalization of euthanasia began with a series of court cases in 1973. In 1984 there was a significant milestone with a Supreme Court ruling in the *Alkmaar case*, in which a physician was prosecuted for giving a fatal dose of curare to a 95-year-old woman who had begged to die. The doctor was acquitted and that year the Royal Dutch Medical Association issued an influential statement on euthanasia. From that moment, euthanasia has been practiced legally in the Netherlands. In 1994, in the *Chabot case*, the Supreme Court ruled in favor of the assisted suicide of a mental patient.[55] In 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act was passed and euthanasia was legalized in those cases where the physician fulfils the due care criteria set out in Article 2 of the Act. To act with due care the physician must: be satisfied that the patient's request is voluntary and well-considered; be satisfied that the patient's suffering is unbearable, with no prospect for improvement; have informed the patient about their situation and prognosis; have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation; have consulted at least one other independent physician, who must see the patient and give a written opinion on whether the due care criteria set out above have been fulfilled; have exercised due medical care and attention in terminating the patient's life or assisting in the patient's suicide.[56]

Under this Act, in 2016 there were 5,856 cases of euthanasia (96.14%), 216 of assisted suicide (3.54%), and 19 of a combination of the two (0.31%). Among the disorders invoked to apply the Act in those 6091 cases were: cancer (4,137), neurological

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[53] Saad (2017), 201–3.

[54] Schauer (1985), 363 argues that it was Yale Kamisar (1958) See also Yale Kamisar (1991).

[55] Gevers (1996), 326-33.

[56] Regional Euthanasia Review Committees (2017).

disorders (411), cardiovascular disease (315), pulmonary disorders (214), multiple geriatric syndromes (244), dementia (141), psychiatric disorders (60), combination of disorders (465), and other conditions (104).[57]

The list shows that euthanasia has not been confined merely to terminally ill patients. Applying euthanasia and assisted suicide (EAS) to psychiatric disorders has proven troublesome. In a study published in 2016 on these patients in the Netherlands, the conclusion was that "persons receiving EAS for psychiatric disorders in the Netherlands are mostly women and of diverse ages, with complex and chronic psychiatric, medical, and psychosocial histories. The granting of their EAS requests appears to involve considerable physician judgment, usually involving multiple physicians who do not always agree (sometimes without independent psychiatric input), but the euthanasia review committees generally defer to the judgments of the physicians performing the EAS."[58]

The increase in the number of euthanasia cases is significant in the Netherlands. In 2002 there were 1882 cases; in 2007, 2120; in 2012, 4188; and in 2016, 6091, accounting for the 4% of the total number of deaths (148,973).[59]

Another situation that demonstrates the slippery slope is the application of euthanasia to children and unconscious people, which I have already analyzed in part in the previous paragraphs. In the Netherlands, under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act it was illegal to apply euthanasia to children under the age of 12, but a Protocol was created at the University Medical Center Groningen, in consultation with the Groningen district attorney in September 2004 giving guidelines for applying euthanasia to severely ill newborns. The Groningen Protocol has been ratified by the Dutch National Association of Pediatricians and those physicians acting under this Protocol will not be prosecuted.[60]

Applying euthanasia to children and unconscious people is a consequence of a utilitarian calculation[61], and euthanasia would be justified if pain exceeds pleasure. Keown explains that

> "once the principle of the inviolability of life is abandoned by endorsing voluntary euthanasia in some circumstances, the bright line grounded in the intrinsic and ineliminable dignity of each patient is usurped by an arbitrary line dependent on subjective judgments about which patients would be 'better off dead' and that, in particular, the endorsement of voluntary euthanasia logically entails the endorsement of non-voluntary euthanasia, that is, the killing of incompetent patients."[62]

Another aspect of the slippery slope argument is whether the State can effectively control the practice of euthanasia once it has been legalized. Nancy Cruzan, Terri Schiavo, Eluana Englaro, Vincent Lambert, and others were the subjects of very disputed end-of-life cases in which it was hard to make a "best" decision. Those cases attracted great public attention and gave rise to large debates in the public sphere. The circumstances of their illnesses and their situations were highly scrutinized, and every single aspect of the decisions was thoroughly analyzed. Those difficult and unique cases

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[57] Regional Euthanasia Review Committees (2017).

[58] Kim, De Vries, Peteet (2016), 362–68. See also George (2007), 1-33 (presenting evidence of a risk that the decisions of some women for assisted death are rooted in oppressive influences inimical to genuine autonomy).

[59] Ferrer (2017).

[60] Vivanco Martínez (2014), 74–75.

[61] Farrell (1985), 118.

[62] Keown (2014), 22.

also generated proposals to change the regulatory framework in various states and countries so as to legalize euthanasia. But those were extraordinary cases, while the laws that decriminalize euthanasia apply to everyday situations in medical facilities where there are different scenarios and no such in-depth analysis would be done.

The problem of controlling euthanasia is inherent in the ambiguity of the underlying diagnosis that must be made. The "Annual Report 2016" of the Regional Euthanasia Review Committees (RTE) in the Netherlands acknowledges this ambiguity when it asks: "When is euthanasia an option for people with a psychiatric disorder or people with (advanced) dementia? When can it be said that a person regards their life as completed? And when does the suffering of a patient with multiple geriatric syndromes have a medical dimension?"[63]

In 1958, Kamisar warned that legalizing euthanasia carried too great a risk of abuse and mistake to warrant a change in the existing law, remarking that "under any euthanasia program the consequences of mistake, of course, are always fatal."[64] For instance, since 1990 in the Netherlands there has been a continual controversy over the application of euthanasia to persons who do not meet the law's requirements. The "Annual Report 2016" found that in ten cases the due care criteria set out in the Act had not been complied with (0.16% of the total number of notifications).[65] In 2018 criminal investigations have been launched into four cases of euthanasia in the Netherlands.[66] Although these cases represent a low proportion of the total number of euthanasia decisions, they indicate a problem that has not been completely resolved.

As Gorsuch says,

> "The alternative to an absolute rule against private intentional killing, moreover, is troubling territory. Once some intentional killings become acceptable, society becomes enmeshed in making moral decisions about which ones are deemed permissible. In the assisted suicide and euthanasia context, unless we unleash the full-throttle neutralist and harm principle right open to all adults, society is forced into a debate over the relative value of different kinds of human life. Judging whose lives may and may not be taken in turn depends upon assessments of quality of life—whether one is young and fit or old and sick. Different human lives are thus left with different moral and legal statuses based on their perceived 'quality of life'."[67]

V. The right to life and justice at the end-of-life

V.1. *Euthanasia and the inviolability of life*

In the two previous sections, I analyzed the arguments proposing the legalization of euthanasia on the grounds of autonomous will and of utilitarian considerations of quality of life. In this section, my aim is to analyze dignity as a value, inherent in the person, that implies the respect for the inviolability of human life. This conception will allow us to analyze the demand for justice in end-of-life decisions.

Any human being, by virtue of his or her humanity alone and irrespective of acknowledgement by the positive legal system, has the fundamental right to life (Article 3,

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[63] Regional Euthanasia Review Committees (2017).

[64] Kamisar (1958), 73.

[65] Regional Euthanasia Review Committees (2017).

[66] Boffey (2018).

[67] Gorsuch (2000), 701–2.

Universal Declaration of Human Rights). The right to life is a pre-requisite for other rights and assumes respect for the inviolability of the physical integrity of each human being. As John Finnis says, life is one of the "basic goods" which make up the fundamental human rights.[68]

The right to life has a double expression: it has a positive sense, which translates into promoting human life; and a negative sense, whose mandate is reflected in the prohibition on killing. In both cases, the underlying principle is the respect for the physical life of every human being. As Gorsuch says, "the intentional taking of human life by private persons is always wrong."[69]

Shepherd considers that there is a default position in favor of continued life in the structure of the law concerning end-of-life decisions.[70] I think that this default position expresses the basic principle of medical care: the protection of life.[71]

The inherent dignity of every human being cannot be conditioned on whether one has autonomous will or not or whether one's life satisfies certain criteria of quality. In fact, in complex end-of-life challenges, instead of letting the individual decide alone we are called to confirm bonds and solidarity, taking charge of the other's needs and accompanying them even through the most painful and difficult moments. As Finnis says, "a just society cannot be maintained, and people cannot be treated with the equal concern and respect to which they are all entitled, unless we hold fast to the truth... that none of us is entitled to act on the opinion that the life of another is not worth living."[72]

If dignity is inherent in personhood and is an intrinsic attribute of any human being, then we may strongly argue that it cannot be subject to the swings of autonomous will; euthanasia, therefore, is rendered inadmissible.[73]

V.2. *The distinction between euthanasia and refusal of overzealous treatment*

The connection between dignity and the inviolability of life does not mean that appropriate distinctions need not be made in order to avoid situations where new medical or biotechnological procedures may lead to protracted agony without genuine improvement. This issue is known as overzealous treatment. Logically, such a refusal or withdrawal or treatment raises questions of coherence in light of the principle of respect for inviolability of human life. In these cases, I maintain that it is legitimate to renounce such treatments.

The conditions[74] for such a renunciation to be legitimate are as follows:

(a) disproportionate medical treatment or intervention, in relation to the prospects for improvement, assessed on a case by case basis, according to the prevailing circumstances of time and place, and also considering the individuals involved;[75]

(b) imminent and unavoidable death;

(c) maintenance of habitual treatment necessary for the patient in these kind of cases, including – in principle – food and hydration.

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[68] Finnis (2000), 117–21.

[69] Gorsuch (2000), 606.

[70] Shepherd (2014), 1693–1748.

[71] Padrón (2015), 173.

[72] Finnis (1998), 1145.

[73] As regards the debate on dignity and the person, see Herrera (2012); Hoyos Castañeda (2005).

[74] Basso (1993), 444.

[75] Sambrizzi (2005), 208.

In this case, the right to life is not affected by permitting the subject's death, since what occurs is simply the acceptance of death, which is an unavoidable aspect of human life. These distinctions are important as far as principles are concerned, although it is clear that their actual application is linked to prudence in any specific case.

A complex aspect in this matter has been the relationship between refusal of overzealous treatment and euthanasia by omission. Some authors contend that euthanasia can only be committed through actions, while any renunciation of a medical treatment is uniformly acceptable. This logic fails to address euthanasia by omission, which is a form of causing death as a consequence of not providing the required treatment. My opinion is that euthanasia may be committed by action or by omission, and, in turn, both cases should be distinguished from renunciation of overzealous treatment. The debate has been mainly focused on the problem surrounding the withdrawal of food and water.[76]

The object of the action and the pursued purpose need to be taken into account for a fair consideration of conduct. What is at stake is a person's life. Similarly, the subtleness of intent should be considered, which enables drawing a distinction between a patient who orders their death to be inflicted and the one who only renounces treatments which prove out of proportion to the prospects for improvement in the face of unavoidable and imminent death As explained by Finnis, there is a difference between refraining from choosing to harm a fundamental human good, and accepting damage to human goods as undesired secondary effects.[77]

In sum, it is important to emphasize once again that euthanasia always consists in causing death, and such causation may be realized by action or by omission. By contrast, in refusing disproportionate procedures there is an essential difference which lies in the absence of causing death. Euthanasia "by omission" should not be confused with the refusal of disproportionate or extraordinary measures in those cases where death is soon to occur and there are no prospects for improvement.[78]

VI. Conclusion

Throughout this article, I have sought to analyze the views proposing the decriminalization or legalization of euthanasia, mainly based on the different views on human dignity at the end of life. I took as a starting point the assertion that taking a human person's life is an unjust act.

Firstly, regarding the view proposing that autonomy is the core element of human dignity and that this entails the need to decriminalize euthanasia and assisted suicide, I highlighted the inconsistency in affirming that certain persons with terminal illnesses or severe suffering are authorized to decide to put an end to their own life, apart from the ambiguity present in the dividing lines that are proposed. Moreover, those patients, may suffer different pressures that condition their freedom. On the other hand, euthanasia by request profoundly alters the physician-patient relationship in including the possibility of killing as another available option. Regarding the right to death, it entails the frustration of a basic human good, which is human life. And, as Finnis has remarked, the ultimate horizon is the common welfare conducive to the flourishing of all the members of a community.[79]

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[76] McGee (2005), 357–85; Keown (2005), 393–402.

[77] Finnis (2004), 57.

[78] Basso (1993), 462.

[79] Finnis (1987), 456.

Regarding the theories proposing the legalization of euthanasia on the grounds of a utilitarian vision of quality of life, I have noted that this view leads to a distinction between lives that are worth living and lives that are not worth living. Such a distinction will necessarily be made by physicians and by society, which can only lead to new forms of oppression of an individual's dignity. The slippery slope argument reinforces this conclusion, since in those jurisdictions that legalized euthanasia for very exceptional and terminal cases, there has been an increase in the frequency with which euthanasia is carried out and the practice has increasingly been extended to situations that are becoming less final and severe.

Finally, I maintain that depriving a person of human life should be legally blameworthy at all times, even in those cases which have been identified as euthanasia. In this sense, I have demonstrated that the connection between dignity and inviolability of life offers a safe criterion for weighing euthanasia, while allowing us to make appropriate and fair distinctions between euthanasia and the rejection of overzealous treatment. What is involved is a certain proportionality between therapeutic measures and the patient's health.[80] In this sense, those who practice medicine must be stronger in demanding endorsement of the principle of inviolability of life .[81]

Ultimately, what is at stake is the question of admissibility of conduct that deprives certain persons of life as a basic good in certain circumstances. In an age in which the biotechnological applications tend to consider that life is a mere biological material available, it is imperative to affirm the demands for justice deriving from the dignity of the human person, especially when the most vulnerable individuals are involved. While it is legitimate to reject biotechnologies in situations of overzealous treatment, it is unjust to put an end to human life deliberately, either by action or omission, using the excuse of a claimed autonomy or a lack of quality of life,.

Legalizing euthanasia betrays the meaning of dignity. Instead of expressing the high value of human life, to die with dignity is understood as getting rid of your life because of its low value.[82] As Finnis says, "persons keep their radical dignity until death"[83], and it is our duty to accompany them until the end of their life, recognizing their inherent dignity with solidarity and compassion.

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[80] Arias de Ronchietto (1996), 15–48.

[81] Gómez Lobo (2008), 780.

[82] Hartling (2006),189–99.

[83] Finnis (1998), 1143.

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