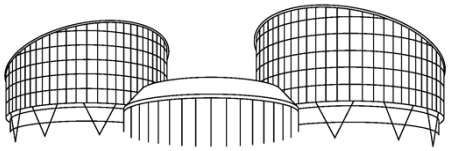

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

THIRD SECTION

CASE OF MORTIER v. BELGIUM

(Application no. 78017/17)

JUDGMENT

Art 2 (substantive) • Positive obligations • Life • Death by euthanasia of applicant's mother, who suffered from depression for about forty years, as authorised by law • Legislative framework capable of ensuring in principle patient's right to life as regards pre-euthanasia acts and procedure • Additional safeguards concerning euthanasia for mental suffering where death not otherwise expected in short term • Margin of appreciation
Art 2 (procedural) • Positive obligations • Lack of independence of board subsequently reviewing all acts of euthanasia, allowing doctor who carried out specific act to vote on its lawfulness • Doctor's sole discretion as to whether to remain silent not sufficient • Requirements of Art 2 not satisfied by review solely on basis of anonymous part of registration document to preserve confidentiality • Excessive length of criminal investigation
Art 8 • Positive obligations • Private and family life • Doctors' failure to involve son in procedure leading to mother's death by euthanasia, in absence of her wish to do so, in accordance with law • Duty of confidentiality and medical secrecy • Fair balance between different interests at stake struck by legislation

STRASBOURG

4 October 2022

FINAL

04/01/2023

This judgment has become final under Article 44 § 2 of the Convention. It may be subject to editorial revision.

In the case of Mortier v. Belgium,

The European Court of Human Rights (Third Section), sitting as a Chamber composed of:

Georges Ravarani*, President*,
Georgios A. Serghides,
María Elósegui,
Darian Pavli,
Peeter Roosma,
Andreas Zünd*, judges*,
Stefaan Smis*,* ad hoc *judge*,
and Milan Blaško, *Section Registrar,*

Having regard to:

the application (no. 78017/17) against the Kingdom of Belgium lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Belgian national, Mr Tom Mortier ("the applicant"), on 6 November 2017;

the decision to give notice to the Belgian Government ("the Government") of the application;

the observations submitted by the respondent Government and the observations in reply submitted by the applicant;

the comments submitted by the non-governmental organisations Association pour le Droit de Mourir dans la Dignité, Care Not Killing, the European Centre for Law and Justice, Dignitas and the Ordo Iuris Institute, which had been granted leave to intervene as third parties by the President of the Section;

the Court's decision of 26 November 2019 not to accept the Government's unilateral declaration;

the withdrawal of Frédéric Krenc, the judge elected in respect of Belgium, from sitting in the case (Rule 28 of the Rules of Court) and the decision of the President of the Chamber to appoint Stefaan Smis to sit as an *ad hoc* judge (Rule 29 § 1 (a));

Having deliberated in private on 3 May 2022 and 30 August 2022,

Delivers the following judgment, which was adopted on the last-mentioned date:

INTRODUCTION

1. The case concerns the death by euthanasia of the applicant's mother, without the applicant or his sister having been informed. The applicant complained under Articles 2, 8 and 13 of the Convention.

THE FACTS

2. The applicant was born in 1976 and lives in Rotselaar. He was represented by Mr R. Clarke, a lawyer practising in Vienna, Austria.

3. The Government were represented by their co-Agents, Ms Justine Lefebvre and Ms Isabelle Minnon, of the Federal Justice Department.

I. THE FACTS LEADING UP TO THE EUTHANASIA

4. The applicant is the son of G.T., who had been diagnosed as suffering from chronic depression for around forty years. She had been treated by B., a psychiatrist, for several years.

5. G.T. had been considering undergoing euthanasia but her general practitioner, Dr W., did not want to take on the role of main doctor in such a procedure, so he referred her to Professor D.

6. On 29 September 2011 Professor D. saw the applicant's mother for a palliative care consultation. G.T. said that she had been receiving psychiatric treatment since she had been 19 years old and that she had tried all medications. She also said that Dr B. had informed her that she had reached the end of her treatment. During the consultation G.T. described her family ties and family history. She stated that she had not had any contact with her son or her grandchildren for two years. She indicated that in 2006 she had had breast cancer, a period she described as the "happiest time" of her life because she had met a new partner in those circumstances. Professor D. concluded that G.T. was severely traumatised, that she had a serious personality and mood disorder and that she no longer believed in recovery or treatment. At the end of their interview, he agreed to become her main doctor under the law on euthanasia. He referred her to Dr V., a psychiatrist, to act as consulting doctor for the purposes of section 3(2)(3°) of the Law of 28 May 2002 on euthanasia ("the Euthanasia Act"; see paragraph 51 below).

7. On 17 November 2011 G.T. met with Dr V., who confirmed that G.T. suffered from chronic depression with "ups and downs". Considering the length of G.T.'s treatment and the failure of all therapeutic measures, Dr V. found the outlook bleak but considered G.T.'s request premature. She therefore suggested that G.T. first try consulting another psychiatrist, and referred her to Dr V.D. for subsequent care.

8. On 23 December 2011 Professor D. had another conversation with the applicant's mother, who told him that she was afraid of being cast aside and having her euthanasia request rejected. She said that she was prepared to see Dr V.D. as Dr V. had suggested but that she was also afraid she might be rejected. She stated that she no longer wanted to have contact with her children. She claimed that her son was aggressive and that she was afraid of him.

9. On 12 January 2012 the applicant's mother told Professor D. that she was exhausted. She again stated that she did not want to contact her children. She said that she had not yet been to see Dr V.D. because she could not reach him. Regarding Dr V., she said that there was a very long wait for another appointment. Professor D. therefore referred her to Dr T., another psychiatrist, for a fresh consultation.

10. On 17 January 2012 the applicant's mother met with Dr T. On that occasion, she stated that she had taught full-time from 1982 to 1985 and then part-time until 2006. In her opinion, she had been able to cope during that period by taking treatment. She also described her family relationships, particularly the problems that she had had with her husband, who had since passed away. She stated that her daughter, with whom she did not have a good relationship, was aware of her euthanasia request. She indicated that she no longer had anyone in her life and that she spent every day alone. She stayed in bed all day and no longer had any desire to do anything. She further stated that her psychiatrist at the time, Dr B., was aware of her euthanasia request but did not want to help her to die. She had asked him what more he could do for her. He had allegedly replied, "Listen to you", but had acknowledged that she was "incurably ill". G.T. stated that she had never been admitted to a psychiatric facility and that such an option had never previously been suggested. She said that she had lost faith in psychiatry. She further stated that her experience in that area had not been good because of her son's admission to such a facility for six months. She listed all the medication that she took. At the end of the consultation G.T. expressed the wish to undergo euthanasia within weeks.

11. On 20 January 2012 the applicant's mother had another appointment with Professor D. and agreed to be assisted by Dr V.D. during the process of clarifying her euthanasia request. That same day it was suggested that she inform her children of her euthanasia request so that they could accompany her throughout the process.

12. On 31 January 2012 the mother sent an email to the applicant and to her daughter, informing them of her euthanasia request, her desire to have a dignified end to life and the intense suffering that she had been experiencing for forty years. It does not appear from the case file that the applicant answered that email. G.T.'s daughter, however, replied that she respected her mother's wishes.

13. That same day Professor D. informed G.T. that she should make an appointment with Dr V.D. because he thought that she could be helped.

14. On 7 February 2012 Professor D. contacted Dr B. because G.T.'s treatment had not formally been terminated. When asked whether there was any chance that the situation of the applicant's mother could improve, Dr B. replied in the negative. In his opinion, the problem was serious and chronic, with an adverse prognosis.

15. On 10 February 2012 Dr B. sent a letter to Dr T. stating that he had known the applicant's mother since 1996 on account of her wide variety of very serious mental health conditions stemming from psychological trauma since childhood. He described G.T.'s situation and concluded that the outlook was extremely bleak.

16. On 14 February 2012 the applicant's mother lodged a formal, handwritten request for euthanasia. That same day Professor D. formally became her main doctor for the purposes of the euthanasia request.

17. Also on the same day Dr T. drafted a report indicating that the applicant's mother had consulted her several times concerning her request for euthanasia on account of intolerable and incurable suffering. According to Dr T., G.T. was rational and clear-sighted. She had been informed of the treatment options that could alleviate her pain but not cure her. Dr T. noted that Professor D. had encouraged G.T. to contact her children, but that G.T. had only wanted to write a goodbye letter. Having noted that there was no pressure from third parties, Dr T. considered that the applicant's mother could be assisted in ending her life.

18. On 17 February 2012 the applicant's mother was examined by Dr V.D. who, on the basis of her condition, considered that she could be assisted in ending her life. It is apparent from G.T.'s medical file that Dr V.D. drew up a report on 20 February 2012 indicating that a euthanasia request had been lodged by an unmarried woman, with two children, who had been receiving psychiatric treatment for mood and personality issues since she had been a teenager. The doctor stated that the patient was living in marked social isolation and had a bitter attitude towards life, among other things refusing any further treatment. He further indicated that the patient's psychiatrist of many years had confirmed her chronic depression and the hopelessness of all other treatment options. He said that the conversation had gone fairly easily with the patient, who had become slightly emotional when talking about her grandchildren, whom she had no longer had any opportunity to see.

19. On 22 February 2012 Professor D. saw the applicant's mother again. According to him, the situation seemed hopeless. He also consulted Dr B., who told him that all treatment and care options had been exhausted. Professor D. once again asked G.T. to contact her children.

20. On 27 February 2012 the applicant's mother drafted a formal, handwritten statement of intent to donate her body to science after her death.

21. On 29 February 2012 the applicant's mother donated 2,500 euros (EUR) to LEIF (LevensEinde InformatieForum), a non-profit association established in 2003 to work for a dignified end to life for all. That association was run by Professor D., and its members included Dr T. and Dr V.D.

22. On 8 and 12 March 2012 Professor D. examined the applicant's mother once again. He concluded that she had no more prospects in life.

23. On 12 March 2012 Dr B. concluded that there was no longer any point in G.T. establishing contact with her children. Dr V. advised informing them by letter. The applicant's mother asked for some time to think it over.

24. On 20 March 2012 the applicant's mother met with P.D., a person of trust, who noted that she had written a goodbye letter to her children.

25. On 3 April 2012 Professor D. and P.D. met with the applicant's mother again. On that occasion she reiterated that she did not want to call her children because she wished to avoid any further problems in her life. She agreed to write her children a letter with the help of P.D. She said that her assessment of her current life was negative and that she had no more prospects in life. She further stated that the medication had had no effect for two years and that she no longer believed in any possibility of improvement. Following the conversation Professor D., jointly with the applicant's mother and in agreement with the psychiatrists consulted, concluded that euthanasia was the only rational option. They set the date of the euthanasia procedure for 19 April 2012.

26. On 10 April 2012 Professor D. had two telephone conversations with the applicant's mother. She expressed her fear that the euthanasia procedure would be postponed because she did not want to contact her son. Professor D. assured her that her wishes would be respected.

27. On 19 April 2012 Professor D. performed euthanasia on the applicant's mother, who died at 11.15 a.m. in a public hospital in the presence of a few friends.

II. THE FACTS SUBSEQUENT TO THE EUTHANASIA

28. On 20 April 2012 the applicant was informed by the hospital that his mother had died by euthanasia the previous day.

A. The Board's automatic review

29. On 20 June 2012 the Federal Euthanasia Monitoring and Assessment Board ("the Board") received the euthanasia registration document completed by Professor D. Part II of that document (the anonymous part) was appended to the Government's submissions to the Court, lodged on 4 March 2020. It mentioned that the patient suffered from a very extensive mental illness, stemming from a bad childhood and a bad subsequent family life, leading to repeated, incurable bouts of depression. The mental suffering had been present since youth, had increased steadily over time and had no prospect of improvement. Neither psychotherapy nor medication was capable of alleviating her suffering any longer. The fact that the patient had been seeking euthanasia for years was proof that the request had been made of her own free will, in a considered and constant manner. The document also indicated that all conditions and procedures prescribed by the Euthanasia Act (see

paragraphs 51-52 below) had been complied with, and that opinions had been sought from two independent doctors, who had confirmed the patient's legal capacity, the incurable nature of her condition and the existence of extreme, intolerable mental suffering which could not be alleviated.

30. On 26 June 2012 the Board, of which Professor D. was co-chair, examined the registration document and concluded that the applicant's mother's euthanasia had been carried out in accordance with the conditions and procedure prescribed by the Euthanasia Act.

B. Steps taken by the applicant with respect to the Board and the Medical Association

31. On an unknown date the applicant sent a letter to Professor D., making reference to a meeting that he had had on 15 May 2012 with Professor D., Dr T. and P.D. about his mother's euthanasia, which had been performed without his knowledge. He stated that he had not had the opportunity to say goodbye to his mother and that he was now in pathological mourning. He said that he had appointed his psychiatrist, Dr C., as official healthcare professional for the purpose of accessing his mother's medical file.

32. In a letter of 17 June 2013 Dr C. contacted Professor D. to consult the medical file of the applicant's mother.

33. On 27 June 2013 Professor D. suggested setting up a meeting by phone.

34. On 2 August 2013 Dr C. examined the medical file of the applicant's mother. In his report of 3 August 2013 he noted, among other things, that the declaration of euthanasia was not in the file.

35. On 23 October 2013 the applicant requested a copy of the euthanasia registration document from the Board. According to the applicant, no reply was given to that request.

36. On 16 February 2014 the applicant lodged a complaint against Professor D. with the Medical Association. According to the applicant, he was not informed of the outcome of his complaint owing to the confidential nature of the proceedings.

37. On 4 March 2014 the applicant once again requested a copy of the euthanasia registration document submitted to the Board.

38. In a letter of 19 March 2014 the Board refused to provide a copy of the document on the ground that it was prohibited from disclosing it by law.

C. The first criminal investigation

39. On 4 April 2014 the applicant lodged a complaint with the Crown Prosecutor against persons unknown concerning the euthanasia of his mother.

40. On 15 October 2014 the applicant lodged his initial application with the Court. It was declared inadmissible in a decision notified on 4 June 2015,

on the ground that all domestic remedies had not been exhausted, since proceedings were still ongoing before the domestic authorities (application no. 68041/14).

41. On 8 May 2017 the applicant was informed that the Crown Prosecutor had discontinued proceedings on account of insufficient evidence.

42. On 6 November 2017 the applicant lodged this application with the Court.

43. On 3 December 2018 the Government were given notice of the application.

D. The second criminal investigation

44. On 2 May 2019 the judicial authorities reopened a criminal investigation into the circumstances surrounding the euthanasia of the applicant's mother. An investigating judge was assigned.

45. On 24 October 2019 the investigating judge appointed a professor of medicine as an expert to examine the medical file of the applicant's mother.

46. On 5 May 2020 the expert submitted an eleven-page report. In it, he noted that the applicant's mother had suffered from a personality and mood disorder since she had been a teenager, and had been treated by several psychiatrists for that reason. He concluded that, on the basis of several doctors' observations, the applicant's mother had indeed been experiencing intolerable mental suffering and could not be cured by any course of treatment. He further stated that she had been aware of the treatment options and had requested euthanasia of her own free will, in a constant and sustained manner. He noted that the various doctors had indicated that the applicant's mother had been legally capable, intelligent and clear-sighted, and that Dr T. had not found any indication of third-party pressure. In addition, the expert observed that a formal request had been lodged on 14 February 2012 and that the euthanasia had been performed more than two months later, in accordance with the statutory waiting period for non-terminal candidates. He also noted that Professor D., in his capacity as main doctor, had obtained opinions from two psychiatrists. The expert observed that the medical team had placed two hurdles to overcome during the monitoring period. First, the applicant's mother had been required to consult another psychiatrist as part of her treatment (Dr V.D.), which she had done without, however, viewing that option as a potential solution to her suffering. Second, the doctors had insisted that she inform her children of her decision. After several conversations, the applicant's mother had agreed to send an email to her two children, to which only her daughter had replied. The doctors had then tried to convince her to inform her children by phone. While she had initially agreed to this, she had subsequently changed her mind. The expert noted that the applicant had thus learned of his mother's death by euthanasia in a very unfortunate way. He

observed that there was nothing in the file concerning the declaration of euthanasia submitted to the Board, or the Board's assessment.

47. After the expert's report was received, Professor D. was interviewed by the police officers in charge of the investigation on 16 June 2020. During the interview he gave further details on some aspects of that report. He stated that the psychiatrists consulted had been independent and that he had repeatedly encouraged the applicant's mother to call her children, which she had consistently refused to do.

48. According to the Government, the Crown Prosecutor found on the basis of those elements that the euthanasia of the applicant's mother had complied with the substantive conditions prescribed by the Euthanasia Act and had been carried out in accordance with the statutory requirements. He requested that the Pre-Trial Division (*Chambre du Conseil*) of the Dutch-language Brussels Court of First Instance close the investigation. Prior to that request, he had asked the applicant whether he wished to have Professor D. summoned to appear before the Pre-Trial Division, but the applicant had replied that that would not be necessary.

49. In a decision of 11 December 2020 the Pre-Trial Division found that there were no grounds for prosecution and closed the criminal investigation. No appeal was lodged against that decision.

DOMESTIC LEGAL FRAMEWORK

I. THE LAW OF 28 MAY 2002 ON EUTHANASIA

50. Section 2 of the Law of 28 May 2002 on euthanasia ("the Euthanasia Act") reads:

> "For the purposes of this Act, euthanasia shall be understood as any act performed by a third party which intentionally ends an individual's life at that individual's request."

51. At the material time the relevant parts of section 3 of the Euthanasia Act provided:

> "§ 1. A doctor performing euthanasia will not be committing an offence if he or she has ensured that:
>
> the patient is an adult or emancipated minor, and conscious at the time of his or her request;
>
> the request has been made of the patient's own free will, in a considered and constant manner, and is not the result of external pressure;
>
> the patient is in a hopeless medical situation and is experiencing constant and intolerable physical or mental suffering which cannot be alleviated and is the result of a serious and incurable accidental or pathological condition; and
>
> he or she complies with the conditions and procedures prescribed by this Act.
>
> § 2. Without prejudice to any additional conditions to which the doctor may wish to subject his or her involvement, the doctor shall first and in any event:

1. inform the patient of his or her state of health and life expectancy, discuss the euthanasia request with the patient and raise any potential treatment options as well as the possibilities offered by palliative care and the consequences thereof. Both doctor and patient must be convinced that there is no other reasonable solution in the patient's situation and that the patient's request is entirely of his or her own free will;

2. ascertain that the patient is experiencing continued physical or mental suffering and expresses his or her wish in a constant manner. To this end, the doctor shall conduct several interviews with the patient at intervals considered reasonable in view of changes in the patient's health;

3. consult another doctor regarding the serious and uncurable nature of the condition, specifying the reasons for the consultation. The consulted doctor shall acquaint him- or herself with the medical file, examine the patient and ascertain that the physical or mental suffering is constant and intolerable and cannot be alleviated. The consulted doctor shall draft a report containing his or her observations.

The consulted doctor shall be independent, in relation to both the patient and the main doctor, and be competent as regards the condition concerned. The main doctor shall inform the patient of the outcome of this consultation;

4. if a care team is in regular contact with the patient, discuss the patient's request with such team or members thereof;

5. if the patient so wishes, discuss his or her request with any such family members and friends as the patient may indicate; and

6. ensure that the patient has had the opportunity to discuss his or her request with the people with whom he or she wished to meet.

§ 3. If the doctor considers that the adult or emancipated-minor patient's death will clearly not otherwise occur in the short term, he or she shall further:

1. consult a second doctor – either a psychiatrist or a specialist in the relevant condition – specifying the reasons for the consultation. The consulted doctor shall acquaint him- or herself with the medical file, examine the patient and ascertain that the physical or mental suffering is constant and intolerable and cannot be alleviated and that the request has been made of the patient's own free will, in a considered and constant manner. The consulted doctor shall draft a report containing his or her observations. The consulted doctor shall be independent, in relation to the patient, the main doctor and the first doctor consulted. The main doctor shall inform the patient of the outcome of this consultation; and

2. allow at least one month to elapse between the patient's written request and the act of euthanasia.

§ 4. The patient's request shall be formalised in writing. The document shall be drafted, dated and signed by the patient him- or herself. ...

The patient may withdraw the request at any time, in which case the document shall be removed from the medical file and returned to the patient.

§ 5. All requests made by the patient, as well as the steps taken by the main doctor and their outcomes, including the report(s) by the consulted doctor(s), shall be regularly recorded in the patient's medical file."

52. Section 5 of the Euthanasia Act reads:

"Any doctor who has performed euthanasia shall, within four working days, submit the registration document referred to in section 7, duly completed, to the Federal Monitoring and Assessment Board referred to in section 6 of this Act."

53. At the relevant time section 6 of the Euthanasia Act read:

"§ 1. A Federal Monitoring and Assessment Board, referred to hereafter as 'the Board', shall be established for the purpose of applying this Act.

§ 2. The Board shall comprise sixteen members, who shall be appointed on the basis of their knowledge and experience in areas within the Board's remit. Eight members shall be qualified doctors, at least four of whom shall be professors in a Belgian university. Four members shall be law professors in a Belgian university, or lawyers. Four members shall have a background in dealing with patients suffering from incurable diseases.

Board members shall not simultaneously hold office as a member of one of the legislative assemblies or as a member of the federal government or a community or regional government.

Board members shall be appointed, with due regard to language equality – with each language group including at least three candidates of each sex – and with a view to ensuring pluralistic representation, by royal decree approved by Cabinet from a list of two candidates presented by the Senate, for a renewable four-year term. A member's term of office shall automatically expire when he or she ceases to have the capacity in which he or she was appointed. Candidates who are not appointed as full members shall be designated alternate members and placed on a list determining the order in which they will be called to sit as a replacement on the Board. The Board shall be chaired by a French-speaking Chair and a Dutch-speaking Chair. The Chairs shall be elected by the Board members belonging to their respective language group.

The Board's proceedings will not be valid unless two-thirds of its members are present.

§ 3. The Board shall draw up its terms of reference."

54. Section 7 of the Euthanasia Act provides:

"The Board shall prepare a registration document, which shall be completed by the doctor each time he or she performs euthanasia.

This document shall comprise two parts. The first part shall be sealed by the doctor. It shall contain the following information:

1. the patient's surname, first names and address;

2. the main doctor's surname, first names, INAMI [*Institut national d'assurance maladie-invalidité* – National Institute of Sickness and Disability Insurance] registration number and address;

3. the surname, first names, INAMI registration number and address of the doctor(s) consulted in relation to the euthanasia request;

4. the surname, first names, address and profession of any individuals consulted by the main doctor, as well as the dates of such consultations; and

5. if an advance decision was prepared designating one or more persons of trust, the surname and first names of any such individual(s) involved.

This first part shall be confidential. It shall be sent to the Board by the doctor. It may not be consulted without the Board's approval, and shall under no circumstances be used as the basis of the Board's assessment duties.

The second part shall also be confidential and contain the following information:

1. the patient's sex, and date and place of birth;

2. the date, place and time of death;

3. the serious and incurable accidental or pathological condition from which the patient suffered;

4. the nature of the constant and intolerable suffering;

5. why this suffering was characterised as being unable to be alleviated;

6. the elements used to ascertain that the request was made of the patient's own free will, in a considered and constant manner, and with no external pressure;

7. whether death was otherwise foreseeable in the short term;

8. whether there is a statement of intent;

9. the procedure followed by the doctor;

10. the qualifications of the doctors consulted, their opinions and the dates of such consultations;

11. the profession of any individuals consulted by the doctor and the dates of such consultations; and

12. how the euthanasia was performed and what means were used."

55. Section 8 of the Euthanasia Act reads:

"The Board shall examine the duly completed registration document provided to it by the doctor. On the basis of the second part of the registration document, it shall verify whether the euthanasia was performed in accordance with the conditions and procedure prescribed hereby. Where there are doubts, the Board may by a simple majority decide to lift anonymity. In such an event, it shall examine the first part of the registration document. It may ask the main doctor to provide it with all elements in the medical file relating to the euthanasia.

It shall give its findings within two months.

Where, by a two-thirds majority, the Board considers that the conditions prescribed by this Act have not been satisfied, it shall refer the case to the Crown Prosecutor with authority over the place of the patient's death.

Where lifting anonymity reveals facts or circumstances likely to affect a Board member's independence or impartiality of judgment, that member shall withdraw or may be excused from the Board's examination of the case."

56. Section 12 of the Euthanasia Act provides:

"Anyone who assists in any capacity whatsoever in the application of this Act shall keep confidential all information received in the performance of his or her responsibilities and relating to the performance thereof. Article 458 of the Criminal Code shall apply to such individuals."

II. THE LAW OF 22 AUGUST 2002 ON PATIENTS' RIGHTS

57. Section 5 of the Law of 22 August 2002 on patients' rights ("the Patients' Rights Act") provides:

> "Patients have a right to receive, from professional practitioners, quality services meeting their needs with due respect for their human dignity and autonomy and without any distinction whatsoever being made."

58. Section 9(4) of the Patients' Rights Act reads:

> "Following a patient's death, his or her spouse, legal cohabiting partner, partner and relatives up to the second degree inclusive shall, through a professional practitioner designated by the requesting party, have the right to consultation under subsection 2, provided that the request is adequately reasoned and specific and that the patient has not expressly objected thereto. The designated professional practician may also consult the personal annotations referred to in the third paragraph of subsection 2."

59. Section 10 of the Patients' Rights Act provides:

> "§ 1. Patients have a right to the protection of their private lives during any dealings with the professional practitioner, in particular as regards information on their health. Patients have a right to respect for their privacy. Unless patients agree otherwise, only individuals whose presence is justified within the context of the professional practitioner's services may be present during care, examinations and treatment.
>
> § 2. There shall be no interference with the exercise of this right except where provided for by law and necessary to protect public health or the rights and freedoms of third parties."

60. At the relevant time section 15(1) of the Patients' Rights Act provided:

> "With a view to protecting the patient's private life under section 10, the professional practitioner in question may refuse all or part of any request by a person referred to in sections 12, 13 and 14 aiming to obtain consultation or a copy under section 9(2) or (3). In such case, the right to consultation or a copy shall be exercised by the professional practician designated by the requesting party."

III. THE LAW OF 14 JUNE 2002 ON PALLIATIVE CARE

61. At the relevant time section 2 of the Law of 14 June 2002 on palliative care read:

> "All patients shall be entitled to receive palliative care as part of their end-of-life care.
>
> The methods of providing palliative care and the criteria for reimbursement of such care by social security shall ensure equal access to palliative care for all incurable patients, for the full range of care available. For the purposes hereof, palliative care shall be understood as all care provided to a patient suffering from a condition likely to result in death once such condition stops responding to curative care. A multidisciplinary care solution is of crucial importance in providing end-of-life care to such patients, be it physically, mentally, socially or emotionally. The primary goal of palliative care is to offer the patient and his or her loved ones the best possible quality

of life and greatest possible autonomy. Palliative care seeks to ensure and to optimise quality of life for the patient and his or her family during the time the patient has left."

IV. THE CRIMINAL CODE

62. Article 458 of the Criminal Code provides for the punishment of breaches of professional secrecy. At the relevant time it read:

"Doctors, surgeons, health officials, pharmacists, midwives and all other persons who through their status or profession are entrusted with secrets and who reveal them, shall be punished by imprisonment for a period of between eight days and six months and a fine of between 100 euros and 500 euros, except where they are called to testify in court or before a parliamentary commission of inquiry and where the law obliges them to make these secrets known."

V. THE OPINION OF THE *CONSEIL D'ÉTAT*

63. On 20 June 2001 the *Conseil d'État* (General Assembly of the Legislation Section) delivered opinion no. 31.441/AV-AG on the private member's bills that led to the Euthanasia Act (*Documents parlementaires*, Senate, no. 2-244/21). That opinion contained a long general comment on the bills' compatibility with the right to life, which concluded as follows:

"10. In sum, it follows from the foregoing that even though the Euthanasia Bill submitted for an opinion provides for a limitation of the protection of the right to life afforded hitherto by law, it remains within the bounds of the national authority's margin of appreciation under Article 2 [of the European Convention on Human Rights] and Article 6 [of the International Covenant on Civil and Political Rights].

In other words, the bill is not incompatible with the provisions of the aforementioned Convention and Covenant."

VI. CASE-LAW OF THE CONSTITUTIONAL COURT

64. Jurivie and Pro Vita, both associations, brought proceedings against the Euthanasia Act before the Administrative Jurisdiction and Procedure Court (*Cour d'Arbitrage*), now the Constitutional Court. That court delivered its judgment (no. 4/2004) on 14 January 2004. The relevant parts read:

"By claiming that the people referred to in sections 3 and 4 of the [Euthanasia Act] are incapable of free choice at the time they make their request, the applicants, appearing to assume that anyone who wants to stop living must be incapable of sound decision-making, give no consideration to the many safeguards laid down in the provisions of the impugned Act to ensure that any individual who expresses his or her wish under the conditions prescribed in sections 3 and 4 does so in total freedom.

Furthermore, the preparatory work for the impugned law shows that the relevant Senate Committees and subsequently the House of Representatives paid constant attention to this aspect of the problem.

The applicants do not make any other arguments under Article 2 of the European Convention on Human Rights that lead to any other conclusion.

The submission is unfounded.

..."

65. In judgment no. 153/2015 of 29 October 2015 the Constitutional Court dismissed applications for judicial review of the Law of 28 February 2014 amending the Euthanasia Act with a view to extending euthanasia to minors. Noting that the Court's case-law afforded national authorities a wide margin of appreciation with regard to regulating euthanasia on the grounds that there was no European consensus on the matter, the Constitutional Court found that the Euthanasia Act, as amended by the impugned law, struck a fair balance between, on the one hand, every person's right to choose to end his or her life and thereby avoid an undignified and distressing end to life, as derived from the right to respect for private life, and, on the other hand, the right of minors to measures preventing abusive euthanasia practices, as derived from the right to life and physical integrity.

VII. THE MEDICAL ASSOCIATION'S ETHICAL GUIDELINES

66. On 27 April 2019 the National Council of the Medical Association adopted a set of ethical guidelines for the euthanasia of patients experiencing mental suffering following a psychiatric illness. The relevant parts of those guidelines read:

"The Law of 28 May 2002 on euthanasia (hereafter 'the Euthanasia Act') provides that psychiatric patients may undergo euthanasia under certain conditions. The National Council, however, considers that euthanasia should only be performed on psychiatric patients subject to extreme caution on account of such patients' specific issues.

...

2. Ethical guidelines for the euthanasia of psychiatric patients

(1) In-person meeting of at least three doctors

The Euthanasia Act provides that any doctor performing euthanasia on a patient who will clearly not otherwise die in the short term must consult two doctors, who acquaint themselves with the medical file, examine the patient and ascertain that the physical or mental suffering is constant and intolerable and cannot be alleviated. The first doctor consulted must be competent as regards the condition concerned. The second doctor consulted must be a psychiatrist or a specialist in the condition concerned. The two doctors consulted must be independent in relation to both the patient and the main doctor and prepare a report containing their observations. The main doctor informs the patient.

Given that a psychiatric condition generally does not in itself cause a patient to die in the short term, any doctor considering euthanasia for psychiatric patients always in practice consults two doctors and those two doctors are psychiatrists.

The National Council considers that any doctor considering euthanasia for psychiatric patients must go one step further still and meet with the two psychiatrists in person. An in-person meeting gives rise to interdisciplinary collaboration, where each doctor explains his or her point of view as objectively as possible. The doctors prepare a report together and reach a joint conclusion, without necessarily agreeing on all aspects.

...

(2) Use of all possible treatments

The Euthanasia Act provides that any doctor considering euthanasia for psychiatric patients must ensure that the patient is in a hopeless medical situation and experiencing constant and intolerable mental suffering which cannot be alleviated and is the result of a serious and incurable accidental or pathological condition.

Determining whether a psychiatric condition is incurable and/or has no prospect of improvement is a complex task for the doctor, especially on account of the significant comorbidity and the high incidence of suicide. The psychiatric condition in itself will not cause the patient's death, and changes in the condition are extremely difficult to assess. The condition may, however, still be found to be incurable or have no prospect of improvement because, for some psychiatric patients, there is no prospect of improvement in their general state of health.

A doctor who observes that a patient is suffering from an incurable psychiatric condition with no prospect of improvement must ensure that all treatments have been used; in other words, the doctor must ensure that the patient has tried all possible evidence-based treatments for his or her condition. Should the patient exercise his or her right to refuse certain evidence-based treatments, the doctor may not perform the euthanasia.

The doctor must exercise restraint and avoid taking treatment to unreasonable lengths. There is only a limited number of treatments that can reasonably be tried. The aim is for the doctor to be satisfied that the patient's situation is such that no further treatment is likely to alleviate his or her suffering from an objective medical and psychiatric point of view.

(3) A condition lasting several years

The Euthanasia Act provides that, if the doctor considers that the patient will clearly not otherwise die in the short term, he or she must allow at least one month to elapse between the patient's written request and the act of euthanasia.

It also provides that the doctor must ascertain that the patient is experiencing continued physical or mental suffering and that his or her wish is expressed in a constant manner. To that end, the doctor conducts several interviews with the patient at intervals considered reasonable in view of changes in the patient's health;

The National Council considers that the doctor can only ascertain the constancy of the psychiatric patient's wish by monitoring him or her for a sufficiently long period of time. Psychiatric patients' health can often change unpredictably. What initially appears to be a hopeless state can change considerably with time and an appropriate course of treatment. It is therefore not acceptable to approve a psychiatric patient's euthanasia request on the grounds that the statutory one-month waiting time since the written request was made has elapsed, unless the patient has followed a treatment programme over a long period.

(4) Involvement of family and friends in the process

The Euthanasia Act provides that the doctor must discuss the request with the family members and friends indicated by the patient prior to the procedure and in all circumstances if such is the patient's wish.

The doctor must encourage the patient to involve his or her family and friends in the process unless he or she has good reason not to do so.

The National Council is aware that conflicts may arise between the patient's autonomy and the interests of the family and/or society. However, the doctor has a duty towards not only the patient but also any third parties who may incur serious harm on account of the patient's request. The support of third parties and the protection of society are inextricably linked to the issue of euthanasia for psychiatric patients.

In addition, involving family and friends in the process is also important for the legal assessment of whether the request was the result of any external pressure. ...

(5) Patient's capacity for discernment and consciousness

The Euthanasia Act provides that doctors performing euthanasia are not committing an offence if they have ensured that the patient is capable of discernment and is conscious at the time of the request.

In this regard, a patient's capacity for discernment should be distinguished from his or her effective capacity.

A person's capacity for discernment is a legal concept. Generally, a magistrate [*juge de paix*], with the assistance of a doctor, will determine whether a person is incapable of discernment and which legal transactions that person may no longer enter into as a result. Any doctor performing euthanasia must check whether such legal protection applies to a patient requesting euthanasia.

Effective capacity, also known as the capacity to express one's wishes or to be conscious of one's actions, is a factual situation that must be assessed by the doctor performing the euthanasia. For psychiatric patients, this assessment is not a simple matter, because psychiatric disorders can impede a patient's ability to express his or her wishes. A psychiatric condition does not automatically entail that a patient is incapable of making a considered and valid request for euthanasia.

..."

EUROPEAN AND INTERNATIONAL LAW

I. COUNCIL OF EUROPE

A. The Oviedo Convention on Human Rights and Biomedicine

67. The relevant provisions of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, signed in Oviedo on 4 April 1997 ("the Oviedo Convention"), read:

"Article 1 – Purpose and object

Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine. ..."

"Article 5 – General rule

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."

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

68. The Committee on Bioethics (DH-BIO) of the Council of Europe at its fourth plenary meeting (26-28 November 2013) approved a guide on the principles that can be applied to the decision-making process regarding medical treatment in specific end-of-life situations. The relevant parts of that guide are presented in the Court's judgment in the case of *Lambert and Others v. France* ([GC], no. 46043/14, §§ 61-68, ECHR 2015 (extracts)).

II. UNITED NATIONS

69. The United Nations Human Rights Committee (HRC) General Comment No. 36 (2019) on right to life (3 September 2019, CCPR/C/GC/36) contains the following information:

"9. While acknowledging the central importance to human dignity of personal autonomy, States should take adequate measures, without violating their other [obligations under the International Covenant on Civil and Political Rights], 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."

THE LAW

I. THE GOVERNMENT'S PRELIMINARY OBJECTIONS

A. The parties' submissions

1. The Government

70. The Government raised two preliminary objections alleging a failure to exhaust domestic remedies. First, they challenged the admissibility of the application on the grounds that the applicant had not applied to the investigating judge to join criminal proceedings as a civil party, had not brought a private prosecution (*citation directe*) before a trial court and had not instituted civil proceedings to establish the State's responsibility. Second, the Government argued in their submissions of 4 March 2020 that the applicant's complaints under Articles 2 and 8 of the Convention were

premature because the criminal investigation had been reopened in 2019 and were still pending at the level of the domestic judicial authorities when those submissions were filed.

2. The applicant

71. The applicant disputed the preliminary objections. In his view it was for the Government to show that the domestic remedies indicated had been effective and available in theory and in practice at the relevant time and that they had offered reasonable prospects of success. The applicant stated that, at the time he had lodged his application with the Court, no case under the Euthanasia Act had ever been successfully brought before an investigating judge. He had nevertheless lodged a complaint with the Crown Prosecutor, who had taken a passive approach before deciding to discontinue proceedings. In addition, contrary to the Government's claims, a private prosecution could only be brought for misdemeanours (*faits correctionnels*), not for the more serious category of offence alleged to be at issue in the present case.

72. Regarding the failure to institute civil proceedings to establish the State's responsibility, the applicant, referring in particular to *Brincat and Others v. Malta* (nos. 60908/11 and 4 others, 24 July 2014), submitted that a compensatory avenue such as this could not be considered an effective remedy in respect of incidents which, as in the present case, were the result of dangerous activities and where no effective investigation had taken place.

73. Lastly, with regard to the supposedly premature nature of his application, the applicant pointed out in his submissions received on 21 December 2020 that on 11 December 2020 the Pre-Trial Division had closed the criminal investigation that had been reopened in 2019. According to him, the Government's objection was thus no longer valid.

B. The Court's assessment

1. Applicable general principles

74. The Court reiterates that, under Article 35 § 1 of the Convention, it may only deal with an application after the exhaustion of those domestic remedies that relate to the breaches alleged and are also available and sufficient. It is incumbent on the Government pleading non-exhaustion to satisfy the Court that the remedy was an effective one available in theory and in practice at the relevant time, that is to say that it was accessible, was capable of providing redress in respect of the applicant's complaints and offered reasonable prospects of success (see, in particular, *Vučković and Others v. Serbia* (preliminary objection) [GC], nos. 17153/11 and 29 others, §§ 74 and 77, 25 March 2014; *Gherghina v. Romania* [GC] (dec.), no. 42219/07, §§ 85 and 88, 9 July 2015; and *Selahattin Demirtaş v. Turkey*

(no. 2) [GC], no. 14305/17, § 205, 22 December 2020). Once this has been shown, it falls to the applicant to establish that the remedy advanced by the Government was in fact used or was for some reason inadequate and ineffective in the particular circumstances of the case, or that there existed special circumstances exempting him or her from this requirement (see *Akdivar and Others v. Turkey*, 16 September 1996, § 68, *Reports of Judgments and Decisions* 1996-IV; *Vučković and Others*, cited above, § 77; *Gherghina*, decision cited above, § 89; and *Selahattin Demirtaş (no. 2)*, cited above, § 205).

75. The Court has frequently underlined the need to apply the exhaustion rule with some degree of flexibility and without excessive formalism (see *Vučković and Others*, cited above, § 76, and *Gherghina*, decision cited above, § 87). It has further recognised that the rule of exhaustion is neither absolute nor capable of being applied automatically; in reviewing whether it has been observed it is essential to have regard to the particular circumstances of each individual case (see, among other authorities, *Gherghina*, decision cited above, § 87).

2. Application of these principles to the present case

(a) The supposedly premature nature of the application

76. The Court notes that the criminal investigation, which had been reopened on 2 May 2019, was closed by decision of the Pre-Trial Division on 11 December 2020 (see paragraph 47 above), thus rendering the Government's objection as to the premature nature of the application devoid of relevance. The objection must therefore be dismissed.

(b) Exhaustion of domestic remedies

77. With regard to the objection that the applicant did not bring a civil action against the State on the basis of the Civil Code, the Court reiterates that determining whether a domestic procedure constitutes an effective remedy within the meaning of Article 35 § 1 of the Convention, which an applicant must exhaust, depends on a number of factors, notably the applicant's complaint, the scope of the State's obligations under that particular Convention provision, the available remedies in the respondent State and the specific circumstances of the case (see *Lopes de Sousa Fernandes v. Portugal* [GC], no. 56080/13, § 134, 19 December 2017).

78. Where death has been caused intentionally, a criminal investigation is generally necessary (see, among other authorities, *Mustafa Tunç and Fecire Tunç v. Turkey* [GC], no. 24014/05, § 170, 14 April 2015, and *Nicolae Virgiliu Tănase v. Romania* [GC], no. 41720/13, § 158, 25 June 2019). In cases concerning unintentional infliction of death, on the other hand, it is sufficient that the legal system affords victims' next-of-kin a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal

courts, enabling any responsibility to be established and any appropriate civil redress to be obtained. Where members of certain professions are involved, disciplinary measures may also be envisaged (see, among other authorities, *Šilih v. Slovenia* [GC], no. 71463/01, § 194, 9 April 2009; *Lopes de Sousa Fernandes*, cited above, § 137; and *Nicolae Virgiliu Tănase*, cited above, § 159). Even in cases of non-intentional interferences with the right to life or physical integrity there may be exceptional circumstances where an effective criminal investigation is necessary to satisfy the procedural obligation imposed by Article 2. Such circumstances can be present, for example, where a life was lost in suspicious circumstances (see *Nicolae Virgiliu Tănase*, cited above, § 160).

79. The Court considers that, where death is the result of an act of euthanasia carried out under legislation that permits it subject to strict conditions, a criminal investigation is not usually required. However, where a relative of the deceased or a third party has made a criminal complaint plausibly indicating the existence of suspicious circumstances, the relevant authorities must open an investigation to establish the facts and, where appropriate, to identify and to punish those responsible (compare *Šilih*, § 156, and *Lopes de Sousa Fernandes*, § 220, both cited above).

80. In the present case the applicant lodged a complaint with the Crown Prosecutor. The choice of this remedy does not appear unreasonable. Nor was it regarded as such by the national authorities, which initiated a preliminary police investigation and subsequently a judicial investigation. The Government did not dispute the appropriateness of the remedy either. Accordingly, the Court does not perceive any reason to consider that the applicant acted inappropriately when choosing to lodge a criminal complaint (see, *mutatis mutandis*, *Nicolae Virgiliu Tănase*, cited above, § 176).

81. In any event, the Court considers that the applicant could reasonably have expected the aforementioned criminal proceedings to address his grievances. In these circumstances, the fact that the applicant did not lodge a separate civil action against the State – even assuming such an action were an appropriate option in the present case – cannot be held against him when assessing whether he had exhausted domestic remedies (see *Nicolae Virgiliu Tănase*, cited above, § 177).

82. For the reasons set out above, the Court considers that the civil action referred to by the Government, the outcome of which would be limited to compensation from the State, is not an effective remedy in the present circumstances.

83. In addition, the Government did not specify how an application to join the proceedings as a civil party would have remedied the alleged gaps in the criminal investigation. Nor did they dispute the applicant's argument that private prosecution was not provided for by law in respect of the criminal offence that he was alleging.

84. The Court therefore also dismisses the objection that domestic remedies have not been exhausted.

II. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

85. Relying on Article 2 of the Convention, the applicant alleged that the State had failed to fulfil its positive obligations to protect his mother's life, since the statutory procedure for euthanasia had not been followed in her case, rendering illusory the rights under that provision. Relying on Article 13 of the Convention, he also complained about the lack of an in-depth and effective investigation into the matters he had raised.

86. The Court, being master of the characterisation to be given in law to the facts of a case (see *Kurt v. Austria* [GC], no. 62903/15, § 104, 15 June 2021), considers it appropriate to examine the applicant's allegations solely under Article 2 of the Convention, which reads:

> "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
>
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
>
> (a) in defence of any person from unlawful violence;
>
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
>
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

A. The parties' submissions

1. The applicant

87. According to the applicant, his mother's situation demonstrated that the statutory framework did not afford an effective safeguard for protecting vulnerable individuals' right to life. The law would not have prevented his mother from ending her professional relationship with her main doctor and instead consulting other doctors over a short period of some months, until she had found some willing to perform the euthanasia on her. The doctor who performed the euthanasia, moreover, had only agreed to do so after the LEIF association, which he chaired, had received a donation of EUR 2,500, showing a clear conflict of interest.

88. The applicant also submitted that several aspects of the Euthanasia Act had not been complied with. His mother had not been in a hopeless medical situation and her suffering had not been such that it could not have been alleviated. In addition, the second doctor consulted had not been independent in relation to the first doctor, since they were both members of the same association. Lastly, no discussion had taken place with the

applicant's mother's usual medical team. The statutory safeguards had thus been illusory in practice.

89. Lastly, the applicant submitted that there had not been an effective investigation into the circumstances of his mother's death by euthanasia. An investigation should be conducted by people who are independent from those involved in the events in question. That had not been the case, because the doctor who had performed his mother's euthanasia had been the co-chair of the board tasked with establishing whether the disputed act had complied with the law. In the applicant's view, both the criminal investigation, which had been discontinued by the Crown Prosecutor, and the judicial investigation, which had been closed by a decision finding no case to answer, had been ineffective.

2. The Government

90. The Government submitted that the applicant's mother's right to life had been respected. States were afforded a wide margin of appreciation in end-of-life matters, particularly as regards how to strike a balance between protecting the patient's right to life and protecting his or her right to respect for private life and personal autonomy, since there was no consensus among member States as to an individual's right to decide in which way and at what time his or her life should end.

91. The Government submitted that, according to the Court's case-law, the conditional decriminalisation of euthanasia was not prohibited but rather the question was left to national legislatures. While the right to life could not be interpreted as conferring a right to die, the inexistence of such a right did not mean that a law authorising and regulating euthanasia requests would breach the right to life, provided that the approach was based on a request made by a conscious patient of his or her own free will, that it required the patient to have been diagnosed as having an incurable medical condition and that it was subject to a number of conditions and an oversight mechanism.

92. Referring in particular to the judgment in *Lambert and Others v. France* ([GC], no. 46043/14, ECHR 2015 (extracts)) and the "Guide on the decision-making process regarding medical treatment in end-of-life situations" (see paragraph 68 above), the Government submitted that, in accordance with the principle of beneficence and non-maleficence, doctors were required not to dispense treatment which was needless or disproportionate in view of the risks and constraints it entailed. The Government further pointed out that doctors had a duty to take care of their patients, ease their suffering and provide them with support.

93. The Government further argued that it had been accepted since the judgment in *Haas v. Switzerland* (no. 31322/07, ECHR 2011) that the right to life obliged States 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. In their opinion, it was apparent from both the *Conseil*

d'État's opinion (see paragraph 63 above) and the Constitutional Court's case-law (see paragraph 64 above) that such was the case in Belgium owing to the Euthanasia Act and the Patients' Rights Act.

94. In the present case, the Government asserted that the applicant's mother had had a serious and incurable pathological condition causing constant and intolerable suffering which could no longer be alleviated in any other way. Many precautions had been taken prior to the euthanasia. The Government further stated that, since the applicant's mother had refused to have her son involved in the process, the doctors had been bound to respect her wishes in accordance with their duty of confidentiality and medical secrecy.

95. With regard to the Board's post-euthanasia review, the Government pointed out that some of the Board's members were doctors who performed euthanasia. The Government further specified that several doctors on the Board also had expertise in palliative care, as the legislature had sought to ensure. The Board was intended to act as a buffer between doctors and the courts. Its main role was to give society, as represented by the Board's pluralistic composition, the power to review acts of euthanasia. The Board could only decide to lift anonymity by a simple-majority vote if it had any doubts. The Government pointed to the statutory provisions governing the withdrawal of Board members and stated that, in the event that anonymity was not lifted, members were required to remain silent where they noticed that they had been involved in a euthanasia case under review. Such members could not withdraw from the review, because that would break anonymity, which was not provided for by law.

96. Referring to the Board report on 2016 and 2017 euthanasia declarations, the Government stated that the Board had decided to lift anonymity and unseal the first part of the euthanasia declaration in 23.7% of cases. Lastly, the Government pointed out that the Board's decision to approve the euthanasia declaration did not shield the doctors from criminal prosecution.

97. Concerning the LEIF association, of which Professor D. and the other two doctors consulted by the applicant's mother had been members, the Government stated that its purpose was to ensure a dignified end to life for all. It served the public interest and its financial resources comprised government grants and donations from individuals. It organised training, conferences and study trips for medical and paramedical professionals. More than 600 doctors had taken training by the association. Those doctors could be accredited to give opinions in euthanasia procedures. In the Government's view, it was therefore not surprising that two doctors belonging to the LEIF association had been involved in the applicant's mother's case.

98. In their initial submissions of 4 March 2020 the Government had not disputed the ineffectiveness of the Crown Prosecutor's criminal investigation from April 2014 to May 2017. In their submissions of 25 March 2021,

however, they argued that the second investigation, conducted after the reopening of the criminal case on 2 May 2019, had been effective. In consequence, Article 2 of the Convention had not been breached under its procedural limb.

B. Submissions of third-party interveners

1. Association pour le Droit de Mourir dans la Dignité

99. Association pour le Droit de Mourir dans la Dignité (Association for the Right to Die with Dignity – "ADMD") submitted that the Belgian legislature had enacted a law decriminalising euthanasia and two other laws on patients' rights and palliative care, respectively, which had had a significant impact on medical law in general, and more specifically on end-of-life medical decisions. It pointed out that the Euthanasia Act had been passed following long debates within society.

100. In ADMD's view, the Euthanasia Act had helped to humanise end of life by offering freedom of choice, since no one was required either to request euthanasia or to take part in a procedure leading to it. Emphasising the statutory conditions to which euthanasia was subject, ADMD argued that the Act preserved the balance between the protection of the right to life under Article 2 and respect for personal autonomy under Article 8 of the Convention.

2. Care Not Killing

101. Care Not Killing ("CNK"), an association, asked the Court to find that legalising euthanasia was incompatible with the negative and positive obligations under Article 2 of the Convention. The cases where deprivation of life would not be regarded as inflicted in contravention of that provision did not include euthanasia. Accordingly, a State could not rely on any exemption to justify the act of euthanasia. Furthermore, the absolute nature of the right to life left States no margin of appreciation in the matter.

102. CNK further submitted that the right to life was considered inalienable under all international human rights treaties. Such inalienability meant that not even the holder of the right to life could renounce it. In those circumstances, the States had an obligation to prevent suicides, and decriminalising euthanasia was in breach of that obligation.

3. European Centre for Law and Justice

103. The European Centre for Law and Justice ("ECLJ") submitted that systematic failures in the regulation of the practice of euthanasia in Belgium had enabled abuse and misuse. The circumstances of the present case highlighted those shortcomings, in terms of both substantive and procedural obligations.

104. The possibility of euthanasia for mental suffering raised the problem of respect for a person's autonomy and his or her ability to express free and informed consent. Respect for personal autonomy should prohibit euthanasia for the depressed and mentally ill because of the subjectiveness of the concept of "mental suffering", which opened the door to abuse. ECLJ thus argued that Belgium's Euthanasia Act was defective and impossible to supervise and gave rise to a violation of the right to life.

105. ECLJ further stated that the risk of abuse was greater from a procedural perspective because of the ineffectiveness of the review entrusted to the Board. It was doubtful that the Board's composition and work met the requirements of the Convention.

4. Dignitas

106. While criticising the strict conditions prescribed by the Euthanasia Act, Dignitas, an association, submitted that euthanasia as it was regulated by that Act did not breach the Convention's requirements since, under the Act, anyone requesting euthanasia had to have the capacity to act and had to be conscious at the time of the request. The provision requiring that the request be made of the patient's own free will, in a deliberate and constant manner, and not be the result of external pressure, was also consistent with the Court's interpretation of the Convention.

107. Dignitas affirmed that if a State's legislation guaranteed that euthanasia could only be performed after obtaining doctors' consent, then that legislation had to be considered as meeting the requirements of the right to life. If a State's legislation further guaranteed that such cases were subsequently reviewed by a board of experts to ascertain their lawfulness, then the State would have sufficiently discharged its obligation to investigate deaths.

108. In the context of euthanasia performed on account of depression, one of the crucial issues would be whether the individual concerned had been capable, despite being ill, of going about his or her daily life without the assistance of a third party. Where such deficiencies could not be detected, the individual in question should be considered capable of judgment, especially with regard to whether he or she wished to end his or her suffering and life.

5. Ordo Iuris Institute

109. For the Ordo Iuris Institute ("OII"), the case raised two separate issues with regard to Article 2 of the Convention: first, whether legalising euthanasia was compliant with that provision of the Convention and, second, what procedural safeguards needed to be provided for in domestic law to protect individuals.

110. Regarding whether legalising euthanasia was compliant with the Convention, OII submitted that the exceptions provided for in Article 2 of the

Convention had to be interpreted strictly. They could not be extended to situations with no relation to those set out in that Article. Accordingly, where an individual experiencing mental or physical suffering asked a doctor or third party to kill him or her or to help him or her to commit suicide, the State could not be exempted from its obligation to protect human life. Neither the motivations of the person performing the euthanasia nor even the consent of the victim would create a legitimate aim to justify derogating from the protection of human life.

111. Regarding procedural safeguards, OII argued that not all patients were capable of making informed, rational decisions about their lives. The domestic law therefore had to define criteria for assessing a patient's capacity to consent to a medical procedure, particularly in the area of euthanasia, in order to protect his or her life from any decision made without a proper understanding of the situation, or on an impulse.

C. The Court's assessment

1. Admissibility

112. The Court reiterates its established case-law to the effect that if the alleged victim of a violation of Article 2 of the Convention has died before the introduction of the application, it may be possible for the persons with requisite legal interest as next of kin to introduce an application raising complaints related to the death (see *Fairfield and Others v. the United Kingdom* (dec.), no. 24790/04, ECHR 2005-VI, and *Varnava and Others v. Turkey* [GC], nos. 16064/90 and 8 others, § 111, ECHR 2009). Thus, close family members, including children, of a person whose death is alleged to engage the responsibility of the State can themselves claim to be indirect victims of the alleged violation of Article 2 (see, concerning the parents of a deceased individual, *Tsalikidis and Others v. Greece*, no. 73974/14, § 64, 16 November 2017).

113. It follows that the applicant can claim to be an indirect victim of any failure by the State to fulfil its obligations under Article 2 of the Convention in the context of his mother's death.

114. The Court further notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention and is not inadmissible on any other grounds. It must therefore be declared admissible.

2. Merits

115. The Court has never ruled on the question which is the subject of the present application. This is the first case in which the Court has been called upon to examine the compliance with the Convention of an act of euthanasia. It therefore considers it necessary to clarify the nature and scope of a State's

obligations under Article 2 of the Convention in this context before examining whether those obligations have been fulfilled in the present case.

(a) The applicable rule

(i) General principles

116. The Court reiterates that the first sentence of paragraph 1 of Article 2, which ranks as one of the most fundamental provisions in the Convention and also enshrines one of the basic values of the democratic societies making up the Council of Europe, requires the State not only to refrain from the "intentional" taking of life (negative obligation), but also to take appropriate steps to safeguard the lives of those within its jurisdiction (positive obligation) (see *Lambert and Others*, § 117, and *Lopes de Sousa Fernandes*, § 164, both cited above).

117. This substantive positive obligation entails a primary duty on the State to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life. It applies in the context of any activity, whether public or not, in which the right to life may be at stake (see *Nicolae Virgiliu Tănase*, cited above, § 135, and the cases cited therein).

(ii) End-of-life case-law

118. While this application is the first case in which the Court has been called upon to examine a complaint under Article 2 of the Convention regarding the consequences of an act of euthanasia that has been carried out, it has nevertheless had the opportunity to rule on a number of cases concerning related issues. A summary of the Court's case-law as it currently stands is given in *Lambert and Others* (cited above, §§ 136-39).

119. In particular, the Court has found that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 (see *Pretty v. the United Kingdom*, no. 2346/02, § 40, ECHR 2002-III, and *Lings v. Denmark*, no. 15136/20, § 52, 12 April 2022).

120. In *Pretty* (cited above), the applicant had argued that a failure to acknowledge a right to die under the Convention would place those countries which did permit assisted suicide in breach of the Convention. The Court, pointing out that it was not for it to assess whether or not the state of law in any other country failed to protect the right to life, considered that the extent to which a State permitted, or sought to regulate, the possibility for the infliction of harm on individuals at liberty, by their own or another's hand, might raise conflicting considerations of personal freedom and the public interest that could only be resolved on examination of the concrete circumstances of the case (ibid., § 41).

121. In the above-cited *Haas* judgment, the Court considered that Article 2 of the Convention 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).

122. In *Lambert and Others* (cited above), which concerned the withdrawal of life-sustaining treatment from the applicants' relative, the Court considered that in the context of French law, which prohibited the intentional taking of life, the case did not involve the State's negative obligations under Article 2 of the Convention (ibid., § 124). The Court examined the applicants' complaints solely from the standpoint of the State's positive obligation to protect life, read in the light of the right of each individual to respect for his or her private life and the notion of personal autonomy which that right encompassed. It took into account various factors, such as the existence in domestic law of a regulatory framework, the extent to which account had been taken of the wishes of the patient, his family and the medical personnel, and the possibility to apply to the courts for a decision protecting the patient's interests (ibid., §§ 150-80).

123. The Court noted that no consensus existed among the Contracting States in favour of permitting the withdrawal of artificial life-sustaining treatment, although the majority of States appeared to allow it. In that context, it considered that while the detailed arrangements governing the withdrawal of treatment varied from one country to another, there was nevertheless consensus as to the paramount importance of the patient's wishes in the decision-making process, however those wishes were expressed (ibid., § 147; see also *Gard and Others v. the United Kingdom* (dec.), no. 39793/17, § 83, 27 June 2017).

124. Lastly, the Court reiterates that the very essence of the Convention is respect for human dignity and human freedom (see *Pretty*, cited above, § 65). Under Article 8 of the Convention in particular, where the notion of personal autonomy is an important principle underlying the interpretation of its guarantees, protection is given to the personal sphere of each individual (see *Christine Goodwin v. the United Kingdom* [GC], no. 28957/95, § 90, ECHR 2002-VI). An individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention (see *Pretty*, § 67, and *Haas*, § 51, both cited above).

(iii) Application to a euthanasia case

125. The present case differs from *Lambert and Others* (judgment cited above) in so far as euthanasia is defined in Belgian law as any act performed by a third party which intentionally ends an individual's life at that individual's request (see paragraph 50 above).

126. The Court therefore has to begin by determining whether such an act can, in certain circumstances, be performed without contravening Article 2 of the Convention. The question which arises in the present case is whether the

performance of the euthanasia, at the request of the applicant's mother, under the Belgian legislation authorising euthanasia, was in accordance with Article 2.

127. In this context, the Court emphasises that the present case does not concern the question of whether there is a right to euthanasia, but rather the compatibility with the Convention of the act of euthanasia performed in the case of the applicant's mother.

(α) Interpretation of Article 2 of the Convention

128. The Court must establish the ordinary meaning to be given to the terms in their context and in the light of the object and purpose of the provision from which they are taken. It must have regard to the fact that the context of the provision is a treaty for the effective protection of individual human rights and that the Convention must be read as a whole, and interpreted in such a way as to promote internal consistency and harmony between its various provisions (see *N.D. and N.T. v. Spain* [GC], nos. 8675/15 and 8697/15, § 172, 13 February 2020). The Court is required to interpret and apply its provisions so as to make its safeguards practical and effective (see, among other authorities, *Loizidou v. Turkey* (preliminary objections), 23 March 1995, § 72, Series A no. 310, and *Güzelyurtlu and Others v. Cyprus and Turkey* [GC], no. 36925/07, § 234, 29 January 2019). Furthermore, the Convention and the Protocols thereto must be interpreted in the light of present-day conditions (see *Haas*, cited above, § 55).

129. The Court notes that the *travaux préparatoires* contain no guidance on how to interpret Article 2 of the Convention. From a textual perspective, Article 2 of the Convention is written in the passive voice, in both English and French. It does not explicitly state whether it applies solely to the deprivation of life by State officials or whether it also applies horizontally to relations between private individuals. As with all of the Convention's provisions, the rights enshrined in that Article can first and foremost be relied on against member States. In this context, while the States mainly have negative obligations, they may also be called upon to adopt positive measures to protect any such rights that may be breached by third parties.

130. The provision must also be read in the light of the exceptions set out in the second sentence of paragraph 1 of Article 2 and in paragraph 2 of that provision. It is the Court's opinion that these exceptions, having regard to their wording, are primarily aimed at State officials and permit, in certain specific circumstances, the intentional deprivation of life.

131. Cases concerning relations between private individuals have thus mainly been examined under the first sentence of paragraph 1 of Article 2 of the Convention, from which the Court has derived a positive obligation for the State to protect the right to life.

132. Such was also the case when deciding whether an abortion could be compatible with Article 2 of the Convention (see *Boso v. Italy* (dec.),

no. 50490/99, ECHR 2002-VII). The Court examined the matter in the light of the substantive positive obligation under that Article to protect the right to life. It noted that abortion, as it was regulated by Italian law at the relevant time, was authorised if there was a risk to the woman's physical or mental health. In those circumstances, the Court considered that such provisions struck a fair balance between, on the one hand, the need to ensure protection of the foetus and, on the other, the woman's interests.

133. The euthanasia in issue was governed by legislation that only permits such an act if it is performed by a doctor and if the patient is in a hopeless medical situation and experiencing constant and intolerable physical or mental suffering which cannot be alleviated and is the result of a serious and incurable accidental or pathological condition (see paragraph 51 above).

134. In cases such as this, the Court is thus required, in examining a possible violation of Article 2, to take account of Article 8 of the Convention and of the right to respect for private life and the notion of personal autonomy which it encompasses (see *Lambert and Others*, cited above, § 142).

135. An individual's right to decide by what means and at what point his or her life will end is one of the aspects of the right to respect for private life (see *Haas*, cited above, § 51). In this connection, the Court has previously not been prepared to exclude that the act of preventing someone by law from exercising his or her choice to avoid what he or she considers will be an undignified and distressing end to his or her life may constitute an interference with his or her right to respect for private life as guaranteed under Article 8 § 1 of the Convention (see *Pretty*, cited above, § 67).

136. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity (see *Pretty*, cited above, § 65).

137. Moreover, as the Belgian Constitutional Court pointed out, the decriminalisation of euthanasia was intended to give individuals a free choice to avoid what in their view might be an undignified and distressing end to life (see paragraph 65 above). It must be said that human dignity and human freedom constitute the very essence of the Convention (see paragraph 124 above).

138. Under these circumstances, the Court considers that, while it is not possible to derive a right to die from Article 2 of the Convention (see paragraph 119 above), the right to life enshrined in that provision cannot be interpreted as *per se* prohibiting the conditional decriminalisation of euthanasia.

139. In order to be compatible with Article 2 of the Convention, the decriminalisation of euthanasia has to be accompanied by the provision of appropriate and adequate safeguards to prevent abuse and thus ensure respect for the right to life. In this connection, the Court also notes that the United

Nations Human Rights Committee has held that euthanasia does not in itself constitute an interference with the right to life if it is accompanied by robust legal and institutional safeguards to ensure that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patient, with a view to protecting patients from pressure and abuse (see paragraph 69 above).

140. The Court's assessment of the effects of such a measure in relation to the Convention can be made only after an examination of the particular circumstances of the case at hand (see paragraph 120 above).

(β) The context of the Court's examination

141. Accordingly, in the context of a case concerning an act of euthanasia alleged to violate Article 2 of the Convention, the Court considers that the applicant's complaints fall to be examined under the positive obligations of the State to protect the right to life within the meaning of the first sentence of paragraph 1 of that provision (see paragraphs 116-117 above). To conduct that examination, the Court will take into account the following questions:

(i) whether there was, in domestic law and practice, a legislative framework for pre-euthanasia procedures which met the requirements of Article 2 of the Convention;

(ii) whether the legislative framework was complied with in the present case;

(iii) whether the post-euthanasia review afforded all the safeguards required by Article 2 of the Convention.

(b) The applicable margin of appreciation

142. End-of-life matters, and in particular euthanasia, raise complex legal, social, moral and ethical issues. The legal opinions and responses among the States Parties to the Convention vary greatly, and there is no consensus as to the right of an individual to decide in which way and at what time his or her life should end (see *Haas*, cited above, § 55, and *Koch v. Germany*, no. 497/09, § 70, 19 July 2012, in relation to assisted suicide, and *Lambert and Others*, cited above, § 147, concerning whether or not to permit the withdrawal of artificial life-sustaining treatment; see also the comparative-law material presented in *Lings*, cited above, §§ 26-32 and § 60).

143. Accordingly, the Court considers that in this area, which concerns the end of life and the means of striking a balance between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy, States must be afforded a margin of appreciation (see, *mutatis mutandis*, *Lambert and Others*, cited above, § 148, concerning whether or not to permit the withdrawal of artificial life-sustaining treatment and the detailed arrangements governing such

withdrawal). However, this margin of appreciation is not unlimited and the Court reserves the power to review whether or not the State has complied with its obligations under Article 2 (ibid.).

(c) The State's compliance with its positive obligations in the present case

144. The issues in the present case are whether the Euthanasia Act, as in force at the relevant time, offered an effective safeguard for protecting vulnerable individuals' right to life and whether the euthanasia of the applicant's mother was performed under conditions compliant with Article 2 of the Convention. The parties also disagree on whether the post-euthanasia review, conducted by the Federal Euthanasia Monitoring and Assessment Board ("the Board") and subsequently by the judicial authorities, was compliant with that Article. The Court will examine each of these three issues in turn.

(i) The legislative framework for pre-euthanasia procedures

145. The Court notes at the outset that the Belgian legislature has chosen not to provide for any independent prior scrutiny of specific acts of euthanasia. In the absence of such scrutiny, the Court is required when examining a given case to look more closely at the existence of substantive and procedural safeguards.

146. In the Court's view, the legislative framework governing pre-euthanasia procedures must ensure that an individual's decision to end his or her life has been taken freely and with full understanding of what is involved. 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 –, obliges the national authorities to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved (see *Haas*, cited above, § 54; see also the European and international material in paragraphs 67 and 69 above).

147. The Court notes that the present case concerns a request for euthanasia made because of mental – not physical – suffering, in the context of which the death of the applicant's mother was clearly not expected to occur otherwise in the short term, within the meaning of section 3(3) of the Euthanasia Act (see paragraph 51 above).

148. In such circumstances, the Court considers that the law must provide for enhanced safeguards in the euthanasia decision-making process.

149. Turning back to the legislative framework implemented in Belgium, the Court observes that the decriminalisation of euthanasia is subject to conditions strictly regulated by the Euthanasia Act, which provides for a number of substantive and procedural safeguards.

150. Thus, under section 3 of the Euthanasia Act, a doctor can only carry out euthanasia if the adult or emancipated minor is conscious at the time of

his or her request, if that request is made of his or her own free will, in a considered and constant manner, and if it is not the result of external pressure. Furthermore, euthanasia is permitted only if the patient is in a hopeless medical situation and experiencing constant and intolerable physical or mental suffering which cannot be alleviated and is the result of a serious and incurable accidental or pathological condition (see paragraph 51 above).

151. The Euthanasia Act also requires doctors to provide the patient with the relevant information and to consult another doctor, who must be independent, in relation to both the patient and the main doctor, and be competent as regards the condition concerned (ibid.). At least one month has to elapse between the patient's written request and the act of euthanasia, thus ensuring that the request is the result of a considered and constant wish. That is particularly important where the requesting patient alleges mental suffering and death will not otherwise occur in the short term.

152. In addition, the law provides for additional safeguards where death will not otherwise occur in the short term. In such cases, the main doctor is also required to consult a second doctor, who again has to be satisfied that the suffering is constant and intolerable and cannot be alleviated and that the request has been made of the patient's own free will, in a considered and constant manner. The second doctor must also be independent, in relation to both the patient and the main doctor, and be competent as regards the condition concerned (ibid.).

153. In view of the foregoing, the Court considers that the legislative framework put in place by the Belgian legislature concerning pre-euthanasia procedures ensures that an individual's decision to end his or her life is taken freely and with full understanding of what is involved. In particular, the Court attaches great importance to the fact that additional safeguards are provided for in cases such as that of the applicant's mother which concern mental suffering and where death will not otherwise occur in the short term, and to the requirement that the various doctors consulted be independent in relation to both the patient and the main doctor.

154. Lastly, the Court notes that the Euthanasia Act has been subject to a number of reviews by the higher authorities, both prior to enactment, by the *Conseil d'État* (see paragraph 63 above), and subsequently by the Constitutional Court (see paragraphs 64 and 65 above), which found, following a thorough analysis, that it remained within the limits imposed by Article 2 of the Convention.

155. Having regard to all the above considerations and to the margin of appreciation enjoyed by the State (see paragraph 143 above), the Court considers that, as regards the pre-euthanasia acts and procedure, the provisions of the Euthanasia Act constitute in principle a legislative framework capable of ensuring the protection of a patient's right to life as required by Article 2 of the Convention.

156. Accordingly, there has been no violation of Article 2 on this account.

(ii) Compliance with the legal framework in the present case

157. Concerning compliance with the legal framework in the present case, the Court emphasises that its power to review compliance with domestic law is limited, since it is in the first place for the national authorities, notably the courts, to verify whether the euthanasia in issue complied with the domestic legislation. The Court's role consists in ascertaining whether the State has fulfilled its positive obligations under Article 2 of the Convention (see, *mutatis mutandis*, *Lambert and Others,* cited above, § 181).

158. The Court will therefore confine itself to examining the applicant's various complaints.

159. With regard to the medical situation of the applicant's mother, the Court is not in a position to substitute its assessment for that of the doctors who examined her. The Court notes that, in accordance with the law, Professor D. consulted two other psychiatrists (see paragraphs 17-18 above). They examined whether the applicant's mother was lucid, whether the request was made of her own free will and in a considered and constant manner, whether she was pressured by third parties and whether she was experiencing intolerable and incurable suffering, before concluding that she could be assisted in ending her life. In the absence of any specific evidence calling into question the competence of the doctors consulted or the accuracy of their medical findings, the Court cannot conclude that the medical situation of the applicant's mother did not fall within the scope of section 3 of the Euthanasia Act.

160. As regards the donation of EUR 2,500 made by the applicant's mother to the association LEIF a few weeks before she died, the applicant argued that the gesture had created a conflict of interest in so far as the medical team involved in the process had a connection to the association (see paragraph 87 above). Professor D. also chaired the association (see paragraph 21 above).

161. The Court notes, however, that the donation in question was made on 29 February 2012, several months after the informal request for euthanasia and fifteen days after the formal request. Moreover, having regard to the amount of the donation, it cannot be considered, in the circumstances of the case, to indicate a conflict of interest. Nor is there anything in the case file to suggest that the applicant's mother made such a donation in order to obtain the doctors' consent to euthanasia.

162. As regards the applicant's allegation of a lack of independence of the two doctors consulted *vis-à-vis* Professor D., given their membership of the same association (see paragraph 21 above), the Court considers that the positive obligations arising under Article 2 of the Convention imply that, for the doctors consulted as part of euthanasia requests to be considered independent, there should be not only a lack of hierarchical or institutional connection but also formal and *de facto* independence both between the various doctors consulted and *vis-à-vis* the patient (see, *mutatis mutandis*,

regarding such a requirement for a system of supervision set up to determine the cause of death of patients in the care of the medical profession, *Lopes de Sousa Fernandes*, cited above, § 217).

163. In the present case, the Court, like the Government (see paragraph 97 above), notes that a large number of doctors, including those who assume responsibility for euthanasia requests, have received training provided by the LEIF association, whose purpose is to ensure a dignified end of life for all. In that context, the Court considers that the fact that the doctors consulted were members of the same association does not suffice, in the absence of other evidence, to prove a lack of independence.

164. The act of euthanasia was ultimately carried out on the applicant's mother some two months after her formal request for euthanasia and after Professor D. had ascertained that her request had been made of her own free will and in a constant and considered manner, without external pressure, that she was in a hopeless medical situation and that she was experiencing constant and intolerable mental suffering which could no longer be alleviated and stemmed from a serious and incurable condition. That conclusion was subsequently confirmed following the criminal investigation conducted by the judicial authorities, which decided that the euthanasia in question had indeed complied with the substantive and procedural conditions prescribed by the Euthanasia Act.

165. Consequently, it does not appear from the evidence before the Court that the act of euthanasia, which was carried out on the applicant's mother in accordance with the established legal framework, contravened the requirements of Article 2 of the Convention. Accordingly, there has been no violation of that provision in this regard.

(iii) The post-euthanasia review

(α) General principles

166. The State's duty to safeguard the right to life must be considered to involve not only substantive positive obligations, but also, in the event of death, the procedural positive obligation to have in place an effective independent judicial system. Such system may vary according to circumstances. It should, however, be capable of promptly establishing the facts, holding accountable those at fault and providing appropriate redress to the victim (see *Nicolae Virgiliu Tănase*, cited above, § 137).

167. In the event of death the Court has held that where it is not clearly established from the outset that the death has resulted from an accident or another unintentional act, and where the hypothesis of unlawful killing is at least arguable on the facts, the Convention requires that an investigation attaining the minimum threshold of effectiveness be conducted in order to shed light on the circumstances of the death. The fact that the investigation ultimately accepts the hypothesis of an accident has no bearing on this issue,

since the obligation to investigate is specifically intended to refute or confirm one or other hypothesis. In such circumstances, the obligation of an effective official investigation exists even where the presumed perpetrator is not a State agent (see *Nicolae Virgiliu Tănase*, cited above, § 161). In the Court's view, these requirements are also to be applied in cases where an act of euthanasia is the subject of a report or a criminal complaint by a relative of the deceased, plausibly indicating the existence of suspicious circumstances (see paragraph 79 above).

168. In such circumstances, the Court considers that the applicable principles are those described in the *Nicolae Virgiliu Tănase* judgment (cited above, §§ 165-71) as follows (references omitted):

> "165. In order to be 'effective' ..., an investigation must firstly be adequate ... That is, it must be capable of leading to the establishment of the facts and, where appropriate, the identification and punishment of those responsible ...
>
> 166. The investigation must also be thorough, which means that the authorities must take all reasonable steps available to them to secure the evidence concerning the incident, always make a serious attempt to find out what happened and not rely on hasty or ill-founded conclusions to close their investigation or to use as the basis of their decisions ...
>
> 167. It should further be emphasised that even where there may be obstacles or difficulties preventing progress in an investigation, a prompt response by the authorities is vital for public safety and in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in, or tolerance of, unlawful acts. The proceedings must also be completed within a reasonable time ...
>
> 168. Also, it is generally necessary that the domestic system set up to determine the cause of death or serious physical injury be independent. This means not only a lack of hierarchical or institutional connection but also a practical independence implying that all persons tasked with conducting an assessment in the proceedings for determining the cause of death or physical injury enjoy formal and *de facto* independence from those implicated in the events ...
>
> 169. In a case such as the present one, where various legal remedies, civil as well as criminal, are available, the Court will consider whether the remedies taken together as provided for in law and applied in practice, could be said to have constituted legal means capable of establishing the facts, holding accountable those at fault and providing appropriate redress to the victim. The choice of means for ensuring the positive obligations under Article 2 is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues for ensuring Convention rights, and even if the State has failed to apply one particular measure provided for by domestic law, it may still have fulfilled its positive duty by other means ...
>
> 170. The said obligations will not however be satisfied if the protection afforded by domestic law exists only in theory: above all, it must also operate effectively in practice ... It is not an obligation of result but of means only ... Thus the mere fact that the proceedings have ended unfavourably for the victim (or the next-of-kin) does not in itself mean that the respondent State has failed in its positive obligations under Article 2 of the Convention ...
>
> 171. Finally, the Court reiterates that compliance with the procedural requirement of Article 2 is assessed on the basis of several essential parameters, including those

> mentioned above (see paragraphs 166-168). These elements are inter-related and each of them, taken separately, does not amount to an end in itself, as is the case in respect of the requirements for a fair trial under Article 6. They are criteria which, taken jointly, enable the degree of effectiveness of the investigation to be assessed. It is in relation to this purpose of an effective investigation that any issues, including that of promptness and reasonable expediency, must be assessed ..."

169. The national courts should not under any circumstances be prepared to allow life-endangering offences to go unpunished. This is essential for maintaining public confidence and ensuring adherence to the rule of law and for preventing any appearance of tolerance of or collusion in unlawful acts (see *Öneryıldız v. Turkey* [GC], no. 48939/99, § 96, ECHR 2004-XII, and *S.F. v. Switzerland*, no. 23405/16, § 127, 30 June 2020). The Court's task therefore consists in reviewing whether and to what extent the courts, in reaching their conclusion, may be deemed to have submitted the case to the careful scrutiny required by Article 2 of the Convention, so that the deterrent effect of the judicial system in place and the significance of the role it is required to play in preventing violations of the right to life are not undermined (see *Öneryıldız*, cited above, § 96; *Giuliani and Gaggio v. Italy* [GC], no. 23458/02, § 306, ECHR 2011 (extracts); and *Armani Da Silva v. the United Kingdom* [GC], no. 5878/08, § 239, 30 March 2016).

(β) Application to the present case

170. To determine whether the euthanasia of the applicant's mother had been performed in accordance with the law, there were two levels of oversight: the Board's automatic review and then the criminal investigation opened after the applicant had lodged his complaint. The Court will examine both in turn.

– *The Board's review*

171. The Euthanasia Act introduced a mechanism of automatic subsequent review by the Board for every act of euthanasia performed (see paragraphs 52-53 above). It is the Court's view that, given that the Belgian legislature chose to implement only a post-euthanasia review (see paragraphs 52-55 above), this review must be particularly rigorous in order to comply with the obligations laid down in Article 2 of the Convention.

172. The applicant contended that the Board could not give an independent opinion on the lawfulness of his mother's euthanasia since the matter involved Professor D., its co-chair, who had not withdrawn from examining the case (see paragraph 89 above).

173. The Government submitted in response that the examination had been conducted impartially on the basis of the second part of the registration document, in which no names were given. They further specified that if the euthanasia registration document had been completed by a doctor present, he or she would never take part in the discussion and would not influence it in

any way. With due respect for ethical rules and principles, the doctor in question would remain silent when the Board was examining a case which concerned him or her in one way or another (see paragraph 95 above).

174. As regards the composition of the Board, the Court notes that the Euthanasia Act provides for the presence of qualified doctors, law professors and professionals with a background in dealing with patients suffering from incurable diseases (see paragraph 53 above), thus undoubtedly guaranteeing the multidisciplinary knowledge and practice of its members. Moreover, the fact that the members of the Board are nominated by a legislative assembly is a guarantee of its independence – which the applicant does not dispute.

175. The Court notes, however, that in the present case the Board ascertained, solely on the basis of the second – anonymous – part of the registration document, whether the euthanasia of the applicant's mother had been carried out in accordance with the law. The Board concluded that the euthanasia had taken place in accordance with the statutory conditions and procedure (see paragraph 30 above). It therefore appears that Professor D. did not withdraw and there is no indication that he opted in the circumstances to follow the practice described by the Government (see paragraph 95 above), whereby a doctor involved in a euthanasia case under review remains silent.

176. The Court reiterates that the machinery of oversight put in place at national level to determine the circumstances surrounding the death of individuals in the care of health professionals must be independent. As it held in *Lopes de Sousa Fernandes* (cited above, § 217), this requirement is particularly important when obtaining medical reports from expert witnesses (see also *Bajić v. Croatia*, no. 41108/10, § 90, 13 November 2012).

177. While the Court understands that the withdrawal procedure provided for by law (see paragraph 55 above) is intended to preserve the confidentiality of the personal data contained in the registration document and the anonymity of the persons involved, it nevertheless considers that the system put in place by the Belgian legislature for the post-euthanasia review – based only on the anonymous part of the registration document – does not satisfy the requirements of Article 2 of the Convention. The procedure provided for in section 8 of the Euthanasia Act does not prevent the doctor who performed the euthanasia from sitting on the Board or from voting on whether his or her own acts were compatible with the substantive and procedural requirements of domestic law. The Court considers that the fact of leaving it to the sole discretion of the member concerned to decide to remain silent, where he or she was involved in the euthanasia under review (see the practice described by the Government in paragraph 95 above), cannot be regarded as sufficient to ensure the independence of the Board. While being aware of the autonomy enjoyed by States in this area, the Court considers that such a defect could be avoided and confidentiality safeguarded, for example, if the Board were composed of a larger number of members than the number of those who sit to consider each case. This would ensure that a member of the Board who

performed the specific act of euthanasia would not have to sit when the Board was reviewing it.

178. Consequently, and having regard to the crucial role played by the Board in the post-euthanasia review, the Court considers that the machinery of oversight established in the present case did not guarantee its independence, irrespective of any real influence Professor D. might have had on the Board's decision.

– *The criminal investigation*

179. The Court reiterates that, where death is the result of an act of euthanasia carried out under legislation which permits it subject to strict conditions, a criminal investigation is not usually required. The competent authorities must, however, open an investigation to establish the facts and, as appropriate, to identify and to punish those responsible, where a relative of the deceased or a third party has made a criminal complaint indicating the existence of suspicious circumstances (see paragraph 79 above). Thus, having regard to the criminal complaint lodged by the applicant, who plausibly alleged that the Euthanasia Act had not been complied with in the present case, the Belgian authorities were under an obligation to conduct a criminal investigation.

180. The Court notes that the first criminal investigation, conducted by the Crown Prosecutor following the applicant's complaint, lasted approximately three years and one month whereas no investigative act appears to have been undertaken by the Crown Prosecutor in that time. Moreover, the Government did not dispute the ineffectiveness of the first investigation (see paragraph 98 above). The second criminal investigation conducted under the direction of an investigating judge after notice of the present application had been given to the Government lasted approximately one year and seven months.

181. It is the Court's view that, taken as a whole, and having regard to the inaction during the first investigation, the criminal investigation did not meet the requirement of promptness under Article 2 of the Convention.

182. However, as regards the thoroughness of the investigation, the Court considers that in the course of the second criminal investigation the authorities took all reasonable steps available to them to obtain the information needed to establish the facts of the case. For example, the investigating judge appointed a medical expert, who examined the applicant's mother's medical file and presented his findings in a detailed forensic report (see paragraphs 45-46 above). The police also heard evidence from Professor D. (see paragraph 47 above). It was on the basis of this evidence that the Pre-Trial Division decided that there was no case to answer (see paragraph 49 above).

183. These findings are sufficient to conclude that the second investigation was adequately thorough. In so far as the State was bound by an

obligation of means rather than one of result (see paragraph 168 above), the fact that the judicial investigation was ultimately closed without anyone being committed for trial does not in itself warrant the conclusion that the criminal proceedings concerning the euthanasia of the applicant's mother did not satisfy the requirements of effectiveness under Article 2 of the Convention.

(γ) Conclusion concerning the post-euthanasia review

184. In view of the foregoing, the Court finds that the State failed to fulfil its procedural positive obligation on account of the lack of independence of the Board and of the length of the criminal investigation in the present case.

185. There has therefore been a violation of Article 2 of the Convention in this regard.

III. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

186. The applicant alleged that in failing to effectively protect his mother's right to life the State had also breached his own right to respect for his private and family life. He relied on Article 8 of the Convention, which provides:

> "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. The parties' submissions

1. The applicant

187. The applicant submitted that the respondent State had breached his right to respect for his private and family life by failing to protect his mother's life. He argued that where euthanasia was performed by a doctor who co-chaired the review body, the patient's family members were exposed by the State to an interference with their own psychological integrity and with their family life. In addition, one of the reasons that had driven his mother to euthanasia had been a lack of contact with her family, meaning efforts should have been made to reconnect her with them before her condition could be characterised as incurable. The applicant also complained about not having been informed of or involved in the decision-making process that had resulted in his mother's death by euthanasia.

2. The Government

188. The Government argued that this complaint was absorbed by that raised under Article 2 and that no separate issue arose as to the applicant's right to respect for his private and family life.

189. In the Government's view, the rights enshrined in the Convention aimed to prevent unlawful infringements by the State or third parties, not to limit individuals' capacity for self-determination – at least where the legislature had established such capacity, in accordance with the margin of appreciation afforded to it. In that regard, it was of fundamental importance that the euthanasia was requested by the patient and that there were safeguards in place to ensure the integrity of the request. The *Haas* judgment (cited above), argued the Government, made it clear that an individual's right to decide by what means and at what point his or her life would end, provided he or she was capable of freely reaching a decision on that question and acting in consequence, was one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention. According to the Government, the notion of personal autonomy thus reflected an important principle underlying the interpretation of the guarantees afforded by the right to respect for private life.

190. More specifically regarding the applicant's lack of involvement in the euthanasia process, the Government conceded that patients would ideally be surrounded by their families in such a situation. They pointed out, however, that patients could sometimes prefer to be alone with their doctors for that final stage of their lives. In the present case, the applicant's mother no longer had any ties with her son and had refused to have him be part of the euthanasia process, despite her doctors' efforts to convince her to reestablish contact with him. Doctors needed to respect this legitimate wish, in accordance with their duty of confidentiality and medical secrecy.

B. Submissions of third-party interveners

1. Association pour le Droit de Mourir dans la Dignité

191. ADMD submitted that, under the Euthanasia Act, doctors were only able to discuss an individual's euthanasia request with the family members and friends of his or her choice if such were that individual's wishes. Ideally, the decision to pursue euthanasia would be shared with the family to pave the way for a peaceful departure. However, that would not always be possible, because all families had different sets of experiences, some of which were painful. In addition, any doctor who went against a patient's wish not to talk with his or her family would be in danger of infringing the legislation on patients' rights.

2. Care Not Killing

192. CNK stated that Articles 2 and 8 of the Convention were complementary and formed part of a seamless legal scheme designed to maximise the protection of individuals. Any human death would necessarily affect the interests of many other individuals, including family members, in ways that were the concern of Article 8.

3. European Centre for Law and Justice

193. ECLJ made no submissions on this aspect of the case.

4. Dignitas

194. Referring to the *Haas* judgment (cited above), Dignitas submitted that Article 8 of the Convention recognised individuals' right to decide for themselves when and how they wished to die. It was of great importance that any individual who had requested euthanasia spoke about their intention with his or her family. However, it could sometimes be impossible for that individual to contact his or her family because of the complexity of family relations.

5. Ordo Iuris Institute

195. OII submitted that the issues raised by euthanasia had to be examined from the point of view not only of Article 2 of the Convention but also of Article 8 with regard to the right to respect for the family bond of the euthanasia patient's family members. If the decision on how and when to end one's life was part of the right to respect for an individual's private life, it should also be assumed that part of the right was the possibility to seek advice from close relatives and friends. Even if it were recognised that every adult human being might autonomously decide how and when to end his or her own life, such a decision would have severe consequences for the private and family life of family and friends.

196. It was the view of OII that the family bond, which was guaranteed under Article 8 of the Convention, was broken as a result of euthanasia. That break, especially when it occurred suddenly and without warning, would be associated with mental and, in extreme cases, physical suffering by those who had lost a family member. The right of those family members to meet with their relative while he or she was awaiting euthanasia would then be a key component of the right to respect for family life. Even supposing that the right to euthanasia were a component of the right to respect for private life, that right would have to be counterbalanced by the family's right to respect for their family life.

C. The Court's assessment

197. The applicant submitted that his right to respect for his private and family life had been breached because of his mother's euthanasia, which he argued was contrary to the requirements of Article 2 of the Convention. In particular, he claimed that the domestic authorities had failed in their duty to ensure that he had been involved in his mother's euthanasia process. The Court considers that this aspect of the case was not examined in substance when analysing the complaints under Article 2 of the Convention. It will therefore examine it separately.

1. Admissibility

198. The parties do not dispute that the facts in the present case fall within the scope of the applicant's private and family life. The Court will therefore proceed on the premise that Article 8 of the Convention is applicable in both aspects.

199. The Court further notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention and is not inadmissible on any other grounds. It must therefore be declared admissible.

2. Merits

200. The Court reiterates that in Article 1 of the Convention the Contracting States undertake to "secure to everyone within their jurisdiction the rights and freedoms defined in ... [the] Convention". While the essential object of Article 8 of the Convention is to protect individuals against arbitrary interference by public authorities, it may also impose on the State certain positive obligations to ensure effective respect for the rights protected by Article 8 (see *Von Hannover v. Germany (no. 2)* [GC], nos. 40660/08 and 60641/08, § 98, ECHR 2012; *Hämäläinen v. Finland* [GC], no. 37359/09, § 62, ECHR 2014; and *Bărbulescu v. Romania* [GC], no. 61496/08, § 108, 5 September 2017). In particular, these obligations may involve the adoption of measures designed to secure respect for private and family life even in the sphere of the relations of individuals between themselves (see *Evans v. the United Kingdom* [GC], no. 6339/05, § 75, ECHR 2007-I, and *Nicolae Virgiliu Tănase*, cited above, § 125).

201. Having regard to the circumstances of the case, and in particular the manner in which the applicant framed his complaint, the Court considers that the present case raises the question whether the respondent State failed to fulfil its positive obligation to secure to the applicant, whose mother had died by euthanasia, the right to respect for his private and family life.

202. The principles applicable to assessing a State's positive and negative obligations under Article 8 are similar. Regard must be had in both cases to

the fair balance that has to be struck between the competing interests of the individual and of the community as a whole, the aims in the second paragraph of Article 8 being of a certain relevance (see *Roche v. the United Kingdom* [GC], no. 32555/96, § 157, ECHR 2005-X, and *Hämäläinen*, cited above, § 65).

203. First, the applicant complained of a violation of Article 8 because he argued that his mother's euthanasia was contrary to Article 2 of the Convention. In this connection, with regard to the legislative framework concerning the procedures prior to euthanasia and the conditions in which the act was carried out on the applicant's mother in the present case, the Court has already concluded that there has been no violation of Article 2 of the Convention (see paragraphs 155 and 165 above). It consequently considers that the applicant's right to respect for his private and family life was not breached solely on account of the fact that his mother underwent euthanasia.

204. Next, as regards the applicant's lack of involvement in the euthanasia process, the Court is called upon to rule on a conflict between various competing interests, namely the applicant's wish to accompany his mother in the last moments of her life and his mother's right to respect for her wishes and her personal autonomy (on the latter point, see the general principles described in paragraph 124 above). In this context, the Court has to weigh up the interests at stake.

205. The Court observes that the Euthanasia Act obliges doctors to discuss a patient's request for euthanasia with his or her family members and friends only where this is the patient's wish (see paragraph 51 above). If that is not the case, they cannot contact such individuals, in accordance with their duty of confidentiality and medical secrecy (see paragraphs 59 and 66 above).

206. In the present case, in accordance with the law, the doctors involved in the euthanasia procedure of the applicant's mother suggested to her several times that she should resume contact with her children (see paragraphs 11, 17, 19 and 23 above). However, it is apparent from the case file that she repeatedly objected, stating that she no longer wanted to have contact with her children (see paragraphs 6, 8, 9, 25 and 26 above). She even indicated that she was afraid of her son (see paragraph 8 above). Nevertheless, at the request of her doctors, the applicant's mother sent an email to her children – the applicant and his sister – informing them of her wish to undergo euthanasia (see paragraph 12 above). While the applicant's sister replied to that email stating that she respected her mother's wishes, the applicant does not appear to have responded (see paragraph 12 above).

207. In these circumstances, which relate to a long-standing breakdown in the relationship between the applicant and his mother, the Court considers that the doctors attending to the applicant's mother took all reasonable steps, in accordance with the law, their duty of confidentiality and medical secrecy, and ethical guidelines (see paragraphs 59 and 66 above), to ensure that she contacted her children about her request for euthanasia. The legislature

cannot be criticised for obliging doctors to respect the wishes of the applicant's mother on that point or for imposing on them a duty of confidentiality and medical secrecy. On the latter point, the Court reiterates that respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention and that it is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general (see *Z v. Finland*, 25 February 1997, *Reports* 1997-I, and *M.S. v. Sweden*, 27 August 1997, § 41, *Reports* 1997-IV; and see also, *mutatis mutandis*, *Szuluk v. the United Kingdom*, no. 36936/05, § 47, ECHR 2009).

208. In view of the foregoing, the Court finds that the legislation, as applied in the present case, struck a fair balance between the different interests at stake.

209. There has therefore been no violation of Article 8 of the Convention.

IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

210. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Damage

211. The applicant did not make any claim for pecuniary or non-pecuniary damage. He stated that he was not seeking financial gain but rather wished to see violations of the Convention found and measures taken by the Government to prevent any further such violations in the future. Accordingly, the Court considers that no award should be made under this head.

B. Costs and expenses

212. The applicant claimed 2,828.23 euros (EUR) for the costs and expenses incurred before the domestic courts and EUR 10,800 for those incurred before the Court.

213. The Government did not dispute the costs incurred by the applicant before the domestic courts in the amount of EUR 2,211.30. However, they deducted from the applicant's claim the travel expenses of an ADF International advisor, who had acted *pro bono*. With regard to the costs incurred before the Court, the Government pointed out that, in the claim for just satisfaction, it was indicated that those costs had not been incurred by the applicant as ADF International had acted *pro bono*.

214. According to the Court's case-law, an applicant is entitled to the reimbursement of costs and expenses only in so far as it has been shown that

these have been actually and necessarily incurred and are reasonable as to quantum. In particular, the Court has held that a representative's fees are actually incurred if the applicant has paid them or is liable to pay them. The fees of a representative who has acted free of charge are not actually incurred (see *Merabishvili v. Georgia* [GC], no. 72508/13, §§ 370-71, 28 November 2017). In the present case, regard being had to the documents in its possession and the above criteria, the Court considers it reasonable to award the sum of EUR 2,211.30 for costs and expenses in the domestic proceedings, plus any tax that may be chargeable to the applicant.

FOR THESE REASONS, THE COURT

1. *Dismisses*, unanimously, the preliminary objection of failure to exhaust domestic remedies;

2. *Declares*, unanimously, the application admissible;

3. *Holds*, by five votes to two, that there has been no violation of Article 2 of the Convention on account of the legislative framework governing the pre-euthanasia procedures;

4. *Holds*, by five votes to two, that there has been no violation of Article 2 of the Convention on account of the conditions in which the act of euthanasia was performed on the applicant's mother;

5. *Holds*, unanimously, that there has been a violation of Article 2 of the Convention on account of shortcomings in the post-euthanasia review in the present case;

6. *Holds*, by six votes to one, that there has been no violation of Article 8 of the Convention;

7. *Holds*, unanimously,
   (a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, EUR 2,211.30 (two thousand two hundred and eleven euros and thirty cents), plus any tax that may be chargeable to the applicant, in respect of costs and expenses;
   (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amount at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

8. *Dismisses*, unanimously, the remainder of the applicant's claim for just satisfaction.

Done in French, and notified in writing on 4 October 2022, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Milan Blaško Registrar	Georges Ravarani 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 Elósegui;
(b) partly dissenting opinion of Judge Serghides.

G.R.
M.B.

PARTLY CONCURRING, PARTLY DISSENTING OPINION OF JUDGE ELÓSEGUI

I. INTRODUCTION

1. The applicant complained that his mother had undergone euthanasia without being afforded sufficient procedural safeguards (Article 2) and without her children having been consulted (Article 8).

I agree with the majority on two important points: first, that there has been a violation of Article 2 of the Convention on account of the shortcomings in the post-euthanasia review in respect of the applicant's mother (point 5 of the operative provisions) and, second, that there has been no violation of Article 8 of the Convention in the present case (point 6 of the operative provisions).

However, I voted against two other points (points 3 and 4) because in my opinion there has also been a violation of Article 2 of the Convention on account of the legal framework governing the pre-euthanasia procedures.

The present case is important because it would appear to be the first time that the Court has had the opportunity to examine the scope and nature of a State's obligations under Article 2 with regard to euthanasia and to psychiatric patients requesting that procedure.

2. In relation to the State's positive obligations to put in place an effective regulatory framework (including an effective post-euthanasia investigation), I agree with the majority in affirming that there has been a violation of Article 2 in the present case on account of the lack of an effective post-euthanasia review in the domestic system, set up to determine the cause of death of euthanasia patients. Independence requires not only a lack of hierarchical or institutional connection but also that all parties tasked with conducting an assessment in the procedure for determining a patient's cause of death enjoy formal and *de facto* independence from those involved in the events.

3. In the scarce current legislation on euthanasia (assisted suicide) there are two different types of regulations: some require a prior review to ascertain that the safeguards established in the legislation have been complied with, while others provide for a post-euthanasia review. Belgian law is the only system in the latter category (for a recent comparative study, see *Lings v. Denmark*, no. 15136/20, §§ 26-31, 12 April 2022)[1].

As judges, we are called upon to rule on specific cases according to the proven facts presented to us and to analyse whether or not there has been a violation of any of the rights guaranteed by the European Convention on Human Rights. Our function is not therefore to act as legislators, nor to

[1] See, for example, Spain's recent institutional law on the regulation of euthanasia, enacted on 18 March 2021. A pre-euthanasia review is required (report of 6 April 2021). See the website of Association pour le Droit de Mourir dans la Dignité (ADMD).

declare principles in the abstract. In the recent case of *Lings* (cited above, § 47), it is reiterated as follows:

> "Under the Court's well-established case-law, in proceedings originating in an individual application under Article 34 of the Convention, its task is not to review domestic law *in abstracto*. Instead, it must determine whether the manner in which it was applied to, or affected, the applicant gave rise to a violation of the Convention."

For this reason, the vote I cast here on the points both on which I concur and on which I dissent does not bind me in future cases in which the national legislation – or absence thereof – and the facts may be different. No matter how carefully we apply the Court's case-law, there are no identical cases, or even homogeneous interpretations of our own case-law.

In the following analysis, I will concentrate on the compliance or lack thereof with the Belgian law itself in the present case, confining my examination to the proven facts and reviewing whether in practice the specific safeguards provided for in the legal framework were complied with. As a consequence, after examining the case, I will arrive at the conclusion that neither the post-euthanasia review nor the Board established by the Belgian Euthanasia Act complied with Belgian law and, moreover, that this shows sufficiently that a system based on a post-euthanasia review in cases involving mentally ill (vulnerable) persons is not compatible in practice with the guarantees established in Article 2 of the Convention, because of those individuals' special vulnerability.

II. CONFLICT OF INTEREST IN DOCTOR-PATIENT RELATIONSHIPS

4. As I have said above, I am in agreement with the conclusion of the majority that there has been a violation of Article 2 in the present case because the doctor who performed the euthanasia was also on the Board and did not withdraw from the review. The present judgment gives some more specific indications to the Belgian legislature or the Belgian Government as to how that Board should organise withdrawals in order to preserve anonymity (see paragraph 177 of the judgment). In relation to this aspect, having myself been the Vice-President of the Bioethics Committee of the Autonomous Community of Aragon (Spain, 2012-2018) for five years and a member of the Ethics Committee of the hospital of my university in Saragossa (Spain) for fifteen years, I consider that, in line with the usual criteria for conflicts of interest, it is possible to appreciate that a doctor who has performed an act of euthanasia cannot sit on the Board reviewing the act and that it is not enough that he or she remain silent. That doctor has to withdraw from the review in order to secure the safeguards and the role of the Board. I subscribe to the observation made by the majority in paragraph 178 of the judgment:

> "Consequently, and having regard to the crucial role played by the Board in the post-euthanasia review, the Court considers that the machinery of oversight established in the present case did not guarantee its independence, irrespective of any real influence Professor D. might have had on the Board's decision."

I agree with the majority on this specific point, because I consider that the current framework under Belgian law, which allows a doctor who performs an act of euthanasia to also sit in the review session and vote on his or her own actions, is not compatible with the safeguards required by Article 2 of the European Convention on Human Rights, especially in cases concerning psychiatric patients. I believe, however, that the issue is not limited to the present case and that the current regulatory framework in general, which provides for a post-euthanasia review, cannot be considered to provide sufficient safeguards against abuse, irrespective of the actual influence that one person may have on the decision.

5. Turning to the definition of conflict of interest in doctor-patient relationships, this concept "is a moral figure that appears in the conduct of someone who has a duty or obligation (primary interest) that collides with an interest of a personal nature (secondary interest), which can distort their professional judgment in an unacceptable way, causing fear that justice be injured"[2].

According to many doctors in medicine, "[t]hese debates show up the interest of democratic societies for justice and social ethics that demand fair play in making decisions that may affect third parties, particularly patients"[3]. Moreover:

> "Despite the fact that in recent decades in the West the paradigm shift of the clinical relationship has been consolidated, moving from medical paternalism to the promotion of patient autonomy, patients generally approach the health system seeking help in a situation of necessity, relying on the moral integrity and competence of medical professionals. This asymmetry, which will always be present in the clinical relationship, requires analysing the conflicts of interest in medicine more rigorously than in other areas, where users have a greater capacity to defend themselves against the damage caused by unfair decisions, as occurs in a relationship of a commercial scenario. On the contrary, patients are generally in a position of inferiority before decisions biased by conflict of interest in the field of medicine."[4]

Furthermore, "[t]he legal certainty and the fear of a legal complaint can generate professional actions that do not have as a priority the interest of the

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[2] Davis M., "Conflict of Interest" in Chadwick R. (ed.), *Encyclopedia of Applied Ethics* (San Diego: Academic Press, 1998), pp. 589-95; Morreim E.H., "Conflict of Interest" in Reich W.T. (ed.) *Encyclopedia of Bioethics* (New York: Simon & Schuster Macmillan, 1995), pp. 459-65; Thompson D.F., "Understanding Financial Conflicts of Interest" in *N Engl J Med* (1993) vol. 329, pp. 573-76, DOI: 10.1056/NEJM199308193290812.

[3] R. Altisent, Delgado-Marroquín M.T. and Astier-Peña M.P., "Conflicts of Interest in the Medical Profession", *Atención Primaria*, 24 June 2019. Abstract: https://doi.org/10.1016/j.aprim.2019.05.004. This article is available as open access with the licence CC BY-NC-ND (http://creativecommons.org/licenses/by-nc-nd/4.0/).

[4] Ibid., p. 3.

patient but the protection of the professional, constituting the so-called defensive medicine that some authors have defined as a true conflict of interest"[5].

In my opinion, not only in the present case were there shortcomings in the post-euthanasia review, but also the regulations governing the Board did not provide the guarantees and safeguards required by Article 2 of the Convention and such a manner of organisation cannot be tolerated as part of the margin of appreciation afforded to the States[6].

The judgment avoided an in-depth analysis of how the independence of the consulted doctor *vis-à-vis* the patient and the main doctor (see section 3 of the Act) is understood and applied in practice.

III. THE BELGIAN LEGAL FRAMEWORK ACCORDING TO THE BELGIAN GOVERNMENT'S SUBMISSIONS

6. As to the Board's role, the Belgian Law of 28 May 2002 establishes a procedure of post-euthanasia review. Within four days following the act of euthanasia, the doctor must submit a declaration to the Federal Euthanasia Monitoring and Assessment Board. To reiterate, the Board is composed of sixteen members: eight doctors, four legal professionals (university professors or practising lawyers) and four members with a background in dealing with patients suffering from incurable diseases. Their term of office is a renewable one of four years. Linguistic parity must be respected, as must pluralistic representation: the Board may have members who are not necessarily in favour of the decriminalisation of euthanasia. For the renewal of Board members, a call for candidates is published in *Le Moniteur belge*. Applications must be submitted to the Chamber of Representatives which, after examining the skills and profiles of the candidates, draws up two lists: one of the sixteen regular Board members, and another of their alternates. It should be noted that several doctors on the Board also have skills in palliative care. The legislature wanted the Board to include doctors with real expertise in the field.

7. The Board was designed as a bridge between doctors and the judiciary. Its main role is to review acts of euthanasia on behalf of society. It therefore has to examine, on the basis of declarations, compliance by doctors with the conditions provided for by law. In principle, all participants remain

[5] Ibid., p. 4, referring to Hurst S.A. and Mauron A., "A Question of Method. The Ethics of Managing Conflicts of Interest" in *EMBO Reports* (2008) vol. 9, pp. 119-23, http://dx.doi.org/10.1038/sj.embor.2008.4.

[6] See also Sprung C.L., Somerville M.A. and Radbruch L., "Physician-Assisted Suicide and Euthanasia: Emerging Issues From a Global Perspective" in *Journal of Palliative Care* (2018) vol. 33, pp. 197-203: "Slippery slopes: There is evidence that safeguards in the Netherlands and Belgium are ineffective and violated, including administering lethal drugs without patient consent, absence of terminal illness, untreated psychiatric diagnoses, and nonreporting".

anonymous, and anonymity can only be lifted concerning the names of the patient and of the doctors involved. The Board's deliberations are confidential. The last paragraph of section 8 of the Law of 28 May 2002 provides that "[w]here lifting anonymity reveals facts or circumstances likely to affect a Board member's independence or impartiality of judgment, that member shall withdraw or may be excused from the Board's examination of the case". According to the Belgian Government's submissions, the Board members clearly abide by the rules and principles of ethics over and above their legal obligation. Any members – doctors or not – who have taken part in a euthanasia procedure take care to remain silent when they notice that a file concerning them is being examined in any degree of detail. Withdrawing is not advised, because it would imply breaching anonymity in a way that is not provided for by law.

8. According to the Belgian Government, anonymity has been lifted in a number of cases. As stated in the eighth Board report on 2016 and 2017 declarations (p. 26):

> "In 23.7% of the files, the Board decided to lift anonymity and unseal part I, in order to request additional information from the declaring doctor. In 6.9% of the declarations, this unsealing was solely justified by the will of the Board to point out to the doctor – essentially for information and educational purposes – shortcomings in his or her answers or errors of interpretation concerning the procedures followed. However, those errors did not call into question compliance with the legal conditions. In these cases, no response from the doctor was sought. In 16.8% of the declarations, part I was unsealed to obtain additional information from the doctor for the Board concerning one or more points in the document that had been incorrectly or insufficiently completed or left empty. Most of these points concerned missing administrative information or the details of the procedure. Each time, the answers provided useful information and the declarations could be approved."

If the Board is not satisfied with the doctor's written explanations, or even the interpretation of the information by the doctors who must be consulted, it invites the doctor concerned to appear before it. This situation occurred in five reviews after 2015. On four occasions, the Board considered that the explanations given by the doctors during their interviews were sufficient to find that the essential conditions of the law had been met. In one case, the file was referred to the courts[7].

IV. THE APPLICANT'S VIEW

9. In contrast, the applicant alleged (see the applicant's submissions, § 21) that the specific workings of the Board warranted further scrutiny[8].

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[7] The eighth Board report is available at: https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

[8] In addition, the ECLJ, which intervened in the proceedings as a third party, stated that the Board had only referred one file to the Crown Prosecutor, out of a total of

To begin with, in principle, the file submitted to the Board is anonymous: it does not contain the personal details of the individual and doctors involved. It is only when the Board decides to lift anonymity that it has access to that information (see section 8 of the Act). According to the applicant, the Government, in their submissions, had explained that section 8 of the Belgian Act provided that "[w]here lifting anonymity reveal[ed] facts or circumstances likely to affect a Board member's independence or impartiality of judgment, that member shall withdraw or may be excused from the Board's examination of the case". However, in practice, in the majority of cases – apparently including the present one – anonymity was not lifted. There is therefore no provision in the law for preventing a conflict of interest. Moreover, a conflict of interest is likely, given the number of doctors on the Board who perform euthanasia. According to the applicant, although no detailed information on the practices of the doctors is available, the 2012 report states that three of the four French-speaking doctors on the Board were also members of ADMD's board. Of the four Dutch-speaking doctors required on the Board by law, two were members of the LEIF (LevensEinde InformatieForum – Life End Information Forum) board at the same time.

In conclusion, it is easy to observe that the safeguards for the application of the law, including the system of "review", were defective, that there is a need for an independent body in charge of reviewing compliance with those safeguards in each specific case and that there is a further need for a real judicial review.

10. The applicant complained of a conflict of interest (see the applicant's submissions, § 64). In my opinion, there must be an element of public scrutiny of the investigation or its findings to secure accountability in practice. The investigation also has to be independent of those involved in the events in terms of both hierarchy and institution. To this end, the family must have access to the investigation because they are the only interested parties and guarantors, especially in cases of vulnerable, fragile and lonely people (see *Hugh Jordan v. the United Kingdom*, no. 24746/94, § 109, 4 May 2001).

According to the applicant (see the applicant's submissions, § 66, referring to the Belgian Government's submissions, § 3):

> "Furthermore, the [respondent Government reveal] that the decision of the [Board] in this case was 'unanimous'. There is no indication of any abstention. So then, either [Doctor] D. voted to approve euthanasia in his case, or the information provided by the [respondent Government] is wrong or misleading, further demonstrating the inadequacies of the purported mechanism of oversight in Belgium."

11. According to the Government, the practice is that anyone who has participated in a euthanasia procedure stays silent. But how does anyone

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14,573 euthanasia procedures performed between 2002 and 2016 (see ECLJ's submissions, § 16). In this connection, it cited Grouille D., "Fin de la vie : les options belge, suisse et orégonaise" in *La revue du praticien* (January 2019) vol. 69.

know subsequently whether such persons have remained silent or not, if the deliberations are confidential? Besides, only a colleague would be able to suspect and report involvement. It all seems very unlikely.

In contrast, the common practice in courts and other bodies is that any person recusing him- or herself should not be present in the deliberation room when the case is examined (see *Paul and Audrey Edwards v. the United Kingdom*, no. 46477/99, §§ 80-84, ECHR 2002-II, and *McKerr v. the United Kingdom*, no. 28883/95, § 34, ECHR 2001-III).

12. According to paragraph 43 of the applicant's submissions:

> "... [T]he Belgian law requires a written request in each case. However, according to the First Report of the Federal [Board], there were 14 cases without a written request. The [Board] did not refer any of these cases to the prosecutor. Furthermore, the report is an official document which is provided to the Belgian senate which similarly took no action in this regard [Federal [Monitoring and Assessment Board], *First Report* (2004), 18]. Similarly, this report records a number of cases of 'medically assisted suicide' which is outside the scope of the Belgian law and despite the decision of Parliament *not to legislate to allow this practice*, the [Board] writes that 'it considers that ... the practice falls within the scope of the law ...' [ibid., 17. See also *Second Report* (2006) ... [S]ee also *Third Report* (2008), 24. This pattern of recorded violations continues through to the *Fifth Report* (2012), 17]. The [Board] has no authority to re-write the law in this way."

13. Of the 12,000 cases reviewed by the Board, only one was referred to the prosecutor (see the applicant's submissions, § 71), and that case was only reported as a result of a documentary that was screened in Australia. It involved an 85-year-old woman who had suffered from depression owing to the sudden death of her daughter. The doctor who performed the euthanasia did not consult a psychiatrist (ibid.). The case was discontinued because it was considered that the doctor had given the woman the poison but that she had taken it by herself and that therefore this act was not subject to the legal requirements for euthanasia (ibid., § 72).

Only one case reached the Ghent Assize Court. It concluded on 31 January 2020 and resulted in three acquittals despite an acceptance by both sides that one of the three doctors who had apparently authorised the euthanasia had had "his signature ... misused by the other two" (ibid., § 45; acknowledged by the Belgian Government in their submissions[9]).

V. THE DISAPPEARANCE OF THE EUTHANASIA REGISTRATION DOCUMENT

14. One of my first tasks on the Healthcare Ethics Committee of the Lozano Blesa Hospital at my university in Saragossa (Spain), which I performed from 1996 until 2013, was to review the informed consent forms

[9] Bradshaw L., "Jury Acquits All Three Doctors in Euthanasia Case", *Flanders Today* (31 January 2020), https://www.thebulletin.be/jury-acquits-all-three-doctors-euthanasia-case.

of all the hospital services to see if they met the requirements of Spanish legislation, namely Law no. 14/1986 of 14 April 1986 on general health, later Basic Law no. 41/2002 of 14 November 2002 regulating patient autonomy and rights and obligations in terms of information and clinical documentation. There were more than sixty different forms owing to the diversity of areas.

15. According to the case-file material before the Court and included in the judgment, the registration document was not given to Doctor C. along with the rest of the medical file (see paragraph 34 of the judgment) and the Board refused to provide a copy of that document to the applicant, because it was confidential (see paragraphs 35 and 37-38 of the judgment). The applicant had no access to that document from 26 June 2012, when the Board – which was co-chaired by Professor D. – examined it and unanimously concluded that the euthanasia had been performed in accordance with the conditions and procedure provided for by law (see paragraph 30 of the judgment), to 4 March 2020, the date on which part II of that document, the anonymous part, was annexed to the Belgian Government's submissions to the Court.

16. On the basis of the version of the facts that is reflected in the Court's judgment and which we consider to have been proved, when Doctor C., who was appointed by the applicant to access his mother's medical file (see paragraph 31 of the judgment), consulted the file on 2 August 2013, he pointed out that the euthanasia declaration was missing (see paragraph 34 of the judgment). The applicant then asked the Board again, on 23 October 2013, for a copy of that document, but received no response (see paragraph 35 of the judgment). On 16 February 2014 he lodged a complaint with the Medical Association, to which he received no response (see paragraph 36 of the judgment). He requested that document again from the Board on 4 March 2014. The Board erroneously based its decision on the alleged fact that the applicant did not have the right to access that information. According to Belgian law, family members and/or interested parties are entitled to consult the information in the file once the euthanasia has occurred, unless the patient expressly stated that he or she did not authorise anyone to access his or her post-mortem data, which the applicant's mother did not do in the present case.

The applicant's initial complaint before the Crown Prosecutor, dated 4 April 2014, was only answered three years later, in 2017, and it has become clear that the reason why the proceedings were reopened was because on 15 October 2014 the applicant brought an action before the Court (see paragraphs 39-40 of the judgment). However, the Court rejected that first application for failure to exhaust domestic remedies (see paragraph 40 of the judgment). So, on 8 May 2017, the Crown Prosecutor decided to discontinue the case on account of a lack of evidence that the euthanasia had been carried out in breach of the legal requirements (see paragraph 41 of the judgment).

Again, it was only after the applicant had lodged a fresh application before the Court on 6 November 2017, and the Belgian Government had learned that

the case was before the Court, that on 2 May 2019 the judicial authorities decided to reopen the criminal case at domestic level, and it was discontinued again on 11 December 2020 (see paragraph 49 of the judgment).

17. Another striking issue, which indicates the absolute lack of procedural guarantees and safeguards provided for by law for vulnerable people, is that the medical expert who was appointed by the investigating judge in Brussels to examine the medical file of the applicant's mother (see paragraph 45 of the judgment), and who drew up an eleven page report, curiously and mysteriously observed that "there was nothing in the file concerning the declaration of euthanasia submitted to the Board, or the Board's assessment", as indicated in the judgment in the last lines of paragraph 46.

The prosecutor then concluded, on the basis of these elements, that the euthanasia had fulfilled the conditions prescribed by law. In my humble opinion as a judge, there is scope to wonder on what basis the prosecutor could reach that conclusion, if neither he nor anyone else throughout the procedure had seen the euthanasia registration document (see paragraph 48 of the judgment).

18. This does not cease to amaze me. It was precisely because of the absence of an informed consent document that a Chamber of the Third Section of the Court unanimously found against Spain in the *Reyes Jiménez* case, in which the parents of a child of under six years of age had not given their written consent before a surgical act, as required by Spanish law. It was proved that this document did not exist, but the Spanish domestic courts (in an administrative appeal against the hospital for lack of informed consent) had sought to protect the doctor who had performed the operation, and who had written in the medical record, in his own hand, "family informed" (see *Reyes Jiménez v. Spain*, no. 57020/18, 8 March 2022).

VI. THE REAPPEARANCE OF THE EUTHANASIA REGISTRATION DOCUMENT AND ITS CONTENT

19. The judgment conveniently points out that there was no subsequent access by the applicant to his mother's file and that the process was very long, lasting eight years before being discontinued in 2020. This leads to the conclusion that the procedural safeguards were not complied with on several points.

20. First, it was only as a result of his application to the Court that the applicant was able to access his mother's euthanasia registration document for the first time and that that document was made available to a court. Specifically, the applicant (or his representative, the doctor he appointed) was denied access to the document in question for eight years (see the applicant's submissions, § 11). Only once the case had been brought before the Court did the Government make that document available to the applicant. As pointed out above, the Board refused to make the document available to the doctor

appointed by the applicant. According to Belgian law, only a doctor appointed by a family member may consult the file. The Belgian Government submitted that such access had to be granted by a judge, but the fact is that the applicant had already brought criminal proceedings, which were repeatedly discontinued.

21. Second, and more importantly, although Belgian law provides for a series of safeguards for the euthanasia of psychiatric patients, for whom three medical reports are required (two of which must be prepared by psychiatrists) – that is, one more than for other patients – in the present case the doctor who performed the euthanasia requested the other two reports from two psychiatrists who were members of the association LEIF, which was founded and chaired by Doctor D. and therefore lacked the requisite independence (ibid., § 12, pp. 4-5). As can be verified in the documentation provided to the Court, the euthanasia registration document of the applicant's mother does not meet the requirements of Belgian law. As the applicant explained (ibid., § 12, p. 5):

> "... [I]t is recorded that one of the required referrals was conducted (according to question 9.2) on 17 January 2012 and yet, also according to the form (question 8), the formal request for euthanasia was only made on 14 February 2012. The law explicitly requires the referral doctors to be independent of the 'treating' doctor and of the patient. It would therefore appear that either this psychiatrist should have been excluded by her prior association with the referring doctor, or her prior association with the patient – or both. There is therefore no support for the [respondent Government's] contention that 'the opinion[s] of two freelance doctors were obtained'. Moreover, when the Applicant's representative [the doctor who he had appointed in accordance with section 9 of the Patients' Rights Act] examined the medical file in the presence of [Doctor] D., [Doctor] D. explained that the three doctors who authorised the euthanasia were himself, [Doctor] T. and [Doctor] V. or [Doctor] B (the regular psychiatrist). This does not accord with the information he entered on the form which indicat[ed] that it was himself plus two LEIF doctors, only one of which was a psychiatrist. Moreover, the patient notes record that 'contact with [Doctor] B. no longer makes sense' as of 11 March 2012. The regular psychiatrist appears to have been removed from the process and yet the notes and documentation leave it unclear who signed off on this life-ending act in circumstances in which no fewer than six doctors became involved – a number of whom did not consider the euthanasia law to be satisfied."

22. In addition, there is some debate about what is considered incurable depression. Although the Court does not have the immediacy of the evidence, it appears from the documents provided by the applicant that, in the specific procedure applied to his mother, the legislation in Belgium was not complied with. Doctor D. on 19 April 2012 performed euthanasia by lethal injection on the applicant's mother for "incurable" depression. At the relevant time she was physically healthy but had struggled for some years with depression. Doctor D. had no known psychiatric qualifications and the psychiatrist who had treated the applicant's mother for twenty years did not consider that his patient met the legal conditions for euthanasia, because he believed that the depressive illness she suffered from was not incurable. The applicant's

mother's usual doctors did not agree to euthanise her. For this reason, she looked for a new doctor from the association in favour of euthanasia who would agree to perform the procedure on her. In the case file the difference can be seen between the medical judgment of the doctors who knew the patient and that of the Government which, in their submissions, consider depression and all other mental illness incurable.

23. In relation to the practice of euthanasia on psychiatric patients, there are two crucial and problematic aspects. The first is the diversity of psychiatric positions when deciding whether a psychiatric patient, especially one with depression, is incurable. The second is the question of the principle of autonomy, that is, whether a mentally ill patient can give informed consent to euthanasia. Since our role as judges is to rule on specific cases, I must say that, when reading the parties' submissions, I had many doubts, given the diversity of medical opinions, about whether the patient had been fully autonomous, aware and free to make her decision. There are many discordant details in the procedure followed in the country, be it by the Board, by the prosecutor or by the courts.

VII. NOTIFICATION TO THE FAMILY OF THE DECISION TO PERFORM EUTHANASIA IN THE LIGHT OF ARTICLE 8 OF THE CONVENTION. THE PRINCIPLE OF PATIENT AUTONOMY AND THE OTHER THREE PRINCIPLES OF BIOETHICS

24. In relation to Article 8 of the Convention, I also agree with the fact that we have considered the complaint admissible and Article 8 applicable, and with the judgment's finding that in the present case there does not seem to be any indication that that provision has been violated in respect of the applicant because his mother decided to request euthanasia without informing her children.

25. In the case of this particular applicant there is evidence of a lack of proper communication with his mother, which led us to conclude that there had been no violation of the right to respect for family life in his specific case, because a person cannot be obliged to have a relationship with his or her adult children against his or her will. That does not, however, mean that the role of family should not be considered part of the remedies available to prevent suicide precisely on account of loneliness or isolation.

26. The fact that in the present case the applicant's mother had not wanted to inform her children of the decision she had taken, or that she had finally agreed simply to send them an email, does not mean that the family life and environment of the patient should not be taken into account at all by doctors, especially when it comes to psychiatric illness. In the case of mentally ill patients, their autonomy may be diminished. Furthermore, psychiatric patients have a tendency to isolate themselves and commit suicide. Precisely one of the guidelines of psychiatry is to avoid leaving such patients alone.

27. As a precaution, it should be underlined that it cannot be said in an exhaustive way that the principle of autonomy always and at all costs has primacy over the other three principles of bioethics. In particular, we must take into account the consequences of our actions on the rest of the family unit and on our circle of friends.

28. The judgment makes a brief reference to the Council of Europe guide on terminally ill patients ("Guide on the decision-making process regarding medical treatment in end-of-life situations", see paragraph 68 of the judgment).

It is worth highlighting the reference to the four principles of bioethics. Although the guide focuses on the decision-making process and does not address the issue of euthanasia or assisted suicide, which some national legal systems authorise and regulate through specific rules, some of its definitions are useful in the present case. The relevant parts read (pp. 9-10):

> "The decision-making process regarding medical treatment in end-of-life situations raises questions concerning the main, intentionally acknowledged ethical principles, namely autonomy, beneficence, non-maleficence and justice. These principles form part of the fundamental rights enshrined in the European Convention on Human Rights and are transposed into the field of medicine and biology by the Convention on Human Rights and Biomedicine. These principles are interrelated and this should be taken into account when considering their application.
>
> A. The principle of autonomy
>
> Respect for autonomy begins with recognition of the legitimate right and the capacity of a person to make personal choices. The principle of autonomy is implemented in particular through the exercise of free (without any undue constraints or pressure) and informed (following the provision of information appropriate to the proposed action) consent. The person may change his or her mind at any time with regard to consent.
>
> ...
>
> An end-of-life situation is very often a moment of high vulnerability in a person's life, which can have a profound impact on the patient's ability to exercise autonomy. ...
>
> Autonomy does not imply the right for the patient to receive every treatment he or she may request, in particular when the treatment concerned is considered inappropriate ... Indeed, health-care decisions are the result of a reconciliation between the will of the patient and the assessment of the situation by a professional who is subject to his or her professional obligations and, in particular, those arising from the principles of beneficence and non-maleficence as well as justice.
>
> ...
>
> The principles of beneficence and non-maleficence refer to the doctor's dual obligation to seek to maximise the potential benefit and to limit as much as possible any harm that might arise from a medical intervention. The balance between benefits and risks of harm is a key aspect of medical ethics. The potential harm may not be only physical but could also be psychological, or take the form of infringement of the individual's privacy.
>
> On a normative level, these principles are reflected in the right to life enshrined in Article 2 of the European Convention on Human Rights and the right to protection from

inhuman and degrading treatment established in its Article 3. They also form the basis for the assertion of the primacy of the human being over the sole interest of society or science set out in Article 2 of the Convention on Human Rights and Biomedicine and, more precisely, the obligation to comply with professional obligations and standards laid down in Article 4 of this convention."

VIII. THE DANGER OF REPLACING YESTERDAY'S MEDICAL PATERNALISM WITH TODAY'S MEDICAL ABUSE AND THE DANGER TO VULNERABLE SICK PEOPLE OF PROMOTING FALSE PATIENT AUTONOMY AND EXCLUDING THE FAMILY

29. Referring to the principle of autonomy without taking into account the other three principles of bioethics is in itself deficient from a legal point of view. Not only that, but the concept of autonomy, like many other legal concepts, is an abstract one that can be defined in many ways. Western countries have moved from so-called "paternalistic" medicine, in which the doctor decided everything without informing the patient and without his or her consent, to a new model of healthcare in which the capable adult patient is the one who must take his or her care decisions. In the past, the family itself made decisions regardless of the will of the patient or without consulting him or her. Today, however, we are witnessing other types of dangers to patients' dignity and rights. The first is to leave defenceless and vulnerable individuals, once again, alone in the hands of the doctor, separating them from their family and friends[10].

30. In the present case the applicant's mother was alone and isolated (see paragraph 18 of the judgment), since her partner had died two years earlier and her daughter lived abroad, meaning that she could not see her grandchildren. It is noteworthy that one of the doctors, Doctor B., felt permitted to think that there was no longer any point in the applicant's mother establishing contact with her children (see paragraph 23 of the judgment). That means that in the end the doctor decided in the place of the patient.

31. There are many visions of autonomy. Some consider that autonomy has a relational character (which encompasses the patient's environment):

[10] This observation perfectly reflects the issues raised by the ONG ECLJ in relation to Switzerland. See the Swiss Academy of Medical Sciences' position paper "Problèmes de l'assistance médicale au suicide en Suisse, prise de position de la Commission centrale d'éthique (CCE) de l'Académie suisse des sciences médicales" (20 January 2012), which highlights "indefensible practices concerning medically assisted suicide, whether with or without the involvement of a suicide-assistance organisation. Sensitive situations include those involving the assessment of an individual's capacity for discernment and the constant nature of the wish to die, the exclusion of the individual's family and friends or main doctor (in such cases the problem lies in the fact that the family and friends or family doctor may only be informed with the consent of a patient capable of discernment), consideration of the patient's medical history, and assisted suicide for individuals with psychiatric or chronic illnesses and elderly people who are 'tired of living'" (see ECLJ's submissions, § 22, note 60).

they argue that the autonomy of the person – whether healthy or sick – is not absolute[11] and that deep down we are all interdependent people, meaning that we have not only rights but also obligations towards others. Another conception of autonomy is based on pure individualism, where the doctor-patient relationship is reduced to a merely contractual exchange. Here, in the end, there is a risk of vulnerable patients, especially the mentally ill and people with Alzheimer's, being abandoned in the hands of an anonymous health system and arrogant doctors, increasing their alienation from their family and friends.

32. Several of the NGOs that submitted reports to the Court in the present case highlighted the relational nature of human life, as well as the difficulty of knowing if a person has diminished autonomy due to illness (see paragraph 104 of the judgment for the European Centre for Law and Justice; paragraph 110 for the Ordo Iuris Institute; and paragraph 108 for Dignitas). It is a proven fact that in European societies in which the family accompanies the mentally ill, the suicide rate is much lower than in countries with greater State interventionism in healthcare and perhaps with greater economic means, but in which the sick are left to their own devices[12].

33. All the third-party interveners agree in one way or another on the importance of the family accompanying the mentally ill person who wants to make that decision. In addition, some, such as Ordo Iuris, insist on the repercussions of such a decision on the other members of a family, stating that, "even recognising that every adult human being may autonomously decide on how and when [to] end [his or her] own life under the right to privacy (which is questionable), it cannot be denied that such a decision [has] severe consequences for [the] private and family life of friends, people related by marriage and relatives" (see Ordo Iuris's submissions, § 14). Euthanasia affects not only the person who decides to undergo it, but also family members because it breaks all possibility of a bond upon the death of that person (ibid., § 15). The third-party interveners also refer to the trauma experienced by family members when a suicide is committed without any prior notice and posit a right to say goodbye (ibid., § 16)[13].

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[11] Habermas J., *The Future of Human Nature* (Polite Press, 2003); Taylor C., *The Sources of the Self, the Making of Modern Identity* (Harvard University Press, 1992); Sandel M., *Liberalism and the Limits of Justice* (Cambridge University Press, 1998); MacIntyre A., *Dependent Rational Animals* (Open Court Publishing Co. US, 2001).

[12] Iglesias García C. et al., "Suicide, Unemployment, and Economic Recession in Spain", *Revista de Psiquiatría y Salud Mental* (2017) vol. 10(2), pp. 70-77, DOI: 101016/j.rpsm.2016.04.005.

[13] Garciandía Imaz J.A., "Family, Suicide and Mourning", *Revista Colombiana de Psiquiatría* (2013) vol. 43(S1), pp. 71-79, DOI: 10.1016/j.2cp2013.11.009. Department of Preventive and Social Medicine, Department of Psychiatry and Mental Health, Faculty of Medicine, Pontificia Universidad Javeriana, Bogotá, Colombia. "The suicide of a loved one is an event that may contribute to pathological grief and mental dysfunctions in surviving relatives."

34. Dignitas is in favour of talking openly about the desire to commit suicide and offers counselling and assistance. It supports assisted suicide. In its submissions it stated:

> "The report on suicide shows that the suicide rate in Switzerland has fallen continuously since 2005. In parallel, the assisted-suicide rate has risen over the same period. However, the figures for assisted/accompanied suicide remain low in absolute terms: 'In 2014 the Federal Statistical Office recorded 742 cases of assisted suicide among Swiss residents, corresponding to 1.2% of all deaths'."

Dignitas is also in favour of the family participating in the process and being informed of the patient's decision, although it concedes that in its experience that is not always possible, because there are relatives who do not respect that decision. On the other hand, it insists on the importance of preventing suicides:

> "In other words, the social obligation gives rise to an obligation for the State to make efforts to prevent premature deaths. It is important – although this aspect is unfortunately often overlooked – to take effective measures to prevent suicide attempts and therefore suicides."

35. Care Not Killing is a UK-based alliance of individuals and organisations which brings together disability and human rights organisations and healthcare and palliative care groups (see Care Not Killing's submissions, § 1.1). It provided information on how assisted suicide was organised in Belgium. Assisted suicide is a public service, funded by the State, since everyone is covered by public health insurance. The State finances all public hospitals, where 42% of euthanasia procedures are carried out. It also funds semi-private establishments, which include nursing homes, where a further 12% of euthanasia procedures are carried out. Public money is also used to pay the doctor who performs the certification prior to the euthanasia, and the doctor who performs the euthanasia itself, whether this occurs in any of the aforementioned places or in the patient's home. The State also pays for the drugs used to carry out the euthanasia (ibid., § 3.1)[14]. Doctors are the only ones authorised to perform euthanasia and they have the status of "State agent".

36. Care Not Killing insisted on the importance of Article 8 (right to respect for family life), in relation here to Article 2 (right to life), with the relevant parts of its submissions stating (ibid.):

> "12.2 ... Any human death necessarily affects the interests of many others in ways that are the concern of Article 8.
>
> 12.3 This is a consequence of the relational nature of human existence – a relationality reflected in the societal concerns described in Article 8 § 2."

[14] Source: Federal Euthanasia Monitoring and Assessment Board report for 2014 and 2015. According to this report (p. 12) an IV injection of Sodium Thiopental either alone or in combination with other drugs was used in 99% of all acts of euthanasia in this period.

Care Not Killing underlined the fact that allegedly voluntary euthanasia in patients with incapacitating mental illness resulted in involuntary euthanasia (ibid., § 12.4) and that the relationship between patients and doctors was also affected.

37. For its part, the European Centre for Law and Justice (ECLJ), highlighted the risks of abuse, referring to a series of cases[15] and the problems relating to a potential lack of autonomy in patients experiencing mental suffering (see ECLJ's submissions, § 5)[16]:

> "According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5), the will to die is one of the indicators used to diagnose depression (American Psychiatric Association, 2013). This depression means that the will to die and the resulting request for euthanasia may be more the symptom of the illness than a well-thought-out manifestation of will. In this situation the patient's capacity to decide on his or her own death could be seriously challenged."

ECLJ added that, according to the Belgian Committee on the Rights of Persons with Disabilities, the suicidal thoughts of a person suffering from depression are a consequence of his or her vulnerability and not a free expression of will. ECLJ stressed that it was problematic to affirm that a person in such a condition was in possession of his or her full freedom to consent and capacity for discernment, and that, on the contrary, such an individual was at risk of abuse and medical shopping[17].

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[15] See the ECLJ's submissions, note 7: "See, for example, European Institute of Bioethics, 'Le parquet de Bruxelles classe sans suite les plaintes contre Wim Distelmans' (6 February 2018), and 'Belgique : nouvelle plainte contre un médecin pour euthanasie', *Gènéthique* (25 April 2014). The facts are similar to those in the present case: Margot Vandevenne complained that her mother, who had been suffering from depression for a year, had been euthanised without the family being informed. See also the case of Tine Nys, a woman who was diagnosed with autism a few months before she underwent euthanasia: 'Belgium Launches First Criminal Investigation of Euthanasia Case', *The Guardian* (26 November 2018), and 'En Belgique, trois médecins poursuivis pour empoisonnement après l'euthanasie d'une jeune femme pour souffrances psychiques', *Gènéthique* (23 November 2018)."

[16] The ECLJ in its submissions (note 11) also referred to *Aktepe and Kahriman v. Turkey*, no. 18524/07, § 66, 3 June 2014, in which the Court found that giving a weapon to a suicidal person amounted to a violation, and to *Serdar Yiğit and Others v. Turkey*, no. 20245/05, § 44, 9 November 2010.

[17] According to this third-party intervener, 253 Belgian healthcare professionals have called for a pre- rather than a post-euthanasia review. In 2020 the House of Representatives Public Health Commission advised against extending the Euthanasia Act to the mentally ill, considering that "purely psychological suffering can never result in euthanasia" (see ECLJ's submissions, § 8). See also "L'euthanasie dans le cas de patients hors phase terminale, de souffrance psychique et d'affections psychiatriques", European Institute of Bioethics, summary of opinion no. 73 of the Belgian Bioethics Committee, 11 September 2017, pp. 4-6 (ibid., note 25).

PARTLY DISSENTING OPINION OF JUDGE SERGHIDES

I. Introduction

1. This case concerns the active euthanasia of the applicant's mother without the knowledge of the applicant or of his sister. The act of euthanasia was carried out by a lethal injection administered by Professor D., a doctor in a public hospital (see paragraph 27 of the judgment).

2. I agree with points 1, 2, 7 and 8 of the operative part of the judgment, but I respectfully disagree with points 3, 4 and 6, as I voted to find a violation of both Articles 2 (right to life) and 8 (right to respect for private life) of the Convention. Regarding point 5 of the operative part, which concerns the deficiencies of the post-euthanasia review, I voted for the finding of a violation of Article 2, not because I accept or wish to imply that euthanasia is or was permissible under the Convention, but merely because such shortcomings constitute an additional violation after that entailed by the act of euthanasia itself.

II. Is euthanasia prohibited by Article 2 of the Convention?

3. Article 2 of the Convention protects the right to life of everyone, and indeed there is no right to die under this provision or any other provision of the Convention.

4. Euthanasia or anything related to it is not included in Article 2 of the Convention as an exception to the right to life (see the first paragraph of that Article) or as a circumstance or event "not [to] be regarded as inflicted in contravention of" such right (see the second paragraph of the same Article). Consequently, no question arises as to any counterbalancing factors or guarantees for an exception which does not exist.

5. With due respect for the case-law of the Court and the opinion of my learned colleagues in the majority, and being, I think, faithful to the Convention's aim of effectively protecting the right to life, I believe that no form of euthanasia or legal framework regulating such practice – whatever its quality or "guarantees" may be – can safeguard the right to life under Article 2 of the Convention: euthanasia's purpose is to put an end to life, whereas the purpose of Article 2 is to sustain and protect life. On the contrary, in my humble view, euthanasia or any enabling legal framework would not only have no legal basis under the Convention, but would also militate against the Convention's fundamental right, the right to life. Stated otherwise, I wonder how the right to life could be practical and effective if one were to accept a procedure, in particular a euthanasia procedure, which would result in negating that right. If the drafters of the Convention had wanted to include euthanasia as an exception to the right to life, they would have stated this either in Article 2 of the Convention or in a separate protocol to the

Convention. However, they did nothing of the sort. In the same way that deprivation of life in the execution of a sentence of a court, as an exception to the right to life under Article 2 § 1, was removed by Protocols Nos. 6 and 13 to the Convention, euthanasia could be added as a new exception to the right to life under a specific protocol if the member States so agreed. Hence, with due respect, I believe that without such a protocol or amendment to Article 2, domestic authorities cannot consider euthanasia as not contravening the Convention or as being compatible with it, and cannot accordingly seek to regulate it.

6. The argument that Article 2 § 2 of the Convention does not deal with or remains silent on euthanasia because it is confined to the use of lethal force against individuals by State agents, and therefore that it does not prohibit euthanasia, is not valid. Article 2 § 2 should be read together with Article 2 § 1, which secures the protection of everyone's life, regardless of whether the threat comes from State agents using lethal force or from State organs applying euthanasia procedures and practices, or indeed from a failure by a State to take appropriate positive steps to protect the life of individuals from actions by third persons or from environmental or other risks. Otherwise, there would be no room for the positive obligations of the member States to protect human life, which is one of the most significant pronouncements and developments of the case-law of the Court. The protection of Article 2 must be holistic rather than piecemeal, and Article 2 must be read in a coherent manner, aimed at effectively protecting the right to life from any source of risk.

III. The yardstick for whether the rights under Articles 2 and 8 of the Convention are compatible should be the former provision and not the latter

7. Neither Article 8 of the Convention, which safeguards the right to respect for one's private life, including personal autonomy, nor any other Convention provision can, on the pretext or with the sincere intention of protecting the right to private life, personal autonomy or human dignity, be employed such as to negate the right to life. The life of every human being is unique, precious, irreplaceable and worthy of respect by all, including the State, and the maintenance or preservation of human life must not be dependent in any manner on the margin of appreciation of a member State. Without life, which is an individual's greatest and most precious asset, none of his or her other human rights can be exercised or enjoyed, rendering them nugatory; consequently, the yardstick or the basis of comparison for whether Article 2 and Article 8 rights are compatible should be the former provision and not the latter, and the principle of internal coherence or harmony between the Convention provisions – an aspect or function of the principle of effectiveness (effective protection of human rights) – should be exercised in

that manner and direction, such as to ensure that Article 2 prevails regarding the issue in question. Furthermore, it is not to be forgotten that, unlike Article 8, Article 2 is a non-derogable right under Article 15 § 2 of the Convention, except in time of war. The human dignity implicit in Article 8 cannot be relied on to negate the right to life under Article 2, because (a) human dignity underlies every Convention provision, naturally including Article 2, and (b) Article 2 is one of the most important provisions of the Convention, together with Protocols Nos. 6 and 13 to the Convention (prohibiting the death penalty), which can be considered the ark preserving human value and life.

IV. Member States' negative and positive obligations to protect the right to life

8. It is my humble submission that member States have both negative obligations prohibiting them from allowing, adopting or implementing euthanasia procedures or from practising euthanasia, passively or actively, and positive obligations imposing on them the duty to take measures to preserve human life by providing continuous and efficient support and assistance to all persons in need and close to death.

V. The "living instrument" doctrine cannot be employed to abrogate a Convention right

9. The doctrine that the Convention is a living instrument to be adapted to present-day conditions cannot be employed in such a manner as to negate a fundamental right – in the present case, the right to life. This doctrine is an aspect or a capacity of the principle of effectiveness and can in no way be used such as to render the right in question neither practical nor effective, or even to abrogate it on the pretext of other considerations.

VI. Finding of an additional violation for deficiencies in the post-euthanasia review

10. As has been said above, no "guarantee" with respect to euthanasia can protect the right to life, owing to the very nature and aim of that practice. On the contrary, any guarantee of human life must go in the opposite direction – the right direction – and maintain and protect human life itself.

11. In any event, even assuming that the euthanasia guarantees to which the judgment refers were able to safeguard the euthanasia procedure, one cannot overlook the fact that the judgment rightly found a violation of Article 2 on account of the deficiencies in the post-euthanasia review.

12. This point strengthens my submission that only guarantees which maintain and protect human life can be considered *true* guarantees of human life, compatible with Article 2.

VII. Violation of the applicant's right to respect for his private and family life under Article 8

13. I also found justifiable the applicant's complaint that the respondent State, by failing to effectively protect his mother's right to life, breached his own right to respect for his private and family life under Article 8 of the Convention.

VIII. Conclusion

14. In view of the above, I conclude that in the present case, where an act of *active* euthanasia put an end to the life of the applicant's mother, there has been a violation of Article 2 and Article 8 of the Convention.