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The right to die through the prism of the right to dispose of one’s body in Physician-Assisted Suicide

El derecho a morir bajo el prisma del derecho a disponer del propio cuerpo en el suicidio asistido por un médico

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Abstract

This article explores the legal and ethical challenges associated with the recognition of a “right to die” in France following the adoption on first reading of the bill enshrining a “right to aid in dying”, i.e. Physician-Assisted Suicide (PAS). The article examines how medicalization, institutional norms, and individual autonomy have redefined the end-of-life experience. The analysis focuses on interpretations of the “right

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to die" and the "right to dispose of one's body," as well as their legal foundations. It reveals significant constraints tied to human dignity, moral responsibility, and third-party involvement. The study argues that establishing the "right to die" would undermine the foundation of the "right to life". Instead of presenting death as a right, the article proposes strengthening palliative care and developing legal and ethical approaches that honor vulnerability and human solidarity.

Keywords: euthanasia, assisted suicide, autonomy, end-of-life care.

1. Introduction

Life and death are "no longer natural facts, but rather objects of medical decisions" (1) that depend on willpower. In the context of end-of-life (EOL) care, these decisions are made in three spheres (2). The first one is the personal sphere, where the only measure of any right is the desire and determination to take control. The second one is the social sphere, which imposes its own norms and values on individuals. These norms and values are based on ideologies rather than objective reason. The third one is the political sphere. It transforms desires and ideologies into laws because politicians hold the "power to create and repeal laws, […] which also influence the way citizens think" (2). Thus, on May 17, 2025, the French National Assembly approved (3) the creation of a "right to assistance in dying" during the examination of Olivier Falorni's proposed law (4). According to the latter, "the right to assisted dying consists of authorizing and assisting a person who has requested a lethal substance […], so they can administer it themselves or have a physician or nurse administer it". In other words, it is Physician-Assisted Suicide (PAS) or Physician-Assisted Dying (PAD). In the light of biopower and biopolitics as the culmination of the will to control life and death, PAS implies the "right to die" (5). Yet a fundamental question arises: is it pertinent to invoke a right to die? Analyzing the concepts of the right to die [2] and the right to dispose of one's body, as expressions

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of patient autonomy [3] can provide fundamental elements to answer to this question.

2. Hermeneutics of the right to die

The analysis of the concept of the right to die is inseparable from the factors that have contributed to its emergence [2.1] and the interpretations it may have [2.2].

2.1. *The emergence of the right to die*

Four main factors have contributed to the demand for the right to die: the medicalization of the EOL and death [2.1.1], the institutionalization of death [2.1.2], the relationship with death [2.1.3] and rights movements [2.1.4].

2.1.1. *The medicalization of the End-of-life and death*

Since the mid-20th century, technoscientific advances have made it possible to control life and, consequently, death. The medicalization of the EOL process has led to the medicalization of death (6) on three levels:

a) Prolonging life by postponing death, without curing but without suffering, as in the case of palliative care;
b) Prolonging life by postponing death, but causing suffering, as in the case of therapeutic obstinacy;
c) Anticipating death in order to "free oneself" from suffering, as in assisted dying, which includes euthanasia and assisted suicide.

2.1.2. *The institutionalization of death*

The medicalization of death leads to its institutionalization. In France, the number of deaths occurring in a healthcare institution far

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exceeds those occurring at home (7). According to the French National Institute for Statistics and Economic Studies (INSEE), in 2024, 28.4% of deaths occurred at home, compared to 52.09% in healthcare establishments, 16.3% in residential facilities for dependent elderly people (EHPAD), and 3.2% in retirement homes (8). However, a 2015 study found that most people at the end of life wish to die at home, yet only a quarter do so (9). This desire to die at home is closely linked to the existential experience of death.

2.1.3. *The relationship with death*

The medicalization and institutionalization of death have fundamentally changed our relationship with it. On the one hand, the tension between technoscientific thinking and a subjectivization of death dispossesses "the dying of their own death" (10). On the other hand, the disappearance of religious rites that accompanied the dying has created a symbolic and existential void. These rites have been replaced by a purely medico-social aspect, such as consent, health protocols, and the removal of the body from an "impersonal room" as soon as death is pronounced. Apart from religious rites, the family, fraternal and interpersonal aspects that considered the dying person as an individual have given way to simple gestures towards the dying patient. Death is no longer a "rich, social, symbolic and profoundly human experience" (11), but rather an individual event. In this sense, "learning about our death means admitting that the world will outlive us and that our life is subject to constraints beyond us. It means understanding the concept of normality" (12, p. 42).

2.1.4. *Rights movements*

The individualism that characterizes our societies centers on personal freedom and self-determination. This is why many movements and associations are calling for the right to die. The right to die with access to euthanasia (including PAS) has been present in the United

States since 1938, with the Euthanasia Society of America founded by Charles Francis Potter (13). However, the concept took on greater scope in the period between 1967 and 1969, with Luis Kutner (14), who was at the origin of the Living will (advance directives). Since then, various movements have developed in favor of a right to die, such as the French Association for the Right to Die with Dignity (ADMD) since 1980 (15), the World Federation of Right to Die Societies since 1980 (16), the American Death with Dignity Association since 1997 (17), and many others. According to these movements, the right to die, to choose one's death, to program it, is a perfect expression of the ultimate realization of individual freedom.

2.2. *Various interpretations of the right to die*

The expression "right to die"[1] (15,18) does not appear to be unequivocal. It can have three broad interpretations —namely, the right not to suffer [2.2.1], the right to refuse treatment [2.2.2] and the right to refuse therapeutic obstinacy [2.2.3]— and one strict interpretation, namely, the right to be killed or to be helped to kill oneself [2.2.4].

2.2.1. *The right to not suffer*

The right to die can be understood as the right to die without suffering. In France, since the Neuwirth law of February 4, 1995 (19), pain management has been an integral part of care. This approach evolved with the introduction, in 1999, of the right of access to palliative care (20). The French Public Health Code (FPHC) states:

> Any sick person whose condition so requires has the right of access to palliative care and support" (art. L. 1110-9). Since the Kouchner Law of March 4, 2002 (21), the FPHC has stipulated

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[1] In French, there are two different expressions for this right: "*droit à mourir*" and "*droit de mourir*".

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that "healthcare professionals shall use all means at their disposal to ensure that everyone lives with dignity until death (art. L. 1110-5).

2.2.2. *The right to refuse treatment*

Another interpretation of the right to die is related to refusing treatment and care. Although the Kouchner law enshrines the right to refuse or interrupt treatment, there is no indication on EOL issues. Art. L. 1111-4 of the FPHC states: "every person has the right to refuse or not to receive treatment. However, the patient's care remains the responsibility of the physician, in particular palliative care". Nevertheless, the medical team is obliged to inform the patient of the consequences of his/her decision, and to try to convince him/her not to do it if the refusal endangers his/her life. In this case, the patient must reaffirm his/her decision within a "reasonable time". In all cases, it is clear that no medical act or treatment can be carried out without the free and informed consent of the patient. When a person is incapable of expressing their wishes, any intervention or decision to stop life-threatening treatment must comply with the collegial procedure (involving the doctor in charge of the patient and all the healthcare professionals concerned in this care), the advance directives or the consultation of the trusted support person, the family or close friends (FPHC, art. L. 1111-4).

2.2.3. *The right to refuse therapeutic obstinacy*

A third interpretation of the right to die is that which expresses the refusal of therapeutic obstinacy. In France, the Leonetti Law of April 22, 2005 (22) prohibits this practice. Also known as "unreasonable obstinacy", this practice involves unnecessary, disproportionate, and suffering-inducing acts and treatments whose only effect is the artificial maintenance of life. The Claeys-Leonetti Law of February 2,

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2016 (23) includes artificial nutrition and hydration among the treatments that can be stopped.

Thus, the right to die while refusing to undergo relentless treatment takes the form of pain management, support for the patient and his/her beloved ones, and the possibility of deep and continuous sedation until death. This can be done at the patient's explicit request or through his/her advance directives, or at the doctor's request; in both cases, with a collegial procedure (FPHC art. L. 1110-5-2 and art. R. 4127-37-1).

2.2.4. *The right to be killed or to be helped to kill oneself*

The final interpretation of the right to die is a strict one. It is intrinsically linked to the absolute voluntary autonomy of the subject to be deprived of life, either by claiming to be killed (euthanasia) or by claiming to be helped to kill oneself (i.e. PAS). The main argument in favor of this right is based on the right to autonomy (24,25)irremediable suffering from a medical condition is a legal requirement for access to assisted dying. According to the expressivist objection, allowing assisted dying for a specific group of persons, such as those with irremediable medical conditions, expresses the judgment that their lives are not worth living. While the expressivist objection has often been used to argue that assisted dying should not be legalised, I show that there is an alternative solution available to its proponents. An autonomy-based approach to assisted suicide regards the provision of assisted suicide (but not euthanasia embodied in the right to control one's own body.

3. The right to dispose of one's body

Cases relating to EOL issues must necessarily consider the argument of the right to dispose of one's body. The legal underpinnings of this right [3.1], often fragile are bound to reinforce its limitations [3.2] when it comes to assisted suicide.

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3.1. *The legal foundations of the right to dispose of one's body*

There are two ways to understand the availability of the human body. On the one hand, there's material availability, which is the possibility of destroying the body; something that the person themselves can do. For example, the person can resort to masochistic acts (26, § 31), can injure himself and can commit suicide. On the other hand, by involving a third party, availability becomes legal. It is thus an authorization granted to "attack" bodily integrity, giving the possibility of "performing a legal act aimed at the partial —or even total— destruction of one's body" (27, p. 168). In the biomedical field, such authorization is regulated through legislative derogations allowing healthcare personnel to perform a medical act on another person's body, generally with the latter's consent (for example, healthcare personnel do not need to obtain a patient's consent before providing care if his/her life is in danger or his/her integrity is threatened). In the context of the EOL, the aim is to provide patients with the medical products they need to commit suicide. However, there right to dispose of one's body is not explicitly enshrined in legal texts. It may derive from three other rights, which may constitute an argument for a legal derogation permitting medical intervention on one's body. These rights are the right to bodily liberty [3.1.1], the right to autonomy [3.1.2] and the right to respect for private (the right to privacy) [3.1.3].

3.1.1. *The right to bodily liberty*

In France, some jurists, such as S.-M. Ferrié (27, pp. 74-83), X. Bioy (28, pp. 491-499) and D. Lochak affirm that the principle of availability of the human body is deduced from the "very general principle of freedom" (29, p. 29). More precisely, the bodily liberty refers to individual freedom recognized as a constitutional principle deriving from art. 2 and 4 of the 1789 Declaration of the Rights of Man and of the Citizen (DDHC): "freedom consists in being able to do everything that does not harm others". Additionally, it can also refer to art. 3 of the Universal Declaration of Human Rights (UDHR), which states that "everyone has the right to life, liberty and security of person".

3.1.2. *The right to autonomy*

Others (30) see this freedom to dispose of one's body as deriving from the principle of personal autonomy enshrined, in 2002, by the European Court of Human Rights (ECtHR) in Pretty v. United Kingdom (31). In this case, the applicant was a 43-year-old woman who suffered from motor neuron disease, a progressive and incurable illness that leads to paralysis and ultimately death. After being diagnosed in 1999, her condition quickly worsened. Wanting to avoid a distressing and undignified ending, she wanted to control how and when she dies. As assisted suicide is a criminal offence, her lawyer sought assurance her husband would not be prosecuted if he helped her. The Director of Public Prosecutions refused the request "and the Divisional Court refused an application for judicial review". This is why they have recourse to the ECtHR. While rejecting the petition, the Court defined autonomy as the "ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned" (31, § 61). However, there is no obligation on States to implement procedures facilitating the practice of assisted suicide (31, § 15, 44).

3.1.3. *The right to respect for private life*

Some (32,33) consider that the right to control one's own body derives from art. 8 of the European Convention on Human Rights (ECHR), which guarantees the right to respect for private life. In two cases submitted to the ECtHR, the applicants used the argument of the right to private life (the right to privacy) to claim the right to die.

In the first case, the applicant, suffering from severe bipolar affective disorder, had applied to the authorities for permission to

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obtain the lethal substance (pentobarbital) from a pharmacy without a doctor's prescription. His request was refused, and he took it to the ECtHR on the grounds of respect for the right to privacy (art. 8 of the ECHR). Thus, in Haas v. Switzerland, the Court affirmed that "Article 8 of the Convention did not impose on the States Parties a positive obligation to create the conditions for committing suicide without the risk of failure and without pain" (34, § 10). Furthermore, the Court points out that this case is not about the right to die or the liability of a third party who assists in a suicide. Rather, it concerns the applicant's ability to obtain a lethal substance without a prescription from a doctor. In fact, the applicant invoked the right to die with dignity, claiming that the absence of pentobarbital would render his suicide undignified, even though he was not suffering from an incurable terminal illness. The Court recalls that the Convention must be read as a whole: Article 2 requires the State to protect vulnerable people, including against themselves, if their decision to die is not free and informed. Therefore, the State has a duty to prevent suicide when the individual's will is uncertain or influenced (34, § 52, 54). Thus, the Court ruled unanimously that there had been no violation of the right to privacy (art. 8 of the Convention).

In the second case, the applicant has an advanced stage of amyotrophic lateral sclerosis (ALS). "He wishes to end, or shorten to a minimum, this phase of his disease by availing himself of some form of physician-assisted dying […] in order to maintain his physical and mental integrity" (35, § 14). In Hungary, however, assisted dying (euthanasia and PAD/PAS) is not legal. He therefore lodged his application with the ECtHR on the grounds of the right to respect for private life. Nevertheless, in Daniel Karasai v. Hungary, the Court made it clear that it "is unable to accept this argument [existential suffering] as one which militates for an obligation under Article 8 of the Convention to legalize PAD [physician-assisted dying]" (35, § 158).

It follows that the right to respect for private life cannot constitute grounds for a right to die, nor for a positive obligation on the State "to take the necessary measures to permit a dignified suicide"

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(34, § 53). However, for the first time, the Court refers to a positive obligation concerning palliative care. It affirms that the "heightened state of vulnerability warrants a fundamentally humane approach by the authorities to the management of these situations, an approach which must necessarily include palliative care that is guided by compassion and high medical standards" (35, § 158).

3.2. *The limits of the right to dispose of one's body*

There are four main obstacles to the freedom to dispose of one's body when claiming a right to die: the moral obligation [3.2.1], the involvement of a third party [3.2.2], the question of the body as property [3.2.3] and the principle of the unavailability of the human body [3.2.4].

3.2.1. *The moral obligation*

In the practice of free disposal of one's body, moral obligation towards oneself can put a stop to it. However, this obligation is not a legal one (27, p. 184), i.e. it is not a binding law, but a matter of intimacy. Thus, a person who commits suicide may not consider the act as morally wrong. This is how we can understand the decriminalization of suicide (since the French Penal Code of 1791), which is based on art. 4 of the UDHR, which states: "Freedom consists in being able to do everything that does not harm others".

3.2.2. *The involvement of a third party*

If moral obligation is not legal for oneself, this is not the case when it comes to the involvement of a third party. In fact, autonomy in the free disposal of the body, even in the act of taking one's own life, is acceptable as long as it "does not involve a third party" (27, pp. 47, 61). There are two main reasons for this when it comes to PAS: the basis of the medical act (a) and the freedom of conscience (b).

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a) The medical act

A set of rules and ethical principles govern medical acts, including those at the EOL. For example, art. R. 4217-38 of the FPHC states: "the physician must accompany the dying person until his/her last moments, ensure the quality of a life that is coming to an end through appropriate care and measures, safeguard the dignity of the patient and comfort those around him/her. The physician does not have the right to deliberately provoke death".

This principle of not deliberately causing death, in other words "not killing", which is in keeping with the Hippocratic oath, remains the very foundation of medical practice, and clearly responds to the basic principle of medical ethics: non-maleficence. Thus, giving death, or treating through death, cannot be considered as a medical act, as a care (36–39).

b) The freedom of conscience

According to the ECtHR, freedom of conscience "is one of the foundations of a 'democratic society' within the meaning of the Convention. In its religious dimension, it is one of the most essential elements of the believers' identity and their conception of life, but it is also a precious asset for atheists, agnostics, skeptics and the indifferent. It is a question of the pluralism —dearly won over the centuries— that is consubstantial with such a society" (40, § 31). It implies the ability to act according to one's own conscience (positive dimension) and not to be forced to act against one's own conscience (negative dimension).

At the international level, this freedom of conscience is recognized by art. 8 of the International Covenant on Civil and Political Rights (ICCPR), art. 9 and 10 of the ECHR, the Resolution 1763 (2010) of the Parliamentary Assembly of the Council of Europe (41), the ECtHR's case of Bayatyan v. Armenia (42) and art. 10.2 of the Charter of Fundamental Rights of the European Union. In France, freedom of conscience derives from art. 10 of the Constitution. In the context of questions relating to PAS, this freedom of conscience applies to all individuals and particularly healthcare professionals.

In the case of any individual, this freedom of conscience can limit the exercise of the freedom to dispose of one's body in two ways. Firstly, there is a duty to assist a person in danger. Indeed, a person who claims the right to die in the name of freedom of bodily disposal may be in danger, since he/she wishes to kill himself/herself imminently. Thus, failure to assist a person in danger is an offence (art. 223-6 of the French Penal Code). In EOL cases, the aim is to dissuade the person from resorting to PAS (and euthanasia). Note that even a doctor is obliged to assist a person in danger, as specified by art. R. 4127-9 of the FPHC. Secondly, freedom of conscience implies the right to oppose a law, which goes against one's conscience, but which also, transgresses a universal principle (not to kill). This is freedom of expression. With the proposed law on aid in dying, art. 17 seriously undermines freedom of conscience by dissuading people from euthanasia or assisted suicide and limiting the right to freely express one's views on the subject.

In the case of healthcare professionals, the freedom of conscience can limit the exercise of the freedom to dispose of one's body. It is embodied in the right to conscientious objection and enshrined as a fundamental right. It is a duty not to obey an order, not because of its legality in relation to the validity of the law (positive law), but because of its legitimacy in relation to the question of right and wrong as discerned by conscience (natural law). This fact is enshrined in the Declaration of Geneva (1948), which states that physicians have a duty to exercise their "profession with conscience and dignity, in accordance with good medical practice". In France, conscientious objection is expressed through the conscience clause, which is twofold. On the one hand, there is the general conscience clause governed by art. R. 4172-47 of the FPHC, which stipulates that "except in emergencies and when failing in his duties of humanity, a doctor has the right to refuse care for professional or personal reasons". On the other hand, there is also a specific conscience

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clause concerning contraceptive sterilization, embryo research and abortion. In Falorni's law proposition, a specific conscience clause has been created in art. 14. However, this law excludes pharmacists.

3.2.3. *The body as property*

If the disposal of the body can be considered as "an act with serious consequences on the patrimony" (in this case the body), an act that "engages the future" (in this case death) (27, p. 80), some people justify PAS by considering the body as a property that the person can dispose of (43). However, a fundamental question stands out: is it possible to consider the body as property? (44, pp. 74–76).

Property rights are based on the exclusion of others, a principle symbolically applied to the human body. Although the French Law considers the body as the person himself in his materiality (45), the French Civil Code (FCC) affirms the non-patrimoniality of the body/non-proprietary status (art. 16-1) and its protection against harm (art. 16-3), nevertheless, there is still this tendency (28, pp. 347-350) to consider that "My body belongs to me". This vision allows a certain *usus* (enjoy and take advantage from one's body) and *abusus* (dispose of one's body) (46). If we follow this interpretation, it is possible to favor the idea of free disposal of one's body by asking for PAS. However, such a vision is reductive and presents a meta-ontological problem. The human being is not just "his" body, and the body cannot exhaust the "totality" of the human being. If this is the case, we fall into the anthropological monism according to which only the individual will become the norm through the process of subjectivization. This "is the process of appropriation and domination of reality by the mind" (47, p. 95) through total liberation from all constraints and laws that impede this freedom to dispose of one's body. Consequently, according to this reasoning, one may ask for PAS.

If we are to consider the body as property and dispose of it freely, the right of ownership presupposes also a spatial distance between the subject and the object, which is not possible between the person and his body. In this sense, it is impertinent to claim a right to die in the name of the availability of the body, which is not property. Beyond this impossibility, the ethical-legal approach also implies viewing the body in both its individual and universal dimensions. This is how T. Pech reformulates this idea through such clear-cut reasoning:

> a) No one disposes of 'the humanity of human being, b) The person is the juridical entity bearing this humanity, c) The body is assigned to the person and is not a property of the person, d) The body is therefore also the bearer of this humanity of human being, e) Therefore, no one can freely dispose of his/her body or the body of others (48).

3.2.4. *The unavailability of the human body*

Although it is not explicit in international and national legislation (27, pp. 55-56; 28, pp. 699-702), the principle of the unavailability of the human body derives from three other principles attached to the French constitutional principle of safeguarding human dignity (49). The three principles are inviolability (protection against infringement by third parties, art. 16-1 of the FCC and art. 3 of the ECHR), non-patrimoniality (rejection of the commercialization of the body, art. 16-1, al. 3 of the FCC) and integrity (art. 16-3 of the FCC). In the context of PAS, the principle of the integrity of the human body occupies an important place. Indeed, disposing of one's body for a medical act presupposes the act of damaging that body. However, this possibility is strictly permitted if it respects two conditions according to art. 16-3 of the FCC: therapeutic interest (a) and consent (b).

a) The therapeutic interest

"The integrity of the human body may only be violated in cases of medical necessity for the person in question, or exceptionally in the

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therapeutic interests of others" (art. 16-3 of FCC). Disposing of one's body by allowing a third party to interfere with the body is only based on medical or therapeutic necessity.

However, in a state of intractable suffering, "the person who requests euthanasia [or PAS] is not, a priori, in a state that would medically necessitate euthanasia [PAS], in the sense that euthanasia [or assisted suicide] would enable him or her to recover" (50). Therefore, there is no medical necessity or therapeutic motive to result in the person's death, considering that the aim of medicine is to promote survival, healing, and relief while maintaining life (without therapeutic obstinacy, as presented in the Claeys-Leonetti 2016 law).

b) The consent

Consent is a second condition for being able to dispose of one's body by allowing it to be violated and thus reclaiming a right to die. For consent to be valid, it must be free from error, fraud and violence. The person giving consent must be in full possession of his/her mental and intellectual faculties (FCC, art. 1145-1150), which implies the freedom of the individual.

Nevertheless, two main constraints stand in the way of consent (51, pp. 54-55). The first one is the internal constraint, with the feeling of being a burden to loved ones (52,53), not to mention the psychological state one may be going through during a serious illness or vulnerability (54). The second one is the external constraint, expressed by familial, economic (55), political (normative) and media pressures (56,57). Indeed, Falorni's law rejected all amendments (58) guaranteeing free and informed consent and creating some kind of external constraint, such as these:

- AS14 addresses the suppression of psychological suffering, which «is often complex and multifactorial. Its assessment is not may vary considerably from one health professional to another; [...] it could lead to abuse, particularly towards vulnerable people who may feel compelled to request euthanasia because of external pressures or temporary mental disorders".

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- AS51: Do not be in a state of weakness or psychological vulnerability.
- AS281 concerns the opinion of a psychologist before PAS.
- AS559 concerns the doctor's right to contact Public Prosecutor, if the doctor has any doubts about the patient's free request and the pressure exerted on him/her.
- AS967, which "aims to prevent the act of aid in dying being used as a platform or instrument for political or media pressure".
- AS994 emphasizes the importance of verifying discernment so that it is not impaired.
- AS1019 on free and informed consent, which must be revocable without form and at any time (as states art. 5 of Oviedo Convention and human rights principles regarding health).

This rejection implies that access to PAS can be provided through abuse of weakness, without consent, without discernment and without the capacity to make an informed and enlightened decision. Is it possible to talk about the right to dispose of one's body and the right to die if consent is biased?

4. Conclusion

The question of the right to die is a legal and logical issue that can only be addressed in the light of the right to life, since the right to die "paradoxically presupposes what it denies and denies what it presupposes, namely life itself" (59, p. 61). Indeed, without life, it is impossible to presuppose all other rights (60, p. 156). In other words, any claimed right can only derive from life, as a universal fundamental right and value, and can only serve life. This is why, the ECtHR, in case Pretty v. the United Kingdom, clearly stated that "that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the

Convention [the right to life]" (31, § 40). Hence, the three main conclusions are:

a) Although the National Assembly has created a right to assistance in dying, this right remains an aberration because it constitutes a categorical negation of all other rights. Death itself is not a right, but a fact that all living beings, including human beings, have to face. The demand for a right to die, or to be helped to die in the strict sense of the term, remains an impertinent right, as it raises fundamental ethical and legal dilemmas. It only reflects a medical, political and social evolution that has transformed our approach to death.
b) The right to dispose of one's body is not an absolute freedom, since its exercise is subject to several limits. It is neither an enforceable right, which is a legal concept meaning that "the right that has been recognized to the citizen can be 'opposed' to an authority charged with implementing it" (61). A person cannot "demand any positive action from the State other than the protection of this freedom against third parties" (28, p. 496), while respecting the fundamental rights of these third parties and the moral public order (26,62). In EOL issues, moral public order implies not violating the universal principle of not killing or asking for help to kill oneself.
c) The PAS and EOL are not questions of the right to die. Rather, they should lead us to reevaluate our relationship with death and encourage «other forms of solidarity [such as palliative care] besides the gift of death in order to take on our human responsibilities where they are legitimate and committed» (63, p. 152).

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