Bulletin of the *Transilvania* University of Braşov
Series VII: Social Sciences • Law • Vol. 18(67) Special Issue – 2025
https://doi.org/10.31926/but.ssl.2025.18.67.3.10

THE PROMOTION OF HUMAN DIGNITY THROUGH THE ENVISIONING OF AN EU LEGAL FRAMEWORK ON END-OF-LIFE ISSUES: AN IMPREGNABLE MATTER OR A CONCRETE POSSIBILITY OF UNION LEGISLATION?

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Abstract: *In 2025, the EU Commission responded to the possibility of regulating end-of-life matters across the Union, denying that it has a general power to intervene in this area. In the Treaties it is laid down that the Union only has coordinative or supportive competence with respect to the protection and improvement of human health. Yet, one may question if primary law provisions might be the legal basis for legislative action here. In the same fashion, the CFREU and the ECHR need to be paid attention to. Hence, this article seeks to outline whether the EU has an actual (legislative) power to regulate the matter and investigate whether the EU can expand the scope of the protection of individuals' human dignity, despite its past reluctance to do so.*

Key words: *Dignity, End-of-life, European Union, Healthcare, Legislative competence.*

1. Introduction

Advocates and observers have argued that with medical and other advancements that prolong life, it is inevitable that end-of-life issues will become a major legal topic for the political agenda of sovereign States or international organisations (Pridgeon, 2006; Frawley, 2025). From its standpoint, the European Union (EU) does not at present have standardised guidelines nor proper legal acts on the matter. Responsibility for citizens' healthcare, including decisions about the way of dying, remains the responsibility of Member States. Yet, the matter becomes relevant when it's accepted that, from the references contained in EU law, dignity may be intended not so much as a subjective right, but as an objective principle or founding value with an autonomous prescriptiveness (Pocar, 2002, p. 87). Nonetheless, neither EU Law nor the European Convention on Human Rights (ECHR) contain provisions precluding EU countries from

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legislating on "dignified death" – be it euthanasia, assisted suicide or the turning off of life support machines.

Whilst all EU Member States agree on the abstract concept of human dignity, when it comes to bioethical issues the divergence of positions taken by different countries is noticeable. Indeed, some States in the Union have taken a more liberal view than others: several have a legislation in force that allows euthanasia to be administered by physicians (Belgium, Spain, Luxembourg, Netherlands); other EU countries permit assisted suicide, but not euthanasia (Austria, Germany, Italy, Luxembourg); there are also Member States currently working on either euthanasia or assisted dying legislation (Cyprus, France, Ireland, Malta, Portugal, Slovenia).

One might wonder if any supranational harmonization would be required at this point in time. A common legal framework becomes particularly relevant bearing in mind that bioethical questions and the new developments in biomedical research are of a transnational nature. For instance, the so-called "sin shopping" throughout the EU – where citizens' cross borders for experimental treatments, surrogate motherhood and euthanasia – is a clear demonstration of how bioethics issues can grow to be internal market issues in addition to being fundamental rights, or more specifically, dignity, issues.

But over the years, in response to pressing questions from Members of the European Parliament, the European Commission has abundantly reiterated that the EU is not competent to deal with it in any way. Not surprisingly, as pointed out in the latest answer of 20 May 2025 (E-000811/2025), the second von der Leyen Commission held that any responsibility "for terminally ill patients as well as related ethical questions, rests with the Member States". But, at the same time, the issue is increasingly being "monitored" and ruled upon by the European Court of Human Rights (ECtHR), responsible for the interpretation of ECHR's provisions.

Hence, from such statement stems the main research question of the present paper: is it truly so? Close to be an impregnable matter and regardless of the rigid wording of the Treaties, is the EU actually not entitled to undertake any legislative activity on end-of-life matters? Or can it, in some way, try to legislate in this field?

To answer this question, the paper will try to first focus on the previous EU legislation regarding bioethics in an attempt to demonstrate how the Union eventually exerted influence on ethical questions (Section 2). Accordingly, it will discuss a potential two-fold way of exercising a legislative power on end-of-life matters. With different benefits and drawbacks, it is contended that this could be done through the use of its internal market regulatory powers (Section 3) or the application of a human rights-based approach rooted in the two distinct bill of rights relevant to the Union, namely the Charter of Fundamental Rights the EU (CFREU) and the ECHR as well as the latter's caselaw (Section 4). Lastly, some final remarks will draw conclusions on the original research question and tentatively foresee future developments on the matter at hand (Section 5).

2. The European Union's Action on Bioethics: Stretching the Treaties' Boundaries

Basically, EU healthcare policy is complex. It meshes economic policy, human rights, criminal law, professional licensing and many other areas into one concept. Furthermore, the cultural expectations are incredibly diverse. Ethical and bioethical questions in general were not seen, for a long time, as an issue for the then European Community, given that it was primarily an economic community. So, it has been contended that the EU cannot legislate on end-of-life issues due to the boundaries set by the Treaties (Pridgeon, 2006).

Today, apart from "public health matters" as a shared competence (art. 4, para. 2, let. k), TFEU), the EU does not have legislative competence for policy areas in which bioethical questions are central, namely "human health" (art. 6, let. a), TFEU). On such matters, the Union can only support, coordinate or supplement the actions of the Member States. Rather, the principle of subsidiarity applies (art. 5, para. 3, TEU) to both public health and human health policies: it is the Member States that take the fundamental decisions in this field, such as whether or not to allow assisted suicide or euthanasia in their country. Additionally, "human health" is recalled by a horizontal clause demanding the Union, "in defining and implementing its policies and activities" to take into account its promotion (art. 9 TFEU); but such wording does not alter the solid grasp of Member States on the matter whatsoever. One should also add to this tentative list art. 182 TFEU, as it establishes the framework of EU's research policy and thereby determine what, in the field of biomedical research, can be funded.

A "limited" EU individual health policy addresses objectives relating to the provision of medical care and individual health. Its objectives include creating universal access to health care (Council Conclusions, 2006/C 146/01), which entails regulating the medical field in general, as well as allowing access to medicinal products, health-care professionals, and health insurance. But, in the European context, it is an area peculiarly regulated through different modes of market regulation without having its proper legislative basis. This leads to what we could call an *indirect* legislative policy by the Union. A dated example would be Regulation (EEC) 1408/71 on the application of social security schemes to employed persons and their families moving within the EU.

And, from this stance, a number of elements could be listed in support of the notion that a body of EU biomedical or bioethical law does indeed exist. Directives that regulate the circulation of goods for individual health are those relating to patents (Directive 98/44/EC), blood, (Directive 2002/98/EC), tissue (Directive 2004/23/EC), and organs (Directive 2010/45/EU). It is riveting to see how these acts do not refrain from referring to dignity, suggesting that this is an element of interest to the European legislator after all. For instance, Directive 2004/23/EC (recital 16) requires that "the dignity of the deceased donor should be respected", for instance through the reconstruction of the donor's body.

And, rather decisively, the EU is legislating on euthanasia at this very moment, just not with reference to human beings. In the amendments adopted by the European Parliament on 19 June 2025 on the *Proposal for a regulation on the welfare of dogs and cats and their traceability* (P10_TA(2025)0135), the amended text renders a crystalline

definition of euthanasia (art. 3) as well as actual rules to follow in order to consider such treatment legally provided. The cumulative requirements include: a not achievable recovery; severe pain or suffering that cannot be alleviated; contrariety to the rules of well-being; an action exclusively carried out by a veterinarian and with the prior consent of the operator.

Momentarily setting aside the legal acts investing medical services (Regulation (EC) 883/2004; Directive 2011/24/EU), surely capable of regulating a medical treatment causing the voluntary death of the patients, additional evidence of the EU's involvement in ethical matters can be found in soft law, (*e.g.*, P5_TA(2000)0375) and in the advisory bodies' work. Furthermore, from 1995 to 1998, the European Commission supported the "Basic Ethical Principles in European Bioethics and Biolaw" research project, based on the cooperation between 22 partners coming from most EU countries, which ended up publishing the so-called Barcelona Declaration. The aim of the project was to identify and describe the ethical principles – autonomy, dignity, integrity and vulnerability – to be considered as essential values for European bioethics and biolaw (1998). Specifically, the Barcelona Declaration features a definition of dignity, which is "variously, identified with the capacity for autonomous action" (Section C, point 1). However, that did not transition into an actual stance on autonomy in end-of-life matters, which are to be cautiously "subject of extensive debate and public consultation" (Section D, point 15). Nonetheless, even when the document seems to rule out an EU overarching legislation, since its principles "do not abolish cultural variations in Europe" (Section D, point 5), it then adds a subsidiarity condition open to interpretation ("as long as they comply with the principle of subsidiarity").

This only contributes to the impression that – given that the Union has already dealt with bioethical issues – it is more likely that the EU "does not want to" legislate on end-of-life matters, rather than "cannot". Eventually, the "stretching" of the Treaties described could be replicated through internal market integration or via a human rights-based approach (HRBA).

3. A First Solution: (Technical) Regulation of End-of-Life Matters Through the Internal Market

The main route to follow in the potential Union's regulation of bioethics relies on art. 114 TFEU. The provision, broadly used by the European legislator to cover a wide array of matters, is the legal basis for an EU's action meant to regulate the internal market and, in the interest of this research, the circulation of medical services. In truth, the already existing legislation on (transnational) medical services as well as the caselaw brought forth by the European Court of Justice (ECJ) jointly push towards a direction where "morality norms, which define collective identity, are moving towards a European-wide formulation" (Kurzer, 2004, p. 10).

More than Regulation (EC) 883/2004, on the coordination of social security systems, it is Directive 2011/24/EU, on the application of patients' rights in cross-border healthcare, that represents an (again indirect) act of legislation on end-of-life matters. Indeed, the directive ensures that travel or cross-border settlement of patients can happen freely, or

that health services – among which euthanasia or assisted suicide are included – can be delivered from the territory of one Member State into the territory of another. The directive aims to facilitate access to safe and high-quality health care provided or prescribed in a Member State other than the Member State of affiliation. At the same time, however, it also has the objective of promoting cooperation on health care and clarifying the relationship of patients' rights, as developed in the internal market, with cross-border health care. Directive 2011/24/EU therefore admits "sin shopping" in the name of the marketing of services and freedom of movement, but obviously it cannot impose any ethical consideration on the States, namely a national legislation on euthanasia. In other words, Directive 2011/24/EU allows end-of-life services to be carried out in the Union, but only in a transnational context where Member States already have such legislation in place.

Nevertheless, a top-down harmonisation in bioethical matters can be observed in the ECJ's caselaw regarding the internal market. In particular, the Court has considered that the legal categories that form the ordinary grammar of internal market legislation and policies ("goods", "services", etc.) can be technically applied to biomedical issues.

In the *SPUC v. Grogan* case (C-159/90, 1991), on access to health care in another Member State for the purpose of terminating a pregnancy, the Court established that health care falls within the ambit of the freedom to provide and receive services. But not only that. In the same case, the Court held that a citizen of any EU Member State is in principle allowed to travel freely to another Member State for medical services, unhindered by legislative and possible moral obstacles. The same reasoning process was seen in *Josemans* (C-137/09, 2010), concerning the marketing of soft drugs for medical use.

This means that the Court "adopted a 'patients-centred' and 'needs-based' approach" (De Ruijter, 2019, p. 101) and, according to some, circumvented national legislation based on ethical and moral considerations – such as those relating to reproductive, drug and end-of-life tourism (Hervey & McHale, 2004, p. 144). What can be stressed is that the ECJ relied on technical arguments to rule on an ethical issue and, as was duly noted, at the same time avoided "to engage with the substance of the ethical choice" (van Leeuwen, 2018, p. 1422), which of course rests on Member States.

The Court's initial narrative of granting freedom of movement no matter what, where the diversity of national legislations was seen as an impediment to market integration, was confirmed in *Kohl* (C-158/96, 1998). In this case, the ECJ determined that any prior authorization procedure, through which Member States had strengthened their autonomy by limiting access to cross-border health care, could be in direct breach of primary treaty law (art. 56 TFEU). However, in order to only just stretch and not overstep the boundaries of the Treaties, at a certain point the Court preferred to curb the expansion of internal market-related rights.

For instance, in the *Tobacco Advertising* case (C-376/98, 2000) it was established that the European legislator cannot create legislation with health as a central and single objective. There must be an internal market connection as a legal basis for most EU health law. Additionally, in *Smits and Peerbooms* (C-157/99, 2001) the Court determined that the maintenance of the balance of a social security system may provide reason to

override the application of the freedom-of-movement principles. The *Conegate* case (C-121/85, 1986), concerning the export to the UK of sex dolls manufactured in Germany, and later *Jany* (C-268/99, 2001), about prostitution, already cleared that any Member State can be able to "prove" the existence of an ethical choice that is different from that of another Member State. Under these circumstances of genuine differences in ethical positions, following a "substantive proportionality test" (de Witte, 2013, p. 1550), restrictions on free of movement may be allowed within the internal market.

Despite this, the aforementioned reasons are not good justifications to completely shield ethical cases from the application of internal market law. In 2011, the ECJ had the chance to rule on the Directive 2004/48/EC, in the field of intellectual property law, which prohibited Member States from issuing patents for inventions in which human embryos were used. Precisely, in *Brüstle* (C-34/10, 2011), the Court held that the concept of "human embryo" should be given an autonomous definition in EU law (paras. 25-26). As such, it can be said that the ECJ has effectively harmonized what constitutes a human embryo under EU law, *i.e.* achieving harmonization on the matter regardless of the transnational context. In this sense, as a drawback, it must be noted that any harmonised legislation, for instance on end-of-life matters, could only technically describe "how" to deliver euthanasia or assisted suicide, but not "if" such medical service is to be granted in EU Member States – not differently from what has been seen *supra* with the current text of the proposed regulation on the welfare of dogs and cats.

Furthermore, not so long ago the ECJ has been capable, to a certain extent, of forcing Member States into (at least) accepting the ethical choices of the others. In *Coman* (Case C-673/16, 2018), the Court held that those EU States that don't recognize same-sex marriages have to interpret the concept of "spouse" under Directive 2004/38/EC in such a way that it applies to same-sex couples who have lawfully concluded a marriage in another Member State allowing same-sex marriages. This not only effectively leads to mutual recognition of same-sex marriages in the EU in the case at issue but, to protect the *effet utile* of the free movement provisions, could be used in the future for other ethical-sensitive matters, such as cross-border recognition of wills and euthanasia declarations. But by acting so, the EU is – in a way – regulating euthanasia.

Afterall, taking into due consideration the potential conflict with the subsidiarity principle, "[d]espite its fundamentally and intrinsically economic origins, the EU legal order has arguably always been open to non-market values" (Vauchez, 2017, p. 47).

4. A Complex Second Solution: Human Rights Enforcement as a Tool to Oblige the States to Regulate the Matter

So far end-of-life issues have been treated as issues of competence, with it being evident that the European Union lacks a clear-cut power to regulate human or individual health. Yet, healthcare that is "increasingly patient-centred and individualized" reveals an inextricable connection between itself and fundamental rights – other than the internal market-related ones – to the point that the Union acknowledges the "citizens' and patients' rights as a key starting point" (COM/2007/0630 final). Hence, an

involvement of the EU in health could have fundamental rights implications while at the same time going “beyond” its competences.

One could ask if this could turn into a legitimate action thanks to the human rights-based approach, nowadays spreading from (substantive) rule of law to transnational and international criminal law (Oriolo 2024). Fundamental rights in the EU can have a role in the process of policymaking in order to determine the legitimacy of a peculiar policy as well as can be used for judicial review of EU legislation or national law within the scope of Union law (arts. 2 and 6 TEU). Besides, outside their formal status in Union law and the scope of application of the CFREU, said rights have value and importance that extends beyond their formal judicial enforceability (Lenaerts, 2012).

As for the Chater, it protects a number of individual rights that are particularly relevant to the end-of-life context. Even though human dignity stands as a preeminent value (art. 1 CFREU), almost considered to be of a “holy character" and “a sort of "sanctuary” (Di Stasi, 2011, p. 18), the right to the integrity of the person in the field of medicine and biology gains relevance through its emphasis on the “free and informed consent of the person concerned” (art. 3 CFREU). Prohibition of torture and inhuman or degrading treatment or punishment (art. 4 CFREU), potentially recalled by those undergoing unwanted medical treatment, and a mere “principle” of health care (art. 35 CFREU) also need to be considered. On the other hand, the right to life (art. 2 CFREU) – eventually used as a factor cautioning against access to end-of-life services in another Member State – do complete a multifaceted fabric. Nevertheless, this framework recognizes that the violation of fundamental rights in the context of health policy can be viewed as a “dignity violation”. Yet, the legal significance of these rights may be diminished by its scope of application (art. 51 CFREU), which is not to exceed established EU competences in a particular policy field.

Even when considering that the EU has limited competence with respect to the provision of health care (arts. 4, 6 and 168 TFEU) as well as the underwhelming ECJ’s caselaw on end-of-life matters, a potential leeway could be found in light of art. 52 CFREU, that ensures the necessary consistency between the CFREU and the ECHR. An “equivalence clause” (para. 2) establishes that, insofar as the rights enshrined therein correspond to rights guaranteed by the ECHR, the meaning and scope of those rights, including authorised limitations, are the same as those laid down by the ECHR and the European Court of Human Rights (ECtHR), whose caselaw on end-of-life issues is extensive.

In particular, an equivalence between the provisions of the two bills of rights emerges with respect to right to life (art. 2 ECHR), prohibition of torture (art. 4 ECHR) and the right to respect for private and family life (art. 8 ECHR), understood as encompassing the right to exercise an autonomous informed consent. Should the ECtHR find that States do need to include euthanasia or assisted suicide in their legal systems in the interpretation of these rights, it might therefore clarify both “how” and “if” the Union can regulate the matter given the existence of corresponding provisions in the CFREU.

4.1. The ECtHR's Contribution to Define End-of-Life Issues and their Regulation

First and foremost, *Pretty v. United Kingdom* (2346/02, 2002) is a noteworthy judgment on a case of denied euthanasia where the ECtHR held that there had been no violation of the right to life, finding that art. 2 ECHR could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die. Neither the Court held that there had been a violation of the prohibition of inhuman or degrading treatment, nor that the applicant's choice to avoid what she considered an undignified and distressing end to her life fell within the scope of the protection of private life accorded by the ECHR.

Even if the ECtHR could not but be sympathetic to the applicant's apprehension that, without the possibility of ending her life, she faced the prospect of a distressing death, nonetheless it was cleared that the invoked positive obligation on the part of the State would require that the Party States shall sanction actions intended to terminate life, an obligation that cannot be derived from the ECHR. The judgment is also relevant as it also cared to explain that the "very essence of the Convention is respect for human dignity and human freedom", especially 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" (para. 65).

Meaningful novelties were found in *Lambert and others v. France* (46043/14, 2015), where the ECtHR again laid down that there would be no violation of art. 2 (right to life). Nonetheless, in addressing the question of the administering or withdrawal of medical treatment, the Court created *a set of criteria* to be used as a test for the present and future cases: the existence in domestic law and practice of a regulatory framework "compatible" with the requirements of art. 2 ECHR; whether account had been taken of the applicant's previously expressed wishes and those of the persons close to him, as well as the opinions of other medical personnel; the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interests (para. 143).

Finally, in *Karsai v. Hungary* (32312/23, 2024) the judges of Strasbourg observed that there were potentially broad social implications and risks of error and abuse involved in the provision of physician-assisted dying. The ECtHR took note of a growing trend towards the decriminalisation of medically assisted suicide, especially with regard to patients suffering from incurable conditions (para. 143). Conversely, the judges also noted that the Convention must interpreted and applied in the light of the present-day conditions. The need for appropriate legal measures should therefore be kept under review, taking into account developments in European societies and in international standards in medical ethics in this domain.

The Court further considered that high-quality palliative care, including access to effective pain management, was essential to ensuring a dignified end of life (para. 154). Additionally, the ECtHR found that the refusal or withdrawal of treatment in end-of-life situations was intrinsically linked to the right to free and informed consent (art. 8 ECHR), rather than to a right to be helped to die, and was widely recognised and endorsed by the medical profession, and also laid down in the Council of Europe's Oviedo Convention

(para. 175). Furthermore, highlighting a differentiation of conducts, refusal or withdrawal of life-support was allowed by the majority of the Party States whereas proper euthanasia or assisted suicide was not. The Court therefore took the view that the alleged difference in treatment of the two categories is objectively and reasonably justified (para. 176).

To sum up, at the present time, it is not possible to deduce from the ECHR the existence of a duty to live, neither that of a right to die for individuals, nor an obligation upon States to provide for it. A connection with the right to private life has been found instead (*Karsai v. Hungary*). Consequently, this affects the corresponding CFREU provisions. Meanwhile, the wide margin of discretion afforded to States in this respect does not mean that they are completely free to take any initiative, either preclusive or permissive (Zannoni, 2020, p. 211). Indeed, the sole existence of arts. 2 and 8 ECHR imply that State Parties must draft comprehensive legal guidelines setting out the conditions for euthanasia and assisted suicide, as reasoned in *Lambert and others v. France*. Such could be the content from where a hypothetical future EU legislation on end-of-life matters could start. Moreover, the distinction drawn in *Karsai v. Hungary* between the legal status of refusal/withdrawal of life-support and that of euthanasia/assisted suicide suggests a certain degree of ethical maturity in the region. Furthermore, if euthanasia and assisted suicide are not legalized, at least in extreme circumstances, it is easy to foresee a future in which the ECtHR will be prompted to denounce it as a violation of art. 8 ECHR, notwithstanding all the controversy surrounding this issue.

5. Conclusion

The increased circulation in the EU of patients intending to make use of end-of-life medical services accentuates the tensions and contradictions in a system relying on national morality standards. From its part, the EU has demonstrated its capacity to regulate on bioethical and biomedicine matters. This is possible by stretching the scope of application of art. 114 TFEU, rather than by relying on art. 168 TFEU. In this respect, it appears that the EU would be perfectly able to define at least the cross-border aspects of end-of-life matters or, eventually, contribute to a technical harmonisation of euthanasia and assisted suicide, without the possibility to oblige States to envision them in their national legal systems. It's even possible that unrestricted access to private medical facilities for EU citizens and the gradual growth in cross border patient flows will push Member States themselves to increase interest in harmonising standards and regulations. Accordingly, it has been said that the "function of the free movement provisions is to build bridges between different ethical positions in the EU" without replacing their national identities (van Leeuwen, 2018, p. 1436). However, staunch opposition considers this as a risk of "EU assuming the bureaucratic control of death" (Frawley, 2025, p. 42).

On the other hand, resorting to a human rights-based approach, allowing to assess the legality of the acts from EU institutions and Member States in the view of human rights, seems a less desirable and feasible solution today. Apart from sympathy and some

(narrow) guidelines, the current interpretation of both the CFREU and of the ECHR has not produced any true State obligation to grant a dignified death to those who are willing to obtain it. An EU legislation supported by this chassis seems unlikely at this time.

Interestingly, the EU is also an ally for public opinion, which picks and chooses different elements of a European dialogue to fault national decision-makers. That's the case of the petition (art. 24 TFEU) entitled "Voluntary Assisted Dying as a Fundamental Human Right in the EU", which was submitted to the European Parliament in 2024 by EUmans and other 38 NGOs. It explores the Union current (and future?) competences to advance an alternative dignity-based agenda contrary to the preferences of the national leadership and could somehow provide a bottom-up legitimacy for future actions on dignified death.

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