Essays

The Construction of the Fundamental Right to a Dignified Death by the Colombian Constitutional Court in the Face of Legislative Silence

Gonzalo Arruego*

ABSTRACT: This study analyses the more than quarter-century case-law journey on the "fundamental right to a dignified death" of the Colombian Constitutional Court. It opens with the exam of the birth of the right in 1997 and then explores how, over more than two decades, the Constitutional Court has progressively defined its nature and scope. Finally, it examines the first extension of the clinical cases that qualify for medically assisted death, as well as the definitive elimination of an incomprehensible inconsistency: how the decriminalisation of euthanasia under certain conditions has coexisted with the absolute prohibition of assisted suicide for 25 years.

KEYWORDS: fundamental right to a dignified death; euthanasia; assisted death; fundamental right to life; Colombian Constitutional Court

SUMMARY: 1. Introduction – 2. (1997) A New Fundamental Right Is Born by Surprise: "The Fundamental Right to a Dignified Death" – 3. (1997-2025) Shaping a Complex and Autonomous Fundamental Right To Manage the Final Moments of One's Own Life – 4. (2021 and 2022) The Power of the Consistency Argument and the Return to the Constitutionality of the Criminal Code: The Extension of Assisted Dying Cases a Quarter of a Century After 1997 – 5. Final Considerations.

1. Introduction

Reflecting on the concept of death and on how to face our own death, even deciding when and how to die and even resorting for that purpose to the help or company of others, who will also inevitably deal with their own death when the time comes, seems inextricable from the human condition. This is obviously not new.

What is new in recent decades is the debate about the possibilities opened up by our limited, albeit growing, ability to manage our death as a process and a decision-making space in a clinical setting. While this debate may be more limited in scope, it is undoubtedly more sophisticated and can only be understood in a context where profound socio-cultural changes and new scientific and technological scenarios

* *Public Law Department, School of Law, University of Zaragoza; Member of the Research Group AGUDEMA. Mail: garruego@unizar.es.* *This research has been carried out under the National Project "Parliamentarianism weakened or threatened? Analysis of the dynamics and trends of representative systems and their effects on legislative processes" (Parlegislativo; PID2023-153065NB-I00), funded by, MICIU/AEI/10.13039/501100011033 and FEDER/UE. Where possible, the relevant case law is cited indicating: Ruling Number of the Ruling/Year/Paragraph. All translations are by the author. The article was subject to a double-blind peer review process.*

continuously inform each other[1]. A debate that encompasses the possibility of voluntarily ending our lives in certain circumstances with the help of specialised personnel.

As is well known, the traditional legal response to this dilemma has been, and largely continues to be, criminal repression. This is an undeniable reality. However, it is also true that events have recently accelerated to the extent that there appears to be an emerging trend towards the legalisation of assisted death in Europe,[2] to a greater or lesser extent.[3] In this sense, despite the fact that currently only a few States allow some form of (medically) assisted death,[4] we are experiencing a period of change that, depending on the case, originates from jurisdictional and/or legislative impulses.[5]

---

[1] On these issues see, among others, and in the Spanish constitutional scholarship, R. CHUECA, *El marco constitucional del final de la propia vida*, in *Revista Española de Derecho Constitucional*, 85, 2009 and, more recently, G. CÁMARA, *La tríada "bien constitucional vida humana/derecho a la vida/inexistencia de un derecho a la propia muerte" (acerca de la constitucionalidad de la regulación de la eutanasia en España en perspectiva comparada)*, in C. TOMÁS-VALIENTE (coord.), *La eutanasia a debate: primeras reflexiones sobre la Ley Orgánica de Regulación de la Eutanasia*, Madrid, 2021 and *La regulación de la eutanasia y el suicidio asistido en el mundo. Panorama general y comparado*, in *Anuario de Derecho Eclesiástico del Estado*, 37, 2021. In this context, it is classic to quote Judge Brennan's dissenting opinion in *Cruzan* and the reasoning of the European Court of Human Rights in *Pretty*: "Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity", Justice Brennan dissenting opinion in *Cruzan v. Director*, MDH, 497 U.S. 261 (1990); "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", *Pretty v. UK* (2002) § 65.

[2] Although they are different actions, the generic term "assisted death" has been used throughout the text for the sake of consistency, as it encompasses both euthanasia (without any adjective) and (medically) assisted suicide, see G. ARRUEGO, *Derecho fundamental a la vida y muerte asistida*, Granada, 2019, 3.

[3] The ECtHR has recently stated that, "the Court cannot but note that a certain trend is currently emerging towards decriminalisation of medically assisted suicide, especially with regard to patients who are suffering from incurable conditions"; a trend whose evolution cannot be ignored if the ECHR is to be interpreted as a living instrument, *Karsai v. Hungary* (2024) §§ 143 and 167.

[4] The three Benelux countries (Belgium, the Netherlands, and Luxembourg) in the early 2000s and, almost two decades later, Spain in 2021 (Ley Orgánica 3/2021, de 24 de marzo, *de Regulación de la Eutanasia*), Austria in January 2022 following the ruling of its constitutional court in December 2020 (*Bundesgesetz, mit dem ein Sterbeverfügungsgesetz erlassen wird sowie das Suchtmittelgesetz und das Strafgesetzbuch geandert werden* and Ruling G-139/2019-71) and Portugal, after several attempts and two rulings by its Constitutional Court, almost three years ago (Lei n.º 22/2023, de 25 de maio, *Regula as condições em que a morte medicamente assistida não é punível e altera o Código Penal* and Rulings 123/2021 and 5/2023). And let us not forget the peculiar cases of Italy and Germany and, outside the European Union but also within the framework of the Council of Europe, the well-known case of Switzerland.

[5] Let's consider some recent examples. Over a year ago, the French National Assembly was debating the *Bill on the accompaniment of the sick and the end of life*, but the discussion was interrupted by the early election called after the European Parliament elections. However, in May 2025 the assembly took the first step to legalise assisted death in France: it voted in favour of the *Bill on the right to assisted death*, which would grant French nationals and regular residents in France the right to medically assisted suicide if they suffer from a serious, life-threatening, incurable condition in an advanced or terminal stage that causes unbearable suffering. In January, the Senate rejected the Bill and returned it to the National Assembly. Between April and June 2024, the Nuffield Council on Bioethics commissioned a Citizens' Jury in the United Kingdom to explore public opinion on assisted death, revealing overwhelming support for it. In fact, the House of Commons recently passed the *Terminally Ill Adults (End of Life) Bill*, which allows terminally ill patients with a life expectancy of six months or less to obtain medical assistance in dying. Scotland has

In fact, constitutional and human rights jurisdictions have been particularly active in this area in recent years, to such an extent that this turning point in the regulation of medically assisted death is arguably more a result of how the courts interpret the relevant rights and principles than legislative action:[6] the *Carter and Truchon* cases in Canada in 2015 and 2019;[7] the *Cappato* case in Italy in 2018 and 2019;[8] the German Federal Constitutional Court's February 2020 ruling on providing assisted suicide as a service;[9] the Austrian Constitutional Court's December 2020 ruling on assisted suicide;[10] Rulings 123/2021 and 5/2023 of the Portuguese Constitutional Court on "medically assisted anticipation of death"; Rulings 19 and 94/2023 of the Spanish Constitutional Court on the Organic Law on the Regulation of Euthanasia (LORE); Ruling 67-23-IN/24 of the Constitutional Court of Ecuador, which declared the criminal offence of homicide partially unconstitutional[11]...and fundamentally, the constant evolution of the ECtHR's doctrine from *Pretty* (2002) to the more recent *Mortier* (2023) and *Karsai* (2024) cases.

However, many years before this recent series of rulings, more precisely, in 1997, the Colombian Constitutional Court became the first to change the traditional criminal law response to (medically) assisted death.[12] It did so by declaring its blanket prohibition unconstitutional as a result of the "discovery" of a new fundamental right that allows a person to control their dying process: the "right to a dignified death". Since then, the Court has progressively shaped this right through a series of decisions that perfectly exemplify the problems and dilemmas that usually arise when the legalisation of assisted death is the result of jurisdictional action. Mainly, the tension and potential blurred boundaries between constitutional judicial action and legislative inaction.[13] In this sense, more than 25 years after its first call on the Congress

been debating its own legislation since March 2024 and the islands of Jersey and Man are expected to have their own legalisation in 2027. In March 2024, an all-party parliamentary committee recommended that the Republic of Ireland should legalise assisted death for individuals with an irreversible and incurable illness that is expected to cause death within six months (or 12 months in the case of neurodegenerative conditions) and which causes unrelievable suffering. Parliamentary work on the *Voluntary Assisted Dying Bill 2024* did begin, but it expired as a result of the dissolution of the Houses of the *Oireachtas* in November 2024.

[6] See G. ARRUEGO, *Acuerdos, y apenas desacuerdos, en el examen de constitucionalidad de la muerte asistida*, in *Revista Española de Derecho Constitucional*, 136, 2026.

[7] *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331 and *Truchon v. Canada (Attorney General)*, 2019 QCCS 3792.

[8] Rulings 207/2018 and 242/2019; subsequently, above all, Rulings 135/2024 and 66/2025.

[9] BVerfGE of 26 February 2020.

[10] Ruling G-139/2019-71.

[11] On 15 October 2025, Uruguay became the first Latin American country to legalise assisted death by law with the approval of the *Dignified Death Bill. Regulation*.

[12] Despite this, the scant doctrinal attention paid to it in comparison with other jurisdictions has been highlighted: "However, both in bioethical literature and in the global media, the Colombian case is not usually examined in depth and is almost always reduced to a mere mention. Often, only the cases of the Netherlands, Belgium and Oregon in the United States are discussed [...]. Could this oversight be another example of the predominance of the perspectives and debates of developed countries in bioethics?", E. DÍAZ AMADO, *La despenalización de la eutanasia en Colombia: contexto, bases y críticas*, in *Revista de Bioética y Derecho*, 40, 2017, 127. The same author provides an overview of the situation in Colombia up to 2019 in *El morir dignamente y la eutanasia en Colombia*, in A.M. MARCOS DEL CANO, J. DE LA TORRE, (eds.), *Y de nuevo la eutanasia. Una mirada nacional e internacional*, Madrid, 2019.

[13] Precisely, one of the most repeated criticism in the several dissenting opinions to the 1997 ruling was that the Court had exceeded its powers by assuming a legislative function. A contrary opinion in G. LOZANO VILLEGAS, *La eutanasia activa en Colombia. Algunas reflexiones sobre la jurisprudencia constitucional*, in *Revista Derecho del Estado*, 11, 2001, 99.

to regulate assisted death,[14] Colombia still lacks such regulation,[15] a circumstance that has forced the Court to specify, with increasing detail and through its rulings, the scope of the right.[16] During this time, we have witnessed the evolution of the discussion surrounding assisted death (opening up to new situations and facing the dilemma of minors and psychiatric patients) and how some obvious inconsistencies have been addressed (the coexistence of euthanasia with the prohibition of assisted suicide).

The following pages analyse this more than quarter-century case-law journey (Ruling C-239/1997 to Ruling T-438/2025). They open with the exam of the birth of the fundamental "right to a dignified death" in 1997 and then explore how, over more than two decades, the Constitutional Court progressively defined the nature and scope of the right. Finally, they analyse the first extension of the clinical cases that qualify for medically assisted death, as well as the definitive elimination of an incomprehensible inconsistency: how the decriminalisation of euthanasia under certain conditions has coexisted with the absolute prohibition of assisted suicide for a quarter of a century.

2. (1997) A New Fundamental Right Is Born by Surprise: "The Fundamental Right to a Dignified Death"

As described above, it was in 1997 when the Constitutional Court of Colombia became the first judicial body to proclaim that its constitution recognises a "fundamental right to a dignified death" ("derecho fundamental a la muerte digna") in a pioneering, but also surprising and controversial move. It was in its C-239/97 ruling, in which the Court examined the constitutionality of the then article 326 of the Colombian Criminal Code, which criminalised "mercy killing".[17]

[14] As the legal regime governing assisted death must be established by the legislature, the Court urged the Parliament to regulate it as soon as possible, with the proviso that "while the issue is being regulated, in principle, all mercy killings of terminally ill patients must give rise to the corresponding criminal investigation in order to determine whether the doctor's actions are unlawful under the terms indicated in this ruling", Ruling C-239/97/II.D. Currently, the Colombian Senate is discussing the *Bill on the fundamental right to a dignified death in the form of medically assisted death, along with other provisions*.

[15] A problem present today, though to a lesser and very different extent, in Italy or Germany. Recently, the Italian Constitutional Court has "strongly reiterate[d] the hope already expressed in Rulings n. 207/2018, n. 242/2019 and, most recently, n. 135/2024, that the legislator and the National Health Service take prompt action to ensure the timely and concrete implementation of the provisions contained in Ruling n. 242/2019. This does not prejudice the legislator's ability to establish different rules in accordance with the requirements referred to in this Ruling", Ruling 66/2025/8.

[16] As Correa-Montoya explains, "The emergence of the right to die with dignity in Colombia is a process in which the judiciary, specifically the Constitutional Court, has played a central role. Through its role as an advocate and creator of rights, it is the Court that has led this process, often acting alone in the face of a virtually absent legislature and an executive branch that is frequently limited in its compliance with judicial orders". In his opinion, "in its role as a creator of law, the Court has taken particular care to link this creative process with existing rights in the international and constitutional legal spheres, giving it substance, coherence and structure, and ensuring that its emergence is neither capricious nor authoritarian on the part of judicial elites", L. CORREA-MONTOYA, *Muerte digna. Lugar constitucional y núcleo esencial de un derecho humano emergente*, in *Opinión Jurídica*, 20(41), 2021, 131 and 135.

[17] "Mercy killing. Anyone who kills another person out of mercy, to end intense suffering caused by bodily injury or serious or incurable illness, shall be imprisoned for between six months and three years". Currently, Article 106 of the Criminal Code (Law 599 of 2000) provides that "Anyone who kills another out of mercy, to end intense suffering resulting from bodily injury or serious and incurable illness, shall be liable to imprisonment for between sixteen (16) and fifty-four (54) months".

It is striking that, unlike what we might consider the 'usual' approach, the plaintiff sought the declaration of unconstitutionality of this criminal offence not because he objected to its criminalisation, but because the penalty for it was less severe than for homicide. In his opinion, this violated the State's duty to protect every human life equally[18] under article 11 of the Colombian Constitution.[19]

Despite the appellant's intentions, the Court ultimately upheld the Criminal Code provision but introduced a significant difference due to the "discovery" of a new fundamental right not explicitly stated in the Constitution: the "right to a dignified death". Thus, the Court ruled that, when performed by a doctor at the free request of the passive subject, who must also meet certain clinical conditions (terminal illness), "no criminal liability may arise".[20]

In other words, and returning to the 'traditional' parameters of the debate, the Court considered the constitutional problem to be that the Criminal Code sanctioned that type of homicide even when the alleged victim had given their consent, something that it considered to be contrary to the constitution.[21]

In this sense, one of the key factors in concluding that there is a fundamental "right to a dignified death" was, precisely, the Court's interpretation of the constitutional guarantee of the right to life and, above all, the consequent delimitation of the scope of the State's duty to protect it.

Always departing "from a secular and pluralistic point of view that respects personal autonomy and individual rights and freedoms",[22] the Court based its ruling on three premises.

The first was "human dignity" which, as the foundation of the constitutional order and a supreme value underlying all fundamental rights, demands respect for the autonomy and identity of the person. Dignity would serve to transcend, from a twofold perspective, the conception of the right to life as a mere guarantee of physical existence: it cannot be reduced to mere subsistence because it also encompasses living

[18] In Michalowski's opinion, "[…] it might have been desirable for the Court to deal more explicitly with the question of whether, in recognising mercy killings based on the health of the victim, the legislator discriminates against and attaches less value to the lives of people who experience extreme suffering caused by physical injury or a grave and incurable illness. This problem is to some extent exacerbated by the fact that unlike in many other countries that allow for a lesser offence of mercy killing […] [under the Colombian Criminal Code] a request by the individual to have his/her life ended is not a prerequisite of the lesser punishment", S. MICHALOWSKI, *Legalising active voluntary euthanasia through the courts: some lessons from Colombia*, in *Medical Law Review*, 17(3), 2009, 188. In the Court's opinion, and unlike "simple" or "aggravated" homicide, where "an existence is annulled because [in the perpetrator's view] it has no value", in "mercy killing" the act is committed "not out of contempt for the other person but out of totally opposite feelings. The perpetrator considers the victim to be a person of equal dignity and rights but who is experiencing such severe suffering that death can be viewed as an act of compassion and mercy", Ruling C-239/97/II.B.1.b.

[19] "The right to life is inviolable. There will be no death penalty".

[20] The Court "[Declares] Article 326 of Decree 100 of 1980 (Criminal Code) to be CONSTITUTIONAL, with the proviso that when the action is performed by a doctor at the free request of a terminally ill patient, no criminal liability may be attributed to the doctor, as the conduct is justified".

[21] Indeed, from the outset the Court made it clear that Article 326 of the Criminal Code did not consider the wishes of those who suffer, which is why it examined its constitutionality from a radically different perspective. According to the Court, the 1991 Constitution "introduced significant changes in relation to fundamental rights, requiring the Criminal Code to be reinterpreted in this new light; that is why the Court is analysing whether it is legitimate within this new constitutional order to criminalise a person who commits a mercy killing at the request of the victim", Ruling C-239/97/II.C.

[22] This is a salient point in its reasoning, resulting from the apparent identification of the punishment of assisted death with the imposition of moral and religious convictions. In the European context, the Portuguese Constitutional Court has also recently invoked the pluralistic and secular nature of (Portuguese) society, Ruling 123/2021/24.

adequately in conditions of dignity, nor can it be interpreted without "losing sight of the value that the person attributes to their life".[23] The second was the free development of personality "as the highest expression of fundamental rights". And, finally, the third was the constitutional principle of solidarity, which obliges every citizen to help those in need.[24]

Taken together, these elements led to the recognition of individual autonomy and responsibility when making decisions that primarily affect oneself, and to the conclusion that, in principle, no duties should be imposed on anyone except those relating to other members of society.[25] Consequently, the State could not impose a specific concept or idea of what human life is through its norms and, furthermore, the positive duty to protect human life could only be interpreted in terms of autonomy, dignity and the free development of the individual.[26]

Surprisingly, given the traditional arguments in favour of assisted death, the Court neither reinterpreted the right to life as a liberty nor affirmed the existence of a fundamental right to dispose of one's own life. And this, despite the fact that the leading idea of its argumentation was, apparently, the protection of individual self-determination with regard to the most intimate and personal decisions, including death, in the light of dignity and free development of the personality.[27] Conversely, the Court proclaimed a new and autonomous fundamental right, the "right to a dignified death", without altering the interpretation of the fundamental right to life as primarily a negative right, from which positive protection duties for

[23] This had already been affirmed in Rulings T-366/93 and T-123/94. The Court reiterates this idea in other rulings stating, for example, that one consequence of the concept of human dignity is that "a preponderant and absolute value cannot be assigned to the biological concept of life, forgetting that a human being is much more than respiratory and cardiac functions", Ruling C-233/14/IV.4.3.1.

[24] In the Court's words, "It is not difficult to discern the altruistic and compassionate motive of someone who acts out of a desire to alleviate the suffering of others", Ruling C-239/97/II.B.1.b. Michalowski has highlighted the importance of the constitutional principle of solidarity in the ruling: "Autonomy requires that it must be left to the individual to determine whether or not life is worth living. Dignity comes into play in particular where the individual experiences such suffering that continued life would be perceived as undignified, and it prevents the state from imposing on the individual limits on the exercise of autonomy in the name of the religious convictions of others. However, this in itself would not necessarily go any further than to justify that competent individuals can refuse life-saving or life-sustaining medical treatment, or that they can commit suicide. In order to reach the conclusion that autonomy and dignity require the state to decriminalise active voluntary euthanasia, the principle of solidarity is important, because it provides a constitutional basis for the argument that the Constitution condones the active intervention of third parties in the dying process", S. MICHALOWSKI, *Legalising active voluntary euthanasia through the courts: some lessons from Colombia*, cit., 193. As will be shown below, the principle of solidarity once again plays an important role in Ruling C-164/2022.

[25] "[…] the Constitution is inspired by the idea that individuals are moral subjects who can make responsible and autonomous decisions about matters that primarily concern them. The State's role is limited to imposing duties in relation to other moral subjects with whom individuals coexist", Ruling C-239/97/II.C.1.

[26] *Ibidem*, particularly II.C.1 and II.C.3.In light of the citizens' obligation to take care of their health (Article 49 of the Constitution), the Court imposes the duty to protect life not only on public authorities, but also on the individuals themselves.

[27] Contrary to the conclusion reached by the German Constitutional Court in BVerfGE, of 26 February 2020, probably taking part of the ECtHR's doctrine to its ultimate consequences.

public authorities arise. Furthermore, and without any explanation, the Court limited this right exclusively to terminally ill patients experiencing unbearable suffering.[28]

This shift in reasoning is probably why the Court then resorts to other traditional arguments in the assisted death debate, such as avoiding physical and psychological suffering and ensuring that one dies in circumstances that align with their personal conception of dignity. The focus of the argument therefore shifted to answering the question of whether, as a consequence of the State's positive duty to protect life, it is possible to prevent individuals from deciding whether or not to continue living in "extreme circumstances" that make their life "undesirable and not worth living".[29] The answer was no. But, it must be emphasized, only in those extreme circumstances: "Terminally ill patients" who are experiencing "extreme and unbearable suffering" that they deem to be incompatible with their "idea of dignity".[30] In such circumstances, that State's positive obligation weakens and yields to the patient's free will because the decision is not about whether to live or die, but how to die[31]. In these circumstances, "the right to live with dignity" implies "the right to die with dignity".[32] Furthermore, the Court affirms that if the person is

[28] From different and even antagonistic points of view, this aspect is highlighted by some of the concurring and dissenting opinions to the ruling, who ask themselves why only those people and only under those circumstances. See, for example, the opinions of judges Hernández, Arango and Gaviria.

[29] Ruling C-239/97/II.C.1.

[30] "[…] if the way individuals face death reflects their own convictions, they cannot be forced to continue living when, due to the extreme circumstances in which they find themselves, they do not consider it desirable or compatible with their own dignity, with the inadmissible argument that a majority considers it a religious or moral imperative [...] the State cannot demand heroic behaviours, even less so if the basis for such behaviour is a religious belief or a moral attitude", *ibidem*. The constitutional guarantee of "moral, ethical and religious" pluralism applies to both patients and healthcare personnel in this area, who cannot be compelled to "perform a specific procedure". As a consequence of the medicalised configuration of the "right to a dignified death", healthcare professionals are granted the right to conscientious objection, but are obliged to arrange for another clinician to perform the procedure, Ruling T-970/14/4.9 and 7.2.11.

[31] As Vargas questions, "So, does the state's duty to protect life yield because the person is at the end of their life, or because an individual has the right to decide whether their life is dignified or not?", P. VARGAS, *Experiencia de Derecho Comparado. El Derecho a una muerte digna en la Jurisdicción Constitucional colombiana*, in *Revista de Ciencias Jurídicas*, 161, 2023, 9.

[32] "[…] In the case of terminally ill patients experiencing intense suffering, the State's duty to protect life gives way to the informed consent of the patient who wishes to die with dignity. In such cases, that State's duty is considerably weakened because, based on medical reports, death is inevitable in a relatively short time beyond any reasonable doubt. In these circumstances, how to face death becomes of the utmost importance for the terminally ill patient, who knows that they cannot be cured and therefore they are not choosing between death and many years of a full life, but rather between dying in conditions of their choosing or dying shortly thereafter in painful circumstances that they consider undignified. The right to live with dignity therefore implies the right to die with dignity", Ruling C-239/97/II.C.3.

not permitted to end their life in this scenario, they are subjected to "cruel and inhuman treatment".[33] Ultimately, it seems that what is really at stake is the right not to suffer.[34]

There was still one last turn in the Court's argumentation: the characterisation of the fundamental right to a dignified death as a benefit right within a medical context.[35] This interpretation, which may also be a consequence of the State's duty to protect human life, is linked in the Court's reasoning to three factors: verifying the patient's clinical condition; ensuring their decision is free and informed; and guaranteeing their death occurs under appropriate circumstances.[36] In this regard, it should not be forgotten that the State's responsibility for protecting human life requires assisted death to be regulated with the utmost care, [37] with two main objectives: assuring the freedom and responsibility of the decision to end one's own life and making sure that only "those who suffer from intense pain as a result of a terminal illness" exercise the "right to a dignified death".[38]

In summary, Ruling C-239/97 concluded that the public authorities' obligation to preserve human life yields to the free and responsible decision of a competent person who is suffering from a terminal illness that causes unbearable pain which is incompatible with their idea of dignity; who understands the nature and consequences of their decision; and who has been properly informed about their illness, prognosis and therapeutic alternatives. Furthermore, only a doctor could actively end the patient's life.[39]

[33] For example, both the ECtHR in *Pretty v. The United Kingdom* (2002) and the Supreme Court of Canada in *Rodríguez v. British Columbia (Attorney General)* (1993) reject this conclusion. In the Court's view, however, "Condemning a person to prolong their life for a short time, when they do not wish to do so and are suffering profound distress, amounts not only to cruel and inhuman treatment, prohibited by the Constitution (Article 12), but also to a nullification of their dignity and autonomy. The person would be reduced to an instrument for the preservation of life as an abstract value", Ruling C-239/97/II.C.3.

[34] For example, "[...] the damage caused to the plaintiff consisted of the physical and psychological suffering she endured until her death. The plaintiff wanted to end that suffering. The damage did not materialise with death, since it was inevitable", Ruling T-970/14/2.8.

[35] Note that the Court only excluded criminal liability for the physician who performed the conduct under the conditions established in the Ruling. The current Resolution 229/2020 of the Ministry of Health and Social Protection, which establishes guidelines for the charter of rights and duties of patients in the General Social Security System for Health, as well as the performance charter of Health Promotion Entities (EPS) in the Contributory and Subsidized Regimes, includes the right to die with dignity and euthanasia in the healthcare system portfolio.

[36] "[…] the Court concludes that the active subject must be a doctor, since they are the only professionals capable of providing patients with this information and enabling them to die with dignity", Ruling C-239/1997/II.C.3.

[37] See G. ARRUEGO, *On the relationship between the fundamental right to life and assisted death*, in *BioLaw Journal – Rivista di Biodiritto*, 3, 2020 and L. WICKS, N. PAPADOPOULOU, *Taking 'the right to life' seriously: addressing the role of 'the right to life' in the context of assisted dying*, in *Medical Law International*, 24(4), 2024.

[38] For this reason, although recognising that this matter falls within the legislature's powers, the Court suggested various safeguards in line with those traditionally adopted by jurisdictions that have legalised assisted death. These include reiterating the decision after a certain period of time has elapsed, requiring judicial authorisation and holding a prior meeting with a support team to discuss the situation and the alternatives.

[39] In these circumstances, the state cannot oppose the decision or its execution with the help of a third party (the doctor), nor can it impose the criminal sanction of Article 326 of the Criminal Code, as the action "lacks illegality". In short, "it is an act of solidarity carried out at the patient's request", which is why the doctor cannot be punished; rather, "the judges must exonerate him/her from responsibility", Ruling C-239/97/II.C.3.

3. (1997-2025) Shaping a Complex and Autonomous Fundamental Right To Manage the Final Moments of One's Own Life

The (apparent) foundation of the "right to a dignified death" in personal autonomy and dignity remained unchanged in the Court's rulings in subsequent decades. Ultimately, and always within the strict limits of the required clinical condition, the Court configured an autonomous fundamental right that enables individuals to manage or govern the final moments of their lives within the healthcare system.

This characterisation began with ruling T-970/14, which marked a significant advance in the thoroughness with which the Court has outlined the "right to a dignified death".[40]It stated that this is an "autonomous"

[40] The ruling once again urged the Congress of the Republic of Colombia "to regulate the fundamental right to a dignified death, according to the criteria established in this ruling" and, above all, it contained two mandates for the Ministry of Health and Social Protection. The first gave the Ministry thirty days to issue "a guideline and [arrange] everything necessary for hospitals, clinics, IPS, EPS, and, in general, health service providers to constitute the interdisciplinary committee referred to in this ruling and comply with the obligations issued in this decision". The Ministry complied with this requirement by approving Resolution 1216/2015, of 20 April, which complies with the fourth order of Ruling T-970 of 2014 of the Honorable Constitutional Court in relation to the guidelines for the organisation and operation of the Committees to enforce the right to a dignified death. The second mandate required the Ministry to "suggest to doctors a protocol that will be discussed by experts from different disciplines and will serve as a model for all the procedures aimed at guaranteeing the right to a dignified death". This is the origin of the 2015 Protocol for the application of the euthanasia procedure in Colombia. In any case, the Court established in its ruling the four principles according to which "doctors and healthcare providers" must ensure the effective realisation of the fundamental "right to a dignified death": "the prevalence of the patient's autonomy", "celerity", "opportunity" and "healthcare professionals' impartiality". The following year, the Ministry approved Resolution 4006/2016, of 2 September, *Establishing an Internal Committee within the Ministry of Health and Social Protection to oversee procedures that enforce the right to die with dignity, regulate them, and issue additional provisions*. The current regulation of euthanasia for adults in Colombia (as discussed below, there are specific regulations for minors) is contained in Resolution 971 of 2021, of 1 July, of the Ministry of Health and Social Protection, *Establishing the procedure for receiving, processing and reporting requests for euthanasia, as well as guidelines for the organisation and operation of the Committee for the Enforcement of the Right to a Dignified Death through Euthanasia*. Broadly speaking, the procedure it establishes is as follows. Both Colombian nationals and foreigners who have resided continuously in Colombia for at least one year and who meet the clinical conditions established by the Constitutional Court's doctrine may submit their euthanasia request verbally or in writing to any doctor (not only their treating doctor or a specialist in their condition). It should be noted that, on the one hand, the resolution still only provides for terminal patients, despite the fact that the Court, as we will see immediately, has recognised the right also to those suffering from a grievous and irremediable medical condition. And, on the other, that it only refers to euthanasia although, as it will be examined *infra* too, medically assisted suicide is also legal in Colombia since 2022. Once the doctor receives the request, they carry out a preliminary verification that the requirements of illness, suffering and capacity are met and inform the patient of the process to be followed, as well as their rights to withdraw the application at any time or to receive palliative care. The doctor then records the request in the patient's medical record and, if the above conditions are met, submits the application to the Scientific-Interdisciplinary Committee for the Right to a Dignified Death within 24 hours. If the doctor does not activate the Committee because they believe that the requirements are not met, the patient may request a second opinion. The request may also be the result of a living will, in which case it is also reported within 24 hours and the corresponding Committee is activated. The Scientific-Interdisciplinary Committees are composed of a physician specialising in the patient's condition, a lawyer and a psychiatrist or clinical psychologist, and, among other functions, they verify within 10 days the presence of the clinical condition that qualifies the patient for euthanasia, the resulting suffering, the applicant's capacity (which, in the case of a living will, was already verified at the time of signing) and the absence of reasonable treatment or symptom relief alternatives. The decision may be positive, in which case the patient is informed so that they can reiterate their

and "complex" right that is "independent but related to the right to life and other rights".[41] As the Court expressly affirmed, although euthanasia tends to receive the most attention, the fundamental "right to a dignified death" is not limited to it. Rather, it encompasses "a set of powers that allow a person to exercise their autonomy, control the process of their death, and impose limits on third parties with regard to decisions made in the context of health".[42] In other words, the Court granted fundamental right status to the patient's right to access certain medical procedures at the end of their lives, enabling them to exercise their autonomy over their own death.

Indeed, euthanasia stands out as the first of the contents of the right, initially accessible, according to Ruling C-239/97, only to terminally ill patients enduring intense pain or suffering. While the former is an objective factor that must be clinically established,[43] the latter is based on the patient's subjective perception.[44] However, euthanasia does not exhaust the content of the fundamental "right to a dignified death", which would also include the limitation of therapeutic effort and access to palliative care[45]. Perhaps paving the way for the extension of euthanasia, which will happen in 2021, the latter were accessible since the beginning not only to terminally ill patients, but also to those suffering from a "chronic, degenerative and irreversible disease" with a "high impact on their quality of life".

The relationship among the different dimensions of the right is one of complementarity, not incompatibility. In this sense, the Colombian Constitutional Court has analysed, in particular, the relationship between euthanasia and palliative care, reaching the same conclusion as other Constitutional Courts:[46] comprehensive palliative care is just one option available to people depending on their medical condition and, therefore, resorting to it to manage the final moments of life is a matter of personal autonomy, never an obligation, and there is no "exclusive disjunction" with regard to euthanasia. Thus, the tridimensionality of the "right to a dignified death" "increases the dignity and capacity for self-determination of all persons on the threshold of death", without "forcing [them] to exhaust one facet before another". This conclusion is accompanied by the recognition that the real possibility of accessing comprehensive palliative care can

---

request, or negative, in which case the patient may request a second opinion from a new committee comprising different individuals.

[41] Ruling T-970/14/4.11 and 5.3. In the Court's opinion, the "right to a dignified death" would meet the three criteria required to be considered an autonomous fundamental right: it is based on human dignity, it can be translated into a subjective right and there is consensus regarding its fundamental nature. Beyond other considerations, it is striking that the Court considered the last requirement to be met: the existence of consensus "at the legislative, judicial, constitutional, or even international human rights law level". Particularly, because the Court reached this conclusion using arguments such as the existence of an agreement "on the need to regulate this matter [because], despite it not being a peaceful issue, the Congress has attempted to regulate it on four occasions [...]. Additionally, the Constitutional Court, through the aforementioned ruling C-239 of 1997, declared that the right to a dignified death is a fundamental right. The discussion seems then to be settled, as this Court, after an argumentative and interpretative exercise of the Constitution, recognised that it is a fundamental right", *ibid*., 5.3.

[42] Ruling T-721/17/6.1.8.

[43] Also, for example, the necessity or futility of a concrete medical treatment, issues that do not depend on the patient's wishes but on the opinion of the doctor or medical team treating them, Ruling C-233/14/IV.4.3.

[44] Ruling T-970/14/7.2.

[45] Both palliative care and the limitation of therapeutic effort are regulated by Law 1733 of 8 September 2014 (*Consuelo Devis Saavedra Law on integral palliative care services for patients with terminal, chronic, degenerative and irreversible conditions at any stage of the disease which significantly impact quality of life*).

[46] For example, the German (BVerfGE, of 26 February 2020), Austrian (Ruling G 139/2019-71), Italian (Ruling 207/2018) or Spanish (Ruling 19/2023) Constitutional Courts.

significantly influence the decision about how to die[47] and it is also connected to the idea that the State is obliged to offer its citizens "every opportunity to continue living" due to its commitment to their lives.[48] The substantive content of the right has been enriched with an additional 'procedural dimension' to ensure that applications to exercise it are processed in accordance with the established protocols. This is, of course, regardless of its final recognition, which depends on the fulfilment of the required substantive criteria.[49]

Throughout its jurisprudence, the Court has broadly interpreted who enjoys the fundamental "right to a dignified death", based on the premise that the connection between the right and human dignity requires it to be recognised without distinction. In its opinion, the contrary would amount to a violation of dignity and equality and to cruel and inhuman treatment. In this sense, the Court has affirmed that minors and persons with intellectual disabilities also enjoy the right. This, let us say, *universal* recognition of enjoyment of the right shifts the problem to assessing the capacity to exercise it effectively and, only in the event of its absence, to the mechanisms to overcome that situation, including third-party intervention through what was initially known as 'substitute consent'.

Unlike in civil law, in the field of medical care capacity is a matter of fact that must be assessed on a case-by-case basis by healthcare professionals. They must determine, in accordance with *lex artis*, whether the person wishing to exercise the fundamental "right to a dignified death" has sufficient intellectual capacity to understand the situation and make a free and responsible decision ("maturity" and "soundness of mind").[50] This fact, plus the recent paradigm shift in the regulation of disability from substitution to providing support, means that the starting point is always the potential possession of sufficient intellectual capacity to exercise the right, a presumption that must be appraised in each individual case.[51] Problems obviously arise when a person lacks that capacity, a dilemma that the Court has also addressed from a broad perspective, permitting the exercise of the right in order to respect the person's "vital interests"

[47] Ruling C-233/2021/457, 459 and 460. The Austrian Constitutional Court has emphasised that the availability of comprehensive palliative care is one of many socio-economic factors beyond our control that can influence our decision about how and when to die, and that public authorities must mitigate through legislative and governmental measures (Ruling G 139/2019-71/16). For this reason, the Spanish Constitutional Court has stressed that those applying the euthanasia law must verify that "the required palliative care has indeed been offered to the patient" (Ruling 19/2023/6.D.c.iii).

[48] Rulings C-239/1997/II.D and C-233/14/IV.4.1. Following the same line of reasoning, the Court reiterates that legalising medically assisted death does not diminish the responsibility of public authorities to develop and implement active suicide prevention policies (Ruling C-164/2002/194).

[49] "[…] the right to a dignified death encompasses not only the medical act of euthanasia, but also the timely and efficient processing of requests submitted by patients seeking to exercise this right. Processing the request does not necessarily entail performing the procedure if the requirements are not met. However, from the moment the patient, or their representatives in this case, express their intention to exercise this right, serious, comprehensive and expeditious attention must be given to the request", Ruling T-544/17/52. In this sense, see the aforementioned Resolution 971/2021.

[50] Already in Ruling C-182/2016, more recently reiterated, in relation to intellectual disability, by Ruling T-48/2023.

[51] With regard to intellectual disability, the Court adopts the doctrine of the Interamerican Court of Human Rights in *Ximenes Lopes v. Brazil* (2006), §129: "[...] mental disability should not be understood as an inability to make decisions, and the presumption that individuals are capable of expressing their will should apply. This presumption must be respected by medical personnel and authorities".

through what the Court initially called "substitute consent" (consent can be substituted by a third party)[52] and now refers to as "supports for interpreting the person's wishes" ("apoyos interpretativos de la voluntad").[53]

Despite the extreme delicacy of the matter, the Court's doctrine lacks the necessary clarity and precision and presents contradictions.[54] This is probably partly a consequence of its desire to ensure the effective universality of the "right to a dignified death". Despite its somewhat chaotic argumentation, I believe it is possible to distinguish in the Court's doctrine a gradation of increasingly problematic cases of assisted death based on the presence or absence of capacity (regardless of age or disability *status*) and the nature of the latter.

Firstly, situations in which those who wish to exercise their fundamental "right to a dignified death", either adults or minors,[55] demonstrate sufficient "maturity" and "soundness of mind". In other words, and

[52] Ruling C-233/2021/131, quoting Dworkin. The possibility of "substitute consent" was first recognised in Rulings T-970/14 and T-721/17. According to the Court, "On the other hand, consent may also be substituted. This form of consent occurs when the person suffering from a terminal illness is factually unable to give their consent. In such cases, and in order to avoid prolonging their suffering, the family may substitute their consent", Ruling T-970/14/7.2.9. In fact, the Court urged the Ministry of Health and Social Protection to amend its Resolution 1216/2015, which was in force at the time and which only permitted the exercise of the right in cases of incapacity *via* a living will, "thereby rendering the right null and void". The same applies to the current Resolution 971/2021 [see Rulings C-233/2021 and T-438/2025, where the Court has stated that, though the desirable scenario is the existence of a living will, "Assuming that this is the only way to access the right to a dignified death, leaves out countless situations in which people have decision-making capacity" (Ruling T-438/2025/145)]. "Substitute consent" already raised many dilemmas, for example, the possibility of encouraging requests influenced by the challenging experience of caring for a sick person (if not for other reasons). This risk is palpable, for example, in Ruling T-721/17, where references to the sick minor's condition are intermingled with appeals to the "ordeal" experienced by her family, particularly her mother. In fact, the Court has recently emphasised that the absence of conflicts of interest, including those arising from personal suffering or feelings for the patient, must be verified (Ruling T-438/2025/152 and 158).

[53] The reason is that, in the Court's opinion, there is in fact no substitution of consent but rather the expression of the patient's will by a third party and revealed either through a living will or through their statements, expressed preferences and values, etc. (Ruling T-438/2025/115 and 116).

[54] For example, the constant reiteration that compliance with the (rest of the) requirements must be more rigorous in the cases of "substitute consent"/"supports for interpreting the person's wishes" is, I believe, an expression of the Court's awareness of the problems posed by its own doctrine and it is contradictory in itself. In this sense, and for example, either the clinical requirements that give access to assisted death are complied with or not, but there are no, let us say, "different degrees of compliance" in this regard. In Tomás-Valiente's opinion, in the case of minors "the reasoning of the Court is both simple and deceptive", C. TOMÁS-VALIENTE, *La evolución del derecho al suicidio asistido y la eutanasia en la jurisprudencia constitucional colombiana: otra muestra de una discutible utilización de la dignidad*, in *Revista Española de Derecho Constitucional*, 116, 2019, 315; the author provides a highly critical analysis of the Court's euthanasia doctrine examining the gradual shift in its reasoning towards what she calls the "suffering factor" and, in her view, the resulting "chaotic" situation.

[55] The Court has paid special attention to the case of minors, affirming for the first time that they too enjoy the "right to a dignified death" in Ruling T-544/17. In its opinion, the opposite would violate the principles of equality and the best interests of the child, as well as the dignity of minors and the prohibition of "cruel and inhuman treatment" (Ruling T-544/17/37). Aware of the sensitive nature of these situations, the Constitutional Court did highlight particularities that would apply in these cases, especially with regard to consent. Rulings T-544/17 and T-721/17 established the guidelines to which the legal regime in this area must conform. Essentially, that "the will of the minor must be given precedence" based on "their psychological, emotional and cognitive development as assessed by experts"; that "where appropriate, the consent of both parents is mandatory"; that if the minor is under guardianship, whether by the State or by persons other than the parents, "the assessment of substitute consent must be

according to the health care professionals' opinion, they have the capacity to make a completely free and responsible decision.

Secondly, scenarios involving persons lacking that capacity.

In this context, we must first distinguish those who are currently in a situation of *de facto* incapacity but who once enjoyed capacity and (formally) expressed their will to exercise their fundamental "right to a dignified death". For example, and in light of the Court's case law and the current Resolutions of the Ministry of Health and Social Protection, this would include adults who signed an advance directive,[56] as well as adults and mature minors who initially requested to exercise the right, but are now unable to reiterate that request, in which case the intervention of a third party would be required.[57]

Secondly, the case of someone who is now in a situation of *de facto* incapacity and has not (formally) expressed their will to exercise the right, but who was previously capable and therefore developed a personal identity and a life project whose values they were eventually able to express and share. In these situations, the Court recognised from the outset the possibility that the person's loved ones, "who are best acquainted with their critical interests", could consent on their behalf provided that it was possible to "determine what the person's position would be concerning dying with dignity";[58] or, in other words, to "validly express the preferences that the person would express if they were conscious enough to do so".[59] This "criterion of best interpretation and preferences" has the purpose of safeguarding the

strict"; and that, in the event of incapacity or insufficient emotional development, consent shall be given by a representative and "the interdisciplinary committee must be more rigorous in addressing compliance with the requirements and analysing the situation". According to these criteria, the Ministry of Health and Social Protection approved Resolution 825/2018, of 9 March, which regulates the procedure for enforcing the right to a dignified death for children and adolescents, whose Chapter III (articles 7 to 16) regulates the "Procedure for ensuring the right to a dignified death through euthanasia for adolescents and, exceptionally, children aged between 6 and 12 years". The Resolution excludes euthanasia in the following cases (article 3): "newborns and infants"; "early childhood"; children aged 6 to 12, unless they have "exceptional neurocognitive and psychological development that allows them to make a free, voluntary, informed, and unequivocal decision and their understanding of death reaches the level expected for a child over 12 years"; "children and adolescents with altered states of consciousness"; "children and adolescents with intellectual disabilities"; and "children and adolescents with diagnosed psychiatric disorders that impair their ability to understand, reason, and make a reflective decision". Therefore, subject to the circumstances of the specific case, euthanasia is generally available in Colombia to minors between the ages of 12 and 17 and, exceptionally, to those aged 6 to 12. Also as a general rule, up to the age of 14 the consent of the person exercising parental authority/guardianship will also be required. However, in the case of minors aged 14 to 17, only information will be provided.

[56] Like in other legal systems such as Spain (article 5.2 of the Organic Law on Euthanasia), the Court has recognised that the right can be exercised through an advance directive, provided the clinical requirements are met (Ruling C-233/2021/312). The Court mistakenly characterised this situation as "substitute consent". Strictly speaking, however, this is not a case of substitution because the person's will does exist, even if it was expressed at an earlier time *via* a living will. According to the initial Resolution 1216/2015 and the current Resolution 971/2021, the existence of a living will is the only scenario in which formerly capable adults now in a situation of *de facto* incapacity can exercise their fundamental right to a dignified death. As mentioned above, this is despite the Court's exhortations, since Ruling T-721/2017, to incorporate the possibility of third party intervention.

[57] According to Article 11 of the aforementioned Resolution 825/2018, living wills are not provided for in the case of competent minors. The only option is for the person with parental responsibility to reiterate the will previously expressed by the competent minor who is now in a situation of *de facto* incapacity.

[58] Ruling C-233/2021/312, following the doctrine first established in Ruling T-970/2014/7.9.

[59] Ruling T-48/2023/86.

autonomy that existed at the time, now absent, and which, in fact, led to the expression of one's personal identity and life project.[60] In this sense, the criterion is based on factors such as the "preferences, values, attitudes, arguments and previous facts, including verbal and non-verbal forms of communication made by the sick person and never on a particular conception of the conditions under which life should be lived [and] is worth living".[61]

Thirdly, we would face different scenarios involving persons with disabilities, the approach to which has been altered by the aforementioned paradigm shift in the legal regime governing disability. On the one hand, there are individuals whose disability, including intellectual disability, could be overcome by resorting to "appropriate support measures".[62] And, finally, those situations that overwhelm any support measure "due to health or cognitive development", and where the intervention of third parties is excluded because there is no prior autonomy to safeguard.[63] However, when addressing this scenario, the Court incurs in clear contradictions which, precisely, open the door to the very dangers it seeks to avert by excluding third party intervention and which were mentioned above. Two examples illustrate this. First, the possibility that the decision to admit (the formerly known) "substitute consent" in these cases may finally depend on the person's clinical condition: either because their death is already inevitable (a criterion that unequivocally refers us back to the 1997 doctrine)[64] or because medical science is unable to alleviate their suffering.[65] And secondly, the most obvious one: after seemingly excluding third party

[60] The criterion only makes sense in the described situations, despite what might be inferred from the Court's reasoning, which would lead us to the impossible task of trying to determine what someone who never had autonomy due to their (profound) intellectual disability, had wanted.

[61] Ruling T-57/2025/188. According to the Court's case law, these scenarios of "substitute consent" or "support for interpreting the person's wishes" can be categorised according to how much we know about the patient's will, as follows: (1) There is a living will. (2) There is no living will: (a) but the patient clearly expressed their views on dignified death to their loved ones; (b) although the patient did not express their views on dignified death, they expressed their preferences and vital interests; (c) there is no information, so it is impossible to know the person's wishes (Ruling T-438/2025/Table 2). The Court has established that when a third party requests euthanasia, the Interdisciplinary Committees must verify that the person or persons making the request have a trusting relationship with the patient and sufficient personal knowledge of them to be able to interpret their wishes. The Committess must also immediately request the information on which their interpretation is based, and ensure that all possible methods of ascertaining the patient's wishes have been exhausted. The committees' decision may be appealed to the Constitutional Court, which will verify these points (*Ibid.* 149 ff.).

[62] *Ivi*, 115: "[…] when the person is unable to express their will, support should be provided to implement the decision that best reflects their life, context, and social and family environment. These factors help to interpret their wishes [...] The level of support required in these cases [intellectual disability] may be much greater, but support can never replace the person's wishes or force them to make a decision they are unsure about".

[63] *Ibidem*: "[…] In cases such as these, substitute consent should not be considered applicable, as there is no previously expressed will or preference that justifies a subsequent decision by a third party with the aim of safeguarding the person's autonomy. From this perspective, and given that euthanasia requires qualified consent, no third party should be authorised to request it on behalf of a disabled minor in situations where there is no expression of will or preference, as this would pose too high a risk to disabled minors, a protected group with a history of violence and eugenics against them under ableist stereotypes".

[64] *Ivi*, 171.

[65] Although the Court refuses to answer, because it is hypothetical, the question of "How should one proceed if the pain cannot be satisfactorily alleviated by the medical treatments ordered in this ruling, according to the EPS diagnosis?", it opens the door to the possibility of requesting a new constitutional ruling if necessary, *ivi*, 200.

consent, the Court reopens its possibility in cases involving profoundly disabled persons on the basis of the principle of beneficence, though ultimately excluding it again.[66]

4. (2021 and 2022) The Power of the Consistency Argument and the Return to the Constitutionality of the Criminal Code: The Extension of Assisted Dying Cases a Quarter of a Century After 1997

After 24 years restricting access to euthanasia only to terminally ill patients, the elimination of this requirement and, therefore, the broadening of the spectrum of its potential beneficiaries, had the exact same origin as the recognition of the "right to a dignified death": questioning, again, the constitutionality of the criminalisation of "mercy killing".[67] This circumstance forced the Court to make a double argumentative effort in the ruling that returned to this issue: Ruling C-233/2021.[68] Firstly, to reopen a matter that was apparently closed in 1997 and which it justified using the "living instrument" doctrine.[69] And, secondly, and as a consequence, to explain how circumstances had changed since 1997 rendering the terminality requirement, which seemed necessary 24 years ago, impossible to maintain.

In this context, the reasons used by the Court to reformulate its doctrine are the same as in Ruling C-239/97, but now, apparently, with a different scope. Thus, the notion of human dignity in its double dimension of autonomy and living conditions once again plays a central role.[70] Ultimately, and from this point of view, the Court partially closes two problematic shifts in its initial doctrine, albeit more than two decades later.

Indeed, and as described *supra*, the 1997 thesis was based on broad arguments about personal autonomy, particularly regarding the most intimate and existential personal decisions, which, however, culminated in the recognition of a right whose beneficiaries were defined by a very restrictive clinical circumstance: terminal illness.[71] This was a problematic conclusion in the context of the ruling's reasoning and,

[66] In paragraphs 190 *et seq*. of the aforementioned Ruling T-57/2025, the Court considers whether the mother of the sick child can "determine what is best for him and request euthanasia" based on the principle of beneficence. Although the answer is negative ("reasons of compassion and solidarity are not sufficient to invalidate that conclusion"), the argument is flawed by the aforementioned references to the child's clinical situation, namely the potential inevitability of death and the possibility of alleviating his suffering. Nevertheless, the Court recognises the validity of third party intervention to request palliative care.

[67] As previously mentioned, currently article 106 of the Colombian Criminal Code, whose wording is almost identical to that of the former Article 326, which was examined in 1997.

[68] The Court had previously ruled on appeals filed by non-terminal patients. For example, in Ruling T-721/2017, emphasis was placed on limiting therapeutic efforts and on palliative care, given the patient's clinical condition. Or, in Ruling T-060/2020, access to euthanasia was rejected because the appellant's clinical condition was not terminal.

[69] "[…] The Constitution is a living document, whose meaning adapts to social, economic, political and cultural changes [...] In this sense, although always on an exceptional basis, a change in the meaning of the Constitution, whether derived from constitutional interpretation or from the transformation of society, enables the Court to issue a new ruling on a previously decided issue", Ruling C-233/2021/167 and 168.

[70] In the Court's words, it must be established "whether Article 106 of the Criminal Code, which provides for the crime of mercy killing, disregards human dignity in its dimensions of living as one wishes or respect for human autonomy and living well, or guaranteeing the physical and moral integrity of human beings [living without humiliation]", *ivi*, 120; see also 203.

[71] The Court acknowledges in para. 358 that "it appears to be standard practice that terminal illness or limited life expectancy is defined as having less than six months to live. Law 1733 of 2014 and the resolutions of the Ministry of

moreover, not only was it not supported by the wording of the criminal offence whose constitutionality was under examination, which referred to those suffering from "bodily injury" or "serious or [currently and] incurable illness", but also called into question whether self-determination was the primary basis of the fundamental "right to a dignified death". In this sense, it should be remembered that in 1997 the exercise of that right in the form of euthanasia was not an expression of choosing between "dying and continuing to live", but of how and when exactly to die when death was inevitable and imminent and, in addition, the person was experiencing conditions of suffering contrary to their personal identity. In other words, when they were already dying in great suffering.

Perhaps for this reason, the Court firstly stresses that, despite appearances, the core of its doctrine since 1997 has been autonomy and personal convictions, albeit in the context of illness, and the interpretation of the right to life as a condition for an autonomous and fulfilling life project in accordance with one's personal identity. In this context, the "right to a dignified death" would be a means of achieving personal autonomy.[72] Secondly, the Court recalls that the wording of the criminal offence had never referred to suffering from a terminal illness.[73]

Three arguments lead inevitably to the extension of euthanasia to not only the terminally ill, but also to those in intense suffering due to a serious and incurable illness. First, respect for dignity as autonomy, particularly regarding the most transcendental decisions over one's own existence and which proscribes the imposition of continuing living in conditions that are considered undignified. Second, a pluralistic constitution prohibits the imposition of religious or metaphysical conceptions about the meaning of life. And, third, the necessary distinction between mere existence and the personal conception of dignified existence.[74] In conclusion, it would be disproportionate to limit euthanasia to the terminally ill because it would restrict personal autonomy and, furthermore, it would amount to "cruel, inhuman and degrading treatment" due to the imposition of "undignified and humiliating" living conditions. At this point, the Court also appeals to (in)consistency: if it is unconstitutional to force someone with a terminal illness to endure

---

Health and Social Protection establish different timeframes for this definition, although the latter two tend to set a timeframe of six months. In this regard, Resolution 825 of 2018 refers to "a life expectancy of less than six months", while Resolution 971 of 2021 refers to "life expectancy of less than six months". See also article 4.5.1.1 f) of the aforementioned Resolution 229/2020. However, in Ruling T-438/2025/Footnote 55, the Court asserts that "there is no consensus on this point in case law".

[72] "[…] It would be wrong to argue that the decision adopted in Ruling C-239/1997 is essentially based on mitigating the duty to protect life. On the contrary, it is founded on respect for the human person and the way in which they value their living conditions as either dignified or undignified and humiliating due to the suffering they endure as a result of a particularly serious health condition", Ruling C-233/2021/397. Furthermore, and as it will be examined *infra*, the Court believes that personal autonomy is realised more intensely in the case of assisted suicide than in the case of euthanasia, because the individual controls the process until the very last moment (Ruling C-164/2022/178, 179 and 206). As Franco explains, "[…] Understanding its relationship with other rights, such as the right to life and health, and grasping the various dimensions that constitute it, will lead us to conclude that, rather than being directed towards the end of existence, it is a commitment to the preservation of life". This is demonstrated by "what we must understand by 'life' in accordance with the case law of the Constitutional Court" and what are "the dimensions or faculties that constitute the fundamental right to a dignified death", D.E. FRANCO, *El derecho fundamental a morir dignamente en Colombia: un análisis desde sus razones filosófico-jurídicas*, in *Revista CES Derecho*, 15, 3, 2024, 130.

[73] Ruling C-233/2021/401.

[74] However, it should be noted that some of the statements made by the Court in its case law appear to refer to "objective" conditions of "indignity" resulting from certain illnesses. For example, see Ruling T-970/14/5.3.

undignified living conditions for a short period of time, then it is even more unconstitutional to do so to someone with a serious, incurable illness who will therefore suffer for much longer.[75]

Due to the extension of the grounds for euthanasia, and probably also due to the need to continue defining the contours of the "right to a dignified death" in the face of legislative silence, the ruling addresses two other issues with very uneven argumentative density.

On the one hand, the Court examines in particular depth the definition of intense pain and suffering which, along with enduring a serious and incurable illness, gives now access to euthanasia.[76] The problem is essentially how to reconcile the highly personal experience of suffering with some objective criteria based on medical knowledge in order to control the access to euthanasia. In this sense, the diagnosis of a serious and incurable illness would act as an objective counterweight to the primacy of subjective experience with regard to pain and suffering.[77] Conversely, the Court dismisses the sensitive issue of access to euthanasia for those with a psychiatric illness in just a few lines, stating that their "right to a dignified death" will depend on the evaluation of their condition by healthcare professionals and, ultimately, the courts.[78]

If twenty-four years after Ruling C-239/97, cases granting access to euthanasia are expanded for the first time, a quarter of a century later, Ruling C-164/2022 finally put an end to an obvious inconsistency: it made no sense that euthanasia had been decriminalised in Colombia for 25 years, while medically assisted suicide remained illegal. Thus, as in 2021, 2022 saw a further extension of the right to a dignified death, albeit from a different perspective. While in 2021 the focus was on cases granting access to euthanasia, this time it was on the various dimensions of the "right to a dignified death", which now will also include medically assisted suicide.

In addition to the powerful and obvious argument of consistency (the Court refers to "proportionality" and "inconsistency"),[79] the unconstitutionality of the criminal penalty for medically assisted suicide when the conditions giving access to euthanasia are met is essentially based on two other pillars: the

[75] "However, insofar as a person is not obliged to endure such suffering and inhuman treatment that they deem to be degrading and alien to their concept of a dignified life when they have received a prognosis of imminent death (meaning that their suffering will, in principle, be short-lived), it is unclear why a person suffering from a serious and incurable illness, with an uncertain life expectancy, should have to endure such conditions", Ruling C-233/2021/414. The Court adds other arguments such as the principle of minimum intervention in criminal law and the deterrent effect that the current regulatory framework would have on the "ethical and altruistic practice" of the healthcare professions.

[76] This is an issue to which the Portuguese Constitutional Court also devotes considerable space in its first ruling on the first attempt to regulate medically assisted death in Portugal, Ruling 123/2021.

[77] According to the Court, this would rule out the possibility of euthanasia being granted to "a person who simply claims to be in pain without any reasonable evidence from health care professionals to support that claim", Ruling C-233/2021/434.

[78] "It is not for the Constitutional Court to establish in which specific cases the suffering derived from mental illnesses may justify access to a dignified death. This possibility will be subject to a case-by-case analysis carried out in principle by the Health System and by judges as a last resort", *ivi*, 433.

[79] Indeed, it does not seem logical that, under equal conditions, the criminal penalty for medically assisted suicide should be maintained, yet euthanasia should not be criminalised. This is particularly obvious given that, according to the Court, medically assisted suicide is considered a greater expression of autonomy and less reprehensible than euthanasia.

constitutional guarantee of personal autonomy and the constitutional principle of social solidarity, in this case projected onto medical professionals.

Leaving aside the fact that, with regard to personal autonomy, we face again the tension between general statements and conclusions limited to a specific clinical condition ("physical injury or serious and incurable illness" causing "intense suffering") and a specific context (medical care), the truth is that the ruling intensifies the projection of self-determination in the case of medically assisted suicide. Firstly, and in line with its previous rulings, it reiterates that medically assisted suicide not only does not violate the right to life, but, on the contrary, is another element that serves to fulfil it. The reason is that, as already mentioned, constitutionally protected life is not mere biological existence, but living in conditions that make possible an autonomous and fulfilling life in accordance with one's personal identity.[80] Furthermore, and secondly, the Court considers medically assisted suicide to be a higher expression of personal autonomy than euthanasia, based on the simple (and problematic) argument that it is the person who takes their own life, thus maintaining control over the process until the very end.[81]

Finally, recourse to the constitutional principle of social solidarity sheds more light on why the "right to a dignified death" has only been recognised in a medicalised context since 1997. In this sense, the duty of everyone to "contribute to the realisation of the rights of others" directly applies to medical professionals in assisted death, given their "social function" and their position as those best placed to provide assistance. In other words, health care professionals' involvement in medically assisted suicide (and, logically, also in euthanasia) would fulfil that constitutional duty by enabling self-determination for those who choose to die and ending their suffering.[82] This would explain the medicalised nature of the fundamental "right to a dignified death". Firstly, in terms of the correct implementation of personal self-determination and the timely verification of the requirements for assisted death: only medical professionals have the knowledge to identify the situation of the patient and provide them with all the necessary information to make a free and responsible decision. Secondly, because only the intervention of these professionals guarantees a "good death".[83]

---

[80] Ruling C-164/2022/145.

[81] "[…] in the case of medically assisted suicide, the realisation of autonomy and human dignity is even greater, since it is the patient who self-administers the prescribed medication to achieve the desired outcome and maintains control over the process of their own death. Those who opt for medically assisted suicide instead of euthanasia are simply claiming the agency to end their suffering, as they prefer not to delegate such an important action to a third party", *ivi*, 178. See also 179 and 206. The problematic nature of this argument is exacerbated, albeit from a different point of view, when it appeals to advance directives: "In fact, in the case of euthanasia, it is possible to sign an Advance Directive (AD). This allows the patient's wishes to be known in cases where they cannot be expressed. However, given the nature of medically assisted suicide, the patient's wishes must remain intact until the very last moment", *ivi*, 179.

[82] *Ivi* particularly 184, 187 and 188. However, in line with other rulings on reconciling patients' and doctors' rights (see Ruling T-970/14/7.2.11, cited above), the constitutional mandate of solidarity would not require anyone to act contrary to their conscience. Instead, it would prohibit anyone with the altruistic disposition to help patients from doing so, particularly through criminal sanctions (*Ivi*, 189 and 207).

[83] "It is not enough for someone to help another person to die; they must do so in the most humane way possible [...] using technical knowledge to ensure that the patient retains their dignity until the very end. Doctors have the pharmacological and physiopathological knowledge that allows them to provide the best possible support [...] the doctor is best placed to provide the patient with all the necessary information, enabling them to exercise their autonomy and decide on the procedure they wish to undergo", *ivi,* 152, 153 and 154.

5. Final Considerations

The jurisprudential journey of the Colombian Constitutional Court on the issue of medically assisted death since 1997 is highly illustrative of the main dilemmas faced in its regulation, particularly when it is the result of a constitutional court decision, and in interpreting its necessary constitutional foundations.

Colombia is undoubtedly a paradigmatic case in terms of the problems and limitations raised by the regulation of medically assisted death as a result of a constitutional court ruling. This is particularly evident when, as in this case, the constitutional court's demands are repeatedly ignored by the legislative branch,[84] even though the latest figures show that there is majority support for assisted death[85]. This situation puts extreme pressure on, if not clearly overwhelms, the position and role of the constitutional judge. In this regard, it is important to note that constitutional courts themselves, including the Colombian Constitutional Court, have repeatedly emphasised that the appropriate place to address the questions and dilemmas raised by the regulation of medically assisted death is the democratic Parliament.[86]

All of this has placed Colombia's Constitutional Court in a difficult position which, in addition to its activism, has led it to make decisions, sometimes very detailed ones, about how medically assisted death has to be regulated. Decisions that, under normal circumstances, would have been the result of the democratic and representative processes characteristic of every constitutional democracy[87]. It is true, however,

[84] "The effectiveness of exhortative rulings depends on the legislature's interest in, and political commitment to, the matter being regulated, as the Constitutional Court has no legal mechanism to enforce such rulings." In this case, "Parliament has shown neither commitment nor political will to comply with them", J. RESTREPO, S. AICARDO, *Derecho fundamental a una muerte digna en Colombia. Una corrección jurisprudencial a la omisión legislativa*, in *Revista Derecho del Estado*, 59, 2024, 57 and 59.

[85] The results of the "Encuesta Polimétrica" (Cifras y Conceptos, September 2021) show that only 19% of the Colombian population want euthanasia to be completely banned, while 38% are in favour of full legalisation and 37% remain neutral on the issue. According to the "Colombia Opina" survey conducted by Invamer in June 2022, 70.1% of Colombians support euthanasia for those experiencing physical and mental suffering resulting from injuries or incurable illnesses (Colombia Opina No. 13, June 2022), see L. CORREA-MONTOYA, C. JARAMILLO, *De muerte lenta3. Panorama actual de las cifras y barreras del derecho a morir dignamente en Colombia*, Bogotá, 2025.

[86] In recent years, we have seen rulings whose effectiveness has been suspended for a period of time to allow the legislature to address the legal problems that would arise from the immediate declaration of the blanket prohibition of assisted death as unconstitutional [Canadian Supreme Court, *Carter v. Canada (Attorney General)* (2015) SCC 4]. There have also been decisions that, in view of this situation, have postponed the ruling and set a new date to discuss the constitutional issues raised as the expression of a "loyal and dialoguing institutional collaboration" with the Parliament [Italian Constitutional Court, Ruling 207/2018 (*Capato*)]. Furthermore, there have been rulings that have openly refused to decide on this sensitive matter in favour of Parliament, as it is better equipped to address the issue as a representative body [Supreme Court of the United Kingdom, *R (Nicklinson and another) v. Secretary of State for Justice; R (AM) v. Attorney General*, UKSC 38 (2014); and *R (Conway) v. Secretary of State for Justice* (27 November 2018)]. Some have even concluded that the absolute prohibition of assisted death is constitutional, while, at the same time, they have signalled that the current criminal framework could be reconsidered in exceptional circumstances [Supreme Court of Ireland, *Fleming v. Ireland and Others*, 2013 IESC 19 (2013)].

[87] In Landau's opinion, the most effective answer the Colombian Constitutional Court has found to respond to Colombian institutional problems, including "legislative abdication", "has been legislative substitution. Here, the Court, at least at some times and on some issues, steps in and performs core legislative functions. In other words, the Court refuses to recognize a clear line between judicial and legislative functions. While this kind of role would be improper in a country with a well-functioning legislature, I argue that it is appropriate in Colombia […] The Colombian Constitutional Court's striking institutional popularity relative to other political institutions suggests that it has more democratic legitimacy than most judicial bodies. The public sees the Court, rather than the legislature, as the best

that legislative inaction has been partially mitigated by the executive branch, specifically by the Ministry of Health and Social Protection through various resolutions that are the result of the numerous occasions the Court has addressed it since Ruling T-970/2014.[88] However, there are clear discrepancies between the Constitutional Court's doctrine and the Ministry of Health and Social Protection's regulation of assisted death, which, as the court has reiterated, must comply with the former.[89]

In this regard, and from another point of view, the examined case law series also shows that once a legal system has decided to regulate (medically) assisted death, and especially if it initially does so with particularly restrictive criteria, time gives rise to new scenarios that, not necessarily because they are unknown, progressively test the limits of that regulation. This reality is not a reflection of the clichéd "slippery slope" argument, but rather the result of the inevitable and logical combination of consistency and socio-cultural changes. For example, and beyond the difficult-to-justify different treatment given for 25 years to euthanasia and medically assisted suicide: not limiting medically assisted death to those suffering from a terminal illness or the question of making it accessible to minors or those suffering from a psychiatric illness.

Finally, as in other constitutional jurisdictions, the doctrine of the Colombian Constitutional Court is not immune to certain argumentative uncertainties, particularly with regard to the meaning and role of the fundamental right to life and which probably stem from the usual excesses in its interpretation.[90] It is not so much a question of overwhelming the boundaries of the right as a result of its enriched reading from

---

embodiment of the transformative project of the 1991 constitution […] the judiciary is willing to step in to re-establish the constitutional vision when the other branches fail to act or act improperly", D. LANDAU, *Political Institutions and Judicial Role in Comparative Constitutional Law*, in *Harvard International Law Review*, 51, 343, 344 and 347. On the Court's "activism" see also, among others, C. RODRÍGUEZ, D. RODRÍGUEZ, *Juicio a la exclusión El impacto de los tribunales sobre los derechos sociales en el Sur Global*, Buenos Aires, 2015 and J. MEJÍA, R. PÉREZ, *Activismo judicial y su efecto difuminador en la división y equilibrio de poderes*, in *Justicia*, 27, 2015.

[88] As the Court itself has recognised, the legislature's silence has been partially remedied by the executive branch: "[…] although the Court maintains its initial position on the need for legislative intervention, it acknowledges that coordination between the Constitutional Court and the administration is necessary for the services to be implemented, even in the absence of such regulation", Ruling C-233/2021/329. In this sense, it has been pointed out that in the case of "those rights whose exercise would require extensive technical regulation, such as voluntary termination of pregnancy and euthanasia [...] administrative regulation could be the most effective way to guarantee [them]", J.P. SARMIENTO, *Control constitucional y oportunidad política, entre las sentencias exhortativas y omisiones legislativas desde la experiencia colombiana*, in *Estudios Constitucionales*, 1, 2023, 136.

[89] See Rulings C-233/2021 and T-438/2025. However, throughout its case law, the court has not only addressed the challenges regarding access to assisted dying posed by the lack of regulation, but also those raised by the administration and healthcare providers, among others. In this context, and in respect of the number of euthanasia procedures carried out in Colombia, it should be noted that there were no official figures available until 2015, and that it is only since the end of 2021 that information has also been available on the number of requests submitted, the activation of the Interdisciplinary Committees, and the time elapsed between the request for euthanasia and the Committee's decision. Between 2015 and 2024, a total of 1,044 cases of euthanasia were carried out in Colombia, distributed as follows by year: 2015: 4; 2016: 7; 2017: 16; 2018: 24; 2019: 43; 2020: 34; 2021: 112; 2022: 181 (461 requests); 2023: 271 (829 requests); and 2024: 352 (1,169 requests). As for euthanasia of minors, only two cases are officially reported: one in 2023 and one in 2024. A detailed examination of the figures, including other factors such as the applicant's gender (relative balance) or the illness suffered (cancer in almost 75% of cases), in L. CORREA-MONTOYA, C. JARAMILLO, *De muerte lenta3. Panorama actual de las cifras y barreras del derecho a morir dignamente en Colombia*, *cit*.

[90] In this regard, it has been usual to draw from the purely factual observation that life is the biological condition that makes it possible to hold all other rights, conclusions that are reflected in its interpretation, granting it a pre-eminent position.

the concept of dignity and the living conditions it imposes (living with dignity),[91] but rather of not overcoming its interpretation as one of the two extremes that are allegedly in conflict in (medically) assisted death: life and autonomy. This fact is striking in general, but even more so in a series of case law that stands out for its constant appeals to personal autonomy and identity.

The fact is that the Constitutional Court of Colombia has never fully freed itself from the traditional conception of the right to life and the resulting conflictual approach to the issue of assisted death. I believe this is evident when we notice that, fundamentally, its argumentation is not about self-determination or defining the public duty to protect life on this basis, but rather about modulating the State's obligation to preserve the inviolability of human life so as not to render it disproportionate in certain (medical) circumstances. Of course, autonomy (personal dignity and identity) plays a crucial role, but note that it always does so in relation to the illness: it is self-determination, yes, but self-determination of a sick person who no longer wants to suffer in a situation that is irreversible and incompatible with their identity.

In this regard, it should be remembered that the fundamental right to a dignified death was born to enable individuals to manage their dying process in a manner most consistent with their personal identity and when they were experiencing unbearable suffering. And, although it might seem that no longer requiring a terminal illness is a paradigm shift, albeit a small one, because it is not anymore a matter of deciding how to die when one is already dying, the truth is that, in reality, what continues to resonate is the argument of disproportionate suffering. Inevitably, therefore, the reasoning always ends up revolving around the circumstances of the person requesting to die: their terminal condition, the severity and incurability of their illness and, above all, their suffering.

It seems no coincidence, then, that the ruling that eradicates the need to suffer from a terminal illness is the one that most thoroughly examines the notion of suffering or recalls that demanding to continue living in such conditions would amount to cruel, inhuman or degrading treatment. Nor is it a coincidence that the principle of social solidarity appeals directly to medical personnel because they have the ability to alleviate suffering. But, then, are we really dealing with a problem of autonomy or a problem of eradicating suffering? Without denying the importance of personal autonomy and identity, is the eradication of suffering not the real driving force behind this doctrine?[92]

[91] Griffin warns about "the ballooning of the content of the right to life", J. GRIFFIN, *On Human Rights*, Oxford, 2008, 212 ff.

[92] Both the Supreme Court of Quebec and the Constitutional Court of Ecuador have explicitly recognised that avoiding suffering is ultimately the most powerful reason for legalising assisted death. As the Supreme Court of Quebec asserts "The rationale is to allow a person suffering from a grievous and irremediable medical condition, who no longer has any hope of improvement, to end his or her suffering and to avoid living until the final agonizing breaths have been drawn, should the person so desire", *Truchon v. Attorney General of Canada* (2019) QCCS 3792 § 497. And the Ecuadorian Constitutional Court explains that, "actually, the question is whether a person should be forced to endure suffering until death", Ruling 67-23-IN/24/89.