THE PATIENT'S RIGHT TO SELF-DETERMINATION AS A FOUNDATIONAL HUMAN RIGHT IN HEALTHCARE

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Abstract: The patient's right to self-determination represents a break from medical paternalism in healthcare law. Although not always explicitly codified, this study argues that the right is constitutionally guaranteed through a holistic reading of dignity, autonomy, and bodily integrity. Framed as a hybrid constitutional right, it imposes both negative and positive obligations on the state. As a 'precondition right', it underpins all other healthcare entitlements. Although widely recognized in theory, restrictive practices—such as bans on abortion, euthanasia, and advance directives—show that this acceptance has not been consistently realized, underscoring the need to secure it as an implicit constitutional right.

Keywords: Human rights, Constitutional rights, Patient rights, Informed consent, Health law, Patient autonomy, Patient's right to self-determination.

1. INTRODUCTION

The patient's right to self-determination, which forms the foundational framework of patient rights, ensures that individuals, once informed about their treatment, diagnosis, and potential risks, are empowered to direct their own medical care and occupy the central decision-making position. Accordingly, the acceptance of treatment, the choice among alternative therapies, or the complete refusal of treatment is determined by the patient's free will. As a moral and rational agent with life plans, beliefs, and values, the patient is, in principle, the primary authority in decisions concerning their own health. While a physician may be best positioned to assess what is medically optimal, they are not entitled to determine what is subjectively best for the patient. This distinction underscores the need for a framework that safeguards personal interests alongside medical benefits.

Despite not being systematically codified beyond its appearance in Charters of Patient Rights, this right is often discussed in relation to the doctrines of informed consent or euthanasia. However, informed consent functions as a procedural safeguard enabling the exercise of self-determination, while certain forms of euthanasia may be outcomes resulting from its application. This conceptual conflation has obscured the independent normative status of self-determination and led to questions about its true legal character: does the patient's right to self-determination genuinely exist as a distinct legal entitlement?

This study responds affirmatively, advancing two core claims: (1) that the right to self-determination transcends its grounding in patient rights legislation, attaining the

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status of a universal and fundamental human right; and (2) that, by virtue of this normative status, it can be located within constitutional frameworks through a holistic interpretation of fundamental rights and freedoms. In this context, the study further proposes that the patient's right to self-determination should be understood as a precondition right—a foundational entitlement upon which the realization of other healthcare-related rights depends. As such, it functions not only as an individual right but also as a normative prerequisite that shapes the interpretation and implementation of all medical rights and duties. Crucially, this framing highlights that without recognizing self-determination as a precondition, rights such as informed consent, privacy, or even the right to life risk being hollowed out in practice, reduced to procedural safeguards rather than substantive guarantees. In the light of constitutional integrity, this study argues that the importance of self-determination goes beyond written laws and states have to avoid paternalistic or moral limits which might weaken its core. Only then as patient rights can be protected, this is because a patient's right to self-determination is not secondary; rather, it is a basic constitutional principle. Therefore, it is widely accepted that this right is based on basic provisions like human dignity, integrity, and the right to privacy. Yet this consensus conceals important tensions in practice: in many constitutional systems, regulations directly affecting patients' autonomy—such as restrictions on advance directives, or outright bans on euthanasia and abortion—remain heavily limited or prohibited. If autonomy, dignity, and privacy are constitutionally guaranteed, the persistence of such restrictions demonstrates that the patient's right to self-determination has not, in practice, been adequately acknowledged as an implicit right embedded within constitutional integrity, thereby revealing the gap between theoretical consensus and practical implementation. Therefore, the notion of implicit rights reconceives this entitlement not merely as an extension of negative liberties but as a subjective public right that guarantees individuals the ultimate capacity to determine the course of their own lives. Recognizing implicit rights creates a constitutional interpretive space in which self-determination may prevail over restrictive readings of the right to life or appeals to public order. In this sense, abortion, end-of-life choices, and the binding force of advance directives in states of incapacity can all be justified through the constitutional primacy of autonomy. This approach not only strengthens the theoretical status of self-determination as a constitutional right but also provides a framework for addressing contested situations in practice through the lens of constitutional integrity. At the same time, the purpose of this study is not to provide a detailed doctrinal analysis of euthanasia, abortion, or advance directives. These examples serve only to illustrate the constitutional tensions that reveal the need to reinterpret the patient's right to self-determination as an implicit right. The distinctive contribution of this article is not to resolve the specific legal regimes governing these practices, but to demonstrate how they underscore that self-determination must be recognized as an implicit constitutional right—and to show the importance of making this recognition explicit.

Adopting a rights-based approach, this study grounds the legal status of self-determination not in the legal order of any single country, nor through a full-scale comparative analysis, but in a holistic interpretation of contemporary constitutional and human rights principles. The research also employs a qualitative legal methodology, examining self-determination through legal, ethical, and institutional lenses. Central reference is made to international instruments such as the Lisbon and Bali Declarations, the Amsterdam Declaration, the European Charter of Patients' Rights, the European Convention on Human Rights (ECHR) and the case law of the European Court of Human Rights (ECtHR), as well as the Convention on Human Rights and Biomedicine (Oviedo Convention). This framework is further enriched by the Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Rights of the Child (CRC), both of which reshape contemporary understandings of capacity, supported decision-making, and evolving autonomy.

This study aims to show how the right to self-determination is recognized or limited in real court decisions and legal regulations, rather than a theoretical approach. Comparative legal references are used only as illustrative examples. They are particularly from Anglo-Saxon jurisprudence, to illuminate conceptual claims without collapsing into a doctrinal comparative study. In this way, the analysis embeds all findings within a comprehensive literature review, drawing on interdisciplinary academic sources to deepen its theoretical structure.

Accordingly, it aims to explore: (1) the right to self-determination and paternalistic models of care are incompatible; (2) the content and normative scope of the right within medical contexts; (3) the role of informed consent as a safeguarding mechanism; and (4) the legal and constitutional structures through which the right can be affirmed. Ultimately, the study argues that the right to self-determination must be recognized not as a subsidiary principle but as a foundational tool of modern healthcare law and ethics, which is founded in constitutional integrity.

2. The ethical content of the patient's right to self-determination

2.1. The principle of patient autonomy

The patient's right to self-determination derives from the principle of autonomy, which means that patients have to make their own decisions about their health situations freely. It has therefore often been used synonymously with the patient's right to self-determination (Katz, 1986, p. 105; Nordgren and Fridlund, 2001, p. 118). Etymologically, the term derives from the Greek autos (self) and nomos (rule), originally describing the independence of city-states (Breier-Mackie, 2001, p. 512). This historical meaning of self-rule later acquired a normative dimension in medical ethics, where autonomy refers to an individual's capacity to use free will and independent reasoning in decisions about their own health, encompassing both self-governance and self-direction (Cohen-Almagor, 1994, p. 11).

As a principle enabling independent choice, autonomy has significantly influenced the development of informed consent and the patient's right to self-determination (Faundes and Barzelatto, 2006, p. 100). Although autonomy has often been presented in scholarship as finding its practical expression in informed consent and self-determination, courts have approached the matter differently. Judicial practice—particularly in the case law of the ECtHR and U.S. courts—treats informed consent primarily as a safeguard of bodily integrity (and, in the U.S., privacy). In this sense, autonomy and informed consent cannot be collapsed into a single concept: autonomy operates as a normative principle and constitutional value, whereas informed consent functions as a procedural mechanism to protect bodily integrity. For instance, the ECtHR in Glass v. United Kingdom (2004) emphasized that treatment without valid consent violates bodily integrity, while the U.S. Supreme Court in Cruzan (1990) rooted informed consent in privacy. Both courts highlight consent as protection from intrusion, not as a direct expression of autonomy. Yet the effectiveness of informed consent depends on the deeper ethical and constitutional commitment to autonomy; without the normative foundation of self-determination, consent risks becoming just a formality. A sum of patient autonomy and the patient's right to determination underlies the same idea. However, autonomy serves more as a moral and ethical principle, whereas self-determination constitutes a legal norm. In other words, the right self-determination is the legal framework of the autonomy principle (Struhkamp, 2005, p. 105).

2.2. The principle of paternalism

In contrast to patient autonomy, medical paternalism is grounded in the principles of beneficence and non-maleficence (*primum non nocere*) (Drane, 1994, p. 41; Dworkin, 1986, p. 6; Krummradt & Van Reen, 2002, p. 29; Linzer, 1996, p. 19). While beneficence emphasizes the physician's duty to promote welfare, non-maleficence requires refraining from harm (Aydın, 2001, p. 40; McMillan et al., 1987, p. 21). Derived from *pater* (father), paternalism denotes protective authority: physicians, like family heads, act for the patient's good without necessarily considering their input (Alan, 2005, p. 6; Wear, 1998, p. 32).

Thus, physicians may direct care without full disclosure or shared decision-making, justifying this on expertise and good intent (Angelos, 2007, p. 14; Childress, 2001, p. 18; Hayry, 1991, p. 1; Rich, 2001, pp. 11–12). This shows patients as passive or incapable, a perception that risks ethical and legal overreach. Its weakness lies in defining benefit purely in clinical terms, neglecting personal values and lived experience. For example, Jehovah's Witnesses refusing blood transfusions show that what is medically optimal may conflict with personal convictions (Beauchamp & Childress, 2013, p. 270; Sulmasy, 2006, p. 94). True healing requires respect for spiritual and psychological well-being (Kleinman, 1988, p. 139).

Accordingly, ethical care must integrate clinical outcomes with patient self-determination, since only the patient can assess the meaning of suffering and acceptable risks. Physicians may know the optimal treatment clinically, but not what is personally meaningful. Paternalism may be justified only in limited cases—minors, incapacity, or emergencies—but beyond this, it risks subordinating moral agency to clinical judgment. Narrow definitions of 'benefit' reduce autonomy and may even undermine its constitutional value.

Building on this, the study reinterprets the autonomy–paternalism dichotomy not merely as an ethical issue but as a constitutional question of rights. Unlike literature emphasizing objective benefit (Angelos, 2007; Drane, 1994; Linzer, 1996), we argue that benefit must be defined subjectively, aligned with the patient's values and life plans

(Childress, 2001; Dworkin, 1994). Thus, autonomy must be seen not only as a negative liberty but also as a constitutional right imposing positive duties on the state—ensuring accessible information, appropriate communication, and institutional safeguards (Katz, 1986; Klein, 2002; Krummradt & Van Reen, 2002). The transition from paternalism to autonomy is therefore not just an ethical shift but a legal transformation, with autonomy affirmed by courts and embedded in human rights law (BVerfG, 2020; Montgomery v Lanarkshire Health Board, 2015; Tysiąc v. Poland, 2007).

3. The content and scope of the patient's right to self-determination

The patient's right to self-determination is recognized by legal systems to ensure that patients who are capable of making their own decisions can exercise their choices regarding their lives freely and without undue influence. Many other patient rights, such as the right to be informed and the right to privacy and confidentiality, essentially serve this primary right, underscoring its centrality within the framework of patient rights. The purpose of granting these rights is ultimately to empower patients in matters concerning themselves. For instance, if a patient is unable to make decisions regarding their care, the right to be informed becomes largely meaningless (Bagceci, 2023, p. 110).

The choices individuals make in directing their lives stem from their unique values, capacities, and beliefs, which should be regarded as inseparable elements of their personality (Young, 1986, p. 1). Accordingly, patients should determine their treatment choices and the course of their lives. The right to self-determination embodies this principle, extending even to the refusal of treatment considered medically necessary. This control should be recognized as a requirement of the right to life, the preservation of bodily integrity, and the necessity of living in a humane and dignified manner (Bagceci, 2023, p. 111).

The right to self-determination is widely considered as euthanasia, although it is not. Euthanasia means to help or allow a patient to die to ease their pain. And this is only the broader part of the idea of self-determination. It is because the idea of self-determination is to allow patient to respect their choices not only in such dying cases, but in all areas of health care where a decision has to be made (Bagceci, 2023, pp. 111-112).

While the right is often emphasized in the context of terminal illness, its significance is not confined to such circumstances. In Bartling v. Superior Court (1984), the California Court of Appeal recognized that a competent adult has a constitutional right to refuse life-sustaining treatment—even when not terminally ill—and held that neither the patient's religious beliefs nor the hospital's institutional values could override this right. The court further clarified that withdrawal of life support following explicit patient refusal constitutes the natural progression of disease and does not impose liability on the hospital or its staff (Bartling v. Superior Court; Ulrich, 2001, p. 24).

Critics argue that self-determination promotes an illusion of individualism by treating life-and-death decisions as affecting only the patient, overlooking their impact on family and loved ones (Hardwig, 1997, p. 57). However, this interpretation is overstated.

Acknowledging the social dimension of healthcare decisions does not negate the primacy of autonomy; rather, it underscores the need for informed and responsible choices by those who bear the ultimate consequences. While critiques of excessive individualism exist, the right remains applicable within the limits defined by decisional capacity.

Here, the competence to consent becomes crucial, as when a person lacks the capacity to decide or consent, the question arises who will act on their behalf. Therefore, in modern conventions such as CRC and the CRPD no longer accept the notion of total incapacity and Article 5 of the CRS signals 'involving capacities' which means that as the children's ability to make decisions grows with their age, consent must be taken accordingly. Article 12 further protects children to express their views freely in all matters that concern them, considering their level of maturity. Similarly, CRPD supports this approach, and Article 7 requires states to respect evolving capacities of disabled children.

Together, these provisions show that a patient's right to self-determination does not disappear in situations such as minority or disability. Instead, with a person's evolving abilities are supported through mechanisms that protect both their dignity and their participation in decisions that affect them.

As so, national regulations and international instruments also contain explicit provisions on these matters. For instance, Article 5(a) of the Bali Charter requires the consent of a legal representative when the patient is a minor or lacks capacity, while emphasizing that such patients should still be involved in the decision-making process to the extent their condition permits[1]. Similarly, Article 6 of the Oviedo Convention provides that interventions on minors without capacity require authorization by a representative or designated authority, while considering the minor's age, maturity, and mental capacity.

The decision process for those with mental disabilities is decided mostly by guardians or representatives. Article 6(3) of the Oviedo Convention explicitly states that when an adult lacks capacity due to a mental disorder or disease, interventions may only proceed with the authorization of their representative or an authority provided by law. However, the CRPD departs from this model of substitute decision-making. Article 12 enshrines equal recognition before the law and requires States to establish supported decision-making mechanisms, ensuring that persons with disabilities are enabled—rather than replaced—in the exercise of their legal capacity. This shift showed that incapacity is not a reason for exclusion and the patient must be involved in medical decisions as much as possible.

Crucially, decisional capacity must also be reassessed over time, as conditions can improve (Devettere 2000, p. 147). The ECtHR has also highlighted this principle, holding in Winterwerp v. the Netherlands (1979) that 'unsoundness of mind' may justify compulsory detention, but only if it is subject to periodic review (Hoggard, 1989, p. 85).

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[1] The same expression is also found in Article 3, paragraph 5 of the Amsterdam Declaration.

Patients in a coma likewise lack decision-making capacity, raising questions about who decides for them and how far physicians can intervene. While unconscious patients are often grouped with minors and individuals with mental incapacities, a key distinction arises in emergencies. In urgent cases, physicians may act immediately to save life or avert serious harm. Both the Bali Charter (Article 4) and the Oviedo Convention (Article 8) allow interventions in emergencies without prior consent, though representatives must be consulted as soon as possible and presumed consent may apply unless an advance refusal exists (Forrester and Griffiths, 2005, p. 138).

Beyond these situations, there are times when people who are still capable of making decisions want to prepare for the possibility that they might lose that capacity in the future. In such cases, advance directives become essential. These documents allow patients to state in advance what kinds of treatment they would or would not want if they later become unable to decide for themselves. Advance directives are more than practical medical tools—they are expressions of personal autonomy that extend into possible future incapacity. By allowing a person's choices to guide care even when they cannot communicate, they help preserve both dignity and personal identity. When a patient's wishes are unclear, the state has a duty to create fair procedures for tu understand their likely intent, such as consulting family members, reviewing written statements, or relying on known preferences. In this way, advance directives show how the right to self-determination continues to operate even when direct consent is no longer possible, ensuring that medical decisions remain rooted in the patient's own values and choices.

The rules of advance directives in the European Union are different from one country to another, and only 15 member states out of 28 have specific laws concerning advance directives. However, most of them approved Oviedo Convention on Human Rights and Biomedicine.

Countries such as Switzerland, France, Germany, Finland, Denmark, and the Netherlands have adopted specific regulations on advance directives (Nys, 1997, pp. 185-187)[2]. In contrast, countries such as Ireland, Italy, Malta, Poland, and Sweden have neither passed laws nor signed the Convention. However, they usually have binding rules that protect patients' advanced wishes. The notable exceptions are Denmark and France, where the provisions function merely as guidelines for clinical decision-making rather than binding rules, thereby limiting their enforceability in practice (Porcar et al., 2021, pp. 66-70). Spain, while having adopted legislation, still struggles with limited implementation and effectiveness (Herreros et al., 2020, pp. 1-2). This shows that if the right to self-determination were fully recognized in the constitutions as a fundamental right, these gaps between countries would be much less. The idea of autonomy would have been accepted in a greater sense, and advance directives would be treated as an important part of health care, rather than being optional.

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[2] German Civil Code § 1901a details requirements for advance healthcare directives, allowing individuals to determine their consent.

4. INFORMED CONSENT AS A SAFEGUARD FOR THE PATIENT'S RIGHT TO SELF-DETERMINATION

Informed consent is frequently treated as a patient's right due to its intrinsic connection to the principle of autonomy. However, in essence, it serves as a procedural safeguard designed to actualize the patient's right to self-determination. Through informed consent, the patient's bodily integrity, dignity, and autonomy are not only protected but also meaningfully exercised. The core function of the doctrine is to ensure that patients can freely shape their medical future based on accurate and comprehensible information provided by the physician.

Informed consent is also necessary for any medical treatment to be lawful. Otherwise, it will be considered as assault or battery since it will cause the violation of one's bodily integrity. So informed consent protects both sides: it safeguards the patient's intent and protects doctors' legal security. Also, Article 5 of the Oviedo Convention states that without patient consent, medical intervention cannot take place. In other words, informed consent is a real conversation between patient and doctor because only then can patients take an active role in their health issues for real. In this sense, informed consent is a necessary precondition for exercising the right to self-determination (Bagceci, 2023).

Beyond its ethical and legal functions, informed consent also serves regulatory and compensatory roles (Berg et al., 2001, p. 146; Kroft, 1997, p. 464). The regulatory function defines the legal boundaries of the physician's duty to inform and clarifies clinical responsibility. The compensatory function provides grounds for legal redress in cases where insufficient disclosure leads to harm.

Most importantly, this study asserts that informed consent should be situated within the broader constitutional framework. Rather than being seen solely as a clinical instrument, it must be understood as a constitutional safeguard that enforces the right to bodily integrity, dignity, and autonomy. In this way, informed consent transforms autonomy from an ethical ideal into a justiciable public right—anchored in the rule of law and enforceable within systems committed to human dignity.

To obtain valid informed consent, physicians must provide clear and sufficient explanations. The content and threshold for such disclosures may vary across jurisdictions and medical contexts (Kroft, 1997, pp. 465-469). Nonetheless, certain elements are widely accepted as essential: (1) the nature and purpose of the proposed intervention; (2) the qualifications of those performing it; (3) the location and manner of its performance; (4) foreseeable risks and benefits; (5) alternatives and their comparative risks and benefits; (6) the likely consequences of refusal; and (7) significant characteristics of the medications or devices to be used.

5. LEGAL FOUNDATIONS OF THE PATIENT'S RIGHT TO SELF-DETERMINATION

5.1. From the perspective of fundamental rights

The patient's right to self-determination is not explicitly enshrined as a distinct right in constitutions. Indeed, no constitutional framework directly mentions such a right. This right, which emerges from the principle of patient autonomy, has been grounded in rights such as individual liberty (as in the 5th Amendment in the United States) or the right to the free development of personality (as in Article 2(1) of the German Basic Law). Similarly, in Canada, the right to life, liberty, and security of the person under Section 7 of the Canadian Charter of Rights and Freedoms underscores a patient's autonomy in making decisions about their own body and health. The Supreme Court of Canada has clarified in a ruling that the concept of security of the person in this provision encompasses not only physical but also psychological integrity, stating that state interference with an individual's body and health can violate this security (R. v. Morgentaler, 1988). Despite lacking a written constitution, the United Kingdom also safeguards this right through common law principles and statutory regulations, particularly via the concept of consent, as evidenced by significant court decisions. A landmark ruling in this area established the duty of physicians to disclose risks to their patients that a reasonable person in their situation would consider significant, thereby adopting a patient-centered understanding of informed consent (Montgomery v Lanarkshire Health Board).

In Switzerland, the right to life and human dignity are the core basis for patient self-determination (Articles 7 and 10 of the Federal Constitution). They also have other provisions, such as patient's right to informed consent 8 Article 28c of the Swiss civil Code) and right to make advance directives (Patientenverfügung) on their future care (Articles 370 and following of the Swiss Civil Code. Similar principles also appear in many other constitutions. For example, in France, patient autonomy and the right to self-determination are explicitly regulated and legally framed primarily by Article L1111-4 of the Public Health Code (Code de la Santé Publique). This article mandates the obtaining of informed consent and guarantees every individual's right to accept or refuse treatment. On the other hand, regulations such as Article 32 of the Italian Constitution, which recognizes health as a fundamental right, also serve as significant constitutional underpinnings. Indeed, Italy, within this framework and as an extension of this constitutional principle stating that medical treatment is contingent upon consent, has subsequently legally recognized the practice of living wills through a specific law. Similarly, Article 15 of the Spanish Constitution, which addresses the right to physical and moral integrity, serves as a general constitutional principle supporting the right to self-determination (Senado de España, 2025). This has enabled the enactment of detailed regulations on the matter, leading to the adoption of the Patient Autonomy Law 41/2002 within this constitutional framework. These and similar examples demonstrate that even when the patient's right to self-determination is not explicitly stated in constitutions, other articles enable the enactment of various regulations, thereby allowing for the extensive safeguarding of this right. Thus the right to self-determination is not explicitly enshrined in most constitutional texts, yet we argue that it is nonetheless constitutionally guaranteed. This guarantee emerges from a holistic interpretation of fundamental rights such as human dignity, personal autonomy, the right to life, and the right to privacy. So, it becomes evident that these holistic considerations of provisions not only protect the right to self-determination and general freedom of action but also emerge as a subjective public right that guarantees the exercise of the powers it encompasses.

Additionally, in constitutional theory, the right to self-determination has traditionally been classified as a negative liberty, imposing merely a duty of non-interference on the state. However, this study contends that the complexity of modern medical care—marked by information asymmetry, bureaucratic fragmentation, and patients' variable capacity to understand medical risk—requires its redefinition as a hybrid right. In this context, the state bears not only the obligation to refrain from interference but also the positive duty to ensure that patients are adequately informed, empowered, and supported in exercising their autonomy.

For example, in the European Court of Human Rights' (ECtHR) decision in Tysiąc v. Poland (2007), the Court held that although abortion was legally permitted in certain conditions, the absence of effective procedural mechanisms to enable the applicant to enforce her rights violated Article 8 of the ECHR. This decision illustrates how mere non-prohibition is insufficient unless the state ensures real, informed, and timely access to care and legal remedies.

Similarly, in the German Federal Constitutional Court's decision on assisted suicide (BVerfG, 2020 – 2 BvR 2347/15), the Court emphasized that the right to a self-determined death is protected by Article 2(1) of the German Basic Law (GG), and that this protection imposes not only negative duties but also positive obligations to create a legal framework that makes autonomous decision-making practicable. In the same way, the Swiss Federal Supreme Court, in its 2021 decision (6B_1187/2020), reaffirmed that the right to die with dignity—while not absolute—requires the state to establish clear legal and institutional mechanisms through which individuals can exercise autonomous end-of-life decisions. The Court highlighted that such mechanisms must be accessible, comprehensible, and sufficiently safeguarded to prevent arbitrary denial of the right (Tribunal Fédéral Suisse, 2021).

In modern settings the decisions are made in highly tecnical way and this makes patients not to understand treatment options effectively and fully (O'Neill, 2002). So just signing consent forms does not mean patients truly understand and agree to what they read and sign (Beauchamp and Childress, 2013). This leads to many scholar to think that consent processes often limitedly understood by patients due to social, cultural and economic factors and this weakens their autonomy (Berg et al., 2001; Doyal & Gough, 1991). Therefore, positive duties of states must involve clear communication and sensitive practices, especially for vulnerable groups (O'Neill, 2003). So, self-determination is not guaranteed just by being free from any intervention but also by being supported by the state actively (Christman, 2004; O'Neill, 2002). Therefore, it becomes necessary to accept this as a fundamental right within the constitutional order.

These evolving interpretations demonstrate that, even in the absence of explicit textual reference, a patient's right to self-determination can gain constitutional recognition through judicial elaboration and statutory embodiment. In this respect, while most constitutions are silent on the explicit mention of the patient's right to self-determination, this silence can be constitutionally interpreted as a normative gap that must be filled by high-ranking statutory regulations or constitutional court jurisprudence, thereby initiating a bottom-up recognition process.

This bottom-up recognition process also aligns with contemporary constitutional theory, particularly the doctrine of 'implied limitations' of fundamental rights (Cattinari, 2015, pp. 1-6). According to this view, rights are not externally curtailed by vague appeals to public interest or paternalistic protection, but only by the internal necessity of preserving the system of fundamental rights as a coherent whole. Applied to healthcare, this means that the patient's right to self-determination may be limited only where its exercise would directly impair another fundamental right of equal or superior rank. Restrictions based solely on moral, paternalistic, or utilitarian grounds lack constitutional legitimacy.

A parallel reinforcement of this argument emerges from U.S. constitutional jurisprudence, where the Supreme Court has treated Due Process and Equal Protection precedents as selectively interchangeable in implied fundamental rights cases. While theoretically distinct—the former securing substantive liberty, the latter ensuring comparative equality—the Court has, in landmark cases such as Eisenstadt v. Baird (1972), and Roe v. Wade (1973) invoked both strands to articulate a privacy-based autonomy right broad enough to encompass reproductive choices. This shows that protecting autonomy in constitutional law depends on how you interpret it, rather than strictly applying what is solely written. Thus, it is similar to the implied limitations idea because here the main idea is to protect the core meaning of a right rather than to rely on a vague concept such as public interest (Farrell, 2007, pp. 208–212).

From this view, the main argument of this study becomes clear: even if self-determination is not written directly in the constitution, it should still be seen as an implied constitutional right. Then advance directives, reproductive choices, and end-of-life decisions become fundamental parts of personal autonomy rather than being secondary rights, and their limits should only be set in relation to other basic rights, not public order or benefit.

Although many agree that the patient's right to self-determination has a constitutional basis, this statement is often only in words. Because if it were true, then we would not see strict limits on euthanasia in most countries, the near-total ban on abortion likely in Poland and Malta, or weak regulations of advance directives, such as in France and Denmark. So constitutional provisions as a whole do not provide real protection, and ongoing debates prove that this agreement has not yet turned into an actual guarantee. That is why self-determination must be recognized as an implied constitutional right—otherwise, it risks remaining just a promise that can easily be limited by paternalistic laws and practices.

5.1.1. The patient's right to self-determination within the scope of the right to life

The ontological foundation of human rights rests upon life as a biological process; accordingly, the right to life constitutes the primary prerequisite for the enjoyment of all other rights (Bağçeci, 2023; Koyuncuoğlu, 1980, p.13). It is enshrined in the UDHR (Art 3) as: 'Everyone has the right to life, liberty and security of person,' and the ECHR (Art 2) as: 'Everyone's right to life shall be protected by law,' (Art. 2), imposing on states both negative obligations to refrain from arbitrary deprivation of life and positive duties to safeguard it (Tezcan et al., 2004, p. 204).

On the other hand, the right to life, in a broad sense, is a right inherent to individuals solely by virtue of being human, with human dignity at its core. Therefore, the right to life encompasses the protection of an individual's moral existence, including the safeguarding of their self-respect (Bedau, 1968, p. 567). When the right to life is understood as protecting both the material and moral existence of the individual, its material dimension entails the prohibition of killing, the inviolability of bodily integrity, and protection from ill-treatment, while its moral dimension requires humane living conditions. Beyond mere biological survival, living humanely presupposes access to shelter, health, and a clean environment, as well as the ability to shape one's life in accordance with personal values and beliefs (Feinberg, 1978, p. 94). An individual can therefore be said to fully exercise the right to life only when they are able to sustain a healthy existence and ascribe personal meaning to it (Oğuz, 1994, p.41).

A recurring debate concerns the apparent conflict between a patient's right to self-determination and the right to life. For example, should a patient's refusal of a blood transfusion on religious grounds, or a terminally ill patient's request to end suffering at the cost of life, yield to the primacy of life? According to the sanctity-of-life view, the right to life entails an absolute prohibition on being killed (Savcı, 1978, p. 2). It is inseparable from the protection of bodily integrity, which obliges safeguarding individuals not only from third parties and the state but even from themselves (Savcı, 1980, pp. 18-40). On this account, no right may prevail over life, and its existence cannot be interpreted to include a freedom to end one's own life (Mumcu, 1992, p. 124).

In contrast, modern perspectives shaped by individualism emphasize autonomy, arguing that decisions over one's own life, body, and death cannot be restricted. Actions taken under personal sovereignty are not seen as harming any legal value (İnceoğlu, 2006, p. 290). Accordingly, individuals should freely make the choices that define their 'good life,' provided they do not infringe upon others' freedom or cause harm (Manning, 1998, p. 28).

Similarly, another understanding that bases the qualified life view on the right to autonomy proceeds from the premise that there must be an interest for a right to be protected and argues that everyone has a lifestyle they believe to be right and continues their life by making choices in accordance with it (Dworkin, 1991; Dworkin, 1994; Dworkin, 2002, pp. 242-285). Accordingly, if the answer to the question of whether keeping a person in a vegetative state alive protects the patient's interests is negative, then it cannot be said that there remains a reason to protect that life. According to the understanding that focuses on the meaning of life, the word 'life' has two meanings: biological and biographical. Accordingly, the biological meaning is used for a living organism. The biographical meaning, unlike merely being alive, refers to the actual life that is the subject of the right to life. A person's life extends beyond biological existence. Life is the sum of a person's character, plans, hopes, beliefs, disappointments, human relationships, and values. In this sense, life is what the person sees and evaluates it to be. The distinction between biological and biographical life points to the difference between being a living organism and having a life (İnceoğlu, 2006, pp. 83-92; Rachels, 1975; Rachels, 1997, p. 74).

The full exercise of the right to life requires that individuals direct their existence through free will, determine their future, and realize autonomy (Oğuz, 1994, p. 41). In this sense, human dignity is the core source for everyone, even though it varies person to person, which makes life meaningful. Also, the right to have a material and moral life is not only a freedom to act freely but also a guarantee that one can truly exercise freedom (Gören, 1993, p. 74). Since life is a right, not a duty, patients should not be compelled to preserve it against their will and must be free to shape their future (Özkan, 1997, p. 19). Therefore, in addition to national regulations, the patient's right to refuse treatment, which underlies these regulations, has been explicitly protected in patient rights declarations[3].

Balancing the right to life with the patient's right to self-determination means far from the idea that life must always be preserved. The right to life is not only a duty to survive but to live in a way a person desires according to their own values, beliefs, and sense of meaning. Otherwise, life becomes only a biological condition, losing its deeper moral and constitutional value. So, constitutional rights and provisions must reflect the realities of modern medical approaches and patient choices, especially in end-of-life decisions. Accordingly, the right to life when guided by dignity and autonomy already includes the patient's right to self-determination, and even stronger when joined with privacy and bodily integrity, which together make self-determination a true part of constitutional protection.

5.1.2. The patient's right to self-determination within the scope of right to privacy

Private life constitutes an individual's inviolable sphere of existence, within which the person has the right to remain undisturbed and free from external intrusion. It is built upon two core dimensions: privacy and independence. Independence refers to the individual's authority to determine their way of life, personal choices, conduct, and social relations, thereby affirming autonomy as a central component of private life (Kaboğlu, 2002, p. 293). Privacy, in turn, establishes boundaries that shield the individual from unwanted interference or exposure, protecting aspects of existence that are beyond the legitimate curiosity of third parties. This includes both informational and physical dimensions of seclusion. In particular, privacy implies a prohibition against the unsolicited observation, touching, or discussion of intimate areas of the human body, reflecting a broader cultural and legal recognition of personal inviolability (Nişanyan, 2009, p. 516). Keeping medical information confidential is also a basic right protected by national and international law. Sharing such information without consent is a clear violation of patient rights. Indeed, Article 8 of the ECHR expresses this right as, "Everyone has the right to respect for his private and family life, his home and his correspondence." It is stated that an individual's private life must be protected against two situations. The first is protection against public authorities, and the second is protection against third parties. It is emphasized that this protection should not be interpreted as the state leaving the individual alone against public authorities, and that the state has a positive obligation to protect private life. The state

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[3] *Declaration on the Rights of the Patient*. Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981; amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995; revised by the 171st WMA Council Session, Santiago, Chile, October 2005; reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015;

must create the necessary conditions for individuals to defend and protect themselves against interventions into their private lives by public authorities (Tezcan et al., 2004, p. 382; Smartt, 2006, p. 69). Indeed, a case brought before the ECtHR arose from the sexual abuse of a 16-year-old mentally disabled patient. According to Dutch law, the complaint filed by the child's guardian on this matter was not valid because the complaint had to be lodged by the victim. Following its judgment, the Court stated that the decision of the Dutch Court had failed to provide adequate protection for private life and ruled that the Convention was violated (X and Y v. The Netherlands).

Thus, privacy is recognized as a constitutional right in both national and international law. This includes respect for privacy, confidentiality of medical data, and the doctor's duty to maintain secrecy. Patients will not hesitate to act on their decisions only when they believe that their information will remain private. So from this perspective, privacy is not only about keeping information confidential, but also linked to a patient's capacity to make free decisions. Therefore, if a patient's capacity to choose and decide freely is interrupted by violating their medical privacy, then true self-determination can not be guaranteed.

This interdependence has also been affirmed in constitutional jurisprudence. In its decision legalizing abortion, the U.S. Supreme Court recognized that the right to respect for private life protects and enables the exercise of self-determination (Roe v. Wade). In this sense, privacy primarily secures the conditions for making confidential and intimate choices. At the same time, self-determination extends this freedom to all matters concerning the individual's life, whether public or private. Thus, the two rights remain conceptually distinct yet mutually reinforcing, each ensuring that individuals can shape their existence in accordance with their values (Ruiz, 1998, p. 49).

5.1.3. The patient's right to self-determination within the scope of human dignity

Human dignity constitutes the cornerstone of fundamental rights and freedoms. It functions simultaneously as the foundational principle of the constitutional order and as the minimum core content inherent in every right. While individual rights enshrined in constitutions provide specific spheres of protection, their ultimate function is to safeguard dignity, ensuring that any potential violation is addressed within this framework. Thus, dignity is not only the highest constitutional value but also the normative essence through which all fundamental rights derive meaning and coherence (Kaboğlu, 2002, p. 25).

Once human life begins, it is crucial that this life continues in a manner respectful of human dignity. Human dignity means that a person should be treated as a being with their own worth, not as an object or a tool. This can be done when people have rights that enable them to protect their both physical and moral well-being. Thus, an individual can only realize themselves through having personal autonomy. According to Maslow's theory, self-actualization is the highest-level need in the hierarchy that encompasses human needs. For a person to discover these needs, they must satisfy their needs starting from the lowest level and progressing towards the highest. Consequently, an individual's self-actualization is possible if their physiological and bodily needs, and subsequently their safety and social needs (such as being loved and respected, and being appreciated), are met. A person who can meet these needs has achieved self-actualization (Maslow, 1954).

In this sense, the decisive characteristic in terms of humanization is the ability to be master of one's own future and destiny (Eroğul, 1993, p. 13). For example, alongside the rule explicitly stating the inviolability of human dignity (Art. 1/1), the Constitution also includes a similar rule granting everyone the right to freely develop their personality (Art. 2/1). Furthermore, the Federal Constitutional Court has stated in one of its decisions that the value and dignity of a human being who acts as a free member of society and can determine their own future constitutes the focal point of the order established by the Constitution (Klein, 2002, p. 153).

Altough the right to self-determination helps to protect dignity, it can still be violated even when this right appears to be respected. Euthanasia, as an example, should also be seen such a practice that serves to protect human dignity and is grounded in the patient's right to self-determination (Dimmock & Fisher, 2017, pp. 123-124; Hess et al., 2013, pp. 53-58).

From the perspective of the law of freedoms, euthanasia—often described as a painless or dignified death—is best understood as an exercise of the patient's right to self-determination rather than as an expression of a so-called 'right to die.' The latter phrase is conceptually misleading: it suggests the existence of an autonomous and general freedom to choose death at will, in direct opposition to the right to life. If death were itself a subjective right, any individual could claim it unconditionally, a position that no constitutional system has recognized. Indeed, even in jurisdictions where euthanasia is regulated, constitutional texts do not enshrine a 'right to die'; rather, they decriminalize euthanasia under narrowly defined circumstances. The legal and moral justification lies in respecting the patient's autonomy and dignity when continued existence would constitute inhumane and unbearable suffering. Thus, euthanasia is not a derivative of a fictitious 'right to die' but a consequence of the patient's constitutionally grounded right to self-determination, exercised at the limits of human dignity (Bağçeci, 2023, pp. 261–262).

5.2. From the perspective of international conventions: The Oviedo Convention (Convention on Human Rights and Biomedicine)

The Convention on Human Rights and Biomedicine, as the Oviedo Convention, was adopted by the Council of Europe in 1997 following Recommendation 1160 (1991) of its Parliamentary Assembly[4]. The Convention is the first legally binding instrument within Europe that addresses developments in biology and medicine, taking into account significant medical ethics (bioethics) concerns (Aydın, 2001, p.4).

Convention, in this sense, should be considered as a set of rights recognized to protect patients within daily healthcare services and additionally, they regulate patient

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[4] Council of Europe, European Treaty Series-No. 164, *Preamble.*

rights such as the right to equitable access to healthcare (Art. 3), informed consent (Art. 5), respect for private life and right to information (Art. 10), right to complain and to obtain fair redress (Arts. 23-24).

Although the patient's right to self-determination is not explicitly mentioned in the Oviedo Convention, informed consent and advance directives are. These provisions are enabling patient autonomy to be legally enforced in biomedical law. This also suggests that the Convention functions not only as an ethical guide, but also as a constitutional text in Europe, and how ethical principles gradually become binding rights. Articles 5 and 9 reflect the key ideas of self-determination by addressing informed consent and respecting patients' prior wishes. This supports the idea that the Convention plays an essential role in recognizing patient autonomy as a legal right.

Convention states that medical treatment can take place only after obtaining free and informed consent. To achieve this, patients must receive accurate and clear information regarding their health treatment, its purpose, risks, and possible outcomes. They can also withdraw their consent at any time, and no medical intervention can be done against their will. This rule directly indicates that the patient's right to self-determination is protected; decisions about treatment belong to the patient at any level.

Article 9 of the Convention also indicates that the patient's previously stated wishes should be accepted if they cannot express their wishes at the time of treatment. Similarly, Article 3.4 of the Amsterdam Declaration allows doctors to act on the basis of consent in emergency situations where obtaining consent is impossible, unless there are prior patient wishes refusing the treatment. This makes clear that the patient's right to self-determination is respected even if immediate consent cannot be obtained.

6. CONCLUSION

The patient's right to self-determination stands as a cornerstone of modern healthcare ethics and law, empowering individuals to make autonomous decisions regarding their bodies and medical treatments. For those with decision-making capacity, it secures the freedom to accept, refuse, or withdraw from interventions without undue external influence. In doing so, it allows patients to align medical choices with personal values, life plans, and moral convictions, thereby safeguarding their physical and moral integrity, privacy, and dignity.

As such, self-determination functions as a normative force that reshapes healthcare institutions and professional obligations in accordance with constitutional commitments. It transforms the patient from a passive recipient of care into an active participant in the therapeutic process. Accordingly, this study argues that self-determination must be acknowledged not as a mere ethical aspiration or statutory construct, but as a universal human right deeply rooted in constitutional values of dignity, autonomy, and bodily integrity. Moreover, self-determination operates as a precondition right since it is a core right that grounds all other rights in healthcare.

Even though most constitutional texts remain silent on this right, this does not mean it does not exist. Rather, it highlights the need for clear regulations, constitutional provisions, careful interpretation, and court decisions must be made.

Through a holistic reading of dignity, bodily integrity, autonomy, and privacy, this study contends that self-determination is indeed constitutionally guaranteed, even in the absence of explicit reference.

On this basis, the right is best understood as a hybrid constitutional right. It entails negative duties—such as the obligation of non-interference—and positive duties, requiring the state to inform, educate, and provide conditions that enable meaningful autonomy. This is the balance to be maintained in modern health care since not interfering is not enough to ensure true self-determination.

At a deeper level, this right should also be seen as an implicit part of the constitution, rooted in the idea of constitutional integrity. As a basic or 'precondition' right, it helps keep the system of patient rights consistent and enforceable, while protecting individuals from paternalistic or utilitarian limits that weaken autonomy. However, simply assuming that self-determination is already recognized as a constitutional right is not enough. If this recognition were truly effective, strict laws on abortion, euthanasia, or advance directives would be much harder to defend. Therefore, implicit recognition alone is insufficient—the right to self-determination must be clearly affirmed and supported through legal and institutional measures as a core part of constitutional integrity.

In conclusion, this study affirms that the patient's right to self-determination must be recognized not only as a universal human right but also as a subjective public right—an entitlement individuals may invoke to enforce their autonomy in healthcare relations. Embedding this right within constitutional and statutory frameworks is essential for protecting dignity, empowering patients, and establishing a future-oriented, patient-centered healthcare model. In doing so, it strengthens the legal and ethical foundations of modern healthcare while broadening the scope of freedom and participatory justice in medical decision-making.

For this to be achieved, constitutional courts must keep interpreting the laws in order to protect patient rights and keep up with new ethical and technological developments. Accordingly, healthcare systems need foreseeable, precise, and clear laws that ensure openness and patient participation. Only then can self-determination be realized and become part of healthcare, rather than being just an abstract idea.

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