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LEGALIZED EUTHANASIA: A HUMAN RIGHTS AND BIOMEDICAL ETHICAL DIAGNOSIS

Abstract

Euthanasia has been the subject of much legal, religious, moral, and human rights debate in recent years. At the center of this debate is how to reconcile competing values: the wish of patients to choose to die by waiving their right to life through voluntary consent, and the necessity to uphold the inviolable right to life of every person, as recognized by Article 6 (1) of the ICCPR. Even though euthanasia is mostly illegal, there is an ever-increasing drive towards legalization. As more States begin to re-examine and, in some instances, rescind their bans on euthanasia, the international human rights legal community needs to re-examine and reconfirm its viewpoint on the utmost essential human right, that is, the inviolable natural law right to life. By validating euthanasia through national statute, the fundamental human right to live is *de facto* nullified for many more people than the few whose assumed right to die is compromised. Regrettably, illogical arguments based on obscure and fictional rights, such as "the right to die with dignity," largely go unopposed, while insistence on respect for true natural law and fundamental human rights, as well as established international *jus cogens* norms, including the right to life, are negated. The key medical moral criteria – autonomy, beneficence, non-maleficence, and justice – are characterized and illuminated in the context of euthanasia to provide

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a general, ethical, and moral analytical framework that aids policymakers in making ethically sound judgments.

Keywords: biomedical ethics, euthanasia, international human rights law, natural law, informed consent, *jus cogens*, fiduciary criterion of morality

INTRODUCTION

The theological, ethical, and juridical discourse relating to the right to end one's own life is as old as civilization itself. Thomas Aquinas (1225–1274), in his *Summa Theologiae* (1265–1274), examines the moral dilemma of ending one's own life to escape life's despairs and concludes that to kill oneself is altogether unlawful for three reasons: First, it is inimical to the natural disposition as it contradicts the natural law. Second, it harms the community, and third, it is a sin as only God should decide when the gift of life comes to an end (Aquinas 1702; May 2015).

Over the past two decades, legislation permitting assisted suicide and voluntary euthanasia has been enacted in an increasing number of States across the globe. Since it was first legalized in the Netherlands in 2002 (Rietjens *et al.* 2008), several States in the United States of America, Australia, Belgium, Canada, Colombia, Ecuador, Portugal, Luxembourg, New Zealand, and Spain have enacted legislation legalizing euthanasia or assisted suicide (Colombo and Gianpiero 2024). Following the implementation of its euthanasia law in 2016, euthanasia has now become a leading cause of death in Canada (Raiken 2024). In May 2025, lawmakers in France voted to legalize assisted dying for some terminally ill residents in the final stages of life (Corbet 2025). Most statutes share key eligibility criteria: patients must be adults, residents of the sanctioning state, mentally competent, diagnosed with a terminal illness causing pain and suffering, make voluntary requests, and give informed consent. Typically, eligibility in the final instance is confirmed and approved by two independent medical practitioners.

Initially, euthanasia applied only to consenting adults of sound mind with a terminal illness; however, its extent and application expanded over time to now include children, dementia patients, the mentally ill, those with psychiatric conditions, and anyone who is in a hopeless medical

condition. In 2014, Belgium became the first nation to make legal child euthanasia (Deak and Saroglou 2017; Reingold 2020). In 2022, the Canadian parliament expanded euthanasia to include the mentally ill (Douthat 2022). In 2023, the Netherlands amended regulations to include the euthanasia of children under 12 without their consent (Maisonneuve 2023). Euthanasia is now a disturbing practice that violates legal and ethical boundaries, compromising medical practitioners' moral duty to heal and not harm.

Whether national legislation should allow euthanasia is one of the most contentious subjects facing progressive liberal democracies. Globally, the main obstacle to legalization has proved to be the valid disputation that, even if morally acceptable in narrowly defined cases, euthanasia could not be efficiently regulated and monitored to prevent abuse of the most vulnerable, and humanity would slide down a slippery slope to practices that most societies would agree to be ethically intolerable (Lewis 2007; Pollard 2001). In particular, it is argued that euthanasia legislation does not and cannot prevent the unlawful death of vulnerable patients who did not make a legitimate and genuinely free and properly informed voluntary request, or for whom appropriate palliative treatment would have offered a feasible option (Keown 2018).

Authorizing euthanasia by national statute raises ethical, academic, and theological concerns, in addition to the juridical standing of such legislation in terms of natural law and International Human Rights Law (IHRL) (Zdenkowski 1997). The focus of this article will be on the central question of whether the right to life can be waived in terms of natural law and IHRL through the voluntary consent criterion that is seen as a *conditio sine qua non* in all euthanasia legislation. The cornerstone medical moral rudiments – autonomy, beneficence, non-maleficence, and justice – are also characterized and illuminated in the context of euthanasia to provide a general, ethical, and moral analytical framework that aids policymakers in making ethically sound judgments.

DEFINING EUTHANASIA

The word "euthanasia" originates from the Greek words *eu*, meaning "good," and *thanatos,* which means "death" (Shala and Kilda 2016; Jakhar *et al.* 2021). Generally, it describes the procedure of purposefully ending a person's life prematurely to alleviate their pain and suffering (Knoetze and De Freitas 2019). Bluntly put, legalized

euthanasia presents killing with intent as an acceptable and routine medical treatment and management option (Finnis 1997).

Euthanasia in this article means "active voluntary euthanasia," which requires the person seeking euthanasia's prior voluntary consent with a physician either directly or indirectly administering the deadly substance (Finnis 1997; Knoetze and de Freitas 2019).

INTERNATIONAL HUMAN RIGHTS LAW

The International Covenant on Civil and Political Rights

The legally binding International Covenant on Civil and Political Rights (ICCPR 1966), ratified by 174 States Parties, requires that States implement laws and regulations that honor their international legal obligations as set out in the ICCPR.

Article 6 (1) of the ICCPR (1966) that deals with the Right to Life provides as follows: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."

Using the declaratory present tense "has" as a substitute for "shall have" is important. The intent of the United Nations General Assembly was, ostensibly, to embed the natural law origin of the absolute right to life. Consequently, the essential character of the right to life and the measure of significance it is given by relevant judicial treaty monitoring bodies seeking to interpret it means that the fundamental right to life should not be narrowly interpreted (Nowak 1993).

The fundamental right to life is of the utmost importance, given that the existence and substance of all additional human rights are rooted in the adequate juridical protection of the natural law right to life. Dinstein (1981, 114) appropriately notes that: "Civilized society cannot exist without the protection of human life. The inviolability or sanctity of life is, perhaps, the most basic value of modern civilization. In the final analysis, if there were no right to life, there would be no point in the other human rights."

Its prominence is further emphasized by being included in Article 4 (2) of the ICCPR (1966), as one of the fundamental human rights that cannot be derogated, irrespective of a national emergency that poses a threat to the life of the nation. The fundamental and inviolable right to life is also recognized in Article 4 of the African Charter on Human and

Peoples' Rights (ACHPR 1981), Article 4 the American Convention on Human Rights (ACHR 1969), Article 2 of the European Convention on Human Rights (ECHR 1950), and Article 3 of the Universal Declaration of Human Rights (UDHR 1948).

Duty of the State to Protect the Right to Life

The ICCPR (1966) Article 2 denotes that: "Each state party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, color, sex, language, […] or other status."

Reference to "or other status" obviously includes the status of being terminally ill and in a state of chronic pain. Article 6 (1) further specifically states: "This right shall be protected by law." Article 2 and Article 6 impose on States Parties the legal duty and responsibility to provide statutory safeguarding of the fundamental right to life. States Parties, therefore, need to refrain from legislative action that may lead to a violation of the right to life (Zdenkowski 1997).

Some legal scholars correctly point out that the specific language used in Art 6 (1) places a positive legal duty of protection on national legislatures (van Aardt 2004). International law demands that the fundamental human right to life should be shielded by national legislative provisions instead of being infringed or violated by statutes, as is currently occurring in the case of euthanasia-permitting laws and regulations.

Scope and Application of Article 6 (1) of the ICCPR

Article 6 (1) of the ICCPR (1966) further expressly determines that "No-one shall be arbitrarily deprived of his life." The legal defense against the "arbitrary" dispossession of the right to life is consequently of crucial significance.

Important questions that arise are whether any procedures authorized by national legislation may be seen as "arbitrary," given that the right to life is a vital standard of IHRL, and whether certain meticulously crafted exceptions can be allowed if regulated by national legislation? Within the bounds of Article 6 (1), the phrase "no arbitrary deprivation" signifies exemptions to the right to life with the objective

of requiring the highest possible degree of protection of the fundamental right to life and to constrain permissible deviations therefrom to the most extreme limits, such as justifiable homicides, self-defense, and capital punishment for serious offenses (Ramcharan 1993; Zdenkowski 1997).

If one accepts that national legislation and its practical ramifications might be "arbitrary" – and rationally, this seems to be the case from laws enacted in Nazi Germany and many other unprincipled governments over the centuries – then it follows that even if permitted by national legislation, euthanasia still could amount to a violation of Article 6 (1) of the ICCPR (1966).

No Legal Right to Die in terms of IHRL

There is a common misconception that there is a 'right to die,' in the sense of a legal, ethical, and moral right to decide the manner and time of one's death, and that a demand for this legal right will be adequate ground for decriminalizing active voluntary euthanasia (Bartels and Otlowski 2010). There is a moral right to die in the sense of being permitted to die when a person dies, if it is in that person's best interest to die by ending or not initiating unwanted or useless medical therapy.

There is, however, no legal right to die in terms of the natural law. The right to be killed on demand has also never been recognized in IHRL as a legal right. Its assumption conflicts directly with the fundamental human right to life, recognized and protectively articulated in Article 6 of the ICCPR (1966). A right to die directly contradicts and violates the right to live. It is a *contradictio in terminus* to argue for the equal protection of both rights at the same time. A right to die on request, at the hands and subjective discretion of another, conflicts with and nullifies the judicial principle that human life that presents no threat to another is sacred and that protection for all innocent life is needed (Flemming 1996; Pollard 1998).

While IHRL has not established a "right to die," many legally binding international covenants, such as the ICCPR (1966), ECHR (1950), and ACHR (1969), contain explicit protections of the right to life. Under IHRL, the right to life creates both positive and negative legal obligations for States Parties. Put differently, States Parties must not only avoid taking actions that infringe the right to life, such as euthanasia legislation leading to arbitrary decisions by medical professionals that cannot be effectively prohibited or monitored, but also act in a positive

way to create conditions required to protect this imperative IHRL norm (Reingold and Mora 2019).

WAIVING THE RIGHT TO LIVE

The presence or absence of informed, voluntary consent differentiates active voluntary euthanasia from active non-voluntary euthanasia or murder. Critical legal questions to consider are: whether the consent of the patient is legally valid and whether the consent of the patient renders null and void what would otherwise represent an apparent breach of the ICCPR's Article 6 (1) (1966). Put differently: Can a human being waive his or her fundamental human right to life?

The right to life is an absolute natural law right incapable of legal waiver

It is crucial to determine whether the right to life is a mandatory absolute human right or a discretionary relative human right in terms of natural law. If absolute and mandatory, the right to life is immutable and consequently not capable of legal waiver, notwithstanding the demands or desires of the legatee of the right (Flemming 1996). If the right to life is relative and discretionary, the person entitled to the right would be able to waive the right. The classification of the right to life as relative and discretionary or absolute and mandatory has been labeled as the root of the issue with legalized euthanasia (Ramcharan 1993; Zdenkowski 1997).

In terms of the Social Contract philosophy, when a civilized community is established to gain the benefits of alliance with other people, the benefits are positive in nature. One of the most important benefits is the protection of one's fundamental human rights by the State. Sir William Blackstone (1723–1780) writes the following on the: "For the principal aim of society is to protect individuals in the enjoyment of those absolute rights, which were vested in them by the immutable laws of nature" (Blackstone 1979, 120).

Protection of one's fundamental human rights, such as the right to life, is thus a positive legal claim and entitlement against the State. This encompasses a positive legal duty of protection not only from State repression and tyranny but also from private acts of aggression and exploitation. The government observes its positive duty of security via

the enactment of various just, reasonable, and rational laws that regulate society, and by respecting and effectively protecting fundamental human rights (van Aardt 2004, 41).

Blackstone's interpretation of the common law, which he defined as common due to its application to both the king and his subjects, differentiated two types of substantive human rights, "relative rights" and "absolute rights" (Blackstone 1979, 119). "Relative rights" protected individuals in their different dealings with one another as members of a community. "Absolute rights" were rights that belonged to persons in a state of nature. According to Blackstone, the essential and greater purpose of all government statutes was to safeguard people in the full and unfettered possession and mastery of their natural law, absolute natural law rights (van Aardt 2004, 40). The safeguarding of relative rights had a lesser and subordinate objective. Absolute rights, *inter alia*, were defined as the rights to personal security, which were seen as an individual's right to legitimate and continuous mastery of body, life, and well-being. Personal security was distinguished not simply as a negative legal prerogative, but as a positive legal prerogative to protection by law. The absolute rights to personal security, which included the right to life, were protected by the law, which had as its principal aim the safeguarding of basic human rights (van Aardt 2004, 43).

Statutory provisions allowing for the voluntary request and consent to be killed by another with final, irreversible life-ending consequences, that are in the final instance subject to the arbitrary, subjective discretion of others, brutally interrupt the enjoyment by an individual of "his life, his limbs, his body, his health" and as such violate the social contract (Blackstone 1979, 125).

Flemming (1996, 47) correctly points out that "fundamental rights are inalienable as well as inviolable. These are rights of which I may not be deprived and of which I may not deprive myself. To deprive myself of these rights threatens the rights of others."

A right to die on request would nullify the principle that the gift of life is inviolable and that protection of the right to live against predation is needed. If the natural right to life is truly innate and inalienable, that is simply not possible (Pollard 1998).

The right to life is a non-derogable *jus cogens* norm

International law encompasses various sets of international laws that protect essential human rights, including human rights law, humanitarian law, and the different laws governing states of disaster. Contained in this legal frame, there are certain norms, such as the proscriptions against the deprivation of life, enslavement, capricious imprisonment, and medical practices and procedures devoid of free and informed consent, which are observed as peremptory norms that entail mandatory rules not permitting any derogation (Criddle and Fox Decent 2016b, 208; van Aardt 2022b; Yarwood 2010, 61–68). It specifies *jus cogens* IHRL norms that are binding and mandatory in nature. It originated from ancient Roman jurisprudence that there are edicts that cannot be renounced or waived, due to the essential and imperative moral principles they uphold (Lagerwall and Carty 2015; van Aardt 2022).

Natural law peremptory norms have been integrated into contemporary International Law by the International Law Commission, which was dedicated to codifying and developing the legal structure applicable to international treaties. This effort culminated in the ratification of the Vienna Convention on the Law of Treaties (1969). Article 53 explicitly renders null and void any agreement that violates a *jus cogens* norm (Bianchi 2008, 496; van Aardt 2022a, 63).

This means that a State Party cannot release itself from the positive legal duty mandated by the peremptory norm, also not through an international contract nor by enacting national legislation. Consequently, it is a mandatory norm of general international law creating a crucial constraint on a State's executive and legislature not to breach *jus cogens*. (Yarwood 2009). Any State action or statute that violates a mandatory norm of IHRL is rendered illicit in terms of the doctrine of *jus cogens* (Orakhelashvili 2008; van Aardt 2022b). Peremptory norms therefore, limit the state's ability to only craft national legislation that respects and protects peremptory norms (Koji 2001; van Aardt 2022a, 65).

A number of international agreements determine governments' protective legal duties to protect their citizens' basic human rights. The most important presupposition underlying universally recognized human rights is that they are: a) permanent and unassailable; b) universal in application (including to persons in pain at the end of life); and c) co-dependent, commanding respect for specific individual rights as mutual reinforcement for respect of all rights (Farer 1992).

The ICCPR's Article 4 identifies several basic human rights that can never be violated or derogated, which include the fundamental human right to life (1966). A person cannot lawfully waive his right not to be murdered in violation of Article 6 of the ICCPR (1966), just as a person cannot legally consent to be tortured or waive the legal right to not be subjugated to medical experimentation in violation of Article 7 of the ICCPR (1966). A person can also not waive their right to freedom and sell himself or herself into slavery in violation of Article 8 of the ICCPR (1966) and established *jus cogens* norms.

Active voluntary euthanasia violates Article 6 (1) of the ICCPR (1966) irrespective of the absence or presence of the patient's authentic informed consent authorizing his own death, given that consent cannot legally be provided. Any law authorizing the waiver of the right to life ought to be regarded as an arbitrary deprivation of the fundamental and inalienable right to life.

The fiduciary criterion of legitimacy

The government's principal obligation is to govern through administration, laws, and regulations that are ethical and that ultimately protect and respect fundamental human rights (Zenović 2012; Johnson 2018, 340). In order to verify whether governmental activity is lawful or not, the "fiduciary criterion of legitimacy" test must be analyzed (Fox-Decent and Criddle 2018). The underlying idea is that the norms of IHRL and *jus cogens* originate from a fiduciary relationship between the state and individuals subject to its powers (Fox-Decent and Criddle 2016a, 4). Fox-Decent and Criddle (2018, 765) clarify: "The fiduciary criterion of legitimacy is a standard of adequacy for assessing the normative legitimacy and lawfulness of the actions of international public actors. The criterion demands that public actions have a representational character in that, for them to be legitimate and lawful, they must be intelligible as actions taken in the name of, or on behalf of, the persons subject to them."

By their very nature, *jus cogens* IHRL norms prohibit illicit public policies and national statutory provisions that infringe basic human rights, which could never be reasonably understood to be implemented in the name of the persons subject to them. Statutory provisions that allow for the arbitrary deprivation of life, consent to slavery, torture, cruel, inhumane, and degrading treatment, and conducting medical

experimentation lacking voluntary and educated consent are not reasonably coherent as actions that can be implemented "in the name of, or on behalf of," their targets (van Aardt 2022b). By distinction, statutory provisions and government regulations that sensibly restrict human rights for reasonable, intelligible reasons, such as statutes relating to motor vehicle seatbelts or the proscription against purchasing or trading narcotics deemed unsafe, are comprehensible as legislative requirements that can be implemented in the name of, and on behalf of, the persons subject thereto (Criddle and Fox-Decent 2016b).

In the case of IHRL peremptory norms such as the right to life, no such justification is permissible given that any violation of these norms (such as the infringement through euthanasia laws decriminalizing death on demand at the hands and subjective discretion of another), constitutes a unlawful infringement of the absolute non-derogable natural law right to life, and therefore cannot rationally and judiciously be viewed as an legal action "taken in the name of, or on behalf of," the individuals made to endure the ultimate infringement.

EUTHANASIA AND THE VOLUNTARY CONSENT STANDARD

Legal informed consent means that the person involved: a) should have the legal capacity to give consent, b) should be able to exercise free power of choice, without the intervention of any element of duress, or coercion; and c) should have sufficient comprehension of the subject matter involved as to enable him to make an enlightened decision (Hospers 1980, 259–264).

Three necessary markers are required to determine that a decision has been made voluntarily: I.) No Intimidation and Coercion, II.) Educated and informed consent and III.) Sound Psychological State of Mind (Hospers 1980; van Aardt 2022).

No intimidation and coercion

The patient's consent cannot be labeled as voluntary when any degree of intimidation is present. The extreme example of intimidation is one in which the Government apprehends an individual, and state physicians inoculate him with a deadly substance against his will. More often, intimidation consists not of brute force but of the threat of it or

another undesirable consequence for non-acquiescence: Such as not being able to contribute to your family and being in a bedridden state, is not a life worth living, and is unfair to your family. Contrasting the first example, in cases threatening undesirable consequences, there is a choice. But getting a lethal injection to save your loved ones from financial ruin or the burden to take care of you is not a choice the person would have made except for euthanasia-based coercion. The patient was compelled to make a decision that they would not have made willingly. Any coercion or force set on a person inhibits and, consequently, nullifies the voluntary element of the consent provided (Hospers 1980, 264).

Educated and informed consent

Given the practice to allow minors and dementia patients to provide consent to euthanasia, the principle of informed consent relating to children, the mentally impaired, and the sedated needs some exposition. If consent is not fully informed, it cannot be voluntary. Generally, to be held to a contractual agreement, an individual must have the legal capacity to conclude a contract in the first instance, referred to as the capacity to contract. An individual who is incapable, due to mental impairment, sedation, or age, of comprehending what he or she is doing when signing an agreement lacks the capacity to contract. For example, a mentally disturbed person under guardianship totally lacks the capacity to contract. Any agreement signed by such a person is void *ab initio* (van Aardt 2022). In terms of the law of contract, a minor cannot form an enforceable contract. Even if the child narrates all the possible statutory eligibility criteria for euthanasia, the youngster is not able to grasp the complicated consequences of his or her euthanasia consent. Children lack the psychological, practical, and intellectual fortitude to appreciate the potential ramifications of such a decision (Hospers 1980, 263). To contend that a 5-year-old or 17-year-old child possesses the capacity to discern the legal concept of euthanasia and appreciate its various dimensions, and that such a child can give informed voluntary consent to euthanasia that has inevitable fatal and final consequences is ludicrous on any view and ridicules basic medical ethics and the rule of law (Hospers 1980, 263; van Aardt 2022).

A sound psychological state of mind

A human being may not be intimidated and coerced and may well be fully informed, and yet may provide consent in an irrational emotional state of mind. A schizophrenic may be psychologically disturbed, but apart from this extreme, an individual may be psychotic, unhinged, ambivalent, confused, intoxicated, in chronic pain, under severe mental stress, or severely depressed. Usually, when a patient is in such a position, he or she can't be categorized as "fully informed." Circumstances may also arise where a patient is not coerced, all of the relevant details and required information are in the open, and yet, the patient is not able to make a rational decision, due to his or her emotional and mental condition. A human being in a manic-depressive or psychotic condition may be utterly aware of all the relevant information, yet a presentation of normally shocking facts, including his or her own imminent demise, may well not move him. When a person is in such a psychological state, his choices cannot be depicted as entirely voluntary (Hospers 1980, 264; van Aardt 2022). Given the mental state of such a person, one obviously cannot judiciously describe the consent given as voluntary. The argument that an individual at the end of life, in a state of severe distress and mental anguish, while being subjected to sedatives, in one of the most vulnerable states of human existence, is in a healthy state of mind is not a rational contention.

BIOMEDICAL ETHICAL DIAGNOSIS

Judging medical interventions such as euthanasia through biomedical ethical optics delivers a plain, easy, understandable, and apolitical basis to find morally acceptable and virtuous solutions to guide prudent governmental action in a health care legal environment (van Aardt 2021). Moral laws differ from laws relating to science. Moral laws are rigid, conscientious, and righteous, dictating and prescribing what is the morally upright thing to do. Moral laws are also standardizing, in nature, establishing guidelines and doctrines that need to be adhered to (Beauchamp and Childress 2001).

The four core ethical criteria of Beauchamp and Childress – autonomy, beneficence, non-maleficence, and justice – have been highly instrumental in the sphere of biomedical moral rectitude and are central for appreciating the contemporary methodology to moral

judgment in medical care (Mandal *et al.* 2017). The four cornerstone criteria provide the most universal and complete norms intended to guide morally acceptable medical ethical standards (Beauchamp and Childress 2001, 2019; Gilon 1994, 2015; Levit 2014).

If any one of the principles is violated, the medical intervention would be deemed unethical and immoral.

Autonomy

Autonomy is the patient's ability to act of their own free will (Beauchamp and Childress 2001; Levit 2014). Personal autonomy refers to self-governance, which is free from both intimidation and coercion by others, as well as from cognitive limitations, due to mental impairment or age, that prevent one from comprehending what they are doing and thereby hindering informed consent (Iserson 1999, 524). Regard for autonomy entails the moral responsibility of physicians to regard and value the freedom and autonomy of their patients (Beauchamp and Childress 2019; Gilon 2015; Varkey 2021).

Advocates of euthanasia argue that there is a moral right to determine how, when, and where one should exit this life, centered on the notion of autonomy and self-rule (De Beaufort and van de Vathorst 2016, 1464; Clarke 1999; Jost and Cox 2000). However, if a patient is persuaded through duress, intimidation, or impairment of the patient's own will, then autonomy has been violated (Sneddon 2011, 105). Legitimate concerns exist regarding extremely vulnerable patients, such as the incurably sick, the psychologically impaired, and the frail patients advanced in years. Autonomy in biomedical ethics is built into the legal standard of 'informed consent,' which requires that patients are of sound mind and able to provide informed consent that is legally binding.

John Stuart Mill (1806–1873), in his *On Liberty* (1859), asserts that the right to autonomy prohibits the intentional termination of the state of affairs needed to maintain autonomy, which would transpire by terminating life through euthanasia (Beauchamp and Childress 2001). Mill asserts that: "By selling himself for a slave, he abdicates his liberty; he foregoes any future use of it beyond that single act. He therefore defeats, in his own case, [...] the principle of freedom cannot require that he should be free not to be free. It is not freedom to be allowed to alienate his freedom" (Mill 1859, 194). Similarly, with active voluntary euthanasia, a person defeats, in his own case, the purpose of autonomy.

The criterion of freedom does not involve the right to die. Freedom does not entail being authorized and empowered to permanently forsake freedom through death.

Jean-Jacques Rousseau (1712–1778), in his famous *Social Contract* (1762), considers similarly unenforceable a contract by which a person commits to sell himself as a slave, as trading yourself into slavery denies you the prospect of exercising your free will, as it denies all your actions of your own moral character. To Rousseau, the fact that a contract to self-enslavement contains no mutuality and is wholly to the advantage of one party and wholly to the detriment of the other party, such an agreement is "null and void, not only as being illegitimate, but also because it is absurd and meaningless" (Rousseau 1762, 5–8). The agreement nullifies and defeats the slaves' fundamental human rights. It is *in toto* to his detriment and disadvantage. Legalized euthanasia depends entirely on the subjective judgment of medical practitioners and is, in the final instance, not the decision of the patient. Consent to euthanasia by terminally ill patients has been observed as hardly ever autonomous, as many critically ill people are not in a sound psychological state of mind (Pereira 2011). To respect self-governance and autonomy is to duly appreciate the patients' unique circumstances, perceptions, and capabilities (Beauchamp 2007). An individual who is incapable of comprehending what he or she is doing when signing an agreement due to coercion, mental impairment, or age lacks the capacity to contract and therefore cannot consent to euthanasia (Hospers 1980). From a medical ethical perspective, the modern-day practice of euthanasia without consent or to obtain informed consent from individuals incapable of providing such consent is a total perversion of the legal informed consent criterion and therefore unethical.

Beneficence and Non-Maleficence

The Hippocratic apothegm to medical doctors – *bring benefit and do no harm* – conveys the criteria of beneficence ("bring benefit") and non-maleficence ("do no harm") (Beauchamp and Childress 2001). This Hippocratic maxim has been a rudimentary criterion of morally upright medical practice.

Beneficence

Beneficence in biomedical ethics describes the principle that medical interventions should be done to the patient's benefit (Levit 2014). This limits permissible medical interventions to include only those that benefit the patient.

Supporters of euthanasia contend that relieving a patient from their discomfort and anguish will do more good than harm. They claim that the essential moral values of empathy and compassion necessitate that no human be allowed to suffer debilitating pain, and that doctors should be allowed by law to end a patient's life (Ebrahimi 2012). The principle of beneficence, however, emphasizes the obligation to defend and protect the human rights of others. In terms of the principle of beneficence, a medical professional must prevent evil or harm; a medical professional must remove evil or harm, and a medical professional must do or promote good (Beauchamp and Childress 2001).

The principle of beneficence encourages several more specific moral rules that include:

- Defending and protecting the rights of others.
- Preventing injury or harm from happening to others.
- Eliminating conditions that will cause harm to others.

It is self-evident that "active voluntary euthanasia," which has as its prominent and leading actor a physician, not preventing evil and harm but committing the ultimate evil and harm by directly or indirectly taking the life of a human being proactively violates the right to life and the ethical principle relating to beneficence.

Non-maleficence

The criterion of non-maleficence denotes the obligation to abstain from injuring or harming patients. It is expressed in the basic guideline to medical practitioners *Primum non nocere* ("Above all do no harm") (Beauchamp and Childress 2001; Gilon 1994; Iserson 1999, 526; Varkey 2021). The principle of non-maleficence exclaims *one ought not to inflict evil or harm* on another (Levit 2014). The principle of non-maleficence also includes several other detailed ethical guidelines that include that a physician shall not, by any means, murder, disable, or dispossess patients of the conveniences of life.

The established ethical obligation of medical treatment is to provide net benefit to those being treated, causing little or no harm. In practical terms, this means that physicians should balance the benefits of treatment against the burdens of the treatment and abandon those treatments that are potentially inappropriately burdensome (Beauchamp and Childress 2019; Varkey 2021; van Aardt 2021).

From a net benefit perspective, euthanasia provides the ultimate harm with maximum injury resulting in death, clearly violating the ethical principle relating to non-maleficence.

Justice

The criterion that justice should be administered stems from Aristotle's (384–322 BC) theories relating to justness, fairness, and egalitarianism, and contains elements of legal justice, corrective justice, and distributive justice. Justice demands that others be treated fairly and that their fundamental human rights be respected and protected.

Justice in health care demands reasonable, just, and fair-minded treatment of patients or, as Aristotle stated, "that which is equal or fair" (Rackham 1926). It is unjust when patients are denied a benefit to which they are entitled, or when patients are unjustifiably burdened (Levit 2014). Imposing the burden on the most vulnerable and terminally ill to decide to accept euthanasia as a means to relieve loved ones from the financial and emotional stress is clearly an example of a burden that is imposed unjustifiably. Aristotle further argued that dispensing justice goes beyond egalitarianism (Rackham 1926). Patients can be dealt with unjustly despite being dealt with the same. It is of crucial importance to deal with *equals equally and to treat unequals unequally* in relation to their ethically appropriate disparities and weaknesses (Beauchamp and Childress 2001). To attribute the same cognitive ability of the healthy and sound mind to children, the mentally ill, and the vulnerable under severe mental stress is unjust.

Undermining and violating the fundamental human right to life of the most vulnerable patients is the ultimate injustice. Accommodating policies that could potentially allow patients with diminished capacity due to age or mental state to accept euthanasia is unethical.

CONCLUSION

Proponents of the legalization of euthanasia by voluntary consent to die depend on claims of an alleged autonomous right to die. My response is fourfold. Firstly, those States that enacted euthanasia legalization have evaded their rudimentary responsibility to rationalize the origins of the so-called right to die and outline its limits as a right assumed to trump the natural law fundamental human right to live. Secondly, they have neglected to adhere to their indisputable IHRL legal obligations as set out in Article 6 (1) of the ICCPR (1966). In other words, they are disregarding essential non-derogable *jus cogens* norms and obligations *erga omnes* with a flagrant disregard for the constitutional limits to their policymaking. Third, they proceed on an incorrect conception of the nature of the right to life as an absolute natural law fundamental human right incapable of waiver. Finally, they rely on a perverted prognostication of autonomy and voluntary consent, which should be rejected for the same types of reasons that lead us to reject as a matter of law the right of the mentally ill or the underage to contract and the right to free oneself from the economic burdens of life by selling oneself as a slave (Finnis 1997).

From an IHRL and natural law perspective, the right to life is an inalienable, absolute, fundamental human right and *jus cogens* norm that transcends the individual. Human life remains intrinsically inviolable and sacrosanct even when the condition of one's existence is adversely affected by discomfort, agony, and infirmity.

Through the legalization of active voluntary euthanasia, the natural law right to life and not to be subjectively and capriciously denied the right to live is *de facto* nullified for many more people than the few whose assumed right to die is compromised. Regrettably, illogical arguments for obstruse and fictional rights, such as "the right to die with dignity," largely go unopposed, while insistence on respect for actual natural law, fundamental human rights, and established international *jus cogens* norms, such as the right to life, are negated (Pollard 1998; Finnis 1997).

Fleming (1996, 44) correctly asserts that: "The State cannot allow or tolerate euthanasia because it violates international law, and constitutes a threat to the social contract whereby the ruler is bound to secure the right to life of the citizenry." Any law authorizing active voluntary euthanasia is a violation of the social contract, the natural

law, and Article 6 (1) of the ICCPR (1966) as legislative safeguards. A patient's consent simply does not warrant that the denial of the right to live is not random and arbitrary. Legalized active voluntary euthanasia represents the statutory deposition of the natural law and IHRL and a breach of the line between aiming to take life and aiming to cure, remedy, relieve, palliate, and compassionately care (Pollard 1998).

Every single one of the ethical criteria is to be regarded as a basic requirement that needs to be satisfied. Notwithstanding their viewpoint, theories, fiscal interests, moral convictions, or subjective opinions, government officials must commit to upholding and adhering to the four cornerstone biomedical ethical criteria. Regulations that accommodate and encourage active voluntary euthanasia are unethical, measured against the four moral criteria applicable to autonomy, beneficence, non-maleficence, and formal justice.

States should respect the internationally recognized right to life, consistent with the natural law basis of human rights (Fontalis, Efthymia, and Kulkarni 2018). The various illicit regulations that violate IHRL and ethical norms and Standards again highlight the prerequisite for governments to adhere to universal ethical guiding principles and normative standards in relation to the formulation and implementation of public health policies. Normative IHRL, the natural law, medical ethics, and morality determine that national legislators ought not enact legislation facilitating euthanasia.

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ЛЕГАЛИЗОВАНА ЕУТАНАЗИЈА: ДИЈАГНОЗА ИЗ УГЛА ЉУДСКИХ ПРАВА И БИОМЕДИЦИНСКЕ ЕТИКЕ

Резиме

Еутаназија је последњих година била предмет многих правних, верских, моралних и расправа о људским правима. У средишту ове дебате је како помирити супротстављене вредности: жељу пацијената да изаберу да умру одричући се свог права на живот кроз добровољни пристанак и потребу да се одржи неповредиво право на живот сваке особе, како је признато чланом 6 (1) МПГПП (1966). Како све више држава почиње да преиспитује, а у неким случајевима и укида своје забране еутаназије, међународна правна заједница за људска права мора да преиспита и поново потврди свој став о најважнијем људском праву, односно неповредивом природном праву на живот. Валидацијом еутаназије кроз национални закон, основно људско право на живот је *de facto* поништено за много више људи него за оне малобројне чије је претпостављено право на смрт угрожено. Нажалост, нелогични аргументи засновани на нејасним и измишљеним правима, попут „права на достојанствену смрт", углавном остају без отпора, док се инсистирање на поштовању истинског природног права и основних људских права, као и утврђених међународних норми jus cogens, укључујући право на живот, негира. Основно право на живот је од највеће важности, с обзиром на то да су постојање и суштина свих додатних људских права утемељени у адекватној правној заштити природноправног права на живот. Члан 2 и члан 6 МПГПП (1966) намећу државама потписницама законску обавезу и одговорност да обезбеде законску заштиту основног права на живот. Државе потписнице стога морају да се уздрже од законодавних мера које могу довести до кршења права на живот. У оквиру члана 6 (1), израз „нема произвољног

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лишавања" означава изузећа од права на живот са циљем захтевања највишег могућег степена заштите основног права на живот и ограничавања дозвољених одступања од њега на најекстремније границе. Не постоји законско право на смрт у смислу природног права. Право на убиство по захтеву, такође, никада није признато у МПЉП као законско право. Његова претпоставка је у директној супротности са основним људским правом на живот, признатим и заштитно артикулисаним у члану 6 МПГПП (1966). Тврдити да постоји једнака заштита оба права истовремено је *contradictio in terminus*. Право на смрт на захтев, од руке и субјективног нахођења другог, сукобљава се са и поништава судски принцип да је људски живот који не представља претњу другом свет и да је потребна заштита свих невиних живота. Право на живот је апсолутно право природног закона којег се не може законски одрећи. Законске одредбе које дозвољавају добровољни захтев и пристанак да неко буде убијен од стране другог лица са коначним, неповратним последицама које у крајњој инстанци подлежу произвољној, субјективној дискрецији других, крше друштвени уговор и МПЉП. Право на живот је такође норма jus cogens од које се не може одступити, а која је обавезујућа и императивна по природи. То значи да држава потписница не може да се ослободи позитивне правне дужности коју прописује императивна норма, чак ни доношењем националног законодавства. По самој својој природи, норме jus cogens МПЉП забрањују националне законске одредбе које крше основна људска права, за које се никада не би могло разумно схватити да се примењују у име лица на која се односе. Свако кршење императивних норми МПЉП, као што је право на живот (кроз законе о еутаназији који декриминализују смрт по захтеву од стране и по субјективном нахођењу другог), представља незаконито кршење апсолутног, неотуђивог, природног права на живот и стога се не може рационално посматрати као правна радња „предузета у име или за рачун" појединаца који су приморани да трпе коначно кршење. Правни информисани пристанак значи да укључена особа: а) треба да има законски капацитет да да пристанак, б) треба да буде у стању да користи слободну моћ избора, без интервенције било каквог елемента принуде или наметљивости; и ц) треба да има довољно разумевања предметне материје како би могла да донесе информисану одлуку. Сагласност за еутаназију терминално болесних пацијената је изопачење критеријума правног информисаног

пристанка, јер многи критично болесни људи нису у здравом психолошком стању и нису способни да дају законски пристанак. Са становишта медицинске етике, савремена пракса еутаназије крши сваки од четири кључна медицинска морална критеријума – аутономију, доброчинство, ненаношење штете и правду – и стога је неетичка. Са становишта МПЉП, право на живот је неотуђиво, апсолутно, фундаментално људско право и jus cogens норма која превазилази појединца. Људски живот остаје суштински неповредив и свет чак и када су услови нечијег постојања негативно погођени нелагодношћу, агонијом и немоћу. Било који закон који одобрава активну добровољну еутаназију представља кршење друштвеног уговора, природног права и члана 6 (1) МПГПП (1966). Сагласност пацијента једноставно не гарантује да ускраћивање права на живот није случајно и произвољно. Легализована активна добровољна еутаназија представља законско поништавање природног права и међународног права за људска права и кршење границе између циља да се одузме живот и циља да се излечи, лечи, ублажи, палијативно ублажи и саосећајно негује.

Кључне речи: биомедицинска етика, еутаназија, Међународно право људских права, природно право, информисани пристанак, *jus cogens*, фидуцијарни критеријум морала

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