**International Journal of Law**
**ISSN: 2455-2194; Impact Factor: RJIF 5.12**
**Received: 16-05-2020; Accepted: 26-05-2020; Published: 18-06-2020**
**www.lawjournals.org**
**Volume 6; Issue 3; 2020; Page No. 306-312**

# The legal challenges of decriminalizing non-voluntary euthanasia

**Wafa Trad JD**
Graduate, College of Law and Public Policy, Hamad Bin Khalifa University, Doha, Qatar

**Abstract**
Euthanasia is a controversial topic that states have dealt with it differently based on their religious and social norms. These different approaches have resulted in 'creating' various types of euthanasia, such as non-voluntary euthanasia, which lacks the patient's consent.

This paper argues that non-voluntary euthanasia fails the legality test as it violates the right to life, the right to privacy and the right to self-determination. Also, by applying the 'Principlism' framework it is concluded that non-voluntary euthanasia is also questionable from a bioethical view point.

By looking at three different jurisdictions: namely, a civil law jurisdiction (France), a common law jurisdiction (UK), and a Sharia Law jurisdiction (Qatar); it becomes evident that the issue of non-consent represents a dilemma that needs to be regulated. For this purpose, this paper provides a set of recommendations, that includes inter alia, developing health directives in a way that addresses potential hypothesis where a patient becomes incapacitated; and a shortlist of 'priority' carers whom he trusts to decide on life or death matters. This aims not only to avoid future conflicts between carers' desires, but most importantly, to reflect –to the extent possible- the patient's desire.

**Keywords:** non-voluntary euthanasia, consent, bioethics, the right to life, the right to privacy, right to self-determination

## 1. Introduction

Euthanasia is one of the most controversial issues, because such an act "would be considered a crime if it is performed on patients that are not extremely ill or hopelessly incurable" [1]. The debate over Euthanasia exceeds the medical context to include other social, religious, and arguably, economic aspects. Thus, the degree of controversy associated with euthanasia depends on the geographical context: the more conservative the society is, the more likely euthanasia will be objectionable. Also, the controversy of euthanasia varies within the same country depending on the degree of the medical intervention which ranges from passive (seizure of life support) to active (e.g. lethal injection). For example, in Germany, passive euthanasia is legal, while active euthanasia is illegal.

Despite the conceptual and technical differences between the various types of euthanasia; it is held that "death occurs in patients in the terminal stages of incurable diseases" [2]. However, the reality has shown that "euthanasia is not only applied to terminally ill patients but also to individuals with irreversible, but not terminal, disease" [3]. To 'add insult to injury', consent is not always obtained. In fact a study has revealed that the percentage of non-voluntary euthanasia in patients in their 80s increased to 52.7%, while in those with diseases other than cancer, this figure reached 67.5%. The patients' wishes were ignored in 77.9% of cases [4].

These figures raise serious doubts about the real motive behind euthanasia; this is especially true, if we take into consideration the age factor (80 years). Is it really conducted to relief the patient and his carers? Or to relief the overloaded hospital by providing 'an extra bed that could be used more efficiently'? These are merely rhetorical questions and will not be the subject of this paper as it is almost impossible to prove 'intent' neither scientifically nor empirically.

This paper argues that non-voluntary euthanasia must be criminalized on the grounds that it is an unethical and illegal practice that violates human rights. The paper starts with introducing the concept of euthanasia. The first section will address the issue of consent, its requirements and the challenges it poses in the case of incapacitated patients. The second section argues that non voluntary euthanasia violates various human rights provided for in a number of domestic, regional and international instruments. The third section is a contextualization that sheds the light on how different jurisdictions (a common law, a civil law and a sharia law jurisdiction) have dealt with non-voluntary euthanasia. The fourth section will assess non-voluntary euthanasia from a bioethical perspective, using the 'Principlism' framework. Finally, this paper will conclude with a set of recommendations.

## 2. Terminological framework

"The word "euthanasia" comes from the Greek euthanatos, meaning "good death". It is also, referred to as "mercy killing". Euthanasia aims to allow easy, good and painless death (to the extent possible) of the patient who is suffering from a terminal illness and extreme pain" [5]. Euthanasia takes various forms, yet, for the purposes of this paper distinction will be only drawn between two categories of euthanasia based on the issue of "consent" and the "method" through which euthanasia is performed, as follows:

Consent:

1. Voluntary euthanasia: Where consent is obtained, or euthanasia is performed upon the patient's request.
2. Non-voluntary euthanasia: the act of ending the patient's life where neither his consent nor his objection was expressed [6].

It is worth noting that one should not confuse between non-voluntary and involuntary euthanasia. In the former, death occurs absent the patient's consent due to his incapacity to provide express consent. However, in the latter the patient is able to express consent, but still death occurs despite his dissent. It is held that "this type of euthanasia is condemned internationally" [7].

## Method

1. Active euthanasia: "intentionally causing the death of the patient by way of an act, usually by a lethal injection" [8].
2. Passive euthanasia: also referred to as "limitation of treatment" [9], meaning "letting the patient die by an omission, e.g. withdrawal of life support machines" [10].

## Consent

Consent is a core component of the ethical treatment of the patient. There are different types of consent depending on the procedure being performed [11]. However, all forms of consent must satisfy three requirements in order to be valid. Namely:

- "Non-coercion: this means that it must be provided voluntarily and without fear or pressure.
- Information: refers to the doctors' duty to explain the outcome of the treatment to the patients in order to enable them to make an informed decision.
- Capacity: which refers to the mental capacity of the patient" [12].

These three elements were further reaffirmed in a UN report entitled "The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health" [13]. According to this report "an informed consent shall respect: the legal capacity, the personal autonomy and; the completeness of information" [14].

Clearly, consent is very problematic in the context of non-voluntary euthanasia. This is because the patients are usually deeply incapacitated. Hence, none of the aforementioned requirements applies. Yet, this should not mean that consent is waived or omitted. Rather, some legal systems have dealt with this dilemma, namely, the UK through the Mental Capacity Act MCA (2005).

## The MCA identifies a separate category of 'adults lacking capacity' and defines them as follows

"{A} person lacks capacity in relation to a matter if he is incapable of taking his own decision because of an impairment of the mind or brain" [15]. According to this Act if a person was found to lack capacity, then "he or she can be offered a treatment that is in his or her best interests" [16].

The application of this legal framework to the notion of non-voluntary euthanasia, raises a number of questions; namely, could letting someone die be considered as a 'treatment'? Could a non-expert (i.e. a layperson) third party (e.g. a relative) identify the best interest of a patient? And on what basis? Whether death could be considered as 'the best interest of a patient'? And if so, when? And more generally could incapacity be an excuse to terminate people's lives upon others' decisions?

In fact, the issue of consent can become more problematic in cases of non-voluntary euthanasia given the fact that crucial decisions affecting the patients' lives will be made based on what is referred to as "their best interest".

A patient's 'best interest' is identified in the light of a number of criteria, inter alia, "the views of others, such as family, friends, and carers who knew the patient best and can help when outlining the patient's wishes when capacity was present" [17]. However, the risk of potentially conflicting views may arise at any point.

In the *Winkfield v. Children's Hospital* case, the patient's relatives and physicians have disagreed on whether to perform surgical procedures upon her body when her brain activity is in complete cessation, but her body moves occasionally" [18]. The hospital refused to operate considering that the patient is dead; while the relatives considered that since her body moves, she is alive and she has the right to receive treatment. What complicates this matter more is that the Winkfield "had an expert testimony stating that their daughter is not dead" [19]. This indicates that declaring that a patient is in a hopeless status is not technically straightforward, and therefore, disagreement may occur among physicians themselves.

In a similar case, *Cruzan v. Director, Missouri Dept. of Health*, the patient was diagnosed as being in a persistent vegetative state (PVS). While the patient' parents asked the doctors to remove the life support which will result in her death, "the hospital refused to do so without a court order" [20].

In fact, the conflict may arise among the patient' relatives themselves. In re *Schiavo Schindler v. Schiavo*, the parents wanted to keep their daughter alive, while her husband wanted to remove the life support machines [21]. This dispute has lasted fifteen years until the final judgment was rendered in 2005.

Therefore, on one hand, it seems that this diversified approach that aims to reach the patient's best interest can complicate the matter more, leading to a deadlock to which litigation is the sole solution. On the other hand, a unified decision-making process by one or a body of experts can be even riskier. This is because "many physicians wrestled with the certainty of the clinical signs of death" [22]. According to a study conducted by a number of neurosurgeons in Canada "about 20% of patients diagnosed with "brain-dead" are misdiagnosed – so, those patients could be conscious and likely to recover" [23]. And indeed, "recovery of brain function has been reported" [24].

This brings us back to the initial question of who should have the authority to terminate the life of an incapacitated, and on what basis?

All in all, informed consent is defined as "a voluntary and sufficiently informed decision [that] protect[s] the right of the patient to be involved in medical decision-making and assign[s] associated duties and obligations to health-care providers" [25]. Consent is also recognized as one of the 'United Nations Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care'. Moreover, the right to consent is "highlighted in the Universal Declaration on Bioethics and Human Rights (UDBHR), the Inter-American Convention on Protecting the Human Rights of Older Persons, and the Convention on Human Rights and Biomedicine" [26].

Therefore, it is safe to say that absent the patient consent, euthanasia should not be decriminalized as it violates the patient's basic right to consent and other rights as we shall see in the following sections.

## 3. Euthanasia contravenes with supranational laws

The right to life under CRPD

This part aims to identify the analogous status of a disabled person and a person in a comma in order to expand the applicability of the right to life granted under CRPD to Persistent Vegetative State patients (PVS) on whom performing non-voluntary euthanasia is considered to be ethically permitted [27]. It is worth mentioning that the aim of this analogy, is not to underestimate these ‘differently abled’ persons. Rather, it is to compare the ambiguous legal status of these patients with a more regulated category of people.

On one hand, according to the Convention on the Rights of Persons with Disabilities (CRPD) “People with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with different barriers may hinder their full and effective participation in society on an equal basis with others” [28].

On the other hand, the Oxford Dictionary defines PVS as “A condition in which a medical patient is totally unresponsive to psychological and physical stimuli and shows no indication of higher brain function, being kept alive just by medical intervention” [29].

The main difference between a PVS and a disabled person; is the former is “being kept alive only by medical assistance”. This reason makes some scholars argue that a PVS or brainstem dead person is legally dead. According to Hayden J “it is hard to understand why the still breathing body is regarded as alive, even though ‘breath’ may be performed by machine” [30].

However, these two definitions share a lot in common, namely, that the individual in both cases seems to be disconnected from the outside world (“impairment”, “hinder participation”, “unresponsive”). The other similarity is that both conditions are of a “long term”. The nuance, however, is the degree of capacity: while the former refers to “effective participation”, the latter addresses the issue of “complete unresponsiveness”. In other words, while the former is partially disconnected because of a physical, a mental condition or both, the latter is totally disconnected and unconscious.

The aim of this analogy is firstly, to reject the definition of death based on the element of “consciousness or social interaction” [31]. In fact, ending someone’s life based on these grounds is, technically, extremely risky. This is because it is very difficult to distinguish PVS (absence of conscious) from a state of minimal preserved consciousness (i.e. “minimally conscious state,” MCS). “The rate of misdiagnosis is high and has been estimated at 37–43%” [32]. And secondly, to stress the fact that similarly to disabled people, these patients must be provided with a special treatment: medically and legally. Their right to life must be protected by the state. Article 10 of CRPD considers the right to life as an inherent right, and that states have to take the needed measures to guarantee “the effective enjoyment” of it [33]. This article not only highlights the importance of protecting this right of the disabled persons, but it also reaffirms that it is a right that must be granted to any individual despite his physical or mental status (“all human being”).

In this sense, state parties that have legalized non voluntary-euthanasia have breached their obligations under CRPD. In fact, article 10 of CRPD imposes a positive obligation on states to take effective measures to ensure the enjoyment of the right to life on an equal basis.

Therefore, it is safe to conclude that, likewise taking a disabled person’s life is a crime and shall be condemned internationally, depriving an incapacitated patient of his right to life without his consent shall also be criminalized.

The right to life under the European Convention on Human Rights (ECHR)

The right to life is well settled under the ECHR, according to Article 3 “the right to life is guaranteed to everyone by the law. The only exception where someone’s life can be taken intentionally is if that person commits a crime punishable by the law”

The key word in this definition is “intentionally”. This because as opposed to natural death, euthanasia is the act of intentionally terminating a patient’s life. Therefore, according to the ECHR’s standards, non-voluntary euthanasia is inconsistent with article 3, so state parties that have legalized it, are in violation of the ECHR.

Euthanasia contravenes with constitutional rights:

### The right to life

The most commonly cited definition of the right to life is that of Article 6 of the International Covenant on Civil and Political Rights (‘ICCPR’). The article recognizes the inherent right of every person to life, adding that this right "shall be protected by law" and that "no one shall be arbitrarily deprived of life" [34].

Clearly, terminating a patient’s life without his consent is arbitrary in nature. Hence, it is safe to say that non-voluntary euthanasia violates the right to life.

### The right to privacy

“The right to privacy has a positive and a negative definition. The latter refers to protecting the individuals’ private lives from undesirable interference by both the state and private actors into their private life. The former obliges states to remove obstacles for an autonomous shaping of individual identities [35]”.

By applying the former definition to non-voluntary euthanasia (i.e. “a person puts an end to the lives of competent patients without their request or will, provided that the patient cannot and did not previously express consent”) [36]; non-voluntary euthanasia represents a flagrant violation of this right as it includes the 1- unwanted intrusion (absence of consent); and 2- by a third party (someone will decide for them given their inability to do so).

### The right to Self-determination

In addition to the “people’s collective right to freely determine their political status” [37], self-determination is an individual right that refers to the individuals’ ability to make decisions about their own life. This right imposes two obligations on the state, a negative one that prevents the state from interfering in the individual’s private sphere; and a positive obligation, to take actions when necessary in order to protect the exercise of self-determination [38].

In the light of this definition, absent the individual’s consent, euthanasia should be criminalized: no one other than the patient should have the right to decide when to terminate his life. This also means that the state should act as the guardian of this right by criminalizing non-voluntary euthanasia and punishing perpetrators.

1. Contextualization: how the consent dilemma is dealt

with in practice

In this section, a comparison will be drawn between euthanasia laws in three different jurisdictions: a civil law jurisdiction (France), a common law jurisdiction (UK), and a Sharia Law jurisdiction (Qatar). The aim is section is to show how this controversy was reflected the legislators who are striving to strike a balance between the conflicting rights, without compromising the public opinion.

France

Euthanasia, be that passive or active, was legalized in several civil law countries. Namely, in the Netherland, Switzerland and Belgium. In fact, these countries have gone to legalize 'Assisted Suicide' unlike Germany, where such an act is criminalized.

France, however, presents a grey area between these extremes. In 2016, France has promulgated a 'Law creating new rights for the sick and people at the end of life'. This law is unique because: firstly, "it bridges the gap between the right to life and the right to death by creating a third category 'the right to a deep and continuous sedation' ("*le droit à une sédation profonde*"), secondly, it solves the dilemma of consent for incapacitated patients; and finally, it respects the patient's autonomy" [39].

More specifically, this law provides for maintaining the patient in deep sedation until death occurs in one of the three following cases:

a. "upon the patient's request when his symptoms can only be controlled through the use of sedation;
b. Upon the patient's request when he decides to withdraw the artificial life support, this withdrawal would lead to his vital prognosis being engaged in a short time and susceptible to involve unbearable suffering; and
c. When the patient is incapable of expressing his desire and when the physician, after a collegiate consultation, withdraws a treatment which maintains the patient alive" [40]

In a nutshell, it is clear that the French legislator has resorted to "continuous deep sedation (CDS)" as an attempt to find a balance between the two clashing rights of life and death with dignity. In fact, a closer look at the context would help to understand the reasoning behind this legislation. This is because France has been engaged in 'the end of life debate' since the late 1970s [41]. However, the challenge has always remained the same. That is when it comes to refusing the treatment, a patient's autonomy is given little if no attention at all. The preponderant part of the attention focuses on the physicians' discretion. In other words, it is the physician who decides what the best interest of the patient is, and when it is 'the right time' to end his life.

Thus in 2016, the right to CDS appears; such a 'revolutionary' measure aims to ensure that patients can refuse Life Sustaining Treatment (LST) 'without having to suffer' [42]. Therefore, CDS gives more weight to the patients' autonomy without having to compromise the social norms. Thus, it is argued that the French response' provides that the State regulates the healthcare system "in order to preserve society's common values or the 'general will', rather than individual interests as is the case in more liberal societies" [43].

**United Kingdom**

Both assisted suicide and euthanasia in its various forms (active, passive, voluntary and/or non-voluntary) are illegal under English law. In the alternative, the UK provides for other forms of 'End of Life Care'. Namely, 'palliative care' [44].

Palliative care is provided for patients with incurable diseases. "Palliative care includes psychological, social and spiritual support for the patient and his/her family or carers" [45]. The aim is to relieve patients from their pain to the extent possible. The ultimate goal is to help the patients "live as well as possible until they die and to die with dignity" [46]. Hence, it is clear that this law is a response to the proponents of euthanasia who argue that ending someone's life will end his suffering and ensure his right to die with dignity.

However, unlike the French model that is striving to broaden patients' autonomy when it comes to life or death decisions; the UK model seems to pay less if no attention at all to this factor.

**Qatar**

Theoretically, when it comes to the sanctity of life, Islam is not different from the other monotheistic religions (i.e. Christianity and Judaism): "life and death are the prerogatives of God. Thus, ending someone else's life constitutes a 'sin'" [47]. However, there are exceptions to this rule, namely: "execution of a legal sentence, in a just war, or in legitimate self-defense. These are considered 'just causes'" [48]. In this sense, euthanasia is not a just cause. Therefore, it is condemned by Islamic sharia.

Practically speaking, and given the ambiguity and confidentiality that surround this issue in Qatar, it may be useful to refer to a UK case, where the Saudi parents have flown back to their country, with their braindead baby, as "in Saudi Arabia, a life support machine would never be switched off for religious reasons" [49].

However, the situation in Qatar is slightly different given the fact that the Do- Not- Resuscitate (DNR) policy has developed; hence, if a committee of experts have decided, under strict circumstances, physicians may refrain from providing assisted ventilation or any other measures to rescue the patient [50]. Moreover, since the Qatari law [51] considers a brain-dead person as legally dead, machines may be, arguably, withdrawn in case of brain-stem death.

Based on the aforementioned case studies, it seems that even in the liberal system (UK) and even the secular society (France), the law remains partially unable to fully contain and regulate non-voluntary euthanasia. It is also worth noting that the society (i.e. the group be that friends, families or even the wider society through public opinion) plays a detrimental role in deciding on someone's destiny. This paradox of entitling the group to decide on an individual right rather than their collective rights; does not seem like an effective solution for the dilemma, as much as it is the only recourse available for these legal systems to overcome this dilemma.

2. Non-voluntary euthanasia and bioethics

This section will examine the ethicality of euthanasia absent the patient's consent. The drawn analysis will be independent of any positive or divine frameworks, rather, it will be conducted in the light of a theoretical framework. Namely, the 'principlism' to "explore any bioethical issue by applying four 'culturally neutral' principles: 1- Respect for autonomy; 2- Non-maleficence; 3- Beneficence; and 4- Justice" [52]. Each of these principles will be applied in turn on the notion of 'non-voluntary euthanasia'.

### Respect for autonomy

This refers to the patient's right to decide what and/or whether a medical procedure or intervention should or should not be done on his/her body. This principle aims to promote the following:

- Bodily integrity: "the right not to perform any procedures on the body without one's consent" [53]
- Promotes human rights: "all humans have the right to determine what shall be done with their own bodies" [54].
- "Promotes welfare: respecting patients' wishes will promote their welfare. This is because it is unlikely that an individual would make a decision that will worsen his/her situation" [55].

Here, it is clear that non-voluntary euthanasia, where the patient's consent is not obtained, infringes the principle of autonomy.

### Non-maleficence

This principle imposes a negative obligation on the physician not to conduct any medical intervention that would inflict harm on the patient [56]. However, the controversy appears when deciding "what counts as harm" [57]. This concern was partially answered by holding that "what counts as harm is determined to a significant extent by the individual concerned" [58]. Yet, such an answer makes the matter even more absurd not only because it takes us back to the issue of autonomy and consent; but also, because such a decision requires a large extent of foreseeability which is almost impossible given the misdiagnosis dilemma discussed above.

In the context of non-voluntary euthanasia, the question is whether "death" i.e. depriving an individual form his life, is to be considered a form of harm under this theoretical framework. The answer is "it depends". However, given the aforementioned role of the individual in deciding what is harmful for him, the principle of non-maleficence is also infringed.

### The principle of beneficence

Unlike the previous principle, beneficence imposes a positive obligation on the physician to "cure any disease or injury where possible and avoid the infliction of pain where possible" [59]. Proponents for euthanasia argue that the purpose of ending one's life is to end his pain and suffering; and that such a decision is "the best for his interest". Therefore, one could argue that in this sense non-voluntary euthanasia complies with beneficence because the 'act aims to avoid the infliction of pain'.

However, according to Section 1(6) of the Mental Capacity Act (MCA 2005), showing that a certain action was done for the patient's best interest is insufficient, rather, it must be proved that there is not another way that is "equally efficient and that is less restrictive of the patient's rights and freedom" [60]. In other words, the MCA sets a proportionality test to define whether or not the best interest of the patient was achieved.

Here, to end a patient's suffering, the physician could potentially use a pain killer rather than ending the patient's life. If that is not efficacious, the sedation could be the second least restrictive alternative. Clearly, both alternatives will achieve the same purpose without violating the patient's right to life and autonomy. Therefore, non-voluntary euthanasia fails the proportionality test, and so it infringes the principle of beneficence.

### The principle of justice

This principle has two aspects: 1- where there are insufficient funds, a task of prioritization has to be done in order to decide who should be treated and how; and 2- There "should be equal access to medical treatment" [61]. A closer look at this definition signifies that this principle is self-contradictory. This is because on one hand, it mandates a 'positive discrimination' to ensure the efficient exploitation of limited funds. On the other hand, it requires absolute equality among all the patients.

Hence, applying this principle to non-voluntary euthanasia results in two different outcomes; where the former aspect is respected. In the sense that when a patient is diagnosed with brainstem death and there are no hopes for recovery, non-voluntary euthanasia would be the reasonable choice from a cost-benefit analysis. In other words, spending the same resources on another patient who has greater chances of survival, rather than 'wasting' it on a hopeless case. However, the latter aspect will be infringed because in doing that equality is violated. Thus, non-voluntary euthanasia infringes partially the principle of justice. Yet, one could argue that since this theoretical framework aims to examine the ethical aspect of an issue rather than the economic aspect; one should pay greater attention to the "absolute equality" definition of justice and not the efficient allocation of resources.

Overall, it is clear that non-voluntary euthanasia fails to satisfy almost all the four principles, and thus it is safe to say, that it is unethical according to the standards set by this framework.

## 3. Recommendations

Clearly, non-consent is the source of all the issues arising from non-voluntary euthanasia. Therefore, Consent is the key solution to the aforementioned legal and ethical challenges. More specifically, consent on life or death decisions shall only be left for the individual's discretion; while other health decisions can be delegated to a third party to ensure efficiency.

This can be achieved through developing and updating the personal medical databases, which must become more comprehensive to include the patients' wishes in case they went into a comma, or if they had an accident resulting in a brainstem death, or a PVS. This is different from traditional health directives. They address broader aspects, but provides narrower choices. In other words, it is a more detailed form that includes different scenarios namely, in case an individual became incapacitated, would he wishes to be kept alive; and if so, for how long that should be before the withdrawal of Life Support Machines. In fact, here a timeframe ranging from three months up to two years can be set. The data can go even further to include their wishes with regard to their organs (i.e. donation).

Another recommendation is that this database shall also include a list of three people selected by the individual (in preferential order) to avoid conflict, as these agents will make critical health decisions on his behalf (in case he became incapacitated).

Finally, I recommend establishing a separate unit for incapacitated patients, equipped with the latest life support machines and technologies. Ideally, this unit should employ the most qualified staff –available- who have expertise in dealing with such 'critical/ hopeless' cases. This would help to unburden the hospitals' capacity for less serious diseases. And most importantly, this will contribute to achieving some scientific advancement through observing similar situations which will help in developing consistent patterns of findings. This would reduce the impact of scientific uncertainty.

## 4. Conclusion

In conclusion, while Ghaly *et al*. argue that upon experts' approval, DNR should be permissible considering the need for "allocating scarce resources to other patients who can massively benefit from supportive care" [62]. I believe that all individuals should enjoy their right to life and to receive treatment on an equal basis. Therefore, such a cost-benefit analysis does not justify the violation. Not to mention that non-voluntary euthanasia fails to pass the legality test, where it is found to violate different human rights on different levels internationally, regionally and domestically.

Moreover, non-voluntary euthanasia fails to pass the ethical test as set by the 'principlism approach'. This complexity has challenged different legal systems that are striving to balance between conflicting rights, but to no avail. This situation, in its entirety can be attributed to the absence of the individual's consent. Thus, the only way to overcome this challenge is to modify the health systems in a way that preserves life or death decisions only to the individual concerned. A system that recognizes that individual rights should only be decided by the individual, and not the group.

## 5. References

1. Jessica McKenney, 'Informed Consent and Euthanasia: An International Human Rights Perspective, International and Comparative Law Review', 2018, 18(2). <https://doi.org/10.2478/iclr-2018-0041> accessed 20 February 2019.
2. Bioethics Observatory- Institute of Life Sciences, 'Medical, Legal, Social and Bioethical Assessment of Euthanasia: Part I. Medical aspects' (Bioethics Observatory, 02 July, 2018. <http://www.bioethicsobservatory.org/2018/07/euthanasia-medical-procedures/26710> accessed 20 February 2019.
3. Ibid.
4. Bioethics Observatory- Institute of Life Sciences, 'Review of Countries Where Euthanasia has been legalized Increasing Involuntary Euthanasia, without Consent by Patients' (Bioethics Observatory, 15 August, 2017. <http://www.bioethicsobservatory.org/2017/08/euthanasia-in-patients-who-have-not-requested-it/12046 > accessed 20 February 2019.
5. Abulfadl Ebrahim, 'Euthanasia (Qatl al-Raḥma): Islamic Perspective', 2007, 39(4). Journal of the Islamic Medical Association of North America <https://0-search-proquestcom.library.qnl.qa/docview/1914491890?accountid=49936> accessed 22 February 2019.
6. Jonathan Herring, Medical Law and Ethics (Oxford University Press, 6th edn, 2018, 542.
7. Carlo Focarelli, 'Euthanasia', Max Plank Encyclopedia of Public International Law (Oxford Public International Law, 2013) <http://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e793> accessed 22 February, 2019.
8. Ibid 6**.**
9. Bioethics Observatory (n2).
10. Focarelli (n7) 6.
11. Appleby Matthew, 'Ethics, Consent and Capacity in the Older Cancer Patient. in, Problem Solving in Older Cancer Patients (Clinical Publishing- Oxford, 2016.
12. Herring (n6) 155.
13. UN Human Rights Council, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health', 2016. <https://digitallibrary.un.org/record/849534> accessed 23 February 2019.
14. Ibid, 5.
15. Herring (n6) 155.
16. Ibid, 153
17. Ibid (n 11).
18. Rachel Aviv, 'What Does It Mean to Die?' (The New Yorker, 29 January, 2018. <https://www.newyorker.com/magazine/2018/02/05/what-does-it-mean-to-die> accessed 24 February 2019.
19. Latasha Winkfield V. Children's Hospital *et al*., 2014. 4:13-cv-05993-SBA <https://cases.justia.com/federal/district-courts/california/candce/4:2013cv05993/273213/12/0.pdf?ts=1388978158> accessed 24 February 2019.
20. Cruzan v. Missouri Department of Health 497 U.S. 261, 1990. <https://www.law.cornell.edu/supremecourt/text/497/261> accessed 24 February 2019.
21. Anthony Lim, 'The Right to Die Movement: From Quinlan to Schiavo' (Third Year Paper, Harvard Law School, 2005. < https://dash.harvard.edu/bitstream/handle/1/8889450/Lim05.pdf?sequence=1> accessed 24 February 2019.
22. Eelco Wijdicks, 'Critics and Brain Death. In: Brain Death' (3rded, Oxford University Press 2017). <http://oxfordmedicine.com/view/10.1093/med/9780190662493.001.0001/med-9780190662493-chapter-5> Accessed April 16, 2019.
23. Drew Belsky, 'One-in-five 'vegetative' patients is misdiagnosed: Study' Life Site (Canada, 29 May, 2015. <https://www.lifesitenews.com/news/one-in-five-vegetative-patients-is-misdiagnosed-study> accessed 24 February, 2019.
24. Joffe Ari 'Are Recent Defences of the Brain Death Concept Adequate?' 24(2) Bioethics <https://www.worldcat.org/title/articles-are-recent-defences-of-the-brain-death-concept-adequate/oclc/615087290&referer=brief_results> accessed 25 February, 2019.
25. Ibid (n11).
26. McKenney (n1) 124.
27. Neil Soifer 'Euthanasia and persistent vegetative state individuals: the role and moral status of autonomy', 1996, 52(2) US National Library of Medicine National Institute of Health <https://www.ncbi.nlm.nih.gov/pubmed/15156859> accessed 26 February 2019.

28. Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May, 2008. (CRPD) art. 1.
29. Persistent Vegetative State (PVS) < https://en.oxforddictionaries.com/definition/persistent_vegetative_state> accessed 27 February, 2019.
30. Herring (n6) 496.
31. Ibid, 499.
32. Andreas Bender *et al*, ‘Persistent vegetative state and minimally conscious state: a systematic review and meta-analysis of diagnostic procedures’, 2015, 112(14). Deutsches Arzteblatt international <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4413244/> accessed 27 February 2019.
33. CRPD (n28) art. 10.
34. International Covenant on Civil and Political Rights (adopted 19 December, entered into force 23 March 1976) (CCPR) art. 6, 1966.
35. Anna Cornell, ‘Right to Privacy’, Max Plank Encyclopedia of Public International Law (Oxford Constitutional Law, 2016. <http://oxcon.ouplaw.com/view/10.1093/law:mpeccol/law-mpeccol-e156> accessed 3rd March 2019.
36. Focarelli (n7) 2.
37. Underrepresented Nations and Peoples Organization, ‘Self-determination’ (UNPO, 21 September, 2017. <https://www.unpo.org/article/4957> accessed 3rd March, 2019.
38. Ubaldus deVries *et al*, 'Information, Decision and Self-Determination: Euthanasia as a Case Study', 2009, 6(3). SCRIPTed <https://heinonline-org.peacepalace.idm.oclc.org/HOL/Page?public=true&handle=hein.journals/scripted6&div=47&start_page=558&collection=journals&set_as_cursor=0&men_tab=srchresults> accessed 3rd March 2019.
39. Régis Aubry, ‘Médecine Palliative: Soins de Support - Accompagnement - Éthique’, 2016, 15(3). Médecine Palliative <https://www.sciencedirect.com/science/article/pii/S1636652216300022> accessed 5th March 2019.
40. Ibid.
41. Ruth Horn, ‘The ‘French exception’: the right to continuous deep sedation at the end of life’, 2018, 44(3). Journal of Medical Ethics <https://jme.bmj.com/content/44/3/204#ref-3> accessed 5th March 2019.
42. Ibid.
43. Raymond DeVries *et al.*, ‘The moral organization of the professions: Bioethics in the United States and France’, 2009, 57(4). Current Sociology <https://journals.sagepub.com/doi/10.1177/0011392109104354#articleCitationDownloadContainer> accessed 5th March, 2019.
44. National Health Service, ‘Euthanasia and Assisted Suicide’ (NHS, n.d.) <https://www.nhs.uk/conditions/euthanasia-and-assisted-suicide/> accessed 6th March, 2019.
45. National Health Service, ‘End of Life Care’ (NHS, n.d.) <https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/> accessed 6th March, 2019.
46. Ibid.
47. Ebrahim (n5) 174.
48. Ibid 174.
49. A Child. High Court of England and Wales, 4 Re A (A Child) [2015] EWHC 443 (Fam) (High Court of England and Wales), 2015.
50. Tina Bharani *et al*. ‘Palliative Care in Qatar, 2008-2016’, 2018, 8(1). Journal of Palliative Care & Medicine <file:///C:/Users/Wafa/Downloads/Palliative_Care_in_Qatar_2008-2016%20(1).pdf> accessed 23rd April 2019.
51. Law No. (15) Of on Regulating the Human Organs Transfer and Transplantation, Art. 1, 2015.
52. Herring (n6) 24.
53. Ibid 26.
54. Ibid 202.
55. Ibid 26.
56. Ibid 27.
57. Ibid.
58. Ibid.
59. Ibid 28.
60. Ibid 176.
61. Ibid 29.
62. Mohammed Ghaly *et al.*, ‘Palliative Care and Islamic Ethics: Exploring Key Issues and Best Practice’, 2018. <https://www.wish.org.qa/wp-content/uploads/2018/11/IMPJ6078-WISH-2018-Islamic-Palliative-Care-181026.pdf> accessed 21st April 2019.