

Euthanasia: Ethical, Legal, and Medical Perspectives in Contemporary Society

Jyh-Woei Lin

Department of Electrical Engineering, Southern Taiwan University of Science and Technology, Tainan, 710301, Taiwan, Tel: +886(0) 966132209

 <https://orcid.org/0000-0001-6875-0172>

ABSTRACT

Euthanasia remains one of the most complex and controversial issues at the intersection of medicine, law, ethics, and human rights. Derived from the Greek words eu (good) and thanatos (death), euthanasia refers to the act of intentionally ending a person's life to relieve suffering. As medical technology advances and prolongs life beyond natural limits, societies are increasingly confronted with difficult decisions about the quality of life, autonomy, and dignity in death. This article explores euthanasia from multiple perspectives, including ethical theories, legal frameworks, and medical considerations. It examines distinctions between active and passive euthanasia, physician-assisted suicide, and the principle of double effect. Additionally, it analyzes global legal trends, cultural influences, and the role of healthcare professionals. The article concludes by emphasizing the need for balanced regulation that respects patient autonomy while safeguarding against abuse.

KEYWORDS: Euthanasia; Human Rights; Relieve Suffering; Legal Frameworks; The principle of Double Effect

* Corresponding Author: Jyh-Woei Lin

1. INTRODUCTION

The debate surrounding euthanasia (Costa and Carvalho, 2026) (**Figure.1**) has intensified over recent decades due to advancements in medical technology capable of prolonging life, sometimes beyond the point of meaningful recovery. Patients suffering from terminal illnesses, chronic pain, or irreversible conditions often face prolonged suffering, raising questions about whether they should have the right to choose death. Euthanasia is generally categorized into several forms: voluntary, non-voluntary, and involuntary. Voluntary euthanasia occurs when a competent individual consents to the act. Non-voluntary euthanasia involves patients unable to provide consent, such as those in comas. Involuntary euthanasia, performed against the patient's will is widely condemned and considered unethical and illegal. The issue is further complicated by distinctions between active euthanasia—direct intervention to end life, and passive euthanasia, which involves withholding or withdrawing life-sustaining treatment. Physician-Assisted Suicide (PAS) (Drabiak, 2026) (**Figure.2**) refers to a medical practice in which a physician provides a competent patient with the means (usually a prescription for a lethal

dose of medication) to end their own life, typically at the patient's voluntary and informed request. PAS involves providing patients with the means to end their own lives, rather than directly administering a lethal act. This article seeks to provide a comprehensive analysis of euthanasia, addressing its ethical justifications, legal frameworks, and medical implications.

2. HISTORICAL BACKGROUND

The concept of euthanasia is not new. In ancient Greece and Rome, philosophers such as Plato and Seneca expressed support for ending life in cases of unbearable suffering. The Hippocratic Oath is an ancient code of ethics historically taken by physicians to pledge their commitment to honest, ethical, and compassionate medical practice. Attributed to the ancient Greek physician Hippocrates (often called the father of Western medicine), the text dates back to roughly 400 BCE. While its original prose is rarely used today, its core ethical concepts remain the bedrock of modern bioethics. The Hippocratic Oath, which forms the foundation of modern medical ethics, explicitly prohibits physicians from administering deadly drugs. During the 20th century, euthanasia gained notoriety due to its misuse under Nazi Germany's euthanasia program (Outhwaite, 2026) (**Figure.3**), where it was used to justify the systematic killing of disabled individuals. This historical misuse has deeply influenced modern ethical caution. In recent decades, a shift toward patient rights and autonomy has reignited the debate, particularly in Western societies. Western societies encompass the cultures, values, and institutions historically rooted in European civilization. Predominant in Western Europe, North America, and Oceania, they are defined by democratic governance, capitalist economies, industrialization, secularism, and a strong cultural emphasis on individualism and human rights (Natalis, 2026).

3. DISCUSSION

Active euthanasia involves deliberate action to end life, such as administering a lethal injection. Passive euthanasia, on the other hand, involves withholding or withdrawing life-sustaining treatments, such as ventilators or feeding tubes. While passive euthanasia is more widely accepted, active euthanasia remains controversial due to its direct causation of death. Voluntary euthanasia: Conducted with the patient's informed consent. Non-voluntary euthanasia: Conducted when the patient cannot consent. Involuntary euthanasia: Conducted against the patient's will. Only voluntary euthanasia is widely debated as potentially ethical. PAS differs from euthanasia in that the physician provides the means for death, but the patient performs the final act. This distinction is legally significant in many jurisdictions. One of the strongest arguments in favor of euthanasia is respect for patient autonomy. Individuals have the right to make decisions about their own bodies, including the choice to end their suffering. Healthcare professionals are guided by the principles of beneficence (Bokek-Cohen and Gabay, 2026) (doing good) (**Figure.4**) and non-maleficence (doing no harm). Proponents argue that allowing prolonged suffering violates these principles, while opponents contend that intentionally ending life constitutes harm. From a utilitarian perspective, euthanasia may be justified if it reduces overall suffering. However, critics warn of potential abuses and societal consequences. Deontological theories, particularly those rooted in religious or moral absolutism, oppose euthanasia on the grounds that life is inherently valuable and should not be intentionally ended. This principle allows for actions that may hasten

death if the primary intention is to relieve suffering, such as administering high doses of pain medication. Euthanasia laws vary widely across countries: Legal: Netherlands, Belgium and Canada. PAS legal: Some U.S. states, Switzerland. Illegal: Most countries worldwide. The Netherlands was the first country to legalize euthanasia under strict conditions, including voluntary consent and unbearable suffering. Belgium allows euthanasia for both adults and minors under strict regulations. In the U.S., euthanasia is illegal, but PAS is permitted in certain states under "Death with Dignity" laws. Common safeguards include: multiple medical opinions, psychological evaluation, waiting periods and documentation and reporting requirements. Physicians face ethical dilemmas in balancing patient autonomy with professional responsibilities. Many medical associations oppose euthanasia, emphasizing palliative care as an alternative. Palliative care focuses on relieving suffering without hastening death. Advances in pain management challenge the necessity of euthanasia. Patients requesting euthanasia may suffer from depression or existential distress. Proper mental health evaluation is crucial. Most major religions oppose euthanasia: Christianity: Life is sacred and only God can end it. Islam: Strict prohibition against taking life. Hinduism and Buddhism: Mixed views, emphasizing karma and non-harm. Euthanasia represents a deeply complex issue that cannot be resolved through a single ethical or legal framework. While autonomy and relief from suffering provide strong arguments in favor, concerns about abuse and the sanctity of life remain significant. A balanced approach requires: Robust legal safeguards, Investment in palliative care Ethical training for healthcare professionals and Public dialogue and transparency

4. CONCLUSION

Euthanasia sits at the crossroads of compassion, ethics, and law. As societies continue to grapple with the challenges of modern medicine and human suffering, the debate will remain ongoing. While no universal solution exists, thoughtful regulation and ethical reflection are essential in navigating this sensitive issue. Ultimately, the question is not only whether euthanasia should be permitted, but how societies can ensure dignity, compassion, and justice in end-of-life care.

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Compliance with ethical statements consisting of conflicts of interest statements and informed consent

(1) All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

(2) The author declares that there are no conflicts of interest.

- (3) Informed consent was obtained from all individual participants involved in the study.
- (4) This work does not include animals as subjects.
- (5) Declaration of generative AI in scientific writing: The author declares no AI in scientific writing.

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Figure Captions



Figure 1: Euthanasia

Physician-Assisted Suicide (PAS)

Physician-Assisted Suicide (PAS) is a legal medical practice in some jurisdictions that allows individuals with a terminal illness to end their own lives with the help of a physician.



What is PAS?

PAS involves a physician providing a terminally ill, mentally competent adult with medication to end their life. The individual must self-administer the medication.

Eligibility Criteria (varies by jurisdiction)

- 18 years or older
- Diagnosed with a terminal illness
- Mentally competent
- Able to make an informed decision
- Voluntary request, free from coercion
- Often requires a prognosis of 6 months or less to live

Legal Status

PAS is legal in certain countries and regions, including:

- Canada
- Some U.S. states (e.g., Oregon, Washington, Vermont, California, Colorado, Hawaii, Maine, New Jersey)
- Australia (Victoria)
- New Zealand

*Laws are evolving.

The PAS Process (varies by jurisdiction)

- 1. Request**
The individual makes an initial verbal request to their physician.
- 2. Assessment**
The physician confirms eligibility and informs the person of their options, including palliative care.
- 3. Second Request**
A written request is submitted, often followed by a waiting period.
- 4. Confirmation**
A second physician (or other assessor) confirms eligibility in many jurisdictions.
- 5. Prescription**
The physician provides a prescription for medication.
- 6. Self-Administration**
The individual self-administers the medication in a private setting.

Rationale

- Respect for autonomy
- Relief from suffering
- Dignity in dying
- Choice at end of life

Safeguards

- Strict eligibility requirements
- Multiple assessments
- Informed consent
- Voluntary decision
- Documentation and reporting

Key Takeaway

PAS remains a complex and deeply personal issue involving medical, ethical, legal, and societal dimensions. Laws and perspectives continue to evolve.

Ethical Considerations

Arguments in Support

- Respects personal autonomy and choice
- Provides relief from unbearable suffering
- Allows for a dignified death

Arguments of Concern

- Risk to vulnerable populations
- Potential for coercion
- Impact on palliative care and disability rights
- Moral and religious objections

i PAS is distinct from euthanasia, where the physician administers the medication.

Figure 2: Physician-Assisted Suicide (PAS)

Nazi Germany's Euthanasia Program "Aktion T4"

The Nazi regime launched a systematic program of euthanasia aimed at people with disabilities, mental illnesses, and other perceived "life unworthy of life." It was one of the earliest and most horrifying expressions of the regime's ideology.

BACKGROUND	THE T4 PROGRAM	METHODS
<ul style="list-style-type: none"> • Rooted in Nazi eugenics and the belief in racial purity. • Influenced by the 1920 Law for the Prevention of Hereditarily Diseased Offspring. • Enabled by a January 1939 decree signed by Hitler. 	<ul style="list-style-type: none"> • Began in 1939 under the codename "Aktion T4," named after its Berlin address: Tiergartenstrasse 4. • Targeted individuals in hospitals, mental institutions, and nursing homes. • Victims were deceived, often told they were being transferred for treatment. • Approximately 70,000 people were murdered between 1939 and 1941. 	<ul style="list-style-type: none"> • Victims were transported to "euthanasia centers" such as Hadamar, Grafeneck, Brandenburg, Hartheim, and Sonnenstein. • Murdered using carbon monoxide gas in sealing rooms, disguised as showers. • Bodies were cremated, and ashes often sent to families with fake death certificates.

TIMELINE

- 1933: Nazi regime comes to power.
- 1939: "Aktion T4" begins.
- 1941: Public protest led to the official halt of T4, but killings continue under decentralized programs.
- 1945: End of WWII. Perpetrators of the program are tried in court.

BEYOND T4


While the official T4 program ended in August 1941 due to public and Church protests, euthanasia continued in other forms:

- Hunger and neglect in institutions
- Lethal injections
- Medical experiments


These practices continued throughout the Nazi era and into occupied territories.

"The Führer has ordered that incurably sick persons be granted a mercy death."
— From an internal memo signed by Hitler, 1939


"Life unworthy of life is not worth living."
— Nazi propaganda slogan



Transport bus used to deport victims to killing centers.



Crematory oven at one of the killing centers.



Victims of the euthanasia program.

LEGACY

The euthanasia program was a precursor to the Holocaust. It demonstrated how bureaucracy, deception, and ideology could be used to justify mass murder. Many of the doctors and officials involved went on to participate in the Final Solution.

Figure.3: Nazi Germany's euthanasia program

The Principles of Beneficence

Beneficence is the ethical obligation to act in the best interest of others by promoting their well-being and doing good.

1. Act in the Best Interest
Always seek to promote the well-being and good of others.

2. Prevent Harm and Promote Good
Not only avoid causing harm, but also take positive steps to benefit others.

3. Support Others' Well-being
Help others achieve better physical, mental, and social well-being.

4. Respect Individual Needs
Recognize and respond to the unique needs and values of each person.

5. Build Trust and Compassion
Demonstrate kindness, empathy, and a genuine concern for others.

6. Balance with Other Principles
Beneficence should be balanced with respect for autonomy, justice, and non-maleficence.

In Practice
Beneficence guides healthcare professionals, caregivers, and all helping relationships to make decisions and take actions that improve lives and foster well-being.

At its core, beneficence means: **Do good, help others, and make a positive difference.**

Figure.4: The principles of beneficence