THE RIGHT TO DIE WITH DIGNITY: AN ENDLESS STRUGGLE BETWEEN EUTHANASIA AND THE RIGHT TO LIFE

Oluremi Savage*

Abstract

Euthanasia, whether active or physician-assisted, has been a contentious issue and remains one to date. In fact, the debate, which is centered on the right to die with dignity, is one that encompasses ethical, legal, and human rights perspectives. Just like every human rights issue relating to the right to life, the practice of euthanasia continues to invoke major ethical dilemmas in medical practice in several jurisdictions all over the world. This article seeks to explore the unending struggle between the proponents of euthanasia, who mainly rely on the right to dignity to advocate for individuals' autonomy in choosing to end their suffering by dying with dignity, and those who seek to uphold the sanctity of life at all costs through their unwavering emphasis on the inviolability of the right to life. The article explores several issues, including the dilemma related to the practice of euthanasia, patient vulnerability, and medical ethics, by examining different jurisdictions and legal frameworks. It also considers the implications of legalizing or prohibiting euthanasia on patients, healthcare providers, and society at large. Finally, this article intends to provide a balanced view of the right to die with dignity, the moral dilemmas attached to it and the necessity for providing pragmatic solutions that hopefully result in dignified end-of-life experiences.

Keywords: Euthanasia, beneficence, nonmaleficence, right to dignity, right to life, and medical ethics

* Public and Private Law Department, Faculty of Law, Lagos State University, Ojo, Lagos, Nigeria. Email: remisavage@yahoo.com; oluremi.savage-oyekunle@lasu.edu.ng

1. INTRODUCTION

Throughout history and across the globe, euthanasia, much like other critical life and death issues, often incite significant controversy and diverse viewpoints fundamentally grounded in legal, social, religious, economic, and ethical/moral principles.[1] From a legal perspective, many opponents of euthanasia ground their objections primarily on the principle of the sanctity of human life and the imperative to uphold and respect its preservation by vigorously opposing legislations that undermine the preservation of the sanctity of life.[2] Conversely, proponents of euthanasia often base their argument on the ethical principles of autonomy and self-determination, considerations of quality of life, and the concept of justice.

Euthanasia has undergone significant evolution over time. In ancient Greece, although life was regarded as sacred, there was the belief that it had a threshold beyond which it lost its value and significance. Based on their belief that it wasn't all lives that was necessary to sustain or preserve, unhealthy children with deformities were left to die to prevent them from living miserable and unfulfilled lives [3] Philosophers such as Socrates, Plato, Pythagoras and Aristotle were in support of euthanasia. In their opinion, people who were not healthy and lived their lives amidst illnesses and medicines should be left to die as the ceasing of life was better to avoid a long and torturous agony.[4] In fact, Herodotus was condemned for inventing a way to prolong death and over manage the symptoms of serious illnesses thus resulting in situations where his

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[1] B E Oniha, 'Legality of Euthanasia and The Right to Die in Nigeria' (2016) 1 <https://edojudiciary.gov.ng/wp-content/uploads/2017/07/legality-of-euthanasia-and-the-right-to-die-in-nigeria-by-bright-e.-oniha-corrected.pdf> accessed 21 September 2024.

[2] As above, 2.

[3] O O Familusi, 'A Religious Response to the Paradox of Euthanasia and the Sanctity of Life' *Ibadan Journal of Humanistic Studies* (2017) (27) 126.

[4] Y A Picon-Jaimes *et al* "Euthanasia and assisted suicide: An in-depth review of relevant historical aspects" (2022) 75 *Annals of Medicine & Surgery* 2

patients, though biologically present, were in a state of total dependence on medical equipment. According to Stoics, the presence of unbearable pain is one of the reasons a wise person chooses to separate themselves from life.[5]

In Nigeria, where customs and traditions are deeply ingrained, life is regarded as a sacred divine gift that must not be taken lightly. The reverence for life is such that even the most precarious state of health is preferable to death. Thus, the practice of euthanasia is considered taboo as it starkly conflicts with the nation's societal norms. In addition to societal norms, the major religions practiced in the country, Islam and Christianity, unequivocally denounce euthanasia. As a result of the above beliefs, it can be stated that there is virtually no historical precedent for the practice of assisted suicide or euthanasia in Nigeria. Obi[6] however notes that during the inter-tribal wars of the 19th and 20th centuries, a form of non-voluntary euthanasia could be said to have occurred when helpless infants were abandoned by their parents while seeking refuge from enemies. The abandoned children often succumbed to death due to their exposure to harsh weather and other dangerous elements.

In recent years, euthanasia as a practice, has attracted significant attention due to several factors; first is the fast-paced developments and technological advancements in the medical field and second is the significant shift perception and understanding of death. [7] Unlike before, especially in western countries, death is no longer considered as a natural event, and it is believed that it is not worth clinging to a life filled with untold pain due to chronic illness when a person can choose to exit it

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5 As above, 3.

6 M C Obi, 'A critical appraisal of euthanasia under Nigerian laws' (2014) 5 *Nnamdi Azikiwe University Journal of International Law and Jurisprudence* 79.

7 Obi (n 6) 75.

dignifiedly.[8] On the other side of the fence are still many countries in Europe and Africa, like Nigeria, who are opposed to the practice of euthanasia.[9]

The debates that have arisen because of the practice of euthanasia are such that a careful exploration of concept needs to be reviewed *viz* the intrinsic value place on human life and the possible societal repercussions of the practice if misused. Thus, it is pertinent to examine the incessant struggle between euthanasia and the right to life in relation to the endless clamour for the right to die with dignity. To achieve this, this paper is divided into reasonable parts. The introduction is followed by a brief elucidation of the concept of euthanasia. The types and forms of euthanasia are also examined before analysing the current legal framework on euthanasia. Human Rights Implications on euthanasia are also addressed without leaving the ethical framework on euthanasia untouched. This is followed by the religious perspective on euthanasia, arguments for and against euthanasia, emerging trends on euthanasia and practicable recommendations where available.

2. THE CONCEPT OF EUTHANASIA

The word "Euthanasia" is derived from two Greek words "eu" which means "good cheer" and "thanatos" which means "death". Euthanasia refers to the deliberate act of ending the life of an individual who is experiencing severe and incurable suffering, typically with the intention of

[8] Human rights have been used to especially canvass for the practice of euthanasia. For example, euthanasia is legal in Netherlands, Belgium, Luxembourg, and Spain. Other countries, like Austria and Finland, allow passive euthanasia under specific circumstances. Also, New Zealand, Canada, Netherlands, Belgium and Luxembourg have legalized both active euthanasia as well as physician-assisted suicide (PAS). It is also noted that states like Washington and Oregon in the United States have enacted legislations regulating physician-assisted suicide.

[9] European countries like Norway, Ireland, Germany, China and Italy actively prohibit euthanasia. Note that most African countries also do not legalize euthanasia or physician-assisted suicide.

relieving pain. The concept is often described as mercy killing because it involves the intentional termination of life in order to alleviate unbearable medical distress.[10] According to Omipidan, euthanasia is the act or practice of painlessly putting to death persons suffering from incurable and painful diseases or incapacitating physical disorders.[11] Likewise, the Blacks' Law Dictionary defines euthanasia as 'the act or practice of painlessly putting to death persons suffering from stressing and incurable disease as an act of mercy'.[12] Several scholars have also defined euthanasia. While Annadurai *et al* see it as the hastening of death of a patient to prevent further sufferings; Muckart *et al* regard it as any conduct that brings about easy and painless death for persons suffering from incurable diseases or conditions'.[13] Whichever way it is defined, euthanasia involves the intentional termination of a person's life, either by direct intervention or by deliberately withholding life-support services.

It is necessary to point out that the criteria for eligibility for euthanasia essentially varies across jurisdictions depending on the legislation in place in the different countries. Irrespective of the differences however, criteria that cuts across jurisdictions to qualify to choose death with dignity, are similar and includes the patient being diagnosed with a terminal disease that is likely to cause death within six months as confirmed by a healthcare provider; the patient being resident in a state or country where the law allows the practice of euthanasia or assisted suicide; the patient must possess autonomy and have the capacity to not only make informed decisions but also the ability to clearly communicate the decisions to

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[10] See Obi (n 6) 75; R I Adebayo, 'Euthanasia in The Light of Islamic Law and Ethics' *Journal of Nigeria Association of Arabic and Islamic Studies* (2008) (11) 1.

[11] B A Omipidan 'Euthanasia: The 21st Century Culture of Death' *Nigerian Bar Journal* (2011) 7(1) 213.

[12] B A Garner, Black's Law Dictionary 9th Ed. (Texas; Law Prose Inc., 2009), 634.

[13] K Annadurai *et al*, 'Euthanasia: Right to Die with Dignity' *Journal of Family Medicine and Primary Care* (2014) 3(4) 477; D J J Muckart *et al* 'Palliative care: Definition of euthanasia' *South African Medical Journal* (2014) 104(4) 259.

his/her healthcare provider among others.[14] In the Netherlands where assisted suicide,[15] a form of euthanasia is also legal, the procedure is only allowed in situations where a person experiences intolerable or unbearable suffering with no prospect of improvement and in order to reach the above conclusion, a physician must not only satisfy six conditions including the conviction that the request by the patient was voluntary and well-considered; that he has informed the patient about his medical condition and his prospects for healing; and he holds the conviction that the patient's suffering is long lasting and unbearable, but he must have also consulted at least another physician, who must physically see the patient and thereafter write an opinion that the physician has satisfied the conditions of due care. [16] In addition, the physician is to notify the municipal pathologist who is to issue a death certificate together with him.[17] In the Oregon, United States of America, a person qualifies for euthanasia if he is terminally ill and in the opinion of his physician, he has just six months or less to live. This is in addition to the conviction that the patient is autonomous and capable of making and communicating health care decisions for themselves.[18] It should be noted that a minimum of 15 days must elapse between a patient's initial oral request for a prescription and the eventual writing of the prescription.[19] The 15-day period is to

[14] A Giorgi, 'Euthanasia: Understanding the Qualifying Factors and Legality' <https://www.verywellhealth.com/euthanasia-8701113> Accessed 8 May 2025.

[15] Assisted suicide is the process where a patient ends his/her life with the assistance of others. This procedure is also referred to as Physician Assisted Suicide (PAS).

[16] See Article 2 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002; Government of Netherlands, 'Euthanasia' <https://www.government.nl/topics/euthanasia> accessed 8 May 2025; Omipidan (n 14) 213.

[17] See Articles 9 and 10 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.

[18] Death with dignity Act,1997 <https://www.oregonlegislature.gov/citizen_engagement/reports/deathwithdignityact.pdf> accessed 8 May 2025.

[19] In 2020, the 15 days waiting period will be shortened to 48 hours for patients who have less than 15 days to live. See Oregon Health Authority, 'Oregon's Death with

allow the patient to reflect on their decision and reconsider the request if he/she so wish.[20]

3. FORMS AND TYPES OF EUTHANASIA

The various types of euthanasia are discussed in the sub-section below:

3.1 Active Euthanasia

Active euthanasia is an act of commission whereby the intent is the death of the patient. It is irrespective of whether the patient dies due to the deliberate act of a health care provider administering a lethal dose of drugs or injection to end a terminally ill patient's life. [21] According to Black's Law Dictionary, this form of euthanasia is carried out by a healthcare provider who not only provides the means of death but also performs the final death-causing act.[22] According to Chao *et al*, there are three types of active euthanasia *viz* active voluntary euthanasia which is usually undertaken by a physician at the terminally ill patient's request; active non-voluntary euthanasia which is undertaken by the healthcare provider without the patient's consent because he/she is not able to give consent and active involuntary euthanasia, where the act still occurs irrespective of the fact that the terminally ill patient does not give consent at all.[23]

Dignity Act' <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx#:~:text=A%3A%20Starting%20January%201%2C%202020,second%20oral%20requests%20for%20medication> accessed 8 May 2025.

[20] In addition, counselling should be provided if the patient is suffering from a mental disease or depression which can affect his judgment. It is also compulsory that the next of kin of the terminally ill patient is notified, in addition to informing the relevant state authorities.

[21] B.E. Oniha, (n 1).

[22] Garner (n 15) 634.

[23] D V K Chao *et al,* 'Euthanasia revisited' *Family Practice* (2002) 19(2) 128-134.

3.1.1 Active Voluntary Euthanasia

This form of euthanasia is usually carried out with the informed consent of a terminally ill patient who gives consent beforehand[24] explicitly stating his/her desire for life to be terminated at a particular time. It may also involve the patient requesting the cessation of life-sustaining treatment, fully aware that the request will inevitably lead to their death. [25] In *R v Cox*,[26] Nigel Cox, a physician, had treated the patient for over 13 years. The patient was terminally ill with arthritis and conventional treatment had not succeeded in alleviating her pain. After repeatedly asking the defendant to end her life, the physician administered a dose of potassium chloride on her and she died. However, because it was not clear whether her death was due to her terminal condition or the injection, the physician was charged with attempted murder. To secure a conviction, it was necessary for the prosecution to show that the defendant physician intended to end the patient's life. The defendant on his part argued that he administered the injection to relieve pain and not to kill. The court, after examining the case, and the arguments proffered by both sides, convicted him of attempted murder. He was subsequently given a suspended sentence.[27]

Previously unlawful in several jurisdictions, voluntary active euthanasia is now practiced legally in several countries.[28] Despite its legalization

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[24] The terminally ill patient gives the consent either through a living will or express directive to the physician and his relatives.

[25] Oniha (n 1) 6.

[26] *R v Cox* (1992) 12 BMLR 38.

[27] Ipsa Loquitur '*R v Cox*' https://ipsaloquitur.com/criminal-law/cases/r-v-cox/ accessed 8 May 2025.

[28] As at 2024, voluntary active euthanasia is legal in Belgium, Canada, Colombia, Ecuador, Luxembourg, the Netherlands, New Zealand etc. See also Güth *et al*, 'Medical Aid in Dying: Europe's Urgent Medico-Ethical Challenge' *International Journal of Public Health* (2023) 68:1606538 <https://pmc.ncbi.nlm.nih.gov/articles/PMC10507858/pdf/ijph-68-1606538.pdf> accessed 9 May 2025

however, the ethics codes of major medical organizations do not support the practice for several reasons ranging from the fact that the procedure goes against the goals of medicine to the possibility that the procedure may be used on unwilling persons and vulnerable populations.[29]

3.1.2 Active Non-Voluntary Euthanasia

Active non-voluntary euthanasia refers to a healthcare provider deliberately taking action to end the life of a patient who is unable to decide or provide consent. This occurs in cases where the patient is terminally ill and either unconscious or in a persistent vegetative state. In situations like this, the wishes of the patient are not known because of incompetence or incapacity.[30] Ahaneku and Arinze-Umobi[31] argue that all forms of euthanasia, except active voluntary euthanasia, should be discouraged, as they place physicians in a difficult ethical and legal position. If a doctor acts out of sympathy and ends the life of a terminally ill patient, they risk being charged with murder.

Conversely, if they choose not to intervene, they may struggle with guilt, knowing that the patient remains in persistent pain with no hope of recovery.[32] It is personally felt that blanketly discouraging every other form of euthanasia except active voluntary euthanasia, is a wrong approach to adopt as this may lead to a continuation of agony both for terminally ill patients, who are in a persistent vegetative state (PVS) and their relatives, who though not ill, also undergo untold mental torture due to the medical condition of their relative. Instead of adopting the position

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[29] Australian Human Rights Commission 'Euthanasia, human rights and the law' (2016) <https://humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law#Heading239> accessed 9 May 2025.

[30] See Airedale NHS v Bland (1993) ALL ER 82 (HL); Oniha (n 1) 7.

[31] S.O. Ahaneku & C.C. Arinze-Umobi, 'Legalizing euthanasia in Nigeria: Comparative study of law of euthanasia in Netherland, Belgium and Canada' *Law* (2024) 11 (4) *Nnamdi Azikiwe University Journal of Commercial and Property* 141.

[32] As above.

opined by the learned authors,[33] a better approach as already adopted in other jurisdictions will be establish ethics committees to not only draft regulations to be abided by healthcare providers but also ensure that individual cases of euthanasia are determined on their merits as done in the Indian case of *Aruna Ramchandra Shanbaug vs Union of India & Ors*[34] where the court in deciding the petition brought by the petitioner, Ms. Pinki Virani claiming to be the next friend of the terminally ill patient, requested that she be euthanized by the withdrawal of life supporting treatment. In this instance, the court, personally reviewing the patient's situation, dismissed the petitioner's application after receiving independent reports from different physicians about the patient's state. It was on the above basis that it held that Aruna Ramchandra Shanbaug, though in a PVS, was not brain dead and the hospital staff taking care of her for the past 37 years had not provided any evidence that she needed to be euthanised.[35]

3.1.3 Active Involuntary Euthanasia

Active involuntary euthanasia involves a physician intentionally ending a terminally ill person's life through lethal means, without the patient's consent. This type of euthanasia differs from active voluntary euthanasia, where the patient clearly demands and consents to the action. In this case, the terminally ill patient remains capable of making rational decisions and does not seek assistance in dying. Nevertheless, their life is ended without their request for the procedure. The practice of active involuntary euthanasia is thus not only unethical and illegal in all jurisdictions but also a major reason canvassed for opposition to the practice by those against its legalization.[36]

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33 As above.

34 Aruna Ramchandra Shanbaug vs Union of India & Ors (2011) 4 S.C.R. 1057 <https://indiankanoon.org/doc/235821/> assessed 9 May 2025.

35 As above

36 Active involuntary euthanasia, which is done against the patient's will, is illegal in all countries and is usually regarded as murder. See A. G. Oluwaleye, 'The Legalization

3.2 Passive Euthanasia

This is the deliberate act of discontinuing medical treatment with the obvious intention of hastening the patient's death. In this situation, life-sustaining support used to keep the terminally ill patient alive is withdrawn by the physician or healthcare provider.[37] According to McQuoid-Mason,[38] passive euthanasia seeks to avoid unnecessarily extending the dying process by allowing a terminal illness to take its natural course either by withholding or withdrawal of medical intervention thereby suggesting that the illness itself, rather than any medical intervention or lack thereof, is responsible for the patient's death. Thus, the key distinction between active and passive euthanasia is the physician's direct role in ending the life of a terminally ill patient in the former, whereas in the latter, the decision is merely to refrain from intervention by withholding life-sustaining treatment as seen in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*.[39]

3.3 Physician-Assisted Suicide

Physician-Assisted Suicide (PAS) or Assisted Suicide (AS) is a practice in which a physician, upon the request of a terminally ill patient, provides a prescription for a lethal dose of medication. The patient then has the option to self-administer the drug with the clear intention of ending his/her life.[40] Thus, control lies in the hands of the terminally ill patient himself and no one else. Like all medical procedures related to euthanasia,

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of Euthanasia in Nigeria: A Right to Die or a Threat to Life' (2025) <https://sabilaw.org/the-legalization-of-euthanasia-in-nigeria-a-right-to-die-or-a-threat-to-life/ > accessed 13 May 2025.

37 Oniha (n 1) 5.

38 D.J. McQuoid-Mason, 'Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held liable for murder' South African Medical Journal (2014) 104(2)102-103 < https://pubmed.ncbi.nlm.nih.gov/24893534/> accessed 9 May 2025.

39 *M.D.P.D.T v Okonkwo* (2001) All N.L.R 305.

40 Obi (n 6) 78; AAHPM 'Physician-Assisted Dying' https://aahpm.org/advocacy/where-we-stand/pad/ accessed 12 May 2025.

physician-assisted suicide remains the focus of several debates including debates on the proper terminology to use.[41]

4. LEGAL FRAMEWORK FOR EUTHANASIA

4.1 Nigeria's constitutional baseline: life, dignity, privacy, and decisional autonomy

Nigeria's constitutional order begins from a strong presumption in favour of the preservation of life. Section 33(1) of the Constitution guarantees the right to life and prohibits intentional deprivation of life save in execution of a court sentence in respect of a criminal offence of which a person has been found guilty in Nigeria, and other exceptions as stipulated in the Constitution.[42] This textual commitment to life, however, exists alongside rights that are frequently invoked in end-of-life controversies: the right to dignity of the human person (including protection against inhuman and degrading treatment) under section 34, and the right to private and family life under section 37. The doctrinal question is therefore not whether the Constitution values life; it plainly does, but whether the constitutional matrix recognises a protected sphere of decisional autonomy over medical interventions at the end of life, and, if it does, how far that autonomy extends where death is a foreseeable outcome.

The leading Nigerian authority in this regard is *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*, in which the Supreme Court affirmed the primacy of a competent adult's choice to refuse medical treatment, even where refusal may lead to death. The Court

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[41] In some jurisdictions, physician assisted suicide (PAS) is also referred to as physician assisted dying (PAD), voluntary assisted dying (VAD), physician aid in dying (PAID) and medical aid in dying (MAID). See Compassion and Choices, 'Medical Aid in Dying Is Not Assisted Suicide, Suicide or Euthanasia' <https://compassionandchoices.org/resource/not-assisted-suicide/> accessed 12 May 2025; Güth *et al* (n 28 above).

[42] The Constitution of the Federal Republic of Nigeria, 1999.

reasoned that, absent in the absence of a compelling and legally cognisable overriding state interest (for example, where dependent minor children or another strong public interest requires intervention), the law must respect the liberty of the competent adult to decide a course for their life and body.[43] This decision is not a direct legalisation of euthanasia; rather, it supplies the constitutional and common-law foundation for recognising lawful treatment refusal and withdrawal of treatment as part of the patient's rights-based control over bodily integrity.

4.2 Criminal law: active euthanasia and assisted suicide as homicide-related offences

Nigeria's criminal statutes do not employ the term "euthanasia". Their technique is more direct: they criminalise acts and assistance that intentionally cause death, and they deny the exculpatory force of consent to being killed.

First, section 299 of the Criminal Code provides in categorical terms that a person's consent to the causing of their own death "does not affect the criminal responsibility" of the person who causes that death. This provision is structurally fatal to any claim that voluntary active euthanasia (even with written consent and informed request) is lawful under current Nigerian criminal law in the Southern states where the Criminal Code applies.[44]

Secondly, the Criminal Code criminalises assistance in suicide. Under section 326, procuring, counselling, or aiding another to kill themselves attracts felony liability. In parallel, the Penal Code regime applicable in many Northern states and the Federal Capital Territory criminalises attempted suicide and provides related offences on encouragement/abetment of suicide. Taken together, Nigeria's penal architecture treats active euthanasia and physician-assisted suicide as

[43] *M.D.P.D.T v Okonkwo* (n 39 above).
[44] Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004.

criminal conduct, either as murder/manslaughter (where death is caused) or as assistance offences (where a person helps another to die).[45]

The case law aligns with this strict approach to consent. In *State v Okezie*, the deceased's request that a charm be tested by firing a shot at him did not negate criminal responsibility; the accused was convicted notwithstanding the victim's consent. The doctrinal message is consistent with section 299: consent does not convert a killing into a lawful act.[46]

4.3 The legal "space" for passive euthanasia: refusal/withdrawal of treatment

Although Nigerian criminal statutes disallow direct killing and suicide assistance, the law is more nuanced regarding withholding or withdrawal of treatment. The Supreme Court's reasoning in *Okonkwo* supports the view that a competent adult may lawfully refuse life-prolonging treatment and that a clinician's obligation in such circumstances is to provide comfort and palliative support rather than forced intervention.[47] This jurisprudence functions as a legal recognition of a form of end-of-life choice that is sometimes characterised as "passive euthanasia", though analytically it is better understood as lawful treatment refusal grounded in autonomy, privacy, and bodily integrity.

That said, Nigeria still lacks a comprehensive statutory framework regulating: (i) advance directives; (ii) "do not resuscitate" orders; (iii) substituted decision-making for incapacitated patients; and (iv) institutional ethics review processes. The result is a significant regulatory gap: while *Okonkwo* clarifies the position for competent adults refusing treatment, it does not fully resolve hard cases involving incapacity,

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45 Sections 231 and 232, Penal Code Act, Cap P3, Laws of the Federation of Nigeria 2004.

46 *State v Okezie* (1970) ECSLR 414; *R v Nwokocha* (1949) 12 WACA 453.

47 As above, 9.

persistent vegetative state, contested family interests, or allegations of undue influence.

4.4 Professional regulation: medical ethics and disciplinary exposure

Even where the criminal law is not triggered, medical practitioners face professional-ethical regulation. Nigerian medical practice is governed through the Medical and Dental Council of Nigeria's regulatory framework and professional conduct standards.[48] In practical terms, any move toward normalising euthanasia would require not only criminal-law reform but also explicit professional-ethical guidance addressing: (i) end-of-life counselling; (ii) palliative care obligations; (iii) documentation and independent review; and (iv) safeguards against coercion and abuse of vulnerable persons.

5. HUMAN RIGHTS IMPLICATIONS OF EUTHANASIA

Over the years, there has always been arguments for and against the practice of euthanasia. Majority of these arguments are often canvassed from a human rights perspective. Those who argue against euthanasia and assisted suicide are often regarded as "pro-life" adherents. The argument of the pro-life adherents is principally based on sanctity of human life and the need to accord utmost respect to its sustenance. They therefore actively seek to discourage any law or policy that deviates from protection of the sanctity of life. Pursuant to this resolve, pro-life adherents often cite a host of International and national legal instruments that guarantee the right to life and the promotion of its sanctity.[49] These instruments include the municipal constitutions[50] of most countries of the world and international instruments such as the International Covenant on civil and

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48 Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004.

49 Oniha (n 1 above) 2.

50 Constitution of the Federal Republic of Nigeria 1999, ss 33 and 34.

Political Rights (ICCPR) 1966,[51] the Universal Declaration of Human Rights (UDHR) 1948,[52] and the African Charter on Human and People's Rights 1981.[53]

On the other hand, those who are in support of the practice of euthanasia are often referred to as pro-choice advocates. The pro-choice adherents believe that people should have freedom of choice, including the right to control their own body and life (as long as they do not abuse any other person's rights), and that the state should not create laws that prevent people being able to choose when and how they die.[54] They further argued that euthanasia, particularly passive euthanasia, is allegedly already a widespread practice, just not one that people are willing to admit to, so it is better to regulate euthanasia properly.[55]

6. PHILOSOPHICAL AND ETHICAL FRAMEWORK ON EUTHANASIA

Debates concerning euthanasia are deeply embedded in philosophical and ethical reasoning about the value of human life, the alleviation of

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[51] Article 6, International Covenant on Civil and Political Rights 1966 <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights> accessed 13 February 2026.

[52] Article 2, Universal Declaration of Human Rights (UDHR) 1948 <https://www.un.org/en/about-us/universal-declaration-of-human-rights> accessed 13 February 2026.

[53] Article 4 African Charter on Human and People's Rights 1981. The African Charter is domesticated in Nigeria through The African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, codified as Cap A9 LFN 2004. See African Charter on Human and People's Rights 1981 <https://www.oas.org/en/sla/dil/docs/African_Charter_Human_Peoples_Rights.pdf> accessed 13 February 2026.

[54] Clear Chemist, 'Euthanasia and Assisted Suicide - Arguments for and Against Euthanasia and Assisted Suicide' <https://www.clearchemist.co.uk/az-health/euthanasia-and-assisted-suicide/arguments-for-and-against-euthanasia-and-assisted-suicide> accessed 22 May 2024.

[55] As above.

suffering, and the role of medical professionals in end-of-life care. Ethical evaluation of euthanasia frequently draws upon a number of well-established principles in biomedical ethics, including *Non-maleficence, Beneficence, the Hippocratic medical tradition, the Doctrine of double effect, religious objections often framed as the "Playing God" argument, and considerations of justice.* Each of these frameworks offers a distinct normative lens through which the permissibility of euthanasia may be assessed.

6.1 Non-maleficence

The ethical principle of non-maleficence is widely recognised as a foundational element of medical practice. Commonly expressed through the maxim primum non-nocere meaning first do no harm, the principle obliges healthcare professionals to refrain from conduct that may cause unnecessary injury, pain, or suffering to patients.[56] In end-of-life care, the application of this principle raises an important ethical question: does the continued use of life-sustaining medical treatment in circumstances of irreversible illness constitute harm rather than benefit?

Modern medical technology has significantly expanded the ability of physicians to sustain biological life through interventions such as mechanical ventilation, artificial nutrition and hydration, and advanced resuscitative procedures. While these technologies can be life-saving in many situations, their use in cases involving irreversible conditions has generated complex ethical concerns. Patients suffering from advanced neurodegenerative conditions or persistent vegetative states may be maintained in prolonged states of medical dependency despite having little prospect of recovery.[57]

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[56] Tom L Beauchamp & James F Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019) 153.

[57] H Kuhse & P Singer, *Should the Baby Live?* (OUP 1985) 128.

In such circumstances, medical intervention may extend the physiological process of dying without improving the patient's quality of life. Some scholars have therefore argued that the ethical duty to avoid harm may require physicians to reconsider the continued use of invasive treatments that merely prolong suffering.[58] This perspective has been recognised in judicial decisions concerning the withdrawal of life-sustaining treatment. In *Airedale NHS Trust v Bland*, the House of Lords held that the discontinuation of artificial nutrition and hydration from a patient in a persistent vegetative state could be lawful where continued treatment served no therapeutic purpose.[59] The court reasoned that the continuation of futile treatment may not necessarily promote the interests of the patient. From this standpoint, proponents of euthanasia contend that the physician's duty to prevent harm may, in exceptional circumstances, support interventions aimed at relieving unbearable suffering where no curative treatment exists.

6.2 Beneficence

Closely related to non-maleficence is the principle of beneficence, which requires healthcare professionals to act in ways that promote the welfare and best interests of their patients. Beneficence imposes a positive obligation on physicians to alleviate suffering and improve the well-being of those under their care.[60]

However, disagreement arises regarding how beneficence should be interpreted in cases involving terminal illness. One view maintains that beneficence obliges physicians to preserve life wherever possible, even where treatment may impose substantial burdens on the patient. Under this approach, the preservation of life is regarded as an overriding ethical objective.

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[58] J Rachels, *The End of Life: Euthanasia and Morality* (OUP 1986) 34.
[59] *Airedale NHS Trust v Bland* [1993] AC 789 (HL).
[60] Beauchamp and Childress (n 56) 202

An alternative interpretation places greater emphasis on the patient's subjective experience of suffering and the importance of respecting autonomous choices. According to this perspective, beneficence may require physicians to respond compassionately to patients who are enduring unbearable pain with no realistic prospect of recovery.[61] In such circumstances, supporters of euthanasia argue that assisting a patient to achieve a peaceful death may represent a humane response consistent with the physician's duty to relieve suffering.

Recent developments in several jurisdictions illustrate the growing influence of this perspective. For example, the Supreme Court of Canada in *Carter v Canada (Attorney General)* held that a blanket prohibition on physician-assisted dying violated the constitutional rights of competent adults suffering from grievous and irremediable medical conditions.[62] The court emphasised that respect for individual autonomy and human dignity may justify permitting assisted dying under carefully regulated conditions.

6.3 The Hippocratic Oath

Opposition to euthanasia has historically drawn support from the Hippocratic medical tradition, which emphasises the physician's commitment to healing and the preservation of life. The classical Hippocratic Oath contains a well-known prohibition against administering lethal drugs to patients.[63] For many critics of euthanasia, this prohibition represents a foundational ethical commitment that precludes physicians from intentionally causing the death of those under their care.

Nevertheless, contemporary scholarship recognises that the Hippocratic Oath emerged within a historical context vastly different from modern

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[61] R Gillon, 'Euthanasia, Withholding Life-Prolonging Treatment and Moral Differences' (1990) 16 *Journal of Medical Ethics* 115.

[62] *Carter v Canada (Attorney General)* [2015] 1 SCR 331 (SCC).

[63] L Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (Johns Hopkins Press 1943).

medical practice. The oath predates contemporary medical technologies capable of sustaining life for prolonged periods and does not reflect modern concepts such as patient autonomy and informed consent.[64] Consequently, many medical ethicists argue that the spirit of the Hippocratic tradition should be interpreted in light of contemporary realities rather than applied rigidly.

Modern professional ethical frameworks increasingly emphasise the importance of balancing the preservation of life with compassion for patients who experience profound suffering. From this perspective, assisting a patient in achieving a dignified death may, in certain circumstances, be consistent with the broader ethical objectives of medical practice.

6.4 Morality and the Principle Of Double Effect

Another important ethical doctrine frequently invoked in end-of-life discussions is the principle of double effect, which originates in Thomistic moral philosophy. The doctrine holds that an action producing both good and harmful consequences may be morally permissible where the harmful outcome is not intended but merely foreseen.[65]

In medical practice, the principle is commonly applied in the administration of high doses of analgesic medication for the relief of severe pain in terminally ill patients. Physicians may prescribe medications such as opioids to alleviate suffering even where the treatment may inadvertently shorten the patient's life by depressing respiratory function.[66] Under the doctrine of double effect, such treatment is considered morally permissible because the physician's primary intention is the relief of suffering rather than the hastening of death.

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64 A Jonsen *et al*, *Clinical Ethics* (8th edn, McGraw-Hill 2015) 58.

65 J Finnis, *Natural Law and Natural Rights* (2nd edn, OUP 2011) 281.

66 J Boyle, 'Toward Understanding the Principle of Double Effect' (1980) 90 *Ethics* 527.

Despite its widespread acceptance in medical ethics, the principle has attracted criticism. Some commentators argue that the distinction between intended and foreseen consequences is difficult to sustain in practice, particularly where physicians are aware that the administration of certain treatments will almost certainly accelerate death.[67] This critique has led some scholars to question whether the doctrine meaningfully distinguishes palliative care from forms of physician-assisted dying.

6.5 Playing God

Another frequently cited objection to euthanasia is the claim that intentionally ending a human life constitutes an attempt by physicians to "play God." This argument is rooted in religious and moral traditions that regard human life as sacred and believe that decisions concerning life and death should remain within divine authority.[68] From this perspective, euthanasia represents an impermissible usurpation of moral authority by human actors.

Critics of this argument observe that medical practice routinely involves interventions that alter the natural course of illness. Physicians administer life-saving treatments, perform surgeries, and employ advanced technologies to prolong life. If such interventions are not regarded as impermissible interference with divine authority, it is argued that medical decisions aimed at relieving suffering should not automatically be characterised as morally objectionable.[69]

6.6 Justice

The principle of justice concerns fairness and the equitable treatment of individuals within society. Within the context of euthanasia, justice raises questions about whether it is fair to deny terminally ill patients the option

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67 Rachels (n 58) 45.
68 D Callahan, *The Troubled Dream of Life* (Georgetown University Press 1993) 97.
69 P Singer, *Practical Ethics* (3rd edn, Cambridge University Press 2011) 162.

of a peaceful and dignified death while compelling them to endure prolonged suffering.

Some commentators argue that strict legal prohibitions on euthanasia impose significant emotional, physical, and financial burdens on patients and their families.[70] Patients experiencing severe and unrelenting pain may be forced to endure prolonged suffering because the law prohibits medical assistance in dying. Additionally, some terminally ill individuals may lack the physical capacity to end their lives without assistance. Denying such individuals access to assisted dying may therefore create an inequality in the exercise of personal autonomy.

At the same time, concerns about justice also underpin arguments against euthanasia. Opponents of euthanasia also raise concerns that legalisation may place vulnerable groups such as the elderly, persons with disabilities, and individuals experiencing economic or social hardship at risk of indirect pressure to choose death earlier than they otherwise would.[71] These concerns form the basis of the widely discussed "slippery slope" argument, which suggests that permitting euthanasia in limited circumstances may gradually expand to include broader categories of patients.[72]

Consequently, discussions of euthanasia must carefully balance the ethical imperative to alleviate suffering with the need to protect vulnerable individuals from coercion or abuse.

7. ARGUMENTS IN SUPPORT OF EUTHANASIA

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[70] M Battin, *Ending Life: Ethics and the Way We Die* (OUP 2005) 210.

[71] E J Emanuel, 'Four Myths About Doctor-Assisted Suicide' (1997) 12 *Hastings Center Report* 31.

[72] Y Kamisar, 'The Rise and Fall of the Right to Die' (1998) 25 *William & Mary Law Review* 794.

Arguments advanced in favour of euthanasia are generally grounded in two central considerations: respect for individual autonomy and self-determination, and the assessment of quality of life in circumstances of profound suffering. These arguments build upon the ethical principles discussed earlier particularly autonomy, beneficence, and compassion in medical practice and contend that, in limited circumstances, permitting euthanasia may represent a morally defensible response to irreversible suffering.[73] While the permissibility of euthanasia remains contested, these arguments have significantly influenced contemporary debates on assisted dying in both ethical scholarship and legal reform across several jurisdictions.

7.1 Autonomy and Self-Determination

The most prominent philosophical justification for euthanasia is rooted in the principle of personal autonomy, which recognises the right of competent individuals to make decisions concerning their own bodies and medical treatment.[74] In medical law, autonomy is closely associated with the doctrines of informed consent and bodily integrity, which establish that medical interventions cannot ordinarily be imposed on competent adults without their voluntary agreement.[75]

Proponents of euthanasia argue that this principle logically extends to decisions concerning the timing and manner of death where an individual is suffering from a serious and irreversible medical condition. From this perspective, forcing a competent patient to endure prolonged suffering against their wishes may constitute an unjustified interference with personal liberty and dignity.

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[73] J Herring, *Medical Law and Ethics* (8th edn, Oxford University Press 2022) 153.
[74] R Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia and Individual Freedom* (HarperCollins 1993) 179.
[75] J Herring (n 73 above).

In European human rights jurisprudence, the relationship between autonomy and assisted dying has also been examined. In *Pretty v United Kingdom*, the European Court of Human Rights acknowledged that decisions concerning the manner of one's death fall within the scope of the right to private life under Article 8 of the European Convention on Human Rights, although the Court ultimately upheld the United Kingdom's prohibition on assisted suicide.[76]

Taken together, these developments illustrate the increasing recognition that personal autonomy is central to modern medical law. Advocates of euthanasia therefore argue that respecting the wishes of competent individuals who voluntarily request assistance in dying represents a legitimate extension of this principle.[77]

7.2 Quality-of-Life Considerations

A second major argument advanced in support of euthanasia concerns the quality of life experienced by individuals suffering from severe illness or irreversible medical conditions. Proponents contend that the value of continued existence cannot be assessed solely in biological terms but must also consider the individual's subjective experience of suffering, dignity, and personal well-being.[78]

Advances in medical technology have significantly increased the ability of physicians to prolong life through interventions such as mechanical ventilation, artificial nutrition, and other life-sustaining treatments. However, these technologies may sometimes sustain life in circumstances where patients experience profound physical pain, cognitive decline, or complete dependence on others for basic care. In such situations, some

[76] *Pretty v United Kingdom* (2002) 35 EHRR 1.
[77] J Keown, *Euthanasia, Ethics and Public Policy* (CUP 2002) 44.
[78] As above 15

individuals may regard continued existence as inconsistent with their conception of dignity or meaningful life.[79]

Empirical evidence from jurisdictions where assisted dying has been legalised suggests that concerns relating to quality of life frequently influence patients' decisions. For example, data published by the Oregon Health Authority under the Death with Dignity Act consistently indicate that the most commonly cited reasons for requesting assisted dying include loss of autonomy, inability to participate in activities that make life enjoyable, and the perception of being a burden on family members or caregivers.[80] Similar motivations have been documented in Canada and several European jurisdictions that permit medically assisted dying under regulated conditions.[81]

Supporters therefore argue that allowing euthanasia in strictly regulated circumstances may represent a compassionate response to individuals experiencing intolerable suffering. From this perspective, euthanasia is viewed not as a rejection of the value of human life but as a means of preserving personal dignity and control at the end of life.[82]

Nevertheless, quality-of-life arguments remain controversial. Critics warn that evaluating whether a life is "worth living" risks introducing subjective judgments that could disadvantage vulnerable individuals, including persons with disabilities or those experiencing temporary psychological distress.[83] These concerns have informed the development of strict legal safeguards in jurisdictions that permit assisted dying,

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[79] Battin (n 70 above) 214.

[80] Oregon Health Authority, *Oregon Death with Dignity Act: 2023 Annual Report* (OHA 2024).

[81] J Downie & J Chandler, 'Interpreting Canada's Medical Assistance in Dying Legislation' (2018) 61 *McGill Law Journal* 795.

[82] Gillon (n 61 above)115.

[83] Emanuel (n 71 above) 31.

including requirements relating to mental capacity, voluntary consent, independent medical assessment, and waiting periods before the procedure can be carried out.[84]

Despite these concerns, proponents maintain that where competent individuals freely determine that their suffering has rendered life intolerable, the law should recognise their right to make decisions concerning the manner and timing of their death.[85] From this standpoint, euthanasia is framed as an extension of respect for personal dignity, autonomy, and compassionate medical care.

8. ARGUMENT AGAINST EUTHANASIA

One of the strongest objections to euthanasia is based on the doctrine of the sanctity of human life. According to this view, human life carries an intrinsic and inviolable worth which the law and society have a duty to protect against deliberate termination. The concept of sanctity of life reflects the belief that life is intrinsically valuable and should not be deliberately terminated, irrespective of considerations relating to suffering or perceived quality of life.[86]

The principle has deep roots in legal, medical, and religious traditions. Within legal systems, the sanctity of life is often reflected in constitutional protections and criminal prohibitions against the intentional taking of life. In Nigeria, for example, section 33 of the Constitution of the Federal Republic of Nigeria 1999 (as amended) guarantees the right to life and provides that no person shall be intentionally deprived of life except in circumstances permitted by law.[87] This constitutional commitment is reinforced by criminal legislation that treats unlawful killing as one of the

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84 J Griffiths *et al*, *Euthanasia and Law in Europe* (Hart Publishing 2008) 45.
85 E Jackson, *Medical Law: Text, Cases and Materials* (5th edn, OUP 2019) 899.
86 Keown (n 77 above) 12.
87 Section 33 Constitution of the Federal Republic of Nigeria 1999

most serious offences, punishable under the Criminal Code Act as murder or manslaughter.[88]

From a legal perspective, opponents of euthanasia argue that permitting physicians to intentionally end a patient's life would undermine the legal framework designed to protect human life. The law traditionally draws a clear distinction between allowing natural death and actively causing death. This distinction has been emphasised in several judicial decisions. For instance, in *Washington v Glucksberg*, the United States Supreme Court upheld state laws prohibiting assisted suicide, emphasising the longstanding legal commitment to protecting human life.[89]

The sanctity-of-life principle is also strongly reflected in the ethical traditions of the medical profession. Historically, the Hippocratic tradition emphasises the physician's duty to protect and preserve life. The classical formulation of the Hippocratic Oath contains an explicit prohibition against administering a lethal drug to a patient even when requested.[90] Although modern medical ethics has evolved considerably, the commitment to preserving life remains a foundational aspect of professional medical practice. Critics of euthanasia therefore contend that involving physicians in intentionally ending life would fundamentally alter the moral character of the medical profession.[91]

Religious traditions further reinforce the sanctity-of-life argument. Many religious perspectives regard human life as a sacred gift that originates from a divine source and therefore lies beyond the authority of human beings to terminate intentionally. From this viewpoint, decisions

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88 Sections 316–317 of the Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004.

89 521 US 702 (1997)

90 Edelstein (n 63 above) 3.

91 M Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (McGill-Queen's University Press 2001) 45

concerning life and death ultimately belong to a higher moral authority rather than to individual preference. In Christian moral teaching, for example, the prohibition against unlawful killing expressed in the Sixth Commandment has historically been interpreted as prohibiting the intentional taking of innocent human life.[92]

Consequently, opponents of euthanasia argue that legalising the practice would erode respect for the intrinsic value of human life and could weaken the social commitment to protecting vulnerable individuals. From this standpoint, euthanasia is regarded not as a compassionate medical intervention but as a violation of the fundamental moral and legal obligation to preserve human life.[93]

9. RECENT DEVELOPMENT ON THE STRUGGLE FOR LEGALIZATION OF EUTHANASIA

Recent developments in the regulation of euthanasia and physician-assisted dying reveal significant shifts in legal frameworks, medical practice, and public attitudes toward end-of-life decision-making. Several jurisdictions have moved from outright prohibition to carefully regulated regimes that permit medically assisted dying under specified conditions. The Netherlands and Belgium remain among the most prominent examples, having enacted comprehensive legislation allowing euthanasia under strict procedural safeguards.[94] In these jurisdictions, the number of reported cases has gradually increased over the years, reflecting both

[92] Exodus 20:13 (King James Version)

[93] Finnis (n 65 above) 285.

[94] Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 < https://wfrtds.org/wp-content/uploads/2021/01/Law-on-the-Termination-of-life-on-request-and-assisted-suicide.pdf> accessed 15 March 2026; Belgian Act on Euthanasia 2002 < https://www.newtral.es/wp-content/uploads/2023/06/belgium-act-on-euthanasia.pdf> accessed 15 March 2026.

greater public awareness and the institutionalisation of euthanasia within regulated medical practice.[95]
Notably, the scope of eligibility in some jurisdictions has expanded beyond patients suffering from terminal illnesses to include individuals experiencing severe and incurable medical conditions that cause enduring suffering, even where death is not imminent. In Belgium, for example, amendments to euthanasia legislation have allowed the practice in certain circumstances involving psychiatric conditions, subject to stringent procedural requirements.[96] Similarly, debates in the Netherlands have explored whether euthanasia should be extended to individuals who experience persistent suffering but are not necessarily terminally ill.[97] These developments illustrate an evolving interpretation of suffering and dignity within contemporary euthanasia discourse.

In parallel with these legal changes, there has been growing public support for assisted dying in several parts of the world. In North America, Canada's system of Medical Assistance in Dying (MAiD), established following the decision of the Supreme Court in *Carter v Canada (Attorney General)*, represents one of the most significant legal developments in recent decades.[98] Legislative reforms in Canada have subsequently broadened eligibility criteria to include certain non-terminal

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[95] Regional Euthanasia Review Committees, *Annual Report 2022* (Netherlands Government 2023) < https://www.euthanasiecommissie.nl/site/binaries/site-content/collections/documents/2022/april/6/jaarverslag-2022/REGIONAL+EUTHANASIA+REVIEW+COMMITTEES-Annual+report-2022.pdf> accessed 15 March 2026.

[96] Belgian Act on Euthanasia (amended 2014) permitting euthanasia in certain non-terminal cases including psychiatric suffering. See K Raus, 'The Extension of Belgium's Euthanasia Law to Include Competent Minors' (2016) 13(2) *Journal of Bioethical Inquiry* 305 - 315. J

[97] Griffiths *et al* (n 84 above) 85.

[98] *Carter v Canada (Attorney General)* [2015] 1 SCR 331 (Supreme Court of Canada).

conditions, subject to additional safeguards.[99] Comparable developments have occurred in a number of European jurisdictions and several states in the United States where physician-assisted dying has been legalised under statutory frameworks.[100]

Flowing from the above, these developments suggest an ongoing shift in the global euthanasia debate from a narrow focus on terminal illness toward broader discussions about autonomy, suffering, and the scope of medical assistance at the end of life. While these reforms remain controversial, they demonstrate an increasing willingness among some societies to reconsider traditional legal prohibitions on assisted dying in light of evolving ethical and social perspectives.

10. CONCLUSION AND RECOMMENDATIONS

The debate surrounding the right to die with dignity continues to represent one of the most complex ethical and legal dilemmas in contemporary medical jurisprudence. At the centre of this debate lies a persistent tension between two fundamental principles: the autonomy of individuals to make decisions concerning their own bodies and lives, and the legal and moral obligation to preserve and protect human life. Proponents of euthanasia emphasise compassion, dignity, and the right of competent individuals to determine the circumstances under which they may end unbearable suffering. Opponents, however, stress the sanctity of human life and express concern that legalising euthanasia may expose vulnerable persons, including the elderly, persons with disabilities, and those experiencing psychological distress, to potential coercion or abuse.

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[99] Government of Canada, Criminal Code (Medical Assistance in Dying) Amendment Act 2021 <https://www.canlii.org/en/ca/laws/astat/sc-2021-c-2/latest/sc-2021-c-2.html> accessed 13 March 2026.

[100] Oregon Death with Dignity Act 1997 (ORS 127.800-897); Washington Death with Dignity Act 2008.

Advances in medical technology have further complicated this debate by enabling the prolonged maintenance of life through sophisticated medical interventions. While such developments have significantly improved survival outcomes, they have also created difficult questions regarding the extent to which life should be sustained where patients experience severe and irreversible suffering. Consequently, societies across the world are increasingly confronted with the challenge of balancing respect for individual autonomy with the broader social commitment to protecting the value of human life.

Given these competing considerations, a balanced legal and ethical approach is essential. Governments should ensure that their legal systems clearly define and distinguish between the different forms of euthanasia, including voluntary euthanasia, non-voluntary euthanasia, involuntary euthanasia, and physician-assisted suicide. Such clarity would help prevent ambiguity in legal interpretation and ensure that appropriate safeguards are established where end-of-life decisions arise. Where euthanasia or assisted dying has been legalised, robust regulatory frameworks must be established to prevent misuse. These frameworks should include strict procedural safeguards such as independent medical assessments, mandatory documentation, waiting periods, and oversight mechanisms designed to protect vulnerable individuals. Regulatory systems should also ensure transparency and accountability through proper reporting and review of cases. In addition, governments should consider the establishment of independent ethical review bodies or oversight committees to examine complex end-of-life cases so that decisions relating to assisted dying are carefully scrutinised and consistent with established professional standards.

For jurisdictions where euthanasia remains unlawful, policymakers may consider the possibility of conditional legalisation under clearly defined circumstances, subject to strict regulatory safeguards. Any such framework must prioritise voluntary and informed consent, mental capacity assessments, and comprehensive palliative care options to ensure

that patients are not choosing death as a result of inadequate medical support.

Finally, laws governing end of life care should be periodically reviewed to reflect developments in medical science, evolving ethical debates, and changing societal values. Continuous evaluation of legal frameworks will ensure that policies remain responsive to emerging medical realities while preserving respect for human dignity and the protection of life. The challenge for lawmakers and policymakers lies in developing a regulatory framework that respects individual autonomy without undermining the societal commitment to protecting life. A carefully balanced approach grounded in compassion, legal safeguards, and ethical responsibility offers the most promising path toward addressing the complex questions raised by euthanasia and the right to die with dignity.