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**REVIEW ARTICLE**

# Euthanasia: medical positions and current legal

**Dámarys Isabel Fernández-Arráiz[1], Sebastián Leonardo Valle-Chimbo[1], Denisse Isabel Suaste-Pazmiño[1]**

[1]Universidad Regional Autónoma de Los Andes, Ambato. Ecuador.

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## ABSTRACT

**Introduction:** the debate on euthanasia remains complex due to persistent tensions between the protection of life, personal autonomy, and the legal frameworks governing the end of human existence.
**Objective:** to comparatively analyze current medical and legal positions on euthanasia based on recent evidence.
**Methods:** a descriptive bibliographic review with a qualitative approach was conducted using a documentary strategy. The search was performed across several databases with related descriptors and predefined inclusion criteria. After screening following the prisma methodology, the main sources were selected for thematic analysis.
**Development:** the literature reveals divergent perspectives. The medical viewpoint predominantly upholds the preservation of life, the relief of suffering through palliative care, and the rejection of active practices that intentionally cause death. In contrast, the legal perspective is grounded in rights such as dignity, liberty, autonomy, and the free development of personality. Among opposing arguments, ethical, religious, and deontological concerns stand out regarding potential violations of fundamental principles. Supportive stances emphasize the legal recognition of assisted dying as an option for individuals experiencing irreversible suffering.
**Conclusions:** euthanasia remains a multidimensional topic of debate. While medicine prioritizes the protection of life and palliative care, the law recognizes autonomy as a basis for regulation. A comprehensive understanding of the issue requires ethical, clinical, and legal dialogue. Regulatory differences persist across continents and legal systems, particularly in cases involving psychiatric conditions or minors.

**Keywords:** Right to Die; Patient Rights; Ethics, Medical; Euthanasia; Suicide, Assisted.

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## INTRODUCTION

As affirmed by members of the Bioethics Committee of Spain,[1] in their report on end-of-life care and attention during the dying process, the complexity of euthanasia arises from the difficulty of reconciling two important bioethical principles: protection of life and individual self-determination. According to Arimany et al.,[2] the current debate on the implementation of euthanasia and assisted suicide may become demagogic and superficial if it fails to consider those involved in the process, as the proposed decriminalization in Europe and certain countries in the Americas must address associated risks—such as decision-making capacity in end-of-life situations—based on adequate protocols.

In this regard, Altisent et al.,[3] argue that positions favoring euthanasia do not seek to impose anything on anyone; on the contrary, they aim to prevent the traditional moral conception of the end of life from being universally imposed—an argument others find inconsistent, since withdrawing the State's role as guarantor of life and authorizing physicians to end it with the patient's consent effectively imposes a specific moral view of death on all citizens.

Euthanasia is not an issue that can be viewed narrowly, as Mazuera and Mazuera,[4] assert; thus, framing it as a legal problem requires maintaining an interpretive balance that allows analysis of the subjective experience of the ill body at any stage. In this sense, medical characterizations of the ill body, the evolution of clinical practice, and health as both a right and an institution are factors that influence the determination of legal frameworks and the integration of this issue into the configuration of the Social State of Law, grounded in individual freedoms. However, not every advance in medical science implies progress in terms of dignity at the end of life.

In Ecuador, various arguments regarding euthanasia refer to the respect and recognition of patients' will to decide on its practice, based on the constitutional right established in Article 66, paragraph 9 of the Constitution of the Republic of Ecuador,[5] which guarantees the right to make free, informed, voluntary, and responsible decisions about one's life, sexuality, including sexual orientation. However, there is no legal provision for its implementation, as the legal landscape remains unclear in this regard, according to Huera et al.,[6] leading to contradictions and differing interpretations, and resulting in a legal vacuum on the subject.

Moreover, generalizations cannot be made without considering an ethical and medico-legal reflection involving health professionals, patients, and relatives directly, as European experiences,[7] have shown that in certain cases, specialized palliative care is required by most patients and their families, even when they have not yet made definitive decisions at the end of life.

Nevertheless, people die each year in intense suffering that could be avoidable with adequate resources to relieve continuous pain—alternatives other than choosing to end the sufferer's life. Experiences regarding comprehensive care and appropriate approaches to the end-of-life process influence public opinion on legal regulation, raising the question: How do current ethical, medical, and legal positions on euthanasia compare globally? In light of this, the present review was conducted with the objective of comparatively analyzing current medical and legal positions on euthanasia based on recent evidence.

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## METHODS

A bibliographic review was carried out through a qualitative documentary approach, structured as a review article aimed at providing a comprehensive update on euthanasia, addressing aspects of interest regarding medical and legal positions based on recent and contrasting evidence. An exhaustive search was conducted in medical databases including PubMed, SciELO, Redalyc, and Google Scholar, ensuring coverage of available literature.

To ensure accuracy and relevance, specific keywords in English and Spanish were used: "Eutanasia," "Euthanasia," "Médica," "Medical," "Jurídica," and "Legal," combined with Health Sciences Descriptors (DeCS). The time period established for inclusion of publications was 2019–2024; inclusion criteria were precisely defined to ensure that compiled data were pertinent and up to date. Review articles and original studies in Spanish and English that provided concrete and recent data related to mercy killing, medical attitudes, legal practices, bioethics, assisted suicide, knowledge, and current legislation were included. Exclusion criteria were also established, discarding non-peer-reviewed articles, editorials, article abstracts, theses, publications in other languages, and those that did not provide concrete data on the topic (Fig. 1).

Boolean operators ("AND," "OR") were used in the search criteria, combined with selected keywords and the established publication date range, to optimize the sensitivity and specificity of the information retrieval process. The strategy initially identified a total of 352 articles. After applying exclusion criteria—related to duplication, lack of thematic relevance, unavailability of full text, or methodological insufficiency—325 records were discarded. Consequently, 27 documents that fully met the inclusion criteria were selected and deemed relevant for analysis within the research framework.

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Rev Ciencias Médicas. 2025; 29(S1): e6953

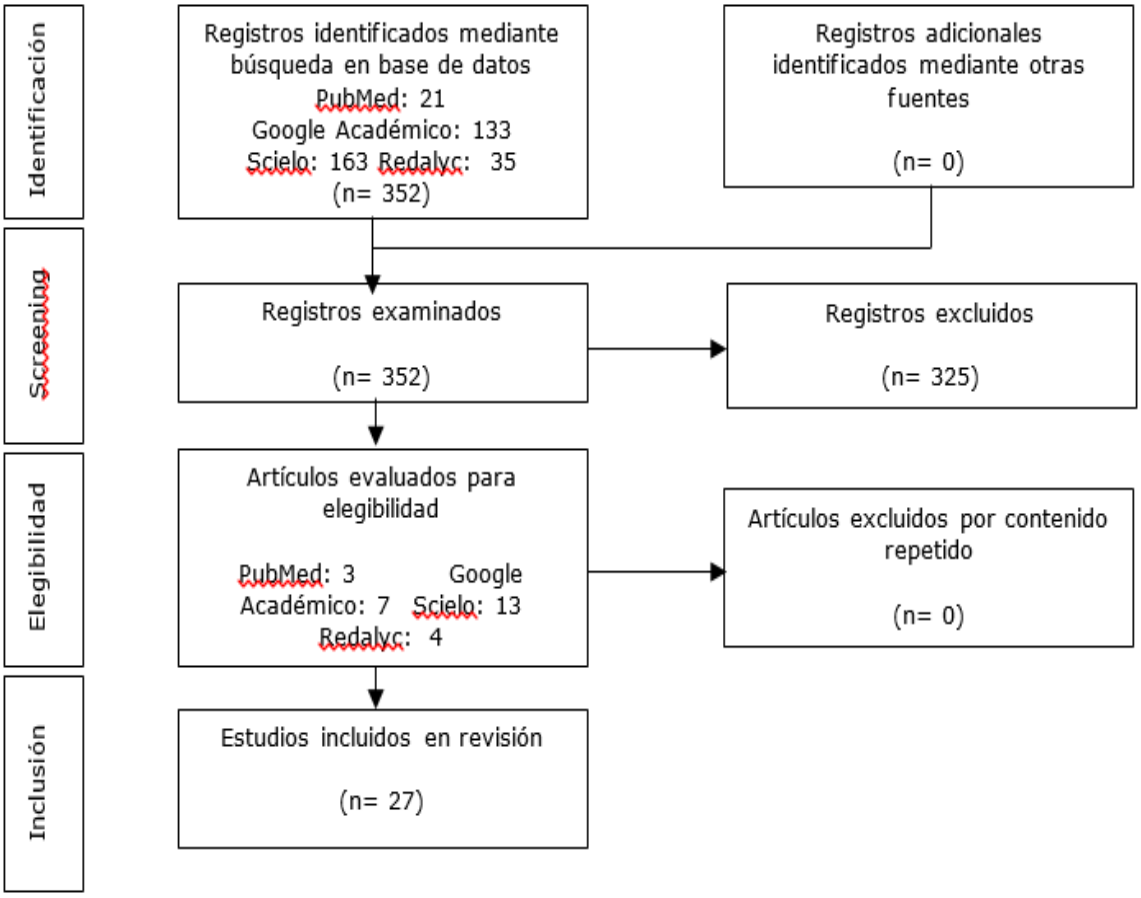


**Fig. 1** Document selection flowchart.

## DEVELOPMENT

Of the 27 selected articles, 14,81 % were original articles and 85,19 % were review papers. Regarding the geographical origin of the studies, 66,67 % were conducted in the Americas and 33,33 % in Europe; no research from other continents was reported in the last six years.

In this context, based on the compiled data and considering arguments against euthanasia, 44,44 % of the analyzed studies highlight legal and moral nuances in each country that underscore its prohibition, as Velásquez et al.,[8] note, and Salas et al.,[9] similarly affirm that the primary role of physicians is always to help patients and alleviate suffering; thus, causing death is often considered a failure of medicine.

Conversely, arguments supporting the application of euthanasia account for 55,56 % of the studies, showing majority research support for the topic, linked to legislation and approval by the highest courts worldwide, where experience indicates that bioethical aspects related to euthanasia and assisted suicide are not widely discussed, as Mazuera and Mazuera,[4] state.

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Rev Ciencias Médicas. 2025; 29(S1): e6953

Regarding specific aspects of euthanasia, it is conceived as the shortening of life to prevent suffering in terminally ill patients, as Ivankovics et al.,[10] state, where the patient requests a health professional or another person to hasten death to avoid painful periods. Meanwhile, González et al.,[11] note that dysthanasia (unknown to many), unfortunately practiced in healthcare, is the opposite—characterized by a painful death, prolonging life through therapeutic and pharmacological means but without quality of life.

In this sense, euthanasia has been categorized by type, as expressed by Dubón and Bustamante,[12] into various categories—whose purpose is always the same: to end a person's life—including:

- By purpose:
  - Eugenic: death of deformed or ill individuals to prevent racial degeneration
  - Economic: elimination of incurable patients, disabled persons, or the elderly to relieve society of "useless" individuals who impose economic and care costs
  - Merciful: motivated by compassion for those enduring severe suffering
  - Solidarity: painless death of terminally ill individuals to use their organs for therapeutic purposes
- By mode of action:
  - Active: requested by the patient in a terminal stage and caused by the positive action of a physician or health personnel
  - Passive: patient's death due to omission of necessary therapeutic treatment or interruption of therapy to avoid prolonging suffering

This distinction between active and passive euthanasia tends to disappear under the terminology "limitation of therapeutic effort," with general acceptance that it is unjustifiable to prolong suffering in a completely futile manner.[13]

- By intention:
  - Direct: deliberate and immediate induction of death using precise means
  - Indirect or lenitive: action or omission that indirectly (as a side effect) causes death

- By volitional content:
  - Voluntary: performed at the patient's request with informed, express, and conscious consent
  - Non-voluntary: two scenarios—first, when the patient's death is promoted because they cannot understand the choice between life and death; second, when it is imposed against the patient's will, violating their wishes. The non-voluntary modality is intensely debated, as it is seen as an imposition rather than a voluntary act, and is thus considered homicide.[14]

- By authorship:
  - Heteronomous: involves one or more third parties
  - Autonomous: performed by the patient themselves. This modality is referred to as suicide.[15]

According to Díaz and Briones,[16] from a legal perspective, legalized euthanasia grants power to medical or health personnel to end the lives of individuals in particularly dependent conditions, representing a clear ideological manipulation of expanded power, precisely in the name of the subjective rights of those deemed (in terms of quality of life) to be in an undignified condition.[17]

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Rev Ciencias Médicas. 2025; 29(S1): e6953

According to Aurenque,[18] appropriate legislative criteria for implementing euthanasia or medically assisted death must be detailed and carefully verified, highlighting the following aspects:

1) The patient's voluntary and express request
2) Confirmation of unbearable and irreversible physical or psychological suffering that cannot be alleviated by palliative sedation and is not attributable to a temporary depressive state
3) Full awareness of the personal situation and an incurable, hopeless prognosis
4) Self-determination regarding the unviability of other options
5) Confirmation of diagnosis by two independent physicians
6) The termination of life must be carried out *ope legis* (by legal authority)[14]

According to Bertolín,[19] Spanish Law 3/2021,[20] on the regulation of euthanasia requires the existence of intolerable suffering, dependent on personal, existential, social, and cultural factors, supporting provisions in Articles 3b, 3c, and 5d of the same law, which specify that the condition must be serious and incurable, so that the patient's decision—based on an intolerable pathology and confirmed by the therapeutic team—determines that it is refractory. Many existentially distressing problems subjectively deemed unbearable involve limited life expectancy and could be better managed with appropriate treatment.[21]

Defending the medical position on ethical and deontological grounds, health professionals have an obligation to preserve life,[22] compounded by religious considerations rooted in belief systems.[9] Likewise, the condition of the chronically ill patient necessitates the use of analgesics,[13] reducing the drama of death with less pain.[23]

In this regard, culture and religion constitute the greatest barriers to ethical decision-making in medicine, with racial and ethnic differences influencing preferences regarding death,[24] compounded by the view of assisted suicide and euthanasia as attacks on life, leading to their rejection on both medical and legal ethical grounds.[16] In response to offering euthanasia as a solution to suffering, palliative care should be proposed instead,[25] with physician involvement even though it may be considered a non-medical act.[9]

Thus, medicine defends and revises its own ethos and core tasks in response to social needs, culture, and available technologies,[18] as technological advances in healthcare allow death to be postponed through supportive measures, adapting therapeutic approaches rather than resorting to euthanasia.[26] It has also been observed that individual will expressed through informed consent, combined with the collective character embodied in legislation, is insufficient to establish a right that may affect others,[25] as legal safeguards for euthanasia do not resolve conflicts of rights and interests nor grant true patient autonomy.

These conversations must occur not only in clinical practice but in all educational settings,[27] considering the increase in assisted death in countries where euthanasia is legal or decriminalized—a "slippery slope" that may lead to adverse outcomes such as violations of the right to life and population decline.[28] However, the direct link between life and personal dignity, the right to freedom, and the free development of personality form the basis of constitutional guarantees,[29] and discussions on the right to euthanasia and assisted death in courts worldwide are increasingly recognized, raising hopes for medical assistance in dying well.

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In this context, the recognition of the right to life and health is emphasized, valuing appropriate treatment for individuals who choose a dignified death,[27] where physicians can analyze the best option for the patient and their family, distinguishing between prolonging life and allowing a dignified death,[12] with personal autonomy prevailing as the essential right invoked for euthanasia—whereas opposing views are based on personal moral reasoning and religious ethics.[14]

In Ecuador, Quintero,[30] indicates that the fundamental right to die with dignity has been possible since the 1991 Constitution and continues under the current (2008) Constitution, as an emerging rights process recognized in rulings by the Supreme Court. Therefore, the issue of euthanasia must be addressed primarily among older adults, considering the rights of elderly individuals in their specific reality to provide the option of choosing a dignified death.[6]

Similarly, in Colombia, euthanasia is legitimate through rulings by the highest court, based on individual authority in the face of suffering and violation of the right to a dignified death,[4] although despite legal evolution regarding euthanasia and assisted suicide, individual autonomy to exercise this right faces resistance to decriminalization—especially in patients with severe neuropsychiatric disorders and minors.[31]

In this sense, Trejo,[32] states that in countries where euthanasia or assisted suicide is regulated and legal, the most frequent reasons for requests by patients and their families are neurological diseases and dementia—an aspect that increases annually in euthanasia requests, at a rate ten times higher than for assisted suicides.[33]

Arguments against euthanasia include the deontological criterion grounded in international medical ethics, which prevails in medical practice;[22] for others, the argument stems from religious beliefs regarding the sanctity of life as a divine act, [9] along with the humanistic obligation to assess the patient's and family's situation according to disease severity. [13] Maintaining interpersonal relationships between physicians, nursing staff, and families, combined with the use of extensive medications and/or analgesics, can help families cope with the acceptance of death as painlessly as possible for the patient. [23]

However, arguments in favor of euthanasia confirm that its defense is based on the direct link between life and personal dignity, along with the rights to freedom and the free development of personality—constitutional guarantees in most countries worldwide.[29] The growing prominence of euthanasia and assisted death discussions in global courts provides medical hope even in death,[15] compelling many countries' courts to recognize medical assistance in dying. Evaluating the heterogeneous and controversial scientific and legal developments to date remains useful.

Furthermore, societal unfamiliarity with the topic demonstrates the need to create spaces for information and dialogue on euthanasia and various processes and forms of dignified death, [8] as end-of-life medical decisions must be individualized according to cultural, religious perspectives, and patient wishes.

According to González et al.,[11] most patients with terminal or degenerative illnesses, their families, and health professionals agree that the fundamental principle for performing euthanasia is the autonomy of the individual's will—not only referring to the patient's freedom to decide about their life, but also the information provided about the intervention, mode of administration, risks, and objectives, enabling a decision based on criteria expressed by professionals. Although autonomy is important, the principle of justice takes precedence.

**ISSN:** 1561-3194 **RNPS:** 1877
Rev Ciencias Médicas. 2025; 29(S1): e6953

This informational effort may be initiated and developed at the request of family members or medical personnel themselves, who use all available means to sustain the patient's life, while rejecting life-prolonging measures focused instead on pain relief so that death occurs with dignity.[34]

Orthotanasia is the method endorsed by most legislation worldwide and is closely linked to palliative care, where the patient is addressed while respecting their spiritual, physical, psychological, and social needs until death occurs with dignity, as Galea and Matamoros affirm.[7]

Currently, cases are evident worldwide where courts, instead of guaranteeing the protection of individuals' fundamental rights, violate essential rights to life, autonomy, integrity, equality, and professional freedom by prohibiting euthanasia and assisted suicide; [15] however, in Colombia all rights are respected; in Canada, life, individual autonomy, and integrity are respected; in Austria, life and autonomy; in Italy, autonomy and equality; and in Germany, personal autonomy and professional freedom to assist individuals requesting euthanasia.

According to Butirica and Agón,[35] the regulation of euthanasia and assisted death varies significantly worldwide, especially in cases of mental illness or requests by minors. In Europe, countries such as Germany, Austria, Switzerland, Belgium, the Netherlands, Spain, and Luxembourg permit euthanasia for incurable diseases, while in the Americas only Colombia and Canada authorize it—Germany notably allowing it even for curable diseases under judicial approval. Generally, most countries permit some form of assisted death in terminal illnesses, although active euthanasia and assisted suicide remain prohibited in the United States, the United Kingdom, and Ireland.

Moreover, in the legislation of the Netherlands and Switzerland, forensic investigation and analysis are mandatory in specific cases, requiring results that justify the application of euthanasia to the patient with family approval or request, with details that must be fully demonstrated during the processing of the case.[7]

## CONCLUSIONS

The medical position prioritizes solidarity and respect for life, promoting palliative care that minimizes suffering in terminally ill patients. Legally, the aim is to decriminalize euthanasia for professionals who practice it in accordance with national laws and deontological codes. Ethically, a protective regulatory framework is defended—one that respects individual rights while first exhausting palliative options, ensuring professional responsibility, respect for values, and patient- and family-centered care. Euthanasia must be carried out under strict legal and ethical requirements, with protocols established by competent authorities.

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