The Right to a Dignified Death: Between Criminal Liability, the Legalization of Euthanasia, and the Legislator's Fears

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Abstract

The concept and the ethical and legal framework of every person's right to a dignified death are inextricably linked to the concepts of euthanasia and assisted dying, which pertain to the will to live - concepts with far-reaching philosophical, religious, moral, and ethical implications. This concept has sparked heated debates in medical, ethical, and legal circles, as well as in religious ones, based on the principles enshrined in the right to life and its protection throughout legislation, including in the European Convention on Human Rights and in EU law. As more and more states regulate assisted dying and euthanasia without criminalizing these acts, others have adopted hybrid solutions, with reduced penalties for forms of killing at the victim's request. At the same time, representatives of monotheistic religions (Christianity, Judaism, and Islam) have adopted a Joint Declaration condemning any form of euthanasia and/or medically assisted suicide and have proposed the promotion of palliative care. The sole purpose of this scientific study is to analyze the most recent arguments raised in the academic debate, as well as the recent legislative changes introduced by several states, from the perspective of ethical and medical arguments, as well as criminal law. The main issue lies in the difficulty of finding a unified solution; the validity and significance of the arguments presented by the proponents of each theory or idea, as well as the accuracy of the principles invoked and the medical arguments, make it difficult to resolve this theoretical dispute with far-reaching practical consequences in criminal law.

Keywords: criminal law; assisted dying; euthanasia; conscientious objection

1. Introduction

The fundamental human right to life, physical integrity, and health, viewed from a legal perspective, increasingly raises the issue of the right to die with dignity. We wish to emphasize that this approach takes only a legal perspective on criminal law in relation to this broad concept, which is essentially of a

religious and philosophical nature. There are numerous studies on this topic (tens of thousands of studies have been conducted over the past decade), and it would not be possible to cite or even mention a significant portion of them; therefore, we will limit ourselves to a sequential approach from the perspective of criminal law (and medical science, which is inextricably linked to this concept).

Essentially, this right was defined by Francis Bacon in one of his most relevant works, of course in a philosophical sense, as "a good and peaceful death" (Bacon, apud. Stănilă, 2014), although, etymologically speaking, the term originates from Greek (*eu* means "good," and *thanatos* means "death").

Since then, the concept has sparked heated debates, with arguments put forward by jurists, philosophers, doctors, and clergy, each with their own cultural context. This concept, par excellence, calls not only for reflection and introspection, but also for respecting and/or transcending the technical rigors of legislation; approaching the concept involves multiple dimensions, as well as a moral component. In fact, the science of law involves a profound moral aspect, but it also essentially contains religious concepts, corresponding almost to the 10 biblical commandments.

2. Research Methods

In order to take a holistic approach to the study, we used several complementary research methods, precisely to try to find an appropriate answer to the problem under analysis in an objective manner.

a. The historical method was used to a lesser extent, as it would have required an elaborate analysis and would have shifted the focus of the topic, so we preferred to highlight the legally significant moments. This argument is rooted in the very legal nature of the study, which analyzes a real-life situation that is criminalized in some legal systems, legalized in others, or criminalized in a hybrid manner. Consequently, the only possible approach from a scientific perspective is to formulate working hypotheses, taking as a starting point the legislation in force as of the date of this study.

b. The teleological and systematic method was the most frequently used; this method involves conceptualizing, within the framework of legal scientific research, the proposals adopted at the political level and translating them into legal arguments, starting with the legal architecture of euthanasia (active or passive), the rules of substantive law, and the reflection of the principles of legality in criminalization. All of this at a time when many states prefer a new approach to the concept, from the perspective of the quality of life of a person suffering from certain illnesses incompatible with a minimum quality of life.

c. The etiological method was also employed, based on the idea that it involves an investigation of the issue from the perspective of the social, political, historical, and purely legal causes of concepts, principles, and institutions, particularly regarding the analysis of the cause-and-effect relationship and its implications. This method also led to the conclusion that some states preferred more radical approaches, by including conditions that are not necessarily incompatible with a relatively normal quality of life (such as advanced age), while others have preferred a more rational approach, considering only diseases that cause physical or mental suffering that is difficult to bear.

3. Results

Given the sensitive nature of the research topic, we consider it extremely difficult to draw a definitive conclusion as a result of this study, since no one other than the person concerned can determine what the best solution would be: continuing a life of questionable quality or ending it, as this is a purely subjective judgment that takes into account not only the desire to live under any circumstances, but also the person's religion and subjective assessment of quality of life.

Therefore, our study is limited to analyzing the most recent legislative trends that recognize a person's right to decide whether they wish to continue living under certain conditions caused by illnesses that not only severely affect quality of life but also involve severe physical or psychological suffering. However, in our opinion, certain laws that might permit euthanasia for elderly people who do not suffer from serious illnesses could constitute an overreach of legislative authority.

3.1 The modern approach to the concept in various European countries

Active euthanasia has been legalized in several European countries, such as the Netherlands, Belgium, the Grand Duchy of Luxembourg, the Swiss Confederation, and the Kingdom of Spain. Germany and Austria have legalized medically assisted suicide; currently, there are legislative and regulatory proposals regarding active euthanasia in Portugal and the United Kingdom, while in France a parliamentary debate has been opened regarding the legalization of medically assisted suicide.

A few terminological clarifications deserve to be made. Euthanasia is the deliberate act, at the patient's request, of ending life to put an end to the suffering caused by a very serious illness, meanwhile, medically assisted suicide is a procedure distinct from euthanasia, consisting of the help or assistance provided by a physician to bring about the death of a patient suffering from a terminal illness (Stănilă, 2014, pp. 27-43). In this case, the doctor's assistance is limited to facilitating access to the means necessary for suicide, in compliance with legal requirements and ensuring the accuracy of the act.

The importance and sensitivity of the issue justify our assertion that a uniform solution or definitive answer to this dilemma cannot yet be provided, which is why states have opted for different legislative approaches: some have opted for a more relaxed legalization of active euthanasia (the Netherlands, Belgium, and Switzerland), others for detailed regulation (Luxembourg and Spain), and others for medically assisted suicide (Austria, Germany, and France; in the last-mentioned country, the debate is still ongoing).

Nevertheless, most European legal codes that do not permit active euthanasia or assisted suicide criminally punish a form of killing at the victim's request, which is a hybrid—a mitigated form of active euthanasia and, at the same time, a mitigated form of homicide.

Without claiming to contribute to resolving the legal (as well as philosophical, religious, ethical, moral, and social) dispute regarding a person's right to self-determination, including with regard to their own life, we believe that a possible legal analysis could be based on the principle of the free exercise of personality. This is also because suicide is not subject to criminal prosecution (nor could it be, as it would be purposeless). We raise this argument to the point that only a life freely chosen by the individual could be the subject of criminal protection, with special reference to the fact that only the individual's life (and a dignified one, we might add) is the subject of protection under the rule of law, which is consistent with the concept of the individual as the holder of rights and obligations. In this regard, the Charter of Fundamental Rights of the European Union, published in OJ C 326/391 of October 26, 2012, promotes human dignity in Article 1: "Human dignity is inviolable. It must be respected and protected."

For instance, the anticipated death was deemed lawful by the German Supreme Court in a 1996 ruling[1], essentially on the grounds that it should be extended to all terminal illnesses, that is, to

[1] *The essence of the German Supreme Court's argument is as follows: "It is not inappropriate to administer, in accordance with lex artis, a medication intended to alleviate the pain of a dying person, in accordance with the patient's express or implied will, when, without intending death, its anticipation is accepted as a consequence". The Supreme Court did not specify what the justification for this conclusion should be. "The correct criterion would be to assess the existence of a justifiable state of necessity. The obligation to preserve life for as long as possible gives way to the obligation to alleviate the patient's pain. Although the cited decision is not conclusive on this point, this conclusion must also be drawn when the shortening of life is not merely probable but certain. The threshold for criminal liability is crossed when death does not occur in the context of palliative care, but when, for the purpose of alleviating the patient's pain, the patient is intentionally killed. There is also a debate regarding whether the admissibility of life-shortening palliative therapies should be limited to "terminally ill patients," as asserted by the German Medical Association (Bundesärztekammer). However, situations of unbearable pain—for example, in cancer patients - can arise weeks or even months before death, at which point the patient cannot yet be considered "terminally ill".*
Therefore, the admissibility of indirect euthanasia should be extended to all terminal illnesses, that is, to illnesses in which medical intervention is no longer decisive in preventing the process of death. This was the opinion of the 2006 German Lawyers' Conference (Deutsche Juristentag). The admissibility of indirect euthanasia should also be extended beyond pain management to other situations of severe suffering, provided that these cannot be avoided

illnesses in which medical intervention is no longer decisive in preventing the fatal process. The German Supreme Court took this reasoning further, emphasizing that it should be extended beyond pain management to other situations of severe suffering, provided that such suffering cannot be avoided through palliative care.

Of course, these ideas deserve a doctrinal debate on multiple levels, not just legal ones, but, in our opinion, such a solution would represent respect for the individual's right to dignity, to quality of life, and to die with dignity.

The solution of euthanasia is regarded as a subjective right to a service (Espericueta, 2025), that is, the right to receive a medical service consisting of inducing death, at the express request of the right holder.

3.2 The Approach to the Concept in Other Countries. Canada

Canada was one of the first countries that regulated both euthanasia and assisted suicide outside the scope of criminal law, representing the vanguard of this broad process of depenalization of such acts.
The need to analyze this country's legislation arises from the permissiveness it offers, in the sense that not only people suffering from serious, incurable illnesses that cause them intense suffering may request MAiD, but also people whose death is not foreseeable and who suffer only from mental disorders that do not impair their judgment.

In this country, euthanasia (in its legal, voluntary form) is called "medical assistance in dying"[2] and became legal, along with assisted suicide, in June 2016, for individuals whose death was reasonably foreseeable (Minderhoud and Zekveld, 2025).

A brief historical overview of the evolution of Canadian legislation

In its original form, the law provided for the possibility of euthanasia or assisted suicide only in cases where the person in question was suffering from a serious, incurable illness and where their death was imminent and foreseeable within a relatively short period of time. Prior to this date, it was illegal and punishable as a form of manslaughter (Kluge, 2000, p. 83]. In one of the prominent cases, the criminalization of the act was reversed by a February 2015 decision of the Supreme Court of Canada in Carter v. Canada (Attorney General - 2015 SCC 5[3], which ruled that "the provisions of the Criminal Code criminalizing the assistance of a person in ending their life violate the Canadian Charter of Rights and Freedoms and that eligible adults with serious and incurable medical conditions have a right to assisted dying".).

In this context, the Court delayed the suspension of the invalidity for a period of 12 months to allow Parliament to make legislative amendments, to the extent it deemed necessary.

A very important part of this decision analyzed the specific situation of the person who brought the action, who had serious health problems: "The trial judge concluded that the negative impact of the prohibition on a person's life, liberty, and security was 'very serious and, therefore, grossly disproportionate to its objective." (para. 1378). We agree that the impact of the ban is severe: it imposes unnecessary suffering on those affected, deprives them of the ability to decide what to do with their own bodies and how they will be treated, and may cause those affected to take their own lives sooner than they would have done had they been able to receive medical assistance to die. Against this argument, it is contended that the purpose of the ban - to protect vulnerable individuals from being induced to commit suicide in a moment of weakness - is also of major importance. We consider it unnecessary to decide whether the ban also violates the principle of gross disproportion, given our

through palliative care. Such a situation would be, for example, severe respiratory difficulties that cause fear of suffocation." (Roxin, 2013, pp. 313-327).

[2] *MAiD – https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html.*
[3] *https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/14637/index.do.*

conclusion that it is excessively broad." (ibid., para. 90). Consequently, in January 2016, the Court ordered a further four-month extension to give the legislator more time. However, as an interim measure, it ruled that provincial courts may continue to approve requests for euthanasia and assisted suicide in accordance with the criteria established in the Carter decision. In June 2016, the draft law on the legalization and regulation of euthanasia was passed by the Canadian Parliament[4].

It is worth noting that one of the conditions of the previous law was that natural death be "reasonably foreseeable, and the medical condition be serious and incurable" (ibid., 241.2).

Eligibility for medical assistance in dying has long been contested and controversial regarding how the Supreme Court limited the original ruling, which required that euthanasia be available to all adults with serious and incurable medical illnesses.

The British Columbia Civil Liberties Association (BCCLA) raised a constitutional challenge to the previous law on the grounds that it *"excludes people with long-term disabilities, as well as those with 'curable' medical conditions, whose only treatment options may be deemed unacceptable by patients. These medical conditions should fall under the court's definition of "serious and incurable"*[5]. The Supreme Court of British Columbia and the Supreme Court of Quebec, in the Truchon case, ruled in 2019 that the law cannot limit euthanasia solely to individuals whose death was reasonably foreseeable[6].

In March 2021, the law was amended (through Bill C-7 to amend the Criminal Code[7]) to include individuals who do not suffer from a serious and incurable condition, whose death was not reasonably foreseeable, such as: mental illnesses - depression, anxiety, or other conditions that cannot cause death and are not likely to cause suffering, certain disabilities[8].

The inclusion of people with mental illnesses in the assisted suicide program has been controversial from the outset and has been repeatedly postponed. It should be noted that the legality of this postponement until 2027 is being challenged in court, although it has been argued that the new law requires a joint parliamentary committee to conduct a comprehensive review of eligibility for MAiD for individuals suffering exclusively from a mental illness within two years of the bill's approval by the King. This review could serve to examine progress made regarding the overall readiness of the healthcare system and to assess the need to amend the Criminal Code[9].

On the other hand, the intensity and scale that the MAiD program has attained have led to condemnation of the state by UN human rights experts and disability rights groups in Canada[10] and, furthermore, have been the subject of substantial international criticism[11].

There has been and continues to be a heated debate, as human rights advocates have argued in their critiques that Canadian laws on euthanasia are characterized by *"a lack of safeguards, the devaluation of the lives of people with disabilities, encouraging medical staff and doctors to suggest euthanasia to people who would not otherwise consider this option, and the killing of people who have not received adequate government support to continue their lives"*[12].

From a statistical perspective, there has been a steady increase in the number of people requesting MAiD. Thus, according to the fifth annual report on MAiD, 15,343 cases of MAiD were reported in Canada, representing 4.7% of all deaths; since the legislation was introduced in 2016, 60,301 deaths by MAiD have been reported in Canada[13].

It should also be noted that the current law prohibits the classification of mental illnesses as

4 https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent.
5 https://bccla.org/wp-content/uploads/2016/08/2016-06-27-Notice-of-Civil-Claim.pdf.
6 https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/c7/c7-eng.pdf.
7 https://www.canada.ca/en/department-justice/news/2021/03/new-medical-assistance-in-dying-legislation-becomes-law.html.
8 https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html.
9 https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s1_1.
10 https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts.
11 https://www.csmonitor.com/World/2023/0110/As-assisted-dying-broadens-countries-wrestle-with-new-ethical-lines.
12 https://apnews.com/article/covid-science-health-toronto-c631558a457188d2bd2b5cfd360a867.
13 https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical_assistance-dying-2023.html.

serious and incurable conditions, but this prohibition was initially set to expire on March 17, 2023. However, on February 2, 2023, the Canadian government passed a law to extend the temporary exclusion from eligibility by one year, until March 17, 2024, in cases where a person's sole medical condition is a mental illness[14].

Again, in 2024, this measure was postponed until 2027[15]. Therefore, after that date, people with mental illnesses may be eligible for assisted dying, subject, of course, to any subsequent changes or other new regulations.

It should be noted that the Canadian law on euthanasia includes certain legal safeguards designed to prevent any form of abuse and to ensure the mandatory nature of informed consent[16].

It is mandatory that both the legal witness and the medical practitioners involved have no legal or financial interest in the patient's death. This consent must be expressed repeatedly and explicitly, including immediately prior to death. On the other hand, consent may be revoked at any time and in any manner by the patient, without consequences and without limitations regarding the frequency or number of times it may be requested.

We note that doctors have the right to suggest euthanasia to patients, even if they have already stated that they do not want euthanasia or assisted death, a provision that has sparked heated debate (Kluge, 2000).

The law provides (as an essential condition for euthanasia) that patients suffering from terminal illnesses, disabilities, or serious conditions must sign a written request expressing their wish to end their lives (in the presence of an independent witness who can confirm that this was done voluntarily, without any coercion). Following this request, two physicians and/or nurses must independently confirm, through their written consent, that the patient suffers from an incurable, serious, and irreversible medical condition that is in an advanced stage of irreversible decline, and that the patient is competent and has the capacity to receive and wishes to receive euthanasia.

If the patient's death is not reasonably foreseeable, the request must be signed by an expert/specialist in the underlying medical condition, and their assessment must be conducted within a period of at least 90 days. In addition, the patient must be informed about other forms of treatment, including palliative care, and must refuse all such forms of treatment, including palliative care[17].

Thus, Canadian legislation is similar to that of other countries that permit euthanasia, requiring that at least two physicians confirm the details of the diagnosis (Szlajen, 2021). Canadian legislation is more restrictive than that of Belgium and the Netherlands in terms of not allowing minors access to euthanasia, and at the same time, it is less restrictive because it does not require the patient to exhaust all other treatment options beforehand, unlike in Belgium and the Netherlands (Archer et al., 2025).

Of course, a single article cannot cover a comparative examination of legislation regarding the criminalization or decriminalization of euthanasia and/or assisted dying, as there is insufficient space, nor of the motivations of these states, since, as I emphasized at the beginning of the article, there are different options, each justified by relevant and solid arguments in support of one of the adopted approaches, with the debate unfolding on multiple levels, given the eminently interdisciplinary nature of the subject. Nevertheless, we consider that the legal opinions and those expressed in academic circles regarding the conscientious objection of physicians who may refuse to perform euthanasia or assisted dying are fully justified (Soria, et al., 2022, pp. 272-278; Card, 2020; Szlajen, 2023; Keown, 2018, pp. 611-629; Moniz, 2017; Ramos Olivares and Hoffman, 2012).

14 https://www.canada.ca/en/department-justice/news/2023/02/delay-of-eligibility-for-medical-assistance-in-dying-for-persons-suffering-solely-from-mental-illness-proposed-by-ministers-of-justice-and-health.html.
15 https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s1_1.
16 https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/c7/c7-eng.pdf, pp. 11-12.
17 https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html#a3.

3.3 The objective and subjective elements of the crime of killing at the victim's request

In most countries that have adopted a criminal policy of incriminating and punishing euthanasia, a hybrid approach has been adopted, designed to strike a balance between the need to protect the right to life and the right to die with dignity.

For example, in Romania, a country that does not permit euthanasia or assisted dying, the act of killing at the victim's request is criminalized under Article 190 of the Criminal Code: *"Killing committed at the explicit, serious, conscious, and repeated request of a victim suffering from an incurable disease or a serious, medically certified disability that causes permanent and unbearable suffering is punishable by imprisonment for one to five years".*

Therefore, the offense is a hybrid form, a mitigated variety of active euthanasia and a mitigated form of murder. The term "killing at the victim's request" was preferred over "murder at the victim's request" because it does not constitute homicide and to exclude this act from the aggravating circumstances of murder provided for in Article 189(e) of the Criminal Code (Cioclei, 2020, p. 38).

Since the act is committed at the victim's request, the victim's consent does not constitute a justifying cause, given that Article 22(2) of the Criminal Code forbids consent from having any effect in the case of crimes against life.

The passive subject of the offense can only be a person suffering from an incurable illness or a severe disability certified by a physician. Furthermore, the condition of mental discernment must be met (ibid.), based on the logical and natural reasoning that only a person with intact mental discernment can make an explicit and serious request to have their life taken. Furthermore, the victim must suffer from a serious illness or disability, certified by a doctor. This is because the illness or disability must be incurable and irreversible and cause permanent and unbearable suffering. It is irrelevant whether or not the victim was capable of committing suicide, as some people lack the strength to do so or do not wish to commit suicide for religious reasons.

Therefore, medical reasons are the sole and exclusive basis for the victim's request to have their life ended. If the reason the victim asks the perpetrator to kill them is other than the medical reason described in criminal law (for example, depression caused by romantic despair or a religious inability to commit suicide), the act will constitute the crime of murder.

The essential and significant difference between the crime of killing at the victim's request and murder is the victim's consent expressed through a serious, explicit, and repeated request - attributes found in a tautological list (Bogdan and Şerban, 2020, p. 78), intended to express and emphasize valid consent and which, in our opinion, constitutes the premise (Cioclei, 2020, p. 38) of the crime.

For this reason, a request to die made by children or by persons in a state of alienation or panic, intoxication, or under the influence of a misrepresentation or threats cannot constitute a serious request within the meaning of criminal law, since in this case the act constitutes murder, and the perpetrator cannot benefit from a more lenient penalty.

Indirect euthanasia may occur when a person diagnosed with a terminal illness leading to death is administered treatment intended to alleviate their pain, even if this may accelerate the moment of death. The acceleration of death constitutes, in itself, murder and, if committed at the victim's request, murder on request.

From an objective standpoint, the act is committed by action (administering a lethal substance, disconnecting the patient from devices that support the vital functions of their weakened body, etc. (Oprea and Orjan, 2018) or by omission, as in the case of homicide.

The offense has a condition attached to the material element, namely the existence of an explicit, serious, conscious, and repeated request from the victim to end their suffering, which does not raise issues of interpretation, the only exception being the repeated nature of the request (Bogdan and Şerban, 2020, p. 78).

Therefore, the term "explicit" means that the request made by the victim must be expressed explicitly, clearly, and unequivocally; consequently, such a request cannot be inferred from gestures, words, or attitudes (ibid.).

The conscious nature of the request means, in fact, the existence of the victim's unimpaired

discernment, who fully realizes the request they are making to the agent and its consequences, and which is complemented by the remaining conditions regarding the request, namely that it be serious, explicit, and repeated, although the list is tautological in nature, but serves to reinforce, beyond any doubt, the victim's desire to die.

Another condition related to the material element is the existence of an incurable disease or a serious medical condition that causes permanent and unbearable suffering. These are the reasons why the victim wishes to end their life, reasons linked to a pathological condition (Cioclei, 2020, p. 40) that causes the victim permanent and unbearable suffering.

This condition, in turn, imposes other conditions, in the sense that the illness must be incurable, incapable of being cured or alleviated, and the disability must be severe.

Although the legislator does not define the concept of "severe disability," we consider, as legal doctrine has already emphasized (Bogdan and Şerban, 2020, p. 81), that it may have a relative meaning and believe it should be interpreted in accordance with medical science, that is, a morphological and/or functional change that places the person in a state of inferiority, seriously affecting their quality of life, such as certain neurodegenerative diseases affecting neurons in the brain and spinal cord, or complete paralysis and even hemiplegia.

We express the view that the victim's life becomes unbearable and that it is a purely subjective matter, depending on each individual, whether they are able and willing to live under conditions where their quality of life no longer exists.

Furthermore, the European Court of Human Rights has also expressed an opinion that cannot be considered categorical: the applicant suffered from an incurable progressive degenerative disease, as a result of which her health had rapidly deteriorated; she was completely paralyzed, could no longer express herself coherently, and was being fed through a tube, but her intellectual faculties and abilities remained intact. Since she was unable to take her own life, she sought the consent of the British authorities for her husband to assist her in ending her life. The British authority's refusal was challenged in the national courts and, subsequently, before the European Court of Human Rights, on the grounds that every person should have the right to choose whether or not to live and the right to refuse medical treatment (ECHR: Pretty v. the United Kingdom, 2002; Nicklinson and Lamb v. the United Kingdom, 2015).

However, the Court held that the right to life cannot have a negative aspect, stating that "*there is no connection between Article 2 and the quality of life or what a person chooses to do with their life*" and, therefore*, "it cannot be interpreted, without risking a distortion of language, as conferring a right diametrically opposed to the right to life, namely the right to die"* and that *"no right to die, whether with the assistance of a third party or a public authority, can be inferred from Article 2 of the Convention"*.

We share the opinion (Bogdan and Şerban, 2020, p. 81) expressed in the specialized literature regarding the existence of an incurable disease or a severe disability that has not yet caused permanent and unbearable physical suffering, which is inevitable and specific to the disease or disability, since it would be absolutely inhumane to require the victim to suffer in this way before making the request.

For the offense to exist, the illness or disability must also be medically certified - there must be medical documents confirming their existence, which is rather an essential evidentiary requirement (Bogdan and Şerban, 2020, p. 81). However, we consider that the existence of the illness or disability could also be proven by other means of evidence, such as a statement from the attending physician (ibid.).

Therefore, a request by the victim that is not based on these grounds, even if it meets the requirements, cannot lead to the establishment of this offense; the act constitutes the offense of murder if the perpetrator carried it out.

Legal doctrine (ibid.) has also emphasized the need to distinguish this offense from assisted suicide, since in the latter case, the victim carries out the suicidal act entirely on their own, having full control over the execution and completion of this act, while the agent merely assists the victim or facilitates this action; the agent's act cannot be classified as the crime of killing at the victim's request, on the grounds that it does not constitute an act of taking the life of that person.

4. Conclusions

Given the sensitivity of the topic and its interdisciplinary reach, without analyzing in detail the three existing currents regarding euthanasia - vitalism, dignified death, and hastening the process of death (Stănilă, 2014) - each presenting arguments that are worthy of consideration, we believe that there can be no universal solution until doctrine (based on factual reality) provides clear answers to the numerous questions that arise:

- Does a person have the right to ask another person (within or outside the medical field) for the right to request this service?;

- If so, to what extent does the right of medical personnel to invoke conscientious objection extend?;

- How will the act of a person (who is not a member of the medical profession) to end (upon request and out of love) the life of someone suffering greatly (physically and morally) be incorporated into legislation?;

- Could there be a risk that the state might lose control over this phenomenon? We are referring to the use of euthanasia for other categories of people, such as: the elderly or young people who are alone and lack material, family, or emotional support; people with disabilities or those experiencing temporary states of depression, anxiety, bulimia, etc.; newborns with severe malformations, as might be the case in Canada and as already appears to be the case in the Netherlands and Switzerland (the scandal in Switzerland regarding the Sarco assisted suicide capsule: *"Lawyers argue that Sarco offers a suicide option that does not rely on drugs or doctors and that it expands access to euthanasia, as the portable device can be 3D-printed and assembled at home. However, there has also been opposition in Switzerland, despite the fact that the country has some of the most permissive laws in the world regarding assisted dying. Critics fear that the device's modern design appeals to people and could encourage its use, and the fact that it can be used without medical supervision is* concerning");

- Could these individuals, who have become relatively useless to their families or to society, be subjected to a form of psychological pressure? (We refer to the provision in Canadian law that allows doctors to propose euthanasia, even if the person in question has previously expressed firm opposition to it, wishing to live - including for religious reasons - since assisted suicide is considered a sin of death in nearly all religions). This statement is based on the Joint Declaration in which the Christian, Jewish, and Muslim faiths condemn all forms of euthanasia and medically assisted suicide and advocate for the promotion of palliative care; (D'Antuono, apud. Stănilă, 2014).

- As time passes and these ideas gain acceptance, could euthanasia or assisted suicide come to be perceived as a form of treatment or an option for the elderly, for those who are suffering or have disabilities or malformations, given the lower costs compared to those that their treatment or the improvement of their quality of life would entail?

We have certainly not exhaustively addressed all the questions that could be raised in the context under discussion, and for this very reason, we consider it pertinent to conclude with a quote from a distinguished professor: *"The problem is that this approach reverses the order of values. Human dignity does not depend on the ability to produce, to fend for oneself, on aesthetic appearance, or on the absence of suffering. Dignity is inherent in every person, regardless of their physical or mental condition. When it is subordinated to 'quality of life' understood in a utilitarian way, the door is opened for life to no longer be considered worth living once these conditions deteriorate. The result is a dangerous slope where dignity ceases to be an absolute value and becomes a conditional and fragile currency*." (Szlajen, 2025).

And who could say with certainty that a person is about to die (death being imminent and rapid) or could still live? And under what conditions of quality of life? Is there a right to die (from a legal standpoint) or only the right to live and to shape and mold our lives in accordance with the ethical, philosophical, religious, and moral values of each of us? Which of these could be classified as immoral or, even more so, illegal? How would it be possible to reconcile these values and draw a line (more or less firm) between them?

Only the future could provide an answer. At this point, there are only well-reasoned opinions, and the answer lacks clarity and coherence. However, from a legislative standpoint, a solution is needed that does not distort humanity's fundamental values.

5. AI Use Statement

I declare that no artificial intelligence tools were used in the preparation, writing, analysis, or editing of this manuscript. The content of the manuscript was prepared entirely by the author Simona Franguloiu.

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