With modern medicine’s advanced life-sustaining technologies, euthanasia’s meaning has shifted from the physical and spiritual process of dying to specific (in)actions medical practitioners take that hasten a suffering patient’s death. The Hippocratic oath prohibits physicians’ assisting death. Euthanasia advocates argue that if a patient explicitly, repeatedly expresses the wish to die because of intolerable suffering, resulting from an irreversible state of terminal illness, physicians should heed that wish. Limited cognitive functioning or competency and unconsciousness problematise the expression of choice.

Euthanasia’s dimensions include active/passive, voluntary/involuntary, and direct/indirect. Indirect euthanasia describes interventions that relieve suffering but hasten the patient’s death. Passive euthanasia implies earlier death by foregoing life-sustaining treatment. Physician-assisted suicide and active euthanasia actively hasten death to end suffering. Oregon state (USA) has legalised physician-assisted suicide. Only the *Netherlands has legalised active euthanasia. Surveys undertaken there show how very difficult it is to maintain boundaries between types of euthanasia (all are practiced) and to resolve conflicts between the principles of patient autonomy and best interest.

Euphemised as ‘euthanasia’, *social Darwinism reached its apex during the Nazi regime: By 1945, hundreds of thousands of disabled adults and children—stigmatised as ‘life unworthy of life’—had been murdered by their doctors. Discussion of ethics surrounding euthanasia legalisation lags behind advancing medical technology and costs, with issues such as states’ regulatory roles, unequal access to *health care, and human rights requiring further social and scientific debate.