

NON-MALEFICENCE AS A FUNDAMENTAL ETHICAL BARRIER TO EUTHANASIA LEGALIZATION: A CRITICAL ANALYSIS

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ABSTRACT

This paper explores non-maleficence as a key moral ground against euthanasia and assisted suicide legalization. Applying critical approaches to foundational bioethics literature, medical professions' stances, and empirical knowledge from jurisdictions with legalized euthanasia, this paper indicates that physician participation in intentional death is in direct violation of the “do no harm” principle that characterizes medical practice. Slovenia’s 2025 legalization offers today’s context for thinking through how non-maleficence acts as a moral safeguard against the shift in medicine from healer to death-dispensing profession. The case analysis shows that the empirical findings in Belgium, the Netherlands, and Canada support slippery slope concerns about medicine—a concern that has been shown to threaten vulnerable populations with increased risks when euthanasia becomes medicalized. The paper argues that non-maleficence is the most important ethical principle to oppose euthanasia legalization as it preserves professional medical integrity and human dignity.

Keywords: non-maleficence, euthanasia, medical ethics, bioethics, physician-assisted suicide

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Introduction

Euthanasia decriminalisation now is one of the most serious ethical dilemmas facing modern medicine. Laws permitting doctors to deliberately end a patient's life or assist their suicide were passed globally, in places like the Netherlands (2002), Belgium (2002), Luxembourg (2009), Canada (2016), and most recently Slovenia (2025). In the face of consistent resistance from such major medical organizations as the American Medical Association, the World Medical Association and the American College of Physicians, which collectively hold that euthanasia fundamentally violates basic principles of medical ethics,^[1] this progress has been made. As the first Eastern European country to legalize assisted suicide, Slovenia's legalization in July 2025 marks a landmark event. With overwhelming opposition from national medical ethics committees and the Medical Society of Slovenia as well as the Slovenian Medical Chamber's opposition^[2], the National Assembly brought about the Act on Assisted Voluntary Ending of Life by vote of 50–34.^[3] Within the context of this legislation being designed in an area where only 20 percent of those in need receive palliative services available here^[4], the only hospice inpatient facility serving the entire Slovenia is one.^[5] The Slovenian case reveals the troubling scenario where the legalization of euthanasia does not emerge from supportive care to save lives but rather from

there not being one – something that is no different in other jurisdictions. The ethical principle of non-maleficence (first, do no harm) is based in the Hippocratic maxim “primum non nocere”, and has served as the basis of medical practice for two millennia.^[6] It imposes a “boundless obligation” to physicians to not engage in harm-inducing activities which harm patients, thus providing what Beauchamp and Childress classify as a negative constraint which forbids certain behaviors despite their perceived benefits.^[7] When doctors partake in euthanasia, they cross beyond this boundary by being the actual cause of patients' deaths rather than the preserver of these lives.^[8] This paper contends non-maleficence to be the most serious moral obstacle for the legalization of euthanasia and by examining various medical ethics literature and evidence from legalized euthanasia-enforced states shows that physician engagement in lethal harm is inherently antithetical to medicine's aim of healing. The analysis proceeds in three parts — the first covers historical and philosophical foundations of non-maleficence in the Hippocratic tradition. It then examines why this principle contravenes euthanasia policy and what if any of the resulting harm suffered by vulnerable groups in countries where euthanasia has been legalized provides empirical proof for slippery slope concerns.

1. The Principle of Non-Maleficence: Ancient Origins and the Hippocratic Tradition

The first medical statement that clearly articulates non-maleficence is the Hippocratic Oath, which states that no patient should ever be given deadly substances, even if requested: “I will not, even if asked, prescribe a lethal drug to anyone, or by advice induce him to think so”.^[9] This prohibition is not a matter of religious dogma, but of wisdom derived from ancient physicians, who figured that the healing would most effectively only be permissible if there exists clarity for the ethical boundaries where the power to heal should be limited, if trust in public and integrity of professional practice are to be maintained. The Hippocratic tradition, Miles demonstrates, put the responsibility on physicians to see that medical practice as a moral endeavor, one that was to make the people they served better rather than harm them.^[10] In modern bioethics, Beauchamp and Childress systematized non-maleficence as one of four general principles governing medical practice, together with autonomy, beneficence, and justice.^[11] They also point out that the virtue of non-maleficence cannot be attributed to beneficence because non-maleficence, in its nature, is negative. It cannot entail some beneficial action for a physician (they must not do harm). This distinction emerges as important to what is said about euthanasia’s prevention due to non-maleficence. The for-

mer could even provide a means of alleviating suffering by death. But non-maleficence constitutes an absolute prohibition on intentionally causing death.^[12] The philosophical foundation of non-maleficence is further from consequentialist comparisons of benefits and harms. Globokar points out that classical moral theology makes a distinction between physical and moral evil: whether or not we have a moral obligation to harm humans – e.g., by amputating them to prolong life – is irrelevant because moral evil, which is the intentional behaviour done maliciously, is always unacceptable.^[13] This deontological principle indicates that, as an intentional death act, euthanasia is a moral evil regardless of the outcomes or suffering it claims to relieve. The principle persists in their relevance based on its presence as a factor in defining medicine’s defining essence where a solemn commitment to non-maleficence is reduced to a technical skill to be used for a number of purposes, including harming patients. As such, the ban on intentional killing is not just a subjective barrier but an essential component of medicine, one that creates a distinction between healing and biological manipulation. When physicians take part in euthanasia, which violates non-maleficence, they violate the very trust that facilitates the patient-physician relationship.

2. Why the Principle of Non-Maleficence Opposes Legalization of Assisted Suicide and Euthanasia

The principle of non-maleficence opposes euthanasia legalization at three interrelated levels for three arguments: the intrinsic wrongness of intentional killing, the corruption of medical practice, and the impossibility of containing harm once legalized. All these angles illustrate how euthanasia runs counter to the very underlying ethical principle of no harm, described in medical ethics as “do no harm”. Firstly, euthanasia inflicts not indirect injuries, but rather intentional, direct and harmful harm on the patient through the intentional causing of death. As White stresses, when a physician prescribes lethal medication with full knowledge of the patient’s suicidal intent and provides instructions for its use, that physician becomes a proximate cause of the death of the patient just as certainly as if the doctor had injected lethal drugs directly.^[14] The causal relationship remains unyielding: The patient’s death would not have happened except for the physician’s behavior. This intentional causal death constitutes a paradigm breach of non-maleficence: It turns the physician from healer into death-agent. An appeal to patient autonomy does not absolve a non-maleficence violation. Beauchamp and Childress acknowledge the role of autonomy as a basic medical ethical principle, however, they cannot trump the prohibition of harming.^[15] What, beyond

that, the request for death by one patient compels physicians and others to partaken in participation in the harmful act, and thus violates their duty in professionalism for physicians and the Hippocratic oath. The social aspect of euthanasia means it never can be fully autonomous — it can never be fully autonomous — and so must corrupt the medical profession’s allegiance to healing. Second, euthanasia perverts medical care, since it alters the nature of the physician’s role and the nature of what medicine is meant to be, and therefore the way it should be. To allow physicians to kill violates trust between doctor and patient, respect for the medical profession, and the value of medicine itself, Kass argues.^[16] When healing professionals become agents of death, the trajectory of medicine takes a complete turn. As Schockenhoff notes, physician participation in suicide is to share the intention of the one who wishes to commit suicide and becomes morally equivalent to the conduct of the principal actor.^[17] This shift from safeguard of life to terminator of that life is an elementary betrayal of the business of medicine. In addition the notion of human dignity grounds non-maleficence’s opposition for euthanasia. Globokar insists that every human being, whatever his or her health status, has his or her dignity, which would shield him or her from being interfered with in his or her life by anyone.^[18] The dignity associated with this implies that human life has intrinsic significance – it is worth something – in the absence of measures of quality

of life or ability to function. Non-maleficence ensures such dignity, which forbids those who refuse to respect human life as disposable when distress / disability undermines quality. Third, the social impacts of the legalization of euthanasia show that damage is beyond just personal cases but also to the oppressed and society at large. Oh points out how the euphemistic language “death with dignity” and “medical aid in dying” helps to hide the moral truth of euthanasia and make it seem normal.

^[19] These linguistic tactics reflect a larger social shift in which suffering is no longer bearable, and death replaces either disability or dependence. As Globokar cautions, for euthanasia to be legal puts silent pressures on the sick, the disabled, and the elderly to choose leaving this world and not bearing the burden of families and their environment.^[20] That euthanasia itself becomes the expectation of those considered burdensome.

3. The Slippery Slope Argument and Increased Harm in Case of Legalization of Euthanasia

Although frequently dismissed as speculation as the slippery slope argument against legalization, there is significant empirical support for it in jurisdictions that have legalized it. Evidence from the Netherlands, Belgium, and Canada shows systematic expansion of euthanasia beyond initial parameters, validating that legalization invariably entails greater application and harm to vulnerable populations.

What started as euthanasia for terminally ill adults facing intolerable physical hardship in the Netherlands has grown considerably. In 2024, the Regional Euthanasia Review Committees (RTEs) in the Netherlands received 9,958 euthanasia notifications, marking a 10% increase from 9,068 in 2023 and accounting for 5.8% of the country’s 172,049 total deaths. The gender distribution was nearly equal, with 4,996 males (50.2%) and 4,962 females (49.8%). Termination of life on request comprised 9,753 cases (97.94%), assisted suicide 187 (1.88%), and combinations 18 (0.18%). Common somatic conditions dominated at 8,593 cases (86.29%), including cancer (5,346), neurological disorders (681), cardiovascular disease (429), pulmonary disorders (346), and somatic combinations (1,791). Dementia accounted for 427 notifications (340 decisionally competent patients), psychiatric disorders for 219, multiple geriatric syndromes for 397, psychiatric-somatic combinations for 90, and other conditions for 232. The highest age group was 70-80 years (3,284 cases), followed by 80-90 (2,980) and 60-70 (1,731); three cases involved minors aged 12-18. Most euthanasias occurred at home (7,728), with others in nursing homes (675), hospices (863), care homes (337), hospitals (226), or elsewhere (129). General practitioners notified 7,913 cases, elderly-care specialists 424, psychiatrists 72, and the Euthanasia Expertise Centre was involved in 1,417. Organ/tissue donation followed euthanasia in at least 28 cases, and “double euthanasia” occurred 54 times (108 patients). Six

notifications failed to meet due care criteria, with an average processing time of 40 days.^[21] This expansion mirrors Belgium's experience. Since euthanasia legislation became legal in 2002, cases rose from 236 cases in 2003 to 2,700 cases in 2021.^[22] Belgium was the first country to legalize euthanasia for minors without age restrictions, and in 2014, the request went out, asking for only a child's capacity for "capacity of discernment."^[23] Euthanasia in non-life-threatening conditions has steadily increased, with psychiatric disorders accounting for 370 cases (2002–2021) according to the Belgian Commission on Control and Evaluation.^[24] As Raus et al. note, Belgium's 'tired of life' conversation^[25] highlights the drive to extend the criterion beyond simply medical conditions and to include existential suffering. The fastest-growing program is Canada's Medical Assistance in Dying (MAiD). Legalized in 2016 for terminally ill adults, eligibility expanded in 2021 to cover non-terminal conditions; as of 2022, MAiD alone is now the fourth leading cause of death in Canada: 4.1% of all deaths were attributed to MAiD in 2022.^[26] The financial examination by Jamil and Pearce yields concerning incentives, estimating the available government income savings of CAD \$1.273 trillion by 2047, if MAiD extends to vulnerable communities including the mentally ill, homeless, and indigenous peoples.^[27] By this economic construct euthanasia does not simply stop being medical but becomes a cost-reducing means, putting a systemic burden on

already-vulnerable groups who eat up more resources than they produce. The expansion into psychiatric disorders is an especially stark example of the slippery slope. Kim et al. An analysis of psychiatric euthanasia in the Netherlands found that between 2011 and 2014, 66 patients received euthanasia for psychiatric disorders, with 70% being women.^[28] The subjectivity of "unbearable suffering" in mental illness coupled with the semi-episodic characteristics of many psychiatric disorders makes an assessment of hopelessness itself intrinsically problematic. As Verhofstadt et al. note, clinicians find it difficult to discern between the virtues of "attentiveness" and paternalism in psychiatric euthanasia requests; some consider "a triadic dialogue in which the patient and her relevant health carers with her social circle of friends and family is involved".^[29] But that expanded decision-making undermines individual agency while escalating social pressure. Disability rights organizations have raised particular concerns^[30]; euthanasia contributes to discriminatory presumptions that all lives lived with disability are worse. A society that prefers death to appropriate support services sends a clear message to vulnerable people: those lives are perceived as less deserving of protection and investment. Euthanasia as a normalization transforms cultural perspectives on suffering, disability, and human value. This contradiction shows how normalization functions as the slope itself—what used to seem unthinkable, becomes routine.

Conclusion

The principle of non-maleficence remains the most powerful ethical boundary against the legalization of euthanasia, based on millennia of medical tradition and supported by modern empirical evidence. This has shown three pathways by which physician engagement in intentional death violates the founding tenet of “do no harm”: direct causation of death as paradigmatic harm; a perversion of the healing purpose of medicine, and inexorable widening of harm to vulnerable populations after it is legalized. The real evidence from the Netherlands, Belgium, and Canada also shows that the transition from limited exceptional euthanasia to normal medical practice is not theoretical but demonstrable reality. What begins as a compassionate response to unbearable terminal suffering becomes an inexorable means of covering the psychiatric patient, the disabled, children or those with existential distress. The shift to cost-effective medical options, exemplified by Canada’s MAiD program, illustrates both that economics can drive ethical degradation once the principle of non-maleficence is violated. Functional capacities, quality of life, or social utility cannot be the basis of human dignity. When medicine abandons its solemn and moral obligation to protect life — even in an unprecedented event — it undermines not only individual patients but the core equality and inviolability of all human beings. One of the most obvious instances of this involves the

apparent linguistic manipulation described by Oh,^[31] where euthanasia has become “medical aid in dying” and suicide “death with dignity” as acts of euphemism: intentional attempts to cover up moral reality. Such semantic shifts in turn help to normalize practices that had the weight of past generations of physicians’ judgment as the ultimate breach of medical ethics. Reclaiming such exact wording which recognizes euthanasia as intentional killing is necessary in retaining ethical clarity. For future research and ethics the analysis raises some difficult questions: First, how can societies create effective palliative care systems that meet the real suffering that drives requests for euthanasia, but do not compromise non-maleficence, and how do these systems relate to the principle of non-maleficence? The Slovenian case shows that the legalization of euthanasia follows primarily from inadequate supportive care, far from even excellent alternatives. This can lead to research that investigates how holistic palliative care, including psychological and spiritual support can also support a commitment to life in the face of an unfulfilled existence. Second, how does economic perspective become relevant for end-of-life medical decisions — can health care systems overcome financial incentives to portray vulnerable lives as burdensome? The Canadian experience shows that cost-benefit analysis can make euthanasia more than just an extraordinary form of medical interven-

tion, but also an ideal economic solution. To navigate this, the ethical frameworks need to bring together the economics of healthcare coupled with human dignity to prevent the commodification of death. Third, how does the medical profession maintain that commitment to non-maleficence in the face of cultural dynamics that promote autonomous choice as the highest good? As societies come to value self-determination at the expense of traditional medical ethics, the dichotomy of individual autonomy and professional integrity must be rediscovered. A research challenge is to examine in what ways can physicians exercise patient autonomy and provide appropriate boundaries and protect themselves from helping to intentionally end lives. The rule of non-maleficence saves not only patients but the profession of medicine itself.

When physicians take up the role of agents of death, they relinquish the essential commitment that distinguishes healing from mere technical manipulation of biology. Studies from places with euthanasia as an instrument of healthcare law reveal that once the moral and philosophical barrier is exceeded, growth is certain, and harm begins to spread across the vulnerable. The complete prohibition of doctor involvement in intentional death is not outdated paternalism but necessary medical integrity and human dignity protection. In the era of increasing pressure on society to legalize euthanasia, the principle of non-maleficence holds the ethical clarity necessary to fight against the recasting for medical practice of medicine in such a way that medical practice of healing becomes a practice of the instrument of death.

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