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Mercy Killing in Bioethical, Legal, and End-of-Life Care Perspectives

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ABSTRACT

Mercy killing remains a highly contested issue in bioethics, medical law, and end-of-life care because it involves the deliberate ending of life under the justification of compassion. Although the term is often associated with euthanasia and assisted dying, it must be carefully distinguished from refusal of treatment, withdrawal of life-sustaining treatment, do-not-resuscitate decisions, and palliative sedation, since these practices differ in intention, causation, consent, and legal consequences. This study aims to analyze mercy killing from bioethical, legal, and end-of-life care perspectives, with particular attention to patient autonomy, human dignity, vulnerability, palliative care, professional conscience, and implications for the Indonesian health-care context. Using a normative bioethical and legal-analytical approach, this article examines the ethical tension between relieving unbearable suffering and protecting human life. The analysis shows that autonomy cannot be separated from decision-making capacity, freedom from coercion, adequate information, and access to meaningful alternatives, especially palliative care. It also emphasizes that vulnerable groups, including older persons, disabled individuals, economically disadvantaged patients, and people with mental disorders, require stronger protection against subtle social pressure. In Indonesia, where law, religion, culture, and medical ethics strongly emphasize the sanctity and protection of life, the central priority should not be the normalization of active life-ending practices, but the strengthening of palliative care, legal clarity, clinical ethics consultation, and humane communication at the end of life.

INTRODUCTION

Mercy killing remains one of the most morally difficult issues in contemporary bioethics because it stands at the boundary between compassion and the deliberate ending of human life. The term is commonly used to describe an act intended to end the suffering of a person who is terminally ill, severely debilitated, or experiencing a condition perceived as unbearable. However, the emotional force of the term often obscures its ethical complexity. Compassion may explain the motive behind the act, but it does not automatically determine its moral or legal acceptability. For this reason, mercy killing must be examined through a careful assessment of intention, consent, causation, vulnerability, and professional responsibility.

The conceptual difficulty of mercy killing arises from its proximity to several distinct end-of-life practices, including euthanasia, physician-assisted suicide, medical assistance in dying, voluntary assisted dying, withdrawal of life-sustaining treatment, refusal of treatment, do-not-resuscitate orders, and palliative sedation. These practices may occur in similar clinical contexts, yet they differ in purpose, agency, legal status, and ethical justification. Directly causing death is not morally identical to respecting a patient's refusal of burdensome treatment, just as palliative sedation for refractory symptoms is not equivalent to euthanasia when death is not intended. Global debates on euthanasia and assisted dying show substantial variation in public and professional attitudes across disease conditions, cultures, religions, and clinical roles (Grove et al., 2025).

A central argument in favor of mercy killing is grounded in patient autonomy. From this perspective, a competent person who experiences intolerable suffering should have the moral authority to determine whether continued existence remains acceptable. Autonomy is especially persuasive in modern medical ethics because patients are no longer regarded as passive recipients of professional decisions. Nevertheless, autonomy in end-of-life care is never absolute. A request for death must be assessed in relation to decision-making capacity, adequate information, freedom from coercion, psychological stability, and the availability of meaningful alternatives. The claim that assisted dying may constitute a human right remains controversial because it requires balancing self-determination against the legal and moral protection of life (Wittrock, 2025).

Human dignity is another crucial concept in the debate, yet it is interpreted in different and sometimes conflicting ways. For some, dignity means the ability to maintain control over one's body, identity, and final moments; therefore, the loss of independence, severe pain, or total dependence may be experienced as indignity. For others, dignity is intrinsic and does not disappear when a person becomes weak, disabled, unconscious, or dependent on care. This distinction matters because a society that equates dignity with independence may unintentionally devalue those who require assistance. A relational account of dignity emphasizes that dignity is preserved not only by choice, but also by respectful care, communication, presence, and social recognition (Martineau et al., 2024).

The role of palliative care is essential because many requests for death emerge from suffering that may be reduced through appropriate clinical, psychological, social, and spiritual support. Palliative care does not aim to hasten or postpone death; rather, it seeks to improve quality of life through symptom control, communication, family support, and holistic accompaniment. Where access to palliative care is limited, the language of autonomous choice becomes ethically fragile because patients may request death not because they freely prefer it, but because adequate care is unavailable. Global inequities in palliative care therefore complicate assisted dying debates, especially in health systems where pain relief, trained professionals, and home-based support remain insufficient (Sallnow et al., 2025).

The issue becomes even more sensitive when vulnerable populations are considered. Older persons, disabled persons, economically disadvantaged patients, socially isolated individuals, and people with mental disorders may experience subtle pressure to view themselves as burdens. Such pressure does not always appear as explicit coercion; it may arise through family exhaustion, treatment costs, loneliness, internalized stigma, or lack of care. In psychiatric contexts, the desire to die may also be entangled with hopelessness, impaired future perception, or treatable symptoms. Ethical evaluation must therefore distinguish between a stable autonomous request and a request shaped by remediable suffering, structural neglect, or inadequate mental health support (Favron-Godbout & Racine, 2023).

In Indonesia, mercy killing is particularly complex because legal norms, religious values, medical ethics, and family-centered culture strongly emphasize the protection of life. Nevertheless, the rejection of active euthanasia does not eliminate the ethical problems faced by terminally ill patients, families, and clinicians. Many patients still experience uncontrolled pain, fragmented communication, medically futile intervention, and uncertainty about lawful treatment limitation. The absence of clear end-of-life guidance may lead either to overtreatment or to moral confusion among families and health professionals. Therefore, the objective of this study is to analyze mercy killing from bioethical, legal, and end-of-life care perspectives, with particular attention to autonomy, dignity, vulnerability, palliative care, professional responsibility, and implications for the Indonesian health-care context.

RESEARCH METHODS

This study uses a normative bioethical and legal-analytical approach to examine mercy killing as a contested end-of-life issue. The analysis is not designed as an empirical clinical trial or statistical meta-analysis, but as a critical academic examination of concepts, principles, and arguments that shape ethical and legal reasoning. The central concepts analyzed include mercy killing, euthanasia, assisted dying, refusal of treatment, withdrawal of life-sustaining treatment, do-not-resuscitate decisions, palliative sedation, autonomy, dignity, vulnerability, and professional conscience. The bioethical analysis is grounded in the principles of autonomy, beneficence, non-maleficence, justice, human dignity, and proportionality, while the legal analysis focuses on consent, causation, protection of life, professional responsibility, and the boundaries of lawful end-of-life decision-making.

The materials used consist of peer-reviewed journal articles, bioethical scholarship, and legal-health policy discussions relevant to euthanasia, assisted dying, palliative care, and end-of-life decision-making. Sources were selected based on their relevance to the conceptual, ethical, legal, and clinical dimensions of mercy killing, with priority given to works that address contemporary debates, vulnerable populations, palliative care, health professional responsibility, and institutional safeguards. The analysis proceeded through three stages: first, distinguishing mercy killing from other end-of-life practices; second, evaluating the ethical arguments for and against life-ending assistance; and third, interpreting the implications for health-care systems where active euthanasia remains legally and culturally contested. This method allows the issue to be examined not merely as an individual choice, but as a broader question of care, justice, law, and social responsibility.

RESULTS AND DISCUSSION

1. Definitional Boundaries of Mercy Killing

Mercy killing must be distinguished from other end-of-life decisions because moral evaluation depends on intention, causation, consent, proportionality, and professional role. A death that occurs after treatment withdrawal is not necessarily equivalent to a death caused by direct lethal intervention. In withdrawal of life-sustaining treatment, death results from the underlying disease after burdensome or non-beneficial treatment is stopped. In active euthanasia, death is the intended outcome of an intervention. This distinction is ethically important because medicine often permits the refusal or discontinuation of disproportionate treatment, while still prohibiting direct killing. Confusing these categories produces legal fear, moral panic, and poor clinical decisions (Kadir, 2025).

Euthanasia can be voluntary, non-voluntary, or involuntary. Voluntary euthanasia occurs when a competent patient explicitly requests life-ending action. Non-voluntary euthanasia occurs when the patient cannot express a preference, such as in profound unconsciousness. Involuntary euthanasia occurs against the patient’s will or without respecting known preferences, and it is morally closest to homicide (Kadir, 2026c). The voluntary form receives the most bioethical attention because it appears to combine compassion and consent. Yet consent alone does not settle the issue, because legal systems often treat life as a protected good that cannot be surrendered in the same way as ordinary property or preference.

Physician-assisted suicide differs from euthanasia because the patient performs the final act. The physician may prescribe or provide the means, but the patient retains direct control over administration. In medical assistance in dying or voluntary assisted dying systems, eligibility is often restricted through age, capacity, diagnosis, suffering, voluntariness, independent assessment, waiting periods, and reporting requirements. These safeguards aim to separate regulated assisted dying from impulsive suicide, coercion, or homicide. Policy variation across jurisdictions demonstrates that assisted dying is not a single universal practice, but a family of legal models shaped by culture, institutional capacity, and health-system design (Isaac et al., 2024).

Refusal of medical treatment is ethically and legally different from mercy killing. Competent patients generally have the right to refuse chemotherapy, ventilation, dialysis, artificial feeding, surgery, or resuscitation, even when refusal may shorten life. The ethical foundation is bodily integrity and informed consent: treatment requires permission, and permission may be withdrawn. In such cases, clinicians do not aim to kill; they respect the patient’s refusal of unwanted intervention. Death may follow, but it is caused by disease rather than by a direct lethal act. This distinction protects both patient autonomy and professional integrity, while preventing unnecessary medicalization of the dying process.

Palliative sedation must also be separated from euthanasia. Its purpose is to relieve refractory suffering by reducing consciousness when symptoms such as severe pain, terminal agitation, or breathlessness cannot be controlled through ordinary measures. The ethical justification lies in proportionality, medical indication, and intention to relieve suffering rather than to cause death. Although deep sedation near the end of life may be emotionally difficult for families, it is not equivalent to mercy killing when appropriately used. The principle of double effect is often invoked: a foreseen but unintended shortening of life may be ethically distinguishable from an intended death.

Autonomy is one of the strongest arguments used in favor of assisted dying. Competent adults are normally allowed to make decisions about their own bodies, including decisions that others may regard as unwise. In health care, this principle supports informed consent, refusal of treatment, advance directives, and respect for personal values. If a person can refuse a life-sustaining treatment, it may seem inconsistent to deny that person assistance in ending unbearable suffering. Yet assisted dying differs from refusal because it asks another person, usually a clinician, to participate in a life-ending act. Autonomy therefore encounters the moral agency of others (Kadir, 2026a).

Autonomy must be understood as more than the formal statement of a preference. A decision is meaningfully autonomous only when the person has decision-making capacity, understands the relevant information, appreciates consequences, communicates consistently, and is free from coercion or undue influence. End-of-life choices are especially vulnerable to distortion because pain, fear, depression, isolation, financial pressure, family exhaustion, and perceived burdensomeness may shape the wish to die. For this reason, autonomy in mercy killing cannot be reduced to the sentence "the patient requested it." Ethical assessment must examine the conditions under which the request emerged and whether alternatives were genuinely available.

A further difficulty arises when autonomy is framed as a human right to assisted dying. Rights language is powerful because it gives moral urgency to individual claims, but not every autonomous preference creates a duty for another person or the state to fulfill it. A person may have a right to refuse bodily invasion, but it does not automatically follow that there is a right to receive medical assistance in dying. The ethical and legal question is whether assisted dying is an extension of self-determination, an exception to the protection of life, or a medical service with strict boundaries (Lilleker, 2023).

Dignity is central to the mercy killing debate because both supporters and opponents use it to defend opposing conclusions. One view treats dignity as control over the timing and manner of death. Under this interpretation, a patient may feel that extreme dependence, loss of bodily function, or irreversible decline has made continued existence incompatible with personal dignity. Another view treats dignity as intrinsic and independent of condition. Under this interpretation, illness, disability, dementia, weakness, or dependency cannot reduce human worth. The conflict is therefore not between dignity and its absence, but between different accounts of what dignity requires.

A multidimensional account of dignity is necessary because end-of-life experience is both personal and social. Ontological dignity refers to the inherent worth of every human being. Subjective dignity refers to the patient's felt experience of self-respect, control, and identity. Relational dignity refers to how dignity is upheld or damaged through the behavior of others. A patient who is cleaned gently, spoken to honestly, touched respectfully, and surrounded by love may experience dignity even in profound weakness. The assisted dying debate becomes more ethically precise when dignity is treated as layered rather than reduced to independence alone (Downar et al., 2023).

Suffering also has multiple dimensions. Physical pain is important, but many requests for death are driven by loss of meaning, fear of future decline, dependency, humiliation, loneliness, or the belief that one has become a burden. These forms of suffering are not imaginary, but they are not always solved by ending life. They may call for better communication, psychological care, family mediation, spiritual support, social assistance, and palliative expertise. A purely biomedical response may miss the deeper anguish behind the request. A purely legal response may ignore the bedside reality of a person asking for relief.

The danger of a narrow dignity discourse is that it may unintentionally devalue people who live with dependency. If dignity is equated with independence, then the lives of older persons, disabled persons, chronically ill persons, and cognitively impaired persons may appear less worthy. This does not mean that their choices should be ignored, but it does mean that society must be careful about the messages embedded in its laws and clinical practices. A compassionate society should not imply that needing help makes life undignified. Care itself should become the social expression of dignity.

Palliative care is not a passive waiting for death. It is an active, interdisciplinary approach to serious illness that aims to relieve pain, manage symptoms, support families, address psychological distress, and accompany spiritual concerns. Its purpose is neither to hasten nor to postpone death, but to improve the quality of life of patients and families. In many cases, the desire for death decreases when pain is controlled, breathlessness is relieved, communication is honest, and the patient feels heard. Thus, palliative care represents the most important ethical response to suffering before any discussion of life-ending intervention can be morally credible.

The relationship between assisted dying and palliative care remains contested. Some argue that both practices arise from the same concern: the relief of suffering at the end of life. Others argue that assisted dying contradicts the ethos of palliative care because it changes the clinician's role from accompanying the dying to causing death. The tension is real, particularly in institutions where palliative professionals fear that assisted dying may be used as a substitute for better care. Still, end-of-life systems must acknowledge that palliative care cannot eliminate every form of suffering in every circumstance (Stergiopoulos et al., 2024).

Palliative care also raises questions of justice. In high-resource settings, patients may have access to opioids, specialist teams, home-based support, hospice services, spiritual care, and bereavement counseling. In low- and middle-resource settings, many patients die without adequate pain relief or professional support. Under such conditions, the language of choice can become morally misleading (Colburn, 2025). A patient who chooses death because pain relief is unavailable has not been offered meaningful freedom. Global inequity in palliative care means that assisted dying debates must never be separated from access to essential medicines, trained professionals, and community-based support (Chatzinikolaou et al., 2025).

Requests for assisted death involving mental illness are among the most difficult issues in contemporary bioethics. Psychological suffering can be severe, persistent, and disabling. It should never be dismissed as less real than physical pain. However, mental disorders may affect hope, self-worth, future-oriented reasoning, and the ability to imagine recovery. Depression, trauma, psychosis, severe anxiety, and personality disorders can produce a desire for death that may fluctuate over time. The ethical challenge is to distinguish a stable autonomous request from suicidal despair requiring treatment, protection, and relational support.

The concept of irremediability is especially difficult in psychiatry. In many terminal physical illnesses, prognosis may be uncertain but still clinically bounded. In mental illness, prediction of permanent non-recovery is more complex because symptoms, social conditions, therapeutic relationships, and treatment options may change. A patient who has suffered for years may reasonably feel exhausted, yet clinicians must remain careful about declaring a life beyond help. Mental health systems often fail patients through long waiting lists, fragmented care, underfunding, stigma, and lack of continuity. Assisted dying in such contexts may risk converting system failure into an individual death decision (R. Thomas et al., 2023).

Capacity assessment in mental illness must be rigorous but not discriminatory. People with psychiatric diagnoses should not automatically be presumed incapable. Many can understand information, appreciate consequences, reason coherently, and communicate preferences. At the same time, a wish to die may be bound up with treatable symptoms, demoralization, or social despair. Capacity should therefore be evaluated in relation to the specific decision, the stability of the request, the adequacy of prior care, and the presence of ambivalence. The clinical process must include time, second opinions, psychiatric expertise, and attention to family and community context (Bastidas-Bilbao et al., 2024).

Complexity also requires appropriate evaluation design. Assisted dying for mental illness cannot be assessed through a simple checklist of eligibility criteria because it involves clinical uncertainty, ethical disagreement, social determinants, professional judgment, and long-term system consequences. Evaluation must consider who requests assistance, who is approved, which treatments were available, what safeguards functioned, and how families and clinicians were affected. It must also examine whether marginalized persons are overrepresented because they lacked care. A practice that touches psychiatry, law, suicide prevention, disability rights, and public trust must be assessed as a complex intervention rather than a routine medical procedure (Munro, 2025).

Health professionals occupy a morally difficult position in mercy killing debates. They are expected to relieve suffering, respect patient autonomy, protect life, obey the law, and maintain professional integrity. These duties may conflict when a patient requests assistance in dying. Some clinicians view assisted dying as an extension of compassionate end-of-life care. Others regard it as incompatible with medicine's healing purpose. Neither position should be caricatured. The moral burden is real because the clinician is not merely a technical operator; the clinician is a moral agent whose participation or refusal carries ethical significance for patients, families, and institutions.

Conscientious objection must be taken seriously. A physician or nurse should not be forced to perform an act that he or she believes to be killing. At the same time, conscientious refusal should not become abandonment. Patients must still receive information, symptom management, emotional support, and access to legally available services where such services exist. Health systems therefore need procedures that protect conscience while preventing obstruction, confusion, and inequity. Clear policy is essential because unstructured refusal can leave patients and families navigating personal beliefs rather than institutional standards (K. J. Thomas et al., 2022).

Institutional responsibility is equally important. Hospitals, hospices, religious facilities, aged-care homes, and community services may adopt different positions on assisted dying. Some may provide it, some may allow external providers, and some may object institutionally. Institutional objection can affect access, continuity, transfers, staff morale, and family experience. The ethical problem is not only whether an institution has values, but how those values are communicated and implemented. Patients should not discover restrictions only after crisis develops. Transparent policy, referral pathways, staff education, and respectful communication are necessary to prevent institutional values from becoming patient harm (Haining et al., 2025).

Rural and smaller care settings face additional difficulties because staffing, specialist access, privacy, community relationships, and professional overlap may intensify the emotional burden. In a small hospice, the same clinicians may provide palliative care, support family members, negotiate institutional policy, and respond to assisted dying requests. Even when staff remain committed to safety and respect, the arrival of voluntary assisted dying can alter workplace culture, training needs, and perceptions of professional identity. Rural contexts therefore require tailored support rather than simple transplantation of metropolitan policy models (Auret et al., 2025).

2. Legal and Policy Dimensions

Law plays a crucial role because it defines which acts are permitted, prohibited, or protected. In many legal systems, intentionally ending another person's life remains a criminal act even when motivated by compassion and requested by the person who dies. This reflects the legal principle that life is a protected interest not entirely transferable to individual preference. Jurisdictions that allow assisted dying usually create narrow exceptions with strict eligibility requirements and reporting obligations. These exceptions are designed to protect patients, professionals, and the public from abuse, error, coercion, and normalization of premature death.

Legalization does not remove ethical controversy; it relocates controversy into procedures, definitions, safeguards, eligibility, institutional policy, and oversight. Who qualifies? What counts as unbearable suffering? How should capacity be assessed? Must death be reasonably foreseeable? What if mental illness is the sole underlying condition? How should conscientious objection be accommodated? What must be reported, audited, and reviewed? These questions show that assisted dying law is never merely symbolic. It creates practical pathways that shape clinical behavior, professional education, institutional responsibility, and public expectations about medicine's role at the end of life (Yee et al., 2025).

In jurisdictions where euthanasia remains prohibited, law must still clarify ordinary end-of-life decisions. A legal system that bans active euthanasia but fails to protect appropriate treatment limitation may unintentionally prolong suffering. Clinicians may continue ventilation, dialysis, resuscitation, or intensive care because they fear accusation, even when such treatment offers no reasonable benefit. Families may interpret withdrawal as killing because they lack legal and ethical guidance. Thus, opposition to mercy killing requires a parallel commitment to lawful refusal of treatment, proportionality, palliative sedation, DNR decisions, advance care planning, and clinical ethics consultation.

For Indonesia, legal clarity is particularly important because family decision-making, religious expectations, and fear of criminal liability often shape end-of-life care. Active euthanasia is widely regarded as legally and morally unacceptable, but many ethically legitimate decisions remain poorly understood. Patients and families need guidance on refusing burdensome treatment, limiting futile intervention, and receiving palliative sedation when symptoms are refractory. Clinicians need protection when they act according to professional standards and informed consent. The law should not force medicine to prolong biological dying when treatment no longer serves the patient's welfare.

Religion strongly influences attitudes toward mercy killing because many traditions regard life as sacred, entrusted by God, and not subject to absolute human control. From this perspective, intentionally ending life violates a moral boundary even when motivated by compassion. Suffering may be interpreted through spiritual endurance, dependence on divine will, repentance, purification, or preparation for death. Such beliefs can provide comfort and meaning for patients and families. However, religious opposition to euthanasia should not be confused with indifference to suffering. Most religious traditions also emphasize mercy, care for the sick, accompaniment, and relief of pain.

A religiously sensitive approach to end-of-life care must therefore hold two commitments together: rejection of intentional killing and active care for the suffering. If a community condemns mercy killing while allowing patients to die in untreated pain, isolation, or fear, its moral witness becomes incomplete. Spiritual care should include prayer, reconciliation, forgiveness, family presence, rituals, and meaning-making. It should also support appropriate medical relief of pain and symptoms. Good palliative care is not a secular alternative to religion; it can be a practical expression of religious compassion when delivered with respect for belief and conscience.

Culture shapes decision-making as much as formal ethics. In many Asian and Indonesian families, medical decisions are collective rather than purely individual. Families may ask physicians to withhold a terminal diagnosis from the patient, continue aggressive treatment to show devotion, or avoid DNR discussions because they fear appearing disloyal. Such patterns can protect patients from isolation, but they can also silence the patient's own wishes. Ethical care must respect family bonds without erasing patient agency. The challenge is not to replace family decision-making with Western individualism, but to create honest, compassionate dialogue among patient, family, and clinicians (Aggarwal & Jain, 2024).

The cultural ideal of "fighting until the end" also requires reinterpretation. Fighting does not always mean accepting every intervention. It may mean fighting pain, fear, loneliness, and indignity. It may mean choosing to go home, to speak with children, to pray, to settle conflicts, or to die without machines that no longer heal. Families often need reassurance that limiting futile treatment is not abandonment. They also need language that allows love to be expressed through comfort rather than technological escalation. A humane death may require courage not only to continue treatment, but also to stop treatment that has lost its purpose.

3. Mercy Killing and the Indonesian Health-Care Context

Indonesia's most urgent end-of-life challenge is not the absence of assisted dying law, but the uneven availability of dignified care for patients with serious illness. Many patients with advanced cancer, organ failure, neurological disease (Kadir, 2026b), dementia, and chronic degenerative conditions experience pain, late referral, financial burden, fragmented communication, and limited home support. Intensive care may become the default setting for dying because families feel that hospital technology represents hope. Yet technological intensity does not always equal humane care. A patient may be surrounded by monitors while still lacking comfort, conversation, spiritual support, and meaningful presence.

Palliative care should become a central component of Indonesian health policy. It should not be limited to cancer hospitals or final days of life. Patients with progressive disease need early symptom control, family counseling, spiritual support, and planning for future care. Primary care, community health centers, hospitals, and home-care systems should develop basic palliative capacity. Access to essential pain medication must be improved while maintaining safe regulation. Professional education should teach clinicians that palliative care is not giving up; it is active care when cure is no longer possible or when disease burden exceeds treatment benefit.

Medical education must also strengthen end-of-life communication. Many clinicians are trained to diagnose and treat, but not to discuss prognosis, dying, uncertainty, or treatment limitation. Families may receive fragmented explanations from different specialists, producing confusion and conflict. Patients may never be asked what matters most to them. Communication skills should include breaking bad news, discussing goals of care, explaining DNR orders, responding to emotion, and involving religious or cultural support. Better communication can prevent two harmful extremes: aggressive treatment without benefit and premature despair without support.

Clinical ethics committees are needed in hospitals because end-of-life decisions often involve conflict, uncertainty, and moral distress (Kanamori et al., 2021). A committee can help distinguish euthanasia from treatment limitation, assess proportionality, support family meetings, protect patient preferences, and reduce the burden on individual clinicians. Ethics consultation should not be reserved only for dramatic cases; it should become part of responsible care when values conflict. Such committees can include physicians, nurses, legal advisors, ethicists, psychologists, social workers, and spiritual care representatives. Their role is not to replace the patient or family, but to structure careful deliberation.

Public education is equally important. Many people equate stopping treatment with killing, or palliative care with abandonment. These misunderstandings create fear and delay (Loader & Sparks, 2020). Society needs clearer language: refusing burdensome treatment is not suicide; withholding futile resuscitation is not murder; palliative sedation is not euthanasia when properly indicated; comfort care is not neglect. Public literacy can help families make decisions without guilt and help clinicians practice without excessive defensive medicine. In Indonesia, where family and religion are deeply important, education must be culturally sensitive rather than confrontational.

CONCLUSION

Mercy killing is a bioethical problem that cannot be reduced to a simple opposition between compassion and prohibition. It requires careful distinction among active euthanasia, physician-assisted suicide, medical assistance in dying, voluntary assisted dying, refusal of treatment, withdrawal of life-sustaining treatment, DNR orders, and palliative sedation. These practices differ in intention, causation, consent, professional role, and legal meaning. Patient autonomy deserves serious respect, but autonomy must be evaluated within real conditions of capacity, information, freedom from pressure, and access to care. Human dignity should not be equated only with independence, because persons remain worthy of respect even in weakness, disability, dependence, and terminal decline.

For Indonesia, the ethically urgent priority is not to normalize active life-ending practices, but to ensure that dying patients are not abandoned to pain, futile treatment, poor communication, and family confusion. Strengthening palliative care, improving access to symptom relief, clarifying legal standards for treatment limitation, developing clinical ethics committees, and training health professionals in end-of-life communication are essential steps toward dignified dying. A society committed to human dignity must protect life while also relieving suffering. The strongest response to mercy killing is therefore not silence, fear, or technological escalation, but a health-care system capable of accompanying patients until death with honesty, competence, compassion, and justice.

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