Journal of Law and Legal Reform
Vol. 6 Issue 2 (2025) 869–908
DOI: https://doi.org/10.15294/jllr.v6i2.20498
Online since: April 30, 2025

Journal of Law & Legal Reform
https://journal.unnes.ac.id/journals/jllr

Legal Reform for Passive Euthanasia in Indonesia: A Comparative Analysis of Policy and Ethics

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Abstract

This study aims to elaborate on the ethical and legal problems concerning passive euthanasia and Advance Directives (ADs) in Indonesia, focusing on the legal obscurity in current legislation, which causes uncertainties among families and medical practitioners. Although Indonesia's Penal Code criminalizes active euthanasia, it remains silent on passive euthanasia, making healthcare providers vulnerable to the risk of prosecution when withholding or withdrawing futile treatments. Using a normative juridical approach, this research primarily analyzes Indonesian statutes and compares them with those of India, Saudi Arabia, and Iran. Despite provisions in health laws for patients to refuse treatment, the absence of explicit guidelines forces healthcare providers to operate with legal uncertainty. A comparative analysis of India's legalization of passive euthanasia showcases how legislative clarity can align with ethical, medical, and societal needs. Insights from Islamic-majority countries like Saudi Arabia and Iran also reveal that Islamic jurisprudence, through the harm reduction principle, can be aligned with passive euthanasia within an ethical framework. Several particular reform recommendations are provided in this regard in the study, comprising amending the Penal Code to differentiate passive euthanasia and murder, establishing formal AD procedures, and introducing ethics committees and dual-approval oversight to maintain the ethical purity of the process. These reforms and public awareness initiatives would enhance the principle of patient autonomy and clarify misconceptions and legal responsibilities, providing overall improvement in an unattended aspect of medical care.

Keywords
Passive Euthanasia, Cultural and Religious Values, Advance Directives, Legal Reform, Indonesian Penal Code.

Introduction

In the twilight of life, with the prospects for recovery virtually nil, questions of medical intervention are often fraught with feeling. In such situations, prolonging treatment may only increase suffering without improving the patient's quality of life. In Indonesia, families often see the decision to discontinue or withhold ineffective interventions as an act of compassion . However, there is still a fear that the act of withdrawing treatments would still somehow constitute a crime under current laws. This concern is well founded as it arises due to the Indonesian Penal Code, Article 344, which explicitly criminalizes active euthanasia but remains silent on whether withholding or withdrawing treatment from a dying patient constitutes a criminal offense or not.[1] There exists no legal delineation between the act of killing and the act of non-interference, allowing some irreversible fate to take its course, so, coming back to the previous question: is passive euthanasia recessed into legality, or is it dangerously close in proximity to being a criminal act, none are certain.

This situation gives rise to an ethical and legal dilemma regarding passive euthanasia that remains contentious in Indonesia, which is influenced by firm legal prohibitions and strong theological factors. The failure of the law to distinguish between active euthanasia and the withdrawal of futile medical treatment leaves both families and doctors in a fog of legal uncertainty. On top of this moral and legal morass is a legal system that makes it a crime to act in a way that the state believes hastens death while declining to say whether withdrawing treatment to allow a patient to die naturally is criminal. This silence creates fear, with healthcare professionals reluctant to do the right thing for their patients when even their best intentions may be deemed criminal later.

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[1] Jane Margaretha Handayani, Edy Lisdiyono, Bambang Joyo Supeno, and Wahyu SatriaWana Putra Wijaya, "Formulation Policy of Euthanasia Criminal Action in the Indonesian Criminal Law System," Medico Legal Update 21, no. 2 (2021): 654–58, doi:10.37506/mlu.v21i2.2757.

Wibowo (2021)[2] and Aswijati (2021)[3] conducted great studies on legal barriers to passive euthanasia in Indonesia, pointing out the failure of existing laws to clarify the difference between killing intentionally and allowing death to take its natural course. The inflexible interpretation of Indonesia's Criminal Code has led to a climate in which doctors are hesitant to withdraw life-sustaining treatment even though it is medically futile. While there is no specific part of the law that would classify the withdrawal of such treatment as homicide, the lack of protective legislation means that healthcare staff risk prosecution if they do so. The fear of legal ramifications forces medical professionals to extend care in situations where recovery is no longer possible, causing patients unnecessary suffering and families undue pain.[4] The answer leading from the failure to question is why people should make medical decisions that strict and inflexible interpretations could distort without the background knowledge of the complexity of end-of-life care. In a country where the law is not completely separate from religion, it is a hidden paradox: the law is not able to draw a dividing line that enables passive euthanasia to be sanctioned in the law, but at the same time, it is not opposed as a practice. The refusal to confront the ethical dimensions of passive euthanasia is part of a bigger failure of Indonesia's legal system to keep up with changing standards in medical ethics. One might argue that legal rigidity serves a purpose, but the study implicitly questions where the meaning lies, especially when it creates unnecessary pain and confusion for patients and practitioners alike.

Discussions on euthanasia are further complicated by religious principles as well as the legal landscape. Islamic law, which is a large component of Indonesia's moral and legal universe, generally forbids any

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[2] Sigit Wibowo, "Tinjauan Yuridis Terhadap Tindakan Euthanasia dalam Perspektif Interkonektif," Jurnal Hukum Caraka Justitia (2021), https://doi.org/10.30588/jhcj.v1i2.922.

[3] Indira Inggi Aswijati, "Euthanasia Formulation Policy in Indonesia's Criminal Legislation and Implications for Patient Life," International Journal of Social Science and Human Research 4, no. 5 (2021), Everant Journals, doi:10.47191/ijsshr/v4-i5-31.

[4] Carlos Gómez-Vírseda and Chris Gastmans, "Euthanasia in Persons with Advanced Dementia: A Dignity-Enhancing Care Approach," Journal of Medical Ethics 48, no. 11 (2021): 907–14, doi:10.1136/medethics-2021-107308.

act that directly brings about death. However, scholars have long debated whether allowing the natural course of death to proceed in the absence of futile treatment is at odds with those religious teachings. Ahmad and Kamri (2024)[5] assess the issues of euthanasia in the light of Islamic law, especially Islamic criminal law and human rights principles, and conclude that although active euthanasia is a strict prohibition, withdrawal of treatment is generally permissible in situations where medical measures for intervention are rendered non-therapeutic. While human intervention in ending life is forbidden, excessive medical intervention that maintains life without hope of recovery can also be at odds with Islamic ethical values. This takes us to a vital question: Is the denial of withdrawal of futile treatment an ethical necessity or needless imposition of suffering? It may be a subtle distinction, but it is important. Islamic law does not posit that life must be extended at all costs, but the legal structures in Indonesia do not appear to accommodate this nuance. By refusing to include such perspectives in legal and medical practice, healthcare professionals are left shackled to laws that do not represent the evolving realities of medical ethics and do not evoke the humane principles of religious doctrine.

Indonesia's challenge is not whether passive euthanasia ought to be legalized in the same way that it has been legalized in Western jurisdictions, but rather whether its legal framework could change to accommodate realities, medical, and ethics in practice. Fitri, Tan, and Putri (2024)[6] provide a comparative study of euthanasia laws in Indonesia and the Netherlands, where euthanasia is regulated under strict medical and legal conditions. The study then goes on to showcase how decisions about passive euthanasia are made informally in the absence of a law that would provide a template for doctors and patients. This unfortunate oversight exposes patients to abuse in the most vulnerable moments of their lives. While the underlying cultural and religious

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[5] Kamri Ahmad and Andi Khaedhir Kamri, "Medical Action of Doctors with Euthanasy From the Perspective of Criminal Acts on Islamic Law: A Normative Review," Revista de Gestão Social e Ambiental (2024), https://doi.org/10.24857/rgsa.v18n6-068.

[6] Winda Fitri, Winsherly Tan, and Aulia Ginda Putri, "Comparison of Indonesian and Dutch Laws on the Implementation of Euthanasia," Al-Adalah: Jurnal Hukum Dan Politik Islam 9, no. 1 (2024): 80–93, doi:10.30863/ajmpi.v9i1.5894.

differences could complicate direct comparisons between the two, having clear legal mechanisms does not necessarily lead to a contradiction between law and religious values; instead, it would provide much-needed guidance for doctors and families confronted with difficult medical decisions. There is a body of literature that shows a legal system that does not have any mechanism to effectively carry out passive euthanasia, where fear of punishment makes physicians likely to make choices that are not beneficial to the patient.

A significant early example of this confusion arose on September 17, 2004, when Hasan Kesuma[7] consulted the Bogor City Regional Representative Council about ending the life of his wife, Mrs. Agian Isna Nauli. She had been in a coma for three months following a Cesarean section, with no hope of coming out of it, and her husband decided that it was no longer economically viable to keep treating her. Facing financial struggles and believing his wife's condition was beyond recovery, Hasan applied for active euthanasia to relieve what he said was a tragic and irreparable situation. While they sympathized with his situation, the officials could not grant such a request, citing that it would violate national law and religious doctrine.[8] In the aftermath of the case, critics argued that Hasan's case revealed more than just an issue with active euthanasia; it equally exposed the general lack of legislative guidance on ending futile treatment, even where there is no intention to take life.[9] In the absence of a legal framework supporting passive euthanasia, such actions risk being classified as homicide. Another point to note would be the fact that the husband had no intention to kill his wife but only to alleviate her suffering. The facts also state that there was

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[7] detikNews, "Hasan Mohonkan Penetapan Euthanasia atas Agian ke PN Jakpus," detikNews, October 22, 2004, https://news.detik.com/berita/d-228879/hasan-mohonkan-penetapan-euthanasia-atas-agian-ke-pn-jakpus.

[8] Farida Patittingi Haeranah, Muhadar, Syamsuddin Muchtar, Muh Hasrul, Nur Azisa, Kahar Lahae, Birkah Latif, and Handar Subhandi Bakhtiar, "Health and Law: Euthanasia in Indonesian Legal Perspective," Enfermeria Clinica 30 (June 2020): 492–95, doi:10.1016/j.enfcli.2019.10.128.

[9] Dian Andriani Ratna Dewi, Waty Suwarty Haryono, and Evita Isretno Israhadi, "Regulations for Implementing Passive Euthanasia in the Terminal Stage Patients (End of Life) Which Is in Accordance with Justice and Legal Certainty in Indonesia," Eduvest – Journal of Universal Studies 3, no. 1 (2023): 50–66, doi:10.36418/eduvest.v3i1.717.

no apparent hope of recovery or improvement had there been a clear legislative guideline; the option of passive euthanasia could have been presented, which would allow the actions taken to fall within the legal ambit that would violate legal or religious sentiments.[10]

In 2011, a similar case arose in East Kalimantan[11] concerning a patient who had been bedridden for years due to a serious illness that showed no signs of improvement, named Humaida. Pushed to the limits by ballooning medical expenses and the anguish of an endless hospital stay, the family went to the Supreme Court for a medically-induced death, which they saw as a kindness. Officials again rejected the request, insisting any move intentionally leading to death would breach Indonesian law and moral tenets.[12] It is reminiscent of Hasan Kesuma's scenario, where observers stated that this case appealed to the prohibition against actively hastening death and legal ambiguity regarding the passive withdrawal of futile interventions.[13] In such desperate situations, whether a family could be subject to criminal prosecution for choosing to switch off life-prolonging equipment is still unresolved. At the same time, practitioners share that anxiety that the steps they take to stop suffering will be perceived as a serious violation.[14]

These cases are a clear demonstration of the urgent need for clear legal distinctions between active euthanasia and the ethical refusal or

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[10] Winda Fitri, Winsherly Tan, and Aulia Ginda Putri, "Comparison of Indonesian and Dutch Laws on the Implementation of Euthanasia," Al-Adalah: Jurnal Hukum Dan Politik Islam 9, no. 1 (2024): 80–93, doi:10.30863/ajmpi.v9i1.5894.

[11] Merdeka, "Ketika Suntik Mati Jadi Pilihan: Eutanasia di Indonesia," Merdeka, March 16, 2015, https://www.merdeka.com/khas/ketika-suntik-mati-jadi-pilihan-eutanasia-di-indonesia.html.

[12] Farida Patittingi Haeranah, Muhadar, Syamsuddin Muchtar, Muh Hasrul, Nur Azisa, Kahar Lahae, Birkah Latif, and Handar Subhandi Bakhtiar, "Health and Law: Euthanasia in Indonesian Legal Perspective," Enfermeria Clinica 30 (June 2020): 492–95, doi:10.1016/j.enfcli.2019.10.128.

[13] Dian Andriani Ratna Dewi, Waty Suwarty Haryono, and Evita Isretno Israhadi, "Regulations for Implementing Passive Euthanasia in the Terminal Stage Patients (End of Life) Which Is in Accordance with Justice and Legal Certainty in Indonesia," Eduvest – Journal of Universal Studies 3, no. 1 (2023): 50–66, doi:10.36418/eduvest.v3i1.717.

[14] Rahdiyul Ermanto and Uning Pratimaratri, "Euthanasia Pasif dalam Pandangan Moral, Etika Kedokteran, Agama, Negara Asing serta Hukum Positif Indonesia," Prosiding Simposium Nasional Magister (SINMAG) 4, no. 1 (2020): 338–352.

withdrawal of life-sustaining treatments. There is general agreement that the law forbids killing, but it is less clear whether stopping medical treatment in cases deemed futile should also face penalties.[15] In much of the world, courts and legislators have made a distinction between an active intervention to take and end life and a passive one, where there is a clear indication that further attempts to treat an incurable condition are simply futile or would not reverse the situation. This is illustrated by cases such as Airedale NHS Trust v. Bland (1993)[16] in the UK and Cruzan v. Director, Missouri Dept. Of Health (1990)[17] allowed the withdrawal of mechanical ventilation on the grounds of futility without branding it as a homicide.[18] Such cases demonstrate a global tendency to protect doctors and families from charges of wrongdoing as long as the intent is to alleviate suffering and not be the cause of death. Even though Indonesia is a different culture in terms of religion, perhaps the purpose of avoiding senseless grief can be the same.

A key issue with the passive euthanasia debate is the absence of a formal system to document and uphold a patient's wishes before they lose the ability to express them. In cases such as Hasan Kesuma's and Humaida's, the families made these decisions regarding withholding or withdrawing treatment entirely on their own, influenced by contextual factors including emotional trauma, financial burden, and societal judgment.[19] Without clear, pre-emptive guidance, families often face disputes, hesitation, or guilt as they try to figure out what their loved ones would have wanted. In addition, they continue with treatment that offers no medical value because they fear finding themselves facing

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15 Winda Fitri, Winsherly Tan, and Aulia Ginda Putri, "Comparison of Indonesian and Dutch Laws on the Implementation of Euthanasia," Al-Adalah: Jurnal Hukum Dan Politik Islam 9, no. 1 (2024): 80–93, doi:10.30863/ajmpi.v9i1.5894.

16 Airedale NHS Trust v. Bland, [1993] AC 789 (HL).

17 Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990).

18 Silke Schicktanz, Aviad Raz, and Carmel Shalev, "The Cultural Context of Patient's Autonomy and Doctor's Duty: Passive Euthanasia and Advance Directives in Germany and Israel," Medicine, Health Care and Philosophy 13, no. 4 (2010): 363–69, doi:10.1007/s11019-010-9262-3.

19 Tomy Pasca Rifai, "PASSIVE EUTHANASIA ON INDONESIA LAW AND HUMAN RIGHTS," Law of Medical Practices 1 (2017), https://ojs.ummetro.ac.id/index.php/law/article/view/681.

litigation.[20] The absence of patient-centered decision-making showcases the desperate need for legal tools that empower persons to take control of their medical care before illness. This would relieve the burden on families and ensure that medical care is consistent with an individual patient's values and wishes. This identifies the space in which advanced directives should be vital to the ethical end-of-life care conversation.[21]

In this context, Advance Directives (ADs) are gaining attention as they delineate a patient's choices concerning future medical treatment if a person reaches a stage where he or she cannot make their own decision. While laws such as Law No. 29 of 2004 on Medical Practice[22] and Law No. 36 of 2009 on Health,[23] which protect patient rights, may exist in Indonesia, no provisions explicitly recognize ADs or ensure their implementation.[24] When family connections are strong and faith colors views on life and death, unambiguous orders can relieve the pressure on grieving family members and doctors who would otherwise be left to speculate what a patient would have wanted. When the patient's directives are written down and legally validated, healthcare teams can proceed with confidence that removing nonfunctioning interventions is not criminal but a rightful evolution of compassionate care.[25] This

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[20] Sutarno, "Euthanasia from the Perspective of Indonesian Norms," Systematic Reviews in Pharmacy 11, no. 1 (2020): 192–202, doi:10.5530/srp.2020.1.26.

[21] Stuart Hornett, "Advance Directives: A Legal and Ethical Analysis," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, 1995), 297–314, https://doi.org/10.1017/CBO9780511663444.019.

[22] Republic of Indonesia, Law Number 29 of 2004 Concerning Medical Practice, State Gazette No. 116, Supplement to State Gazette No. 4431 (2004), https://peraturan.bpk.go.id/Details/40752.

[23] Republic of Indonesia, Law Number 36 of 2009 Concerning Health, State Gazette No. 144, Supplement to State Gazette No. 5063 (2009), https://peraturan.bpk.go.id/Details/38685.

[24] Tomy Pasca Rifai, "PASSIVE EUTHANASIA ON INDONESIA LAW AND HUMAN RIGHTS," Law of Medical Practices 1 (2017), https://ojs.ummetro.ac.id/index.php/law/article/view/681.

[25] Dian Andriani Ratna Dewi, Waty Suwarty Haryono, and Evita Isretno Israhadi, "Regulations for Implementing Passive Euthanasia in the Terminal Stage Patients (End of Life) Which Is in Accordance with Justice and Legal Certainty in Indonesia," Eduvest – Journal of Universal Studies 3, no. 1 (2023): 50–66, doi:10.36418/eduvest.v3i1.717.

assurance would pave the way for eradicating the insecurities and emotional distress arising from vagueness within the legal scenario.

Put differently, all of these cases and practical issues demonstrate that Indonesia needs to reform its legislation concerning passive euthanasia and incorporate ADs as part of the standard practice of end-of-life planning. Unless unambiguous guidelines exist, even the most well-intentioned judgments, including those to save someone from further pain, could be treated as an offense.[26] Such a statute would provide that for an individual in a dire and irreversibly hopeless condition, declining or discontinuing treatment that is both futile and possibly harmful is not homicide so that families and medical practitioners are protected from prosecution in appropriate circumstances.[27] At the same time, enshrining ADs in law would ensure that the patient's perspective remains at the center, upholding a dignified manner in which we should approach such ethical obligations. This kind of legislation would not usher in active euthanasia, nor would it ignore our cultural duty to honor life; it would hold space for religious and cultural values as we grapple with the nature of dying.[28] By doing this, Indonesia will present a clear way out for the people stuck in difficult end-of-life decisions, save the anguish caused by legal uncertainty, and re-emphasize commitment to humane patient care.

In Indonesia, the morality of euthanasia is a complex issue because it is closely related to religious and cultural values, especially when talking about passive euthanasia and advance directives (AD). In a society largely comprised of Muslims, where life is a gift from God, all issues surrounding end-of-life experience are complicated. Islamic law, stemming from Sharia, places great importance on the sanctity of life. Although direct action to end life, referred to as active euthanasia, is

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[26] Jane Margaretha Handayani, Edy Lisdiyono, Bambang Joyo Supeno, and Wahyu SatriaWana Putra Wijaya, "Formulation Policy of Euthanasia Criminal Action in the Indonesian Criminal Law System," Medico Legal Update 21, no. 2 (2021): 654–58, doi:10.37506/mlu.v21i2.2757.

[27] Sutarno, "Euthanasia from the Perspective of Indonesian Norms," Systematic Reviews in Pharmacy 11, no. 1 (2020): 192–202, doi:10.5530/srp.2020.1.26.

[28] Winda Fitri, Winsherly Tan, and Aulia Ginda Putri, "Comparison of Indonesian and Dutch Laws on the Implementation of Euthanasia," *Al-Adalah: Jurnal Hukum Dan Politik Islam* 9, no. 1 (2024): 80–93, doi:10.30863/ajmpi.v9i1.5894.

condemned as a sin against God, passive euthanasia, withdrawal, or withholding of life-sustaining treatment, is more complex.[29] Numerous Islamic scholars and Islamic leaders also recognize that discontinuing medical interventions is acceptable in Islam when there is no hope of recovery. This acknowledges the natural life cycle while alleviating needless misery, provided the decision aligns with ethical and religious limitations.[30]

In light of this background, the present study uses legal research to assess the statutory laws of Indonesia regarding end-of-life care, particularly the lack of clear regulations regarding passive euthanasia and ADs. The analysis examines the Indonesian Penal Code (specifically Articles 344, 338, and 340) and multiple health laws for the ambiguities that blur the lines between withholding futile treatments and criminal homicide. The current laws, grounded in Islamic teachings and cultural values, value the sanctity of life while lacking an emphasis on the humanitarian desire to relieve suffering. What happens is that the rigidity of legalism clashes with the ethical need for merciful treatment of the dying. This uncertainty inhibits patients, families, and healthcare providers from making decisions that respect their values and rights.[31] Confronting these challenges is not just an academic exercise but a moral imperative. In doing so, the present study attempts to identify the gaps in Indonesian law and bioethics by analyzing the current laws of the country and comparing them with the legal systems of other nations, such as India, that recognize both passive euthanasia and advance directives (ADs) and by studying how other nations with majority Muslim population integrate Islamic principles in dealing with medical ethics. This research aims to contextualize and develop culturally

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[29] Rahdiyul Ermanto and Uning Pratimaratri, "Euthanasia Pasif dalam Pandangan Moral, Etika Kedokteran, Agama, Negara Asing serta Hukum Positif Indonesia," *Prosiding Simposium Nasional Magister (SINMAG)* 4, no. 1 (2020): 338–352, https://ejurnal.bunghatta.ac.id/index.php/sinmag/article/view/16813.

[30] Klemens Tatag Bagus Prasetyo Utomo, "Analisis Yuridis dan Perspektif Hak Asasi Manusia Terhadap Perkembangan Euthanasia di Indonesia" (undergraduate thesis, Faculty of Law, Universitas Atma Jaya Yogyakarta, 2011).

[31] Indira Inggi Aswijati, "Euthanasia Formulation Policy in Indonesia's Criminal Legislation and Implications for Patient Life," *International Journal of Social Science and Human Research* 4, no. 5 (2021), Everant Journals, doi:10.47191/ijsshr/v4-i5-31.

appropriate and ethics-based reforms of Indonesia's legal system to create a more cohesive and coherent end-of-life care environment that respects Indonesia's societal and religious values and allows individuals to die with dignity.

The study also examines international legal norms and treaties governing end-of-life decisions, highlighting how other countries approach passive euthanasia in their laws. Human Rights declarations, such as the International Covenant on Civil and Political Rights (ICCPR) signed by Indonesia, highlight that human dignity and protection from arbitrary suffering must be observed when medical measures no longer provide significant benefits.[32] In contrast to the approach adopted in many countries, which clearly distinguishes between allowing a natural death and killing, Indonesian statute remained ominously silent on this vital issue. Embedding these deliberations within an international discourse allows for a better understanding of the need for a legal provision regarding passive euthanasia and ADs. This paper argues that a well-defined legislative framework can create space in which paramount considerations of culture and religion work towards rather than against the obligation to safeguard the well-being of all involved (patients, families, and those who provide them with treatment and care) when there is no prospect of life being sustained.

The significance of this study lies in its potential to transform end-of-life care in Indonesia. This calls for legal reforms that efficiently balance respect for patient's autonomy with providers' legal security. If structured based on the balance between human rights and Islamic ethics, Indonesia can create a framework that similar cultural and civilizational parameters can emulate. These reforms would promote the dignity and autonomy of patients and bring contemporary medical practice in line with long-held cultural and religious beliefs. This allows more humane and ethically consistent end-of-life care, as compassion and legality are not forced to operate in opposition to each other, respecting

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[32] Arif Havas Oegrosoeno, "Undang-Undang Republik Indonesia Nomor 12 Tahun 2005 Tentang Pengesahan International Covenant on Civil and Political Rlghts/ICCPR (Kovenan Internasional Tentang Hak-Hak Sipil Dan Polltik)," *Indonesian Journal of International Law* 4, no. 1 (2021), doi:10.17304/ijil.vol4.1.136.

human dignity. In addition, setting legal boundaries for passive euthanasia would relieve the moral and legal burdens on healthcare professionals, allowing them to perform care that is not only ethically sound but also legally sound. More culturally appropriate policies would also create a common understanding of end-of-life care at the societal level, leading to less conflict and creating space for patients and families to collaborate to make treatment decisions. By being based on international human rights principles, Indonesia can also elevate its international integrity as a country that upholds human dignity and rights by enforcing a compassionate and ethical medical practice system. Thus, this study, in the first place, promises the immediate practical solution to the current moral and ethical issues, and, in the second one, needs to be a stepping stone towards a just and more compassionate healthcare system with recognition of the value of both life and the compassionate relief of suffering involved in all stages of dying.

Method

The research uses a normative juridical approach, which emphasizes the study of the texts of the laws on euthanasia and Advance Directives (AD) in Indonesia and the theoretical study of these laws. Since the study focuses on the legal provisions in place, the normative juridical approach is the most appropriate one for this analysis, as it enables the study to expose the paradigmatic inconsistencies and lacunae in Indonesia's legal provisions. The analysis is based on Articles 344, 338, and 340 of the Penal Code, which characterizes euthanasia as voluntary, ordinary, and premeditated murder. Through these articles, this study presents that the lack of legal distinction between active and passive euthanasia creates freedom from dealing with the inherent ethical and medical complexities of end-of-life care.

This research has a comparative dimension inherent to it. It looks at how other jurisdictions have addressed similar questions, focusing especially on choices made by the legal system of India and ethical practices in Islamic-majority countries such as Saudi Arabia and Iran. India represents an illustrative example in this context, where passive euthanasia and ADs are legalized following the landmark judgments of Aruna Shanbaug and Common Cause v. Union of India in 2011 and

2018, respectively. The result was the creation of procedural safeguards that balance patients' right to make their treatment decisions and the ethical standards of the medical profession, including being reviewed by medical boards and being subject to court scrutiny before action was taken. On the other hand, nations with Muslim majorities show that the principles of religion can be incorporated into health law, along with a tolerant view of passive euthanasia. For example, fatwas in Saudi Arabia allow for futile medical treatment to be discontinued in terminally ill patients, balancing the duty to preserve life against the pressure to relieve suffering. By contrasting case studies from different nations, the comparative method locates flexible solutions within Indonesia's unique cultural and legal environment, providing culturally relevant and ethically informed recommendations.

The research is a synthesis of both primary and secondary sources. Examples of primary sources are Indonesian Penal Code Articles 344, 338, and 340, which are the sources cited to criminalize euthanasia. Hence, other laws or regulations will always be referenced or used to understand how patients' rights are framed in Indonesia, including Law No. 29/2004 on Medical Practice and Law No. 36/2009 on Health. While not formally described as such, these laws provide a legal basis for implicit practices of passive euthanasia by allowing the patient to refuse to be treated or to discontinue treatment. The discussion is further illuminated through relevant international conventions, including well-known instruments such as the International Covenant on Civil and Political Rights (ICCPR), using semi-legal terms on patient autonomy and the right to life. Scholarly articles, case law from comparative jurisdictions, and Islamic jurisprudence are some examples of secondary sources. They shine a light on how euthanasia policies are informed by legal, cultural, and ethical frameworks in other countries, allowing a more informed view of the special situation facing Indonesia.

This study has a narrow scope as it focuses on passive euthanasia and advanced directives and excludes active euthanasia, which is strictly forbidden under Indonesian law. Therefore, the narrower scope also means a more intimate and germane examination of end-of-life care's legal, ethical, and cultural dynamics. Restricting the research to passive euthanasia and ADs helps sidestep the wider, more contentious debates

that accompany active euthanasia, which helps to come up with realistic recommendations that fit well with socio-religious values in Indonesia.

Research Design: To begin with, the first stage warrants taking a closer look at provisions available under the statutes in Indonesia, in particular articles relating to the law of crimes such as articles 344, 338, and 340 of the Penal Code and health law statutes (Law No. 29/2004 on Medical Practice and Law No. 36/2009 on Health). The initial exercise recognizes specific areas of concern and critical ambiguities, legislative gaps, and interpretative challenges vis-à-vis passive euthanasia and Advance Directives (ADs). The study engages in close textual analysis to critique the law's language and evaluate its intent, coherence with the broader Indonesian legal system, and compatibility with constitutional and international human rights standards.

The second stage of the study uses a structured comparative legal methodology to analyze models and systems from jurisdictions with useful socio-religious and legal similarities, namely India, Saudi Arabia, and Iran. Instead of focusing on the comparison between laws, this comparative approach emphasizes identifying practical solutions, proven procedural safeguards, and ethically informed cultural practices that are relevant to Indonesia. Analyzing landmark court decisions, legislative products, and religious advisory mechanisms from these comparative jurisdictions helps the study draw flexible and pragmatic insights into these comparative jurisdictions to be implemented in the Indonesian legal and cultural landscape.

The final analytical stage integrates the results of the Indonesian doctrinal analysis with the comparative international perspectives to produce practical, culturally embedded, and legally sound recommendations. The study draws on legal positivism to assess the practical enforceability and effectiveness of legal provisions, but it also incorporates wider normative considerations from international human rights law. As such, by covering the ground clearly and systematically, the research design improves readability and marries practical relevance to its conclusions for policymakers and legal academics alike.

However, the study also has its **limitations**. One of the difficulties is the lack of empirical public opinion data regarding euthanasia and Advance Directives in Indonesia. Again, this research draws on doctrinal analysis, but societal and religious attitudes are just

one-factor influencing public policy. This limitation is indicative of the challenges in obtaining representative data across a culturally sensitive specter in which euthanasia continues to be a contentious topic. However, another limitation of this approach is that legal and normative analysis cannot provide insights into the lived experiences of patients and families or physicians who occupy some daily practice realities. Despite these limitations, integrating comparative insights with legislative analysis helps mitigate this weakness and provides the study with a more culturally aware and balanced view.

This approach allows the researcher to critically analyze Indonesia's laws while taking lessons from other countries. Even if the road ahead must begin with pragmatism, by combining legislative analysis and cultural sensibility, the study then outlines a possible path for reforming euthanasia laws in Indonesia that is capable of responding to ethical and medical urgency while maintaining respect for its religious values.

Result and Discussion

A. Indonesia's Legal Ban on Euthanasia and Its Impact on End-of-Life Practices

Several countries have passed legislative reforms to permit active and/or passive euthanasia. Still, such practices are expressly forbidden by the Indonesian Penal Code, which in Article 344 identifies active euthanasia as murder and prescribes penalties of up to twelve years in prison. This legal provision illustrates Indonesia's firm stand against (even with patient consent) the termination of life by way of euthanasia, which is tantamount to criminal homicide.[33] Moreover, Articles 338 and 340 treat euthanasia as plain and intentional murder and do not exempt acts of mercy or medical urgency. The Indonesian legal system does not differentiate between euthanasia (in particular passive euthanasia) with intent to kill and criminal acts of murder, offering no

[33] Tengku Novita Artika, "Analisis Yuridis Mengenai Pengaturan Tindak Pidana Euthanasia (Suntik Mati) Menurut 344 KUHP Di Indonesia," *Jurnal Smart Hukum (JSH)* 2, no. 1 (2023): 9–20, https://ejournal.ipinternasional.com/index.php/jsh/article/view/621.

alternative for medical practitioners to justify their actions in end-of-life care to make difficult decisions ethically.[34] This inflexibility in law demonstrates a lack of suitable recognition of terminal illness's moral, medical, and human truths.[35]

In Indonesia, passive euthanasia takes place implicitly without formal recognition through legal guidelines. For example, doctors may palliate pain for terminally ill patients but cease all other therapies, making such interventions futile. Second, patients or their families may refuse to continue treatment, commonly discharging the patient to die at home. Such acts, whilst not acknowledged as passive euthanasia, are consistent with its definition as the withdrawal or withholding of life-sustaining treatment.[36] There are multiple legal bases upon which patients can refuse treatment. Article 52(d) of Law No. 29 of 2004 on Medical Practice grants the conditional right to patients to refuse any medical procedures to be carried out on them, provided they have received sufficient information to make an informed decision. Likewise, article 56 of Law No. 36 of 2009 on Health states that a person is entitled to accept or refuse medical action after receiving adequate information, except in cases involving infectious diseases, coma, or severe mental disorders where medical action may be mandatory.[37] The patient's independence as a sovereign human being is alluded to in Article 32(k) of

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[34] Lilik P. Yudaningsih, "TINJAUAN YURIDIS EUTHANASIA DILIHAT DARI ASPEK HUKUM PIDANA Oleh," *Jurnal Ilmu Hukum* 6, no. 1 (2015): 110–26.

[35] Dian Andriani Ratna Dewi, Waty Suwarty Haryono, and Evita Isretno Israhadi, "Regulations for Implementing Passive Euthanasia in the Terminal Stage Patients (End of Life) Which Is in Accordance with Justice and Legal Certainty in Indonesia," *Eduvest – Journal of Universal Studies* 3, no. 1 (2023): 50–66, doi:10.36418/eduvest.v3i1.717.

[36] Ayuning Tyas Azis Putri and Moh. Zeinudin, "Regulasi Penerapan Euthanasia di Indonesia dalam Perspektif Hak Asasi Manusia," *Jurnal Hukum dan Sosial Politik* 2, no. 3 (2024): 195–209, https://doi.org/10.59581/jhsp-widyakarya.v2i3.3462.

[37] Putri Shafarina Thahir and Tongat, "Legal Review of Medical Crime: Patient Protection and Professional Responsibility in Medical Practice," *Audito Comparative Law Journal* 5, no. 2 (2024), https://doi.org/10.22219/aclj.v5i2.33832.

Law No. 44 of 2009 on Hospitals,[38] which guarantees a patient to refuse actions proposed by the hospital.[39]

But these laws come with responsibilities as well, which include the rule that Patients are expected to collaborate with healthcare specialists and also adhere to informed medical advice by Article 53 of Law No. 29 of 2004; public participation is encouraged and recognized as an essential component of promoting public health by Article 9 of Law No. 36 of 2009. Regardless, hospitals are permitted to refuse a patient's request that is contrary to or in violation of standards of practice or regulation under Article 29(1) (k) of Law No. 44 of 2009. It creates ambiguity for healthcare providers as they must continue patient autonomy while having moral and ethical obligations.[40] The lack of formal recognition for passive euthanasia under current laws results in an unregulated practice and the absence of local legal protections, signaling a legislative need to safeguard both patients and providers.[41] According to Dewi et al., withdrawal of life-sustaining treatment in Indonesia shows that 42% of physicians have withdrawn the life-sustaining treatment according to family or patient request; the practice is often justified legally to informed consent. This practice, however, exists in a legal grey area since passive euthanasia is not explicitly stated as a legal concept, nor is it protected under Indonesian law. This ambiguity puts healthcare providers at criminal risk and causes great ethical and professional doubt.[42] Some physicians report that withdrawal of care decisions are

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38 Republic of Indonesia, *Law Number 44 of 2009 Concerning Hospitals*, State Gazette No. 153, Supplement to State Gazette No. 5072 (2009), https://peraturan.bpk.go.id/Home/Details/38789.

39 Novi Hermawati and Faisal Santiago, "Law Enforcement Against Cybercrime in Online Activities," *Edunity: Kajian Ilmu Sosial Dan Pendidikan* 2, no. 1 (2023): 28–37, doi:10.57096/edunity.v1i05.33.

40 Jane Margaretha Handayani, Edy Lisdiyono, Bambang Joyo Supeno, and Wahyu SatriaWana Putra Wijaya, "Formulation Policy of Euthanasia Criminal Action in the Indonesian Criminal Law System," Medico Legal Update 21, no. 2 (2021): 654–58, doi:10.37506/mlu.v21i2.2757.

41 Sutarno, "Euthanasia from the Perspective of Indonesian Norms," *Systematic Reviews in Pharmacy* 11, no. 1 (2020): 192–202, doi:10.5530/srp.2020.1.26.

42 Tengku Novita Artika, "Analisis Yuridis Mengenai Pengaturan Tindak Pidana Euthanasia (Suntik Mati) Menurut 344 KUHP di Indonesia," *Jurnal Smart*

made "under the radar" or "quietly" to avoid any perception of breaching Article 344, pointing towards the continued conflict between the provision of ethical care and adherence to the law.[43] It also provides the results of data from the Gatot Soebroto Army Hospital ICU, revealing a mortality rate of around 21% in 2020 and 16% in 2021. In these instances, the patients are moved to palliative care, where life-saving measures are withdrawn. Using the removal of life support to guide decision-making, the median time from the removal of life support to death is typically 1-3 days. This is analogous to the act of passive euthanasia for patients who are in the terminal stage in the territory of the Republic of Indonesia.[44]

In Indonesia, the culture and religion that pushes back against euthanasia are at the heart of Islamic values, which emphasize the sacredness of life. Life in Islam is a sacred trust from Allah, and directly causing death through active euthanasia is considered a violation of God's will. In particular, active euthanasia is condemned by Islamic law. Nonetheless, withdrawal of futile treatment has been tentatively accepted under certain conditions and aligns with the concept of passive euthanasia, even if not formally recognized in Indonesian law.Islam teaches mercy and harm reduction, and therefore, it is permissible to stop medical interventions when these no longer have an advantage for the patient or when they prolong suffering for the patient without any meaningful benefit.[45] The Dewi et al. study demonstrates how religious

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Hukum (JSH) 2, no. 1 (2023): 9–20, https://ejournal.ipinternasional.com/index.php/jsh/article/view/621.

43 Dian Andriani Ratna Dewi, Waty Suwarty Haryono, and Evita Isretno Israhadi, "Regulations for Implementing Passive Euthanasia in the Terminal Stage Patients (End of Life) Which Is in Accordance with Justice and Legal Certainty in Indonesia," *Eduvest – Journal of Universal Studies* 3, no. 1 (2023): 50–66, doi:10.36418/eduvest.v3i1.717.

44 Mochammad Alwi Fachrezi and Tomy Michael, "Kesuaian Penerapan Euthanasia terhadap Pasien Kondisi Terminal atas Persetujuan Keluarga dalam Hukum Positif Indonesia," *IBLAM Law Review* 4, no. 1 (2024): 228–246, https://doi.org/10.52249/ilr.v4i1.246.

45 Mohammad Manzoor Malik, "Euthanasia: Islamic Perspective," in *The Islamic Worldview, Ethics and Civilization: Issues in Contemporary Interdisciplinary Discourse*, ed. Mohammad Manzoor Malik (Kuala Lumpur, Malaysia: IIUM Press, 2011), 229–250.

leaders have an important and profound role in making decisions for cases involving terminally ill patients, as 68% of families consulted one before withdrawing treatment.[46]

One significant case described by Dewi et al. involved a palliative care patient whose family sought permission to remove a ventilator after extensive consultations with religious clergy and clinicians. While this was consistent with Islamic principles of minimizing harm and the patient's right to refuse treatment, it left the providers in a legally vulnerable position. The doctors could potentially be accused under the Penal Code, and the lack of explicit legislation on passive euthanasia exacerbated the problem. The case highlights the uncomfortable position of medical practitioners as providers of care who must navigate the legal stipulations in Indonesia that criminalize the act of euthanasia but at the same time consider their ethical responsibilities to alleviate suffering.[47]

There are contradictions within Indonesia's legal and cultural stance on euthanasia. The Penal Code completely criminalizes euthanasia, which is indicative of a staunch pro-life approach. However, current health legislation permits behavior that is, in fact, passive euthanasia, such as withdrawal of ineffective treatments. These implicit practices are suggestive of an unspoken acceptance of the moral imperative to passive euthanize in some circumstances, but without any legally sanctioned coverage. This dichotomy creates a moral and legal gray area for patients, families, and medical practitioners, highlighting an urgent need for comprehensive reform incorporating ethical, cultural, and legal considerations. Inappropriate or unclear legislation, on the other hand, may widen this gap, as it may offer ethical and legal reassurance regarding end-of-life care across Indonesian settings.

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[46] Dian Andriani Ratna Dewi, Waty Suwarty Haryono, and Evita Isretno Israhadi, "Regulations for Implementing Passive Euthanasia in the Terminal Stage Patients (End of Life) Which Is in Accordance with Justice and Legal Certainty in Indonesia," *Eduvest – Journal of Universal Studies* 3, no. 1 (2023): 50–66, doi:10.36418/eduvest.v3i1.717.

[47] *Ibid.*

B. India's Legal Approach to Advance Directives and Passive Euthanasia

Even though the two countries differ on many grounds, India and Indonesia share similarities in social, cultural, and legal contexts that affect the issue of Advance Directives (AD), with India's established AD framework offering a highly relevant model for Indonesia. The countries are both prehistorically based on spiritual and religious traditions that dictate social behavior around life and the end of it. Indonesia, home to the largest Muslim population globally, and India, a convergence of Hindu, Islamic, and other religions, share a deeply ingrained cultural and religious belief in the sanctity of life, which shapes societal attitudes toward end-of-life decisions. However, both are committed to easing suffering and maintaining human dignity, ideals embedded in traditions across religious beliefs and cultures.[48] In both countries, the family plays a primary role in the healthcare choices of their loved ones, and the healthcare professional must navigate the intersection of professional obligations with issues of the heart and spirit that deeply impact the respective families.

Legally, the end-of-life situation is mired in ambiguity in both countries. While Indonesia has no express provisions on passive euthanasia or advance directives (ADs), India operated in a legal vacuum on such matters until landmark Supreme Court rulings in 2011 and 2018 established formal recognition of these practices. As such, it reinforces the reasons why Indonesia can take some very meaningful lessons from India should it consider legalizing passive euthanasia and the recognized existence of ADs. Advance Directives are vital for balancing patient autonomy, medical ethics, and cultural sensitivities, offering clarity in ethically complex medical situations.[49] Advance directives (ADs) enable individuals to express their desire for medical treatment in advance and to have their wishes honored when they cannot speak for themselves.

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[48] Pardeep Singh, Avtar Singh Gill, Vikram Lakhanpal, Pankaj Gupta, and Vinod Kumar, "Current Scenario of Euthanasia in India," *International Journal of Ethics, Trauma & Victimology* 6, no. 1 (2020): 27–30, doi:10.18099/ijetv.v6i01.5.

[49] Sunita Vs Bandewar, Leni Chaudhuri, Lubna Duggal, and Sanjay Nagral, "The Supreme Court of India on Euthanasia: Too Little, Too Late," *Indian Journal of Medical Ethics* (2018), doi:10.20529/IJME.2018.028.

They provide transparency and direction for families and healthcare professionals, eliminating the heartache of choosing what to do when making an end-of-life decision.[50] A critical study by Bandewar et al. (2018) emphasizes the relevance of the Advance Medical Directives (AMD) concept in India, which plays a transformative role in the Indian legal system in preserving the dignity of human beings in terminal stages or vegetative states.[51] The study emphasizes the placement of ADs in a manner that conforms to the right to life with dignity guaranteed in Article 21 of the Indian Constitution.

The absence of ADs in Indonesia creates significant legal and emotional burdens for families and healthcare providers, forcing them to manage end-of-life decisions without formal guidance or protection. For example, in terminal cases, families may find themselves torn between keeping the patient on life-sustaining treatment and dealing with the moral guilt of stopping treatment and potentially facing legal challenges. On the flip side, healthcare providers find themselves with little to no guidance, susceptible to allegations of malfeasance while performing in the patient's best interests.[52] The law could meet these challenges by creating a binding framework to respect the patient's expressed wish and putting certain safeguards in the procedure to prevent abuse by third parties. As Anand (2021) points out, ADs protect patient dignity and permit the morally right actions of healthcare providers, which help build trust between stakeholders.[53]

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[50] P. Shruthi and G. Sudaakar, "Knowledge and Attitude Towards Euthanasia and Advance Directives amongst Medical Students in a Private Medical College and Hospital at a Metropolitan City of India," *Indian Journal of Forensic Medicine & Toxicology* 15, no. 2 (2021): 457–61, doi:10.37506/ijfmt.v15i2.14351.

[51] Sunita Vs Bandewar, Leni Chaudhuri, Lubna Duggal, and Sanjay Nagral, "The Supreme Court of India on Euthanasia: Too Little, Too Late," *Indian Journal of Medical Ethics* (2018), doi:10.20529/IJME.2018.028.

[52] Ashutosh Kothari, K. C. Premarajan, and Sethuramachandran Adinarayanan, "Assisted Dying and Voluntary Euthanasia: Awareness and Perception among Health Care Professionals in a Tertiary Care Centre, South India," *International Journal of Community Medicine and Public Health* 7, no. 6 (2020): 2280, doi:10.18203/2394-6040.ijcmph20202486.

[53] Bhogaraju Anand, "Advance Directives for Euthanasia in India," *Telangana Journal of Psychiatry* 7, no. 1 (2021): 3–9, doi:10.4103/tjp.tjp_19_21.

A precise illustration of how ADs can be infused and effectively used while upholding individual rights aligned with global best practices establishing ethical and procedural guardrails is with India's legal framework. It all started in 2011 with the Aruna Shanbaug case,[54] which was, perhaps, the new beginning of passive euthanasia discussion in the legal and moral paradigm of India. She was Aruna Shanbaug, the nurse who lay in a persistent vegetative state for over 40 years after a brutal attack and who became the subject of the landmark Supreme Court ruling. In a historic judgment in 2018, the court permitted the withdrawal of life-sustaining treatment, including artificial nutrition & hydration, subject to strict conditions, marking the first time passive euthanasia was permitted in Indian Jurisprudence.[55] This ruling reaffirmed the moral duty to preserve dignity over just prolonging suffering, especially in clinical futility.[56]

Following this, the Common Cause judgment of 2018[57] Integrated Advance Directives into India's legal framework, introducing procedural safeguards such as verification by attending physicians, medical board review, and, in certain cases, judicial oversight. For the first time, the right to refuse treatment in terminal or irreversible conditions was granted, effectively establishing in the Indian legal system the concept of patient autonomy as an integral component of fundamental rights recognized under Article 21 of the Indian Constitution. The court introduced two procedural safeguards to establish a protective mechanism: First, attending physicians must determine the authenticity of ADs, and second, confirmation must be sought from a medical board set up by the

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54 Aruna Ramchandra Shanbaug v. Union of India. 2011. *Supreme Court Cases* 4: 454.

55 Iain Brassington, "How Not to Talk about Passive Euthanasia: A Lesson from India," *Indian Journal of Medical Ethics* 6, no. 1 (2021): 55–61, doi:10.20529/IJME.2020.75.

56 Pardeep Singh, Avtar Singh Gill, Vikram Lakhanpal, Pankaj Gupta, and Vinod Kumar, "Current Scenario of Euthanasia in India," *International Journal of Ethics, Trauma & Victimology* 6, no. 1 (2020): 27–30, doi:10.18099/ijetv.v6i01.5.

57 Common Cause (A Regd. Society) v. Union of India. 2018. *Supreme Court Cases* 5: 1.

district collector. A judicial review in vagueness or disagreement added another check to the system.[58]

India's recognition of ADs shows how a judicially driven process can effectively deal with complicated ethical and cultural questions to establish a resilient legal foundation. The lessons for Indonesia are clear. To start, the formal recognition of living wills or Advance Directives would leave patients more in charge of their lives and lessen the emotional and stakeholder burden placed on families. ADs would help make hard choices simpler and clearer by allowing patients to record their wishes in advance, reducing the burden on families, and ensuring decisions are grounded in medical truth and personal belief.

The second and perhaps most important thing is that the procedural safeguards by India can serve as guidance to assuage the common fears of coercion or exploitation that satellite states often have. A similar approach could be taken in Indonesia, with medical board review and, where appropriate, judicial oversight, such that advance directives can be operationalized publicly and ethically. Such a layered system would safeguard against misuse and instill confidence in families, healthcare providers, and religious leaders.

Finally, this experience in India highlights the potential role of the judiciary in filling the gaps when legislatures do not or cannot act on important ethical issues. As a substitute for parliamentary politics, the Indonesian judicial system should proactively usher in temporary mandates for ADs and passive euthanasia to move closer to permanent legislation reform. These judicial interventions would relieve some immediate legal murkiness and lead to a larger public debate about end-of-life care.

By looking at India as a reference for active, passive euthanasia and Advance Directives, Indonesia can take a step forward in the form of a more humane legal structure that adheres to the values of the Indonesian people's personality life. With adequate procedural safeguards and ethics oversight, implementing ADs would preserve individual autonomy and resolve moral and legal dilemmas for families and healthcare providers.

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[58] Sunita Vs Bandewar, Leni Chaudhuri, Lubna Duggal, and Sanjay Nagral, "The Supreme Court of India on Euthanasia: Too Little, Too Late," *Indian Journal of Medical Ethics* (2018), doi:10.20529/IJME.2018.028.

C. The Influence of Islamic Jurisprudence on End-of-Life Decisions

Indeed, the sacredness of life has no equivocation in Islamic jurisprudence, as has been proclaimed in the Quran: "And do not kill the soul which Allah has forbidden, except by right." (Surah Al-Isra, 17:33). This verse emphasizes life being a divine deposit which cannot be taken without a valid reason. The Quran also allows for contextual interpretations emphasizing mercy and minimizing harm, rooted in principles such as *maslahah* (public interest) and *darar* (harm reduction). As Allah (SWT) says in Surah Al-Baqarah (2:286) states, "Allah does not burden a soul beyond that it can bear." This principle of *darar* (harm reduction) thus provides an ethical basis for withholding futile treatment in cases where medical intervention only prolongs suffering without benefit.[59] For example, Muslim scholars such as Yusuf al-Qaradawi have interpreted such verses to maintain that when the patient is perceived to be permanently comatose, and no one thinks he/she will recover, it is permissible to withdraw life-sustaining treatment as alleviating harm conforms to Islamic values.[60]

The sanctity of life in Saudi Arabia is based on the foundations of the Quran and the Sunnah, which play a fundamental role in shaping the legal and ethical systems of the state. While Saudi Arabia lacks specific legislation concerning Advance Directives (ADs), Islamic jurisprudence provides a well-structured framework for addressing ethical dilemmas such as passive euthanasia. This process revolves around fatwas, which are formally issued by religious authorities. One example is Fatwa No. 26/3796,[61] which permits physicians to issue Do Not Resuscitate (DNR) orders when Medical treatment has no benefit, the condition is

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[59] Kiarash Aramesh and Heydar Shadi, "Euthanasia: An Islamic Ethical Perspective," *Iranian Journal of Allergy, Asthma and Immunology* 6 (2007), https://www.researchgate.net/publication/228684359.

[60] Hamid Reza Nikookar and Seyed Hassan Jaafarian Sooteh, "Euthanasia: An Islamic Ethical Perspective," *European Scientific Journal*, Special Edition (2014): 179–185, https://doi.org/10.19044/esj.2014.v10n10p%25p.

[61] General Presidency of Scholarly Research and Ifta, "Fatwa No. 26/3796 on the Permissibility of Withdrawing Life Support in Cases of Brain Death" (Riyadh, Saudi Arabia: General Presidency of Scholarly Research and Ifta, 1996).

irreversible, and the patient suffers without need. This ruling embodies the Islamic principle of *la darar wa la dirar*: "Do not harm nor reciprocate harm," a foundation for compassionate medical decision-making. Islam does not require intensive medical measures when they do more harm than benefit. This is further proven by a Hadith from Prophet Muhammad (PBUH) that says, "The best of you are those who bring ease to others." Saudi Arabia exemplifies how religious and medical ethics can be reconciled.[62] Hospital ethics committees comprising Islamic scholars and medical professionals evaluate cases individually to ensure compliance with Islamic teachings. A study among patients with chronic illnesses at King Fahad National Guard Hospital in Riyadh found that while public awareness of advance directives is lacking, more than 60% of the patients expressed a desire to learn about the options available for end-of-life care and the right to refuse invasive treatment at terminal conditions.[63] These results suggest that many patients are prepared for end-of-life care characterized by dignity and comfort, demonstrating that passive euthanasia complies with the ethical and social requirements of Islam.

Another compelling case is Iran, which has evolved under the principles of Shia Islamic jurisprudence. Saudi Arabia being fully Sunni-dominated, Iranian Shia scholars seek to address modern challenges by resorting to ijtihad (independent reasoning). This flexibility enables religious leaders to read Islamic law in a way consistent with advances in medical ethics. While active euthanasia is strictly prohibited, passive euthanasia, on the other hand, is permitted when it is proven that life-sustaining treatments become futile and excessively burdensome. A fatwa by Ayatollah Khomeini permits the withdrawal of artificial aids like mechanical ventilators when they merely prolong suffering without providing therapeutic benefit. This reflects the principle of *raf' al-haraj*,

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[62] R. M. Yousuf and A. R. Mohammed Fauzi, "Euthanasia and Physician-Assisted Suicide: A Review from Islamic Point of View," *International Medical Journal Malaysia* (2012), doi:10.31436/imjm.v11i1.556.

[63] Salim Baharoon, Mohsen Alzahrani, Eiman Alsafi, Laila Layqah, Hamdan Al-Jahdali, and Anwar Ahmed, "Advance Directive Preferences of Patients with Chronic and Terminal Illness towards End of Life Decisions: A Sample from Saudi Arabia," *Eastern Mediterranean Health Journal* 25, no. 11 (2019): 791–97, doi:10.26719/emhj.19.038.

'the removal of hardship', which teaches that alleviating suffering is more important than preserving life without meaningful benefit.[64] In effect, religious ethics boards in Iran, with the collaboration of doctors and clerics, endorse passive euthanasia, shining the frame of Islam on the practice.[65]

Another cultural aspect of Iran that affects end-of-life care is the collectivist nature of its society. The family is at the heart of most decision-making making, often with input from the physician and religious advisors. This shared approach to responsibility gives patients dignity and, at the same time, respects family values as decisions are taken. Research has shown a wide consensus among Iranian healthcare professionals regarding the acceptance of passive euthanasia, especially when medical treatment prolongs suffering.[66] Also, it shows how the integration of religious traditions and medical practice illustrates that Islam helps to make decisions in ethical dilemmas instead of a hindrance to development.

These illustrative examples offer key lessons for Indonesia. As much of its policies are guided by local customs and cultures, although Indonesia is a secular state, religion still significantly influences its society and legal framework. One of the core principles of Indonesia, the Pancasila, is its philosophical foundation, which is to believe in one God, highlighting how big a religious footprint is in the DNA of the nation. Even in a secular legal framework, the country's version of Islam, which is the majority religion there, has an inherent role in decisions. This creates a unique opportunity for Indonesia to propose the legal recognition of passive euthanasia and advanced directives grounded in Islamic ethics.

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[64] Kiarash Aramesh and Heydar Shadi, "Euthanasia: An Islamic Ethical Perspective," *Iranian Journal of Allergy, Asthma and Immunology* 6 (2007), https://www.researchgate.net/publication/228684359.

[65] Farzaneh Zahedi, Bagher Larijani, and Javad Tavakoly Bazzaz, "End of Life Ethical Issues and Islamic Views," *Iran J Allergy Asthma Immunol* 6 (February 2007): 5–15.

[66] Hamid Reza Nikookar and Seyed Hassan Jaafarian Sooteh, "Euthanasia: An Islamic Ethical Perspective," *European Scientific Journal*, Special Edition (2014): 179–185, https://doi.org/10.19044/esj.2014.v10n10p%25p.

Indonesia's secular status makes the case for these reforms even stronger. Reframing passive euthanasia and advance directives through the lens of patient autonomy and dignity means that Indonesia can legitimize these issues in light of universal human rights principles and its constitutional commitment to its citizen's welfare. Indonesian Constitution Article 28[67] guarantees the right to live and to prosper, which may also be interpreted as the right to die with dignity when life-sustaining treatment becomes futile. Moreover, such legal recognition of these practices will align with Islamic teachings. It would show what a secular, but also profoundly spiritual, nation can do to reconcile the two worlds of faith and modern medical ethics.

Legal recognition of passive euthanasia and advance directives in Indonesia would position the country as a leader among Muslim-majority nations. Indonesia could serve as an example and prove that Islam and modern medicine co-exist without compromising religious principles. That would offer a case for other countries in the Muslim world to follow, confronting similar moral challenges. Given that Indonesia often serves as an example of religious moderate and progressive practices, the legal embrace of such practices, in turn, could spur a wider movement throughout the Muslim world toward openness on such end-of-life issues. Indonesia has the religious, cultural, and legal basis for this courageous step. The Quran says Allah does not burden a soul beyond what it can bear (Surah Al-Baqarah 2:286). This suggests a compassionate, merciful alleviation of suffering, which is fully in harmony with passive euthanasia and advanced directives. Adopting such approaches would not mean Indonesia would denounce its Islamic heritage; it would mean embracing it. The pinnacle of Islam is indeed mercy, dignity, and respect for human beings. The legal recognition of passive euthanasia and advanced directives is consistent with this value, reflective of a clear positioning of laws in Indonesia to uphold both the physical and spiritual well-being of its people.

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[67] Republic of Indonesia, *Undang-Undang Dasar Republik Indonesia Tahun 1945* [Constitution of the Republic of Indonesia 1945] (Jakarta: Constitutional Court of the Republic of Indonesia, 1945), https://www.mkri.id/public/content/infoumum/regulation/pdf/uud45%20eng.pdf.

By accepting passive euthanasia and advance directives, Indonesia would not only solve an age-long ethical dilemma but also become one of the pioneer realistic ideas of a country ahead of its time. It would demonstrate that a Muslim-majority nation can embrace reform while proving that Islamic values are compatible with humane and moral decision-making, even in the most challenging aspects of life. It is not merely an opportunity for reform but for Indonesia to demonstrate how faith, law, and compassion can work together to forge a more just and humane society.

D. Legal, Ethical, and Policy Recommendations for End-of-Life Care in Indonesia

The legal and ethical framework of end-of-life care in Indonesia reveals a significant disconnect between modern medical practices and the rigidity of existing laws. Although the Indonesian Penal Code explicitly prohibits euthanasia, it doesn't address the dynamics of passive euthanasia, where withholding futile medical assistance is not an act of killing but an acknowledgment of the inevitability of death. This failure represents outdated legal reasoning, where morally and ethically distinct conduct is collapsed under the singular category of murder.Compounding this conflation is the absence of legislation regarding Advance Directives (ADs), which are globally recognized as essential safeguards for patient autonomy regarding end-of-life care. This absence is not just a regulatory loophole; it is an absence that creates situations in which families are left to guess at a loved one's preferences, and physicians are left to fend off both moral and legal rebuke for decisions made in good faith. Indonesia needs clarity and a vision reflected in laws that respect patients' will, offer legal certainty to medical practitioners, and govern the grey area between cultural tradition and medical ethics. The legal separation of passive euthanasia from active homicide is more than just a technical adjustment, it is a moral imperative, and the passing of an Advance Directives Act would establish a legal precedent for individuals to regulate their end of life decisions within Indonesia's unique cultural and religious context.

This study points out critical gaps in the law in Indonesia. It shows that the framework around end-of-life care needs recalibrating in its

interplay between ethical precepts and the socio-cultural realities of medical practice. The non-existence of regulation concerning Advance Directives and the lack of distinction between passive euthanasia and criminal homicide are obvious inadequacies. Still, they also signal a more fundamental issue: a systematic approach to regulating the evolving medical practice in Indonesian legal and ethical norms. Lost here is the public's trust in the healthcare system itself, and hundreds, if not thousands, of families and medical providers, are left carrying the psychological and moral burden of making impossible decisions without clear guidelines about the legality of what they are doing.

However, the challenge is not only to fill in the gaps in the law but also to rethink legal doctrines to better capture the complexities of end-of-life care. The existing framework does not touch on these decisions' relational and contextual aspects and how the interaction between families, doctors, and patients influences its moral and practical considerations. The dynamics are further complicated by Indonesia's diverse cultural and religious makeup, requiring a legal system adaptable and representative of the multi-religious constituencies. Without such a foundation, the law threatens to become disconnected from those it addresses, producing outcomes that are not only legally ambiguous but also normatively and culturally misguided.

These challenges are compounded by a lack of guidance on operating, providing little to no procedural assistance to healthcare providers facing the difficult balance between ethical practice and legal compliance. Some of this ambiguity will be addressed by introducing new laws, but whether such laws are effective will depend on the processes implemented to put the laws into practice. The law cannot exist in a vacuum. Still, it must be anchored by the strong institutional and procedural frameworks and accountability mechanisms that ensure consistency in its application across the diverse health systems within the land. If no initiative is taken, Indonesia might fall into a statist, reactive pattern of contemporary policy-making, running ever to keep pace with the state of medical practice and never able to set it. Going beyond a focus on short-term gaps, Indonesia can clarify the situation and avoid repeating past mistakes in developing a framework for end-of-life care that is structurally and procedurally compassionate, inclusive, and a true reflection of the principles of its society.

Amending Articles 344, 338, and 340 of the Penal Code to separate passive euthanasia from murder is an essential first step. Under the existing law, all types of euthanasia are classified as murder, merging medical decisions grounded in compassion with homicide. An amended Article 344 should define passive euthanasia as the withdrawal or withholding of life-sustaining treatments in those types of cases where recovery is deemed medically impossible. The amendment may also set out requirements for passive euthanasia to be legal, including a terminal diagnosis given by a licensed medical board, written consent from the patient (and their family, if they are incapacitated), and proof that further treatment would merely prolong suffering. Passive euthanasia would be permitted, aligning with Indonesia's cultural and religious principles, while active euthanasia would remain illegal as it involves deliberate actions to terminate life.

There also needs to be clear legislation in place to recognize Advance Directives. They would create a legal mechanism, for instance, the Indonesian Advance Directives Act, to provide a way for individuals to document their wishes for end-of-life care. This bill should include the following:

a. Validity Requirements: ADs must be signed before a notary public and/or in the presence of a medical practitioner; therefore, they are legally binding and do not allow room for ambiguity (informed consent).
b. Scope and Applicability: The Act must clarify the types of medical decisions under its purview, including withdrawal of life support, resuscitation preference, and palliative treatment.
c. Periodic Review: Advance Directives shall be reviewed every five years to confirm their relevance and accuracy.
d. Right of Revocation: Patients should be able to withdraw or modify their directives at any time and in any way they choose.
e. Cultural and Religious Considerations: The Act could include a provision allowing individuals to consult with religious advisors to ensure their directions are based on their faith.

In addition to the legal reforms, Indonesia should develop moral standards, stating how to make transparent and accountable decisions about euthanasia and Advance Directives. There needs to be a government-mandated ethics board at every major hospital that includes

people from the medical, legal, and religious fields. Such boards would assess complicated cases regarding whether the requirements for passive euthanasia or the use associated with ADs may be met. An ethics board could evaluate the medical prognosis and whether the family's request for the removal of life support is consistent with Islamic principles of mercy (*rahmah*) and harm reduction (*darar*). This cross-disciplinary approach would ensure that decisions involve ethics and cultural sensibility so that trust from the public will be maintained.

The protection of vulnerable groups against coercion or exploitation, of course, is another seriously important ethical safeguard. Patients from disadvantaged backgrounds are under moral pressure not to have treatment overload because of financial issues or relatives. With this in mind, Indonesia should look into establishing independent oversight mechanisms, such as mandating a third-party social worker or legal advisor to ensure that decisions are made voluntarily and with information. They should also require training programs for health care providers, equipping them to recognize and report coercive acts, protecting all patients' rights and dignity.

To implement these reforms, it is important to have procedural clarity. Advance Directives should be based on standardized templates, allowing patients to document their clear choices, such as checkboxes in the templates for scenarios like whether to persist with artificial nutrition or to administer resuscitation in cases of terminal illness. The template should be clear and inclusive to help people make the best choice while reducing uncertainty for health providers. Lastly, there is a need to enact mandatory dual approval processes to lay the groundwork for preventing abuse. In this system, the attending doctor would first assess the patient's or family's treatment request to determine if it is medically appropriate. That decision would then go to the hospital ethics board, which would assess it ethically, legally, and religiously before offering its stamp of approval. An established judicial authority could provide oversight in a disagreement or lack of clarity, facilitating unbiased adjudication.

Public awareness campaigns should help citizens come to terms with such reforms. In Indonesia, one of the main reasons people have a misconception of euthanasia, often due to mistaken identity between passive euthanasia and active killing, is the lack of education on this

related issue. These misconceptions should be addressed through outreach programs that highlight the moral and religious rationale behind passive euthanasia and ADs. Workshops open to the public and informational campaigns could focus on Quranic values that promote harm reduction and compassion, like "Allah does not burden a soul beyond that it can bear" (Surah Al-Baqarah, 2:286). These campaigns should also involve community leaders and religious scholars in public efforts to endorse them to dispel societal backlash that they may experience. This also means producing brochures, videos, and resources online in local languages.

Healthcare practitioners must also be educated about the legal and ethical ramifications of the new framework and what they are advised to do. Mandatory training programs could cover important topics such as the correct application of ADs, the legal distinction between passive and active euthanasia, as well as strategies for dealing with religious and cultural sensitivities when it comes to end-of-life care. If Indonesia provides its medical practitioners with the required knowledge and tools, it could enforce its reforms on the whole healthcare system. These reforms would equip Indonesia with a well-structured system that respects individual autonomy, as well as cultural and religious beliefs within the country, making room for a euthanasia policy that is conducted with empathy, clarity, and responsibility in end-of-life matters.

Conclusion

Euthanasia, as a legal concept and ethical practice, holds a contentious place within Indonesia's socio-legal landscape. Unfortunately, the end-of-life care issues remain largely unaddressed with the existing legislation criminalizing euthanasia under articles 344, 338, and 340 of the Penal Code. Despite its prohibition of active euthanasia, its policy leaves a grey area surrounding passive euthanasia. Indonesian health laws, including Law No. 29/2004 on Medical Practice and Law No. 36/2009 on Health, implicitly allow patients or relatives to refuse or quietly withdraw futile treatments. Without a clear legal red line, there are consequential moral dilemmas for healthcare providers and families and potential legal risks, which means the

decision to withdraw treatment is undertaken behind a veil of legal secrecy. This study highlights the need for clear statutory amendments beforehand that articulate the distinction between passive euthanasia and criminal homicide and provide legal safety for health professionals and families participating in such decision-making as their ethical duty to discontinue futile medical efforts.

Comparative legal experiences, particularly from those of India and Muslim-majority countries such as Saudi Arabia and Iran, can offer Indonesia a clear roadmap for reform. India has a judicially-developed framework governing passive euthanasia and Advance Directives (ADs) (Aruna Shanbaug v. Union of India, 2011; Common Cause v. Union of India, 2018) and, like India, ADs in the form of a do not resuscitate order also serves as a mechanism to recognize passive euthanasia, as long as appropriate safeguards are in place. Likewise, Saudi Arabia and Iran provide meaningful examples of enacting religious principles into medical ethics through formalized religious oversight and ethical advisory faculties. Hence, Indonesia might consider a pragmatic approach including mandatory judicial control or independent medical boards as checks for validating Advance Directives and requests for passive euthanasia with specific safeguards against coercion, abuse, or misinterpretation. With significant oversight, this institutional framework would enable reliable procedural clarity, protect patient autonomy, and mitigate abuse or misuse concerns.

Emphasizing the validity of passive euthanasia and Advance Directive in Indonesian regulations can have a very powerful impact on patient care. To productively translate these insights into actual practice, Indonesia needs formal legislation on Advance Directives that details the legal criteria, such as notarization, periodic review, and a formal process for amendment or revocation. Standard Advance Directive forms specifying what end-of-life interventions would be permissible (e.g., withdrawal of artificial nutrition, hydration, and resuscitation attempts) would further solidify legal clarity and enforceability. Because such legal instruments would ensure that patients' wishes steer end-of-life choices, they would spare families emotional anguish and minimize the prospect of civil suits against healthcare providers.

Further, clear legal standards on passive euthanasia and Advance Directives could establish Indonesia as a forerunner in ethically grounded

governance of medical care among Islamic majority democracies. For practical implementation, in-depth public education, including the involvement of community and religious leaders, will be necessary to ensure social acceptance. Mandatory professional training would ensure that healthcare providers understand and comply with new legal standards, thus reducing ambiguity and further strengthening the ethical practice of medicine. These reforms would not only serve to bring Indonesia in line with the challenges it faces at home but also improve Indonesia's reputation internationally through the alignment of national practices against international norms of human rights.

There will be cultural, institutional, and societal obstacles to reforming end-of-life legislation, but they are surmountable. Based on this research, one suggested approach is creating a hospital-based ethics group comprising medical, law, and religious experts to assist in difficult decision-making and ensure such decisions comply with legal and ethical mandates. Independent oversight by specialized legal or social professionals can also protect at-risk patients from coercion, financial strain, or exploitation. This way, there would be a considerable reduction in the emotional and legal ambiguity surrounding passive euthanasia, ensuring clarity and security for both patients and medical practitioners.

Euthanasia in Indonesia, after all, is not only just a legal or medical matter but also a significant indicator of the nation's commitment to dignity, justice, and compassionate care. Transitioning forward requires grit, empathy, and unwavering commitment to justice. In summary, through the explicit acknowledgment of passive euthanasia and the formalization of Advance Directives under a delineated legal framework supported by practical procedural safeguards and awareness campaigns, Indonesia would have a more coherent, humane, and legally sound position on end-of-life care. This can enable the nation to resolve current vagueness effectively, reconcile its religious and ethical perspectives, and advance the Indonesian health system to view the condition of patient rights in a modern perspective, as well as patient autonomy and dignity on a global scale.

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Acknowledgment

The authors would like to thank Parul University and more particularly the faculty at the Parul Institute of Law for developing the academic milieu that has enabled this research to be completed. Furthermore, we thank our colleagues and peers who provided valuable feedback and support during the duration of this effort. We would equally like to thank the editorial board of the Journal of Law and Legal Reform for their helpful comments during submission.

Funding Information

No funding was received for this research. The study was conducted independently, with institutional support from Parul University.

Conflicting Interest Statement

The authors state that there is no conflict of interest in the publication of this article.

Publishing Ethical and Originality Statement

All authors declared that this work is original and has never been published in any form and in any media, nor is it under consideration for publication in any journal, and all sources cited in this work refer to the basic standards of scientific citation.