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Euthanasia for the Medically Ill: How Differences in National Laws Shape End-of-Life Decisions

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ABSTRACT

Euthanasia remains one of the most debated issues in modern healthcare, especially for medically ill adults facing severe, incurable, or end-stage conditions. While some countries offer legal pathways for euthanasia or physician-assisted dying, others prohibit it entirely. These legal differences strongly influence how patients, doctors, and families make end-of-life decisions.

This paper examines how national euthanasia laws shape real-world outcomes for medically ill adults by comparing case studies from the Netherlands, Canada, India, and the United States. Each of these regions approaches euthanasia differently, some allow it under strict safeguards, some allow only assisted dying, and others rely on court rulings or prohibit the practice completely.

Using a literature-based methodology, the study reviews published reports, legal documents, and real case histories to understand how laws affect eligibility, decision-making steps, physician responsibilities, and final outcomes. The findings suggest that when euthanasia is legal and supported by clear safeguards, patients have more predictable pathways and stronger oversight. In contrast, in countries where euthanasia is restricted or prohibited, medically ill adults often face uncertainty, limited options, or lengthy legal appeals.

The study concludes that differences in national laws significantly shape end-of-life outcomes. Effective euthanasia policies must balance patient autonomy with safeguards to protect vulnerable individuals while ensuring access to compassionate, regulated, end-of-life care.

Keywords: Euthanasia, Physician-Assisted Dying, End-of-Life Care, Patient Autonomy, Medical Ethics, National Legislation, Legal Safeguards, Terminal Illness

Introduction

There is a concept in Indian medical tradition (specifically Ayurveda) called Arishta Lakshana, which suggests that individuals can sense when death is near and that their soul is gradually fading into the afterlife (Bharadwaj, 2022). I experienced this personally with my grandmother during her final days battling brain cancer. She would faintly whisper into my Uncle's ear: "Beta [son], it is my time, take me home." During her last days, she did not seem afraid of death but rather relieved. Relieved that all the pain and suffering for her and the family would finally come to an end. Seeing her lose her strength and independence during those final few days raised an important question in my mind: should individuals suffering from incurable and severe disease have the right to voluntarily end their life to avoid experiencing pain and affliction?

Euthanasia is defined as the practice in which a health care professional intentionally ends a patient's life with the patient's consent when the strongest palliative care cannot subdue immense suffering on account of incurable diseases such as late-stage cancers, ALS, chronic organ failure, and neurodegenerative diseases (World Health Organization, 2020). Historically, the word euthanasia means "good death", in other words, death without pain, without suffering (SciELO Bioethics, 2015). In the twentieth century, during the Third Reich, the word gained a negative connotation when it was improperly used in Nazi policies aimed at eliminating lives that were considered not worthy to exist (SciELO Bioethics, 2015). In recent years, medical and ethical discussions have given the term a clear definition, and euthanasia, in its classic sense, is allowed in some countries under clearly defined and strict legal conditions (SciELO Bioethics, 2015).

Euthanasia can be classified into different categories based on how it is carried out and whose consent is taken to implement it. Active euthanasia is the act of deliberately ending a patient's life through clinical means such as lethal injection or fatal pills, while passive euthanasia involves withdrawing life-sustaining support, which leads to the patient dying naturally. Voluntary euthanasia is the act of the patient willingly requesting the intentional end of their life (National Health Service, n.d.). Family members or medical practitioners can also consent to euthanasia, but this only occurs when the patient is physically unable to provide consent. However, numerous ethical viewpoints view involuntary euthanasia as unacceptable, as it is done without the patient's consent. The ethical debate is nuanced, as decision-making in such situations is complex. Terminally ill patients are unable to voice their preference, while family members who feel sadness, fear, and anxiety are stressed out because a loved one is terminally ill, and therefore they have a hard time making appropriate decisions (Akdeniz, 2021).

In spite of these discussions, many countries worldwide have put in place legislation under criminal law, which prohibit or restrict euthanasia and physician-assisted suicide. Even in places where assisted dying is legal, access depends on clearly defined eligibility criteria, multiple medical assessments, and formal approval procedures, showing how legal clarity directly shapes whether patients can realistically obtain end-of-life options (Mroz, 2021).

The debates and discussions around euthanasia are largely centered around four considerations– medical practice, religious belief, legal jurisdiction, and physiological value. Debates on ethics often highlight the contradiction and dilemma between non-maleficence, the duty of doctors to do no harm, and beneficence, their responsibility to relieve suffering. One argument against euthanasia and assisted suicide is that it gives excessive powers to doctors and can compromise the quality of end-of-life care. This viewpoint emphasizes that euthanasia and assisted suicide should not be a substitute for palliative care" (Keis et al., 2025).

Other arguments focus on patient autonomy, saying that individuals alone have the right to decide how and when their life ends. Religious beliefs also play a significant role, as many religions hold the belief that a divine being decides our fate, and humans do not have the authority to end a life before its time. Politicians argue from the perspective of justice and the protection of vulnerable groups from coercion or misuse of euthanasia laws. At the same time, many studies highlight the physiological aspect of euthanasia. Terminally ill patients not only suffer pain, but also a loss of dignity, independence, and overall value of life. This often motivates patients to seriously consider assisted death (Mroz, 2021). Table 1 below illustrates the various stakeholders that can be affected by euthanasia laws.

Table 1. Stakeholders Affected by Euthanasia Laws

STAKEHOLDERS AFFECTED BY EUTHANASIA LAWS

Stakeholder	Short-Term Impact	Long-Term Impact
Medically Ill Patients	Clarity or uncertainty in options	Quality of death, autonomy
Families	Emotional burden	Grief resolution or distress
Physicians	Ethical responsibility	Professional liability
Legal System	Case petitions	Precedent setting
Society	Moral debate	Norms around death & care

Adapted from Emanuel et al., 2016 & Beauchamp & Childress, 2019

The overall purpose of the study is to compare how different countries interpret and apply euthanasia laws to terminally ill adult patients. We will be utilizing real case studies to track how laws influence outcomes and analyse the ethical principles guiding legal safeguards. The aim is to identify patterns in approvals, denials, and decision-making to answer the central question of this study "how differences in euthanasia laws across countries shape decision-making and final outcomes for medically ill adults seeking end-of-life options?

Literature Review

Traditional End-of-Life Care

Traditional end of life care usually involves reducing the suffering of patients with serious, terminal illnesses to make them comfortable and maintain dignity in their final days. It includes various measures like pain alleviation, managing debilitating symptoms and providing emotional support through hospice and palliative care services. End of life care as the term suggests does not aim to cure illnesses, but to ensure a comfortable and dignified passing. It is also to be noted that end of life palliative care does not always succeed in its objectives. Some patients, in spite of the best of effort, continue to experience extreme physical pain, loss of independence or emotional distress.

In cases involving extreme suffering, additional steps may be considered. One such measure is terminal sedation, where patients are drugged to put them to deep sleep to prevent them from experiencing severe pain or discomfort (Quill & Byock, 2000). In some other extreme cases life sustaining or life prolonging treatments like ventilator support or feeding tubes which are used to keep the patient alive, are withdrawn or withheld. Hospice guidelines consistently stress on the need for close monitoring and responsible ethical decision making in such extreme situations (Cherny & Radbruch, 2009). These measures are legally permitted in some countries provided they are in line with the patient's wishes or are in the patient's best interests from a medical viewpoint . Figure 2 shows how end-of-life care ranges from palliative care focused on comfort to active euthanasia, where life is intentionally ended through medical intervention.

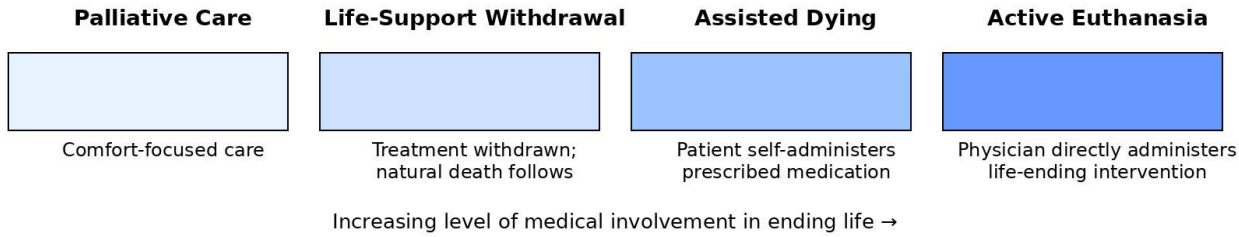

Figure 2. Spectrum of End-of-Life Medical Care

Ethical and Clinical Frameworks

Decisions involving assisted dying or euthanasia are influenced by a multitude of factors. These include ethical considerations, the medical condition of the patient, legal provisions of the country involved and various social and religious considerations. One major consideration is the ethical principle of Autonomy according to which patients have the right to make decisions about their own care. On the other hand are the two concepts of Beneficence and Non Maleficence. Beneficence guides a doctor to reduce suffering while non maleficence makes the doctor duty bound to avoid causing harm to the patient. As is evident, these principles can sometimes

contradict each other in real life situations leading to a moral dilemma. For example, ending a patient's life might be seen by some as relieving suffering while others might see it as willingly causing harm. Here the principle of justice also becomes relevant. This principle emphasizes that vulnerable sections like the elderly, economically and socially weak individuals or severely ill patients are protected and treated fairly by the healthcare system (Beauchamp & Childress, 2019).

Various ethical theories also provide perspective on this debate. The Utilitarian theory focuses on reducing the overall suffering while the deontological view strongly argues that intentionally ending a life is morally wrong irrespective of the outcome and the circumstances. Medical professionals also face many practical challenges. In patients exhibiting severe mental health issues or emotional distress, it might be difficult for the doctor to convincingly assess whether the patient is actually making a voluntary and informed decision. Another situation where decision-making becomes difficult is when the doctor does not have a clear understanding of how the disease will progress. Additionally, there might be disagreements between the patients, family members and healthcare professionals with regard to end-of-life care and decisions (Rietjens et al., 2009).

Global Legal Models

Legal approaches to euthanasia and assisted dying vary across countries around the world. The Netherlands passed the Termination of Life on Request and Assisted Suicide Act in 2002 and in the process, it became one of the first countries to formally legalize both processes- euthanasia and physician-assisted dying. The law comes with multiple safeguards and only allows these practices under strict conditions. These conditions include voluntary requests from suffering patients and formal, structured medical review procedures (Government of the Netherlands, 2002). Studies from the Netherlands suggest that legalization of Euthanasia and physician-assisted death actually led to greater transparency and better reporting of end-of-life practices (Onwuteaka-Philipsen et al., 2012).

In the same year (2002), Belgium too legalized Euthanasia. Under the system in Belgium, the procedure has to be conducted under strict legal oversight and the physician has to abide by clearly defined eligibility standards and report each case for review. Luxembourg too allowed Euthanasia in 2009 under strict regulated conditions. These European nations have become role models for their structured comprehensive laws on these procedures as well as the formal safeguards involved.

In the United States laws differ by state. While some states do not permit Euthanasia, they allow physician-assisted dying wherein the patient self-administers the prescribed lethal medication. This procedure was first legalized by Oregon in 1997. Washington was the next state to allow it in 2008 followed by California in 2015.

India has taken a different and nuanced approach. India's system is largely driven by court rulings and is not based on legislation, as is the case in the Netherlands (Supreme Court of India, 2011; Government of the Netherlands, 2002). India does not allow active euthanasia and only passive euthanasia, where life-sustaining treatment is withdrawn or withheld, is permitted under safeguards listed by the judiciary. In the often cited Aruna Shanbaug case in 2011, the Supreme Court of India allowed passive euthanasia under judicial supervision. In 2018, the Indian Supreme Court further recognized the right to die with dignity and also allowed living wills, giving clarity to passive euthanasia procedures (Supreme Court of India, 2018)..Even in countries where euthanasia or assisted dying is legally allowed, there are multiple safeguards in place to prevent abuse of the system. These safeguards often include repeated voluntary requests from or on behalf of the patient, assessments of mental capacity, second medical opinions, waiting periods, and detailed paperwork

Outcomes in Practice

To understand how these systems play out in the real world, one needs to carefully examine the experience of countries where euthanasia or assisted dying has been legitimized. Annual review reports and examination of policies from countries which have made these practices legal suggest that these systems operate through well-defined rules, reporting requirements, and close monitoring by healthcare professionals. Studying these systems can enable both patients and doctors to get a clearer understanding of the steps involved and also improve transparency in end-of-life decision making (Downie et al., 2021).

In many cases, requests for Euthanasia or assisted dying comes from the patients themselves. These patients are usually suffering from serious physical illnesses, like advanced stages of cancer or progressive neurological diseases like dementia that cause major physical decline and debilitating ongoing suffering (Downie et al., 2021). These patients are often at a stage where treatment options are limited to alleviating suffering with no hope at all of a full cure. At this point of the illness, patients may want some control over how they pass their last days in order to preserve dignity and reduce suffering. In response, legal systems may provide a formal process for registering these requests and then evaluating them.

At the same time, formulating these laws and enforcing them is a multi-stage complex process as multiple stakeholders have to be consulted and differing opinions have to be understood and accommodated. Doctors may differ on whether a patient’s condition is severe enough or whether the patient's mental capacity is sound enough to make a fully informed, voluntary decision. Psychiatric disorders or dementia add another layer of complexity as decision making ability and consent in these cases may be less clear or acceptable. (Dierickx et al., 2017). Interests of patients who are from weaker socio-economic backgrounds also need to be safeguarded (Beauchamp & Childress, 2019). As a result continuous ethical debate and careful review remain important even in countries where the practice is legal.

Research Gaps

Although recent years have seen significantly higher levels of research on euthanasia and assisted dying, several important gaps still remain. One major issue is that there is no standardized reporting model and every country follows its own process. Some nations publish detailed yearly data on the requests submitted, approvals, and the medical condition and backgrounds of patients, while others release only very limited information on an irregular basis. This makes comparisons difficult and unreliable. It is also difficult to ascertain commonalities and differences across countries. Another major gap is the lack of research focusing on long term repercussions. Most studies are focused on changes in the law, yearly numbers, or ethical debates, but less is known about the long-term impact of these practices on patients, family decision making, healthcare workers including emotional stress, ethical pressure and added responsibilities. Studies need to focus on how these policies may influence healthcare practices and end-of-life care over time (Rietjens et al., 2013).

We also need more studies on how cultural and religious beliefs view and impact the practise of Euthanasia. In some societies, strong religious values may pose a strong opposition while in others the concept of personal choice may support the practice. These beliefs can affect public opinion as well as the way research findings are interpreted. In many countries, especially in non-western developing countries, legal and ethical debates also involve family roles, social expectations, and access to healthcare, which may differ greatly from Western models (Banerjee et al., 2020).

Finally, only a small number of studies compare several countries using the same lens of evaluation. When all countries are evaluated using the same criteria, comparisons would be easier and more logical. It would help show how laws, culture, religious beliefs and medical practice shape euthanasia policies in different contexts and countries. We also need to focus more on how laws can be abused to the disadvantage of the patients.

Materials and Methods

This study uses a literature review along with a comparative case study methodology to compare how euthanasia laws affect the decisions and final outcomes of medically ill adults in different countries. No new interviews or medical data were collected. Instead, all information for the study was gathered from published studies, government reports, court rulings, and real case summaries available from reliable sources. Only literature published in English from the year 2000 onwards was consulted for this paper.

Four countries namely Netherlands, Canada, India, and the United States, were selected as case studies because they represent different legal viewpoints and approaches: legal euthanasia, assisted dying only, partial legalization through courts, and state-dependent frameworks. Case studies were chosen based on clear documentation of the patient's medical condition, the request process, legal requirements, safeguards used, and the final outcome.

Each case was analysed using the same criteria including medical background, request details, legal criteria, ethical concerns, and physician assessments. This comparison allows a clear, detailed understanding of how different laws shape what happens to medically ill adults seeking end-of-life options.

Results

Netherlands – ALS Patient (2016)

Background and Medical Condition

A 2016 patient with Amyotrophic Lateral Sclerosis (ALS), from the Netherlands, applied for euthanasia. ALS is a progressive and debilitating illness that causes muscle paralysis, which subsequently affects the patient's ability to eat, speak, move, and finally, breathe without assistance. The patient had reached an advanced state of incapable suffering without the possibility of recovery, including pain from the ALS itself (Regional Euthanasia Review Committee [RERC] 2017). Although the patient had already tried all possible therapeutic treatments for their condition, the progression of the disease continued. Despite receiving palliative care focused on comfort, the patient faced extremely high levels of mental and physical suffering and was confronted with the eventual loss of all independence and quality of life.

Request and Legal Process

The patient asserted a clear and voluntary wish to receive euthanasia under the law in the Netherlands, which legalized the practice in 2002. All requests must be reviewed according to specific conditions established in law. To obtain approval, the following steps were necessary:
Step 1: Recognizing Capacity to Make Decision – Physicians assess the patient's understanding of their condition, the voluntary nature of the decision, and the understanding that death will occur. Additional mental health assessments may be performed to ensure no issues, such as depression, are impacting the patient's ability to think clearly (RERC, 2017) .
Step 2: Evaluate Independently – An evaluation by a second unrelated physician provides confirmation that the patient is suffering in an unbearable way and that there is no reasonable alternative outcome.
Step 3: Consult and Document – A physician submits the details of the entire case to other involved healthcare providers, and all forms of documentation provide the basis for a full comprehension of the decision.
Step 4: Approved by Review Committee – The case is examined by the Regional Euthanasia Review Committee, consisting of physicians, attorneys, and ethicists, to ensure that all standards, protocols, and ethical boundaries were followed (RERC, 2017) .

Outcomes and Takeaways

Euthanasia procedures can provide some degree of control and certainty for patients in various jurisdictions around the world. The Netherlands provides procedures with significant built-in safeguards. In this case, there was complete clarity regarding the outcome and timing, with virtually no legal battles or a need for the patient to leave the country to obtain euthanasia. This case illustrates how a jurisdiction with clear laws and multiple safeguards can organize a transparent process. The patient received adequate medical care, psychological evaluations, and legal protection. The system does not compromise the rights of patients to make their own choices; rather, it provides oversight to ensure those rights are not abused.

Canada – Pancreatic Cancer (2019)

Background and Medical Condition

In 2019, a patient diagnosed with stage IV pancreatic cancer in Canada made a request for medical assistance in dying (MAID). Pancreatic cancer is an aggressive illness that spreads quickly and causes an incredible amount of pain (Health Canada, 2020) . By stage IV, the cancer had metastasized, leaving no possibility for a cure. The patient understood they were facing months of progressively increasing pain and loss of independence, with only weeks of life remaining. Although the patient underwent multiple rounds of chemotherapy and other treatments, none slowed the progression of the cancer. Pain medication was becoming less effective as the disease advanced, forcing the patient to face a reality of extreme suffering.

Request and Legal Process

In Canada, a law allowing medical assistance in dying became effective in 2016, permitting physicians to assist patients who meet specific criteria. The process for the patient's voluntary request involved several steps:

Step 1: Initial Evaluation – The first health care provider establishes if the patient qualifies under legal definitions, including having a serious and irreversible illness resulting in unbearable suffering and a progressive state of decline. The provider also proves the patient is mentally able to provide informed consent (Health Canada, 2020).

Step 2: Written Application – The patient must submit a written request for MAID, which serves as an official document confirming they have carefully considered the implications of the decision.

Step 3: Waiting and Second Consultation – A mandatory waiting period, usually 15 days, is required between the written request and the procedure to allow the patient time to reconsider. During this time, a second health care provider must evaluate the request for eligibility (Wiebe et al., 2021).

Step 4: Final Approval and Delivery of MAID – Once both providers confirm the patient meets all legal qualifications and the waiting period has ended, the patient receives MAID, and the case is reported for tracking and oversight.

Outcome and Takeaways

Since MAID was introduced in Canada in 2016, more than 150,000 Canadians have accessed the program. This case study demonstrates that the regulations governing MAID are consistent, reliable, and transparent across provinces. The legalization provided patients with certainty regarding their rights and the next steps in their end-of-life care. MAID is a viable option for many patients with limited time to live, creating a safe and effective way to die for those with terminal illnesses. While the need for MAID is seen by some as a societal failure, we must continue improving end-of-life care through regulations that ensure patients receive compassionate care and support for their wishes.

India – Persistent Vegetative State Case (2011)

Background and Medical Condition

Aruna Ramchandra Shanbaug lived in a Persistent Vegetative State (PVS) for many years with minimal medical treatment or social services throughout her adult life. Her lack of awareness and inability to communicate led her family, physicians, and caregivers to agree that she would never regain consciousness. They believed that the continuation of life support would only prolong her physical suffering and loss of dignity. This case marked a major turning point in Indian Statute Law.

Request and Legal Process

Euthanasia did not have a special legal provision in India, and there was no legislative framework to regulate the practice for patients or doctors. End-of-life decisions were based on prior court rulings or interpretations by the Supreme Court of India. The absence of a legal framework required the following judicial process:

Step 1: Petitioning the Supreme Court – Because Aruna could not speak for herself, a petition was filed with the Supreme Court requesting authorization to cease life support and permit a natural death. Medical evidence and evidence of her potential views were presented to support the position that this was in her best interest.

Step 2: Reviewing the Court and the Evidence – The Supreme Court reviewed medical evidence and provided guidance to the medical profession on the ethical considerations involved in granting the request (Chavan & Patra, 2012). The Court had to determine if the request was legally and ethically permissible.

Step 3: Court Ruling – In 2011, the Supreme Court of India decided that passive euthanasia would be allowed according to very strict rules and under the agreement of the court (Aruna Ramchandra Shanbaug Vs Union of India, 2011).

Step 4: Judicial Supervision – After permitting the removal of active medical treatment, the court continues to review the case on an ongoing basis to ensure the order is followed and the patient receives appropriate supportive care.

Outcomes and Takeaways

The ruling established that passive euthanasia is legal in India, though it remains limited in scope, while active euthanasia remains illegal. The Court acknowledged the right to die with dignity in indisputable circumstances through the Judiciary, and in 2018, this was extended to permit "living wills". India's experience demonstrates the challenges of relying on a court system rather than clearly written laws, as the process is longer, more complex, and more uncertain (Chavan & Patra, 2012) . Families are often required to participate in long legal proceedings rather than accessing a well-defined medical process. Nevertheless, through this process, the court successfully found the right to die with dignity.

USA – Brittany Maynard (2014)

Background and Medical Condition

Brittany Maynard was diagnosed with terminal brain cancer in 2014 at the age of 29. Despite invasive treatments, her prognosis was only months to live due to the growing tumor. Brittany did not want to die in pain; she sought to die in peace and with dignity (Maynard, 2014) . She knew the illness would cause her to lose mental function, experience seizures, and eventually die. Beyond having control over how and when she died, Brittany wanted to avoid the suffering resulting from the natural progression of her illness and preserve positive memories of herself for her family.

Request and Legal Process

The United States has no national laws governing euthanasia, and each state has its own rules regarding assisted suicide (Gardner, 2017) . In 2014, California did not allow for physician-assisted death, prompting her to move to Oregon. The request process under Oregon's Death with Dignity Act involved several requirements:

Step 1: Establish Residency – Under Oregon law, the patient must be a resident of the state. Brittany had to leave her home and community in her final months to establish this residency, which added a significant burden.
Step 2: Medical Diagnosis Confirmation – Two Oregon physicians must evaluate the patient to confirm a terminal illness likely to result in death within six months and determine if the patient possesses the mental capacity to make the decision.
Step 3: Written and Verbal Requests – The patient provides a written request for medication and must confirm that request verbally at least 15 days later to allow time for reconsideration (Gardner, 2017).
Step 4: Order for Psychological Evaluation – If physicians have doubts about the patient's mental status, a psychiatric consultation may be required to confirm the patient is capable and not acting out of depression.
Step 5: Self-administration – Unlike laws in the Netherlands, Oregon requires that the patient administer the medication themselves, even though it is prescribed by a physician.

Outcome and Takeaways

Brittany successfully moved to Oregon and obtained the medication needed to end her life. Her story raised national awareness about the lack of uniform end-of-life options in the U.S. (Maynard, 2014) . The case demonstrates that many people lack access to physician-assisted dying based solely on where they live; had she lived in a state like Texas, she would have had no legal option. Brittany's case illustrates the inequity where patients with identical medical conditions have vastly different end-of-life options depending on their geographic location (Gardner, 2017).

Table 2 presents a comparative overview of four landmark cases representing distinct legal and jurisdictional approaches to euthanasia and medical assistance in dying.

Table 2. Comparative overview of euthanasia and assisted dying cases across four jurisdictions.

Country	Year	Condition	Legal Framework	Steps	Key Constraint / Outcome
Netherlands	2016	ALS (advanced stage)	Active euthanasia Legalized 2002	4	Multi-safeguard statutory process; Regional Euthanasia Review Committee oversight; no need to relocate or pursue litigation
Canada	2019	Stage IV pancreatic cancer	MAID Legalized 2016	4	Mandatory 15-day waiting period; consistent across provinces; 150,000+ Canadians have accessed MAID since legalization
India	2011	Persistent vegetative state	Judicial ruling No statute	4	Passive euthanasia only; Supreme Court petition required; lengthy process; extended to living wills in 2018; active euthanasia remains illegal
USA	2014	Terminal brain cancer (glioblastoma)	State law only Oregon DWDA	5	Required interstate relocation; patient must self-administer; geographic inequity — outcome depends on state of residence

Cases selected to represent distinct legal frameworks: statutory law (Netherlands, Canada), state-level legislation (USA), and judicial precedent (India). Steps reflect the formal procedural requirements at the time of each case. ALS = Amyotrophic Lateral Sclerosis; MAID = Medical Assistance in Dying; DWDA = Death with Dignity Act.

Discussion

Cross-Case Comparison of Legal Systems

Across the case studies we see how end of life decisions in various countries are shaped by the laws of these countries or in some cases like India, by judicial precedent. These laws are not created in isolation. They are drafted taking into consideration various factors such as moral and cultural values, legal systems and the available health infrastructure.

In countries like the Netherlands and Canada, while assisted dying is legally permitted, it comes with strong and multiple levels of safeguards. The laws in these countries aim at reducing the suffering of terminally ill patients while also protecting the patients through a series of strict rules. The patients have to satisfy certain conditions to be eligible, they should make a voluntary request and be accessed by doctors before a final decision is made. Each case is also closely reviewed to ensure that all steps were properly followed, and the entire process is documented to ensure accountability (Government of the Netherlands, 2002; Government of Canada, 2019).
In contrast, India has a far more limited approach which is shaped by judicial decisions and not laws passed by the legislature. Passive euthanasia is allowed under court guidelines, but active euthanasia is prohibited. This means that patients and families have to rely on court approvals which makes the process more complex and less accessible (Supreme Court of India, 2018).
The United States takes the middle ground, and the process is governed by state law as opposed to national law. This means that assisted dying is legal in some states while it is prohibited in others. Oregon was the first state to allow it in 1977 followed by 9 other states like California, Colorado, New Jersey etc. it is also allowed by Washington DC which is a district. The only exception is Montana where the practice is allowed through a court rulings rather than a law. In states like Oregon, assisted dying is legal, but only under strict conditions and the patient has to self-administer the lethal medication (Oregon Health Authority, 2015).

Thus the United States shows uneven access depending on the state of residence. While patient choice is recognized by some states under strict conditions, most states do not allow the practice.

Impacts of Laws on Decision Making

As discussed earlier, the level of access patients and their families have to Euthanasia is largely dependent on the legal and, in some cases, the judicial systems of the countries. This, in turn, influences how end-of-life decisions are made in each of these countries. In countries like the Netherlands, Canada, and Belgium where assisted dying is legal with clearly defined options, patients have a better understanding of the whole process. This often encourages an open discussion between the patients, family members, and doctors. It helps patients plan ahead and allows everyone involved to make clear and well-thought-through decisions in the best interest of the patient (Downie et al., 2021).

On the other hand, in countries like India, the process is ambiguous and often depends on the interpretation of the courts. This leads to slower and more uncertain decision-making. It puts additional emotional stress on patients and their families as they may face confusion, delays, and multiple court proceedings when trying to understand what can be allowed and how to move forward (Supreme Court of India, 2018).

In the United States, access is dependent on the law of the state of residence. In states where assisted dying is legal, patients and families can approach the situation with a sense of control and clarity. However, in states where there is no legal approval, patients do not have the same options, making the process difficult and stressful. Since access varies, patients and families handle end-of-life situations in different ways (Oregon Health Authority, 2015).

Ethical Tensions in Practice

There is a high level of ethical debate around Euthanasia. Doctors have to strike a delicate balance between their responsibility to lessen suffering and their overall duty to save lives. These contradictory ethical viewpoints put both doctors and the legislative systems in a dilemma. Another pertinent question relates to what counts as a sufficient level of suffering and how doctors decide whether the patient's suffering meets that threshold. (Beauchamp & Childress, 2019).

case studies also show that the situation becomes even more complicated when the patients are suffering from mental illness or are not in a position to make a sane, well-thought-through decision due to medical or other conditions. For example, the cases from Belgium have raised questions about whether patients with psychiatric conditions should be allowed to give consent (Dierickx et al., 2017). This underscores the need for a very well-defined review process with multiple levels of checks and safeguards.

Impact on Healthcare Practice

When Euthanasia or assisted dying becomes legal in a country, the role of healthcare professionals also changes. Instead of just providing care, they are now required to be actively involved in assessments and decision-making. Doctors are required to take a call on the level of patient suffering, confirm patient consent, and follow the required documentation and reporting procedures. This added responsibility can place healthcare professionals under emotional stress and ethical pressure (Keis et al., 2025).

An unambiguous, well-defined process with sufficient checks and balances can be of great help to patients, family members, and doctors, allowing them to make the best possible decision. In contrast, systems that lack clarity in the absence of a well-defined process present a different

picture. In the absence of clear guidelines, patients, families, and healthcare workers may be confused about what actions are allowed, which can affect decision-making and patient care.

Human Dignity and End-of-Life Care

One key theme in the discussions around euthanasia is the idea of human dignity. Arguments in support of the practice not only focus on reducing suffering but also on allowing patients to have control over their final days and choose a dignified ending to their lives. International human rights organizations also emphasize the importance of dignity in end-of-life care (UNHRC, 2017).

However, this further leads to the question of what defines human dignity in these situations? Some viewpoints define dignity as enabling the patient to choose the timing and manner of death, while others hold the belief that dignity can be preserved without ending life through supportive palliative care. Differing viewpoints on the idea of human dignity are not just used in ethical discussions but also play a role in how laws are formed (Stanford Encyclopedia of Philosophy, 2022).

Overall Interpretation

Taken together, the findings suggest that ultimately, the legal system of a country decides how end-of-life decisions are made. Countries with clear laws have organized and transparent processes. Countries that have restrictive laws and ambiguous processes create confusion, uncertainty, and stress for patients, doctors, and families.

At the same time, legal clarity does not give ethical consent to the practice of Euthanasia. There are ongoing debates with differing viewpoints on patient suffering, consent, and fairness. This is because of the fact that a sensitive subject like Euthanasia cannot be viewed through the lens of legality alone. It is also a deeply emotional, ethical, and social issue that involves consensus-building with empathy.

Conclusion

A comparison of euthanasia related laws in countries included as case studies in this paper leads us to conclude that national laws play a pivotal role in how medical decisions are made during the final stages of life for terminally ill patients. In countries where euthanasia or assisted dying is legal under a clearly defined system, patients and their families have a better understanding of the process and the available options. They are able to make well-thought-out decisions as they are assisted by well-defined legal procedures, medical assessments, and multiple levels of

safeguards. In contrast, in countries that have unclear systems, end-of-life decisions are marked by uncertainty, delays, and emotional stress for both patients and their families.

Euthanasia is a very sensitive and highly debated topic. There are various, often contradictory viewpoints from the fields of medicine, ethics, law, religion, societal norms, and personal beliefs. Even in countries where the practice has been given legal consent, the debate around the practice is ongoing. Questions around consent, dignity of the patient, mental capacity, religious beliefs, and fairness continue to remain central to this discussion.

Doctors and families find themselves in emotionally difficult situations as they have to choose between alleviating suffering and preserving life. International organizations have constantly stressed the need to protect human dignity and ensure carefully monitored safeguards in making euthanasia related decisions (European Court of Human Rights, 2015). At the same time, other medical organizations continue to oppose euthanasia and physician-assisted suicide on ethical grounds. They hold the belief that the primary duty of doctors is to preserve life, and they should focus on making patients comfortable through care rather than assisting in suicide (World Medical Association, 2022).

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