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Euthanasia, Ethics, and Perspectives Across North America, Europe and Australia

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ABSTRACT

Over the course of history, the perspectives surrounding and status of euthanasia has varied across regions, cultures, and time periods. This literature review delves into the multifaceted history presented by euthanasia, with ethical considerations that surround this practice and the variations in perspective across North America, Europe and Australia. The review synthesizes a vast array of articles and navigates frameworks both for and against assisted suicide whilst also delving into what the future of euthanasia may look like from region to region, and how to navigate discussions around the topic. Moreover, the review looks through the diverse factors that come into play, such as differing religious perspectives, varying legislative action being taken, and histories of the regions in which this subject is being investigated. By examining the intrinsic nuances of the discourse over the legislative status of this issue, the cultural influences that determine contrasting outlooks, and esoteric philosophical ideas, this literature review contributes to a deeper understanding of the moral complexities behind euthanasia an lays the groundwork for fostering further discussion and research into this controversial topic.

Introduction

In the realm of medical ethics, euthanasia has emerged as a significant topic evoking discourse between scholars and professionals alike. Euthanasia, which means “good death” in Greek, refers to the deliberate action of ending the life of another at their request with the intent of relieving that person of suffering (typically terminal illness). Under this umbrella term, there are many different variations including voluntary, involuntary and non-voluntary. As the name suggests, voluntary euthanasia is defined as the action of ending the suffering of someone else at their request. The process involves the patient being put under anesthetics, usually with laughing gas, or nitrous oxide, a tool that has been used for surgical procedures for over a century (1). Involuntary euthanasia is when one is able to give consent but fails to do so, and non-voluntary euthanasia is when a patient is unable to give consent due being in situations that render them unable to do so. Instances of this mostly include having severe illnesses such as dementia or other circumstances such as being in a coma. Similarly, physician assisted suicide/dying (PAS/PAD), is defined as a form of euthanasia in which a physician, or another licensed medical professional, assists the patient in the dying process, most commonly through a means such as providing medication which the patient will take themselves (2). Note, this is different to euthanasia, which, although sometimes referred to in a broader context, is typically done directly by a medical practitioner (e.g. lethal injection) rather than the patient themselves. The distinction between these variations in methods and practices is crucial as different countries have specific laws in regards to them. Within these countries, the concept of euthanasia was discussed more in some and less so in others. Additionally, the history of countries has created a distinct set of values and cultural ideas that significantly influence the way people think about euthanasia, whether it be a particular event that occurred, or religious ideas that have made their way through the political system. Finally, the perspectives of those who are involved and/or educated in this topic, typically philosophical thinkers and medical practitioners, are, to a large extent, critical to the feelings of this practice. All of these factors collide together to form what is today the state of euthanasia and physician-assisted dying in nations all over the globe.

Methodology

In order to search for the papers that were used in this review, a systemic approach was implemented that involved conducting searches through reputable sources such as PubMed and ScienceDirect. Keywords such as "physician-assisted dying", "ethics", "perspectives" and "culture" were utilized in order to filter relevant research papers and studies. Searching for journals by the countries in which they were legalized provided a way to directly compare varied perspectives surrounding the topic of euthanasia.

Legalization

Early Legalization

Before delving into the varying perspectives of euthanasia, examining the legal status of the euthanasia in America, Europe, and Australia is a necessary foundation needed for further analysis. Legalization differs globally, with countries that border each other and even states within a single nation having opposite views on PAD. A small number of countries have legalized it thus far (2). Amongst this fraction of countries with legalized euthanasia, a number of them are located in Western and Northwestern Europe, such as the Netherlands, Belgium, Luxembourg and Switzerland.

The substantial legislations for euthanasia seen in the landscape in Europe can be linked to the first records of debate dating to ancient Rome and Greece. Furthermore, the development of ether, a colorless substance used as an anesthetic, by scientist Valerius Cordus in 1540 in Germany, further prompted discussion about its potential uses in euthanasia processes., Ether was used in America as well, demonstrated in Boston by American dentists William T.G Morton (1).

The first account of legal steps in regards to physician treatment of patients in the Netherlands began with a series of acts in the mid-late 1800s. *Law on Medical Practice* and the *Burial Act*, two national statutes that tightened safeguards on medicine, required physicians to pass a state exam and made them subject to government inspection, whilst also provisioning the burial of patients by physicians. *The Penal Code*, a criminal law act passed in 1881, made killing a person at their request a crime (3).

The issue would not make significant headway until over a century later, during the latter-half of the 20th century, following a series of court cases, including the infamous "Postma case"(3), revolving around physician involvement into euthanasia, despite its outlaw, the Royal Dutch Medical Association involved themselves in the situation, holding a position of affirmation. Through enforcing a strict set of guidelines, although changed on multiple instances, they had brought out their vision of euthanasia being performed in a fair and humane way. More recent cases, mainly throughout the 80s, continued to contribute to the progression of euthanasia legalization. One of these such cases was the Schoonheim case, making headlines as this was the first case judged by the Dutch Supreme Court (3). A 95 year old patient was suffering unbearable pain, losing many physical senses such as hearing and speech, in addition to what is said to be a loss of dignity. In this case, the Court ruled that the physician who performed the euthanasia would be free from any and all charges as they decided that he did what he did out of necessity. Such cases, alongside a steep increase in public support, led to the Euthanasia Act being passed in 2001 and put into effect on the 1st of April, 2002. Introducing a six-step criteria, including persistent request of euthanasia on the patient's behalf and consultation with more than one physician (4), the act legalized euthanasia after decades of debate, discussion and changes in policy. However, one of the more contentious groups when it comes to euthanasia are psychiatric patients. Cases where euthanasia is granted to these patients are very low, with only 1.3% of assisted suicide cases being linked to psychiatric reasons (5). According to some psychiatrists, these rates could be considered discriminatory, however no legal precedent on this issue has been established yet.

The next country to legalize euthanasia is Belgium. The nation initially faced opposition from government commissions, but was able to pass the Act on Euthanasia. Whilst there are some similarities between Belgium and the

Netherlands in terms of the guidelines surrounding euthanasia, numerous distinctions are present. For example, Belgium extends it to all ages and requires repeated requests and written consent. The general pattern between the two major euthanasia acts in these two countries is that Belgium has much more constricted terms regarding how and when euthanasia is deemed legal and appropriate (6). However, the Netherlands' euthanasia act was created in this way that is more open to interpretation in order to prevent the need to create amendments in the future, as this more loose construction allows for maneuverability in the future. The low countries, which comprise of the Netherlands, Belgium and Luxembourg, in general have all been pioneers in legalizing euthanasia, which can be traced to their more liberal outlooks, an area that will be discussed later in the review.

Switzerland, however, is unique in the way that the nation handles euthanasia. The legality of suicide was first mentioned in the penal code in 1918, stating that it is "not a crime" (7). In the same section, succoring, or giving aid to, somebody else in suicide is also not illegal if, and only if, the intentions behind it are not malicious and selfish, but instead are purely for the benefit of the other person. When comparing this to euthanasia in the previously discussed countries, in law, Switzerland appears to portray euthanasia in the most explicit light, making explicit the requirement of good intent. This distinction in the legislation is significant as this has never been done before previously in any other nation, a break from the status quo and a clear example of how this issue has developed over time. Whilst PAS is legal, with the condition of there being an absence of selfish motives, active euthanasia has still not been legalized. This differs from assisted suicide as euthanasia requires the physician to kill the patient directly, and PAS is when a lethal prescription is given for the patient to take themselves. The Swiss government commissioned a group of medical experts and other officials to determine the best course of action in regards to the issue after it was brought up to the government. After extensive examination, the group was split, but the majority agreed that it should remain illegal. The disagreement was about the decriminalization of cases in which euthanasia was performed on a completely competent and willing patient, in which the majority put forward the idea of allowing situations in which euthanasia was a last resort option with explicit consent from the patient who was in dire suffering (7). No changes have currently been enacted, but the issue is being debated. The future outcome of these debates is yet to be predicted due to the confluence of factors that make this topic inherently subject to change.

Recent Legalizations

These earlier legalizations of euthanasia were followed by two other European countries, Spain and Germany, doing the same. The topic had not been thoroughly discussed in Spain until about 20-30 years ago, when "a dignified death" was being fought for (8). The Organic Law outlines and structures euthanasia in a way that considers it to be on par with other Constitutional rights, and similar to precedents of other countries who, by this point, already legalized euthanasia, it is required by law that the patient is competent and coherent (9). Germany as well, in February of 2020, allowed for the possibility of PAD, by announcing that the ban on assisted suicide was unconstitutional. Euthanasia was around during the 1800s for incurable illness, but the first major instance of euthanasia in Germany however was during the Nazi rule during the Second World War. The "euthanasia program" was done in order to purify the Aryan German population by disguising the murder of those who were said to not be for society (asocials, mentally ill, disabled) as euthanizing them (10). This program was terminated in 1941, but the mass murder continued in a similar fashion until the war's end. Nowadays however, through a ruling made by the Federal Constitutional Court, known in Germany as *Bundesverfassungsgericht*, or BVerfG for short, all people have the option of assisted suicide if wanted under the premise that people have the right to life, and therefore the right to death (11). Whilst this is the case, the overall view of euthanasia in the eyes of the public is relatively negative, mainly in part due to the heavy Nazi connotation linked with terms like euthanasia (12). This is the most drastic example of legislative change in the nation in terms of the extremity of the issue.

On the other hand the United States and Australia have a dynamic situation, with the numerous states that comprise the nations having different laws regarding euthanasia (13). Historically, assisted suicide was not as easy of a topic to handle legally in contrast to crimes such as homicide and suicide. Some jurisdictions viewed PAS as the

same as homicide, others found it to be imposing a lesser penalty, others created separate laws and others outright ignored it (14). The movement first began in the early 1800s and really started to gain traction after the debates in Britain that took place during the dawn of the 19th century. They were later being sidelined by the Second World War for obvious reasons but were picked back up afterwards, in which there was a shift of focus to ending the suffering of those in fatal circumstances and unbearable pain, "the cancer victim begging for death", from involuntary euthanasia, "the permanently insane or the senile" (14). Many bills were introduced in the 30s in NY and Nebraska but weren't successful. California and Washington were defeated as they would also have to authorize mercy killing (euthanasia) as well as PAD, which wasn't as morally defensible. Following these initial defeats, Oregon, the first US state to legalize PAD, decided to leave out the unappealing word of "suicide" in the legislation. The "Death with Dignity Act" was put in force in 1994 but, due to opposition, was delayed to 1997. Proceeding this legalization, many other states followed such as Michigan, Maine, Massachusetts, etc. Whilst it differs state by state, there is a shared commonality regarding the guidelines under which euthanasia can be performed, that being the individual has to be competent (i.e. able to make autonomous and well-informed decisions) and willing, similar to other pro-euthanasia countries in Europe (15). However, the US is more strict in that the patient has to have less than six months to live, differing from for example the Netherlands where unbearable suffering is the constituting requirement. Furthermore, Canada, despite being similar to the US in that it is split into separate provinces, legalized euthanasia and PAS nationally in 2016 following the introduction of medical aid in regards to dying in Quebec two years prior (16). Despite legalization in certain parts of Canada and the US, Mexico and Central America has yet to decriminalize active euthanasia.

Australia has as of late legalized voluntary-assisted dying (VAD), as it is called in Australian law, in all of its 6 states as recently as November 2023 (17). However, VAD is still illegal in its two territories, those being the Northern Territory and the Australian Capital Territory. It took nearly 20 years for Australia, after 50 attempts, to implement voluntary euthanasia, effective since June of 2019, now called voluntary assisted dying enabling people with advanced incurable disease to take substances prescribed by adequately trained medical practitioners that will bring about death at the time they chose. The biggest reason behind implementation of this legislative law was that it was a government sponsored process. Moreover, if we take the Australian society and world by large there have been drastic social changes over the past two decades and greater demand from people, especially baby boomers. Victoria's scheme is unique but is modeled after that of Oregon, which has had assisted dying laws even before it got implemented down under. The most common reason for the use of VAD is cancer, with it comprising over 80% of all VAD cases, mainly in part of Australia being the country with the highest cancer rate in the world (17). As North America, Australia and Europe navigate the intricate landscapes of euthanasia and PAS, a visible but slow march to legalization is what seems to be the rising trend, but the future is not predictable with the vast amount of differing opinions and cultures that motivate people's opinions on this topic to one side or the other.

However, there have been just as many countries to directly state euthanasia and PAD to be crimes as there have been those that have legalized it. Italy, for example, has outlawed both. In fact, it is not distinguished from aid in suicide, according to article 580 of the Criminal Code (18). The UK is similar in this fashion, as it also classifies euthanasia and PAD in the same vein as assistance in suicide in accordance to the Suicide Act of 1961. Australia's Northern Territory has also banned euthanasia, being an outlier as all other states and territories in the country have had euthanasia and PAD be legal for a few years (19).

Cultural Norms

Pro-Euthanasia Camp

One of the driving factors behind distinct perspectives on euthanasia are cultural norms, intertwined with differing beliefs and values. These interpersonal and latent attitudes molded—through social norms, individual upbringings and the history of nations—play a major role in the determination of whether those who are eligible for euthanasia are able

to receive it. The Netherlands, a nation known for its progressive outlook and stance on a multitude of other issues (20), has had its attitudes guided by these liberal values. Euthanasia is seen as a human right of dignity, and the autonomy of the patient is respected. Due to this, Dutch law respects the wishes of patients and permits both voluntary and non-voluntary euthanasia, under a strict set of conditions that prevent conviction of the physician that took part in the process: the patient was in insufferable and lasting pain and consented, the patient was informed of their situation and knew that there was no other rational solution (21). On top of that, James Kennedy, an American-Dutch historian, stated his belief as to why the Netherlands was the first country to legalize euthanasia. There were three contributing factors: "the typical Dutch mentality; a healthcare system based on solidarity which ensures that there is no economic pressure to let people die; and a minority of Christian political parties in the Dutch parliament" (21). He describes the fact that the religious thinking present, which is seemingly a barrier to the legalization of euthanasia, actually contains ideas of "self-determination in matters of life and death". Dutch culture has evolved overtime where now the country has grown to favor euthanasia for five distinct reasons. First of all, topics that were once seen as taboo (e.g. death and suicide) are now more openly discussed. This can be attributed to the culture of openness seen in Protestant Christianity. Secondly, the inevitable rise and improvement of medical technology would enhance life-saving abilities, but consequently would also enhance life-ending abilities. Spirituality and religion have also drastically changed over the past few decades in the country. The country, historically, was split between Protestants and Catholics. However, throughout the 20th century, especially after World War 2, there has been a marked decline in religious affiliation and observance due to secularization. This decrease in traditional religious adherence has significantly contributed to the permissive attitude toward euthanasia Dutch culture (21).

Education is another factor associated with one's perspective on euthanasia and PAD. Studies performed both in Belgium and Switzerland reported results that showed that those with education past a high school diploma possess more favorable attitudes towards euthanasia. The main reason for this is because it gives those individuals a heightened sense of self-autonomy and resilience, qualities that are associated with people who have higher intelligence. These people also tend to be more active and willing to participate in their end-of-life decisions, linked to their desire to not have to suffer overtreatment during euthanasia (22). On the other hand, lower education levels more likely leads to more skepticism of euthanasia due to it being a more unfamiliar subject, which links to the low level of opposition to the high education standard in these European countries. Forms of media can also be a factor in this issue, on varying levels. In New Zealand, debates on social media platforms, despite the fact that they represent the voices of the people of the nation, were found to be quite unhelpful when it came to determining the majority opinion of the population due to the polarizing nature of such sensitive topics (23).

Moreover, contemporary attitudes are mostly shaped by previous events with similar circumstances in which a specific perspective became the majority view of most people in that region. A key example of this is the state of Oregon, where there has been a history of public support and "anti-authoritarian decision making" in terms of medicine that led to the success of euthanasia (24). Citizens fought profusely against mandatory vaccination, government interference in medicine and claims that stated the opinion of medical professionals overrides the decisions of individuals during the Progressive Era of the US, lasting from the late 1800s to WW1. This independent mindset stems from the unique origins of the state, as it was initially a territory constantly being claimed by Britain, Russia and Spain until it came to be part of the United States, continuing to sport this attitude. Combined with the overwhelming public support, with over 60% of citizens showing support along with their many numerous activist groups such as the Oregon Right to Die, led to the proposition of Death with Dignity Act which was passed due to the distinct social and political landscape of the state (24). Oregon has paved the way for people across the country to make their decisions about the future of euthanasia in their own respective states.

Anti-Euthanasia Camp

Just as much disdain, however, of euthanasia lies in numerous other countries which have shown clear adversarial attitudes towards it, or have banned it outright. Many factors affect a nation's stance on this divisive topic, with religion

being one of the main considerations. In contrast to secularism, which has shown to have a correlation with pro-euthanasia attitudes, religious dogma tends to create opposition based on the teachings of said dogma. In all three of the Abrahamic religions, Christianity, Islam and Judaism, euthanasia is prohibited (25). In predominantly Catholic countries such as Italy, Poland, Malta and Ireland, there are deeply rooted religious doctrines that often underpin a disinclination to euthanasia. Using the Bible as its main source, the Catholic Church teaches the sanctity of life which is a major part of the cultural norms that support and prioritize the preservation of life, despite any debilitating suffering that one might be experiencing (26). Moreover, God is seen as the giver of the gift of life, and taking that away for any reason is seen as one of the greatest sins one can commit. Not dissimilarly, the Bible Belt region of the United States, also influenced by these conservative Christian values, oppose euthanasia as well.

Opponents also often cite the "slippery slope argument", the idea of one event resulting in a chain reaction that leads to more events eventually having disastrous consequences. In this circumstance, the argument is that euthanasia and PAD will become so liberal with its outreach that eventually, it will be legal for anyone to request euthanasia regardless of the reason (27). Pointing to the Netherlands, critics cite how the Dutch have been implementing less restrictions on the cases in which euthanasia can be performed (28). The previous prerequisite of having to be "older than 70 and be tired of living" and having to have a terminal illness has been, over time, subsiding and now a wide array of people are eligible. Critics often cite the fact that children aged 12-16 are able to be euthanized with consent from parents. In fact, the slippery slope argument sometimes refers back to the Nazis and their euthanasia program, citing that eventual decline or diminution of safeguards and restrictions can possibly result in a similar situation. Potential for abuse is high according to these arguments. Whilst there may be some truth in this to a certain extent, with half of the cases of euthanasia in Belgium being undocumented, those who support euthanasia point out the fallacies present in this opposition. Primarily, there is no physical evidence to substantiate these claims, besides the recall to the history of Germany in which the radicalization of euthanasia was rather an effect of the extreme political ideology rather than something that spurred up on its own. In addition, the slippery slope tends to develop as a sense of pathos, appealing to emotion rather than using facts and logic, which can be seen as manipulative. Rates of euthanasia cases where no patient consent was given has not been raised since legislation that made euthanasia more available, further contributing to the evidence against the claims brought up by the defenders of this argument (29).

Ethics

Philosophical Frameworks

After considering logistics and views of the public, opinions of mental health experts and philosophers are imperative to the understanding of euthanasia attitudes in Western culture. The extent of the consideration of the consent given can be properly understood and evaluated through the professional lens of psychiatrists and psychologists as, in many occasions, there is likely some underlying mental health concerns tied in with the desire of euthanasia. This discussion can be traced back to Classical Greece (510-323 BCE) in which Greek philosophers were seen to be against any forms of active euthanasia, in which actions are performed with the intent of killing the patient, however passive euthanasia, in which treatment in withheld, is seen as altruistic. A prime example of this is in the works of Plato, known to be the 'father of Western philosophy', being the pupil of Socrates and the teacher of Aristotle. In his *Laws*, one of his final dialogues, Plato displays his disdain for what would be a modern definition of active euthanasia by outright stating that doctors who administer drugs with the intent of killing the patient should be punished by execution. However, when a patient is in extreme pain and debilitating circumstances, Plato recognizes the need for those people, who in his eyes are no longer useful members of society, to not receive treatment that would prolong their life (30). In this sense, Plato aligns his views with that of his protege, Aristotle, as they both believe that both suicide and assisted suicide, if committed for selfish purposes, the action goes against the law, the will of the gods, and is a downright injustice against society.

Most well known however is the philosophies of Hippocrates. Known as the "father of medicine", due to his teachings being the standard for medicine in a majority of both Western and Eastern societies, Hippocrates refused to directly give a patient a lethal substance as he was against active euthanasia, similar to many of contemporaries such as the aforementioned Plato. The Hippocratic Oath, attributed to but not written by Hippocrates, contains the line "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan", suggesting a stance against euthanasia (31).

Debates have also arisen about the moral implications and differences of allowing versus doing harm. A popular dilemma that relates to this concept is the trolley problem, in which a trolley is heading towards five innocent people who will be killed, however there is a choice to divert the trolley so that it kills one innocent person instead. In this context, the argument surrounds the two cases of letting a patient die naturally yet painfully, or killing the patient directly but painlessly (32). Both of these scenarios have caused extensive debate about whether involvement in a death constitutes harsher punishment or if it is no different to not taking action regarding a preventable death.

Medical Considerations

Just as important as those of philosophers, arguably even more so, are the input and judgements of medical professionals, especially physicians as they are the ones who carry out the action of assisted suicide. In the US, public support of PAS has been rising over the past few years, and alongside this, albeit at a slower rate, support amongst physicians has been also steadily increasing, with approval for the practice going from 46% in 2010 to nearly 60% in 2016 (33). Similar trends can be seen with physicians in Canada and Europe. Despite the support of PAS, only 22% of physicians are actually willing to perform the task itself. Reasons for this discrepancy vary, including religious factors, the mention of the Hippocratic oath (a medical oath that states that medical professionals swear to do no harm), and general uncertainty or lack of experience with performing the practice. On top of these personal concerns, some have worries about the amount of pain that a patient will feel when going under PAS or euthanasia. If all goes as intended, patients should be feeling zero pain when undergoing euthanasia. Unfortunately, there have been instances in the Netherlands in which patients have received the incorrect dosage of anesthetic and are at risk of having a cardiac arrest as the lethal injection does not stop heart and lungs instantly, but within a few minutes (34). From these concerns of precariousness and inexperience with PAS, inferences can be made that with more training, physicians would feel that the practice would be more in their scope and have more confidence (35). However, most still relate death with a negative connotation, as studies have shown that suicides in Oregon have been associated with PAD legislation (35), which is one of the underlying factors that pushes many physicians away from wanting to perform PAS. Cancer is another factor that is associated with assisted-dying quite often. In Switzerland, cancer constitutes for over 40% of PAS, making it a significant issue (36). The median age for those who have a cancer disease and decide to opt for PAS in Switzerland was found to be 73, only 1 year younger than the median age of all oncological deaths. The relatively small difference in age could be attributed to the fact that only PAS is legal in Switzerland, meaning the patient has to take a lethal substance themselves. The elderly in particular seek to have autonomy over their death, thus making this decision more active for the patient (36).

Furthermore, extra precaution must be taken when taking into account depressive symptoms and other mental health conditions that can affect patients' decision making, especially with those who are terminally ill. Depression rates of patients seeking PAD are quite considerable, with nearly 25% of euthanasia-seekers in Oregon showing signs of depression and some even being clinically diagnosed (37). The question that must be taken into consideration is whether or not these illnesses severely impact the patients' decision regarding euthanasia or PAD. Differing conclusions have arisen from several debates. One study showed that only 6% of physicians feel confident that they can accurately determine the effect of the mental state of the patient on their decision (37). However the general conclusion is that depression does not fully inhibit decision making skills and abilities, rather it tends to warrant a more nihilistic outlook from patients, leading them to make more irrational choices than they would in comparison to being in a more stable mental state (38). With this idea in mind, scientists and clinical specialists have generally come to the consensus

that attempts should be made to treat any depressive symptoms beforehand rather than simply going through with the patients' desire, as there are instances in which the patient has actually rebuked their wish after receiving such treatments.

Looking to the Future

With so much discourse and differentiation amongst those who actively partake in such discussions, the exact future of euthanasia is uncertain. However, through the trends in religion, social changes in each region, and correlations with education levels, we can make some educated guesses about how this issue may develop in the future. It is most likely liberal countries that have historically had a positive and affirming view of euthanasia, and healthcare in general, such as the low countries, will continue to follow these ideas and perhaps expand on legalization policies, such as ensuring that requests from vulnerable populations are handled with increased scrutiny. Other places such as the United States, where a much more politically and culturally mixed landscape is present, have a more uncertain future with the legality of euthanasia, differing from region to region whilst maintaining strict safeguards in places where it is legal. Australian legislation will still be heavily discussed as well due to the recent legalization of VAD, with the emphasis continuing to be on end-of-life care for cancer patients.

Perceptions of death and dying vary across populations influenced by culture and knowledge, hence engaging people to define their own values and preferences at end-of-life care by having frank discussions with care teams can be extremely challenging. End-of-life is an essential part of medical decision making which should have continuous attention in health care policies and training. Periodic research on understanding of end of life care in modern medicine should be recognized as an equally important goal as the traditional aim of disease cure and prolonging life, as both of these scenarios are seen as viable options depending on the circumstances. At this point, some types of research that would be beneficial would be studies that delve into the emotional and psychological effects of euthanasia requests on patients, their families, and involved healthcare providers. Additionally, grief and depression should be examined, alongside how informed consent is managed. Further qualitative research and surveys should be conducted exploring public and professional attitudes towards euthanasia and PAS in order to continue developing our understanding of this topic. In any case, it is vital for society to keep discussion civil and foster further meaningful dialogue between scholars, medical professionals and the general public in order to align the legal landscapes of this profound issue with the needs and wants of humanity as a whole.

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