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What Are We Talking about When We Talk about End-of-Life? A Descriptive Analysis of End-of-Life Discussions from Five Countries

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Abstract

End-of-life (EOL) regulations vary significantly across countries, not only in terms of legal frameworks and ethical principles but also in the societal processes and public debates that shape them. This paper explores these dynamics in five countries—Belgium, Germany, Hungary, Israel, and the Netherlands—each of which offers a distinct perspective on EOL decision-making, shaped by its unique historical, cultural, religious, political, and legal contexts. A central theme in this paper is the role of the medical profession in shaping EOL policy. For over five decades, the World Medical Association has maintained a firm stance against physician-assisted dying (PAD), often placing it at odds with more liberal national debates. This paper offers both a detailed account of national developments and a comparative analysis of the five countries. We examine how historical trajectories, public debates, and professional attitudes have shaped EOL policies, and how tensions between public opinion and medical ethics continue to influence the implementation of these laws. Ultimately, we reflect on how societies with moral pluralism navigate the complex terrain of end-of-life decision-making.

Keywords

End-of-Life, Euthanasia, Suffering

1. Introduction

End-of-life regulations vary significantly across countries, not only in terms of legal frameworks allowing or prohibiting assisted dying [1]-[4], but also in ethical and religious views, professional experiences, societal processes, and the public debates that shape them [2] [5] [6].

This paper explores these dynamics in five countries—Belgium, Germany, Hungary, Israel, and the Netherlands—each of which offers a distinct perspective on end-of-life decision-making, shaped by its unique historical, cultural, religious, political, and legal contexts.

The evolution of modern bioethics is closely tied to post-World War II developments in medicine, which have transformed the nature of illness, suffering, and how we deal with dying. Advances in medical technology have prolonged life but also contributed to the medicalisation of death, often creating tensions between patients' evolving rights and physicians' traditional obligations. One such tension concerns the long-standing medical axiom of preserving life at all costs, which is increasingly challenged by the recognition of patients' rights to refuse treatment or request assistance in dying. This shift has also marked a broader transition from paternalistic medical authority to shared decision-making. However, the extent to which patients' voices are acknowledged—and their choices respected—varies widely across jurisdictions and cultural traditions. In some countries, such as Hungary and Israel, legal rights to refuse treatment exist but are often undermined by bureaucratic obstacles or cultural resistance.

A central theme in this paper is the role of the medical profession in shaping end-of-life policy. For over five decades, the World Medical Association has maintained a firm stance against physician-assisted dying (World Medical Association, 2019) [7], often placing it at odds with more liberal national debates. A notable exception is the Netherlands, where the medical profession publicly supported euthanasia as early as 1984.

Historical legacies also play a critical role. In Germany, the atrocities committed by the medical profession during the Nazi era have cast a long shadow over end-of-life debates, contributing to a cautious and emotionally charged national discourse [8] [9]. In contrast, religious and cultural values in Israel and Hungary continue to prioritize the sanctity of life, often overriding individual autonomy. In Israel, the prioritization is not so clear, as we discuss later.

Parliamentary politics further influence the development of end-of-life legislation. In countries such as Belgium and the Netherlands, liberal laws permitting euthanasia and physician-assisted dying were enacted only under secular, progressive governments. In Belgium, political momentum for legal reform emerged from a coalition of liberal parties and segments of the medical field, despite resistance from within the palliative care sector.

Even in jurisdictions with liberal end-of-life laws, significant discrepancies remain between legislation and clinical practice [10]. Conscientious objection by physicians, for example, can limit access to legal options. Importantly, neither Bel-

gian nor Dutch law imposes a duty on physicians to perform euthanasia, nor does it grant patients a right to receive it. It does, however, offer the legal possibility of asking for euthanasia.

Throughout the paper, our primary aim is descriptive comparative: we report how national legal, professional, and cultural frameworks have developed. When evaluative terms such as "progress" or "regress" are used, they refer not to a single moral ranking of countries but to a procedural lens: the extent to which a system enables transparent deliberation, respect for patient self-determination, and meaningful participation by professional and civil actors.

This paper offers both a detailed account of national developments and a comparative analysis of the five countries. We examine how historical trajectories, public debates, and professional attitudes have shaped end-of-life policies, and how tensions between public opinion and medical ethics continue to influence the implementation of these laws. Ultimately, we reflect on how societies with accepted and practiced moral pluralism navigate the complex terrain of end-of-life decision-making.

2. Country Cards

2.1. Hungary

2.1.1. Historical and Legal Background

Hungary's approach to end-of-life (End-of-life) decision-making is shaped by its postwar history as a former Soviet satellite state, where individual rights in healthcare were significantly constrained. Prior to the democratic transition, the Hungarian Supreme Court last addressed the legal dimensions of suicide in 1981, in the context of a homicide case. While suicide and attempted suicide were not criminalized, the legal system treated related acts—such as inducing or assisting suicide—as distinct criminal offenses. This stance reflected the prevailing socialist moral framework, which, although not punitive toward suicide itself, regarded it as a socially dangerous act contrary to socialist values.

Although Hungary's 2013 jurisprudence clarified that suicide is not a criminal offense under national law, remnants of the earlier moralistic legal approach persist in contemporary legal literature. The 1997 Health Care Act, modeled after European standards, introduced the right to refuse life-sustaining or life-saving treatment, thereby allowing the natural course of illness to proceed. However, the law provides only limited scope for physicians and patients to engage in broader end-of-life decision-making. Despite several constitutional petitions, including a landmark ruling in 2001, subsequent decisions have failed to bring about substantive changes in practice.

2.1.2. Current Legal Framework

Euthanasia remains explicitly prohibited in Hungary. Nevertheless, the Health Care Act recognizes the right to refuse treatment, including what is sometimes referred to as 'passive euthanasia'. In practice, however, this right is heavily circumscribed. Lifesaving or life-sustaining interventions generally do not require

patient consent, thereby enabling physicians to act paternalistically in such cases [11].

Competent patients may only refuse such interventions under strict conditions: they must be diagnosed with a serious, incurable illness that is expected to result in death within a short timeframe, even with appropriate medical care. The refusal must be validated by a three-member medical committee, which must unanimously confirm in writing that the patient is fully informed and that the illness remains terminal. The patient must then reaffirm his or her decision three days later, in the presence of two witnesses.

For patients lacking decision-making capacity, treatment refusal requires court approval through a substituted consent process [12]. This is particularly relevant in cases involving minors or incapacitated adults, where the withdrawal of life-sustaining treatment—such as mechanical ventilation—cannot proceed without judicial authorization [13].

2.1.3. Public and Ethical Debate

A recent case brought renewed attention to Hungary's restrictive end-of-life policies. On August 10, 2023, constitutional lawyer Dániel Karsai submitted a petition to the European Court of Human Rights (ECHR), challenging Hungary's prohibition on assisted dying [14]. Diagnosed with Amyotrophic Lateral Sclerosis (ALS), Karsai argued that the ban violated fundamental human rights, including the right to self-determination, the prohibition of inhumane treatment, and freedom of conscience.

Although the ECHR ultimately rejected his application, Karsai's case ignited a significant public debate. Legal scholars, theologians, politicians, and journalists engaged in the discussion, yet professional medical organizations—most notably the Hungarian Medical Chamber—remained largely silent. While the case did not yield immediate political change, it underscored a growing societal interest in reforming Hungary's end-of-life legislation [15].

2.1.4. Institutional and Structural Challenges

Since the 2010 elections, Hungary has undergone sweeping political reforms that have centralized power and blurred the boundaries between state and government. These post-2010 centralizing reforms, often described as an autocratic shift, have curtailed the autonomy of individuals, civil society, and professional organizations, thereby impeding bottom-up initiatives and cross-sector collaboration—particularly in ethically sensitive domains such as end-of-life care. The most important professional organization of physicians was not an exception. Following a series of disputes, the Hungarian government took action against the Hungarian Medical Chamber, altering its legal status in a way that diminished its influence over healthcare policy decisions [16].

Despite these constraints, the hospice movement has made notable strides. As a civil initiative, it introduced modern standards for palliative care and was eventually integrated into the state healthcare system. Nonetheless, palliative

care in Hungary continues to face systemic challenges, including chronic underfunding, workforce shortages, limited training, and inadequate strategic planning [17]. As a result, equitable access to high-quality palliative care remains elusive.

Empirical data suggest that treatment limitation is a common practice: among patients who died in intensive care units, 72.6% experienced some form of treatment restriction [12]. These decisions are often driven by resource constraints—such as limited hospital beds and staffing—as well as the severity of patient suffering. While Hungary's solidarity-based healthcare system aspires to universal access, the quality of care and the institutional culture surrounding patient autonomy remain inconsistent and underdeveloped.

2.2. Germany

2.2.1. Historical and Legal Background

Germany's end-of-life debate is deeply shaped by its historical legacy, particularly the atrocities committed under the Nazi regime [8] [9]. The systematic killing of vulnerable individuals under the guise of "euthanasia" created a long-standing societal and professional taboo around any form of life-ending medical intervention. From 1945 to the 1970s, public discourse on end-of-life ethics was largely suppressed, with early post-war legal and professional voices calling for a complete ban on euthanasia discussions.

This silence began to break in the 1970s, spurred by medical advances in life-prolonging technologies and public intellectuals advocating for the right to die [8]. However, the German Medical Association maintained a clear stance against any intentional shortening of life. The post-war constitution, adopted in 1949, placed strong emphasis on individual rights and human dignity, in direct response to the abuses of the Nazi era. This constitutional framework continues to shape the legal and ethical boundaries of end-of-life care.

2.2.2. Professional Guidelines and Ethical Shifts

In the absence of specific legislation on medical acts at the end of life, professional guidelines have played a central role in shaping practice [18] [19]. Beginning in the 1990s, the German Medical Association and other professional bodies developed ethical frameworks that moved away from ambiguous terms like "passive euthanasia." Instead, they emphasized a shift in therapeutic goals, from curative to palliative care, when treatment no longer serves the patient's best interest [20].

Professional guidelines stipulated that the voluntary refusal of nutrition and hydration, as well as palliative sedation with informed consent, are ethically acceptable [21]-[23]. The obligation to provide life-sustaining interventions, including artificial nutrition, is not absolute and must be evaluated in light of the patient's condition and wishes.

2.2.3. Legal Status and Terminology

Germany currently has no comprehensive law regulating medical acts at the end

of life. While "killing on request" remains a criminal offense, suicide and assisted suicide are not illegal, provided the act is autonomously initiated and carried out by the individual. This legal distinction has led to nuanced interpretations of assisted dying, particularly in light of recent constitutional court rulings.

The medical profession has significantly influenced public discourse by reframing end-of-life care in terms of therapeutic goals and patient autonomy. Rather than focusing on the cessation of treatment, the emphasis lies on transitioning to symptom relief and comfort care ("changing goal of therapy"), in alignment with a patient's values and rights.

2.2.4. Institutional and Structural Challenges

Germany's end-of-life framework remains largely shaped by professional guidelines and court rulings rather than comprehensive legislation. A pivotal moment occurred in 2020, when the Federal Constitutional Court overturned a 2015 law that had criminalized "business-like" assistance in suicide. This law had been introduced in response to concerns over foreign euthanasia organizations operating in Germany and was supported by the German Medical Association, aligning with the World Medical Association's opposition to physician-assisted dying.

The court's decision marked a significant shift in the legal landscape. It ruled that the right to a self-determined death is protected under the German constitution, including the right to seek assistance in suicide [24]. The court emphasized that offering such assistance also falls under constitutionally protected freedoms. However, it left room for future legislation to introduce procedural safeguards to prevent abuse.

The ethical debate has since evolved into a human rights–based discourse. Proponents of liberalization argue for personal autonomy and the right to choose one's own values, while opponents emphasize the need to protect life as the foundation of all other rights [20]. Despite the court ruling, the Bundestag has yet to pass new legislation regulating assisted suicide. In the absence of legal clarity, organizations from Switzerland, such as Exit and Dignitas, continue to offer assistance. Meanwhile, "killing on request" remains a criminal offense, though its future status may be influenced by the court's broad interpretation of personal rights.

Public opinion in Germany generally supports assisted suicide, though approval for euthanasia is lower [25]. Surveys reveal a persistent gap between public attitudes and the positions of professional organizations, including the German Medical Association, which maintains that assisted suicide contradicts medical ethics [26]. Notably, many citizens still, and even now, remain unaware that assisted suicide has never been categorically banned—only restricted under the now-overturned 2015 law.

2.2.5. Moral Pluralism and the Future of Regulation

Germany's current legal and ethical landscape reflects a broader societal challenge: how to navigate moral pluralism in the absence of legislative consensus. The

2020 Constitutional Court ruling affirmed a broad constitutional understanding of individual self-determination in end-of-life decisions, including the right to seek assistance in suicide. However, both the German Medical Council and several medical societies reject assisted suicide as part of medical practice, arguing that intentionally shortening life increasingly violates core medical ethics—a view consistent with the World Medical Association's position.

Despite the court's liberal interpretation of personal rights, no new legislation has secured a parliamentary majority. Draft laws aiming to regulate assisted suicide have repeatedly failed, leaving a legal vacuum. This has led to a situation where assistance in suicide is legally permitted but remains ethically contested and institutionally largely unsupported within the medical field.

The future trajectory of regulation remains uncertain. The disconnect between public perception, professional ethics, and legal reality complicates policymaking in a representative democracy.

Germany thus finds itself in a state of moral diversity without a clear legislative path forward. Whether society will move toward greater integration of opposing views or remain in a state of unresolved tension is unclear. What is evident, however, is that the challenge of governing end-of-life decisions in a pluralistic society will require careful balancing of individual rights, professional ethics, and democratic deliberation.

2.3. The Netherlands

2.3.1. Historical and Legal Background

The Netherlands' approach to end-of-life regulation is rooted in profound societal shifts during the 1970s, marked by increasing individualism, secularization, and a growing emphasis on patient autonomy. These changes were reflected in broader social domains—such as education, the workplace, and healthcare—and culminated in a strong public and legal focus on self-determination at the end of life.

Uniquely, the Dutch medical profession played a proactive role in this transformation. From the 1970s onward, physicians began advocating for truth-telling and patient involvement in decisions about life-prolonging treatments. This included the emergence of a covert practice of euthanasia, which initially divided the profession. However, in 1984, the Royal Dutch Medical Association (KNMG) publicly endorsed physician involvement in euthanasia under strict conditions in order to protect physicians involved in euthanasia and assisted suicide. This stance led to the temporary exclusion of Dutch representatives from international medical bodies.

Public support for euthanasia and physician-assisted suicide (PAS) has steadily increased over time—from 57% in 2010 to 87% in 2019—while opposition has declined significantly [27] [28].

2.3.2. Key Legal Precedents

The Dutch legal framework evolved through a series of landmark court cases between 1974 and 2002, which laid the foundation for the 2002 Euthanasia Act.

These cases progressively defined the conditions under which only physicians could legally assist in ending a patient's life, while euthanasia and assisted suicide still remain criminal offenses for anyone else. These precedents culminated in the formal legalization of euthanasia and PAS under strict conditions, codifying the evolving legal and ethical consensus [29].

2.3.3. Legal Codification and Institutional Practice

The final key legal case in 2002 involved an elderly patient experiencing cumulative, non-terminal suffering. The Supreme Court ruled that only suffering caused by a medically classifiable somatic or psychiatric condition could justify euthanasia. Requests based solely on existential suffering or being "tired of life" were excluded, as such suffering falls outside the scope of medical expertise.

Political consensus on euthanasia legislation was delayed until around 2000, largely due to opposition from Christian parties. This delay, however, allowed for a collaborative process involving political actors, the judiciary, and the medical profession to develop a regulatory framework. From 1997 onward, physicians were required to consult a second medical professional and self-report euthanasia cases to legal authorities via a consulting physician. These reports are reviewed retrospectively to ensure compliance with due care criteria.

The resulting Termination of Life on Request and Assisted Suicide Act, enacted in 2002, codified existing practices and, in addition, introduced the previously not possible inclusion of euthanasia for legally incompetent patients over 16 with a valid advance directive [30]. Euthanasia and assisted suicide still remain crimes: euthanasia is not a right of a patient, nor is it a duty for a physician. However, these interventions are possible under certain conditions.

The law is thus physician-focused and includes several safeguards: a voluntary, well-considered request of a competent patient, unbearable and hopeless suffering, the absence of an acceptable alternative, a mandatory consultation with an independent physician, self-reporting of the act, and review by a multidisciplinary Euthanasia Review Committee (comprising a lawyer, physician, and ethicist). In cases involving psychiatric suffering, an additional second independent consultation prior to the end-of-life act is required. Every five years, a national evaluation assesses the law's implementation with respect to all MDELs (Medical Decisions at the End of Life) and its broader impact on the outcomes of end-of-life care.

2.3.4. Contemporary Ethical Debates and Emerging Trends

Since the law's enactment, reported euthanasia cases have risen from approximately 2000 in 2002 to over 9000 in 2023 [31]. The majority involve patients with terminal cancer (56%), most of whom are treated in primary care settings or receive home care. Since 2012, cases involving psychiatric disorders, dementia, and elderly patients with multiple chronic conditions have become more common, reflecting a gradual expansion of eligibility.

This expansion has sparked new debates, particularly around the concept of a "completed life"—the idea that individuals should have the right to end their lives

even in the absence of suffering from a medical disease. Proposals have emerged advocating for access to life-ending substances without physician involvement, and for the legal recognition of qualified laypersons as facilitators of assisted dying. The establishment of the Expertise Centre Euthanasia (EE), formerly the Life Ending Clinic, in 2012 reflects this trend. The centre provides euthanasia and assisted suicide services, particularly for patients with psychiatric or cognitive conditions, made possible because a prior treatment relationship is not legally required.

2.3.5. Ongoing Challenges and Future Directions

The Dutch euthanasia debate remains dynamic. The 2023 national evaluation of the law identified several areas for potential reform, including the independence of consulting physicians, the legal status of written versus oral requests, and the permissibility of euthanasia when patients lose consciousness shortly before the planned procedure.

A 2020 legislative proposal by a liberal party sought to extend euthanasia access to individuals with a "completed life" and to allow non-physicians to assist in dying. Although the proposal was defeated, it remains part of the broader public and political discourse. Five potential regulatory scenarios are currently under discussion, reflecting the Netherlands' ongoing efforts to balance autonomy, medical ethics, and societal values in end-of-life decision-making [32].

2.4. Israel

2.4.1. Historical and Legal Background

End-of-life decision-making in Israel is shaped by the country's dual identity as both a Jewish and democratic state. Jewish tradition emphasizes the sanctity of life and the duty to heal, while also recognizing the importance of not unnecessarily prolonging suffering. Balancing these goals may be complicated when dealing with end-of-life decisions, particularly when dealing with contemporary situations that did not exist in the past [33]. These values are reflected in the Dying Patient Act, enacted in 2005 [34], which represents a compromise between religious principles and democratic values such as autonomy and quality of life [35].

The Dying Patient Act applies to terminally ill adults (aged 17 and over) and explicitly prohibits active euthanasia, assisted suicide, and the withdrawal of continued care such as a ventilator [36]. While the law affirms the right of competent patients to refuse life-prolonging treatment, it also mandates efforts to persuade them to accept basic care, including hydration, nutrition, and palliative support. For incompetent patients, treatment may be withheld if significant suffering is documented through advance directives or a legal proxy. However, hydration must be maintained unless it causes harm. The law outlines advance directives for the future health care of a terminally ill patient. The directives define in advance which medical treatments the patient is willing to accept and which treatments they wish to avoid if they are diagnosed with a terminal illness. Advance directives must be signed in the presence of a physician and a witness and are valid for five

years if registered with the Ministry of Health, after which they may be renewed [37].

Despite its progressive intent, the law's implementation has been limited. Only about 4% of the population has completed advance directives, due in part to complex procedures, limited public awareness, and bureaucratic hurdles [38].

2.4.2. Current Ethical Debates

A recent court case involving a 20-year-old patient who refused life-saving treatment after multiple suicide attempts reignited public debate regarding the right to die [39]. In this court ruling, the court prioritized the sanctity of life over the patient's autonomy, in spite of the absence of a psychiatric evaluation regarding patient competency. Critics argued that this decision undermined the principle of self-determination and highlighted the tension between religious values and individual rights. A new case elevated the debate regarding active euthanasia once again in September 2025. This is the case of Michael Podolvsky, an ALS patient who was granted by court a right to die and, for the first time in Israel, donate organs after death. That process necessitates active euthanasia [40]. Time will tell if this case signifies the beginning of a new era or a special case not to be repeated.

That said, public opinion in Israel remains polarized on end-of-life issues, particularly regarding patient autonomy and medically assisted dying. Studies show a strong correlation between religiosity and support for life-extending interventions, reflecting the broader societal divide [5].

2.4.3. Challenges in Implementation

Since its enactment, the Dying Patient Act has faced significant implementation challenges. Physicians often lack the time, training, or institutional support to engage in meaningful end-of-life conversations. The dominant moral atmosphere, influenced by Jewish halakha, and physicians' inherent inclination to do all in their power to prolong life [41] reinforce a strong bias toward preserving life, even when patients express a desire to forgo treatment. In addition, it is shaped by the existential perception of the individual [42].

Additional barriers include the complexity of legal forms, emotional stress on families, and communication difficulties in Israel's multicultural healthcare environment [43]. Moreover, the law excludes certain patient groups, such as those in a persistent vegetative state or with degenerative diseases, raising concerns about equity and access [44].

2.5. Belgium

2.5.1. Historical and Legal Background

Belgium legalized euthanasia in 2002, following years of public and political debate. Prior to this, end-of-life decisions were made in a legal grey zone, often without explicit patient consent. The growing emphasis on patient autonomy and self-determination, supported by ethicists and civil society, laid the groundwork for legislative change [45].

A pivotal moment came in 1998, when the Belgian Advisory Committee on Bioethics—comprising both secular and religious voices—defined euthanasia as "the intentional termination of life by a person other than the person concerned, at the express request of the person concerned" [46]. This definition shaped subsequent political discussions. The 1999 federal elections, which resulted in the first coalition government without the Christian Democratic Party since World War II, created the political conditions necessary for legal reform.

2.5.2. Current Ethical Debates

The 2002 law defines euthanasia as the intentional termination of life by a physician at the explicit request of a patient experiencing unbearable physical or psychological suffering with no prospect of improvement. The law includes strict procedural safeguards and reporting requirements.

Belgium's legislation is among the most permissive globally. In 2014, it became the first country to remove age restrictions for euthanasia, allowing minors to request it under strict conditions, provided they possess the capacity for discernment. This expansion reflects Belgium's commitment to autonomy, although it remains controversial internationally.

2.5.3. Public Debate and Legal Challenges

Since legalization, over 33,000 euthanasia cases have been officially reported. Public debate has continued, particularly around euthanasia for psychiatric conditions, dementia, and minors with a serious medical disease without treatment options. A landmark case in 2020 involved the prosecution of three physicians who performed euthanasia on a woman with severe depression. The case, which ended in acquittal, highlighted tensions around the interpretation and application of the law's criteria.

2.5.4. Ongoing Challenges

Despite its liberal framework, Belgium faces ongoing challenges. Critics have raised concerns about the functioning of the Federal Commission for the Control and Evaluation of Euthanasia and the lack of consensus on extending the law to patients with advanced dementia. Political gridlock in recent years has stalled legislative reform, with advocates calling for expansion and opponents demanding a thorough evaluation of existing practices. The direction of future policy will likely depend on the composition and priorities of the next federal government.

3. Discussion

With all the differences between the five countries that we discussed, there is a need for a choice in relevant frames of understanding and a choice for major important lines of development to understand. Moreover, the analysis presented here seeks to examine the cultural context that shapes end-of-life medical practices in various societies. The various social systems within each society (law, jurisprudence, medical practice, medical codes of ethics, religion, and the political

system) are interconnected in a complexity that cannot be reduced to simpler terms [47]. The interaction between these systems is not a single, so-to-speak "physical" causal relationship.

While the focus on different aspects of social systems is a strength of this analysis, it also reveals a weakness. It is not an empirical sociocultural study. Rather, it resembles a narrative "meta-analysis" that examines the respective legal regulations, public ethical debates, as well as discussions within relevant professional associations and the political sphere of the respective countries.

Given the abundance and complexity of differences between these nations with respect to historical, cultural, political, legal, and medical ethical issues, the following questions regarding the present-day situation are of central importance.

3.1. Understanding Cross-National End-of-Life Frameworks

The comparative analysis of end-of-life laws and practices across Belgium, Germany, Hungary, Israel, and the Netherlands reveals a complex interplay of legal, ethical, cultural, and historical factors. These countries differ not only in their regulatory frameworks—ranging from permissive to restrictive—but also in the societal values and institutional dynamics that shape these frameworks [48].

To make sense of these differences, we must move beyond a static, synchronic comparison and adopt a diachronic perspective that considers how historical developments, cultural shifts, and medical advancements have influenced end-of-life decision-making over time. While each country operates within the same global era of medical progress and human rights discourse, their trajectories reflect distinct national narratives and moral landscapes [49].

3.2. Historical and Cultural Shifts in Death and Dying

Two broad historical trends are essential to understanding contemporary end-of-life debates. First, cultural attitudes toward death have shifted significantly, independent of medical innovation. As Philippe Ariès famously documented in The Hour of Our Death, Western societies have moved from communal, visible experiences of dying to a more medicalized and privatized process [50]. The transfer of dying from the home to the hospital, beginning in the early 20th century, contributed to the "denial of death" and the marginalization of dying as a natural part of life.

Second, the post–World War II era brought unprecedented medical progress, transforming the nature of illness and dying. The shift from acute to chronic and degenerative diseases, combined with life-prolonging technologies, has extended the dying process and introduced new ethical dilemmas. Patients can now be kept alive for prolonged periods, often in states of diminished consciousness or suffering, raising questions about the quality and meaning of life.

These developments have intensified moral tensions at the end of life, particularly regarding the balance between alleviating suffering and preserving life. Central to these tensions is the evolving relationship between physicians and patients.

The traditional model of medical paternalism has increasingly given way to a rights-based framework that emphasizes patient autonomy. However, as our country analyses show, the extent to which this autonomy is recognized and operationalized varies widely.

3.3. Recurring Ethical Frameworks and Historical Continuities

The ethical debates surrounding end-of-life decisions are not new. As early as the 19th century, the introduction of anaesthetics like ether and chloroform sparked public and professional discussions about the morality of alleviating suffering at the end of life. In the UK and Germany, for example, debates following S.D. Williams' 1870 publication on euthanasia continued well into the 20th century, echoing many of the arguments still present today [51]-[53].

These historical debates can be categorized using the ethical typology proposed by Finns and Bacchetta [54]:

- Deontological arguments emphasize duties and prohibitions, such as the sanctity of life and the moral injunction against killing.
- Consequentialist arguments focus on outcomes, such as reducing suffering or respecting autonomy.
- Clinical-pragmatic arguments consider the practical realities of healthcare settings and the lived experiences of patients and providers.

In the 19th century, deontological objections to euthanasia often invoked religious principles, viewing suffering as divinely ordained and morally instructive. These arguments persist today, particularly in countries like Israel and Hungary, where religious and cultural traditions continue to shape legal and medical norms.

3.4. Historical Ethical Arguments and Their Legacy

The ethical debates surrounding euthanasia in the late 19th and early 20th centuries reveal a striking continuity with contemporary discussions. Arguments were often framed within deontological or consequentialist frameworks, with some also reflecting early pragmatic concerns about clinical practice.

Deontological arguments in favor of euthanasia emphasized duties to alleviate suffering and the moral acceptability of voluntary death when life had become burdensome or meaningless. Some even argued that prolonging suffering was unnatural or cruel, especially in light of new medical tools such as chloroform. Conversely, deontological arguments against euthanasia invoked religious imperatives, such as the sanctity of life and the belief that suffering had spiritual value or divine purpose.

Consequentialist objections focus on the societal risks of normalizing euthanasia: weakening resilience, undermining care standards, and shifting moral attitudes toward suffering. These concerns resonate with modern fears about slippery slopes and the potential marginalization of vulnerable populations.

By the early 20th century, particularly in Germany, the tone of debate began to shift. Arguments increasingly emphasized collective interests over individual

rights, with some advocating for the termination of lives deemed "unproductive" or burdensome to society. These ideas merged with eugenic thinking, culminating in the infamous work of Binding and Hoche (1920), whose writings laid the ideological groundwork for the Nazi regime's euthanasia programs targeting people with disabilities and psychiatric conditions.

This historical trauma has shaped German discourse on end-of-life issues, at least until the seventies [8]. After World War II, remarks such as "Discussions about euthanasia, medical research without consent, and genetic interventions in Germany are no longer possible without reference to history" were often heard. For some time, the legacy of these atrocities fostered a deep-seated caution in German medical and legal institutions. Yet, as has already been made clear, that situation has changed since the seventies [8] [9].

3.5. Preliminary Conclusions of This Discussion

Contemporary debates on end-of-life decisions reflect both historical continuities and significant shifts. Six key themes recur across time and jurisdictions: the sanctity of life, the role of suffering, the implications of legalizing euthanasia, concerns about regulatory containment, the medicalization of dying, and the rise of self-determination.

While some arguments—such as the duty to alleviate suffering—persist, others, like autonomy, have emerged more recently. The normative weight of these changes depends on the context from which they arise. As Callinicos notes, any theory of history must account for the singularities of different societies [55]. Rather than treating legal change as linear moral progress or decline, this paper shows how expansions of autonomy, institutional safeguards, professional participation, and protection of vulnerable persons may develop unevenly across national contexts.

4. Conclusions and Final Reflections with Annex

4.1. Final Reflection

Our comparative analysis of end-of-life regulations and debates across five countries underscores the complexity of establishing ethically sound and socially responsive policies. Much work remains to be done, regardless of the direction that future reforms may take.

The preceding analysis reveals significant variation in moral frameworks, legal structures, and practices surrounding end-of-life care, despite broadly similar medical cultures. Across countries, the expansion of options reflects a shared confrontation with medical possibilities and the growing importance of autonomy in increasingly complex end-of-life contexts.

A central question is why laws and regulations differ so markedly. One explanation lies in the moral diversity of modern societies, where individuals claim the right to shape both their lives and deaths—within legal boundaries and with respect for others' rights. Ideally, such diversity would allow human rights to be

secured as well as individuals to choose freely without imposing limitations on others.

Each country's approach reflects its unique cultural and historical context. These differences are shaped by dominant political and moral majorities, raising the question of whether recent political shifts have fostered genuine moral pluralism or have merely replaced one dominant framework with another.

- In the Netherlands and Belgium, legal frameworks support voluntary end-of-life choices, including euthanasia and physician-assisted suicide, grounded in patient rights. In contrast, Israel continues to wrestle with the tension between the sanctity of life and modern principles of autonomy and quality of life.
- Germany shows a special feature: even though, and perhaps despite having a long-standing constitutional right to suicide and assisted suicide, legal frameworks with respect to end-of-life do not exist. Even though there is an unrestricted right to assisted suicide, killing-on-demand remains a criminal act.
- The current challenge, then, is to translate this constitutional right into coherent policy, especially within medical contexts. Physicians (institutionalised into the Medical Council) have rejected assistance with suicide as not being part of medical practice.

Hungary's situation is particularly striking. Post-2010 legislation has curtailed individual autonomy and weakened the role of professional and social institutions in many areas of life. The consequential marginalization of medical organizations has undermined their capacity to contribute to healthcare policy and ethical deliberation—an example of institutional weakening when assessed through the paper's procedural lens of autonomy, professional participation, and public deliberation.

4.2. Annex: Comparative Overview of Legal and Ethical Frameworks

A review of five countries—Hungary, Germany, the Netherlands, Israel, and Belgium—reveals diverse legal landscapes and ethical orientations.

4.2.1. Introduction to Annex: Comparative Overview of Legal and Ethical Frameworks

Significant legislative or judicial developments occurred in:

- The Netherlands and Belgium (2000-2002);
- Israel (2005);
- Hungary (2010);
- Germany (2015, 2020).

These dates mark the relatively recent formalization of end-of-life medical practices, with Germany currently experiencing notable legal and ethical turbulence.

4.2.2. Legal Status of Euthanasia and Assisted Suicide

- Hungary: Euthanasia is prohibited; suicide is decriminalized, but assisted suicide remains a criminal offense, reflecting strong state influence.

- Germany: Euthanasia is illegal. Officially and legally, assistance with suicide is unrestricted, even if offered by organizations with this goal, foreign or German. There is no requirement for the existence of any disease at all. The only requirement is that the person who wants to commit suicide is free from any constraints. The medical profession remains opposed.
- Netherlands: both euthanasia and assisted suicide are legal under the strict condition of a physician being the actor, with conditions of independent medical consultation before the act, and with the legal duty to report and seek justification of the actions within the law before a Euthanasia Review Committee afterwards.
- Israel: both euthanasia and assisted suicide are criminalized, prompting some citizens to seek assisted death abroad.
- Belgium: euthanasia is legal under conditions of unbearable suffering due to incurable illness. Palliative sedation is also practiced, often without an explicit patient request.

4.2.3. Autonomy and Procedural Barriers

- Hungary: patients may refuse life-sustaining treatment only under strict conditions, including committee approval.
- Netherlands and Belgium: autonomy is central, with patients playing a convincing role in end-of-life decisions, based on the conditions of the Euthanasia Law.
- Israel: a Patient Rights Act enacted in 1996 ensures the autonomy of patients regarding the care they receive. However, there are exceptions regarding emergency situations and patients refusing care (clauses 15(2) and (3)).

According to the latter and more specific Dying Patient Act 2005, to be able to avoid providing medical treatment, the doctor requires the explicit expression of a patient's will if the patient can provide his consent, as well as explicit instructions on courses of action in situations where the patient is not capable of providing his or her consent due to his medical condition. The medical condition of a terminally ill patient, his will, and the extent of his suffering are the exclusive considerations in determining a patient's end-of-life care. A person is entitled to prepare instructions in advance for a situation in the future when he or she will be regarded as incapacitated to make his own decisions.

That said, it is prohibited to conduct active euthanasia and assisted suicide, as well as to withdraw continued treatment if it may cause patients' death.

- Germany: A patient rights law has existed since 2013. It ensures patient self-determination and participation. Living wills to refuse medical care are honoured. Foregoing medical treatment at the end of life or at patients' request is routine in medical practice. Palliative care services are highly developed, and costs are covered by public insurance. Patients' wishes such as voluntary refusal of nutrition and hydration are respected. Palliative sedation is performed if indicated (to control symptoms) and if it is in line with patients' preferences.
- Netherlands: Based on a law (Civil Law, book 7), self-determination is to be

respected and honored in all medical decisions. Based on adequate information, refusal must be respected even when medical treatments are still available.

- Belgium: In addition to granting patient autonomy as a core value of today's health care in Belgium, any person capable of expressing his or her will may draw up an advance declaration of euthanasia (living will) so that, should he or she become incapable of communicating their wishes, a doctor may carry out euthanasia in accordance with the conditions and procedures laid down by law.

4.2.4. Suffering and the Challenge of Containment

The intention to alleviate suffering is often so self-evident that it remains implicit in national descriptions. Generally, the duty to alleviate suffering at the end of life implies the possibility of life-shortening interventions, such as what still is called passive euthanasia, even though there is wide agreement that this term is no longer of ethical significance. International bodies reject the notion [56]. Historical debates from 1870 through the 1920s–30s also show that suffering was a foundational argument, appearing 13 times, in the list of arguments and regardless of the stance taken.

In the Netherlands, early court cases established that "unbearable suffering" should not be restricted to a terminal illness. Chronic conditions with a longer life expectancy may still qualify as a fulfilled condition for the legal assessment. Courts later extended this to include the mental suffering of psychiatric and dementia patients, also patients suffering through cumulative ailments of old age. This remains in contrast with all U.S. physician-assisted suicide laws, where the legal condition for allowance is limited to a life expectancy of six months or less.

In Germany, both historical and some stakeholders in the current debates reflect a strong fear of losing control over euthanasia practices, often referred to as Dammbruch (dam burst). This concern is not explicitly present in reports from other countries.

In Israel, the Dying Patient Act allows an accepted balance to prevent suffering by regulating directives by which it is possible to set up instructions in advance on accepting or declining life-prolonging medical therapy. The law is intended to regulate the terminally ill patient's medical treatment, while striking a balance between respecting the sanctity of life and the autonomy of the patient, and recognizing the importance of the quality of life. The law is based on values that lie at the foundations of the State of Israel in the domains of morals, ethics, and religion, and have won broad support from most sectors.

4.2.5. The Role of the Medical Profession

- Hungary: The medical profession has been largely absent from public debate, with its influence diminished under the current government.
- Germany: The medical profession has opposed both euthanasia and assisted suicide by physicians. Foregoing life-sustaining treatment is routine if it will

only prolong dying or at a patient's request, irrespective of the stage of a disease. In conclusion, end-of-life decisions are shaped by medical practice, court rulings, and most prominently by professional guidelines, but not codified in a specific law.

- Netherlands: The medical profession has actively supported euthanasia and assisted suicide for physicians since the 1980s, working closely with legal and political institutions. Physicians are central to the legal assessment process via Euthanasia Evaluation Committees and national reviews conducted every five years.
- Israel: Implementation of the Dying Patient Act faces procedural and educational barriers. Physicians often lack time and incentives for end-of-life discussions, which are crucial in Israel's multicultural and ideologically diverse context. Many professionals are inclined to prolong life, influenced by Jewish halakhic ethics. Bureaucratic hurdles and limited public engagement with advance directives further hinder the Act's effectiveness.
- Belgium: The professional organization has played a limited moral role in shaping euthanasia policy, focusing more on institutional maintenance than on ethical leadership.

4.2.6. The Role of Politics in Shaping End-of-Life Legislation

- Hungary: The 2010 elections marked a turning point in Hungarian policy, centralizing power and curtailing individual autonomy. This shift also weakened social institutions and professional organizations, obstructing bottom-up initiatives related to death and dying.
- Germany: The 2015 law aimed to restrict the long-standing but not generally experienced right to assisted suicide by prohibiting assistance from people or organizations that offer it in a businesslike manner. The idea behind this was (based on conclusions from empirical data) that a regular offer of assistance with suicide (a default offer from whatever person or organization, including physicians) would lead to an excessive increase in the number of suicides. Nota bene: Exceptions were cases with existential participation, e.g., assistance with suicide by relatives. This restriction of the formally not completely forbidden assistance with suicide was overturned in 2020, and the current political challenge is to respond to the High Court's mandate to develop legislation that defines the right to assisted suicide, including its application in medical settings—general practice, hospitals, and other institutions.
- Netherlands: A public movement advocates for expanding euthanasia and assisted suicide beyond medical contexts to include individuals with a "completed life", through a procedure solely based on patient autonomy without medical assessment. Despite its introduction in 2020, the proposal has some public support but lacks parliamentary support and remains stalled.
- Israel: The prohibition of medical aid in dying has been widely debated over the past two decades. Many Israelis circumvent the ban by traveling abroad, as illustrated by Nobel laureate Daniel Kahneman's decision in 2024 to end his

life in Switzerland. However, access to medical aid in dying remains unequal, raising ethical dilemmas for medical teams. A recent court ruling permitting life-saving amputation against the will of a competent young patient sparked intense bioethical debate. On the other hand, a more recent court ruling granting an ALS patient the right to die and, moreover, to donate his organs to others immediately afterwards indicates a significant step towards protecting the right to die with dignity while encouraging altruism. In this context, the future of the broader right to die with dignity remains uncertain, and the future will tell.

- Belgium: Political debate is polarized between progressives advocating for the extension of euthanasia to patients with dementia and conservatives calling for an evaluation of the current law before any expansion. Given the composition of recent coalitions—ethically mixed—the debate remains at an impasse, governed by a tacit agreement to avoid legislative initiatives.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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