

# **Sociological and Philosophical Study of the Netherlands and the United States Pertaining to the Right to Die**

by

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Spring 2019

A thesis  
submitted in partial fulfillment  
of the requirements  
for a baccalaureate degree  
in Sociology and Philosophy  
*in cursu honorum*

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Submitted to  
the Honors Program, Saint Peter's University

Monday, March 25<sup>th</sup>, 2019

### **Acknowledgements**

First, I want to thank my grandmother and my uncle for giving me the experiences, emotions, and passion to write this thesis. Without them I would not be where I am and although their stories are sad, there are important lessons that lie within them. My grandmother was the purest and strongest women I have ever met, and this paper is dedicated to her. Life without her still does not feel the same. They are deeply missed.

Mom and Dad, thank you for always pushing and supporting me throughout my education. I have never met such supportive parents and I am forever grateful for you guys. I will never be able to thank you enough. I would not be here without you. Everything I do is to make you proud and I love you.

To my boyfriend Andrew and best friend Becca, thank you for being my emotional anchors throughout college and being there for me through all these events. I do not know where I would be without either of you.

Lastly to my advisor, in thesis and in life, Dr. David Surrey. You were the first person at Saint Peter's to believe in me and you are the entire reason I am presenting this thesis. You have continuously pushed me and raised the expectations for me. I will never be able to thank you enough.

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## **I. Introduction**

In this thesis I will contrast the fluid cultural, political, religious, legal, and ethical perspectives within and between the United States and the Netherlands on self-determination and the right to assisted suicide. This topic is under-researched considering the vast number of individuals joining the geriatric community as the baby boomer generation gets older and the medical advances that are capable of prolonging lives for all ages regardless of the quality of these lives. This paper compares real life cases of assisted suicide and refusal of treatment as well as the functioning of euthanasia in the Netherlands and the United States. The reasons for picking this topic are both academic and personal.

In the Fall of 2015, my uncle who suffered from multiple chronic conditions, was readmitted to the hospital, his second home. He fought through everything thrown at him: diabetes; heart attacks, and strokes. He got tired of fighting and he wanted to die with his dignity still intact. He did not see a life of quality in being repeatedly in and out of the hospital. He chose to refuse a feeding tube after being told he was also suffering from dysphagia and would need one to survive. He did not want to live a life where food was being fed to him through a tube. He was tired of fighting as that is all he did his entire life. My uncle had a stroke a couple years before this occurred and was living with my grandmother, who really was the family caretaker. He expressed his views on refusing a feeding tube to the family, but he was not the one who formally made his medical decisions. He was too heavily sedated toward the end to make his own decisions.

My grandmother (my nan) obtained power of attorney toward the end of his life because he was not competent or functioning enough to make his own medical decisions. He was transferred to hospice due to the refusal of a feeding tube. This is where he died. This experience

opened my eyes to patient rights and the idea that an individual has a right to refuse certain medical treatments. When my uncle did this, I never knew it was a form of assisted suicide.

In the Summer of 2018, my grandmother's kidneys stopped working. She had never been sick, never experienced a lack of mobility or lacked quality of life. However, she was now told she needed to sit attached to a machine three hours a day three days a week. For my grandmother we all knew this was not going to be an easy task. She was eighty-five years old and never even experienced needing a walker or even glasses She was the strongest women anyone in our family ever knew. She was a social worker who was always used to helping others like she did with our family. She was not used to needing help from anyone. She did dialysis for almost five months. We all knew dialysis was not going to be a permanent fix, but my aunt told her to persevere until after I graduated from college in May 2019, and she agreed.

In early November last year, after leaving dialysis, my grandmother fell. She broke her hip and shoulder. My aunt had multiple conversations with my grandmother about if she wanted to continue dialysis. My grandmother was very clear that she did not want to continue and it was her time. A woman who never experienced a lack of mobility and was rarely sick would obviously have an extremely hard time with life in a hospital attached to machines. She felt like her independence was stripped of her and she was someone who needed to die with her dignity. She continued refusing dialysis and she knew when her time was coming. She even claimed to have seen my cousin who passed four years before coming to get her.

Both stories have sparked my interest in patient rights and the refusal of treatment. One step further than that, physician assisted suicide is something I feel very strongly about after watching my uncle struggle. That is why I picked this topic and that is what I want to pursue in life. I intend to be a medical social worker and help with patient rights and medical decisions. I

finally feel like I have learned my place in the world and want to follow my nan's footsteps in being a social worker. She took care of me when my parents struggled, and she truly formed who I am. This paper is dedicated to her.

This thesis is a hybrid between sociology and philosophy. It will cover sociological terms such as culture, theories on social trends, traditions, and accepted ideas of a society which are learned and always changing. Religion is one of these social institutions which falls under sociology. The paper will also discuss philosophical aspects of assisted suicide such as the ethics, which is the acceptance or condemning of a certain practice which can be analyzed under a multitude of theories that are defined within the thesis. The fallacy of a slippery slope defined above is also a philosophical teaching.

In this paper I will largely focus on the United States in comparison and contrast to the Netherlands. I picked the latter because it has comparable technology but as a nation has arrived at very different decisions in this area. I will also examine various philosophical and social theories when appropriate. There are logical reasons why the policies of the United States cannot be the same as the Netherlands. The Netherlands and the United States are two drastically different countries and some of the policies there would never work here.

Throughout this thesis I will discuss both active and passive euthanasia. Active euthanasia is only legal in the Netherlands. Active euthanasia is when a physician intentionally, with the patient's agreement, ends an individual's life making the doctor the direct cause. Passive euthanasia is when a physician lets the patients die from their diseases due to withholding treatment such as a respirator or feeding tube. The latter process occurs in the Netherlands and the United States. These processes can be performed voluntary which means directly requested and wanted by the patient. They also can be involuntary which would mean the individual did

not want to go through with it and the procedure is done against their will. The last form is nonvoluntary which means the individual never specified their preferences. They may be in a vegetative state or slip into a semi-conscious state where they were never able to express their interests. This is typically when power of attorney would kick in and typically kin would make this decision on the patient's behalf.

In the Netherlands involuntary euthanasia and nonvoluntary ending of a life are important to understand because due to these forms there are individuals who argue that a slippery slope exists. A slippery slope is a fallacy that once one thing is accepted a line is not drawn and a constant chain of events occurs until you have undesired effects. What this means for this paper is once a nation legalizes euthanasia in the accepted manners such as voluntary active euthanasia it is difficult to draw a line and undesired results such as involuntary euthanasia may occur. There argue that this is occurring in the Netherlands and that too many individuals are being euthanized involuntarily. There are also arguments in the other direction that the criteria for euthanasia is too strict and doctors are just trying to speed up the process with actions including falsifying death certificates (PatientsrightsCouncil.org, 2019).

Individuals in the Netherlands not only have the right to euthanasia, but they also have the right to universal healthcare. Over 98% of the population has at minimum basic healthcare coverage. Their basic healthcare is priced based on salary, so it is affordable. They receive all basic healthcare procedures including general doctor, hospital, and pharmacy needs (Watson, 2016). This allows over 98% of the population to have basic coverage including the right to self-determination to end their lives. Self-determination means that they get to be the ones making the decision in how/if they die. Most individuals do not want to suffer on their way to death, which is why individuals have the right to be autonomous at the end of life and decide their own fate.

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In the United States as will be discussed below, Assisted Suicide is legal in seven states and one district in the United States. There are strict conditions for it and it is something that could be implemented in every state. Multiple states are going to be reviewing the Death with Dignity Act this year including New Jersey. This thesis will not only describe what the systems of assisted suicide in these two countries look like now, but what they could look like using cultural, ethical, political, and religious perspectives in both countries.

## II. Location Matters

An average of 6,300 in the world people die each hour (Anon, 2019). How many of these people were able to control how to end of their lives? Far fewer than I anticipated when I began this research. However, peoples' chances, opportunities and even consideration of self-determination significantly depends on where they are located. With the advancements in medicine individuals can be kept alive for a strenuously long time, sometimes suffering from a terminal disease. In some areas of the world people have the autonomy to choose when or if these diseases will control their ultimate biological time clock. Culture, religion, economic class, technology, geography and ethnicity can affect this time clock. Specifically, for this research differences between the Netherlands and the United States that affect end of life decisions along these various dimensions will be explored.

In some parts of the world people can make the decision to let a physician prescribe medicine to end the patient's life. In other places the most control people have is to refuse treatment and let the disease prosper until it succeeds. In the Netherlands a doctor legally can end one's life upon request to avoid pain and suffering from terminal diseases. In some parts of the

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United States, the most autonomy a person has is to refuse treatment. As noted above seven states and the District of Columbia consider physician assisted suicide legal (Dignity, 2019).

The Netherlands has a vastly different culture than the United States. Social tolerance is something the Netherlands prides itself on which is ironic since diversity wise it is much less than the United States. The Netherlands was the first country to legalize same sex marriage. Soft drug use, prostitution, and euthanasia are all legal in the Netherlands. The economy in the Netherlands is also impressive considering the smaller size. (Encyclopedia Britannica, 2019). All these cultural aspects have an effect on end-of-life issues because they all largely affect the quality of life an individual experience before they run into a medical decision.

The Netherlands has not only a different healthcare system, but its urbanization and diversity rates are different than those of the United States. The Netherlands is traditionally a very individualistic country, but their healthcare system is a major exception. (Watson, 2016). According to the “Euro Health Consumer Index”, which scores the effectiveness and satisfaction in a healthcare system, the Netherlands scored a 916 out of 1000 (Watson, 2016). This index scores on six categories; patient rights and information, accessibility, outcomes, range and reach of services, prevention, and pharmaceuticals. This means that when each country is rated based on the patient satisfaction experienced. The Netherlands has a universal health mandate where everyone has access to healthcare. It is perceived as a human right unlike in the United States.

This mandate for universal health insurance means individuals in the Netherlands are required to have at least basic health insurance, which is regulated by the government. This insurance covers healthcare practices such as a visit to the general practitioner, hospital and, pharmacy (Vergelijken, 2019). Additional insurance does cost more, and individuals can purchase it. A common misconception people make about insurance in the Netherlands is that it

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is free. It is income based making it affordable, not free (Commonwealthfund.org, 2019). Most individuals also receive government supplements.

While many view having universal healthcare as positive, it has drawbacks as well. This universal mandate for healthcare in the Netherlands has caused the competition in the healthcare market to diminish because the government is now regulating it. Four insurance groups in the Netherlands hold 88% of the total market share (Altenburg-van den Broek and Lynch, 2013).

This lack of competition reduces the quality of the healthcare because there are fewer incentives to convince the public to make choices.

The United States, in the last administration, was approaching many of the aspects of the universal healthcare system of the Netherlands. The Affordable Care Act (Obamacare) was a similar concept to a universal mandate for healthcare. Obamacare was created in order to encourage everyone to have some form of basic healthcare, like the Netherlands (Obamacare Facts, 2019). In the Netherlands less than 1.5% of the population does not have at least basic healthcare insurance (Commonwealthfund.org, 2019). This is what Obamacare was designed to achieve. It also aimed to make healthcare more affordable for individuals. However, there are arguments that it has made insurance more unaffordable for individuals of the middle class as taxes have to increase to insure people who cannot afford to insure themselves (Obamacare Facts, 2019). The current administration has stalled the process of further enacting Obamacare and many of the strengths have been removed (Npr.org, 2019).

A major difference between the United States and the Netherlands is that the United States has far more diversity. According to the “World Population Review”, the Netherlands has approximately 17,000,000 people. (Worldpopulationreview.com, 2019). Approximately 80% identify as Dutch. Of the remaining 20%, five percent are European, and the remaining 15% are

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from other parts of the country (Worldpopulationreview.com, 2019). It is an overwhelmingly white country that has limited amounts of diverse views and beliefs.

The GINI coefficient (BBC News, 2019) is commonly used to evaluate the income gap between the rich and the poor in a country. A zero on this scale means complete equality while a one means complete inequality. Out of thirty-eight countries on this scale the Netherlands is ranked twelfth with a score of .28. The United States comes in 33rd place with a .39. (Ceicdata.com, 2019). This means that the United States compared to other advanced countries has a large amount of inequality. In fact, the gap between rich and poor in the U.S. is growing rapidly. The United States has this amount of inequality compared to the Netherlands, but it should be acknowledged that the United States also has significantly more diversity.

As far as religion in the Netherlands 50% of the country has no religious affiliation; 15% affiliate Protestant, and 23% Roman. The remaining affiliate themselves with Islam or other religions such as Buddhist, Hindu, or Jewish (Indexmundi.com, 2019). A large plurality of the Dutch population therefore agrees to having no religious affiliation. This is a large cohesive group when compared to the multitude of groups in the United States when discussing religion. Diversity and population are factors that contribute to the ability of the Netherlands to make cohesive policy decisions (Indexmundi.com, 2019).

The United States on the other hand has a population of about 328,440,708 according to the 2018 World Population Review (Worldpopulationreview.com, 2019). The United States has a much different demographic profile in terms of religion. This also could explain the vastly different outlook that is taken on end of life decisions. According to the Pew Research Center, 70% of the United States affiliates themselves with a Christian denomination; the most popular ones being Evangelical, Protestant and Catholic in no specific order. Six percent associate with

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non-Christian faiths such as Jewish, Muslim, Buddhist, or Hindu. Only 22% do not affiliate themselves with a religion. (Pew Research Center's Religion & Public Life Project, 2019),

A study by Stefan Kasian, done in 1976, showed that religious and ethnic background in the United States had the largest bearing on an individual's beliefs with end of life decisions. In his study he took 36 different focus groups where diverse individuals shared their beliefs on the process of death and dying. He found that Jewish individuals were most likely to support assisted suicide. On the other hand, Christians are described as individuals who always try to "care, not kill". Muslims are said to be the group least likely to trust the healthcare system. The same can be said for African Americans regardless of their religion, Native Americans, and Latin Americans, according to Kasian. He says that individuals who were/are marginalized are less likely to trust a system that reflects the power structure that marginalized them. (Drstefanjkasian.weebly.com, 2019)

### III. Self-Determination

Even if the United States wanted to continue to implement more healthcare reform pertaining to end of life decisions in a similar manner to the Netherlands, it is too large, diverse, and varied to derive at a national consensus on self-determination. Furthermore, in general healthcare in the United States also does not permit all individuals to have long standing relationships with their doctors like they do in the Netherlands (PatientsrightsCouncil.org, 2019). These variations provide a major explanation as to why euthanasia could not work the same in the United States as it does in the Netherlands. Diversity along cultural, political, urban, religious, economic and ethical perspectives prevent arriving at a universal consensus for laws for self-termination in the United States. For example, perhaps only someone with higher coverage might be able to take advantage of the right to end their life if suffering. Some states

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allow voluntary passive euthanasia, but that is as far as this popular debate has gone. Some religion permits it, while others condemn it.

The Netherlands has fewer blurred lines when it comes to this debate of the sanctity and quality of life. In the Netherlands most individuals who have taken advantage of the right to die have used it as a last resort. For example, it is common there for individuals with certain types of cancer to use physician assisted suicide, according to the Telegraph (Waterfield, 2019). It also is sometimes used for individuals that are not terminally ill, but permanently suffering.

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A counterargument many produce in the Netherlands or elsewhere against this is that for individuals who are suffering and slowly dying there is palliative and hospice care. A response to that would be would you would rather be heavily sedated in hospice making a family wait rather than listen to the patient. Individuals who are against active euthanasia and believe in hospice believe the right to die is a sentimental argument that only takes emotions into account. However, when you are talking about individuals and their life, what else is there to consider? Therefore, it is important to look at the statistics involved with the right to die.

#### **IV. Slippery Slope Fallacy**

To defend against the fallacy of a slippery slope it should be acknowledged that in areas such as the Netherlands and Belgium, where the practice is also legal, it is still a long complex process. The law states that four major prerequisites; you must be an adult, you must be conscious and competent, you must be in a condition of constant suffering, and the only option one has for treatment must be futile meaning no possible recovery (Government.nl, 2019). This last condition is up to the physician to decide.

The decision and process are just as complex to the physician as to the patient. After ideally going through the requirements, the physician must inform the patients of their condition

and any alternatives to end of life decisions. (Knmg.nl, 2019). The physician must also address and get multiple physicians to agree with their decision. After euthanasia the doctor must then report the case to a review committee to ensure that protocol was followed. Therefore, although the idea of a slippery slope is introduced the complexity of this process goes disproves this. Research over time has shown no support of the slippery slope argument (Benatar, 2011). The Netherlands on the other hand has had many people argue that it is present there due to their high rates of euthanasia. (Second-thoughts.org, 2019)

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A study referred to as the Rummelink Report was done in 1991 and again in 1995 by the government of the Netherlands. While dated, this study is still very valuable. It analyzed the rates of euthanasia that were present and if euthanasia that was performed followed regulations. The report found that in 1990, 2,300 people were euthanized upon request falling under active and voluntary euthanasia. Four hundred individuals were given the means to assisted suicide. 1,040 patients were actively euthanized either without the doctor having knowledge of their wishes or consent. 14% of these people were fully competent while 72% never gave an indication of wanting their lives terminated. For the other slim eight percent, the doctors performed euthanasia even when they believed alternative treatments were possible. There were 8,100 patients were given overdoses of pain medication to hasten their death. For 61% of these cases involuntary. There were 11,840 individuals who had their lives intentionally ended by physicians, which accounts for almost 10% of the Netherlands death toll. (Patientsrightscouncil.org, 2019)

The Rummelink Report from 1991 does show significant amounts of deaths that were involuntary. However, it is important to note that the Rummelink Report did not discriminate between involuntary and nonvoluntary (Bioethics.org.au, 2019). In involuntary cases the individual openly expresses their choice against assisted suicide or euthanasia. In nonvoluntary

the individual's requests and wants are not disclosed. The individual may have never disclosed their wants before slipping into an unconscious state.

A second Rummelink Report was done in 1995 to see if there was any improvement in the large number of involuntary euthanasia. (Bioethics.org.au, 2019) A large shift was found when comparing the first Rummelink Report. The first report originally found only 18% of active voluntary cases of assisted suicide were reported. In 1995 it was found that 41% of voluntary active cases were reported. While every case that is taken as far as voluntary active euthanasia should be reported an increase from 18% to 41% is a noticeably large improvement. (Bioethics.org.au, 2019) There was also a large change in the number of competent patients that were being euthanized. In 1995 the number was 37% as opposed to 21% in the first report. The report done in 1995 did acknowledge that even non-voluntary euthanasia was referred to as involuntary. Non-voluntary according to the study accorded for four times as much as physician assisted suicide. Because of the frequency of non-voluntary active euthanasia in the Netherlands individuals have now started to carry cards on them that mean in the case of unconsciousness or incompetency the individual does not wish to be euthanized (Euthanasia.com, 2019). If an individual is euthanized under involuntary means, this means the physician is ending their life against their will.

In the United States individuals can file a Do Not Resuscitate (DNR), which puts on file that they do not wish to be resuscitated if it becomes necessary to save their life. Both my uncle and my grandmother filed these relatively early in their hospital visits. Cardiopulmonary resuscitation (CPR) is the manual application of chest compressions and ventilations to patients in cardiac arrest done to maintain viability. This can be an aggressive and dangerous procedure

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especially for individuals on the frail side. It can result in broken ribs and even brain injuries (Select, 2019). This is one example of refusing treatment in the United States.

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When an individual in the U.S. supports of euthanasia, they are often taking on a perspective that puts more emphasis on quality of life. When the process of euthanasia is legally permitted one must decide the regulations that will coincide with it. For example, who would be permitted to make the decision to end their own life? The de jure and de facto of the legalization of euthanasia in the Netherlands are quite different. Abuse is a norm in the Netherlands when it comes to euthanasia, but many argue this abuse is in order to help the patient. Physicians are expected to self-report and have the liberty to interpret the law. The definition of euthanasia is not even necessarily clear in the Netherlands. The act of non-voluntary euthanasia is seen as a form of palliative care in the Netherlands as it puts individuals out of suffering (UCV et al., 2019). Because of this transition one can argue the possibility of a slippery slope occurring.

John Keown widely discusses this slippery slope in his article in the “*Notre Dame Journal of Law, Public Policy, and Ethics*” (Scholarship.law.nd.edu, 2019). The slippery slope argument against euthanasia says that if we accept voluntary euthanasia then we accept non voluntary euthanasia. If a doctor is permitted to decide whether an individual should be able to die or not, he is ultimately making a judgement call on the worthiness of their life. If non voluntary euthanasia was becoming more common in the Netherlands this might be an example of euthanasia becoming more common. According to Keown one of the most important guidelines broken in the Netherlands is the fact that physicians falsify death certificates (Patientsrightscouncil.org, 2019). When this is done a physician will commonly say that an individual died of natural causes when they died due to euthanasia. This causes a gap in our

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understanding of if euthanasia is voluntary or not. It also causes a gap in our knowledge of a slippery slope since we do not know the circumstances (Scholarship.law.nd.edu, 2019).

Some physicians have defended the slippery slope saying that the guidelines in the Netherlands for euthanasia are too strict. However, this is argued against by many individuals who say no legal criteria was ever given regarding the subject (Patientsrightscouncil.org, 2019). The Federal Court never defined the criteria and the lower courts who attempted to created concurring lists of guidelines (Worldrtd.net, 2019). Some of the terms used in these laws are also subjective. For example, “unbearable pain” can be interpreted in a multitude of ways. The physician is given the right to interpret the law. To one individual something may be unbearable while a different person might not agree. When analyzing the number of euthanasia cases that occur in the Netherlands (2,700 in 1990) the Medical Commission argues this is not enough to say euthanasia occurs excessively. 6,585 individuals in 2017 chose to end their lives with euthanasia. suffering from cancer, heart and artery disease or diseases of the nervous system (DutchNews.nl, 2019).

However, to see if a slippery slope is occurring one would need to see how many times nonvoluntary euthanasia is occurring ( Patientsrightscouncil.org, 2019). It is hard to tell if this number is accurate though due to activities including falsifying of death certificates. Regarding the falsifying of death certificates, physicians are said to do this in the Netherlands to avoid scrutiny from law enforcement and excess paperwork. What the physician does is say that the patient died of natural causes, when they died through euthanasia.

The definitions between voluntary, involuntary, and nonvoluntary are subjective in the Dutch Right to Die Act (Worldrtd.net, 2019). For example, what if an individual is fully conscious and wants to be euthanized but then slips into a semi-conscious state before the

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procedure. Should the physician continue with the procedure or should they wait? The law set by most lower states says if the patient is ill and suffering the doctor may proceed with the semi-conscious state, they are in. If guidelines are followed correctly after a physician euthanizes an individual, they must report the procedure to a review committee, due to the intensity and irreversible effects of the procedure. However, these guidelines are provided but not followed in most cases. There have been cases where physicians have assisted elderly individuals with suicide strictly because they found their life to be meaningless. The physicians were only given token penalties in these cases. Therefore, although these circumstances are given studies find they are rarely followed.

The Dutch do not actually recognize voluntary, involuntary, and nonvoluntary which are subjective terms to begin with. The Netherlands puts down stipulations on suicide, but these stipulations are up to the doctor to interpret and self-reporting has made the data confusing because not all of it is accurate. Currently about 10,000 people in the Netherlands carry anti-euthanasia cards which are a similar concept to the DNR forms that individuals have in the United States (Wvendoflife.org, 2019). The cards mean that the individual never wants any treatment withheld in the opinion of bettering their quality of life. Diametrically different, they also have another card in the Netherlands. Individuals carry DNR medallions which have the same purpose as the forms individuals in the United States have. The medallion means in the case of a medical emergency the individual does not wish to be resuscitated.

One of the major determinants for whether euthanasia is a social norm are the terms and conditions that people are euthanized under. 400 hundred individuals were euthanized without requesting it. It is not distinguished as to how many of these individuals were nonvoluntary and how many were involuntary, just that they did not consent to PAS. The study also said that one

individual a week was being euthanized for mental illness. One in three Dutch doctors are openly willing to euthanize the mentally ill, including autistic individuals. This seems to be an extension of the dispute of giving birth to babies who are going to be born mentally ill, which is a debate in all countries that have the technology for prenatal screening. Guidelines in the Netherlands say that euthanasia should not be used to help people who are mentally ill or suicidal due to mental instabilities (Anon, 2019). However, from what we can see in the statistics individuals with these diseases are reaching out to physicians for help in dying.

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There are also individuals may suffer from dementia, sexual abuse, or even drug addiction. Some of these individuals are requesting euthanasia. Individuals should consider whether these diseases are any less severe than an individual living with cancer. It depends on the conditions people are living in and how happy their life is. These conditions will still hinder an individual's quality of life. There are several reasons though that can explain why there has been a steady increase in the number of physicians assisted suicides in these areas. But here the theory of a slippery slope cannot be eliminated (Worldrtd.net, 2019).

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The main differences between the euthanasia that exists in the Netherlands and the physician assisted suicide that exists in the United States is how the life of the individual is ultimately ends and who ends it. The concept and defense are always mercy. In the Netherlands the physician is the determinant of death and their guidelines are up to their own interpretation. In the United States the patient must end their own life. That person must be the one picking up and taking the prescription that ends their life

## V. Uneven Laws

The debate over self-determination intensifies as the baby boomer generation grows older in a world of life-prolonging medical advances. Therefore, now is the prime time to analyze laws on end of life decisions.

The United States healthcare programs do not give everyone equal treatment. Unlike the Netherlands there is no right to healthcare. There is a discrepancy in who would be eligible for self-termination based on insurance. However, there is physician assisted suicide in some U.S. states which creates prescriptions for patients to take themselves to pass with dignity (Dignity, 2019). The insurance policies and companies in the United States do acknowledge this process and, in some cases, have pushed for it. Some insurance companies have advocated for this method over lifesaving procedures due to cost effectiveness (Churchmilitant.com, 2019). One might argue this is the sign of a slippery slope developing. However, insurance companies trying to save money is not anything new.

There are two sides to that argument. Currently, Oregon, Washington, Hawaii, the District of Columbia, California, Colorado, and Vermont have proceedings for Physician Assisted Suicide (PAS). The proceedings involve a series of requests individuals must make in order to get the prescription that they voluntarily take to end their life. The patients are diagnosed by the doctor with a chronic condition that hinders their quality of lives. They must have a terminal illness expected to lead to death in the next six months. There are of course stipulations where an individual must be eighteen, mentally competent, a resident in these states, and be diagnosed with a terminal disease (Dignity, 2019).

If a case of euthanasia is considered active, then that means an action was done by a physician intentionally to end an individual's life. In passive euthanasia an individual is to an

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extent only refusing or stopping treatment. This means that the disease is still the ultimate determinant. Both active and passive euthanasia can be considered voluntary or involuntary. If euthanasia is voluntary the individual has consented to the actions being done. If it is involuntary this typically means that the individual either refused euthanasia or in most cases their wishes are unknown due to things like comatose. Some individuals also give a separate definition for nonvoluntary which means the patient's wishes were not given due to things like competency.

Oregon was the first state to legalize physician assisted suicide. They approved it in 1994 and put it into action in 1997 (Government.nl, 2019). In retrospect, Oregon was far ahead of the times when discussing PAS. It was the sole state to have assisted suicide until 2008 when Washington legalized and enacted the same law. Each state that followed has different stipulations for the act although there are many commonalities as well. The first step to beginning the process is to place an oral request. Every state has a stipulation that an individual must have an attending physician and one to confirm the proceedings.

In Hawaii individuals must get a psychological screening if a doctor disagrees with the proceedings. In Hawaii a mental health screening is necessary after this request regardless of physician approval. While in some states after this first initial oral request an individual must wait 15 days before making a second oral request, in Hawaii the wait is 20 days.

A written request must be submitted at some point after the first oral request. Every area besides the District of Columbia requires the individual to get two physicians reviewing the request to approve and submit their paperwork. In D.C. individuals must submit their written request after the first oral request and before the second oral request. The stipulations for this request include two witnesses, one of these not being the physician or a family member. In California and Colorado there is no second waiting period; once these requirements are met the

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prescription can be written. This is not true in the other states. A physician has to wait 48 hours after the written request to write the prescription. Individuals may revoke their requests at any point during the process. The individual going through with assisted suicide is the one who ultimately fills and takes the medication (Dignity, 2019).

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Many organizations in the United States recognize the different forms of euthanasia and each reflects upon and accepts them differently. However, no bureaucracy in the United States accepts active euthanasia where the doctor directly causes the end of someone's life (Lee, 2019). Under federal law no form of this is permitted, mercy killing or not. Nonetheless, under federal laws one has the right to refuse treatment in the United States, one just does not have the right to die by a physician's doing (Life, 2019). Therefore, the distinction between passive and active euthanasia are important distinctions.

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The refusal of treatment is permitted in most cases, but the patient must determine if the treatment being withheld is extraordinary or ordinary treatment. Ordinary treatment is common medicine that is used to help a patient and does not have a great burden on the individual (Life, 2019). It does not raise complications for the patient, and it is a common medical procedure in most cases. There can be extraordinary treatment attempts to make a person comfortable but in a lot of cases is burdensome on them. This form of treatment ultimately could prolong the life of an individual, which prolongs the disease as well. If the treatment is one that is burdensome or painful an individual does have the right to refuse this treatment in most cases.

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## VI. Cultural Variations

Another aspect of the United States that contrasts the culture of the Netherlands is fast paced urbanization. As of 2010, 80% of population of the United States was living in an

urbanized area. This factors into many of the reasons why the United States functions much differently than the Netherlands. While 91% of the Netherlands lives in a city (Worldometers.info, 2019), its cities are drastically less populated than U.S. cities as the Netherlands is closest in size comparison to the state of Maryland. (Decision Science News, 2019)

Comment [MOU35]: Is this figure correct

Social norms, culture, and diversity regarding ethnicity and wealth are also much different in the urbanized United States than in the Netherlands. If individuals are from different backgrounds, they develop different personal opinions. Diverse opinions affect end of life decisions because the more different ideas there are flowing the harder cohesive laws become. Ethnic diversity in the United States impacts who has more trust in the medical system and their doctors overall. This can impact opinion of self-termination in the medical field because less trust will make individuals less likely to want to endure lifesaving procedures as they will not believe in these procedures.

. Cultural competence is a popular topic within healthcare as diversity grows in the United States. Culture and diversity can affect the way people accept and interpret illness, the way they make sense of certain symptoms, chose treatment strategies, accept services, and communication with the doctor (Hanssen and Pedersen, 2013). For example, individuals can go into their healthcare provider battling a linguistic barrier (Betancourt et al., 2003). This is one of the major differences between the Netherlands and the United States and how their social attitudes are vastly different. This issue of cultural competency is involved in end of life decisions as individuals in institutions like hospice need to be just as aware of these cultural differences. Diverse backgrounds and experiences might make an individual more or less likely to know or use their patient rights.

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Prolonged lives occur as frequently in cities as in suburban or rural environments or smaller cities with more stable populations such as the Netherlands. The urbanized United States has less of a communal support system compared to the rural environment. Rural environments place much more social importance on families and communities. Miller and Crader in a journal on “Urban and Rural Families used Wirth’s Model of Urbanization” (Imig: 2019) to determine familial norms in urban and rural environments. Rural families have more extended and larger families and they put more importance on tight knit interactions. This article also establishes a correlation between stress and family interaction scores. The more stress in the rural communities the more interactions grow stronger.

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Another effect of urbanization is that the more ideas and specialization these cities bring, the more technology will advance. While this has many positives, there is a drawback this has on terminal diseases. As technology advances individuals will be able to be kept alive longer. While this technology may be available in rural areas it is far more present in cities. A completely brain-dead individual can be hooked up to a sophisticated ventilator that can keep them breathing artificially. If technology keeps heading in this direction individuals with terminal diseases could just be artificially kept alive. If this is the case when is it appropriate to let the disease end an individual’s life? Everything has its costs and benefits and this medical advancement has just that. Therefore, this idea of density creating medical advancement is something that is unique to the U.S urbanized world. Environments such as the Netherlands do not have this dense idea generating environment.

## VII. Family Dynamics

Family relationships have huge effects on end of life decisions. When it comes to individuals who are unable to make their own medical decisions, it is most common that family



will make their medical decisions for them. Patients will commonly choose an individual and give power of attorney to make their medical decisions. This individual oversees deciding what the patient's wishes would be if the patient is in no condition to (Caregiverslibrary.org, 2019).

**Comment [S39]:** Any footnote for this

When discussing the right to die in the United States, there is a monumental case one must analyze. This is the case of Terri Schiavo which began in 1990 and carried until 2005. She was only 26 when she collapsed in her apartment building due to hypoxia. At the age of 26 individuals do not expect to collapse and go comatose. Most do not have living wills or choose individuals to have power of attorney. She was hospitalized and in a permanent vegetative state for four months before she was pronounced incompetent and her husband was given power of attorney. This decision initially went without argument from her parents. The doctors implanted a Percutaneous endoscopic gastrostomy (PEG) for her to eat artificial food through since she could not swallow real food (Perry, Churchill and Kirshner, 2005).

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The debate in the case of Terri Schiavo was less about what to do in the case of someone in a Permanent Vegetative State (PVS), but more of what she would have wanted. Her husband believed she would not want to be kept alive with this quality of life while her parents disagreed. The case went on in the courts with decisions bouncing back and forth as new evidence was produced. Originally the courts sided with the husband and said that he could make the decision to remove the PEG. Her parents then brought more evidence into court and more doctors as experts. Further debate was made, and 15 years passed by the time the higher court again court Terri's PEG could be removed. The case of Terri Schiavo shows a few pertinent examples of end of life decisions in America. The first being the importance of a living will and being open about your desires in unfortunate medical situations. The other being sanctity of life v quality of life.

To put the situation into perspective, Terri Schiavo was kept “alive” in a PVS for fifteen years (Perry, Churchill and Kirshner, 2005).

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An experiment was conducted in 2012 by the *Annals of Public Medicine* which was published in *Time Magazine* (Hofmann, 1997). This experiment set out to determine how accurately individuals interpreted diagnosis from doctors when making medical decisions for family members in critical care. All 80 individuals who were involved in this experiment had actual family members in critical conditions making the hypothetical experiment real for the participants. The physician would tell the family member that the patient had a 90% chance of surviving and would see how optimistic an individual would gauge a 90% chance. If they gauged it correctly which means they were not being unrealistically under or over optimistic, then they interpreted it correctly. Really the family member should be giving a similar percentage to the doctor. The individuals gauged their beliefs by percentage and in this first case scenario sixty percent of the individuals “correctly” gauged the patient survival. Only 26% were more optimistic than the 90% chance given by the doctor (Hofmann, 1997).

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The same individuals were now told to interpret a five percent chance to surviving. Only 22% of the individuals correctly interpreted a five percent chance of surviving. This means assuming a similar percentage to the one given by the doctor. However, unlike the first experiment 65% answered with greater optimism. If the results of this experiment were that individuals just do not understand doctors or prognosis then the results would constantly be interpreted wrong. They were only interpreted incorrectly when individuals were given sad news. This however shows a clue into the faith and hope individuals feel when talking about their own kin. They are more optimistic to believe people are going to make it and their family member can

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fight it. The research shows an optimism bias in individuals when they know the patients (Hofmann, 1997).

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Decisions for termination can be traumatic and individuals may feel regret withholding or stopping treatment. The family must balance if it is worth the physical suffering on the patient and on themselves by the multiple individuals beyond the family who in a real sense are adding in positive and negative was to the complicated decision-making process. There are physicians, nurses, social workers, administrators, perhaps religious mentors and insurance companies. All these individuals serve different purposes and view the situation from a different perspective. Having a closer family like the ones commonly seen in rural/suburban environments make these decisions and experiences different than a distant urban family might experience.

### VIII. Ethical and Religious Perspectives

There are basic ethical theories on euthanasia. In utilitarian ethics the main factors to be considered are the outcomes and overall benefits the pending action has (Sites.dwrl.utexas.edu, 2019). Therefore, if we were to analyze active euthanasia from a utilitarian view, we would be able to allow the right to die if the action could be justified by the benefits. For example, if an individual is suffering from immense pain and nausea and the individual is destined to die soon, would there be benefits in ending their life earlier? A utilitarian might say that there is benefit in this action (Sites.dwrl.utexas.edu, 2019). This is because the individual would be able to stop their suffering and die at their own time. However, if an individual was not suffering and did not have a reason to die there would be no benefit to active euthanasia. Therefore, under utilitarianism the action of physician assisted suicide can be justified. It would just vastly depend on the case and the benefits. In utilitarianism one might not acknowledge the slippery slope argument because even the killings seen as wrongful might have utility to them (Sites.dwrl.utexas.edu, 2019).

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Different religions in the United States have different outlooks on different forms of end of life care. Protestants are the most popular religion in the United States at 48.9% according to World Population Review. The Christian faith is an immense group as it breaks down into multiple different categories like Baptist, Evangelicals, Quakers, etc (Worldpopulationreview.com, 2019). However, this is still the largest religious population in the United States. The Catholic religion is another large group in the United States representing 23% of the population. 22.8% does not have a religious domination. This is interesting because while a large portion of the population does not identify with a religion, this portion is not nearly as large as the 50% of the Netherlands that does not identify religiously. Minority religions such Judaism, Hinduism, Buddhism, etc. have less than 2% of the population (Worldpopulationreview.com, 2019).

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The Catholic Church has been very open about its stand on end of life decisions. They mostly align with Natural Law theory of ethics. The Church does accept that idea of end of life decisions need to be made and have even developed guides in recent years which help individuals make these decisions (Nbccenter.org, 2019). Artificial Nutrition and Hydration in the opinion of the Church is that discontinuing treatments that are burdensome, dangerous, or extraordinary is acceptable. The death is not caused in this case but omitted due to the refusal of treatment. Church clergy frequently work with patients and their families to make sure there is no guilt to the very important decisions these individuals must make. These decision makers and caretakers in a lot of cases depend on clergy to visit patients in hospitals when they know it is getting close to their time.

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Kantian ethics, otherwise known as deontological ethics, focuses on whether an action is right or wrong regardless of the consequences (Oedingen, 1975). It analyzes the action itself.

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When analyzing euthanasia using Kantian ethics the subject you are analyzing is if the action of killing someone. The action of determining someone would never on its own be considered virtuous or good. Therefore, without considering the outcome of relieving people of their pain you could never accept physician assisted suicide using this theory. The action of ending the individual's life is taken wholeheartedly as the outcome, this is what deontological ethics considers. Therefore, under no circumstances in Kantian ethics can you accept the idea of a mercy killing.

### **IX. Definitions and Realities**

When discussing end of life decisions and patient rights it is extremely important to define quality of life and sanctity of life. The American Medical Association defines quality of life by factors like the well-being, functioning, and overall health (including mental health) for the patient (Lee, 2019). For example, say an individual is 85 years old and he/she is experiencing kidney failure. This individual would now have to do dialysis three times a week for three hours and this would not heal their kidney, just sustain his/her life. The question this person would now be forced to ask is if this dialysis is worth enduring to maintain life. The individual has the right to make this decision for themselves. The debate on euthanasia overall is heavily based on the debate concerning the quality of life certain treatment will bring an individual. If the individual is declared mentally competent, they would now have to make this decision if they want to do treatment.

Another example of this is the above-mentioned artificial nutrition and hydration. This is one of the most controversial treatments to try to refuse. Nutrition and hydration are a basic human need. Therefore, some places have been timid with allowing individuals to refuse artificial hydration or nutrition. The American Nurses Association in 2017 released a statement

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regarding artificial nutrition and hydration. This statement reinforced the right for an individual to refuse artificial food and drink. The individual's requests must be met regardless of if consuming food causes harm like aspiration. The nurse must listen to the patients requests and let them choose food or clinically appropriate food (ANA, 2019).

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A man in his mid-50's has been in and out of the hospital the last two decades. The man has endured a stroke, heart attack, and diabetes. He has had his toe cut off, lived in assisted living facilities, and had to move back home with his seventy-year-old mother because he could not function enough to take care of himself. He is constantly in pain and constantly trying to get better, just to end up back in the hospital with a complication. Finally, he is admitted for dysphagia and breathing issues. He is told that in order to survive he now must have a feeding tube inserted. He has had a life of complications and he believes it is his time. Should this man be forced to get a feeding tube? Should the process to getting a feeding tube require many provisions set onto him by the state? That man does not want to live a life where he cannot just enjoy a basic human necessity like solid food. This man was a real person and he refused that feeding tube and based on that was transferred to a hospice where he passed away on his own terms. The main question within this thesis really is if an individual should have the right to control some of these circumstances that may lead to their demise.

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**Comment [MM57]:** That is the story of my uncle, I have no sources.

In her book *"The Least Worst Death"* Margaret Battin writes that there are three fundamental principles to the subject of euthanasia; these principles are mercy, autonomy, and justice. The principle of mercy states that where possible we should relieve the suffering of another individual if it does not contravene with their wishes and the suffering is not giving the individual any overriding good. Therefore, Battin is not defending all cases of involuntary euthanasia under this principle because it would only be applicable if it followed the wishes of

the individual. This means Battin would not defend a slippery slope if it started to occur in areas like the Netherlands. However, Battin does argue that the overwhelming principle that a physician has is to relieve pain (Battin, 1994: 45-49).

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Battin says there are two component duties that coincide with the principle of mercy. The first is the duty of the physician not to cause further pain or suffering. The second is the duty to act to end pain or suffering that is already occurring (Battin, 1994, 64-70). Both principles justify the current policy in the United States that allows individuals to refuse treatment. Treatment may further cause suffering, or the refusal of treatment may cause death in the end because it may end pain or suffering that is already occurring. The contemporary example of not causing further pain or suffering Battin uses is the example of burn victims. In many of these cases survival is unprecedented and with or without the excruciating treatments the patient may not survive (Battin, 1994 76-77). Therefore, in some cases giving the patient mercy is not pursuing the treatments.

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In some cases, whether a treatment is given will determine how long the individual will have to live with a terminal illness. For example, some individuals with amyotrophic lateral sclerosis (ALS) may choose to withhold treatment. This is because the treatment may cause them to have to live longer with a worsening disease that is stripping them of the life they know. That is the whole idea behind the idea of mercy though. There is the idea of a quality of life and a sanctity of life. Should individuals be on this earth for as long as possible even under negative conditions? Advocates for euthanasia say no, it is not about the length of time that an individual is alive for if they are not happy. It should be about the quality of life the individual is experiencing not the length of it.

## X. “Doctor Death”

Jack Kevorkian, a U.S. doctor and advocate for active euthanasia helped individuals engage in euthanasia before PAS was legal in certain states (Time, 2019). Kevorkian, otherwise known as “Dr. Death”, helped individuals with terminal diseases or hindering diseases end their lives. The cases of Kevorkian were odd because as most of them were taped you can see the life the patient is being forced to live. Janet Adkins, one of his patients can be seen on film describing what it is like having to be taken care of as Alzheimer’s ruined her mobility and everyday functioning. She describes not wanting to live in a world where her husband has to bathe, feed, and change her.

Kevorkian's known patients

No.	Date	Name	Age	From
1.	06/04/90	Janet Adkins	54	OR
2.	10/23/91	Marjorie Wantz	58	MI
3.	10/23/91	Sherry Miller	43	MI
4.	05/15/92	Susan Williams	52	MI
5.	09/26/92	Lois Hawes	52	MI
6.	11/23/92	Catherine Andreyev	46	PA
7.	12/15/92	Marcella Lawrence	67	MI
8.	12/15/92	Marguerite Tate	70	MI
9.	01/20/93	Jack Miller	53	MI
10.	02/04/93	Stanley Ball	82	MI
11.	02/04/93	Mary Biernat	73	MI
12.	02/08/93	Elaine Goldbaum	47	MI
13.	02/15/93	Hugh Gale	70	MI
14.	02/18/93	Jonathon Grenz	44	CA
15.	02/18/93	Martha Ruwerts	41	CA
16.	05/16/93	Ronald Mansur	54	MI
17.	08/04/93	Thomas Hyde	30	MI
18.	09/09/93	Donald O'Keefe	73	MI



19.	10/22/93	Merian Frederick	72	MI
20.	11/22/93	Ali Khalili	61	IL
21.	11/26/94	Margaret Garrish	72	MI
22.	05/08/95	John Evans	77	MI
23.	05/12/95	Nicholas Loving	27	AZ
24.	06/25/95	Erika Garcellano	60	MO
25.	08/21/95	Esther Cohen	46	IL
26.	11/08/95	Patricia Cashman	58	CA
27.	01/29/96	Linda Henslee	48	WI
28.	05/06/96	Austin Bastable	53	Can.
29.	06/10/96	Ruth Neuman	69	OH
30.	06/18/96	Lona Jones	58	VA
31.	06/20/96	Bette Lou Hamilton	67	OH
32.	07/04/96	Shirley Cline	63	CA
33.	07/09/96	Rebecca Badger	39	CA
34.	08/06/96	Elizabeth Mercz	59	OH
35.	08/15/96	Judith Curren	42	MA
36.	08/20/96	Dortha Louise Siebens	76	TX
37.	08/22/96	Patricia Smith	40	MO

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38.	08/22/96	Pat DiGangi	66	NY
39.	09/02/96	Jack Leatherman	73	TN
40.	09/07/96	Isabel Correa	60	CA
41.	09/29/96	Richard Faw	75	NC
42.	10/10/96	William Spolar	70	TX
43.	10/17/96	Nancy DeSoto	55	IL
44.	10/22/96	Barbara Collins	65	MA
45.	08/30/96	Loretta Peabody	54	MI
46.	02/03/97	Elaine Day	79	CA
47.	02/03/97	Lisa Lansing	42	NJ
48.	03/07/97	Helen Livengood	59	VA
49.	03/18/97	Albert "Buddy" Miley	41	PA
50.	03/25/97	Janette Knowles	75	NE
51.	04/08/97	Heidi Aseltyne	27	IN
52.	05/07/97	Delouise Bacher	63	CO
53.	06/26/97	Janis Murphy	40	NV
54.	07/01/97	Dorinda Scheipsmeier	51	CA
55.	07/01/97	Lynne Dawn Lennox	54	NJ
56.	08/13/97	Karen Shoffstall	34	NY

56.	08/13/97	Karen Shoffstall	34	NY
57.	08/26/97	Janet Good	73	MI
58.	08/29/97	Thomas Summerslee	55	CO
59.	09/03/97	Carol Fox	54	PA
60.	09/07/97	Deborah Sickels	43	TX
61.	09/20/97	Natverlal Thakore	78	Can
62.	09/29/97	Kari Miller	54	CO
63.	10/03/97	John Zdanowicz	50	IL
64.	10/08/97	Lois Caswell	65	KY
65.	10/13/97	Annette Blackman	34	MI
66.	10/30/97	John O'Hara	54	NY
67.	11/13/97	Naida Foldes	72	NY
68.	11/22/97	Naomi Sachs	84	NY
69.	11/22/97	Bernice Gross	78	FL
70.	12/03/97	Martha Wichorek	82	MI
71.	12/13/97	Rosalind Haas	59	CA
72.	12/16/97	Margaret Weilhart	89	CA
73.	12/16/97	Cheri Trimble	46	IA
74.	12/27/97	Franz-Johann Long	53	PA
75.	12/27/97	Mary Langford	73	FL
76.	01/08/98	Nancy Rush	81	MI
77.	01/18/98	Carrie Hunter	35	CA
78.	02/03/98	Jeremy Allen	52	MA
79.	02/23/98	Muriel Clement	76	CN
80.	02/26/98	Roosevelt Dawson	21	MI
81.	03/05/98	William Cannaughton	42	MA
82.	03/05/98	Patricia Greyham	61	VA
83-99.	Not Available	In March, Kevorkian said there had been at least 100 deaths. He gave no names or dates. The death of Waldo Herman has been counted as death #100 by most media sources.	—	—
100.	03/13/98	Waldo Herman	66	MI
101.	03/26/98	Mary Judith Kanner	67	MI
102.	04/09/98	Shala Semonie	47	AZ
103.	04/13/98	Dixie Coleen Wilson	64	MO
104.	04/17/98	Pricilla Hiles	73	CA

105.	04/17/98	Jack Schenbern	89	FL
106.	04/24/98	Lucille Alderman	86	MI
107.	05/07/98	Matthew Johnson	26	CA
108.	05/19/98	Emma Kassa	68	OH
109.	06/07/98	Joseph Tushkowski	45	NV
110.	09/17/98	Thomas Youk	52	MI

(JACK KEVORKIAN, 2019)

The chart above represents almost all of Kevorkian’s patients. One of the important trends in this chart to realize is that a very significant majority of Kevorkian’s patients were relatively old. There were only three of these patients that were under 40. Most of them were in their 70s or 80s and suffering. The average age of all his known patients comes out to 58 years old. This seems younger than one would assume but this is counting the significantly young outliers. Another thing the chart shows is people were so willing to have his help they would travel from areas like NY just for assisted suicide. Individuals came from Florida, New York, Canada, Virginia, and even Massachusetts and traveled to the West Coast for his help. This shows how strongly certain individuals feel about being forced to live a life they see no quality in.

**Comment [MOU62]:** this average age does not seem right if most are over 70

The reason that one must distinguish between terminal and hindering diseases is not all of Kevorkian’s patients were terminally ill. Some of his patients such as Janet Adkins were not terminal; Janet had Alzheimer’s disease which ultimately would have just hindered the rest of her life. Before the disease advanced, Janet in the tape said: “I have decided for the following reasons to take my own life. This is a decision taken in a normal state of mind and is fully considered. I have Alzheimer’s disease and do not want to let it progress any further. I don’t choose to put my family or myself through the agony of this terrible disease.” (oregonlive.com, 2019).

It is an important again to acknowledge the slippery slope perspective. The idea of ending the life of an individual with life hindering disease is sometimes identified as euthanasia becoming too normal. There is also the argument discussed throughout the thesis that non-voluntary euthanasia is another example of euthanasia being too much of a social norm.

Jack Kevorkian was able to perform at least 130 assisted suicides (he claimed it was more than that) before being convicted of murder in 1993. He was not against the idea of being prosecuted though. Kevorkian knew if he went to court then euthanasia would get to be publicized for a whole airing in court. He never tried to hide what he was doing though; he taped most of his proceedings and interviewed all his patients before following through. The process included several meetings and Kevorkian made sure the individual had lost quality of life and did not want to suffer. In most cases the patient ultimately administered the drugs meaning Kevorkian only assisted. In his last case, Kevorkian administered the drugs to his patient and gave the tape to “Sixty Minutes” to air. He was convicted of first-degree murder and got a sentence of second degree which was 10-25 years. This showed leniency for Kevorkian but at the same time held him accountable as it was the first time, he was both tried and convicted (Time, 2019).

## **XI. The Extent**

In 1994, the American Academy of Neurology set up a task force that had an objective to set the criteria for being in a permanent vegetative state (Medical Aspects of the Persistent Vegetative State, 1994). When an individual is in a permanent vegetative state it means that the patient has complete unawareness of the self and the environment, accompanied by sleep-wake cycles with in some cases partial functioning of the brain stem. This means the individual might partially be able to perform basic bodily functions or respond to stimuli. The task force found

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that there were 6,000 to 10,000 children in a permanent vegetative state and 10,000 to 25,000 adults. This group analyzed cases from 434 adults and 106 children to see the odds of “good recovery”. This means they were able to recover to near the same quality of life they had before. They found that three months after an injury the chances of recovery with only moderate disability was less than 1%. After six months the odds were 0%. Finally, no patient with a traumatic or nontraumatic brain injury had ever **recovered**.

Palliative care and hospice, one of the most popular alternatives to assisted suicide has a purpose to reduce pain and make someone in terminal condition as comfortable as possible. In a lot of cases this may require heavy sedatives. This is what happened in the case of my uncle. He was in so much pain toward the end of his life that they sedated him so heavily he could not make his own medical decisions. If one is going to argue that hospice which includes heavy sedatives is the best option over letting someone pass on their own time with their dignity, then they are arguing to delay an inevitable process. Continuous sedation was the cause for seven percent of all deaths in the Netherlands in 2005 (Bioethics.org.au, 2019). The process of continuous sedation is not considered euthanasia because it is a gradual process where the physician does not need patient’s permission. The effects of heavy sedation are not irreversible like assisted suicide. However, when an individual is in that much pain where they require sedation and they know it’s a matter of time, they should be able to say it is their time and that they are ready to pass peacefully.

**Comment [S64]:** It is essential that you have more recent data. And what you do have needs footnotes

**Comment [MM65]:** Every more recent study uses this one

## **XII. Future of Euthanasia in a Shifting Culture**

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While the opinion of the patient and their wishes matter, the opinions and willingness of the physician matter as well. A study was conducted in 1996 again anything more recent by a group of physicians which sent a questionnaire to over 3,000 physicians. The response rate was 61% with over 1,900 completed surveys. Eleven percent of these physicians said that under the current law (making assisted suicide illegal) they would be willing to hasten a death upon a patient's request by prescribing medicine (current Death with Dignity Act). Seven percent said they would under certain circumstances be willing to provide lethal injection. 36% said that they would prescribe medicine to hasten death if it were legal and 24% would provide lethal injection if legal. 18% of the physicians had received requests for PAS or euthanasia. Three percent have prescribed medicine to hasten death and four percent had administered lethal injection. (Meier et al., 1998)

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This study shows that even before euthanasia or PAS was a debated topic anywhere besides Oregon, it existed. This research is apart of some of the earliest nationwide research in the United States covering assisted suicide. As our culture develops it only moves in the direction for more liberty and autonomy. Twenty states are listed on the Death with Dignity Act website to consider this act this year (Dignity, 2019). These states include New York, New Jersey, Maryland, North Carolina, etc. Most of the states considering it are Democratic states. The states that currently have it are all Democratic (politifact, 2019). The possibility of more states picking up this legislation in the next year or so is not unlikely.

## **XII. Conclusion**

The ending of a life is not something that should be considered lighthearted. However, there is a distinct difference between being a firm believer in assisted suicide or voluntary euthanasia and a believer in euthanasia in general. When an individual believes in assisted suicide or voluntary euthanasia they believe in an individual's autonomy and their right to die peacefully and not in pain. When an individual is sick and in pain and they know it is the end they should be able to choose their last chapter of life. They should be able to say their goodbyes and enter peace without being in agonizing pain or being so heavily sedated they may as well be gone. Before my research I thought I would always believe in euthanasia. However, at the end of my research I have come to conclude that the best option for the United States now is not euthanasia. The United States and the Netherlands are two drastically different countries and we cannot implement euthanasia in the same way they have. However, I believe that every state in the United States should have the right to physician assisted suicide.

Imagine knowing you are at the end of your life and expecting death, but time is moving slower each waking day. That is the pain my uncle and my nan experienced. Every single day for weeks they waited to go. My uncle was basically gone the entire week leading to his demise because he was so heavily sedated. He was not even human. So, I ask, what is the point in forcing these people and their families to agonize and wait for days fearing the unexpected moment when they die? My nan was the worst. We sat by the phone for weeks waiting for the call. Waiting for her to pass away was the most agonizing part. I called my mom every single day for two weeks to see if she was still alive. When my mom called me to tell me she was gone, the words did not even come out of her mouth. They did not have to because I knew.

Control and autonomy, two of the most important human functions. People like to be in control and like to make their own decisions. This should not be any different when discussing death. The right to end of life decisions should be perceived as a human right, just like freedom of speech. Individuals should have the right to choose how far they are willing to lose their independence and quality of life. If an individual is truly suffering and they know they do not want to push through, they should be able to make that decision. Choosing not to push through is not a sign of weakness, it is a sign of being at peace. Nothing about my nan was weak, she liked to be in control of everything and independent. Even when we said she wasn't competent, she fought to the very last day. No one ever needed to use power of attorney. She knew what she wanted, and I know she wanted to refuse treatment. She lived a long life, she loved a lot, and it was her time, she was ready.

This thesis is not an argument for euthanasia in the United States. It is an argument for individuals to have more power in their medical decisions. It is advocacy for end of life care, patients' rights including the refusal of treatment, and for assisted suicide by prescription. Every state should give options such as states like Oregon, Washington, Colorado, California, Hawaii, D.C., and Vermont. With the now more popular topic of assisted suicide, it should be interesting to see where the debate goes and if more states do pick up the Death with Dignity Act. For the sake of suffering yet strong individuals like my nan, I hope they do.



### XIII. References

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