The Ethics of the Extension of Euthanasia to Depression Patients

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By

Amanda Sieger

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Approved by Prof. Kent Wayland, Department of Engineering & Society

Introduction to Depression and Euthanasia

Depression is an extremely common mental illness. Globally, more than 264 million people suffer from it, making it a major contributor to the overall global burden of disease and disability. Even though there are psychological and pharmacological treatments for moderate and severe depression, this debilitating disease, as well as others, can lead to suicide which is the second leading cause of death for those between the ages of 15 and 24 (WHO | *Depression*, n.d.). It is estimated that about 60% of people who commit suicide have severe depression and annually, about 800,000 people die worldwide from suicide (one person every 40 seconds) (*Has the Rate of Suicide in the United States Risen?*, n.d.). Because depression and suicide are so common, in some countries, technologies and procedures have been developed to allow patients to decide to end their own lives humanely through euthanasia. Globally, very few cultures allow euthanasia because it is extremely controversial by nature, and the way mental illness is addressed changes among different environments, cultures, and demographics. The two different countries' perspectives that we will look into in this paper are the United States and the Netherlands.

For the large statistic of people globally that have depression and then utilize suicide as an option, euthanasia can seem like an attractive option. Euthanasia is a painless, deliberate option used by some patients with persistent suffering of some sort, and carried out by physicians in order to end a life. Over time, different cultures and societies have shaped laws regarding euthanasia due to the views from patients, families, physicians, and communities as a whole. In most countries, including the United States, euthanasia for patients with depression is illegal. In the Netherlands, which has some of the most liberal euthanasia laws in the world, it is a very controversial option for patients that have unbearable and never-ending suffering, including

those that suffer from mental illnesses like depression. The extension of euthanasia to not only patients with terminal conditions, but to patients diagnosed with severe depression, poses a new ethical challenge to policy makers who have to decide whether to allow this. The major and unintended consequence of this ethical issue is that if the wrong policies are made, they could fail to alleviate suffering and could lead to more suicides and less treatment of mental illnesses. Throughout this paper, a case study of how a 17-year-old Dutch girl with depression was euthanized will be used to explore and understand the different ethical approaches to the topic and to clarify the ethics of policy choices. Overall, the paper will explore the question: is it ethical to allow depression patients and their physicians to make the decision of using controlled suicide, a humane way to end their lives? This question can be explored through not only the case, but arguments on the Hippocratic Oath, respect for the autonomy of the patient, the responsibility to preserve life, and cultural differences between the United States and the Netherlands.

History of Euthanasia & the Recent Extension to Mental Illness Patients

Dating back about 2,500 years is the Hippocratic Oath, which all doctors take. This oath states directly that a doctor "will neither give a deadly drug to anybody who asked for it, nor make a suggestion to this effect" (*Euthanasia and assisted suicide*, n.d.). As this was written thousands of years ago, many people today hold the opinion that some parts of this oath are outdated. And as more treatments become available for extending life, regardless of its quality, as well as ending it painlessly, euthanasia has become an extremely complex issue. Before reviewing the history of these laws, figure 1 below displays how different actors in society have shaped, advanced and progressed these laws over time.

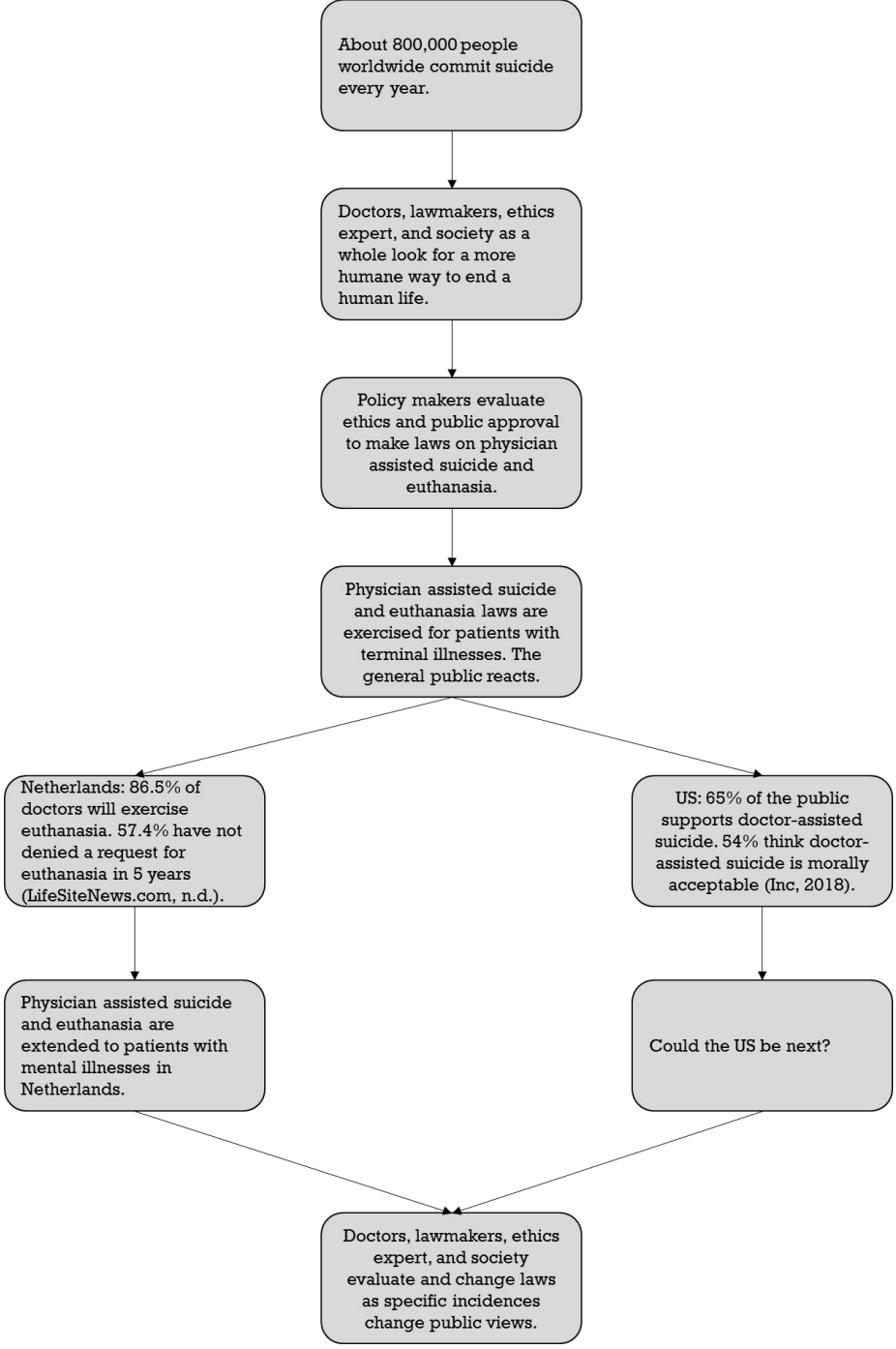

Figure 1. This figure shows how mutual shaping has led to the development of laws governing physician assisted suicide and euthanasia. As time goes on and public and doctor approval increases, laws change to reflect what the people want. (LifeSiteNews.com, n.d.) (Inc, 2018).

Among other countries, the United States has debated euthanasia for a couple hundred years. The first law outlawing euthanasia in the U.S. was passed in 1828 in New York, and later other states followed, but in 1938, a society was created in the United States to gain support for

assisted suicide. Later, in 1990, the Supreme Court permitted the use of passive euthanasia, which involves withholding life sustaining treatments. In 1994, the state of Oregon passed the Death with Dignity Act, which allowed physicians-assisted suicide for terminal patients with a life expectancy of 6 months or less. In 2009 in Washington, this act became the law (*Euthanasia and assisted suicide*, n.d.). In the United States, active euthanasia is illegal for all states, but assisted suicide is legal in a few states, including Oregon, Washington, Vermont, California, Montana, and one county in New Mexico (*U.S. Legal Wills*, n.d.). The ethicality of these laws has been up for debate ever since, especially deciding on which patients should qualify for euthanasia and why.

In some European countries, euthanasia and physician-assisted suicide laws are much more liberal. The Netherlands legalized euthanasia in 2002. The 2001 act that turned into the law in 2002, named the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act" made it so that even mentally ill patients qualify for euthanasia in the Netherlands, not just those with terminally ill conditions. The law also allows that anyone over the age of 12 is eligible for euthanasia, but from ages 12 to 16, parental consent is needed. In 2015, 5,561 people in the Netherlands exercised their right to euthanasia. The Dutch law states that the physician must be convinced that the request for euthanasia is voluntary and that the patient has unbearable and hopeless suffering. The physician must also inform the patient about all of their options and has determined with the patient that there are no reasonable alternatives for their situation. Lastly, the patient must consult with at least one other physician independent of the case before following through with their decision (*Euthanasia for Reasons of Mental Health | Bioethics.net*, n.d.). Since the expansion of euthanasia to mentally ill patients, there has been much controversy over the ethics of this law.

Today, technologies are being developed in order to make euthanasia easier. One of these technologies is known as the "Sarco" suicide machine. It allows for death by hypoxia, a situation where a person can choose to press a button to end their life humanely rather than committing a violent suicide. This machine is being developed in the Netherlands by Australian Dr. Philip Nitschke and Dutch engineer Alexander Bannink (EDT, 2018). Along with the laws, this machine has brought about ethics debates for not only policy makers, but for engineers as well. Many ethics experts argue that with the extension of euthanasia to patients with mental illnesses and with the development of technologies to help along these processes come consequences, which could include a spike in suicide rates. My research will examine the moral acceptability of euthanasia to clarify and strengthen the various views that can be advanced in support or condemnation of euthanasia.

Introduction to the Case Study: 17-Year-Old Noa Pothoven Euthanized in The Netherlands

In 2019, a story was released to the public and this story sparked loads of controversy. In the Netherlands, a 17-year-old girl was euthanized by request because of her everyday unbearable suffering. Noa Pothoven suffered from severe depression, as well as post-traumatic stress disorder and anorexia after being raped at both ages 11 and 14 (Stanley-Becker, 2019). She had first requested assisted suicide or euthanasia at the age of 16 (Bolwerk, 2018). The physician who did her profile deemed her too young to die. She had then written an autobiography detailing her struggling and her reasoning. She wrote how being institutionalized was degrading and dehumanizing because she was put into isolation which only furthered her suffering. Noa had also attempted suicide several times. With the advice of a medical ethicist,

her general practitioner, pediatrician, psychiatrist and trauma therapist, Noa and her parents came together to discuss next steps involving her suffering and her life (Bolwerk, 2018).

Noa had repeatedly made her wish of dying humanely known. She had been examined by several different healthcare professionals before her life came to an end. The request was voluntary, her family eventually consented, she was judged by doctors to have unbearable suffering with no end in sight, and therefore Noa qualified for euthanasia in the Netherlands at 17 years old, even though one's brain isn't considered fully developed until the age of 21 (Bolwerk, 2018). The Netherlands law gives considerable weight to the doctors' professional judgment and this is what sparked such controversy across the world. Many people wondered because of the oath a doctor took if they should have a legal obligation to save a life once they knew of a patient's intention to end it, if the Netherlands had any other options for people with a considerable amount of suffering, and what the Netherlands valued human life at (Kim, 2019). Is it ethical to end a life using euthanasia? Before looking in to the case study further, I will look into the arguments for and against euthanasia for mental illness patients. The examination of this case study will help the public better understand euthanasia in order to inform mental health services.

Arguments for Euthanasia for Mental Illness Patients:

At the center of both the arguments for and against euthanasia are the different ideas that people have about the meaning and value of human life. In the Netherlands, as expressed earlier, the law regarding euthanasia requires that the patient's own request for euthanasia and that his or her condition is considered beforehand. The request by the patient must a voluntary, well-

considered and sustained and the patient must be determined to have unbearable and hopeless suffering. Many that argue for euthanasia for the mentally ill say that "the justification of euthanasia lies in a combination of the principle of respect for autonomy, i.e. the principle that doctors have a duty to respect their patients' autonomous decisions, and the principle of beneficence, i.e. the principle that doctors have a duty to act in the interest of their patients" (Haan, 2002, p. 155-156). Euthanasia can be seen as humane treatment for those that have endless suffering.

Death does not mean the same thing to everyone. Patients with depression can see euthanasia as a way to reclaim control in deciding which course their life will take. Sometimes, for them, going through procedures and therapy is not necessary because they would rather pass on in peace. When a patient, who is evaluated by several professionals and deemed fit to make the decision to die because they do not see an end to their suffering, many believe that it is fair to allow them to do so. Lastly, many people who commit suicide do so in a violent way, and some see euthanasia as a more humane way to end a life if it is properly sought.

Arguments Against Euthanasia for Mental Illness Patients:

Euthanasia for mental illness patients is very controversial. There are several arguments detailing why euthanasia should not be allowed for this specific population. First, there is the argument that euthanasia is considered homicide. A homicide is when one being takes the life of another being, regardless of the reasoning. In many places, the person carrying out the deed would be held legally responsible. This could also lead to unintended personal consequences for the medical personnel who commit euthanasia. Also, for a patient that is diagnosed with a mental

illness, there is a question of if the patient is competent to make the decision. Another argument against euthanasia for the mentally ill is that there are other care options for people suffering from diseases like depression. There are not only counselors and therapists, but there are several medications and programs available that are designed to help and treat these illnesses. Someone not in favor of euthanasia would argue that not trying these options would be pushing a part of the population to the side and that society is even taking advantage of vulnerable populations. The legalization of euthanasia for the mentally ill could lead to an abuse of the law and an abuse of power by doctors, where instead of providing treatment, human beings are euthanized. Many argue that doctors have a responsibility to preserve life. Some consequences that could follow this legalization include increased national suicide rates, decline of care for mentally ill patients, and a slippery slope in which euthanasia laws become even looser leading to involuntary euthanasia of people who are considered undesirable (*Arguments against euthanasia*, n.d.).

Two Sides to Every Topic: The Responsibility to Preserve Life, Respect for the Autonomy of the Patient, and Cultural Differences

The Responsibility to Preserve Life

Regarding euthanasia for people with depression, I am concerned with two main concepts of ethics: respect for the autonomy of the patient and the responsibility to preserve life. The responsibility to preserve life is debated by ancient and modern versions of the Hippocratic Oath. In the original oath, it states directly that a doctor "will take care that they [a patient] suffer no hurt or damage. Nor shall any man's entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so" (Practo, 2015). This version of the oath states that a

doctor shall not administer a deadly drug to any patient and it does not provide any exception. This version of the oath is very clearly in opposition to euthanasia.

On the other hand, the modern version of the oath, that doctors take now, states that a doctor "will apply, for the benefit of the sick, all measures that are required ...warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. If it is given me to save a life, all thanks. But it may also be within my power to take a life. I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being" (Practo, 2015). This version of the oath states that the doctor should save a life if possible, but also has the right to judge if they don't see that saving a life is fit. It encourages sympathy of the doctor for the patient and for the doctor to evaluate not just the medical condition, but the mental condition of the patient. This version of the oath suggests that on a case by case basis, euthanasia could be moral. Thus, the original and revised versions of the Hippocratic Oath differ in their views on the responsibility to preserve life. The first version states that lives should be saved at all costs, the second version suggests that the decision is more complicated than previously thought.

In the case of Noa Pothoven, the physician applied the modern version of the Hippocratic Oath. The doctor used the power to take a life, and the one of a teenager. But, the oath does state that the life should be saved if possible and in this particular case, it was not a physical sickness. It was a mental one and the patient was not dying, at least in a physical manner. The patient did express that she was breathing, but it had been a long time since she had really been alive and due to this, it was okay for her to utilize euthanasia. Some physicians that go by the modern version of this oath, including the doctor on this case, would agree that Noa had tried multiple treatments with no prospect of improvement and that it was okay to end her suffering in this manner. The other side of the argument are physicians that would refer to the ancient version of

the Hippocratic Oath. They would argue that because Noa could still be alive physically, that it was only within the power of doctors to continue to try to save her. They also would argue that brain is not fully developed until the age of 25 and Noa was only 17 and therefore too young to make a decision of this magnitude. Both sides of the argument portray the physician's responsibility to preserve life, but one exercises the meaning of what it is to truly be living, and not just breathing.

Respect for the Autonomy of the Patient

Concerning respect for the autonomy of the patient, there are deontological and utilitarian views by the philosophers Kant and Mill, both which provide moral arguments for the importance of respecting a patient's autonomy. Kant's theory of respect for autonomy is built on being a rational agent and on doing what is right. Kant's idea of autonomy revolves around a being's ability to self-govern and the dignity that being has. From his perspective, in order to respect the autonomy of a patient, it is required that a doctor must respect the patient as an equal. The doctor must see a patient as an equal in order to acknowledge their ability to make their own choices. Autonomous people are considered to have the ability and awareness to determine their own fate, and in Kant's view their choices should be respected (Delany, 2005). The biggest issue here is that patients diagnosed with depression may or may not be, in terms of Kant's definition, rational enough to decide their own fate.

According to Mill, in his utilitarian perspective, decisions should be judged as either 'right' or 'wrong' in terms of the happiness that they bring. From his perspective, the importance of one's autonomy is not whether the person acts for personal reason as Kant said, but that their

decisions signify freedom to choose what would maximize their own happiness or utility. Mill's principle of harm says that a patient has the right to deny medical treatment and that a doctor can desist from acting against the patient's wishes. However, Mill also believed that it was acceptable to intervene when patients are causing harm to themselves when doctors believe that their decision was ill informed (Delany, 2005). This provides a view that is slightly contradicting towards euthanasia for patients diagnosed with depression. Euthanasia does have to be voluntary, well-informed, and requested on the patients end, but if a patient is mentally compromised, it may change how well informed they are on being euthanized because of their mental capacity to understand what is happening to them. This is where the cultural/ethical divide comes to bear.

In the case of Noa Pothoven, she has repeatedly made the request to be euthanized after the trauma that she had endured in her short life. Her parents believed that there was no treatment that could help her, considering that they had tried everything and there had still been no prospect of improvement for their daughter. Noa had written to the many that followed her story, saying that "[a]fter many conversations and assessments it was decided that I will be released because my suffering is unbearable. It's finished. I have not really been alive for so long, I survive, and not even that. I breathe but no longer live" (Stanley-Becker, 2019). Her physician had decided to respect her repetitive requests for death. Mill thought that if a doctor believed that a patient was harming themselves, they had a right to intervene. Using this perspective, many would advise against the use of euthanasia for depression patients because there are other treatments and patients would be harming themselves. On the other hand, Kant stressed the importance of the freedom to choose what would maximize the patient's own happiness. In this case, Noa finally being allowed to die after several years of suffering, was the way to maximize her happiness and end her pain. Many different actors would have different sides in this

argument. The patient would agree with Kant, but the family, physician, and community could fall on either side. Not only could putting a patient to rest give a physician or family peace, but it could also cause trauma, guilt, and sadness.

The cultural differences between the Netherlands and United States

In order to understand the cultural difference behind mental health views in the Netherlands and in the United States, it is important to note the ways in which both countries approach medicine. In a recent study, it is shown that in America, body and mind are seen as separate, meaning that the approach to healing a physical illness is very different than the way that doctors would tackle a mental illness (Gopalkrishnan, 2018). The Netherlands, being more liberal as a whole, views body and mind as one. They tend to make no distinction between treating physical health versus treating mental health (Gopalkrishnan, 2018). This is important when approaching a topic such as euthanasia for people with depression, or even the approach to treating mental illness in general. Since the US treats mental and physical illness separately, it makes sense that euthanasia for people with depression is not legal, but physician assisted suicide for patients with terminal illnesses is legal in some states. The approach that they are taking to physical illness here, they would not apply to mental illness. They allow terminal patients to exercise physician assisted suicide, but would not allow the same for someone who suffers from non-terminal illnesses like depression. On the other hand, in the Netherlands, euthanasia is allowed for both patients with physical and mental illnesses because they view mind and body as equal. As long as the condition of the patient is determined to bring about unbearable suffering, they qualify for this treatment. The cultural difference in the ways that the two countries view medicine lead to the development of very different policies.

The Netherlands got a lot of backlash after Noa died. After all, she was 17 and was physically in condition to live and recover. In the United States, Noa would not have been able to utilize euthanasia as an option and would have been treated further. Knowing that euthanasia was an option, it is possible that Noa was further pushed to use it instead of trying more recovery options. Without euthanasia as an option, is it possible that suicide wouldn't have been an option that she wanted to use?

Possible Unintended Consequences of Allowing Euthanasia for Depression Patients

Lastly, after looking at the ethical debates and the cultural differences between the US and the Netherlands, it is important to acknowledge what could be the unintended consequences of making euthanasia legal for depressed patients. Euthanasia can be thought of as an additional suicide technique, but it can also be thought of as a way to avoid more violent and painful methods of suicide. In the book, *Talking to Strangers* by Malcolm Gladwell, he discusses two theories about suicide, displacement and coupling. He describes that coupling is the idea that behaviors are linked to very specific circumstances and conditions (Gladwell, 2019, p. 273). He then explains that displacement "assumes that when people think of doing something as serious as committing suicide, they are very hard to stop. Blocking one option isn't going to make much of a difference" (Gladwell, 2019, p. 273). If displacement was the theory behind those committing suicide, suicide rates should be steady over time. If you look at Figure 2 below, you can see that the suicide rates are not steady over time. Starting in 1965 and completing in 1977, the UK replaced carbon monoxide with natural gas and the suicide rates plummeted" (Gladwell, 2019, p. 275). The number of gas suicides fell to 0 and along with that the total suicide rate also

fell, implying that the theory behind suicide was not displacement, but instead coupling. Is it possible that taking away a suicide method could decrease suicide rates?

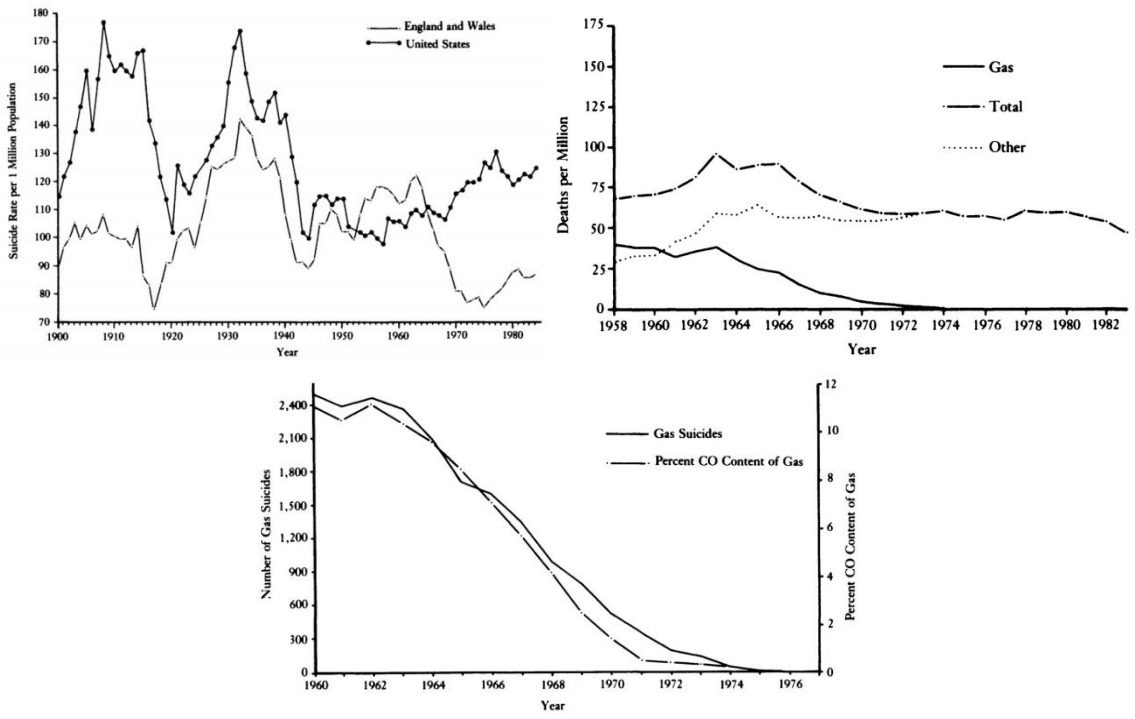

Figure 2. (Gladwell, 2019, p. 272-287).

To restate, coupling is the idea that if methods of suicide are taken away, suicide statistics will decrease. Displacement is the idea that if someone is going to commit suicide, they will do it regardless of if their first choice of method is taken away. Returning to the idea that euthanasia can be thought of as an additional method for suicide, if coupling is the theory behind suicide instead of displacement, this could mean that the allowing euthanasia for people with depression could increase suicide rates. This could happen not only in the Netherlands, but for the countries that may adopt the same laws that they have regarding euthanasia. As stated earlier, euthanasia became legal in the Netherlands in 2002, and between 2002 and 2016, the percentage of euthanasia deaths of the total mortality rate tripled from 2002 to 2016 (*MercatorNet*, n.d.).

Simultaneously, as shown in Figure 3 below, the suicide rates and numbers increased as well. In 2002, the suicide mortality rate was 9.8 per 100,000 population, while in 2016 it was 12.6 (*Netherlands Suicide Rate 2000-2020*, n.d.). Even though correlation does not imply causation, it is important to recognize that suicide rates, per one million population, have not decreased as a result of legalizing euthanasia.

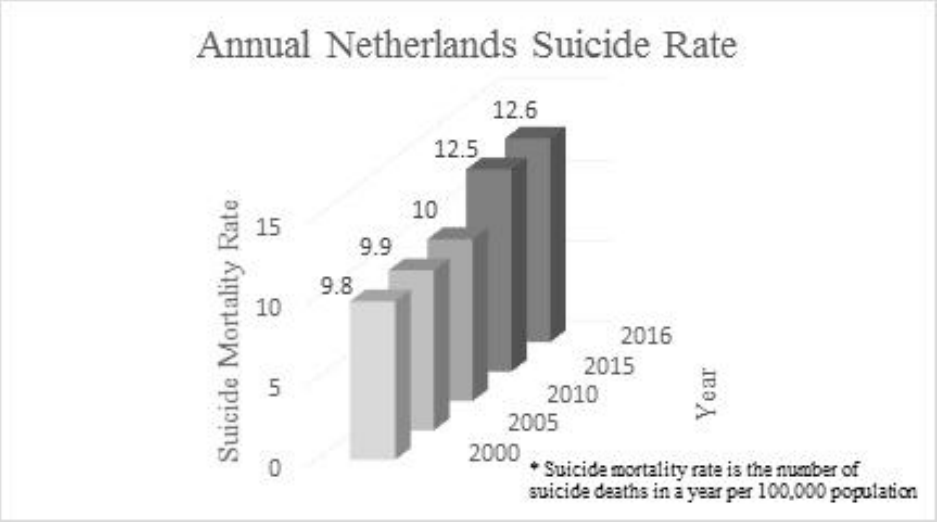

Figure 3. (*Netherlands Suicide Rate 2000-2020*, n.d.). This figure shows the suicide mortality rate in the Netherlands, since euthanasia was legalized in 2002. The suicide mortality rate has increased over time.

If coupling really is the theory behind suicide, it is entirely possible that Noa would have lived. Her behaviors could have been linked to very specific circumstances and conditions, being that she was suffering through a massive trauma and euthanasia was presented to her as an option. As someone who is depressed and struggling, this option being available could be the reason she gave up or decided death was the best and only option for her. Others, who believe that displacement is the theory behind suicide would argue that in her condition, Noa was so far gone that even without euthanasia, she would have found a way to die.

Conclusion & Significance

Worldwide, depression has a strong influence on suicide. It is not the only condition that can result in suicide, but as mentioned earlier in the paper, 60% of people who commit suicide have severe depression. In a few more liberal countries around the world, euthanasia has been extended past the legality for patients with terminal illnesses to patients with mental illnesses like depression, which presents patients, doctors, and lawmakers with the ethical issue of who they should allow to utilize euthanasia and how to keep it from becoming too common or used by patients that it should not be used by. I have explored the costs of legalizing euthanasia which could be the possibility of more suicides, stress for doctors, and long term effects on families. I have also explored the benefits, being that it could result in peace, control over their own fate, and the end to unbearable suffering for patients and less utilization of violent methods of suicides because a safer and regulated option is available for the people that qualify for it.

In analyzing debates on the responsibility to preserve life, respect for autonomy of the patient, and cultural difference between the Netherlands where euthanasia for depression patients is legal and the United States where it is not, two sides of the argument are shown that can be interpreted on a case by case basis. Through the research done, I have found that general laws for a topic as nontraditional and nonconforming as euthanasia do not always work. Each patient, each doctor, and each culture is different. It may be unethical for a patient to have to check certain boxes in order to have the right to die. As euthanasia is a very complex topic, each case deserves its own set of boxes to check. The case of Noa Pothoven is extremely controversial and can be seen as either allowing a patient to take fate into her own hands and maximize her own

happiness, or as allowing a patient who was too young to decide on a massive decision before her brain was fully developed. There are different views from each actor involved in the case.

The culmination of this work is critical in decreasing violent suicides and implementing appropriate euthanasia laws as a safe and successful component in our society. My research works to shed light on the choices we have in addressing this problem. There are several different factors that increase or decrease happiness for each actor and ultimately, we need to be able to see the larger social context of what is it to be in their shoes. Patients and physicians can utilize this investigation of the case of Noa Pothoven as a general guide for developing systems that optimize the happiness of all actors involved and to make sure that patients are mentally fit to decide to die. Additionally, physicians will also benefit from this research as it gives them a double-sided perspective on euthanasia to decide how to manage patients that request it. I believe that this can be carried a step further by closely monitoring how the legalization of euthanasia for depression patients changes not only thought processes in doctors and patients, but the statistics that follow. They need to monitor the policies, suicide rates, and statistics on the methods of suicides in order to later decide if the legalization is in the best interest of the patients, physicians, and community as a whole.

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