EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

An argumentative analysis for the legalisation of euthanasia and physician-assisted suicide

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Abstract

The practise of euthanasia is not new. There was general support for voluntary euthanasia throughout Roman antiquity in lieu of prolonged suffering. This paper will use a normative framework with an argumentative structure to argue for the legalisation of euthanasia and physician-assisted suicide to support terminally ill persons' autonomy rights concerning self-determination and well-being. Further, the paper will argue in favour of the Netherlands model of euthanasia and physician-assisted suicide as being superior to the Belgium model. The aim is to illustrate why the refusal to legalise euthanasia and physician-assisted suicide for terminally ill persons violates the person's rights.

The paper also aims to contribute to the debate on this complex and relevant topic. The line of reasoning will incorporate discourse and critiques concerning why euthanasia should not be legalised and assert that they seem to be founded on invalid argumentation. Moreover, the arguments presented will encompass the utilitarian theory of the right action being the consequences with the most significant outcome. Finally, the thesis affirms that denying a terminally ill person access to euthanasia and physician-assisted suicide when making end of life decisions violates and restricts their human right to autonomy concerning self-determination and well-being. Thus, euthanasia and physician-assisted should be legalised, and if legalised, the Netherlands model is superior to the Belgium model.

Keywords: Human Rights, Euthanasia, Physician-Assisted Suicide, Utilitarianism, Autonomy, Self-determination, Well-being

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TABLE OF CONTENTS

1. Introduction 5
2. Limitations 7
3. Method, Aim and Structure 7
3.1 Method and Aim 7
3.2 Structure 8
4. Background 9
4.1 Euthanasia 10
4.2 Historical Overview 11
4.3 Euthanasia Laws in Belgium and the Netherlands 14
5. Theory 16
5.1 Utilitarianism 16
6. Argumentation 18
6.1 Arguments for Euthanasia 19
6.1.1 Promote Respect for Autonomy in Society 19
6.1.2 Respect for Patients to Control their Life 22
6.1.3 Closure for Family Members 25
6.2 Arguments against Euthanasia and Counterarguments 26
6.2.1 Respect for the Right to Life 26
6.2.2 Autonomy Against Euthanasia 28
6.2.3 Protecting Society from the "Slippery Slope." 30
7. Conclusion and Final Discussion 33
8. Bibliography 36

1. Introduction

Euthanasia and physician assisted-suicide are relevant ethical issues that involve intentionally choosing to end someone's life to relieve them from some kind of suffering. The practice is a complex process of ongoing debate across various nation-states, and it has been the subject of thought in ethical, religious, philosophical, legal and human rights discussions. Additionally, media coverage concerning stories of people who have decided to end their life has also fuelled the fire on the date between opponents and proponents of both practices. Euthanasia and physician assisted-suicide are considered controversial topics due to factors such as different ideals and religious beliefs that influence people's morals in society (Pauer-Studer, 1993). As I write this paper, both practices are the most active areas regarding bioethics. There are many different kinds of euthanasia practiced worldwide, and the type selected by the person is subject to diverse factors. Laws in contemporary society regarding euthanasia and physician-assisted suicide are different across various nation-states. Some countries where the practice has been legalised include the Netherlands, Belgium and Switzerland. Nonetheless, most people still avoid talking about death, and its mention is still one of the greatest taboo subjects in our modern world. The concept of intentionally killing another human being usually elicits extreme reactions of outrage, apprehension, criticism, and impeccable disdain (Walter, 1991).

My interest in euthanasia and physician-assisted suicide stemmed from the concern of a loved one battling terminal cancer which resulted in them expressing their will to die. Over that period, I started researching ways to hasten pain and suffering for terminally ill cancer patients. I quickly realised that it was much easier for a healthy person without any disabilities to end their life in contrast to a person who was terminally ill, physically disabled or suffering from a chronic illness. Furthermore, people who are terminally ill, disabled or struggling with chronic illnesses often need assistance with their daily activities to maintain their well-being. Thus, they would also need assistance to end their lives. Australian ethical and political philosopher Peter Singer believes that voluntary euthanasia is morally justified and argues in favour of the practice being legalised under certain conditions (Pauer-Studer, 1993). After mulling over euthanasia and physician-assisted dying, I decided to dig deeper into this ethical problem for my bachelor thesis in human rights. Some of the questions that come to mind include; What are the ethical pros and cons of euthanasia? Would the legalisation of voluntary euthanasia for terminally ill patients support a peaceful death? What kind of arguments are given by those in favour of legalising the practice? Do persons who request

euthanasia and physician-assisted suicide have the right to demand participation by others? Are physicians the suitable persons to perform euthanasia when it is approved?

Moreover, would the legalisation of voluntary euthanasia be beneficial or detrimental for terminally ill patients? Unfortunately, an in-depth examination of each question mentioned above is beyond the scope of this paper. The topic of euthanasia and physician-assisted suicide is interesting, considering we live in a society with social codes which we are morally obligated to follow in terms of religion, culture, or legal codes. Moral codes help us protect ourselves and our human rights, making the world a safe place to inhabit. The controversy surrounding euthanasia means many different arguments for and against the practice. When analysing human rights and euthanasia, the core question of whether to legalise euthanasia stems from the clash the practice has with competing interests specifically, Article 6 (1) of the International Covenant on Civil and Political Rights and an individual’s wish to die with dignity when faced with unbearable suffering (ICCPR, 1996).

This paper aims to argue for a terminally ill person's right to have autonomy concerning self-determination and well-being respected when making decisions concerning the end of life. I firmly believe that refusing to grant the request of a terminally ill person to end their life is to condemn them to live the remainder of their life in pain and misery. Additionally, failure to assist in the death of terminally ill persons forces them to endure constant physical and mental torture against their will, which goes against all forms of moral codes. **Firstly**, I will argue that to refuse a terminally ill person's request for euthanasia and physician-assisted suicide when making end of life decisions is to deny the person the right to autonomy concerning bodily self-determination and the right to well-being. **Secondly**, I will apply the ethical theory of utilitarianism as a backgrounding framework to argue that when human rights conflict with euthanasia and physician-assisted suicide, a terminally ill person's right to autonomy concerning self-determination and well-being should take precedence. I have opted to use utilitarian moral reasoning since the theory provides a relatively straightforward method to decide the morally correct course of acting for any situation we may find ourselves. The theory holds that a morally correct course of action in any given situation is the one that will generate the most significant balance of benefits over harms for all those that are affected.
Thirdly, the line of reasoning will incorporate discourse and critiques from existing literature concerning why euthanasia should not be legalised and assert that they seem to be founded on invalid reasoning. **Fourthly**, a contrast of the two main models of euthanasia from the Netherlands

and Belgium in the argumentation analysis argues that the Netherlands' laws of the current legislation of euthanasia and physician-assisted suicide have fewer risks of patient abuse, thus making the Netherlands model superior to the Belgium model. Finally, as a consequence of the controversies involving euthanasia and physician-assisted suicide, the motivation behind the thesis is to add to the already existing reflections on this complex and sensitive topic in a fair and balanced way.

2. Limitations

There are various reasons why people seek out euthanasia and physician-assisted suicide. For instance, there have been cases whereby people suffering from mental illnesses or disabilities have requested assistance in dying. However, due to the limited time and number of words, the paper will only focus on voluntary euthanasia and physician-assisted suicide for terminally ill persons. Furthermore, the paper will only focus on the laws governing euthanasia and physician-assisted suicide of the current legislation in the Netherlands and Belgium to argue that the difference in applying the law leads to different rules and procedures. The paper will refrain from bringing up arguments concerning euthanasia and physician-assisted suicide grounded in religious doctrines because contemporary utilitarianism avoids basing moral arguments on religious beliefs. In secular countries, legislation is usually not enacted based on religious beliefs but on other considerations. Further, the reasonable focus when discussing a matter of legislation is to look into non-religious arguments. So far, it seems as though most of the arguments against the practice stem out of religion and the sanctity of human life, which can not be a basis for judging whether something is wrong or right in the modern scientific and technological world we live.

3. Method, Aim and Structure

3.1 Method and Aim

This thesis aims to do a normative argumentative analysis regarding euthanasia and physician-assisted suicide. The paper will re-examine the debate on euthanasia and physician-assisted suicide by exploring the strengths and weaknesses of the legal and moral arguments used by those who aim to overthrow legislation against those practices. Specifically, the paper will do an argumentative analysis in favour of euthanasia and physician-assisted suicide for terminally ill persons. The method used in the paper is a normative argumentative framework since this seems to be the most suitable approach to discuss euthanasia and physician-assisted suicide. In philosophy, a normative

theory aims to make fair judgments on events that focus on maintaining something they conceive as morally good. A normative statement claims how institutions should be designed and appreciated and what things are right or wrong (Corner and Hahn 2013).

The statement that the thesis aims to discuss and defend rationally is; ***Voluntary euthanasia and physician-assisted suicide for terminally ill persons should be legalised based on the Netherlands model of euthanasia and physician-assisted suicide***. This statement will be defended because opposing legalising euthanasia and physician-assisted suicide for terminally ill patients is violating their human right to autonomy concerning bodily self-determination and well-being. Therefore, arguments will be laid out defending euthanasia and physician-assisted suicide in addition to their objections and responses in a fair and balanced way. Additionally, the main arguments will be strengthened by applying the ethical theory of utilitarianism since it is a theory that relies on the agent choosing the act with the most significant expected value for everyone involved. The originality of the thesis is attributed to the method of applying utilitarianism in conjunction with contrasting euthanasia laws in the Netherlands and Belgium with current legislation to argue in favour of the Netherlands model as the framework with less risk of patient abuse. Further, the thesis will use the guidelines presented by Douglas Walton in his book *Argument Structure: A pragmatic Theory* to apply logic and critical thinking to develop the arguments to the best of my ability fully.

3.2 Structure

The paper will be structured in the following manner. First is the introductory chapter, whereby the topic of euthanasia and physician assisted-suicide is introduced. The second is a brief discussion about the limitations of the paper. The third is a section divided into two different subsections. One of the subsections will discuss the method and aim of the paper, while the second subsection, which is the ongoing part, will address the structure of the paper. Chapter four will be divided into various subheadings that will discuss the background information on euthanasia and physician-assisted suicide. In particular, the subheadings of chapter four will cover detailed information concerning what the practice of euthanasia entails and the different types of euthanasia relevant to this paper.

Furthermore, a historical overview of the origins of euthanasia and the concept of death in western society detailing how the idea of death has evolved through the lens of historian Philipe Ariés will be addressed. Additionally, the due care requirements of euthanasia laws in the Netherlands and

Belgium of the current legislative framework. Chapter five will bring up a discourse about the backgrounding theory that has been used in the argumentation analysis section clarifying why the thesis chose to use the utilitarian ethical frame of reference. The section will also address the two different perspectives of utilitarianism and interpret how the theory will be applied in the paper. Further, said chapter will include a brief discussion of the theory's strengths and weaknesses when addressing the moral issue of euthanasia and physician-assisted suicide.

Chapter six is the primary argumentative analysis section whereby ethical and philosophical arguments used in the debate on euthanasia and physician-assisted suicide will be analysed. The section will include two main sections, including arguments for and against the practice of euthanasia and physician-assisted suicide and counterarguments. Moreover, the two main sections of chapter six will be divided into three different subheadings. The arguments supporting euthanasia and physician-assisted suicide will be under the subheadings named ***Promote Respect for Autonomy in society***, ***Respect for patients to control their life*** and ***Closure for family members***. Arguments against euthanasia and physician-assisted suicide will be under the subheadings titled ***Respect for the right to life***, ***autonomy against euthanasia*** and ***Protecting society from the slippery slope.*** The subheadings will also include numbers with various arguments used for and against euthanasia concerning the main subheading. Lastly, chapter seven will be the conclusion and final discussion of the paper, succeeded by section eight, the bibliography, which includes a list of references used for the paper.

4. Background

This section will provide a background on euthanasia, including the meaning of euthanasia and physician-assisted suicide. A brief description of the different types of euthanasia relevant to the argumentation analysis of this paper will be explained. Plus, the due care requirements of euthanasia laws in the Netherlands and Belgium of the current legal framework. For this paper, it is crucial to understand how the law in both countries regulate euthanasia and physician-assisted suicide to formulate clear and concise arguments in the analysis section. The paper will only look into euthanasia and physician-assisted suicide laws in the Netherlands and Belgium since they are neighbouring countries with similar cultures and close cooperation between both governments. Moreover, a historical overview of death in western society will be addressed to understand better how the concept of death has been evolving in the west.

4.1 Euthanasia

In order to understand the moral implications of euthanasia, it is essential to understand how the word is defined. Euthanasia is when a person requests to die. Euthanasia comes from the Greek words "*eu*", which means good and happy and "*Thanatos*", meaning death which adds up to "good or happy death (Australian Human Rights Commission, 2016). The notion behind euthanasia, also known as mercy killing, is that we should not condemn people to a slow and painful death but instead offer patients the possibility to choose to die with dignity. For this paper, euthanasia will be understood as intentionally facilitating to painlessly put to death a person to prevent them from enduring persistent pain and suffering (MU School of Medicine, n.d). Additionally, euthanasia is usually performed when requested by the patient, but it is not limited to the patient's consent. Therefore, the paper will only refer to euthanasia and physician-assisted suicide between a patient and a medical professional.

The request to end a patient's life is usually made to a physician, a medical doctor or a medical practitioner. The two different main categories and ways a medical doctor could bring about the request for death is through active euthanasia and passive euthanasia. ***Passive euthanasia*** is when a patient is left to die. The procedure entails withdrawing or withholding artificial life support such as feeding tubes or ventilators for a patient on life support or in a vegetative state who cannot survive without medical treatment (Khyathi, 2019). Therefore, passive euthanasia is usually understood as letting nature run its course, making it less controversial than active euthanasia. ***Active Voluntary euthanasia*** is when one actively and deliberately causes the death of a patient who has asked for the procedure to be done. For instance, a physician can prescribe a patient an overdose of painkillers, causing their death, or they can inject a patient with a lethal drug (Australian Human Rights Commission, 2016). According to many, there seems to be a moral difference between active and passive forms of euthanasia. For instance, people and nation-states seem to be more susceptive to removing a patient from life support which is viewed as a passive form of euthanasia (Vaughn, 2016). Moreover, it is essential to highlight that although it seems as though the different definitions of euthanasia are easy to understand, there are many instances where there is an overlap which often brings confusion.

Further, there is a third approach to euthanasia known as ***Physician-assisted suicide*,** whereby an act performed on a patient is intended to end their life, just as in the case of active voluntary euthanasia. The primary difference between active euthanasia and physician-assisted suicide is that in active

euthanasia, a doctor is the one who performs the act. In contrast, physician-assisted suicide is when the patient is the one who performs the act (MU School of Medicine, n.d). Moreover, the fourth approach to euthanasia is ***Involuntary euthanasia***, when a physician euthanises a patient. However, they did not consent to the procedure, which can ultimately result in an unlawful act of murder (Khyathi, 2019). Most cases concerning acts of involuntary euthanasia took place during the second world war in Germany when the Nazis used euthanasia for mass genocide. As previously mentioned, the thesis will only focus on cases of voluntary euthanasia for terminally ill patients since involuntary euthanasia is unlawful, and the practice of involuntary euthanasia is an ethical issue that would require another paper to be analysed in a meaningful way. Nevertheless, not all terminally ill patients can end their lives since euthanasia and physician-assisted suicide are not legalised worldwide. This discussion will continue in subheading 4.3.

4.2 Historical Overview

Death is an inevitable part of human life, and the idea that death should be merciful is not new. However, to understand death, one needs to understand how it is understood by those living and how the living deal with death. Many ancient Greek and Roman philosophers considered suicide a "good death" since they viewed it as a suitable and sensible response to many conditions. Further, mercy killings and assisted suicides were standard practices tolerated in ancient Greek and ancient Rome. For instance, people commonly asked physicians to hasten their deaths or provide them with a way to end their lives (Filipo, 2017). Moreover, history has revealed various instances whereby people pulled down the legs of those who had been hanged but not yet succumbed to their death to aid them in quickening their demise. Such practices were tolerated in classical antiquity because they were essentially not at odds with the moral beliefs of the time, which is in stark contrast to contemporary Christianity.

Suicide and active euthanasia have long been the topics of conversation throughout the history of western thought. Philipe Ariés, a French thinker and author, writes a detailed description of death rites and attitudes that came with them in western society in his book ***Western Attitudes toward Death: From the Middle Ages to the Present***. Ariés highlights four consecutive periods of the evolution of attitudes towards death in the western world (Aires, 1974). Firstly, he mentions the "**tamed death**", which encompassed death as a built-in part of daily life in the western world, ending in the 12th century. By this, he meant death was accepted calmly by those experiencing

death in addition to their loved ones. Those dying were aware of when death would be knocking on their door, and they were also prepared for death in terms of putting their affairs in order and confessing to all their wrongdoing. During this time, death was considered to be tamed due to the frequency with which people were dying. Death was all around, and it was a common occurrence due to the decline of the living standards because of the decline of the Roman Empire and primarily due to the black death pandemic (Wood & Willamsoon, 2004; Health, 2001). Therefore, dying was something that was made public since it was challenging to have a private death, and death was also accessible to children.

Secondly, "**one's own death**," a period which began during the eleventh and twelfth centuries and incorporated the personalisation of death. This was a time when people started to accept that all living things were connected to nature, which meant that all living things would reach the end of their lifeline one day. Therefore the idea of the afterlife was born. This included the idea of heaven and hell being introduced by the Christian religion (Filipo, 2017). As a consequence, when one died, they would be judged by God according to how they lived on earth if they would enter the gates of heaven or be sent to hell. Thirdly, "**thy death**" began in the early 18th century and was characterised as the period when most people feared death since they did not consider it a regular part of human life. Therefore, this was a period when death was heavily mourned and dramatised by the community, indicating those left behind accepted the death of another person with much more difficulty than the past. This is a significant change because it shows that people started to be less concerned about their own deaths compared to concern and social awareness of the death of others around them (Airés, 1974).

Lastly, Airés talks about the "**forbidden death**", which he mentions began around the late 19th and early 20th centuries. This period consisted of replacing death with sex as taboo in western cultures. He points out that attitudes concerning death significantly changed during the 20th century. Death became something that was hidden in hospitals, and it became something to be feared and was regulated by the funeral industry (Airés, 1974). People no longer died at home with their family and loved ones but instead died alone in hospitals. This was further influenced by a lessened reliance on religious doctrines and the increased invention of modern scientific medicine regarding the process of dying. The introduction of the modern hospital and the medical technology caused people to go away from cultural and religious beliefs leaving most people unable to deal with death. Therefore people's practices and beliefs concerning death changed over time to people being sent to die in

hospitals and the growing belief that life should be happy and death was something that was considered to be sad. For this reason, death was denied, and as a consequence, children started to become shielded from death (Airés, 1974).

More recently, the history of euthanasia was tainted by the "*life unworthy of life*" ideology, a Nazi euthanasia program. The program aimed to target and kill people the Nazis considered had no right to live, to weed out all genetic defects in the "*Aryan*" population. Those targeted included thousands of physically and mentally ill children and adults or those they considered grossly inferior according to the race policy of Nazi Germany. Furthermore, the concept of "*life unworthy of life*" led to the Nazis using euthanasia as a weapon to exterminate the Jewish population in Europe in what came to be known as the Holocaust (Michalsen & Reinhart, 2006). In modern western societies, death is often not talked about or just ignored; however, questions concerning what happens after death have been answered by different traditions, religions and philosophies, which have helped form and shape attitudes towards the notion of death. Most people usually fear death due to its forbidden nature of engaging in discourse about death. The main reason behind most people's fear is the fear of the unknown caused by not knowing what happens after death which is also connected to external questions concerning mortality and immortality (Filipo, 2017).

Further, fear of death in western society is also due to the concern of dying a long and painful death which significantly reduces the quality of life. Over centuries, western medical ethics operated by standards of the Hippocratic ethics, which meant that euthanasia and physician-assisted suicide were not permissible. For instance, it was forbidden for doctors to give advice or medicine to patients that would lead to the patient's demise even if the patient had requested such information. However, the fading out of the Hippocratic ethics and the spread of human rights awareness debates on mercy killing among health service providers and the public have consequently led to significant changes in the attitudes and approaches people have concerning ethics in medicine (Vishal & Radhika, 2019). As a result, death has begun to become more accepted in the western world with the growth of the hospice movement and more family members being involved with their dying loved ones leading to more people becoming more understanding and accepting of death. Additionally, the advances of medicine in medical science in the 20th century to prolong life have also led to discourse in western society concerning the end of life decisions. Further, such discourse has opened up platforms for debate about the legalisation of euthanasia and physician-assisted

suicide being practised today, especially for terminally ill patients in some nation-states (Filipo, 2017).

4.3 Euthanasia Laws in Belgium and the Netherlands

Euthanasia and physician-assisted (PAS) are illegal in most countries. Nonetheless, both practices were decriminalised in the Netherlands in April 2001 by the ***Termination of Life on Request and Assisted Suicide (Review Procedures) Act for Dutch citizens*** above 12 years old (Judo, 2013). The act lays out the necessary criteria for physicians to legally perform euthanasia. Furthermore, the act highlights that physicians who perform euthanasia will be immune from prosecution, provided that they comply with the strict guidelines when performing euthanasia. On the other hand, euthanasia and physician-assisted suicide in Belgium were legalised in May of 2002 through the ***Belgian Act on Euthanasia*** for competent adults and minors suffering from constant and unbearable suffering (Raus, Vanderhaegen and Sterckx 2021). In both countries, euthanasia and physician-assisted suicide are regulated and available to patients as plausible options when considering the end of life decisions. The laws regulating euthanasia in both nations are similar but have some differences. For example, a similarity in both countries is that the legality of euthanasia is conditioned by following strict conditions and confirmation after a notice procedure.

Furthermore, it is generally accepted in both countries that euthanasia is a relevant medical practice (Defines, 2003). In addition, both countries have a rule that the person involved in requesting either of the procedures be an adult who is mentally competent when requesting assistance in dying. Such rules aim to make the practice of euthanasia public to ensure unified standards for euthanasia and secure the utmost care for the patients.

In the Netherlands, euthanasia and physician-assisted suicide are regulated as two prospects when considering the end of life decisions, in contrast to Belgium, where the law only governs euthanasia. Further, compared to Belgium, the Netherlands has a law with special provisions about requests from individuals between 12 and 18 years old (Defines 2003). Moreover, it is essential to highlight that public debate concerning euthanasia in the Netherlands began in the late 1970s, and the medical association supported the euthanasia laws in the Netherlands. In contrast, the euthanasia laws in Belgium were not supported by any medical association. They were enacted 3years after being debated in parliament and by the Federal Advisory Committee on Bioethics (Defines, 2003). In the Netherlands, a law known as the ***Groningen Protocol*** permits euthanasia for severely ill

newborn babies. The Groningen Protocol allows babies to be euthanised if they are born with unbearable suffering, and there is no alternative solution. Although, the infant's parents, the physician and the independent physician need to agree on the procedure (Raus, Vanderhaegen & Sterckx, 2021).

In contrast to the euthanasia law in the Netherlands, Belgian law makes a clear distinction between incurable conditions and curable conditions. In both jurisdictions, the laws concerning euthanasia define the practice as an act committed by a third person (doctor) that purposely ends a person's life at their request. Moreover, the legislators restricted the practice of euthanasia to only doctors, which means that it is illegal for euthanasia to be performed by anyone else, including nurses (Verhagen and Sauer 2005).

The monitoring conditions necessary to perform euthanasia in Belgium and the Netherlands differ significantly. In the Netherlands, the law leaves it up to the doctor to determine if the patient in question suffers from persistent and unbearable suffering. Therefore the doctor needs to know the history of the patient's medical condition well enough to determine whether the patient's request for euthanasia is voluntary and well-conceived. In Belgium, the patient in question decides for themselves (Judo, 2013). Nonetheless, the doctor can only proceed with the request upon a review procedure. The euthanasia laws in both countries allow doctors to refuse a request for euthanasia since patients do not have an absolute right to euthanasia, and doctors do not have an absolute duty to perform the procedure. As a result, doctors are guaranteed the freedom of conscience in both countries (Judo, 2013). According to the UN Human Rights Committee, there has been a rapid rise in euthanasia and physician assisted-suicide cases in Belgium and the Netherlands since the practices were legalised. In the Netherlands, cases concerning the euthanasia of senior citizens have contributed to the rise of euthanasia. According to a team of scientists and ethicists, the rapid increase in euthanasia cases concerning older people in the Netherlands is due to multiple geriatric syndromes (MGS) (Berg et al., 2020). The geriatric syndrome describes health conditions usually common in frail older adults. A study done by public health expert Kaspar Raus revealed that the rapid rise of euthanasia cases in Belgium is because the scope of the Euthanasia Act in Belgium has been broadened from the terminal and intolerable diseases to include being "tired of life" polypathology. Polypathology relates to complications that occur due to old age, such as chronic pain, fatigue and sight/hearing loss, among other things (CARE, 2021).

5. Theory

The leading framework used to construct arguments in this paper is utilitarianism. This section will explain what utilitarianism is and how to understand the theory. The two different perspectives of utilitarianism within the broader concept will be discussed. Explaining how the essay will apply the utilitarian framework to construct arguments in the argumentation analysis section will also be clarified. Additionally, the paper will mention the strengths and weaknesses of using a utilitarian approach to discuss the ethical issue of euthanasia and physician-assisted suicide since it is essential to be aware of them before the application of the theory.

5.1 Utilitarianism

The paper will use the utilitarianism theory to make its arguments because utilitarianism seems to be one of the most influential theories used to understand the social world. The theory assists in specifying what fundamentally matters and the reasoning behind this statement is that we can all agree that suffering is evil and happiness is good, which is what utilitarianism believes. Utilitarianism is a maximising doctrine, and it is generally accepted morally that human well-being is of great importance and that we should strive for the lives of all sentient humans to go well to make the world a better place (Goodin, 1995). The greatest balance of good over harm is utilitarian moral reasoning that is applied by many of us in our daily life decisions. For instance, in contemporary society, citizens generally accept redistributive taxation since it allows for governments to generate benefits that help raise the overall well-being of the society we live in, which in turn secures the overall good. The reasoning behind the given example can justify why utilitarianism is often used as the starting point for moral hypothesising.

Philosophers Jeremy Bentham and John Stuart Mill are known to have understood the utilitarianism framework as being determined by the pleasure produced by the moral value of an act. However, Mill looked into both the quantity and quality of the pleasure produced, while Bentham was only concerned with the quantity of pleasure (Stanford Encyclopaedia of Philosophy, 2009). Further, I chose the utilitarian framework because I believe there is a need for more philosophical discussions regarding bioethical issues involving death. Their complex nature forces us to bring up the discourse of uncomfortable topics that will help us better our society. There are different perspectives of utilitarianism which means that the theory has different aspects. For instance, ***Act-***

utilitarianism focuses on the ethics of an independent act; this means that an action can be wrong in one setting but right in a different one since it all depends on the situation that will result in the most significant amount of good for everyone involved. On the other hand, ***Rule-utilitarianism*** believes that individual action is morally right when it aligns with the rules already made on a utilitarian basis. According to rule-utilitarianism, a person is supposed to act in a way that aligns with the rule that will result in the most significant outcome of good than bad for everyone involved (Ashcroft et al., 2006).

So how would the application of both rule and act utilitarianism work in the practice of euthanasia and physician-assisted suicide? From the perspective of a rule utilitarian, euthanasia and physician-assisted suicide would be justified if it was believed that a rule allowing euthanasia would lead to better consequences than a rule disallowing it. Plus, others involved would benefit from the patient's decision (Mandal, Ponnambath and Parija, 2016). Therefore, from the perspective of a rule utilitarian, a patient's request for euthanasia is justified if the consequence will bring about more good consequences than bad which is also in agreement with act utilitarianism. Act-utilitarians also believe that if the patient is suffering from intolerable pain and suffering and their death will promote more happiness, the action is justified (Mandal, Ponnambath and Parija, 2016). Therefore, it can be concluded that according to both utilitarian perspectives, an action such as euthanasia or physician-assisted suicide is right if it would result in more good consequences than bad. The main idea is to maximise the good and minimise the harmful consequences despite how the net good is distributed.

The essay will not commit to any specific concept of the two branches of utilitarianism previously explained because the paper will argue for legalising voluntary active euthanasia and physician-assisted suicide. Thus, the distinction between the two perspectives of euthanasia is not relevant to the argumentation analysis of this paper. Nevertheless, the paper will be looking at utilitarianism's primary concern, which is maximising the good and minimising the bad. In the simplest terms, for utilitarianism, the action the agent has chosen to take should make the world a better place by maximising the good and minimising the harmful consequences (Vaughn, 2016). The utilitarian theory is a robust framework because both rule and act utilitarianism make strong points when discussing why euthanasia and physician-assisted suicide should or should not be legalised. For instance, the utilitarian theory looks at both sides of the situation in question before deciding because the theory is concerned with maximising the utility of everyone involved. This specific

element of the theory is respectable because it shows that the theory cares about everyone involved. In the case of voluntary euthanasia and physician-assisted suicide, the theory will consider how the course of action would affect those involved. Additionally, the theory promotes the well-being of a person in ethical matters, which is in line with the law's prime function, which is safeguarding its citizens (Drier, 2006).

The utilitarian approach treats everyone equally in line with the law since it is committed to strict equality of all its citizens (Drier, 2006). Nonetheless, the theory also has its weaknesses. For instance, it allows for moral rules to be broken, which is the case with physician-assisted suicide. However, breaking the moral rules help in maximising utility for everyone, which is justified since it makes sure that the good consequences outweigh the negative ones. Another weakness of the theory is that it can place more value on the interest of one person in comparison to everyone else's interests. The theory believes that what results in the most significant aggregate good is not always what benefits the majority (Mandal, Ponnambath and Parija 2016). For instance, if the consequences of the result of an exception are better than the moral rule, the action is justifiable, which, as we shall see in the argumentation section, is the case for Respect for the patient's autonomy concerning bodily self-determination. Lastly, as mentioned previously, utilitarianism gives no intrinsic weight to the equality of how benefits are distributed. However, this distribution issue will not be necessary when discussing euthanasia and physician-assisted suicide in this paper.

6. Argumentation

This section will discuss ethical and philosophical arguments used in the debate on euthanasia and physician-assisted suicide. The arguments presented below will generally focus on the theory of utilitarianism and will be based on the respect for individual autonomy concerning bodily self-determination and individual well-being. The paper will argue in favour of the Netherlands model of euthanasia as the better model to implement when legalising both practices by contrasting how euthanasia laws are applied in the Netherlands and Belgium. By looking at philosophical arguments that place value on the patient's autonomy and prevention of human suffering, the paper hopes to gain insight into what arguments can be made to support the legalisation of euthanasia and physician-assisted suicide. The essay intends to only focus on voluntary euthanasia and physician-assisted suicide for terminally ill persons; however, there will be arguments made concerning non-voluntary euthanasia in order to explain the slippery slope argument. Furthermore, it is essential to

highlight that the debate on euthanasia and physician-assisted suicide is highly controversial, and it is doubtful that a universal resolution will ever be met. However, this paper shows that arguments for the legalisation of voluntary active euthanasia and physician-assisted suicide regarding the Netherlands model are more compelling when assessed according to standards such as patient autonomy and the prevention of human pain and suffering.

6.1 Arguments for Euthanasia

6.1.1 Promote Respect for Autonomy in Society

First, proponents of euthanasia and physician-assisted suicide argue that legalising both practices will maximise the good consequences for society by strengthening the concept of respect for autonomy concerning self-determination and individual well-being (Brock, 1992). However, when discussing utilitarianism, the notion of autonomy is not straightforward since utilitarian theory views autonomy as valued only in its existence as a resource for the greater purpose of well-being (Foust & Carol, 2009). Such reasoning raises concerns about the conflict between the well-being and autonomy of an individual since, according to utilitarian theory, an individual can be rendered an enslaved person to their mortality system if it is considered to be in the best interest of the individual's well-being. Peter Singer offers a solution to this problem of autonomy when discussing utilitarianism. He suggests that utilitarianism is an obligation to assist if it is in our power to prevent something wrong from taking place without sacrificing anything of equivalent moral significance, we out to do so (Singer, 1977).

Therefore, from a utilitarian perspective, voluntary active euthanasia and physician-assisted suicide are justifiable when the act leads to happiness for the individual and society. For instance, when a patient who is terminally ill sends in a request to a physician to get assistance in dying, by prescription of a lethal dosage of drugs, from a utilitarian perspective, the attending physician would look into the possibility of a justified exception to the rule of "*do not kill*". Utilitarians believe that when one kills someone due to self-defence, their action of killing is a justified exception to the rule *"do not kill"*. A utilitarian would support the assistance in dying by the physician for a terminally ill patient if they believed that the patient in question would be able to escape intolerable pain and suffering, and others involved would also benefit from the patient's decision. Further, from a utilitarian perspective, the Netherlands model of euthanasia would be the more appropriate model to implement because the legislation of the Netherlands model was

gradually developed. Therefore, the legislators of the Netherlands model had more time to allow the idea of euthanasia and physician-assisted suicide to be tolerated by the public and develop their healthcare needs and report procedures. In contrast, the Belgium model was mainly modelled after the Netherlands model without any prior time for the population to get used to euthanasia and physician-assisted suicide (Rurup et al., 2011).

Second, supporters argue that when a terminally ill patient's illness has influenced their ability to perform daily activities or even go to work, their utility has ended. This means that the patient can no longer contribute to the overall happiness of society. Likewise, they are probably not in a position to euthanise themselves and need assistance from a physician. In this case, the Netherlands model of euthanasia is more applicable because it is the only model between the two that has explicitly included physician-assisted suicide in their legislation (Rurup et al., 2011). From a utilitarian point of view, respecting the patient's autonomy by granting the patient request to die would be the right action to take since it will promote overall happiness. To deny them their request would be the opposite of the principle of utilitarianism and respect for patient autonomy (Ezekiel, 1994).

Moreover, they advocate for euthanasia, and physician-assisted suicide for terminally ill patients since granting the patient's wishes will foster trust in doctors treating patients suffering from terminal illnesses. The point of this claim is that legalisation, especially in the Netherlands, shows that terminally ill patients can trust their medical professionals to recognise their desire not to suffer due to doctors' willingness to offer sufficient care, including euthanasia and physician-assisted suicide. Further, enough scientific evidence supports the claim that modern palliative care may gradually reduce terminally ill patients' suffering. However, it does not always provide total relief of agonising symptoms. The doctor's willingness to assist the patients in ending their lives also helps them navigate the end of life decisions with confidence, direction, and purpose (Harris, Richard and Khanna 2006).

Third, supporters argue that autonomy demands the respect of others (Sjöstrand et al., 2011). By respecting others' autonomy, we choose to respect their right to self-determination, which is generally accepted in biomedical ethics law. Proponents of euthanasia and physician assisted-suicide believe that life is sacred; however, according to utilitarianism, terminally ill patients have

the right to request euthanasia and physician assisted-suicide since a patient's life can be worse than death (Ezekiel, 1994). Advocates claim that we entrust healthcare professionals to generally promote our welfare in all circumstances. For instance, if a patient desires to end their life, patients and their loved ones would most certainly require the physicians to offer assistance in their darkest hour of need which is in line with laws regulating euthanasia and physician-assisted suicide in the Netherlands. Therefore, euthanasia and physician-assisted suicide should be legalised to ensure that patients' welfare is promoted overall.

Fourth, defenders argue that permitting voluntary euthanasia and physician-assisted suicide will allow resource allocation. For instance, keeping a terminally ill patient alive who has asked to be euthanised can be viewed as a waste of funds from a utilitarian point of view. Because the resources could be redirected towards infrastructure, curing people of curable illnesses or even research to find a cure for terminal illnesses. From a utilitarian angle, sending the money to research facilities to try and find a cure instead of spending it on a terminally ill patient who has requested euthanasia will lead to the overall happiness of society as a whole. Hence, the utility of active voluntary euthanasia and physician-assisted suicide concerning a terminally ill patient permits the funds to be spent somewhere else. The funds and resources acquired open up the possibilities for research investment that can lead to treatment for incurable diseases, leading to the greatest happiness because, in the future, other patients who are suffering from the same type of illness will no longer pass away from the same disease. This change in resource allocation would increase average life expectancy and quality of life and create inexpensive medicine for decisions concerning the end of life (Ezekiel, 1994).

Fifth, proponents argue that patients request euthanasia and physician-assisted suicide since the patient does not wish to burden others. Thus, no injustice will be done to them since the patient has given free and informed consent (Manning, 1998). Plus, advocates for both practices argue that mercy killings should be legalised since the fundamental moral values of society, such as humanity and clemency, do not permit patients to be left to endure intolerable suffering (Norval and Gwyther 2003). Supporters claim that legalising euthanasia and physician-assisted suicide would make both practices less taboo, making it easier to scrutinise what is happening, which would lead to the prevention of harm to vulnerable people. For example, in the Netherlands, 0.2% of cases reported to the legal authorities were due to varying issues, such as physicians who did not fully comply with the euthanasia laws. In contrast, there were no cases reported in Belgium during the five years after

legalisation, which implies that out of all the 122 euthanasia cases reported, each one was performed in full compliance with the requirements of the euthanasia law (Rurup et al., 2011). Therefore, it can be argued that the physicians in Belgium are not transparent with what is happening on the ground. Because it is possible that since they did not have any cases reported to the legal authorities, the physicians in Belgium are not safely practising euthanasia, which is why they were inclined to make any reports.

6.1.2 Respect for Patients to Control their Life

Sixth, a utilitarian can argue that the most immediate instance in which happiness could be maximised is the action that directly relates to the wishes of the person being euthanised, which is rooted in the respect for the patient's right to control their own life. Peter Singer, a well-known philosopher who advocates for the legalisation of euthanasia and physician-assisted suicide, states, “No one can fear being killed at his or her own persistent, informed autonomous request.” (Singer, 1994). Singer believes that the right to life is interlinked to the right to die; thus, the main idea behind having a right is that we can exercise our rights. For instance, advocates of voluntary euthanasia and physician-assisted suicide for terminally ill patients justify the practice based on autonomy for the patient in question who goes through pain and suffering that can not be cured or relieved. Therefore, proponents who hold the utilitarian perspective of the most immediate instance in which happiness could be maximised is the action which directly appeals to the desires of the one who would be euthanised view the request for euthanasia from a patient as a well thought out and responsible request (Manning, 1998).

From a utilitarian perspective, granting a patient's request for euthanasia poses no threat since receiving expert assistance relieves the patients from fears of having to experience a drawn-out, painful and distressing death that they do not wish to go through. Therefore, refusing a request for euthanasia and physician-assisted suicide for a terminally ill patient is inhumane and fails to respect the patient's autonomy and dignity. Further, forcing the patient to live a life full of pain and unbearable suffering for the remainder of their days alive is an action that would not align with the utilitarian ethics of maximising happiness (Ezekiel, 1994). Moreover, supporters of the practice believe that a person has the right to exercise control over the time and manner of one's death based on autonomy concerning bodily self-determination. The notion of autonomy denotes that every individual has the right to control their own body, which means that autonomous human beings

should be able to choose a peaceful death instead of having to live a life that is not worth living (Bartels and Otlowski 2010). This statement aligns with the euthanasia laws in the Netherlands and Belgium, whereby the patient has to give explicit voluntary requests. For instance, when a terminally ill patient gives consent and is euthanised, the result will be that the patient in question is happy to be free from pain and suffering. The actions taken by the doctor to actively relieve the patient from pain and suffering by actively causing their death instead of passively watching promotes utility for the patient, the patient's family and society as a whole according to utilitarian ethics.

However, the Netherlands model of euthanasia and physician-assisted suicide seems to be the better option than the Belgium model when respecting the patient's right to control their own lives. This is due to the difference in how long a terminally ill patient has to wait before a request for euthanasia is granted. The legislation in Belgium has different requirements for euthanasia concerning patients who are expected to die soon and those who are not, which means that it can take up to a month before a patient's request for euthanasia is granted in Belgium (Rurup et al., 2011). Thus, the patient and their family members would have to undergo a more lengthy process while the patient endures more pain and suffering. John Stuart Mill is a utilitarian who argues that individuals are ultimately the best judges and guardians of their interests. It is widely accepted that grown-up human beings should generally decide how they would like to live (Bostrom, 2008). This statement is grounded on human beings being able to make decisions that best serve their interests since they know their vulnerabilities, talents, aspirations in life, and much more. This general acceptance of individuals being the best person to judge what is best for them also extends to terminally ill patients who have requested euthanasia. Thus, making a patient wait for up to a month while enduring unbearable pain and suffering as they do in Belgium seems to go against Mill's utilitarian ethics.

Nonetheless, even though it can be argued that there are exceptions to this claim, such as people with mental disabilities and children, the majority of people can make the best decisions concerning their well-being. This assertion comes from the hypothesis that autonomy is essential for well-being. Therefore from a utilitarian perspective, granting terminally ill patients the request to end their life by respecting their autonomy and right to control their own lives will promote greater happiness for the patient and loved ones which is in line with utilitarian ethics.

Seventh, advocates of euthanasia and physician-assisted suicide argue that there is no moral significance between active and moral practices of euthanasia. As a society, we pride ourselves on valuing a patient's self-determination, making it possible for opponents of euthanasia and physician-assisted suicide to use the argument for patient well-being and autonomy to allow a patient to refuse life-sustaining treatment. On the other hand, advocates claim that it is only fitting that the same argument is used to justify physician-assisted suicide or voluntary euthanasia in certain circumstances (Veatch, 1997). American bioethicists James Rachel defended the morality of euthanasia and physician-assisted suicide by equating it to the withdrawal of life-sustaining treatment. For instance, Rachel gives the example of a man who is tasked with watching his nephew while the nephew takes a bath. According to Rachel, whether the man pushes the nephew and drowns him or whether the nephew hits his head in the bathtub and drowns, the man is equally responsible for the nephew's death as long as he does not intervene and help the nephew from drowning (Welie and Have 2014). Therefore, supporters of euthanasia argue that the difference between passive and active forms of euthanasia has no moral significance.

Eighth, supporters argue that dangerous acts put more people at risk in comparison to dangerous omissions. Scholars who reject euthanasia and physician-assisted suicide but support treatment withdrawal or withdrawing treatment usually base their argument on the act-omission distinction. Opponents argue that a patient who dies from the withdrawal or withholding of treatment dies from the underlying disease. In contrast, patients who are euthanised die from the actions of the attending physician. However, supporters can argue that by law, the person who turns off a ventilator is taking action that will have an effect of hastening the patient's death, and by law, it would be punishable to turn off the ventilator of a patient without permission. Therefore, it is safe for advocates of euthanasia and physician-assisted suicide to argue that dangerous acts put more people at risk than dangerous omissions.

Moreover, one is less likely to encounter cases of patients experiencing intolerable pain and suffering when euthanasia and physician-assisted suicide are performed on a patient through active voluntary euthanasia, such as in the Netherlands, instead of letting the patient slowly die of the fatal illness. From a utilitarian perspective, respecting a patient's autonomy concerning bodily self-determination means that individuals have an absolute right to exercise control over their bodies which means that they have control over decisions concerning their life and death, as previously mentioned. Therefore, supporters of euthanasia argue that according to fundamental human rights, a

patient has the right to make their own decisions, including choosing to die a dignified death (Manning, 1998).

6.1.3 Closure for Family Members

Ninth, advocates for voluntary euthanasia and physician-assisted suicide have argued that granting patients requests for euthanasia ensures that the patient's family gets closure for their loved one. As a result, the family and friends can gradually get back to their daily lives, promoting happiness in society. Many have argued that to cause death to someone intentionally is immoral. Nonetheless, from a utilitarian perspective, ethics such as liberty and life are suitable means rather than ends. The test to determine whether or not the consequences of an act are good is the overall level of happiness for the people involved. For instance, a study named the "***Effects of euthanasia on the bereaved family: a cross sectional study***" suggested that euthanasia and physician-assisted suicide may give less traumatic grief symptoms and post-traumatic stress to the patient's family in comparison to family members of cancer patients who died a natural death in the Netherlands (Swarte et al., 2003). The study found that a possible explanation for the less grieving symptoms observed in family and friends of patients who suffered from cancer and died through euthanasia was due to the loved ones having the opportunity to say goodbye to the patients when they were not in a comatose state.

Additionally, since euthanasia and physician-assisted suicide are usually planned, family and friends are more aware of the death of their loved one in terms of how it would happen and the day of the procedure. Plus, the planned nature also allows the patient in question to control their situation. Consequently, the family members will have a slightly easier time dealing with the death since when a terminally ill patient requests euthanasia and physician-assisted suicide, it opens up the door for discourse relating to death (Swarte et al., 2003).

Those involved in a patient's end of life decisions could be the patient's family and friends.
For instance, the patient's family and friends would benefit from not having to watch their loved one endure endless pain and suffering. Therefore, from a utilitarian perspective, the patient's request for euthanasia should be granted since the consequence will bring about more good than evil for everyone involved. Hence, as illustrated above, the rule *"do not kill"* can be broken to bring about better consequences for everyone involved. Therefore, when applying the utilitarian framework in

this instance, we can see that most people would agree with the practice of euthanasia and physician-assisted suicide.

6.2 Arguments against Euthanasia and Counterarguments

6.2.1 Respect for the Right to Life

First, the main criticism of euthanasia and physician-assisted suicide is that it is universally accepted that it is wrong to kill an innocent human being. Furthermore, the Universal Declaration of Human Rights generally emphasises the right to life. The right to life can also be found in Article 6 of the International Covenant on Civil and Political Rights and other legal human rights instruments worldwide (United Nations n.d). Those who do not favour euthanasia and physician-assisted suicide claim that the practice violates human rights since it contravenes the fundamental human right to life. Therefore, opponents do not believe in legalising the right to die just because we have a right to live. They claim that the legalisation of euthanasia and physician-assisted suicide would essentially mean making suicide justifiable in every case, making it incompatible with the law (Somerville, 2003).

Nonetheless, it can be argued that such an argument is not valid. For instance, when looking at the euthanasia laws in the Netherlands, one can see that there have not been many cases of incompatibilities with the euthanasia laws since the rules of procedure clearly state what can and can not be done. In contrast, it would be difficult to argue for the euthanasia laws in Belgium since they did not report any misconduct cases to the legal authorities during the first five years after enacting the euthanasia laws (Rurup et al., 2011). Moreover, according to utilitarian ethics, the argument that it is wrong to kill an innocent human is not acceptable, and a total ban on killing is not a general idea. For instance, there already exists cases whereby it is accepted by most people and by law that there are instances when the rule against killing is justified, such as situations relating to self-defence.

Second, opposers affirm that doctors can misdiagnose a patient's condition as a terminal illness when it is not, which means that euthanasia and physician-assisted suicide can take a patient's life due to a mistaken diagnosis (Disability Rights Education and Defence Fund n.d). For instance, we can all agree that doctors sometimes are wrong when determining a patient's condition. They might believe that there is no way to prevent an illness that a patient has from causing the patient

unbearable pain and suffering. However, it could be the case that just when the patient is euthanised, a cure or even better pain reliever for their condition is discovered, meaning that euthanasia and physician-assisted suicide would have contributed to giving up on patients too soon. However, from a utilitarian perspective, mistaken diagnoses and breakthroughs in cures warrant restrictions on when euthanasia and physician-assisted suicide should be considered, which supporters can argue is the case with existing euthanasia laws in the Netherlands and Belgium. Therefore the misdiagnosis argument is not a valid reason to entirely prevent the practice of euthanasia and physician-assisted suicide.

Further, opponents argue that the danger of abuse can also come from the patient's heirs, personnel who need to take care of the terminally ill patient, or persons who need to pay for the medical treatment that the patient receives. The point here is that said persons may be tempted to allow a terminally ill patient to be killed or left to die since they stand to gain from the patient's death. Opponents claim that it is not far fetched to think that they might convince themselves that the patient would be better off dead.

As we have previously observed, the legalisation of euthanasia and physician-assisted suicide is a way to minimise risks for patients (Rurup et al., 2011). For instance, in the Netherlands model, euthanasia and physician-assisted suicide are restricted to patients suffering from persistent pain and suffering, such as terminally ill patients. Moreover, the Netherlands model specifically mentions the physician's role when making end of life decisions. Thus, if a physician were to transgress, they are much more likely to get convicted since there is a written rule in contrast to the Belgium euthanasia law, which does not explicitly mention the physician (Rurup et al., 2011). Nonetheless, from a utilitarian point of view, the point of intentional abuse of the patient does give support to restrictions in both practices. However, it does not carry enough weight when arguing against the legalisation of voluntary euthanasia and physician-assisted suicide.

Third, opponents argue that even though utilitarians claim that there are safeguards in laws regulating both practices, it would be impossible to ensure that everyone complies with all the rules, which means that abuses would most likely occur. However, from a utilitarian perspective, it can be argued that the number of cases of such abuses is not enough to deter society from granting euthanasia and physician-assisted suicide for terminally ill patients that request it. Therefore, it is justified to have a few cases of abuse if legalising euthanasia and physician-assisted suicide would

benefit most of the population by decreasing pain and suffering and increasing autonomy. Additionally, when looking at the success rates of voluntary euthanasia and physician-assisted suicide in the Netherlands, we can concur that the laws governing both practices in the Netherlands are carefully drafted to prevent abuse (Rurup et al., 2011).

Fourth, given a utilitarian framework, another possible concern is that legalisation can create distrust between the patients and physicians. The main idea behind this argument is that some physicians might be more concerned with saving valuable resources than providing care for the patients in question in the healthcare system. Opponents claim that this would scare people from hospitals if they thought there was a possibility of being killed against their will or not being provided with the proper treatment (Brock, 2015). The argument is that public policy should not deter people from seeking medical help from medical experts. Compared to Belgium, the Netherlands is among the countries with the best healthcare services globally (Rurup et al.,2011). Although euthanasia and physician-assisted suicide have been legalised in both countries, it does not seem to have frightened citizens from seeking medical help. Further, opponents argue that no law should be passed that would genuinely threaten to undermine people's commitment to the general prohibition of taking innocent human lives. On the contrary, enacting euthanasia laws can distinguish between people who request euthanasia and those who do not, which aligns with utilitarianism ethics.

The due care requirements for euthanasia laws in the Netherlands and Belgium provide this safeguard. Moreover, passive euthanasia suggests that terminally ill patients do not stay away from hospitals for fear of being worse off than they already are (Garcia, 2017). Nonetheless, opponents argue that patients might fear that the medical staff at the hospital might not take up the opportunity to prolong their life due to the practice of passive euthanasia. However, it can be argued that if a patient is terminally ill and opts not to seek medical help due to fear of being euthanised, they will probably not end up living longer. Hence, they will be missing out on getting expert medical care, especially in the Netherlands, which would help ease their pain and suffering (Rurup et al., 2011). Therefore, one has more to gain by seeking medical help instead of not receiving any medical assistance.

6.2.2 Autonomy Against Euthanasia

Fifth, opponents argue that a patient's request for euthanasia is only autonomous in a handful of cases since most terminally ill patients may not be able to make rational or sound decisions. They claim that autonomy forbids euthanasia since the principle of autonomy does not allow for the voluntary ending of the conditions required for autonomy which would have arisen by ending one's life. Opponents of euthanasia and physician-assisted suicide argue that some terminally ill patients are not capable of making choices related to end-of-life decisions due to them being severely ill. For instance, a terminally ill cancer patient in their last stages might not be able to make rational decisions, which means that someone else, either their loved one or the doctor, will need to make the decision on their behalf. The basis of this argument is that even though utilitarians view an individual as the best capable person of deciding for themselves if the patient cannot make rational, autonomous decisions, the argument of individuals being the best judges of their well-being becomes invalid (Hartling, 2021). During such an occurrence, it can be argued that a medical professional knows what would be in the patient's best interest

Moreover, they argue that the notion of autonomy is not a sufficient justification for the legalisation of euthanasia concerning the realisation of individual autonomy (Ezekiel, 1990). For instance, as previously argued, rationality plays a vital role in making autonomous end of life decisions; hence, the liberty to make authentic decisions depends on the ability to make such decisions (Patterson and George 2005). Nonetheless, it can be argued that patients can be euthanised in the Netherlands and Belgium based on an advance directive instead of verbal requests (Rurup et al., 2011). Therefore, it is still possible for terminally ill patients' autonomy to be respected even when they are in a comatose state based on an advance directive. Therefore a law allowing voluntary euthanasia would support and not undermine the practice of euthanasia and physician-assisted suicide.

Nonetheless, it is essential to highlight that there are fewer cases of patients being euthanised based on the Netherlands' advance directive compared to Belgium. Because doctors have a more challenging time evaluating if the patient's wish for euthanasia is persistent since they are in a coma (Rurup et al.,2011). Although euthanasia performed based on advance directives in Belgium is strictly regulated, it is impossible to ensure that the patient still has the same wish. Opponents of euthanasia and physician-assisted suicide claim that an autonomous choice can damage moral integrity if the choice in question can injure or is at risk of injuring human welfare. By this, opponents view the concept of self-determination as comprising the good of the community as a whole. Furthermore, they claim that just because a decision has been made autonomously does not

mean it deserves to be respected since unregulated autonomy can lead to devastating consequences (Cohen-almagor, 2000).

Sixth, opponents argue that our autonomous actions can impact others even though we are free. Therefore, when making decisions about our own lives, we need to consider how our decisions will impact or harm the community's common good (Callahan, 1992). A patient's consent for euthanasia and physician-assisted suicide can be influenced by external factors such as economic status, social class, and medical circumstances (Conley, 1994). Opponents claim that pressures from outside imply that patients may be prone to select euthanasia and physician-assisted suicide due to a certain degree of coercion without exercising their full measure of self-governance. However, a counterargument to this claim is that both the Netherlands and Belgium have substantive and procedural requirement procedures for patient requests for euthanasia and physician-assisted suicide, which safeguard the patients. For instance, allowing the patient to have adequate time to change their mind, independence of the second physician whom the first physician selects to weigh in with their opinion. Furthermore, without autonomy, the welfare of persons would fall under the mercy of others, including the government (Lewis, 2007). Therefore, if respecting the patient's autonomy would lead to the greater good from a utilitarian perspective, the argument about patients being influenced by outside factors is not valid.

6.2.3 Protecting Society from the “Slippery Slope."

Seventh, from a utilitarian’s standpoint, one can claim that due to international human rights doctrines forbidding the killing of innocent persons, we are protecting the boundary of our human species, which promotes the greater good for society as a whole (Bartels and Otlowski 2010). This argument is grounded in the claim that the legalisation of euthanasia will lead us down a slippery slope to widespread and unjustified killing. Opponents claim that when euthanasia and physician-assisted suicide are legalised, we will start to see cases whereby involuntary euthanasia of vulnerable persons is performed, such as patients who might be in a comatose state. A government-initiated study in the Netherlands called the Remmelink Report found that physicians occasionally euthanised patients without their consent when patients were very close to dying and could no longer give consent (Jochemsen, 1994). However, a counterargument to this claim is that it is a very speculative argument because the Dutch government could not prove that the introduction of voluntary euthanasia led to the abuse of the patients. To show such evidence, the Remmelink Report

would have needed to do a study in the Netherlands and compare it to Belgium or any other country that has legalised euthanasia to show an increase in unjustified killings of terminally ill patients in the Netherlands. Moreover, studies on euthanasia and physician-assisted suicide have been done in the Netherlands, which revealed that there did not seem to be a significant increase in the number of involuntary cases of euthanasia and physician-assisted suicide in the Netherlands, disproving the slippery slope argument (Rurup et al ., 2011).

Eighth, opposers argue that terminally ill patients prone to unbearable suffering end up requesting assistance in dying due to fears of becoming a financial and emotional burden to their families. Many have argued that such patients might feel an obligation to choose death, making the obligation likely to interfere with the patient's autonomy (Stein, 2015). In contrast to Belgium, where cases of euthanasia mainly occur in hospitals, euthanasia cases in the Netherlands take place at home since the countries end of life policies are directed toward home care (Rurup et al.,201). Therefore, patients' chances of financial burdens are significantly lowered in the Netherlands. Nonetheless, opponents argue that when autonomy is regarded as the critical value of the relationship between the patient and the physician, we might be laying the foundations for physicians to enable patients to make ill-advised treatment decisions out of deference to the autonomy of the patient (Conley, 1994). Therefore, opponents argue that respect for autonomy can not be the only value in advising medical decision making. They suggest that doctors should look into other values, such as their responsibility to make sure the patient makes decisions in their best interest while holding the patient's autonomy as the central value (Stein, 2015). Such an argument is valid, and further investigation into the Netherlands and Belgium has revealed that most doctors do their due diligence before granting patients' requests for euthanasia and physician-assisted suicide. Moreover, a study of medical practitioners from the UK has revealed that the ending of patients' life without their explicit request does occur, although in sporadic cases (Rurup et al., 2011; Seale, 2006).

Ninth, opposers assert that many physicians cannot recognise when a patient is depressed and are not good at treating pain since most good pain relief can remove a patient's desire for euthanasia (Preira, 2011). For instance, It has been argued that terminally ill patients are often depressed or have not yet received good palliative care. According to most palliative-care specialists, most pain can be relieved by making patients unconscious by using terminal sedation and being sedated until they gradually pass away. Opponents of euthanasia do not consider terminal sedation a form of

euthanasia even though the patients are not tube-fed, which implies that they are also likely to die from being starved (Awadi, 2016). From a utilitarian perspective, it is hard to view terminal sedation as having any advantages over euthanasia since the patient rendered unconscious does not experience what is going on. According to utilitarianism, from the patient's point of view, terminal sedation or euthanasia and physician-assisted suicide can be viewed as the same thing from the moment the patient becomes unconscious unless the patient, while still unconscious, makes a preference for one thing over the other. A counterargument to terminal sedation is that, as mentioned before, the patients are not fed, which means that their quality of life will be considerably low. It can be argued that leaving a patient to deteriorate until they end up dying slowly from natural courses is inhumane (Sulmasy et al., 2016).

From a utilitarian perspective, voluntary active euthanasia and physician-assisted suicide seem to be better options than terminal sedation. Furthermore, an interesting counterargument to the argument above is that opponents do not argue against the right of a terminally ill patient to refuse life-sustaining treatment or receive pain relief that is sure to shorten their life (James n.d). The point here is that the patients are making choices that will potentially cut their lives shorter than they would have been if they had chosen another route. It is safe to argue that supporting a patient's right to refuse life-sustaining treatment and denying them access to voluntary euthanasia and physician-assisted suicide assumes that a patient can rationally refuse treatment. However, they can not rationally choose between voluntary euthanasia and physician-assisted suicide, which is incomprehensible. Suppose a terminally ill patient can rationally choose an earlier death by refusing life-sustaining treatment or accepting life-shortening palliative care. In that case, they should be able to rationally choose a more accessible and earlier death by choosing voluntary active euthanasia and physician-assisted suicide.

Tenth, combatants maintain that patients who request euthanasia and physician-assisted suicide will not be able to change their minds after their application for euthanasia and physician-assisted suicide is granted and they are euthanised. This claim is based on the fact that people make mistakes. Therefore, if euthanasia and physician-assisted suicide are performed on a patient, they are not in a position to change their mind since they would be dead. The point is that if a patient were to decide that it is worth living out the remainder of their life instead of opting for a quick death, it would be too late. A counterargument to this claim is that in a country such as the Netherlands, such mistakes rarely happen since the country has laws of procedural due care

requirements as set out in the legislation (Rurup et al., 2011). For instance, the patient must be offered consultation by another independent physician, as previously mentioned, in addition to filling out a report to the committee for evaluation by making use of a fixed registration form. Moreover, it is safe to argue that the Netherlands control and Evaluation Committee for patients who request euthanasia and physician-assisted suicide is better since it involves five Regional Euthanasia Committees. In contrast, Belgium only offers one Federal Control and Evaluation Committee (Rurup et al., 2011).

Furthermore, the claim that patients would not be able to change their minds after being euthanised needs to be weighed against the high number of people who have greatly benefited from the legalisation of both practices from a utilitarian standpoint. Since had it not been for the legalisation of both practices, they would still be going through unbearable pain and suffering, wishing that they would have had the option of euthanasia and physician-assisted suicide. There is no way for the patient in question to determine in advance which cause of action would not lead to regret making this claim and invalid argument against legalising euthanasia and physician-assisted suicide. However, it can be argued that if happiness is good, then when a person is euthanised, they are no longer happy, which leads a utilitarian to argue that when one is dead, their preference is no longer fulfilled (The Monist, 1993). However, a very relevant counterargument to this claim is that if the life of the person who has been euthanised had more negative consequences than positive ones before their death, then from a utilitarian point of view, the action taken to end the life of the patient is justified.

7. Conclusion and Final Discussion

The paper has examined the main arguments for and against legalising euthanasia and physician-assisted suicide. The specific statement the paper has aimed to defend is that euthanasia and physician-assisted suicide should be legalised, and two if legalised, the Netherlands model is superior to the Belgium model. The analysis asserts that denying terminally ill patients access to euthanasia and physician-assisted suicide violates their human right to autonomy concerning self-determination and individual well-being. The main reason why many nation-states are still hesitant to legalise euthanasia and physician-assisted suicide is due to concerns relating to the vulnerability of some persons and the concern of the value of human life, which are both linked to the slippery slope argument. However, as we have seen, the issue concerning the argument of the slippery slope

is controversial since there is no concrete evidence to back up the argument of the slippery slope. Moreover, there is no stark evidence of such concerns being realised in countries like the Netherlands, where both practices are legalised, which invalidates this argument. Therefore the paper found that the utilitarian arguments for allowing the legalisation of euthanasia and physician-assisted suicide seem to hold more water because, by utilitarian standards, the action with the greatest number of good is what counts.

The concept of autonomy is an integral part of our human rights. Having autonomy means that we are free to make our own decisions, which makes us feel happy and secure. When terminally ill patients express their personal choice to be euthanised, they realise their autonomy. Hence, their personal choice should be respected since it is a competent individual's fundamental freedom to define how their lives should be lived and ended. Further, legalising euthanasia and physician-assisted suicide promotes the individual's autonomy in contrast to criminalising euthanasia, which restricts autonomy. Before beginning this paper, I did not understand much of the concepts of euthanasia and physician-assisted suicide concerning utilitarian ethics. I had heard and read about the controversies concerning the ethical issue of euthanasia; however, I had never done an in-depth analysis of this magnitude with an ethical backgrounding theory as the guiding framework. Nonetheless, I agree that some of the arguments against the legalisation of euthanasia and physician-assisted suicide give me pause because I believe that there are instances whereby it is justifiable to refuse the request of a person that wants to be euthanised.

However, during my research, I found that most of those instances did not involve terminally ill patients but individuals suffering from mental depression or those who were tired of living, which is not the category of people that the paper aims to defend. Legalising both practices is the right course of action because euthanasia and physician-assisted suicide will continue to happen whether we legalise them or not, as evidence has clearly shown. Thus, it would be better to regulate both practices since regulation is a way to introduce safeguards that help ensure that everyone involved is protected to a certain extent. Further, this will bring the practice of euthanasia and physician-assisted suicide away from the shadows and into the light, whereby the whole community can be well informed of what is going on. Writing this paper has significantly improved my knowledge of this particular ethical issue. Based on my research, I believe I reside more with the utilitarian arguments for legalising euthanasia and physician-assisted suicide based on the Netherlands model. However, I am also inclined to think that the ethical issue of euthanasia and physician-assisted

suicide needs more research in terms of more transparent reporting from the necessary authorities when euthanasia is practised. Plus, more open platforms to discuss such topics without the judgment of religious beliefs.

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