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MEDICAL DECISIONS AT THE END OF LIFE THAT HASTEN DEATH

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ABSTRACT

Medical decisions at the end of life (MDELs) that have the potential to hasten death are increasingly prevalent in medical practice given (a) an aging population and (b) the increase in medical technology that allows life to be sustained beyond what it could be in the past and sometimes beyond what may be comfortable for the patient. When a decision is made to introduce life-sustaining interventions this may imply a later decision to halt these. Attitudes towards medical decisions that hasten death were explored among Greypower members, 55+ years ($N = 595$), Psychology students, 29 years and under ($N = 205$) and General Practitioners, 70 years and under ($N = 120$) in Auckland, New Zealand. Vignette scenarios were used related to withdrawing and withholding life support and nutrition and hydration, denying dialysis to a requesting patient, increasing medication to address pain at the risk of hastening death, physician supplying information, drugs, physician assisting patient to take drugs and physician giving a lethal injection to a terminally ill patient with intractable pain, on request and physician providing assisted death to a requesting tetraplegic patient. The effect of age of patient and consent on decision-making was also explored. Greypower members and Doctors had similar attitudes towards MDELs that are legal in New Zealand but over three-quarters of the Greypower members judged physician-assisted death for a terminally ill patient as justified compared to only one third of the Doctors. Psychology students were more conservative than either the Greypower members or the Doctors for all judgments related to the justifiability of MDELs. There appear to be underlying philosophical differences in the approaches to end of life decision-making by the three groups with Psychology students favouring a Sanctity of Life position and General Practitioners favouring the Status Quo. Greypower members appear to have a pragmatic approach to end of life care that does not favour one position over another.

A second study adapted the questionnaire used in Holland in 1990 by the Remmelink Commission of Inquiry exploring the incidence of MDELs among general practitioners in New Zealand ($N = 1255$). Results indicate that 63% of general practitioners had made an MDEL for the last patient who died in their practice in the previous twelve months. Practitioners could select more than one action for this patient and taking into account the probability that the end of life would be hastened, 37.2% had withheld treatment, 28.8% had withdrawn treatment and 84.9% had increased medication to relieve pain. Medication to relieve pain or other symptoms was increased in part with the intention of hastening the end of life by 24.8% of practitioners.

Actions were taken with the explicit purpose of not prolonging life or hastening the end of life and death was caused by withholding treatment 18.7%, withdrawing treatment 10.2% and prescribing, supplying or administering a drug 5.6%. In 54.8% cases, there was no discussion with the patient prior to the action taken, although in some of these cases a wish had been expressed by the patient at a previous time to have death hastened. Of the 39 cases where a drug was supplied or administered with the explicit intention of hastening death and death occurred, the drug was administered by a nurse alone in 15 cases (under physician orders, implied in the question) and the physician alone in 13 cases. In two cases the patient self-administered the drug.

In order to assess the impact of euthanasia (arguably at the extreme end of the MDEL continuum) on practitioners, a qualitative study was conducted to explore the accounts of ten Dutch doctors who had cared for dying patients, five who had performed euthanasia and five who had not. Themes were compared and contrasted to expose similarities and differences in the approaches of the two groups to patient care. Both groups endorsed palliative care as the preferred approach to the care of the dying patient. Those who had not performed euthanasia expressed their commitment to the patient in continued exploration of palliative options and a stated commitment of non-abandonment of the patient. Those who had performed euthanasia portrayed this action as the “ultimate commitment” to the patient, no other option being seen as meeting patient need. The effect on the doctor of performing euthanasia was intense. Other medical decisions at the end of life that hasten death such as terminal sedation or withdrawing nutrition and hydration were posited by the doctors who had performed euthanasia to be analogous to euthanasia, and the psychological effect on the doctor was similar. Those who had not performed euthanasia stated that these actions were not the same as euthanasia. Dissonance theory was used to explore why the two groups may portray their actions that hasten death in different ways.

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DEDICATION

*This thesis is dedicated with love to the memory of Mary Shane Goodall
August 5 – December 13, 1947*

*There is only one child in the world
and the name of the child is All Children*
Carl Sandburg

TABLE OF CONTENTS

Abstract	ii
Acknowledgements	iv
Dedication	vi
Table of Contents	vii
List of Tables	xi
List of Figures	xiii
Prologue	1
SECTION I	6
Chapter 1	6
Introduction	6
The ethics of intent in medical decisions that hasten death.....	6
Underlying principles of end of life decision-making	7
Morality in end of life decision-making.....	8
Utility and end of life decision-making.....	10
MDELs in New Zealand.....	12
<i>Constraints of health resources</i>	12
<i>Limited health care resources implicated in mercy killings</i>	13
<i>Response of society to “mercy killing” cases</i>	15
<i>The role of society in right to die reform</i>	16
Chapter 2	19
Review of literature: Medical decisions that hasten death.....	19
Withholding and withdrawing treatment.....	19
<i>The concept of death</i>	19
<i>Medical decision-making affected by legal definitions</i>	21
<i>Medical decision-making defined by quality of life</i>	23
<i>Treatment/non-treatment decision-making and futility</i>	25
<i>Nutrition and hydration</i>	27
<i>Terminal Sedation</i>	29
<i>Ventilatory life support</i>	31
Chapter 3	33
Review of literature: Planning for death	33
Advance directives	33
<i>Formalising advance care planning may not increase implementation</i>	34
<i>Advance care planning and the law</i>	34
<i>Barriers to advance care planning</i>	35
<i>Advance care planning does not address all needs</i>	36
<i>The difficulty of forecasting preferences</i>	37
<i>Reliability, durability and validity of advance care planning</i>	38
<i>Values history - the quality of a life</i>	40
<i>Proxy decision-making</i>	41
Chapter 4	46
Review of literature: International perspectives on assisted death.....	46
Physician-assisted suicide and euthanasia.....	46
The Dutch experience with assisted death.....	47
<i>The Rimmelinck Study</i>	49
<i>Research focus after the Rimmelinck Study</i>	51
The Australian experience with assisted death	54
<i>Northern Territory</i>	54
<i>Attitude of physicians to physician-assisted death</i>	55

<i>Attitude of nurses to physician-assisted death</i>	56
The American experience with physician-assisted death.....	57
<i>Attitudes of laypersons towards physician-assisted death</i>	57
<i>Attitudes of physicians to physician-assisted death</i>	58
<i>Physician-assisted death legalised in Oregon</i>	58
Physician-assisted death in New Zealand	62
<i>The Law</i>	62
<i>Parliament</i>	63
<i>Medical profession</i>	64
Comparison between Oregon, Netherlands, Northern Territory and New Zealand of prerequisites/proposed prerequisites for assisted death	66
The purpose of this thesis	4
SECTION II	68
Chapter 5	68
Study One: Perceptions on Justifiability and Legality of Medical Decisions at the End of Life that Hasten Death – Laypersons and General Practitioners in New Zealand	68
Introduction	68
Aim.....	69
Method.....	71
<i>Participants and recruitment</i>	71
<i>Measures</i>	72
Analysis	73
Cross-study results	74
Chapter 6	76
Results: 1. Philosophical principles underlying decision-making	76
Discussion	81
<i>Using Developmental theory as a theoretical framework within which to view differences in decision-making</i>	83
Caveat	87
Chapter 7	90
Results: 2. Physician-assisted suicide and euthanasia.....	90
Discussion.....	101
<i>Doctor supplying information and drugs to end life to a terminally ill patient with intractable pain</i>	101
<i>Doctor assisting a terminally ill patient with intractable pain to take drugs to end life.</i>	108
<i>Doctor administering a lethal injection to a terminally ill patient with intractable pain.</i>	111
<i>Doctor sedating a terminally ill patient with intractable pain.</i>	114
<i>"Palliative treatment" and "Hospice"</i>	115
Chapter 8	118
Results: 3. Withdrawing/withholding life-sustaining treatment.....	118
Discussion.....	123
<i>Place of care impacting on understanding of legality of actions</i>	123
<i>Effect of being unsure of legality of actions.</i>	124
<i>Impact of wording in Living Will on decision-making.</i>	125
<i>Effect of Existence of Living Will on Judging Action Justified</i>	126
<i>The potential for conflict in removing life sustaining treatment</i>	127
<i>MDELS may be more difficult when "starving" the patient is involved</i>	131
Chapter 9	134
Results: 4. Age of patient & consent in decision-making	134
Discussion.....	143

<i>Legality of withdrawing life support or nutrition and hydration</i>	143
<i>Judging withdrawing life support and withholding nutrition and hydration as justified</i>	145
<i>Consent and increasing pain medication at the risk of hastening death</i>	145
<i>Confusion on legality may be related to media reporting</i>	148
<i>Principle of Double Effect and the ethics of hastening death</i>	149
Chapter 10	152
Conclusion	152
Limitations of the study	158
SECTION III	161
Chapter 11	161
Study Two: Medical Decisions at the End of Life that Hasten Death Performed by New Zealand General Practitioners	161
Introduction	161
Aims	162
Method	162
<i>Participants and recruitment</i>	162
<i>Measures</i>	162
<i>Confidentiality and Response Rates</i>	163
Analysis	164
Results	164
<i>Occurrence of MDELs</i>	166
<i>Characteristics of physicians who had made an MDEL</i>	167
<i>Characteristics of treatment withdrawn/withheld</i>	168
<i>Affirmative answers to Question 6</i>	169
<i>Extent of life shortened when MDEL actioned</i>	169
<i>Decision-making process</i>	171
<i>Discussion with patient</i>	171
<i>No Discussion with patient</i>	173
<i>Do-Not-Resuscitate Orders</i>	177
<i>Explicit request to terminate life not carried out</i>	178
<i>Legislation</i>	179
<i>Palliative Care</i>	179
Chapter 12	181
Discussion.....	181
<i>Incidence of MDEL-actions</i>	183
<i>Access to palliative care and decision-making</i>	186
<i>Affirmative answers to Question 6</i>	189
<i>Decision-making in MDELs</i>	189
<i>Extent of shortening life</i>	190
<i>Decision-making – discussion took place</i>	191
- <i>Competency</i>	192
- <i>Discussion initiation</i>	193
- <i>Written directives</i>	194
<i>Decision-making – no discussion took place</i>	194
- <i>A request for hastened death from others</i>	195
- <i>Reasons for no discussion with the patient</i>	196
<i>Other discussants when an MDEL was actioned</i>	197
<i>Explicit request to terminate life</i>	198
<i>Do-Not-Resuscitate Orders</i>	198
<i>Legislation</i>	199
<i>Palliative Care</i>	201

<i>The special case of children</i>	202
<i>Question 6 – Was death caused by a drug prescribed, supplied or administered with the explicit purpose of hastening the end of life (or of enabling the patient to end his or her own life)?</i>	204
-Who administered the drug.....	204
-Discussion/no discussion with patient.....	205
-Physician interpretation of questions implicated in responses	206
Summary and Conclusion	208
Limitations of the study	211
SECTION IV	213
Chapter 13	213
Study 3: The Dutch Experience – Physicians’ Caring for the Dying Patient	213
Introduction & Methodology.....	213
Aim.....	215
Procedure.....	215
Interview Process	216
Analysis	217
Reflexive Account	219
Chapter 14	222
Results:	222
Category 1: Palliative Care.....	223
Chapter 15	244
Category 2: Euthanasia-Palliative Care: Continuum vs Dichotomy.....	244
Category 3: Autonomy	250
Chapter 16	262
Category 4: Euthanasia.....	262
Chapter 17	285
Discussion.....	285
<i>Palliative Care</i>	285
<i>Treatment withdrawal, terminal crises and euthanasia</i>	287
<i>A multi-disciplinary approach to care</i>	288
<i>The development of palliative care as a discipline in Holland.</i>	289
<i>Terminal sedation and euthanasia</i>	291
<i>Autonomy</i>	292
<i>The euthanasia request</i>	294
<i>Protocols and Processes of Euthanasia</i>	296
<i>Effect on doctor of performing euthanasia</i>	297
<i>Using dissonance theory as a theoretical framework within which to examine one approach that may be taken to resolve any psychological discomfort related to death hastening actions.</i>	300
Conclusion and Implications	308
Shortcomings of the study	310
SECTION V	313
Chapter 18	313
"The Pause"	313
References	318
Appendices	318
Appendix A: Culture: Relativity, context & socialisation	
Appendix B: Vignette Questionnaire used in Study One	
Appendix C: Values history form	
Appendix D: Questionnaire used in Study Two, Rummelink replication	
Appendix E: Participant Information Sheet and Consent Form for Study Three	

LIST OF TABLES

Table 4.1: Main conditions under which elective death may be given in Oregon and the Netherlands, formerly given in the Northern Territory* and proposed for New Zealand...	67
Table 5.1: Table showing demographic breakdown of age, gender, ethnicity and strength of religious beliefs of Young and Older Laypersons and Doctors.	75
Table 6.1: Table showing two vignettes compared to investigate possible philosophical differences in how Young and Older Laypersons and Doctors approach decision-making.	76
Table 6.2: Table showing summary statistics for Laypersons and Doctors on judgments of justifiability and legality of assisted death on request for a tetraplegic patient and denying dialysis to a requesting patient.	78
Table 7.1: Table showing four vignettes compared to investigate level of tolerance by Young and Older Laypersons and Doctors for physician-assisted death.	91
Table 7.2: Table showing questions related to the function of palliative care and hospice.	92
Table 7.3: Table showing summary statistics for Young and Older Laypersons and Doctors on level of tolerance and judgments on legality for physician-assisted death and terminal sedation ..	94
Table 7.4: Table showing judgments of Young and Older Laypersons and Doctors on the meaning of the terms "palliative care" and "hospice"	101
Table 8.1: Table showing three vignettes compared to investigate effect of a Living Will on the decision-making of Young and Older Laypersons and Doctors on justifiability and legality of actions.	119
Table 8.2: Table showing summary statistics for Young and Older Laypersons and Doctors on judgments on justifiability and legality of actions with and without a living will.	121
Table 8.3: Excerpts from media reporting on the Hugh Finn case showing the polarity of opinion from several sections of society on the withdrawal of nutrition and hydration in this case.	128
Table 9.1: Table showing vignettes compared to investigate effect of age of patient on the decision-making of Laypersons and Doctors on justifiability and legality of withholding nutrition and hydration.	135
Table 9.2: Table showing vignettes compared to investigate effect of age of patient and consent on decision-making of Laypersons and Doctors on justifiability and legality of actions.	136
Table 9.3: Table showing summary statistics for Young and Older Laypersons and Doctors on judgments on justifiability and legality of end of life actions as a function of consent and age of patient	138
Table 9.4: Table showing effect of ethnicity of Young Layperson respondent on judging it justified to increase pain relief for a child or adult knowing that death could be hastened.	142
Table 10.1: Table showing difference in judgments of Young and Older Laypersons and Doctors on judgments on justifiability of medical decision	153
Table 11.1: Table showing reasons given for not participating in study by general practitioners who returned blank survey.	165
Table 11.2: Table showing demographic breakdown of general practitioners participating in study.	165
Table 11.3: Table showing medical decision at the end of life (MDEL) performed by general practitioner on the last death attended in the previous 12 months	167
Table 11.4: Table showing demographic details of doctors who answered affirmatively to Question 6.	170
Table 11.5: Table showing estimation of shortening life, based on the last-mentioned MDEL taken in the last death attended in the previous 12 months.	170

Table 11.6: Table showing discussion status with the patient about the last-mentioned MDEL.	172
Table 11.7: Table showing characteristics of discussion with patient about the last-mentioned MDEL.	173
Table 11.8: Table showing decision-making after no discussion with patient about the last-mentioned MDEL.	174
Table 11.9: Table showing reason given for no discussion with patient about the last-mentioned MDEL.	176
Table 11.10: Table showing representative statements of reasons given in “Other” option for not discussing possible hastening of death from act or omission with patient	176
Table 11.11: Table showing discussion with others when there was no discussion with the patient and no known wish expressed by the patient.	177
Table 11.12: Table showing Do Not Resuscitate (DNR) order for patients for whom an MDEL was made and those for whom death was unexpected but the doctor had previous contact with patient.	178
Table 11.13: Table showing request to terminate life that was not carried out.	178
Table 11.14: Table showing perceived impact of present legislation in New Zealand on MDEL actioned	179
Table 11.15: Table showing access to palliative care and use of palliative care or pain control services by all respondents (<i>n</i> = 1255).	180
Table 12.1: Table showing comparison between Dutch and New Zealand general practitioners of last mentioned MDEL (withdrawing/withholding combined for analysis).	185
Table 12.2: Table showing reasons given for non-discussion when Question 6 was answered affirmatively (<i>n</i> = 17).	196
Table 12.3: Table showing details of cases answered affirmatively in Question 6.	205
Table 13.1: Table showing position, age and religious affiliation of ten Dutch doctors interviewed.	216
Table 14.1: Table showing categories and themes represented in discursive accounts of Dutch doctors who have performed euthanasia and Dutch doctors who have not.	222
Table 14.2: Table showing issues arising around characteristics of palliative care for Dutch doctors who have performed euthanasia and Dutch doctors who have not.	224
Table 14.3: Table showing issues arising around palliative care, treatment withdrawal and terminal crises for Dutch doctors who have performed euthanasia and Dutch doctors who have not.	232
Table 14.4: Table showing issues arising around team approach to palliative care for Dutch doctors who have performed euthanasia and Dutch doctors who have not.	237
Table 14.5: Table showing issues arising around delivery of palliative care to the consumer for Dutch doctors who have performed euthanasia and Dutch doctors who have not.	240
Table 15.1: Table showing issues arising around palliative care that hastens death for Dutch doctors who have performed euthanasia and Dutch doctors who have not.	244
Table 15.2: Table showing issues arising around autonomy in end of life decision-making for Dutch doctors who have performed euthanasia and Dutch doctors who have not.	252
Table 16.1: Table showing issues arising around the request for euthanasia for Dutch doctors who have performed euthanasia and Dutch doctors who have not	263
Table 16.2: Table showing issues arising around protocols and processes associated with delivering euthanasia for Dutch doctors.	270
Table 16.3: Issues arising on effect of performing euthanasia for Dutch doctors who have done so and potential effect for Dutch doctors who have not.	275

LIST OF FIGURES

Figure 1: Drawing by woman dying of cancer	3
Figure 6.1: "Yes" responses of three groups on justifiability of granting tetraplegic patient request for assisted death and denying requests for dialysis to elderly patient.....	80
Figure 6.2: Combinations of principles employed by Laypersons and Doctors when comparing the justifiability of assisted death of a requesting tetraplegic patient or denying dialysis to a patient who has requested it.....	80
Figure 6.3: Suggested location of underlying philosophical principles used in decision-making according to Kohlberg's theory of moral development.....	85
Figure 7.1: Judgments of Young & Older Laypersons and Doctors on the legality of doctor supplying information, drugs, assisting patient to take drugs, administering a lethal injection & terminal sedation of a terminally ill patient with intractable pain, on request..	93
Figure 7.2: Judgments on justifiability by Young and Older Laypersons and Doctors of supplying information or drugs, assisting to take drugs, giving a lethal injection or terminally sedating a dying patient on request.....	94
Figure 7.3: Relationships between Doctors' religiosity and judgments on justifiability of supplying information or drugs, assisting patient to take drugs or giving a lethal injection to a terminally ill patient with intractable pain, on request.....	96
Figure 7.4: Comparisons between European-Pakeha /Other Ethnicities Combined Young Layperson and Age Comparison 18-35/70-80 year old Laypersons on judgments on justifiability of hastening death action.....	98
Figure 7.5: Figure showing decision tree approach of physician responding to a request for assisted death.	106
Figure 8.1: Judgments on the legality of withdrawing life support and withdrawing or withholding nutrition and hydration from a permanently comatose patient with and without a Living Will.	120
Figure 8.2: Judgments of justification by Young and Older Laypersons and Doctors of withdrawing life support and withdrawing and withholding nutrition and hydration with no Living Will from a comatose patient with no hope of recovery	122
Figure 9.1: Comparisons for Laypersons and Doctors between judging it justified to withdraw life support, withhold nutrition & hydration and increase pain relief with or without consent at the risk of hastening death for an adult or child.....	139
Figure 9.2: Responses of Young Laypersons on judging legality of withdrawing life support, withholding nutrition and hydration and increasing medication at the risk of hastening death for an adult and baby	140
Figure 9.3: Responses of Older Laypersons on judging the legality of withdrawing life support, withholding nutrition and hydration and increasing medication at the risk of hastening death for an adult and a baby.	140
Figure 9.4: Responses of Doctors on judging the legality of withdrawing life support, withholding nutrition and hydration and increasing medication at the risk of hastening death for an adult and baby.	141
Figure 9.5: Effect of ethnicity of Young Layperson on judgments of legality of increasing pain relief for a child or adult knowing that death could be hastened, with consent.....	143
Figure 10.1: Judgments by Young and Older Laypersons and Doctors on justification of medical decisions that hasten death.....	154

Figure 10.2: Judgments by Young and Older Laypersons and Doctors on legality of medical decisions that hasten death.	154
Figure 11.1: Frequencies of treatment withdrawn or withheld by general practitioners making a MDELHD	168