Surf City XIX

Huntington Beach High School

WHO

Topic A: *Addressing the Inaccessibility and Stigma of Vaccines*

Topic B: *Euthanasia and Assisted Suicide*

Welcome Letter

Dear Delegates,

On behalf of the Huntington Beach High School Model United Nations Program, we would like to welcome you to our Surf City XIX advanced conference!

Our annual Surf City conference upholds the principles and intended purpose of the United Nations. Delegates can expect to partake in a professional, well-run debate that simulates the very issues that those at the United Nations discuss every day. Both novel and traditional ideas will be shared, challenged, and improved.

It is our hope that all delegates will receive the opportunity to enhance their research, public speaking, and communication skills as they explore the intricacies of global concerns through various perspectives, some of which may be very different from their own. We hope their experiences here give them new insight and values that they can apply outside of the realm of Model UN for the betterment of the world community.

Please do not hesitate to approach our Secretariat or Staff Members with any questions or concerns that you may have throughout the day. We wish the best to all our participants and hope that they may share a fulfilling experience with us!

Enjoy the conference!

Sincerely,

Zach Bernstein
Secretary General

Vivian Bui
Secretary General

Lauren Le
Secretary General

Alison Miu-Martinez
Secretary General

Meet The Dais

Noelle Sexton

Hi delegates! My name is Noelle Sexton and I am one of your head chairs for this committee. I am a Senior at Huntington Beach High School and have been in MUN all four years. Outside of MUN I am on the girls swim team at our school. I also participate in a few clubs and organizations. I have been part of the Doctors of Tomorrow club since my freshman year and recently co-created the Humanitarian Helpers club. I also participate in the National Honor Society (NHS) and the Trivia club! I hope to graduate this year and spend the next four years at a university. I am majoring in psychology or neuroscience, depending on the school I end up at. My favorite MUN committees include IAEA, UNEP and WHO. I can't wait to meet you all in committee!

Moé Caruso

Hey delegates! My name is Moé Caruso and I am currently a senior at HBHS. I have been a part of MUN for four years, helping me improve my public speaking skills and become more knowledgeable on issues occurring globally. Outside of MUN, I am on the high school swim team and am a part of many clubs such as Robotics, Humanitarian Helpers, Doctors of Tomorrow, and National Honors Society. In my free time, I enjoy watching movies, reading, and trying out new recipes! I have also lived in Japan, increasing my interest in Public Health and Nutrition Sciences because of the different ways that health and food systems operate globally. I cannot wait to meet you all in committee and wish you all the best of luck!

Lauren Chen

Hi delegates! My name is Lauren Chen, and I am a current junior here at HBHS. This is my third year in MUN, and I can't wait to see all of your performances at Surf City XIX! Some of my favorite committees to participate in are IAEA and WHO, which is why I am particularly excited to learn about all of your new, innovative solutions. At school, I am involved in the girl's tennis team, the National Honors Society, Robotics, and my own club called Groceries for Giving, which is focused on mitigating the effects of food insecurity in Orange County. Outside of school, I enjoy baking, cooking, spending time with friends, listening to music, having picnics, finding new local coffee shops, and going to art museums. Good luck to you all, and see you soon!

All Papers are due on **JANUARY 30, 2022** by 11:59pm to

surfcitymun.who@gmail.com

Topic A: Addressing the Inaccessibility and Stigma of Vaccines

Background

For thousands of years, vaccines have been utilized to reduce the effects of disease, helping to lengthen the human lifespan and reduce the detrimental effects of virus outbreaks. As early as 1000 CE, there is evidence that the Chinese utilized smallpox inoculation, where smallpox would be introduced into a healthy person's body to help build their immune response to the virus. Similar practices have also been found in Africa and Turkey before spreading to Europe and the Americas. Notably, in 1796, Edward Jenner created one of the first forms of a modern vaccine through his use of cowpox material to develop immunity to smallpox, directly leading to the eradication of smallpox. Following Jenner's development in 1885, Louis Pasteur created a rabies vaccine that was applied towards the growing creation of vaccines towards human diseases. Throughout the 20th century, there were rapid advancements in vaccines against various diseases, such as diphtheria, tetanus, anthrax, tuberculosis, and cholera. Despite Jenner's success, his efforts were met with heavy criticism from the public. Physicians and scientists who argued in favor of a smallpox vaccine for children were met with objections because of religious, political, and sanitary reasons, along with the fear that underlying economic motives pushed for the mandate of the vaccine.[1]

In addition, many have expressed concern towards vaccine adjuvants, recalls, the safety of vaccines during pregnancy, side effects of vaccines, and government distrust. Vaccine adjuvants are additives used in vaccines to help strengthen the immune response in a recipient, such as the common inclusion of aluminum phosphate, alum, or aluminum hydroxide, which are feared for their possible side effects.[2] Specifically, many people have linked vaccines to the development of autism, despite a lack of scientific data. In addition, there are common, minor side effects of most vaccines such as muscle soreness, chills, or a headache, but some still believe that seizures and fainting are a direct result of receiving a vaccine. The number of tested measures that can be taken to reduce these side effects are often overpowered by the societally induced fear of short or long-term issues that will be received through a vaccine. A strain of the flu in 1976 sparked concern towards the likelihood of developing Guillain-Barré Syndrome (GBS), a rare condition in which the body's immune system damages nerves, which leads to muscle weakness and paralysis. Recent research suggests that people are more likely to develop GBS after the flu rather than a vaccine, but many are still distrustful of this information. While it is rare for vaccines to be recalled, it is still a concern for many individuals because of the possibility that the vaccine will be recalled based on a suspected issue posed by a manufacturer or healthcare facility. Another concern for many women is whether a vaccine is safe to be taken during pregnancy because they believe there is a potential for a vaccine to be carried onto their offspring.[3] Various religious beliefs have supported a pressing global concern towards the stigmatization of vaccines. In particular, some Orthodox Jewish populations believe that vaccines are not included in Jewish theology, as their faith should be enough to heal illness without introducing a foreign, manufactured substance.[4]

A lack of vaccine access is prevalent in many indigenous communities, particularly in Canada, who have a higher risk of human papillomavirus (HPV) infection rates and a lower scanning rate and healthcare assistance. In Indigenous communities, there is a lack of resources,

service infrastructure gaps, and historical mistrust in healthcare systems.[5] Many Indigenous leaders and members have expressed hesitancy towards becoming vaccinated because public healthcare facilities and providers have frequently dismissed the health of Indigenous people. The UN has expressed a desire to honor traditional lifestyles that many Indigenous communities lead, yet are concerned about their lack of protection from constantly changing forms of viruses. Additionally, many assimilation efforts have been instituted along with healthcare institutions that have forced Indigenous people to receive medical procedures against their interests. In addition, systemic racism and their socio-economic marginalization prevent Indigenous groups from accessing many vaccines.[6]

In recent years, the accessibility of social media has played a critical role in vaccine administration due to disinformation that is spread globally. The negative influence of social media is prevalent in France, which encountered a surge in social media engagement regarding misinformation towards vaccines, growing from an average of 3.2 million people to 4.1 million people in the span of 2020.[7] Globally, accounts are commonly run by civilians with a sole disinterest in vaccines and no scientific or medical background, who spread disinformation on the effectiveness of vaccines, the possibility of tracking devices, or DNA altering material in the vaccines. In addition, many social media accounts indicate the development of dictatorships because of the enforcement of vaccinations.[8] In France, nearly 40% of people intended to receive a COVID-19 vaccine, but the numbers decreased to nearly half, credited to the mass spread of misinformation.

Globally, there have also been long-standing disparities in vaccine costs and access to healthcare centers that can safely administer vaccines.[9] Vaccine pricing can place a substantial burden on vaccine access, seen through the HPV vaccine that is considered one of the most expensive, at nearly 200 dollars per dosage, despite the 630 million people that deal with HPV globally.[10] Even in 2010, 87% of high-income countries had access to PCV, while only 2% of low-income countries included this vaccine in their scheduled immunizations.[11]

Most recently, the development of the COVID-19 vaccine has led to the enactment of public policy to encourage vaccination. However, this action has been met with direct backlash because of fears that the vaccine was developed too quickly and was not carefully tested for safety.[12] In combination, many people do not view COVID-19 as a pressing threat to society due to a lack of trust in the government and the developers of vaccines. Particularly, the COVID-19 vaccine has grown to be recognized as a political issue in which political opinions have become associated with the administration of the vaccine, leading to greater polarization on the issue. The COVID-19 vaccine has also highlighted the racial factors that can prevent one from receiving the vaccine, as many racial minorities are less likely to be able to take time off work to rest or take their children to be vaccinated. For instance, in the United States, 38% of parents with an income under 50,000 dollars have difficulty traveling to be vaccinated, while only 3% of participants with an income higher than 50,000 dollars find it difficult to be vaccinated. There are underlying prejudices towards people, signified through a study conducted in the United States where nearly 56% of Hispanic adults who got vaccinated were asked to show their government-issued identification, and 42% were questioned while signing up, posing as a barrier to receiving a vaccine.[13] Globally, there are many restrictions to receiving vaccines, as high-income countries only represent a fifth of the global population but have more than half of all vaccine doses, which causes disparities between populations. The impacts of COVID-19 on developing countries have often not been broadcasted, although nearly half of global mortality from this virus.

United Nations Involvement

Starting in 1948, the World Health Organization (WHO) was established by the UN with its main objective of "the attainment by all peoples of the highest possible level of health."[14] Led by the executive World Health Assembly (WHA), they advocate for maximum health access on a variety of global topics, with particular emphasis on the control of non-communicable diseases through the promotion of vaccine accessibility and destigmatization.[15]

Prior to the COVID-19 pandemic, the UN has had an extensive history in the fight for global vaccination access. In 2005, Resolution WHA58.15 was enacted to introduce the Global Immunization Strategy and Vision, urging member states to strengthen immunization programmes between 2006-2015 with the mobilization of resources in developed nations for more comprehensive vaccine research.[16] In 2012, the WHA issued the Global Vaccine Action Plan (GVAP), which is an extensive framework aimed to prevent millions of avoidable deaths through 2020. Utilizing the newly formed DoV Collaboration consisting of the Bill & Melinda Gates Foundation, UNICEF, United States National Institute of Allergies and Infectious Diseases, WHO, Global Alliance for Vaccines and Immunization (GAVI) Alliance, and various private and public organizations, the GVAP framework provides specialized action plans for each continental region to promote equal vaccine access in all communities.[17] An additional UN Foundation, Shot@Life, focuses on decreasing disease-related child mortality rates through encouraging public action on vaccine accessibility, providing education, and fundraising.[18] Focusing primarily on measles, polio, and pneumonia, Shot@Life has provided over 30 million children with life-saving vaccines while offering an additional 53,000 oral Rotarix and RotaTeq vaccines in developing nations to combat rotavirus.[19]

In 2020, the WHA set a target to eliminate the risks of cervical cancer in women, first starting with the implementation of the 2030 goal of achieving 90% human papillomavirus (HPV) vaccine coverage.[20] Later that year, the UN initiated the Immunization Agenda 2030 (IA2030), which calls upon the collaboration of WHO, UNICEF, and GAVI to strive to provide lifetime vaccination resources for over 20 different diseases.[21] According to this agenda, 50 million disease-related deaths will be prevented, 75% of which in low-middle to low income nations.[22] Rooting from the dire need to curb the continuation of the coronavirus pandemic and its various social and economic effects, the COVAX sector has been established as a part of the Access to COVID-19 Tools (ACT) Accelerator. Combining efforts from the Coalition for Epidemic Preparedness Innovations (CEPI), WHO, and GAVI organizations, COVAX works to accelerate the design, production, and distribution of COVID-19 vaccines across all nations with 144 active participants.[23] Additionally, with the incorporation of the Humanitarian Buffer, COVAX has emphasized the importance of COVID-19 vaccine availability for vulnerable populations, such as asylum seekers, internally displaced persons, minorities, and refugees.[24] In supplement, Resolution S/RES/2565 was passed by the Security Council in early 2021 to address the need for a international peace agreement to provide affordable access to COVID-19 vaccines, particularly in conflict-ridden zones. However, since it was passed so recently, an update on its progress has not yet been recorded, but the international community is in strong support of this global ceasefire as a similar initiate proved highly successful in eradicating smallpox in Ethiopic and Bangladesh during the 1960s.[25]

To mitigate the stigmatization and misinformation spread regarding the safety of vaccines, the WHO established the Information Network for Epidemics, which works with social media teams and technical analysts to track and falsify inaccurate claims spread throughout the internet. WHO has also initiated partnerships with Facebook and WhatsApp to send out COVID-19 vaccine-related guiding messages in several different languages with the ability to

reach audiences of 2 billion and more, and is currently underway in partnering with the International Telecommunication Union to broaden the spread of its messages.[26]

Overall, the UN has proven dedicated to maximizing international health through the advocacy of various vaccines, continuing to push forward into the present to combat one of the leading global catastrophes of the time.

Case Study: England's Smallpox Outbreak

There is a long history of anti-vaccination movements that came before more current opposition. One of the first and most stigmatized vaccines in history was that of smallpox. Smallpox was a common, endemic disease with its strongest effects in the United Kingdom. At its worst, smallpox accounted for 20% of all child burials within the UK, most commonly affecting rural communities.[27] With over 400,000 children killed annually due to smallpox, Edward Jenner's vaccine could save 10-15 million in a few decades. Although a vaccine was created and utilized in the early 19th century, the last case of smallpox in the United Kingdom was recorded more recently, in 1978.[28]

An explosive smallpox outbreak occurred in London, England, from 1800-1840 that is commonly marked by the industrial revolution that caused mass migration to urban cities.[29] The increase in population density increased exponentially, as did the transmission rate of smallpox. While the smallpox epidemic expanded, vaccinations did not increase accordingly due to the stigma and inaccessibility in England.

Transparency and accurate data between cities were scarce in the early 1800s. Infections and vaccinations were poorly recorded, which did not provide accurate or consistent data for the treatment of patients. This was especially concerning in less concentrated, rural areas. To address these concerns, the National Vaccine Establishment was created in 1808 to provide free vaccinations in London train stations. This solution steadily decreased transmission rates until the European outbreak in 1837. The outbreak showed the lack of accessibility to vaccination in mainly rural populations due to the population spread and socioeconomic status of those living in rural areas. As a result, in 1840, the European government enacted the Vaccination Act of 1840. Many mandates were enforced as the epidemic spread, all of which did little to address the inaccessibility of the vaccine. In an attempt to abolish smallpox, in 1867, anti-vaccination penalties and the requirement of child vaccinations before four months of age were imposed, which was successful in increasing vaccine availability.[30]

European smallpox vaccination increased only when government mandates provided opportunities for rural communities to receive vaccinations in healthcare facilities at birth. New discoveries and essential technologies can also be attributed to the smallpox recovery in London and other regions in England. People of lower socioeconomic status were unable to hire private doctors, a common service for much of the upper class at the time. For this reason, they were forced to attend larger clinics that administered vaccinations through unsanitary practices, like needle sharing and the efficiency of the vaccines.[31] As a result, many lower-class families could often only access the mandated vaccine in facilities that risked death because of the spread of disease through shared needles.

The increased use of vaccines can be linked to the success of Edward Jenner's vaccine, despite the original criticism it received from the general public. According to the CDC, vaccines are currently considered one of the ten most innovative achievements in the public health sector over the course of the 20th century because of their complexity and effectiveness in reforming people's protection from infections.[32] While physicians and scientists alike argued for the safety

of the smallpox vaccine for children, a large portion of the public dismissed it due to religious, political, and sanitation complaints.[33] These common concerns increased stigma towards vaccinations for smallpox, as they were seen as a mark of disgrace. In addition, many parents feared the incision in their child's arm for the vaccine could become infected because of the unsanitary vaccination process.

During this time period, many misconceptions spread through the misinformation of vaccines, such as vaccines' interrelationship with autism, syphilis, typhoid, tuberculosis, cholera, and other mental illnesses. At the time, these claims were not completely misinformed. Doctors would practice assembly-line style vaccination administration with the same needles, which would spread diseases not from the vaccine itself, but rather through the blood. The smallpox vaccination movement increased experimentation in the field, leading to the discovery of disease transmission through blood. [34] However, statistics and data from physicians are still questioned despite their increased accuracy.

Many parents' religious beliefs led them to believe that the vaccine was "unchristian" because of the use of animal products as ingredients in vaccines at this time. Specifically, this vaccine used cow DNA, which many religious members believed were medically incorrect because of the injection of an inferior animal into the human body. While no major religion specifically cites opposition to vaccination, this did not deter religious leaders from refusing to become vaccinated. In addition, the argument by religious sects was regarding the supremacy of people "created in the image of God."[35] Many religious groups at the time also used their authority and societal influence to spread misinformation to local communities.

Finally, there was a general fear about how the vaccine worked effectively, or if it had an alternate purpose. People questioned data by health organizations as well as the statements by physicians, which were not always reliable. Many also feared there were other underlying motivations for requirement of vaccine mandates in London, one that was more interested in economic purposes rather than improving the health of children with smallpox. Due to the increased disease during this time, there was also a rapid increase in job opportunities and the expansion of the medical field, which disproportionately favored the wealthy and well-educated.[36] At the same time, individuals under the poverty line were more likely to become sick and unable to access treatment. Across England, a common belief that smallpox had created a "senseless panic" spread quickly. The vaccine became a magnet, attracting individuals who generally distrusted the government. Protests and anti-vaccination movements quickly developed as a result.

The opposition to vaccination through the smallpox epidemic was the first of many anti-vaccination movements. The stigma that began with smallpox also carries into more recent diseases. However, in many ways, the lack of vaccination can not be attributed to its stigma but rather to the inaccessibility of vaccines. In London, smallpox most severely affected rural communities of children.[37] Yet, these populations received the least opportunity and access to vaccination sites. The price of vaccination deterred many from being vaccinated. With the boom of the industrial revolution, rural towns were cheaper and less sought after. Those less fortunate commonly depended on the less expensive prices for housing and products in rural areas. Unfortunately, in many cases vaccination and other non-essential expenses are not likely to attract low-income areas, which at the time were rural regions in England. Whether due to lack of accessibility or stigmatization, vaccination remains a present-day controversy.

Questions to Consider

1. How can member nations improve accessibility to rural and less developed regions, both in and outside of their own country?
2. What security can vaccination reforms provide to individuals who fear stigma associated with current vaccines?
3. What effect does social media have on the spread of anti-vaccination beliefs, and how should national governments regulate this spread of misinformation?
4. How should nations promote increases in vaccinations without violating individuals' religious beliefs?
5. How should nations ensure the protection of Indigenous communities from viral infections without affecting many of their traditional lifestyles and customs?
6. What actions should be done to promote universal vaccine accessibility despite injustices in racial and economic disparities?

Endnotes

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Topic B: Euthanasia and Assisted Suicide

Background

Euthanasia and assisted suicide refer to the intentional action of ending a life to relieve the pain and suffering of a patient. The practice of euthanasia and assisted suicide have, as a result, caused global controversy. Outside of the United States, euthanasia is illegal in most countries. In a survey of 74 countries globally, only 11 of those countries had a majority vote supporting euthanasia.[38] The history of this controversial topic can be traced back to the Hippocratic Oath, which is taken by all practicing doctors for over 2,500 years. The original oath states, "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect."[39] While the modern version of the oath is slightly different, many countries or individuals believe that the original intent of the oath, to preserve life rather than end it, is the job of every doctor who has sworn it. However, the debate over ethical concerns has increased over the years on both sides of this dilemma.

While euthanasia and assisted suicide have the same goal of relieving pain, the two processes are not the same.[44] Euthanasia is when a doctor works in accordance with the law to end a person's life after receiving consent from the patient and their family. If a patient's condition inhibits their ability to provide consent, it is a decision for their family to make. Euthanasia is currently categorized into three primary subgroupings: voluntary, non-voluntary, and involuntary. Voluntary euthanasia occurs with the consent of the patient, while non-voluntary euthanasia occurs with consent from the family when the patient is incapacitated or unable to decide. Involuntary euthanasia is considered a form of murder because neither the patient nor family gives consent to the completion of this practice. In the instances where consent is given, there are then two options carrying out legal euthanasia. First, passive euthanasia withholds necessary medications for life support to allow the patient to die naturally. Secondly, active euthanasia uses lethal substances to kill the patient, which is more controversial in regards to religion, morals, and ethics. It is also necessary to make the distinction between euthanasia and palliative sedation, which is the legal and appropriate treatment for dying patients. This treatment sedates patients to control pain and suffering, differing from terminal sedation, which is when a patient's death is uncertain, and the intention is to accelerate their death. It is clear that both of these terms have similar processes and goals, so advocates of euthanasia argue that the distinction between the two is almost impossible to make. In comparison, assisted suicide is when a doctor helps a patient in self-administered suicide per their request. Most assisted suicides are performed through the self-administration of lethal drugs provided by doctors. Other forms of assisted suicide can include providing strong sedatives to patients or purchasing tickets to countries where euthanasia is legal. All of these actions do not directly end a patient's life, but they assist them in doing so. Global laws regarding suicide have drastically changed over the past decade, such as its decriminalization in the US, where the penalty is typically rehab in a mental institution.[45]

Those who argue for the legalization of euthanasia believe that this practice advocates for freedom of chouse.[40] In addition, this argument is primarily based on the quality of life, as many advocates for euthanasia argue that intolerable pain and suffering should not be forced upon an individual. This argument most commonly applies to cancer patients, who make up over 70% of cases. In many cases, witnesses of euthanasia and assisted suicide tend to advocate for these procedures because they do not see the harm in the practice. Another common argument for the

promotion of euthanasia is that essential resources are taken up by terminal patients. For instance, those who are nearing death utilize valuable beds, machines, and tools that could be used to save the lives of others, especially those in lesser developed nations.

In opposition, arguments against euthanasia are centered around doctors' roles, religion, morality, mental illness, and the possibility of recovery. Many global religions consider suicide a sin, so euthanasia is considered a morally unacceptable practice. For example, under Judaism, human life belongs to God, and those who take it are committing punishable sins, disapproving of the central ideas of this practice. Many are also concerned about the mental health of patients, as some suffer from depression. Depression has many symptoms, including suicidal thoughts, which may increase their likelihood of requesting assisted suicide.[41] Although these instances are rare, there are slim possibilities of false diagnoses in which patients would request euthanasia without realizing the procedure is unneeded. Another primary concern of anti-euthanasia advocates is that the legalization of this procedure will allow for future leniencies in permitting morally unjust actions.[42] These consequences are exemplified by Harold Shipman, a British physician who injected lethal drug doses into dying older people, who believed he was acting out of mercy. While many have supported his actions, Harold did not obtain consent from any of these patients and was charged for multiple accounts of murder. In such situations, doctors may abuse their power as physicians, leading to the slippery slope argument for euthanasia, in which enacted policies continue to expand beyond control. Doctors may first euthanize terminally ill patients that have consented to assisted suicide and, in the future, may feel entitled to perform without legal consent.

There are often extensive debates within the medical community, as some doctors support practicing euthanasia and view it as a more humane end to one’s life. On the other hand, many doctors refuse to practice euthanasia or assisted suicide, following similar reasoning to personal viewpoints regarding ethical and religious beliefs.[43] In a survey conducted in the Netherlands where euthanasia is legalized, 10% of doctors still refuse to practice euthanasia.

Due to the complex nature of euthanasia and assisted suicide, each country has developed its own laws and regulations regarding the topic. In countries like the Netherlands, Belgium, and Lichtenstein, physicians have the legal authority to euthanize patients, while other countries strictly prohibit this act.[46] In countries where euthanasia and assisted suicide are legal, they are responsible for 0.3-4.6% of deaths. Only 7% of doctors agree to aid patients in assisted suicide/euthanasia if their symptoms are unrelated to cancer.[47] This number is extremely small compared to the 90% of doctors who have claimed to receive requests for assisted suicide or euthanasia. In recent years, the shift towards legalization has expanded suicide tourism, leading to an increased number of cases per year. Suicide tourism refers to traveling to countries that have legalized euthanasia, such as Switzerland, which receives 221 people annually to take advantage of their laws.[48] As a result, the international debate on whether or not euthanasia and assisted suicide should be legal continues to escalate.

United Nations Involvement

While the United Nations has not passed any regulatory resolutions on the topic of euthanasia or assisted suicide, they have placed a primary focus on discussing the ethics concerning this issue.[49] During the Human Rights Committee’s 72nd session, they expressed their concern about the Netherlands’ new laws on euthanasia and assisted suicide because of the number of instances in which physicians were not punished when ending patients’ lives without offering any alternative solutions to their suffering or situation. In particular, the UN focused on

the Netherlands' new approval of euthanasia for any person above the age of twelve. While the conditions in which each age group can be euthanized differ, this new provision has the possibility of being abused by medical professionals who would rather offer this solution instead of other medical procedures. In addition, the UN indicates that there must be further regulations put in place to reduce the number of disabled newborns that are euthanized by medical professionals. Based on these concerns, the Committee set forth the recommendation for the Netherlands to re-examine their laws pertaining to euthanasia and assisted suicide to also prohibit the influence of third parties on these life-threatening medical procedures. In addition to this document, the UN has declared euthanasia in the Netherlands to be a violation of the Universal Declaration of Human Rights because of the potential risks of infringing on people's right to safety.[50] In relation, the UN has discussed the failure of the Netherlands' laws to include necessary provisions to prevent patients from feeling pressured into euthanasia and not being allowed a sufficient number of alternatives to this practice.[51]

Additionally, in December of 2017, the UN implemented "The Right to End-of-Life Palliative Care and a Dignified Death" to protect the rights of older persons as they are often mistreated and neglected due to their age or terminal illnesses. For this reason, this document helps to clarify the rights of older persons in relation to their physical autonomy and ability to develop their own health-related decisions instead of by caretakers or family members. In this document, article eleven works in correlation with the International Covenant on Economic, Social, and Cultural Rights and article two of the Universal Declaration of Human Rights to place emphasis on the rights and protections of older persons from discrimination and the ability to indicate their own interests in healthcare interventions, such as euthanasia.[52]

Adopted on October 30, 2019, the United Nations Human Rights Committee (CCPR) released a draft document known as General Comment No. 36 (CCPR/C/GC/36) that protects the right to life for all human beings, which is extended to permitting assisted suicide as long as it complies with domestic laws and each procedure is given full patient approval.[53] The protection employed in this document is essential in encouraging nations and medical professionals to seek out all possible options instead of resorting to assisted suicide.[54]

On January 25, 2021, the UN Human Rights Office of the High Commissioner articulated that disabilities are not a reason to allow medically assisted suicide, which includes old age. In addition, they express that association to no group, whether a racial, gender, or sexual minority, should be a reasonable cause to end one's life because of its violation of Article 10 of the UN Convention on the Rights of Persons with Disabilities, which requires the protection of people with disabilities. Additionally, there are often ableist viewpoints imposed when considering those who are terminally ill or suffering with their lives, especially people with disabilities. The Commission also adds that even with restrictions placed on euthanasia and assisted suicide, many people with terminal illnesses, disabilities, and older persons, with an emphasis on older persons with disabilities, may still feel pressured to prematurely end their lives because of the lack of suitable support and services provided. In addition, the number of people living in poverty with disabilities is nearly double that without disabilities, so they often do not have the proper social protections that prevent them from choosing assisted suicide over other options. To combat this, the Commission recommends the incorporation of organizations that can defend those living with disabilities equal protection.[55]

Case Study: Euthanasia in the Netherlands

Making history in 2002, the Netherlands officially became the first nation to legalize the act of euthanasia.[56] Starting in 1973, the ethical discussion on this topic was first introduced to the Dutch Supreme Court when they ruled the act of euthanasia only penalized with a small symbolic penalty after a doctor performed it on his mother. This led to an increase in debate on this controversial topic among the medical community and national lawmakers, setting the stage for the passing of a Parliamentary Bill in 1991 which recognized it as a legitimate medical procedure. On April 12, 2001, both euthanasia and assisted suicide were officially legalized with the passing of the "Law for the Termination of Life on Request and Assisted Suicide" and was ruled nationally effective on April 1, 2002.

Today, euthanasia and the promotion of suicide are still considered criminal offenses, but with the "criteria of due care" law of the Dutch Termination of Life on Request and Assisted Suicide Act, participating doctors are released from legal liability.[57] This law enacts a strict set of criteria to determine patient eligibility, beginning with the requirement that euthanasia must be well-considered and consented upon by the patient.[58] Additionally, patients must be fully aware of their condition, and their suffering must be deemed intolerable with no prospect for improvement. In discussion with two independent physicians, all other reasonable options for medical treatment must also be exhausted, and the procedure must be authorized, with at least one physician being a psychiatrist. With the 2002 ruling, the Netherlands also became the first nation to permit the euthanasia of minors, requiring parent-participating in the decision for patients aged 16-17 and parental consent for patients between 12-15 years old. Following in 2005, the "Groningen Protocol" was ratified to specify essential steps and conditions for the ending of life in young children and newborns, highlighting the requirements of extreme illness and unsatisfactory "quality of life."

When the law was enacted in 2002, 1,882 cases of euthanasia were initially reported, and this number was more than doubled in 2016 when 6,091 cases were observed. Today, cases of euthanasia in the Netherlands have more than tripled from the initial amount, which is quite high in comparison to the population growth that has only increased 6% from 2002 to 2021. Of these medically assisted deaths, 83% were conducted on patients with incurable diseases and enduring insufferable pain. An additional 10% of cases were performed on patients diagnosed with multiple pathologies, 4% relating to old age and disabilities, 2% on psychological disorders, and 1% for individuals suffering from dementia. According to a 2016 French study on Dutch euthanasia rates, 85% of these cases were authorized by family physicians, and 80% of them occurred in the patient's homes. They also recorded national rates of 16 cases of euthanasia per day, leading to the observation that this procedure accounts for 4% of national deaths every year.

With continually increasing rates of euthanasia and assisted suicide occurring in the Netherlands, subsequent arguments on the tightening and loosening of related regulations have additionally arisen. For example, in October of 2016, the Dutch Supreme Court drafted a new bill to allow assisted suicide in the elderly who feel they have "fulfilled or completed their life," even if they are not suffering from an incurable or excruciatingly painful medical condition. However, in response, a group of doctors, lawyers, and philosophers formed a commission in February of 2016, arguing that "accomplished life" could not be accomplished regardless of age. With this, they also brought up the arguments that some family members may take advantage of this law to "finish off" relatives at old age, or it may cause elders to feel like a community burden that should be removed. Despite these opposing claims, both the Ministry of Justice and Health are still advocating for the bill to be passed, and it is currently still in discussion.

Additionally, in 2014, the Ethics and Law Commission of the Dutch Pediatric Association advised the allowance of euthanasia in children aged 1-12 years old under the parent's and doctor's decision, without necessarily needing the child's consent. However, it was revoked in 2016 when the Minister of Health deemed it unnecessary to extend the specifications of the 2002 law, stating that doctors already had the power to allow assisted death in children if ruled absolutely necessary.

The debate on post-euthanasia organ donation has also increased in emphasis with the rising shortage of organs in the Netherlands. This discussion was exacerbated in March of 2016 when the media idolized a man who opted for organ donation after euthanasia as someone "who saved five lives," thus increasing public support for this medical practice. Later in 2017, the Dutch Minister of Health drafted a set of guidelines for the combination of euthanasia and organ donation, insisting that all procedures must occur in hospitals with physician oversight due to the quick expiration time on extracted organs. Additionally, an appointed team of transplant specialists must be on standby to collect the removed organs. As a result of the passing of these guidelines, greater command of euthanasia was achieved, and the availability of transplant organs was doubled. However, related ethical concerns have also increased as experts began to worry that societal pressure will motivate patients to heroically "sacrifice themselves" for the health of others over themselves.

In 2017, the Dutch Last Will Association developed a suicide pill that allowed individuals to induce death within an hour of consumption without the authorization of a supervisory physician. Consisting of over 3,500 members aged around 70 years old, this association promoted the right of individuals who are not necessarily suffering from intolerable pain to "die with dignity."[59] With the emergence of this technology, increased tensions within the medical and social communities have transpired, increasing stress on the legality of this ethical dilemma both in the Netherlands and internationally.

Lastly, the Netherlands observed a dramatic surge in suicide tourism in 2019 when a story about a Dutch teenager's death was mislabeled as euthanasia, causing an influx of foreign requests asking for this procedure to be performed on individuals who were not in critical pain or suffering. This event involved Noa Pothoven, a seventeen-year-old girl struggling with mental health, who sadly passed away after refusing to eat or drink. Although officially unconfirmed, it is said that she resorted to self-suicide after being denied the procedure of euthanasia by Levenseindekliniek, which is a Dutch end-of-life clinic located in The Hague, because she was deemed too young. After hearing news of the story, Dutch media outlets ran with the falsified claims that her death was due to physician-facilitated euthanasia, inciting heightened international debate on the Netherlands' allowance of this procedure in minors without requirements of unbearable suffering due to specified medical conditions. Following this incident, Levenseindekliniek's weekly average of 1-2 euthanasia requests increased to 25, contributing to its complete number of 12,000-13,000 total applications since its opening. Of these requests, more than 3,500 have been granted, thus increasing global apprehensions on this controversial subject. Therefore, it is crucial that an international agreement on this topic is established, mediating discussions between both the protection of the Hippocratic Oath and the right to a purposeful, pain-free life.

Questions to Consider

1. What alternative forms of palliative care can be provided to patients with considerable pain and/or suffering?
2. How can countries that have legalized euthanasia/assisted suicide prevent the spread of suicide tourism?
3. How can countries ensure that medical professionals are providing patients with various alternatives to euthanasia/assisted suicide?
4. What are measures that could be implemented to further protect the rights of patients with disabilities?
5. What policies should be implemented to prevent the abuse of euthanasia/assisted suicide, especially regarding young children since only their parental consent is required?
6. How could you ensure that people of all socioeconomic backgrounds are able to afford these services?

Endnotes

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