

## Euthanasia: The Way We Do It, The Way They Do It

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### Abstract

Although the Netherlands, Germany, and the United States are alike in having aging populations who die primarily of deteriorative diseases, they face end-of-life dilemmas quite differently. In the United States, withholding and withdrawing of treatment are the only legally recognized means for easing dying. In Holland, voluntary active euthanasia is also practiced; in (West) Germany, assisted suicide is a legal option, usually outside the medical setting. This paper examines objections to these three practices, and observes the differences in the background cultures. Rather than reliance on any of the three, it argues that physician-assisted suicide in terminal illness is the practice most compatible with the United States' special characteristics. *J Pain Symptom Manage* 1991;6:298-305.

### Key Words

Euthanasia, active euthanasia, voluntary euthanasia, suicide, dying, the Netherlands, Holland, Germany, slippery slope, national health care

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### Introduction

Because we tend to be rather myopic in our discussions of death and dying, especially about the issues of active euthanasia and assisted suicide, it is valuable to place the question of how we go about dying in an international context. We do not always see that our own cultural norms may be quite different from those of other nations, and that our background assumptions and actual practices differ dramatically. Thus, I would like to examine the perspectives on end-of-life dilemmas in three countries, Holland, (West) Germany,\* and the USA.

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\*As the medical care system in the German Democratic Republic (East Germany) was structurally different and was faced with many unique problems, especially in terms of shortages in high-tech equipment, I will only be referring to what was known as the Federal Republic of (West) Germany up until 1990. Address reprint requests to: Margaret P. Battin, PhD, Department of Philosophy, University of Utah, 338 Orson Spencer Hall, Salt Lake City, UT 84112.

Holland, Germany, and the United States are all advanced industrial democracies. They all have sophisticated medical establishments and life expectancies over 70 years of age; their populations are all characterized by an increasing proportion of older persons. They are all in what has been called the fourth stage of the epidemiologic transition<sup>1</sup>—that stage of societal development in which it is no longer the case that most people die of acute parasitic or infectious diseases. In this stage, most people do not die of diseases with rapid, unpredictable onsets and sharp fatality curves; rather, the majority of the population—as much as perhaps 70%–80%—dies of degenerative diseases, especially delayed degenerative diseases, that are characterized by late, slow onset and extended decline. Most people in highly industrialized countries die from cancer, atherosclerosis, heart disease (by no means always suddenly fatal), chronic obstructive pulmonary disease, liver, kidney or other organ disease, or degenerative neurological disorders. Thus, all three of these countries

are alike in facing a common problem: how to deal with the characteristic new ways in which we die.

### *Dealing with Dying in the United States*

In the United States, we have come to recognize that the maximal extension of life-prolonging treatment in these late-life degenerative conditions is often inappropriate. Although we could keep the machines and tubes—the respirators, intravenous lines, feeding tubes—hooked up for extended periods, we recognize that this is inhumane, pointless, and financially impossible. Instead, as a society we have developed a number of mechanisms for dealing with these hopeless situations, all of which involve withholding or withdrawing various forms of treatment.

Some mechanisms for withholding or withdrawing treatment are exercised by the patient who is confronted by such a situation or who anticipates it; these include refusal of treatment, the patient-executed DNR order, the Living Will, and the Durable Power of Attorney. Others are mechanisms for decision by second parties about a patient who is no longer competent or never was competent. The latter are reflected in a long series of court cases, including *Quinlan*, *Saikewicz*, *Spring*, *Eichner*, *Barber*, *Bartling*, *Conroy*, *Brophy*, the trio *Farrell*, *Peter* and *Jobes*, and *Cruzan*. These are cases that attempt to delineate the precise circumstances under which it is appropriate to withhold or withdraw various forms of therapy, including respiratory support, chemotherapy, antibiotics in intercurrent infections, and artificial nutrition and hydration. Thus, during the past 15 years or so, roughly since *Quinlan* (1976), we have developed an impressive body of case law and state statute that protects, permits, and facilitates our characteristic American strategy of dealing with end-of-life situations. These cases provide a framework for withholding or withdrawing treatment when we believe there is no medical or moral point in going on. This is sometimes termed *passive euthanasia*; more often, it is simply called *allowing to die*, and is ubiquitous in the United States.

For example, a recent study by Miles and Gomez indicates that some 85% of deaths in the United States occur in health-care institutions,

including hospitals, nursing homes, and other facilities, and of these, about 70% involve actively withholding some form of life-sustaining treatment.<sup>2</sup> A 1989 study cited in the *Journal of the American Medical Association* claims that 85%–90% of critical care professionals state that they are withholding and withdrawing life-sustaining treatments from patients who are “deemed to have irreversible disease and are terminally ill.”<sup>3</sup> Still another study identified some 115 patients in two intensive-care units from whom care was withheld or withdrawn; 110 were already incompetent by the time the decision to limit care was made. The 89 who died while still in the intensive care unit accounted for 45% of all deaths there.<sup>4</sup> It is estimated that 1.3 million American deaths a year follow decisions to withhold life support;<sup>5</sup> this is a majority of the just over 2 million American deaths per year. Withholding and withdrawing treatment is the way we in the USA go about dealing with dying, and indeed “allowing to die” is the only legally protected alternative to maximal treatment recognized in the United States. We do not legally permit ourselves to actively cause death.

### *Dealing with Dying in Holland*

In the Netherlands, voluntary active euthanasia is also an available response to end-of-life situations. Although active euthanasia remains prohibited by statutory law, it is protected by a series of lower and supreme court decisions and is widely regarded as legal, or, more precisely, *gedoeken*, legally “tolerated.” These court decisions have the effect of protecting the physician who performs euthanasia from prosecution, provided the physician meets a rigorous set of guidelines.

These guidelines, variously stated, contain five central provisions:

1. that the patient's request be voluntary;
2. that the patient be undergoing intolerable suffering;
3. that all alternatives acceptable to the patient for relieving the suffering have been tried;
4. that the patient has full information;
5. that the physician has consulted with a second physician whose judgment can be expected to be independent.

Of these criteria, it is the first which is central:

euthanasia may be performed only at the voluntary request of the patient. This criterion is also understood to require that the patient's request be a stable, enduring, reflective one—not the product of a transitory impulse. Every attempt is to be made to rule out depression, psychopathology, pressures from family members, unrealistic fears, and other factors compromising voluntariness. Of physicians responding to a national survey in 1985 and 1986, 48% reported that they had received one or more requests for active euthanasia, and of these cases, 37% of the patients' requests had been honored.<sup>6</sup> In general, pain is not the basis for euthanasia, since pain can, in most cases, be effectively treated; "intolerable suffering," understood to mean suffering that is in the patient's (rather than the physician's) view intolerable, may also include fear of or unwillingness to endure *entlusterung*, or that gradual effacement and loss of personal identity that characterizes the end stages of many terminal illnesses. It is also required that euthanasia be performed only by a physician; it may not be performed by a nurse, family member, or other party.

It is expected that the physician who performs euthanasia report it to the judicial authorities; in 1990, 454 cases were so reported and reviewed by the Ministry of Justice. None were prosecuted, and all were dismissed immediately. However, it is believed that the reported cases represent only a small fraction of the actual cases; the current estimate of frequency is somewhere between 3000 and 4000 cases a year: some 1000–2000 in hospitals, less than 100 in nursing homes, and perhaps 2000 in the patients' home.<sup>7</sup> Four thousand deaths by euthanasia per year would represent, in a country with a population of 14.9 million and an annual mortality of 125,000, just 3.2% of the total deaths per year. If euthanasia deaths were distributed equally (which they are not) among Holland's 30,000 physicians, then this would mean that only 1 in every 7 or 8 physicians would perform a case of euthanasia in a given year, or that a given physician would perform euthanasia once or at most twice in a decade of practice. Because most cases are not actually reported, no accurate figures are available, but euthanasia appears to be comparatively rare. Nevertheless, it is a conspicuous alternative to terminal illness well known to both physicians and the general public. Surveys of public opin-

ion show growing public support for a liberal euthanasia policy (increasing from 40% in 1966 to 81% in 1988), and whereas there is a vocal minority opposed to the practice (including a group of about 1000 physicians), it is apparent that both the majority of the population in Holland and the majority of Holland's physicians support it.

In Holland, many hospitals now have protocols for the performance of euthanasia; these serve to ensure that the court-established guidelines have been met. However, it is believed that most euthanasia is practiced in the patient's home, typically by the *huisarts* or general practitioner who is the patient's long-term family physician. Euthanasia is usually performed after aggressive hospital treatment has failed to arrest the patient's terminal illness; the patient has come home to die, and the family physician is prepared to ease this passing. Whether practiced at home or in the hospital, it is believed that euthanasia usually takes place in the presence of the family members, perhaps the visiting nurse, and often, the patient's pastor or priest. Many doctors say that performing euthanasia is never easy, but that it is something they believe a doctor ought to do for his or her patient, when nothing else can help.

Thus, in Holland a patient facing the end of life has an option not openly practiced in the United States: to ask the physician to bring his or her life to an end. Although not everyone does so—indeed, at least 95% of people who die in a given year do not—it is a choice widely understood as available.

### Facing Death in Germany

In part because of its very painful history of Nazism, Germany appears to believe that doctors should have no role in causing death. Although societal generalizations are always risky, it is fair, I think, to say that there is vigorous and nearly universal opposition in Germany to the notion of active euthanasia. Euthanasia is viewed as always wrong, and the Germans view the Dutch as stepping out on a dangerously slippery slope.

However, it is an artifact of German law that, whereas killing on request (including voluntary euthanasia) is prohibited, assisting suicide—where the person committing suicide is determined to do so—is not a violation of the law.

Taking advantage of this situation, there has developed a private organization, the *Deutsches Gesellschaft für Humanes Sterben* (DGHS), or German Society for Humane Dying, which provides support to its very extensive membership in choosing suicide as an alternative to terminal illness. The DGHS provides information about suicide; it assists in gaining access to the means for suicide; and, if requested, then it provides *Begleitung* or "accompaniment" for the person about to commit suicide, sending someone to be with the person who takes a fatal dose, especially if that person is alone or does not have a family supportive of such a choice. The DGHS runs regular ads in the popular magazines, and apparently is familiar to a sizeable proportion of the populace. I do not know how frequent are suicides assisted by the DGHS, as distinct from suicides in terminal illness generally, but it seems fair to say that the option of self-produced death is more clearly open in Germany than in Holland or in the United States.

### *Objections to the Three Models of Dying*

In response to the dilemmas raised by the new circumstances of death, in which the majority of the population in each of the advanced industrial nations dies of degenerative diseases after an extended period of terminal deterioration, different countries develop different practices. The United States legally permits only withholding and withdrawal of treatment, though of course active euthanasia and assisted suicide do occur. Holland also permits voluntary active euthanasia, and although Germany rejects euthanasia, it tolerates assisted suicide. But there are serious moral objections to be made to each of these practices, objections to be considered before resolving the issue of which practice our own culture ought to adopt.

#### *Objections to the German Practice*

German law does not prohibit assisting suicide, but postwar German culture discourages physicians from taking any active role in death. This gives rise to distinctive moral problems. For one thing, it appears that there is little professional help or review provided for patients' choices about suicide; because the patient makes this choice essentially outside the medical estab-

lishment, medical professionals are not in a position to detect or treat impaired judgment on the part of the patient, especially judgment impaired by depression. Similarly, if the patient must commit suicide assisted only by persons outside the medical profession, there are risks that the patient's diagnosis and prognosis are inadequately confirmed, that the means chosen for suicide will be unreliable or inappropriately used, that the means used for suicide will fall into the hands of other persons, and that the patient will fail to recognize or be able to resist intrafamilial pressures and manipulation. The DGHS policy for providing assistance requires, I believe, that the patient be terminally ill and have been a member of the DGHS for at least 1 year in order to make use of its services (the latter requirement intended, I assume, to provide evidence of the stability of such a choice), but these minimal requirements are hardly sufficient to answer the charge that suicide decisions, which are made for medical reasons but must be made without medical help, may be rendered under less than ideally informed and voluntary conditions.

#### *Objections to the Dutch Practice*

The Dutch practice of physician-performed active voluntary euthanasia also raises a number of ethical issues, many of which have been discussed vigorously both in the Dutch press and in commentary on the Dutch practices from abroad. For one thing, it is sometimes said that the availability of physician-performed euthanasia creates a disincentive for providing good terminal care. I have seen no evidence that this is the case; on the contrary, Peter Admiraal, the anesthesiologist who is perhaps Holland's most vocal proponent of voluntary active euthanasia, insists that pain should rarely or never be the occasion for euthanasia, as pain (in contrast to suffering) is comparatively easily treated.<sup>8</sup> Instead, it is a refusal to endure the final stages of deterioration, both mental and physical, that motivates requests.

It is also sometimes said that active euthanasia violates the Hippocratic Oath. Indeed, it is true that the original Greek version of the Oath prohibits the physician from giving a deadly drug, even when asked for it; but the original version also prohibits performing surgery and taking fees for teaching medicine, neither of which prohibitions has survived into contemporary

medical practice. Dutch physicians often say that they see performing euthanasia—where it is genuinely requested by the patient and nothing else can be done to relieve the patient's condition—as part of their duty to the patient, not as a violation of it.

The Dutch are also often said to be at risk of starting down the slippery slope, that is, that the practice of voluntary active euthanasia for patients who meet the criteria will erode into practicing less-than-voluntary euthanasia on patients whose problems are not irremediable, and perhaps by gradual degrees develop into terminating the lives of people who are elderly, chronically ill, handicapped, mentally retarded, or otherwise regarded as undesirable. This risk is often expressed in vivid claims of widespread fear and wholesale slaughter, claims that are repeated in the Right-to-Life press in both Holland and the USA; however, these claims are simply not true. However, it is true that the Dutch are now beginning to agonize over the problems of the incompetent patient, the mentally ill patient, the newborn with serious deficits, and other patients who cannot make voluntary choices, though these are largely understood as issues about withholding or withdrawing treatment, not about direct termination.<sup>9</sup>

What is not often understood is that this new and acutely painful area of reflection for the Dutch—withholding and withdrawing treatment from incompetent patients—has already led in the United States to the development of a vast, highly developed body of law: namely, that series of cases just cited, beginning with *Quinlan* and culminating in *Cruzan*. Americans have been discussing these issues for a long time, and have developed a broad set of practices that are regarded as routine in withholding and withdrawing treatment. The Dutch see Americans as much further out on the slippery slope than they are, because Americans have already become accustomed to second-party choices about other people. Issues involving second-party choices are painful to the Dutch in a way they are not to us precisely because *voluntariness* is so central in the Dutch understanding of choices about dying. Concomitantly, the Dutch see the Americans' squeamishness about first-party choices—voluntary euthanasia, assisted suicide—as evidence that we are not genuinely committed to recognizing *voluntary* choice after

all. For this reason, many Dutch commentators believe that the Americans are at a much greater risk of sliding down the slippery slope into involuntary killing than they are. I fear, I must add, that they are right about this.

### *Objections to the American Practice*

There may be moral problems raised by the German and the Dutch practices, but there are also moral problems raised by the American practice of relying on withholding and withdrawal of treatment in end-of-life situations. The German, Dutch, and American practices all occur within similar conditions—in industrialized nations with highly developed medical systems, where a majority of the population dies of illnesses exhibiting characteristically extended downhill courses—but the issues raised by our own response to this situation may be even more disturbing than those of the Dutch or the Germans. We often assume that our approach is "safer" because it involves only letting someone die, not killing him or her; but it too raises very troubling questions.

The first of these issues is a function of the fact that withdrawing and especially withholding treatment are typically less conspicuous, less pronounced, less evident kinds of actions than direct killing, even though they can equally well lead to death. Decisions about nontreatment have an invisibility that decisions about directly causing death do not have, even though they may have the same result, and hence there is a much wider range of occasions in which such decisions can be made. One can decline to treat a patient in many different ways, at many different times—by not providing oxygen, by not instituting dialysis, by not correcting electrolyte imbalances, and so on—all of which will cause the patient's death; open medical killing also brings about death, but is a much more overt, conspicuous procedure. Consequently, letting die also invites many fewer protections. In contrast to the earlier slippery slope argument which sees killing as riskier than letting die, the slippery slope argument warns that because our culture relies primarily on decisions about nontreatment, grave decisions about living or dying are not as open to scrutiny as they are under more direct life-terminating practices, and hence, are more open to abuse.

Second, and closely related, reliance on withholding and withdrawal of treatment invites ra-

tioning in an extremely strong way, in part because of the comparative invisibility of these decisions. When a health care provider does not offer a specific sort of care, it is not always possible to discern the motivation; the line between believing that it would not provide benefit to the patient and that it would not provide benefit worth the investment of resources in the patient can be very thin. This is a particular problem where health care financing is highly decentralized, as in the United States, and where rationing decisions without benefit of principle are not always available for easy review.

Third, relying on withholding and withdrawal of treatment can often be cruel. It requires that the patient who is dying from one of the diseases that exhibits a characteristic extended, downhill course (as the majority of patients in Holland, Germany, and the US do) must in effect wait to die until the absence of a certain treatment will cause death. For instance, the cancer patient who forgoes chemotherapy or surgery does not simply die from this choice; he or she continues to endure the downhill course of the cancer until the tumor finally destroys some crucial bodily function or organ. The patient with amyotrophic lateral sclerosis who decides in advance to decline respiratory support does not die at the time this choice is made, but continues to endure increasing paralysis until breathing is impaired and suffocation occurs. We often try to ameliorate these situations by administering pain medication or symptom control at the same time we are withholding treatment, but these are all ways of disguising the fact that we are letting the disease kill the patient rather than directly bringing about death. But the ways diseases kill people are far more cruel than the ways physicians kill patients when performing euthanasia or assisting in suicide.

### *The Problem: A Choice of Cultures*

Thus we see three similar cultures and countries and three similar sets of circumstances, but three quite different basic practices in approaching death. All three of these practices generate moral problems; none of them, nor any others we might devise, is free of moral difficulty. But the question that faces us is this: which of these practices is best?

It is not possible to answer this question in a less-than-ideal world without some attention to

the specific characteristics and deficiencies of the society in question. In asking which of these practices is best, we must ask which is best for us. That we currently employ one set of these practices rather than others does not prove that it is best for us; the question is, would practices developed in other cultures or those not yet widespread in any be better for our own culture than that which has developed here? Thus, it is necessary to consider the differences between our own society and these European cultures that have real bearing on which model of approach to dying we ought to adopt.

First, notice that different cultures exhibit different degrees of closeness between physicians and patients—different patterns of contact and involvement. The German physician is sometimes said to be more distant and more authoritarian than the American physician; on the other hand, the Dutch physician is sometimes said to be closer to his or her patients than either the American or the German is. In Holland, basic primary care is provided by the *huisarts*, the general practitioner or family physician, who typically lives in the neighborhood, makes house calls frequently, and maintains an office in his or her own home. The *huisarts* is usually the physician for the other members of the patient's family, and will remain the family's physician throughout his or her practice. Thus, the patient for whom euthanasia becomes an issue—say, the terminal cancer patient who has been hospitalized in the past but who has returned home to die—will be cared for by the trusted family physician on a regular basis. Indeed, for a patient in severe distress, the physician, supported by the visiting nurse, may make house calls as often as once a day, twice a day, or more (after all, it is right in the neighborhood), and is in continuous contact with the family. In contrast, the traditional American institution of the family doctor who makes house calls is rapidly becoming a thing of the past, and whereas some patients who die at home have access to hospice services and house calls from their long-term physician, many have no such long-term care and receive most of it from staff at a clinic or housestaff rotating through the services of a hospital. The degree of continuing contact the patient can have with a familiar, trusted physician clearly influences the nature of his or her dying, and also plays a role in whether physician-performed active euthanasia,

assisted suicide, and/or withholding and withdrawing treatment is appropriate.

Second, the United States has a much more volatile legal climate than either Holland or Germany; our medical system is increasingly litigious, much more so than that of any other country in the world. Fears of malpractice action or criminal prosecution color much of what physicians do in managing the dying of their patients. We also tend to evolve public policy through court decisions, and to assume that the existence of a policy puts an end to any moral issue. A delicate legal and moral balance over the issue of euthanasia, as is the case in Holland, would not be possible here.

Third, we in the United States have a very different financial climate in which to do our dying. Both Holland and Germany, as well as every other industrialized nation except South Africa, have systems of national health insurance or national health care. Thus the patient is not directly responsible for the costs of treatment, and consequently the patient's choices about terminal care and/or euthanasia need not take personal financial considerations into account. Even for the patient who does have health insurance in the United States, many kinds of services are not covered, whereas the national health care or health insurance programs of many other countries variously provide many sorts of relevant services, including at-home physician care, home nursing care, home respite care, care in a nursing-home or other long-term facility, dietician care, rehabilitation care, physical therapy, psychological counseling, and so on. The patient in the United States needs to attend to the financial aspects of dying in a way that patients in many other countries do not, and in this country both the patient's choices and the recommendations of the physician are very often shaped by financial considerations.

There are many other differences between the USA on the one hand and Holland and Germany, with their different models of dying, on the other. There are differences in degrees of paternalism in the medical establishment and in racism, sexism, and ageism in the general culture, as well as awareness of a problematic historical past, especially Nazism. All of these and the previous factors influence the appropriateness or inappropriateness of practices such as active euthanasia and assisted suicide. For in-

stance, Holland's tradition of close physician/patient contact, its absence of malpractice-motivated medicine, and its provision of comprehensive health insurance, together with its comparative lack of racism and ageism and its experience in resistance to Nazism, suggest that this culture is able to permit the practice of voluntary active euthanasia, performed by physicians, without risking abuse. On the other hand, it is sometimes said that Germany still does not trust its physicians, remembering the example of Nazi experimentation, and given a comparatively authoritarian medical climate in which the contact between physician and patient is quite distanced, the population could not be comfortable with the practice of active euthanasia. There, only a wholly patient-controlled response to terminal situations, as in non-physician-assisted suicide, is a reasonable and prudent practice.

But what about the United States? This is a country where 1) sustained contact with a personal physician is decreasing, 2) the risk of malpractice action is increasing, 3) much medical care is not insured, 4) many medical decisions are financial as well, 5) racism is on the rise, and 6) the public is naive about direct contact with Nazism or similar totalitarian movements. Thus, the United States is in many respects an untrustworthy candidate for practicing active euthanasia. Given the pressures on individuals in an often atomized society, encouraging solo suicide, assisted if at all only by nonprofessionals, might well be open to considerable abuse too.

However, there is one additional difference between the United States and both Holland and Germany that may seem relevant here. At first, it appears to be a trivial, superficial difference—the apparent fact that we Americans are the biggest consumers of “pop psychology” in the world. While of course things are changing and our cultural tastes are widely exported, the fact remains that the ordinary American's cultural diet contains more in the way of do-it-yourself amateur psychology and self-analysis than anyone else's. This long tradition of pop psychology and self-analysis may put us in a better position for certain kinds of end-of-life practices than many other cultures—despite whatever other deficiencies we have, just because we live in a culture that encourages us to inspect our own motives, anticipate the impact of our

actions on others, and scrutinize our own relationships with others, including our physicians. What, then, is appropriate for our own cultural situation? Physician-performed euthanasia, though not in itself morally wrong, is morally jeopardized where the legal, time allotment, and especially financial pressures on both patients and physicians are severe; thus, it is morally problematic in our culture in a way that it is not in Holland. Solo suicide outside the institution of medicine (as in Germany) is problematic in a culture (like the United States) that is increasingly alienated, offers deteriorating and uneven social services, is increasingly racist, and in other ways imposes unusual pressures on individuals. Reliance only on withholding and withdrawing treatment (as in the United States) can be, as we've seen, cruel, and its comparative invisibility invites erosion under cost containment and other pressures. These are the three principal alternatives we've considered; but none of them seems wholly suited to our actual situation for dealing with the new fact that most of us die of extended-decline, deteriorative diseases. However, permitting physicians to supply patients with the means for ending their own lives still grants physicians some control over the circumstances in which this can happen—only, for example, when the prognosis is genuinely grim and the alternatives for symptom control are poor—but leaves the fundamental decision about whether to use these means to the patient alone. It is up to the patient then, and his or her advisors, including family, clergy, physician, other health-care providers, and a raft of pop-psychology books, to be clear about whether he or she really wants to use these means or not. Thus, the physician is involved, but not directly;

and it is the patient's choice, but the patient is not alone in making it. We live in a quite imperfect world, but, of the alternatives for facing death—which we all eventually must—I think that the practice of permitting physician-assisted suicide is the one most nearly suited to the current state of our own somewhat flawed society. This is a model not yet central in any of the three countries examined here—Holland, Germany, or the United States—but it is the one I think suits us best.

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