

EUTHANASIA AND LAW IN THE NETHERLANDS

**EUTHANASIA AND LAW
IN THE
NETHERLANDS**

John Griffiths

Alex Bood

Heleen Weyers

Amsterdam University Press

Cover design: In Petto / Stephanie de Witte, Amsterdam

Typesetting: MAGENTA, Amsterdam

ISBN 90 5356 275 3

© Amsterdam University Press, Amsterdam, 1998

All rights reserved. Without limiting the rights under copyright reserved above, no part of this book may be reproduced, stored in or introduced into a retrieval system, or transmitted, in any form or by any means (electronic, mechanical, photocopying, recording, or otherwise), without the written permission of both the copyright owner and the authors of this book.

Contents

EXTENDED TABLE OF CONTENTS	IX
LIST OF FIGURES AND TABLES	XVII
ACKNOWLEDGEMENTS	I
GLOSSARY	3
PROLOGUE: THE NETHERLANDS AND THE DUTCH	9
CHAPTER 1: INTRODUCTION	15
1.1 What this book is about and for whom it is intended	15
1.2 The definition of 'euthanasia' and of other 'medical behavior that shortens life' (MBSL)	17
1.3 A sketch of the current legal situation	18
1A Criticisms from abroad and the Dutch reaction	20
INTERMEZZO: THE DUTCH HEALTH CARE SYSTEM AND THE CARE OF THE TERMINALLY ILL	31
A. The Dutch health-care system	31
B. Institutions for health care and care of the elderly	33
C. Health-care professionals	35
CHAPTER 2: LEGAL CHANGE 1945-1997	43
2.1 1945-1970: How room for public debate became available	44
2.2 1970-1982: The early stages of public debate	50
2.3 1982-1986: The breakthrough	61
2.3.1 The justification of necessity and the 'requirements of careful practice'	61
2.3.2 The definition of euthanasia and initial proposals for legislation	68
2.4 1986-1997: Efforts to codify emerging practice in legislation; broadening the subject of debate	73
2.5 Concluding remarks on the process of legal change	86
CHAPTER 3: THE CURRENT LEGAL SITUATION	89
3.1 A summary of current law concerning medical behavior that shortens life	91
3.1.1 'Normal medical practice', the 'medical exception' and a 'natural death'	91
3.1.2 The concept 'medical behavior that shortens life' (MBSL)	92
3.1.3 Euthanasia	98
3.1.4 Euthanasia versus assistance with suicide	III

3.2	The reporting procedure	114
3.3	The CAL and NVK reports: law <i>in statu nascendi</i>	118
3.3.1	The legitimacy of decisions to shorten life in the absence of a competent request	119
3.3.2	Severely defective newborn babies (and late abortion)	123
3.3.3	Coma (PVS) patients	127
3.3.4	'Help in dying'	131
3.3.5	Assessment of the approach of the CAL and NVK reports	133
3.4	The demented elderly	134
3.5	Euthanasia in the absence of somatic suffering	139
3.5.1	Persons whose suffering is due to a psychiatric disorder	141
3.5.2	The legal horizon: assistance with suicide by the 'sick' and the 'suffering'	152
3.6	Conclusion	154
CHAPTER 4: THE TERMS OF DEBATE SINCE 1982		157
4.1	Distinguishing euthanasia from other MBSL	157
4.1.1	Killing versus letting die	158
4.1.2	Intentionally shortening life	162
4.1.3	Conclusion	166
4.2	The most important arguments since 1982	167
4.2.1	The principle of autonomy	168
4.2.2	The principle of beneficence	172
4.2.3	The principle of the sanctity of life	174
4.2.4	The slippery-slope argument	177
4.2.5	Control arguments	180
4.3	A fundamental difference of opinion?	182
4.3.1	The nature of a question of legal policy	182
4.3.2	A quest for common ground	184
4.3.3	The appeal to tolerance	186
4.3.4	Respect for life	189
4.3.5	Conclusion	195
CHAPTER 5: WHAT IS KNOWN ABOUT MEDICAL PRACTICE AND ITS REGULATION?		197
5.1	Public opinion concerning euthanasia and other MBSL	198
5.2	The first national survey: euthanasia by GPs and nursing-home doctors	202
5.3	Two major national surveys of MBSL	207
5.3.1	Euthanasia and other MBSL: frequencies, circumstances and characteristics	210
5.3.2	Termination of life without an explicit request	226
5.3.3	Severely defective newborn babies (and late abortion)	229
5.3.4	Psychiatric patients and patients with a psychiatric disorder	233
5.3.5	The control system and its operation in practice	236

5.4	Other recent research	246
5.4.1	Communication between doctor and patient	246
5.4.2	The euthanasia policy of hospitals and nursing homes	248
5.4.3	The role of pharmacists	251
5.4.4	Institutionalized, mentally handicapped patients	252
5.5	Summary and conclusions	252
CHAPTER 6: EUTHANASIA AND OTHER MEDICAL BEHAVIOR THAT SHORTENS		
LIFE AS A PROBLEM OF REGULATION		259
6.1	Criteria for a control system	259
6.1.1	What are the objectives of legal control?	260
6.1.2	What should we expect of a regulatory regime?	264
6.2	Criminal law is the problem, not the solution	267
6.2.1	The regulatory situation recapitulated	268
6.2.2	The intrinsic unsuitability of criminal law	269
6.2.3	The impossibility of enforcing criminal prohibitions	274
6.2.4	Control in the context of criminal enforcement offers the doctor insufficient legal security	276
6.2.5	Can tinkering with the reporting procedure improve the effectiveness of criminal enforcement?	278
6.2.6	Would 'legalizing' euthanasia help?	282
6.2.7	A final verdict on criminal enforcement of legal requirements concerning MBSL	284
6.3	Decriminalization and the prospects of non-criminal enforcement	284
6.3.1	Legalization, decriminalization, and the 'medical exception'	285
6.3.2	A system of decriminalized enforcement	288
6.3.3	A uniform regulatory regime for all MBSL?	296
6.4	Conclusion	298
CHAPTER 7: TWO REFLECTIONS ON THE SIGNIFICANCE OF THE DUTCH		
EXPERIENCE		299
7.1	Whither leads the slippery slope?	299
7.2	Is euthanasia law exportable?	304
APPENDIX I: SOME RELEVANT LEGAL DOCUMENTS		307
A.	Articles 40, 228(1), 255, 287, 289, 293, 294 and 307 of the Criminal Code	307
B.	The amendment to the Law on the Disposal of Corpses and the Order in Council pursuant to the law	308
C.	Some legislative proposals	314
1	The proposal of the State Commission on Euthanasia (1985)	314
2	The proposal of Wessel-Tuinstra (1984-1986)	316
3	The proposal of the Dutch Association for Voluntary Euthanasia (1996)	318

APPENDIX II: THREE LEADING CASES	321
1 Schoonheim (Supreme Court 1984)	322
2 Chabot (Supreme Court 1994)	329
3 Kadijk (Court of Appeals, Leeuwarden, 1996)	341
LITERATURE	353
INDEX	377

Extended Table of Contents

LIST OF FIGURES AND TABLES	XVII
ACKNOWLEDGEMENTS	1
GLOSSARY	3
PROLOGUE: THE NETHERLANDS AND THE DUTCH	9
CHAPTER I: INTRODUCTION	15
1.1 What this book is about and for whom it is intended	15
1.2 The definition of 'euthanasia' and of other 'medical behavior that shortens life' (MBSL)	17
1.3 A sketch of the current legal situation	18
1.4 Criticisms from abroad and the Dutch reaction	20
INTERMEZZO: THE DUTCH HEALTH CARE SYSTEM AND THE CARE OF THE TERMINALLY ILL	31
A The Dutch health-care system	31
<i>Public health</i>	31
<i>Access to health care</i>	31
<i>The cost of health care</i>	32
<i>The organization of health care</i>	32
B Institutions for health care and care of the elderly	33
<i>Hospitals</i>	33
<i>Nursing homes (verpleeghuizen)</i>	34
<i>Residential homes (verzorgingshuizen)</i>	34
<i>Where do people die?</i>	35
C Health-care professionals	35
<i>Doctors</i>	36
<i>General Practitioners (huisartsen)</i>	37
<i>Specialists</i>	38
<i>Nursing-home doctors</i>	38
<i>Nurses</i>	38
<i>Pharmacists</i>	39
<i>Coroners</i>	39
<i>The Medical Inspectorate and Medical Disciplinary Law</i>	40

CHAPTER 2: LEGAL CHANGE 1945-1997	43
2.1 1945-1970: How room for public debate became available	44
<i>Introduction</i>	44
<i>The legalization of abortion</i>	45
<i>Changes in medical practice in the 1960s</i>	46
<i>The case of Mia Versluis: before terminating life-support a doctor must consult other doctors and inform the patient's family</i>	47
<i>The formulation of new ideas on the doctor-patient relationship</i>	48
<i>To sum up</i>	49
2.2 1970-1982: The early stages of public debate	50
<i>Introduction</i>	50
<i>The first advisory reports on euthanasia</i>	50
<i>The Postma case and other cases involving violation of articles 293 and 294</i>	51
<i>The report of the Medical Association of 1975</i>	54
<i>A case of 'indirect euthanasia'</i>	54
<i>The positions taken by various organizations</i>	55
<i>Doctors and euthanasia</i>	56
<i>Attention for assistance with suicide</i>	57
<i>The Wertheim case and prosecutorial policy</i>	58
<i>To sum up</i>	60
2.3 1982-1986: The breakthrough	61
2.3.1 The justification of necessity and the 'requirements of careful practice'	61
<i>Legal doctrines available for legitimizing euthanasia</i>	61
<i>The Schoonheim case: euthanasia can be justifiable</i>	62
<i>The Pols case: euthanasia does not fall within the 'medical exception'</i>	63
<i>The report of the Medical Association of 1984: formulation of the 'requirements of careful practice'</i>	65
<i>The Admiraal case: a doctor who met the 'requirements of careful practice' will be acquitted</i>	66
2.3.2 The definition of euthanasia and initial proposals for legislation	68
<i>Introduction</i>	68
<i>The Health Council report of 1982</i>	68
<i>The Wessel-Tuinstra bill</i>	69
<i>The State Commission on Euthanasia</i>	69
<i>Euthanasia is not a 'natural' cause of death</i>	72
<i>To sum up</i>	73
2.4 1986-1997: Efforts to codify emerging practice in legislation; broadening the subject of debate	73
<i>Introduction</i>	73
<i>Political responses to the report of the State Commission</i>	74
<i>The reaction of the Dutch Association for Voluntary Euthanasia</i>	76
<i>Prelude to a national study of MBSL</i>	76

<i>The Stinissen case: artificial feeding is medical treatment</i>	77
<i>The report of the Rummelink Commission and the Government's reaction</i>	78
<i>The legislation of 1993</i>	79
<i>The Chabot case: assistance with suicide in cases of non-somatic suffering</i>	80
<i>Reports on problematic categories of MBSL</i>	82
<i>The Prins and Kadijk cases: termination of life without an explicit request in the case of severely defective newborn babies</i>	83
<i>A second national study of MBSL</i>	84
<i>Tosum up</i>	85
2.5 Concluding remarks on the process of legal change	86
CHAPTER 3: THE CURRENT LEGAL SITUATION	89
3.1 A summary of current law concerning medical behavior that shortens life	91
3.1.1 'Normal medical practice', the 'medical exception' and a 'natural death'	91
3.1.2 The concept 'medical behavior that shortens life' (MBSL)	92
<i>The patient refuses (further) life-prolonging treatment</i>	93
<i>'Normal medical practice'</i>	95
<i>Termination of life</i>	96
3.1.3 Euthanasia	98
<i>Substantive requirements</i>	100
<i>Procedural and professional requirements ('requirements of careful practice')</i>	104
<i>The patient's right to euthanasia</i>	107
<i>The legal position of third parties</i>	108
3.1.4 Euthanasia versus assistance with suicide	111
3.2 The reporting procedure	114
3.3 The CAL and NVK reports: law <i>in statu nascendi</i>	118
3.3.1 The legitimacy of decisions to shorten life in the absence of a competent request	119
3.3.2 Severely defective newborn babies (and late abortion)	123
3.3.3 Coma (PVS) patients	127
3.3.4 'Help in dying'	131
3.3.5 Assessment of the approach of the CAL and NVK reports	133
3.4 The demented elderly	134
3.5 Euthanasia in the absence of somatic suffering	139
3.5.1 Persons whose suffering is due to a psychiatric disorder	141
<i>Competence</i>	144
<i>Suffering</i>	146
<i>Treatment perspective</i>	146
<i>Institutionalized patients</i>	147
<i>Non-psychiatrists</i>	148
<i>Consultation</i>	148
<i>Other 'requirements of careful practice'</i>	149
<i>The Chabot case</i>	149

	<i>Killing on request or assistance with suicide?</i>	151
	<i>Why psychiatrists?</i>	151
3.5.2	The legal horizon: assistance with suicide by the non-'sick' and the 'suffering'	152
3.6	Conclusion	154
CHAPTER 4: THE TERMS OF DEBATE SINCE 1982		157
4.1	Distinguishing euthanasia from other MBSL	157
4.1.1	Killing versus letting die	158
4.1.2	Intentionally shortening life	162
4.1.3	Conclusion	166
4.2	The most important arguments since 1982	167
4.2.1	The principle of autonomy	168
4.2.2	The principle of beneficence	172
4.2.3	The principle of the sanctity of life	174
4.2.4	The slippery-slope argument	177
4.2.5	Control arguments	180
4.3	A fundamental difference of opinion?	182
4.3.1	The nature of a question of legal policy	182
4.3.2	A quest for common ground	184
4.3.3	The appeal to tolerance	186
4.3.4	Respect for life	189
4.3.5	Conclusion	195
CHAPTER 5: WHAT IS KNOWN ABOUT MEDICAL PRACTICE AND ITS REGULATION?		197
5.1	Public opinion concerning euthanasia and other MBSL	198
	<i>Severely defective newborn babies</i>	200
	<i>Coma patients</i>	200
	<i>Psychiatric patients</i>	200
	<i>Senile dementia</i>	200
	<i>The elderly who wish to determine the time of their death</i>	200
5.2	The first national survey: euthanasia by GPs and nursing-home doctors	202
	<i>Euthanasia and assistance with suicide by GPs</i>	203
	<i>Euthanasia and assistance with suicide by nursing-home doctors</i>	206
5.3	Two major national surveys of MBSL	207
	<i>'Medical behavior that shortens life' (MBSL)</i>	208
	<i>The intent of the doctor</i>	208
5.3.1	Euthanasia and other MBSL: frequencies, circumstances and characteristics	210
	<i>NTBR practice</i>	215
	<i>The 'requirements of careful practice'</i>	216
	<i>Consultation</i>	219
	<i>Carrying out euthanasia</i>	221
	<i>Characteristics of persons who die as a result of a MBSL</i>	222

5.3.2	Termination of life without an explicit request	226
5.3.3	Severely defective newborn babies (and late abortion)	229
5.3.4	Psychiatric patients and patients with a psychiatric disorder	233
5.3.5	The control system and its operation in practice	236
	<i>Self-reporting by doctors</i>	236
	<i>The role of the coroner</i>	240
	<i>Prosecutorial decision-making</i>	241
	<i>Outcomes of criminal prosecutions</i>	245
	<i>The role of medical disciplinary law</i>	245
	<i>Overall assessment of the reporting procedure</i>	245
5.4	Other recent research	246
5.4.1	Communication between doctor and patient	246
5.4.2	The euthanasia policy of hospitals and nursing homes	248
5.4.3	The role of pharmacists	251
5.4.4	Institutionalized, mentally handicapped patients	252
5.5	Summary and conclusions	252
CHAPTER 6: EUTHANASIA AND OTHER MEDICAL BEHAVIOR THAT SHORTENS LIFE AS A PROBLEM OF REGULATION		259
6.1	Criteria for a control system	259
6.1.1	What are the objectives of legal control?	260
6.1.2	What should we expect of a regulatory regime?	264
	<i>Reasonably effective control</i>	264
	<i>Adaptation to the demands of the behavioral situation</i>	264
	<i>Active support from the medical profession</i>	266
	<i>Public confidence</i>	267
6.2	Criminal law is the problem, not the solution	267
6.2.1	The regulatory situation recapitulated	268
6.2.2	The intrinsic unsuitability of criminal law	269
	<i>Conceptual incongruity</i>	269
	<i>System resistance to inappropriate use</i>	273
6.2.3	The impossibility of enforcing criminal prohibitions	274
6.2.4	Control in the context of criminal enforcement offers the doctor insufficient legal security	276
6.2.5	Can tinkering with the reporting procedure improve the effectiveness of criminal enforcement?	278
6.2.6	Would 'legalizing' euthanasia help?	282
6.2.7	A final verdict on criminal enforcement of legal requirements concerning MBSL	284
6.3	Decriminalization and the prospects of non-criminal enforcement	284
6.3.1	Legalization, decriminalization, and the 'medical exception'	285
6.3.2	A system of decriminalized enforcement	288
6.3.3	A uniform regulatory regime for all MBSL?	296
6.4	Conclusion	298

CHAPTER 7: TWO REFLECTIONS ON THE SIGNIFICANCE OF THE DUTCH EXPERIENCE	299
7.1 Whither leads the slippery slope?	299
7.2 Is euthanasia law exportable?	304
APPENDIX I: SOME RELEVANT LEGAL DOCUMENTS	307
A Articles 40, 228(1), 255, 287, 289, 293, 294 and 307 of the Criminal Code	307
B The amendment to the Law on the Disposal of Corpses and the Order in Council pursuant to the law	308
<i>The amended Law</i>	308
<i>The Order in Council pursuant to the Law</i>	309
C Some legislative proposals	314
1 The proposal of the State Commission on Euthanasia (1985)	314
2 The proposal of Wessel-Tuinstra (1984-1986)	316
3 The proposal of the Dutch Association for Voluntary Euthanasia (1996)	318
APPENDIX II: THREE LEADING CASES	321
Schoonheim (Supreme Court 1984)	322
1 Procedure	322
2 Facts	323
3 The opinion of the Supreme Court	324
3.1 The meaning of 'taking another person's life'	324
3.2 Absence of substantial violation of the law	325
3.3 The justification of necessity	326
3.4 Judgment	328
2 Chabot (Supreme Court 1994)	329
1 Procedure	329
2 Facts	329
3 The opinion of the Supreme Court	333
3.1 General considerations	333
3.2 The justifiability of assistance with suicide in the case of non-somatic suffering and a patient who is not in the terminal phase	334
3.3 The voluntariness of the request in the case of a psychiatric patient	335
3.4 Judgment	337
4 The medical disciplinary proceedings against Chabot	338
3 Kadijk (Court of Appeals, Leeuwarden, 1996)	341
1 Procedure	341
2 Facts	342
3 The opinion of the Court of Appeals	344
3.1 Defendant's request to dismiss the prosecution	344
3.2 The meaning of 'taking another person's life'	346
3.3 Appeal to the 'medical exception'	347

3.4 'The defence of necessity'	348
3.5 Judgment	350
3.6 Additional consideration	351
LITERATURE	353
INDEX	377

List of Figures and Tables

- Figure 3.1 The different sorts of MBSL
- Table 5.1 Results of SCP-polls 1966-1991
- Table 5.2 Estimates of frequencies of MBSL, 1990 and 1995
- Table 5.3 Euthanasia experience of different sorts of doctors, 1990/1995
- Table 5.4 Frequencies of MBSL per category of doctor, 1990/1995
- Table 5.5 NTBR practice of different categories of doctor, 1990
- Table 5.6 Procedural safeguards in the case of various MBSL, 1990/1995
- Table 5.7 Activities of consulted doctors, 1995
- Table 5.8 Persons whose death results from a MBSL: Age, 1995
- Table 5.9 Persons whose death results from a MBSL: Sex, 1995
- Table 5.10 Persons whose death results from a MBSL: Disease, 1995
- Table 5.11 Persons whose death results from a MBSL: Estimated shortening of life, 1995
- Table 5.12 Termination of life without the patient's explicit request, 1990 and 1995
- Table 5.13 Frequency of various MBSL as cause of death of newborn babies, 1995
- Table 5.14 Experience of pediatricians with MBSL, 1995
- Table 5.15 Assistance with suicide in psychiatric practice, 1995
- Table 5.16 Reasons for refusing a request for assistance with suicide by a psychiatric patient
- Table 5.17 Cases of euthanasia and termination of life without a request brought to the attention of the prosecutorial authorities, 1981-1995
- Table 5.18 Prosecutorial decisions, 1991-1995
- Table 5.19 Final judicial disposition of prosecutions for euthanasia and termination of life without an explicit request, 1981-1995
- Table 5.20 Euthanasia policies of hospitals and nursing homes in 1989 and 1994
- Figure 6.1 Elements of the reporting requirement in a decriminalized control regime for termination of life

Acknowledgements

We have written this book as a collective project, but nevertheless some of us are more responsible for some chapters than for others. Griffiths bears primary responsibility for chapters 1,3,5,6,7 and the appendices, Bood for chapter 4, and Weyers for the Prologue, the Intermezzo, and chapter 2. Griffiths' work on the book is the culmination of a project that began about 10 years ago and has resulted in a number of publications, several of which form the basis of various chapters of this book.' Bood and Weyers are both engaged in dissertation research, Bood on the legal-philosophical foundations of the Dutch euthanasia debate, Weyers on the process of legal change concerning euthanasia and other medical practices that shorten life.

A book such as this could not have been written without the help and criticism we have received from a large number of people and organizations. We are in particular grateful for the continuous collegial support we have enjoyed from members of the Department of Legal Theory and, more generally, of the Faculty of Law of the University of Groningen, throughout the entire history of this project. In the final stages of preparation of the manuscript we enjoyed the stimulating support of the CHAZERAS Society.

Specific thanks are due to a number of Dutch colleagues who helped us improve the accuracy of our presentation and interpretation of data derived from their research: Or. I. Blad (lecturer in criminal law, Erasmus University Rotterdam), Dr. J.M. Cuperus-Bosma (research associate, Free University of Amsterdam), Dr. A. van der Heide (research associate, Erasmus University Rotterdam), Or. L. Pijnenborg (former research associate, Erasmus University Rotterdam), Dr. M. Trappenburg (lecturer in political science, Leiden University), Prof. G. van der Wal (former Medical Inspector, now professor of social medicine, Free University of Amsterdam).

For reading and commenting on (parts of) the manuscript and saving us from greater and lesser errors of law, fact and interpretation, we would particularly like to thank: A.N.A. Joesphus [itta (former chief prosecutor, Alkmaar), Prof. H.). Leenen (emeritus

In particular, Griffiths 1987, 1994, 1995a, 1995b and 1995c. The insistence of Dr. A. Klijn (Center for Research and Documentation, Ministry of Justice) that the argument of these articles be presented in a systematic way in book form was the initial inspiration for undertaking the enterprise of writing this book.

professor of social medicine and medical law, University of Amsterdam), Prof. L.C.M. Meijers (former Advocate-General of the Supreme Court), Prof. J. Remmelink (former Procurator-General of the Supreme Court), and Dr. M. Trappenburg (see above). We also received valuable criticisms of (parts of) the manuscript from: W. Davids (member of the Supreme Court of the Netherlands), F. Janssens (former lecturer in criminal law, University of Groningen), Prof. J. Legemaate (professor of medical law, Erasmus University Rotterdam, and staff lawyer of the Royal Dutch Medical Association), F. le Poole (vice-president of the District Court, Assen, and member of the First Chamber of Parliament), Prof. A. Soeteman (professor of philosophy of law, Free University of Amsterdam), and Dr. A.J. Tholen (chef de clinique, psychiatry, University Hospital Groningen, and chairman of the Committee on Assistance with Suicide of the Dutch Association for Psychiatry).

Prof. G. Griffiths (emeritus professor of history, University of Washington) read the manuscript thoroughly and saved us from countless errors of style and obscurity; Prof. J. Dombink (professor of criminology, University of California, Irvine) helped us track down sources and gave us the benefit of his critical reaction to the manuscript; J. Weiss (Center for the Legal Rights of the Elderly, New York) reacted in his usual challenging way to what we wrote.

Obviously, while all of those mentioned contributed to whatever merits the book may have, none of them is responsible for the flaws that remain.

Finally, we acknowledge the support of the Netherlands Organization for Scientific Research (NWO) and of the Ministry of Justice, for earlier stages of the project of which this book is one fruit. Weyers' research is currently supported by a grant from the Foundation for Law and Government (Reob), which is part of NWO.

Groningen, October 1997

John Griffiths
Alex Bood
Heleen Weyers

Glossary

ABSTINEREN [ABSTAINING FROM TREATMENT, ABSTINENCE]

refers both to ending (life-sustaining) treatment that has already been undertaken and to refraining from beginning such treatment.

ACTIEVE EUTHANASIE [ACTIVE EUTHANASIA]

formerly contrasted with passive euthanasia but now referred to simply as 'euthanasia'

ADVOCaat-GENERAAL (AG) [ADVOCATE-GENERAL]

a lawyer (of whom there are several) attached to the Supreme Court who submits a brief to the Court setting out his views as to how a case should be decided; this brief is published together with the decision and generally gives a more extensive account than the Court's decision itself of the legal considerations involved in the case. (Also the title of a prosecutor at the level of the Courts of Appeals.)

ARRONDISSEMENTSRECHTBANK [DISTRICT COURT]

the base-line court of general jurisdiction (in civil and criminal cases); there are 19 judicial districts in the Netherlands; serious or difficult criminal cases are heard by a panel of three judges.

BEHANDELENDE ARTS [DOCTOR RESPONSIBLE FOR TREATMENT - ATTENDING] PHYSICIAN]

the doctor(s) regarded as having a doctor-patient relationship with the patient and responsible for his care.

COMMISSIE AANVAARDBAARHEID LEVENSBEEINDIGEND HANDELEN (CAL)

[COMMISSION ON THE ACCEPTABILITY OF TREATMENT THAT TERMINATES LIFE]

a commission appointed by the Royal Dutch Medical Association, author of four reports on severely deformed newborn babies, long-term coma patients, the demented elderly, and psychiatric patients.

CDA - CHRISTEN DEMOCRATISCH APPEL [CHRISTIAN DEMOCRATIC APPEAL]

the Christian Democratic Party.

CONSULTATIE [CONSULTATION]

formal request by a doctor for a second opinion from another doctor.

D66 - DEMOCRATEN 66 [DEMOCRATS 66]

the left-of-center liberal party.

DIRECTE EUTHANASIE [DIRECT EUTHANASIA]

formerly contrasted with indirect euthanasia (i.e., death due to pain relief) but now referred to simply as 'euthanasia'.

EUTHANASIE [EUTHANASIA]

killing another person at his request - prohibited by article 293 of the Criminal Code but when performed by a doctor under specific conditions taken to be justified; the term 'euthanasia' is often used more generally in public discussion and in this book to include assistance with suicide.

GEZONDHEIDSRaad [HEALTH COUNCIL]

official advisory body of the Dutch Government on health matters.

GERECHTSHOF [COURT OF APPEALS]

intermediate appellate court in civil and criminal cases; conducts a trial *de novo*; hears criminal cases in a panel of 3 judges; there are 5 Courts of Appeals in the Netherlands.

HOGE RAAD DER NEDERLANDEN [SUPREME COURT]

the highest court in the Netherlands in civil, criminal and tax cases; considers in *casation* only legal questions; hears criminal cases in a panel of 5 judges.

HUISARTS [GENERAL PRACTITIONER (GP)]

a family doctor, usually in solo private practice; generally speaking, all Dutch residents have a semi-permanent relationship with a GP, who provides general medical care and referrals for the rest of the health-care system (see the *Intermezzo*).

HULP BIJ ZELFDODING [ASSISTANCE WITH SUICIDE]

prohibited by section 294 of the Criminal Code but when rendered by a doctor under specific conditions taken to be justified; for most purposes having to do with its legality not distinguished from killing a person at his request (euthanasia).

HULPVERLENER [PERSON WHO RENDERS PROFESSIONAL ASSISTANCE]

general term in Dutch for all kinds of institutionalized/professional assistance (legal, medical, social, etc.); art. 7:446 of the Civil Code (added by the Law on Contracts for Medical Treatment (see chapter 3 note 12)) refers to a *hulpverlener* as a natural or legal person engaged in a medical profession or business; art. 7:453 imposes as the general duty of care that care characteristic of a 'good *hulpverlener*' and in conformity with the 'professional standard'.

INDIRECTE EUTHANASIE [INDIRECT EUTHANASIA]

term formerly used to refer to causing death as a result of the use of pain killers (usually morphine) in doses known to be likely to shorten life; no longer referred to as a form of euthanasia.

INSPECTIE VOOR DE GEZONDHEIDSZORG - MEDISCHE INSPECTEUR [MEDICAL INSPECTORATE - MEDICAL INSPECTOR]

semi-independent agency charged, among other things, with enforcement of legal provisions relating to medical care; empowered to bring disciplinary proceedings against medical professionals.

KANSLOOS MEDISCH HANDELEN [MEDICAL TREATMENT THAT HAS NO CHANCE OF SUCCESS]

medical treatment whose chance of success is insufficient to legitimize it; proposed by NVK 1992 as one of two elements in an alternative approach to the standard term

medisch zinloos handelen, distinguished from *zinloos medisch handelen* in that the latter concept refers to the possible benefit to the patient.

KONINKLIJKE KEDERLANDSE MAATSCHAPPIJ TER BEVORDERING DER GEKEESKUNST (KNMG) [ROYAL DUTCH MEDICAL ASSOCIATION]

professional association of Dutch doctors, author of a number of position papers on euthanasia and assistance with suicide (see chapters 2 and 3).

KONINKLIJKE NEDERLANDSE MAATSCHAPPIJ TER BEVORDERING DER PHARMACIE (KNMP) [ROYAL DUTCH ASSOCIATION FOR PHARMACY]

professional association of Dutch pharmacists, author of a position paper on the 'requirements of careful practice' for pharmacists asked to supply euthanatica (see chapter 3.1.3).

LEEFBAAR LEVEN | LIFE WORTH LIVING

overall term introduced by NVK 1992 for the criteria by which 'quality-of-life' considerations are assessed in connection with decision-making concerning termination of life in the case of newborn babies.

LEVENSBEËINDIGING ZONDER UITDRUKKELIJK VERZOEK [TERMINATION OF LIFE WITHOUT AN EXPLICIT REQUEST]

intentional, active, direct, non-voluntary termination of life (including coma patients, newborn babies, 'help in dying').

MBSL - MEDICAL BEHAVIOR THAT SHORTENS LIFE; ALSO REFERRED TO AS *MFD/SCHÉ BESLISSINGEN ROND HET LEVENSEINDE* (MBL) [MEDICAL DECISIONS CONCERNING THE END OF LIFE (MOH)]

the general category that includes euthanasia and other acts or omissions by doctors that intentionally shorten life.

MEDISCH EXCEPTIE [MEDICAL EXCEPTION]

the (proposed or implied) exclusion of doctors, acting as such, from the coverage of provisions of the criminal code dealing with offences against the person.

MEDISCH ZINLOOS HANJELEN [MEDICALLY FUTILE TREATMENT]

technical term for treatment that a doctor need (and even may) not initiate or continue, with or without the consent of the patient, because to do so is in conflict with the medical-professional standard governing the authority to practice medicine; NVK 1992 proposes to divide the concept of medical futility into two categories: *kansloos medisch handelen* and *zinloos medisch handelen*.

NAASTEN [FAMILY AND INTIMATE FRIENDS]

those who, in the context of MBSL, are thought of as potential surrogate decision-makers (the Law on Contracts for Medical Treatment, art. 7:465(3) of the Civil Code, refers to spouses or partners, parents, children and siblings).

NATUURLIJKE OORDE [NATURAL DEATH]

death resulting from 'internal causes'; if the responsible doctor considers the death of a patient a natural one, he can file a certificate of natural death, which permits burial or cremation without further legal control.

NEDERLANDSE VERENIGING VOOR KINDERGENEESKUNDE (NVK) [DUTCH ASSOCIATION FOR PEDIATRICS]

author of a report on MBSL in the case of severely defective newborn babies (see chapter 3.3).

NEDERLANDSE VERENIGING VOOR OBSTETRIE EN GYNAECOLOGIE (NVOG) [DUTCH ASSOCIATION FOR OBSTETRICS AND GYNECOLOGY]

author of a report on late-term abortion (see chapter 3.3.2).

NEDERLANDSE VERENIGING VOOR PSYCHIATRIE (NVPJ) [DUTCH ASSOCIATION FOR PSYCHIATRY]

author of a report on assistance with suicide in the case of psychiatric patients (see chapter 3.5.1).

NEDERLANDSE VERENIGING VOOR VRIJWILLIGE EUTHANASIE (NVVE) [DUTCH ASSOCIATION FOR VOLUNTARY EUTHANASIA]

the most important Dutch organization committed to legalization of euthanasia and to giving practical support to those seeking it.

NOODTOESTAND [SITUATION OF NECESSITY]

a defence (justification) to a criminal charge, provided for in article 40 of the Dutch Criminal Code (see appendix 11-1), as interpreted by the courts.

NORMAAL MEDISCH HANDELEN [NORMAL MEDICAL PRACTICE]

behavior that falls within the legal authorization to practice medicine and is regulated by medical ethics and medical disciplinary law.

ONDRAAGLIJK LIJDEN [UNBEARABLE SUFFERING]

term used in conjunction with *uitzichtloos* (hopeless) to indicate one of the conditions of the legality of euthanasia and assistance with suicide; includes but is not limited to pain and can be somatic or non-somatic in origin.

ONTLUISTEIUNG [MENTAL AND PHYSICAL DETERIORATION INVOLVING LOSS OF HUMAN DIGNITY]

one of the forms of (anticipated) suffering that can support a request for euthanasia.

ONVRIJWILLIGE EUTHANASIE [NON-VOLUNTARY EUTHANASIA]

termination of life without an explicit request, no longer referred to as euthanasia.

OPENBAAR MINISTERIE (OM)

collective term for the prosecutorial authorities; members of the OM are associated with the various courts and are responsible to the Minister of Justice.

OVERMACHT [LITERALLY: 'SUPERIOR FORCE']

the defence of *overmacht* in art 40 of the Dutch Criminal Code (see appendix I-A) has been interpreted to include both an excuse (duress) and a justification (necessity).

PASSIEVE EUTHANASIE [PASSIVE EUTHANASIA]

term formerly used to refer to death caused by abstaining from life-sustaining treatment; no longer referred to as a form of euthanasia.

PVDA - PARTIJ VAN DE ARBEID [LABOR PARTY]

the Dutch social-democratic party.

PROCUREL'R-GENERAAL (PG) [PROCURATOR-GENERAL]

the highest prosecutorial authority at the level of the Courts of Appeal; the five PGs formed until 1996 the national Committee of Procurators-General that, subject to instructions from the Minister of Justice, makes all final decisions whether or not to prosecute cases of euthanasia and termination of life without an explicit request; since 1996 the Committee consists of 3 PGs. (Also the title of the most senior of the Advocates-General attached to the Supreme Court.)

SPECIALIST [MEDICAL SPECIALIST]

usually attached to and practising within a hospital (see the *Intermezzo*).

STERVENSBEGELEIDING [SUPPORT IN THE DYING PROCESS]

general support of a dying person and his family and intimates; sometimes more loosely used as synonymous with *stervenshulp*.

STERVENSHULP [HELP IN DYING]

administration of lethal drugs to facilitate the final stages of the dying process, in particular in the situation in which the decision has already been taken to allow the patient to die by abstaining from (further) life-prolonging treatment.

TUCHTRECHT (MEDISCH) [MEDICAL DISCIPLINARY LAW]

a set of legal standards, procedures and tribunals applicable to the behavior of medical professionals; can be invoked by interested private persons (usually patients), by the governing body of the institution in which the person concerned works, or by the Medical Inspector,

UITZICHTLOOS LIJDEN [HOPELESS SUFFERING]

term used in conjunction with *ondraaglijk* (unbearable) to indicate one of the conditions of the justifiability of euthanasia and assistance with suicide; it usually carries the specific additional meaning of irreversibility - lacking any prospect of improvement - but it is also sometimes used in the more general sense of 'without hope' as in: 'abandon hope, all ye who enter here'.

UITZICHTLOZE NOODSITUATIE [SITUATION OF HOPELESS NECESSITY]

term sometimes used to characterize the patient's situation when euthanasia is considered justifiable (see e.g. proposed legislation of the State Commission and of Wessel-Tuinstra, appendix I-C-1, 2).

VERPLEEGHUISARTS [NURSING-HOME DOCTOR]

doctor specialized in the care of nursing-home patients (see the *Intermezzo*).

VERSTERVING [LETTING ONESELF DIE]

self-willed death, particularly of the very old, brought about by ceasing to eat (and to drink), possibly accompanied by palliative care.

VERZUILING [PILLARIZATION]

characteristic feature of Dutch political culture during the greater part of the twentieth century, in which many different sorts of social institutions (politics, health, education, etc.) are organized along the lines of the fundamental religious divisions (see the *Prologue*).

VVD - VOLKSPARTIJ VOOR VRIJHEID EN DEMOCRATIE [PEOPLE'S PARTY FOR FREEDOM AND DEMOCRACY]

the right-of-center liberal party.

WELOVERWOGEN [WELL-CONSIDERED]

requirement (in addition to voluntariness) of a valid request for euthanasia or assistance with suicide.

WILSBEKWAAMHEID [COMPETENCE]

prerequisite of a voluntary and well-considered request and hence of a valid request for euthanasia or assistance with suicide and for a valid refusal of treatment.

WILSBESCHIKKING (SCHRIFTELIJKE) [ADVANCE DIRECTIVE]

(written) request for euthanasia and/or for abstinence under specified circumstances, should the person concerned be unconscious or incompetent.

ZINLOOS MEDISCH HANDELEN [MEDICAL TREATMENT THAT CANNOT SIGNIFICANTLY BENEFIT THE PATIENT]

medical treatment whose possible benefit to the patient is insufficient to legitimize it, in particular because, if successful, it would condemn the patient to an *onleefbaar leven* (unacceptably poor quality of life); proposed by NVK 1992 as one of two elements in an alternative approach to the standard term *medisch zinloos handelen*; distinguished from *kansloos medisch handelen* in that it refers not to the technical chance of success but to the possible benefit to the patient.

ZORGVULDIGHEIDSEISEN [REQUIREMENTS OF CAREFUL PRACTICE]

in particular those applicable to euthanasia - distinguishable into substantive requirements (conditions of legal euthanasia) and procedural requirements *tzorgvuldigheidseisen* (sometimes refers more narrowly to these latter requirements). Since absence of *zorgvuldigheid* is the basis of liability for a negligent tort and thus equivalent to the Common Law idea of lack of 'due care', one might translate the Dutch term as 'requirements of due care'. However, this would wrongly suggest a connection with tort liability, which is the reason we have preferred to translate the term as 'requirements of careful practice'.

Prologue: the Netherlands and the Dutch

This book is about euthanasia and other medical practices that shorten life, and about their legal regulation. The Netherlands is the setting, but it is not the subject. Nevertheless, in interpreting the information and arguments to be presented in the coming chapters, it is necessary to know something about the local context. We try to provide a thumbnail sketch here that goes beyond the relaxed Dutch approach to sex and drugs, or the story of the little boy who put his finger in the dike. We make no pretention to thoroughness or depth.

The Netherlands is a small, flat country of some 16 million inhabitants, one of the most densely populated in the world. It emerged as an independent country in the seventeenth century after a struggle of some 80 years against the authority of the Spanish crown, and with brief interludes in the Napoleonic period and the Second World War, it has been independent ever since. The independence struggle began as one to preserve traditional privileges, especially that of freedom from additional taxation. The opposition gained force when joined by that part of the population (led by Calvinists) which sought reform of the Church. In 1648 the Spaniards finally accepted the independence of the Netherlands, which for a century and a half thereafter was a Republic.

Despite the intermittent warfare, it was in the seventeenth century that the rebellious provinces enjoyed their economic and cultural 'Golden Age'. The Republic was the financial, trading and transport center of the world. Conquests in Asia, Africa and America made of the Netherlands one of the major colonial powers. Men such as Rembrandt van Rijn, Frans Hals, Baruch de Spinoza, Hugo de Groot (Grotius) and Constantijn Huygens made the Republic preeminent in the arts and sciences. Foreign visitors such as Descartes and Locke were attracted to the Netherlands by the abundance of libraries and of publishers, and the intellectual and religious freedom of Dutch life.

During its 'Golden Age' the Dutch Republic attracted a great deal of foreign interest. Jonathan Israeli characterizes the contemporary reaction as follows:

Numerous features of Dutch society ... seemed aberrant or abhorrent to outsiders. Until the late seventeenth century many were appalled by the diversity of churches which the authorities permitted and the relative freedom with which religious and

intellectual issues were discussed. Others disapproved of the excessive liberty, as it seemed to them, accorded to specific groups, especially women, servants, and Jews... [The Netherlands] were widely perceived in Europe as a seedbed of theological, intellectual, and social promiscuity which subverted the usual, and proper, relations between men and women, Christians and non-Christians, masters and servants, nobles and non-nobles, soldiers and civilians....

During the seventeenth and eighteenth centuries, outsiders thought of the Republic as giving its citizens, and foreign residents, greater 'freedom' than other European societies of the time This celebrated 'freedom' of the Dutch Republic was based on freedom of conscience. But as the English ambassador Sir William Temple wrote, around 1672, it extended much further, creating a 'general liberty and ease, not only in point of conscience, but all others that serve to the commodiousness and quiet of life, every man following his own way, minding his own business, and little enquiring into other men's.'

After the seventeenth century, the Republic of the Netherlands entered a doldrums of economic and cultural stagnation from which it did not really emerge until the end of the nineteenth century. After the wars of the Napoleonic period the Netherlands became a kingdom. In 1848 a constitution was adopted that reflected the emergence of liberal political ideals of representative government, separation of powers and the rule of law. It was not until 1919, however, that the democratic promise was realized with universal suffrage for men and women. In the latter part of the nineteenth century, the contours of the modern parliamentary system emerged, in which the government is responsible to the Lower House (Second Chamber) of Parliament and requires the support of a majority of the members of that house.

Dutch elections are on the basis of proportional representation, so that a party's share of the national vote determines its share of the seats in Parliament. From the time universal suffrage was achieved, voters have been able to choose from a large number of parties: a Catholic party, several Protestant parties, and some secular parties of which the most important are liberal or socialist. The three largest religious parties, since 1980 united in the Christian Democratic Appeal (CDA), dominate the political center. There are two liberal parties, one to the left of the political center (D66, founded in 1966) and the other to the right (VVD), and one social-democratic party (PvdA). None of these parties has ever received a majority of the seats in the Lower House of Parliament. The Dutch government is therefore always based on a coalition, and until the present coalition of the two liberal parties and the PvdA, the Christian parties had always been pivotal members of any coalition.

During the nineteenth and early twentieth centuries, the Netherlands had remained a largely agrarian country, economically backward and socially somnolent. According to

the American anthropologist Ruth Benedict, who wrote a report for the Office of War Information during the Second World War, the 'typical Dutchman' of the time was

a moralizing, individualistic, freedom-loving, tolerant, self-assured, proud, ironic, puritanical, proper, careful, thrifty, conservative, domestic, serious and somewhat melancholic person, highly conscious of social station.'

Dutch political culture at the beginning of the twentieth century and until well after the Second World War can best be characterized with the term *'verzuiing'*, which literally means 'pillarization, that is, the organization of many social institutions in terms of the 'pillars' of society, defined in essentially religious terms.³ There was a deep social segregation in which people of different religious persuasion lived in considerable isolation from each other. Each 'pillar' had its own ideology and its own trade unions, schools, employers' organizations, newspapers, radio and TV stations, hospitals, etc. Social contacts over the boundaries of the 'pillar' to which one belonged were - except at the level of the leaders - rare.

Another important feature of Dutch socio-economic organization is 'corporatism', based on the originally Catholic social philosophy that rejects both the socialist idea of class struggle and the bourgeois-capitalist idea of competitive individualism in favor of an ideology of common responsibility for the common good, subject to general supervision by the state. In its Dutch version, 'corporatism' traditionally emphasized the primary responsibility of middle-level social organization, in which, for example, trade union leaders and representatives of employers' organizations (both of them organized in terms of pillars) are included, for the regulation of the economic life of a given branch of the economy,"

Despite its pluriform and segregated character, the Netherlands was - as it still is - a stable democracy.⁵ The reason for this must be sought in the specific political style adopted by the Dutch elite. Pacification of the differences between the 'pillars' was accomplished because the elites, who practised a pragmatic toleration, were businesslike in their dealings with each other and tended to solve differences concerning the distribution of scarce goods on the basis of proportionality. Once the decision was taken to support a particu-

2 Van Ginkel 1997: 102.

3 Lijphart distinguishes three 'pillars': Catholic, Calvinist and secular (Lijphart 1968: 17). The latter 'pillar' consists of a socialist and a liberal bloc.

4 See Andeweg & Irwin 1993: 170-171.

5 See generally Lijphart 1968. The idea among some political theorists that strong divisions at the base of society lead to instability at the top seems to be falsified by the case of the Netherlands. Lijphart shows that it is the cooperation between the leaders of the different 'pillars' and the passivity of their followers that accounts for Dutch political stability.

lar activity - radio, schools, hospitals - this was done in proportion to the number of listeners, students, patients, etc.

When an issue could not be solved by applying the principle of proportionality - for example, in the case of ideological yes-or-no questions like decolonization or abortion-avoidance of a definitive resolution was the solution generally sought. Such avoidance took three forms: by postponing consideration of the issue (for example by referring the issue to a prestigious committee, preferably constituted according to the principle of proportionality), by redefining it in such a way that the government was no longer responsible for dealing with it, or by 'depoliticizing' it.⁶ 'Depoliticizing' involved making the issue appear a 'procedural' or a 'technical' one and therefore politically neutral. In the case of abortion, all three forms of avoidance were used before abortion legislation was finally passed, which came long after abortion had become *de facto* legal and ceased to be any kind of social problem. First, the issue was defined as 'medical' and left to doctors. Then the Government appointed an expert committee to study the issue. And when legislation came to seem inevitable, it was long postponed by endless debates on procedural questions."

In order to pacify political issues in these various ways, the elites had to be able to negotiate with each other without the greater public getting involved in what was going on. Political passivity was an important characteristic of Dutch political life until the 1960s.

After the Second World War, the Netherlands (thanks partly to the Marshall Plan) quickly became a reasonably modern industrialized society with an advanced social security system rooted in the strong Dutch tradition of social solidarity. 'Pillarization' and 'corporatism' continued, however, to influence political affairs. In the post-War years, for example, governments were able to carry out an anti-inflationary incomes policy with little disturbance from strikes and the like at least in part because the leaders of both trade unions and employers' organizations regularly encountered each other in the various institutions of their respective 'pillars' and were prepared to cooperate on behalf of what was seen as the common good. Such cooperation takes place to this day in more or less formal consultations between the Government and the leaders of relevant social organizations. In the case of euthanasia, for example, there have since the 1980s been regular consultations on policy between officials of the criminal justice system and representatives of the Medical Association.

The 1960s and 1970s were a crucial watershed for Dutch society. From a conservative, tradition-bound country the Netherlands were transformed into one that once again, as in the seventeenth century, was a hotbed of social and cultural experimentation. The

6 See Andeweg & Irwin 1993: 38.

7 See Outshoorn 1986: 296.

Netherlands took a prominent place in the sexual revolution, the legalization of abortion, the acceptance of drugs, the democratization of educational institutions, the questioning of religious authority (in particular that of the Catholic Church), and so forth. Societal relationships changed, too, in this period, becoming far more 'democratic' (as the Dutch would say): the social distance between ordinary people and those in positions of authority declined, and ordinary Dutchmen (workers, students, those affected by public projects, etc.) now generally expect to have their views listened to on issues that affect them. In public discussions of important social questions, among them euthanasia, politicians no longer command the respect they used to.

These changes sent shockwaves through the once so quiescent Dutch political landscape. In particular the process of secularization that started in the 1960s gradually undermined the position of the traditional 'pillars' and their institutions. Nevertheless, even such dramatic changes did not lead to political or social instability. To some extent this can be explained in terms of the position that the political elite adopted in response to calls for change. On the whole, after some initial resistance, they did not form a bloc opposed to change; in many cases they supported the new ideas and were even spokesmen for them.^e The political culture of conflict-avoidance, the traditional conviction that it is better to guide social developments than to try to stop them, was of great importance in keeping the social turmoil of these years within limits the society could cope with.

In 1996 the Dutchman Van der Horst attempted to explain the Netherlands and the Dutch to people in other countries. He characterizes them as egalitarian, tolerant, freedom-loving, believers in social solidarity, practical, conscientious, careful, moralistic, paternalistic, inclined to respect authority, conformist, punctual, calm, and very attached to their privacy,"

This, then, is the social and cultural context within which the medical practices and legal developments to be discussed in this book must be understood.

8 See Kennedy 1995: 14.

9 Van der Horst 1996.

1 Introduction

1.1 What this book is about and for whom it is intended

The Netherlands is presently the only country in the world in which euthanasia, under specific circumstances, is legally permissible.' Considerable attention has been paid over a number of years to the problem of regulating it. And information has been systematically collected concerning actual practice. The Dutch experience is therefore of considerable interest both to the Dutch themselves and also to people elsewhere who are considering whether or not to make similar practices legal and, if this is done, how they might most effectively be regulated.

The central focus of the book is on Dutch law pertaining to euthanasia and a number of closely related sorts of medical behavior. We will deal with the legal norms and procedures currently in place, with how these have come to be what they are, and with the direction in which they seem to be moving (chapters 2 and 3). But the book is not confined to the law itself: we will also critically consider the arguments that play a role in the Dutch debate (chapter 4), the available evidence bearing on actual practice and on the effectiveness of current law as an instrument of control (chapter 5), and possible alternative forms of legal control (chapter 6). The book ends (chapter 7) with brief reflections on two questions often asked in connection with the Dutch experience: does that experience confirm or refute the fear of a 'slippery slope' from legalization of euthanasia to social practices that are abhorrent? and is the Dutch experience in some sense 'exportable' to other countries?

We have written this book with a reader in mind who is unfamiliar with the Dutch situation and has no specific technical knowledge of law, and certainly not of Dutch law. We do assume that our reader is interested enough in the problems of public policy surrounding euthanasia to want an account of the Dutch situation that goes beyond generalizations and superficialities and includes as much as possible of the legal and factual information that is important for an informed assessment of Dutch practice and its relevance for other countries. We also assume that our reader has an open mind and does not expect us to tell a tendentious story whose moral is preconceived from the start.

There are a handful of partial exceptions to this generalization, all of them as far as we are aware concerning assistance with suicide. The most important is Switzerland, where assistance with suicide (by non-doctors) is not illegal and is an institutionalized practice.

On the whole, the descriptions of Dutch law and practice concerning euthanasia available in English are either so uncritically apologetic," or so obviously and even maliciously biased;' that the reader who is looking not for an advocate's brief for an exercise in axe-grinding but just a straightforward presentation of the evidence is left not knowing what to believe.' Our ambition has therefore been to present the interested reader with reliable information and serious, balanced assessments. It would be wise for him, however, to respond to such a promise by holding onto his intellectual wallet with both hands. The most biased writers on Dutch euthanasia law and practice proclaim their lack of preconception most vigorously. We will therefore state our own personal convictions here at the outset and try to keep them out of the rest of the book as much as possible. The reader is in any case forewarned about what they are and can keep an eye out for unintended distortion. In general terms, we believe:

- that the law should allow ample room for people to decide for themselves the moment and the manner of their death;
- that effective legal control is absolutely essential to prevent abuse of the power unavoidably involved in medical care in connection with death (but not *more* necessary for euthanasia than it is in the case of a number of related sorts of medical behavior that shortens life).

The subject is so controversial that with the best will in the world even the attempt simply to state the facts and the law proves to be susceptible to vigorous disagreement, as we discovered when we submitted the text of this book to a large number of experts for their reaction." Thus, for example, the question what exactly the 'requirements of careful practice' include (see chapter 3), is a matter on which it is possible for informed persons to disagree.

In chapter 6 we develop an argument about the limitations of current legal regulation and alternative possibilities. Here, by contrast with the rest of the book, we drop all pretense of being neutrally descriptive, although the argument is firmly rooted in the legal

- 2 See for example J. Zaritsky, *An Appointment with Death* (Corporation for Public Broadcasting, 1993), a film which accurately conveys the way the Dutch look at the question of euthanasia and provides interesting information about several cases, but which explores none of the problematic aspects of Dutch practice.
- 3 See section 1.4 below for some examples.
- 4 Battin (1994) is a rather lonely exception to this generalization. While she is not always completely reliable on matters of legal detail (for example, she wrongly describes Dutch euthanasia law as falling under the concept of *gedogen*, or systematic toleration of violations of the law), her account of the Dutch situation is, as far as the essentials are concerned, objective and critical.
- 5 See the Acknowledgements for some of the persons whose advice and criticism we sought.

and empirical material presented earlier in the book. The position we take is not widely shared - most Dutch participants in the euthanasia debate reject, for example, the idea that euthanasia could be considered 'normal medical practice' subject to the 'medical exception' (see chapter 6,3, 1). But we hope that the clarity of the analysis will appeal even to people who quite disagree with us about the legal acceptability of the medical behavior involved and how society should deal with it

Finally, a note on sources. Where possible, we have referred to sources in English and have relied as little as possible on secondary sources in Dutch. The Dutch literature is extensive, but it seems pointless to try to do justice to it in a book intended in the first place for non-readers of Dutch.

1.2 The definition of 'euthanasia' and of other 'medical behavior that shortens life' (MBSL)

'Euthanasia' in the strict - and in the Dutch context the only proper - sense refers to the situation in which a doctor "kills a person who is suffering 'unbearably' and 'hopelessly' at the latter's explicit request (usually by administering a lethal injection). When a distinction is made, then 'euthanasia' is in the Netherlands reserved for killing on request as opposed to assistance with suicide, but generally the two are treated together. We will follow this practice and will often loosely use the single term 'euthanasia' to cover both where the distinction is not relevant.

As we will see in chapters 4 and 5, euthanasia in the limited Dutch sense is only separated by rather problematic boundaries from related phenomena, such as pain relief in doses known to be likely to cause the death of the patient, or the termination or non-initiation of life-prolonging treatment that is either medically futile or is rejected by the patient. Nevertheless, these other practices are generally considered legitimate in the Netherlands and elsewhere even by many vigorous opponents of euthanasia," they are referred to in Dutch medical law as 'normal medical practice' and regarded as quite different from euthanasia.

- 6 Euthanasia by persons not acting in a medical capacity plays essentially no role in the current Dutch political debate and is outside the scope of this book. The difficult position of medical professionals other than doctors - in particular, nurses - will be dealt with in chapter 3.1.3.
- 7 See e.g. Callahan 1993. Fenigsen (1989) is a notable exception: most of his fulmination against 'euthanasia' in the Netherlands in fact concerns other medical practices. Battin (1994: 136) makes the interesting observation that much of the domestic opposition to Dutch practice *seems* to concern "passive nonvoluntary euthanasia [abstinence]' a practice much more accepted in the United States than in the Netherlands': (It might be safer to have said: at least as accepted in the United States.)

There is another category of behavior which is also closely related to euthanasia but which is more controversial: the administration of lethal drugs to shorten the life of persons who cannot or do not explicitly request this (severely defective newborn babies, persons in long-term coma, persons in the final stages of dying, persons no longer competent who at some earlier time indicated a general wish for euthanasia if the time should come). Also controversial is assistance with suicide in the case of psychiatric patients and others whose suffering is not somatic in origin, and of elderly persons who are not currently suffering at all but who do not wish to continue living.

Together with euthanasia proper, all of the behavior described above, when engaged in by doctors, is part of a complex of 'medical behavior that shortens life' (MBSL). Although there are, of course, important distinctions between different sorts of MBSL, and some may well be morally and legally more problematic than others, we will see that for purposes of philosophical analysis (chapter 4), empirical description (chapter 5), and effective regulation (chapter 6), the whole complex must be considered together.

A terminological note: We use the expression 'shortening of life' when referring generally to behavior that the doctor knows is likely to cause the patient to die earlier than he otherwise would have done and in fact leads to the patient's death. We use the expression 'termination of life' (sometimes with the qualifier 'active' when this emphasis is needed in the context) to refer to euthanasia (and assistance with suicide) together with what is referred to in the Dutch discussion as 'termination of life without an explicit request'. In other words, 'termination of life' involves 'active' and 'direct' shortening of life (to use expressions now obsolete in the Dutch discussion), to the exclusion of death due to abstinence and pain relief. Were it not for the fact that drugs like morphine and insulin, and occasionally means like the 'plastic bag method', can be used to terminate life, the category 'termination of life' could be defined in terms of the administration of euthanatica.

1.3 A sketch of the current legal situation

Euthanasia is explicitly and apparently absolutely prohibited by two articles of the Dutch Criminal Code. Article 293 prohibits killing a person at his request (the offence is a 'qualified' variety of homicide, in the sense that the homicide would otherwise be murder). Article 294 prohibits assisting a suicide (suicide itself is not a crime in Dutch law).

Despite the apparently forbidding text of these provisions, the courts have held that article 40 of the Criminal Code makes a defence of justification available to a doctor charged under articles 293 or 294. The first acquittal took place in 1983 and this was upheld by the Dutch Supreme Court in the *Schoonheim* case in 1984. The Supreme Court held that a doctor could invoke the defence of justification due to necessity if, confronted by a conflict between a duty to his patient whose suffering is 'unbearable and hopeless,' and the

requirements of the Criminal Code, and exercising the care required of a medical professional, his choice was "objectively justified": The decision in *Schoonheim* led to a series of judicial decisions in which the conditions and limitations of the defence were gradually worked out.

The opening created by the courts came in the course of the 1980s to be reflected in prosecution policy, which now offers the doctor who keeps within the accepted limits a high degree of safety from prosecution. In this sense, euthanasia in the Netherlands is no longer illegal. Contrary to the impression in much of the foreign press, legislation recently enacted by the Dutch parliament (see chapter 3.2) does not affect the legality of euthanasia but only the procedure for reporting it.

As far as the legal norms concerning euthanasia are concerned, the process of legalization is largely complete, and there is little controversy over the results reached. Legal developments concerning euthanasia itself will in the coming years deal essentially with fine-tuning of the existing system (the requirement of consultation with a second doctor, for example, while itself completely non-controversial, leads to complications in some cases). There are, of course, some exceptions to this generalization. An important example is the status of written euthanasia requests made by persons who later become incompetent (especially due to senile dementia); other remaining problems include such things as how to deal with persons of diminished competence and with minors. But the most important legal developments to be expected in the near future concern not the applicable norms but the system of legal control; in particular, the question whether this could not be better accomplished outside of the criminal law is being asked with increasing insistence.

What has been said of euthanasia proper does not apply to situations in which a doctor administers lethal drugs without the patient having made an explicit request, although here, too, the general contours of the emerging legal norms are becoming clear. In the case of coma patients, severely defective newborn babies, and patients in the final stages of the dying process, recent legal developments seem, as we will see in chapter 3.3, to point the way to a generally acceptable outcome, but these matters remain far more controversial than euthanasia proper.

By contrast with the various forms of 'active termination of life' dealt with so far, pain relief and abstention account for the lion's share of all MBSL (almost 10 times as many deaths as those due to the use of lethal drugs). They have nevertheless received relatively little attention as problems of regulation of medical behavior. Death due to the administration of pain relief in doses known to be likely to shorten life is regarded, legally as well as in medical ethics, as subject to the 'doctrine of double effect': so long as the doctor's 'primary intent' is to relieve suffering, the fact that the earlier death of the patient is also a foreseen and even welcome consequence does not, according to this doctrine, entail

that the doctor 'intended' that death. The case is regarded as one of 'normal medical practice' not subject to any special regulation, rather than one of euthanasia (if there is a request) or murder (if there is not). Apart from the general rules applying to medical practice, there are no substantive or procedural protections surrounding pain relief so long as it falls within the scope of the 'doctrine of double effect'.

Much the same applies to abstinence, often in practice done with the express purpose of causing the death of the patient, but regarded for purposes of legal analysis as an 'omission' and therefore not covered by the prohibitions of euthanasia (in the case of request) or murder (in other cases). Abstinence is considered 'normal medical practice' not subject to any special regulation. In the last few years there has been a growing appreciation of the importance of timely decisions to abstain from life-prolonging treatment (including artificial means of administering food and drink). The increasing legitimacy afforded to abstinence has come to be seen both as providing an alternative in many cases to the use of lethal drugs (euthanasia and termination of life without an explicit request) and as affording a justification for the use of such drugs in other cases, in which the patient's death from abstinence threatens to be an inhumane one. Procedural protections surrounding abstinence decisions are still extremely primitive, but there are signs of growing concern about this situation, and this is an area in which legal development is surely to be expected.

1.4 Criticisms from abroad and the Dutch reaction

As we have seen in the *Prologue*, Dutch society has over the centuries attracted considerable foreign attention. Admiration for Dutch achievements in commerce, social organisation, science, the arts, and engineering (especially water control and land reclamation) has been mixed with scepticism, disapproval, and shock. But foreign characterizations of Dutch society, favorable or unfavorable, often tell us more about the situation in the observer's own country than they do about the Netherlands." The German traveller in the seventeenth century who is shocked at the fact that "servant girls in Holland behaved and dressed so much like their mistresses that it was hard to tell which was which,"⁸ tells us more about how dramatic social differences were expected to be in contemporary Germany than he does about whether such differences were readily visible in Holland.

Of no current subject is this more true than it is of euthanasia. Although the Dutch experience with euthanasia has attracted a great deal of comment, little of this goes beyond expressions of moral outrage to consider what is actually happening in the Nether-

⁸ Compare Van Ginkel 1997: 15-42.

⁹ Israel 1995:2.

lands. ¹⁰ The Dutch experience is seen primarily as a source of ammunition to be used for domestic purposes. ¹¹ Dutch practice, about which a great deal is known, is used to condemn not so much the Dutch but, via them, proposals for liberalization elsewhere where very little is known about actual practice.

Those who are inclined to react to Dutch developments in this way are invited in the succeeding chapters of this book to consider the complexities of the legal, moral and empirical questions involved: on careful reflection, none of these seem to lend themselves to simple, absolute answers. And those who are seriously interested in keeping medical behavior that shortens life under legal control must consider the substantial evidence of various sorts to the effect that simply papering-over behavior of a sort that occurs in all modern medical systems with a moral taboo is not likely to be an effective way of subjecting it to public control.

The general tenor of the criticisms made of Dutch euthanasia practice can be summarized under three headings: ¹² (1) there are terrible things happening in the Netherlands and these are the result of the Dutch acceptance of euthanasia; (2) requests for euthanasia cannot in the nature of things be 'really' voluntary, so that euthanasia in the Dutch sense is impossible; (3) legal control in the Netherlands is inadequate and adequate control would be impossible to achieve, so that legalizing euthanasia necessarily leads - as it already has in the Netherlands - to forms of 'involuntary euthanasia'.

- 10 See for example the resolution of the European Parliament of 8 April 1997, urging member states to prohibit "euthanasia" [sic] of the handicapped, those in long-term coma, defective babies and the elderly. Dutch practice is explicitly referred to in the debates. The proposed text of the resolution referred to "active euthanasia" but the word 'active' was deleted during the debates, making the ultimate meaning quite obscure. The change would seem to imply that the resolution is intended to cover 'passive euthanasia: that is, abstention. However, there is no indication in the debates that the members of the EP wanted to forbid abstention, which is of course generally considered normal and proper medical practice.
- 11 This is particularly true of Gomez 1991 and Hendin 1997, both written essentially as contributions to the American discussion. See also New York State Task Force 1994; British Medical Association 1988.
- 12 Another possibly important criticism sometimes made by doctors from other countries is that there is too little attention given to palliative care in the Netherlands. This criticism is usually made in a way (general, unsupported, denigrating) that suggests it may rest more on medical chauvinism and ideological opposition to euthanasia than on observable fact. Since so far as we are aware there are no reliable data on the matter and it has little connection with the rest of the argument in this book, we will not devote any further attention to it. See Francke et al. 1997 for a literature study of palliative care in the Netherlands.

(1) The charge that terrible things take place in Dutch medical treatment of dying patients is undoubtedly true, since such a general charge would be true of any country in the world and of many social institutions besides euthanasia.^P Criticism that deserves serious attention must offer evidence that the Dutch are afflicted with something less ubiquitous than Original Sin. Furthermore, to get above the level of international mud-slinging, criticism must be based on more than anecdotes, uncontrollable generalities (for example, about what 'most psychiatrists' think about some issue) and surmises. And it is essential to define the kind of behavior involved carefully (so that evidence of abstinence, for example, is not used to 'prove' the charge that 'involuntary euthanasia' is being widely practised). Yet these minimal conditions for fruitful discussion are precisely what is usually missing when this sort of charge is made. Thus a 'conclusion' such as Hendin's to the effect that "the Dutch experience teaches ... that euthanasia brings out the worst rather than the best in medicine" and that "vast numbers of ... patients ... die inappropriately ... in the Netherlands [as a result of legalization of euthanasia]?" makes an implicit comparison between unsubstantiated allegations concerning the situation in the Netherlands and equally unsubstantiated, unstated surmises concerning the situa-

13 Compare Battin's (1994: 138) observation that arguing against Dutch euthanasia practice by invoking allegedly horrible anecdotes is like arguing against the institution of marriage by pointing to occasional cases of 'shot-gun' and other involuntary marriages.

14 1997: 214-215.

tion in the United States, and then makes an unsubstantiated guess that legalization of euthanasia accounts for the imagined difference between the two.¹⁵

- 15 Hendin (1994, 1997) has, of all foreign critics, probably devoted the most effort to collecting information on the Dutch situation. Unfortunately, his research methods are quite inadequate to support the sorts of conclusions he draws (the comments on Gomez' research in note 19 apply *a fortiori* to Hendin's case). The 'findings' which supposedly support his conclusions are so filled with mistakes of law, of fact, and of interpretation, mostly tendentious, that it is hard to be charitable and regard them as merely negligent. His central conclusion, to the effect that Dutch euthanasia practice has increased the power of doctors rather than that of patients, may or may not be true, but there is little in his book other than his own repeated assertion to support it. Hendin has, furthermore, been accused by a number of those interviewed by him of important errors of fact in what he claims to have learned from them, of misrepresenting their views, of breach of trust in publishing (allegedly) verbatim accounts of interviews that had been intended as off the record, and of failing to submit his account of the interviews to them for approval as they say he had promised to do. See Dworkin 1997.

Fenigsen is a Dutch rather than a foreign critic, but his article (Fenigsen 1989) is so regularly invoked as 'evidence' of how terrible the situation is in the Netherlands that a few observations are in order. No sources are given for most of his assertions; according to the *Hastings Center Report*, which published his article, this is because the sources were in Dutch. When we requested the original manuscript from *HeR*, it was obvious at a glance that the heat of Fenigsen's passionate objection to everything he calls 'euthanasia' had overwhelmed elementary considerations in dealing with matters of fact: impartiality, precision, accurate citation and critical assessment of sources, attention to representativeness, etc. No journal which holds itself to serious standards would have considered publishing such a thing (compare Spek, letter to the editor, *HeR*, November/December 1989: 50).

The largest part of Fenigsen's indictment is couched in general terms, in which a conspiracy theory of the motivations of proponents of legalization and an apocalyptic vision of Dutch public opinion find support in bizarre misinterpretations of the Dutch medical, legal and political situation. Occasionally, however, he makes assertions about identifiable instances. When these specific charges were investigated by the Medical Inspectorate at the request of the Dutch prosecutorial authorities (who were alerted by the NVVE to the fact that a number of cases of murder or manslaughter seemed to be involved), it appeared that the 6 cases Fenigsen referred to as based on his own personal knowledge had taken place a decade earlier. One had taken place in Denmark. Of the remaining 5, 4 involved abstinence and one termination of life without an explicit request (apparently a case of 'help in dying'). There seems in several of the cases to have been some carelessness on the part of the doctors involved. Fenigsen himself agreed with these conclusions of the Inspectorate. (See exchange of letters between Fenigsen and Plokker, Medical Inspectorate, North Brabant, 23 February 1990 and 29 March 1990.)

In short, Hendin and Fenigsen are both quite unreliable guides to the Dutch situation.

(2) Some critics of Dutch practice seize the psychological high ground: a request for euthanasia *cannot* be voluntary because a person cannot desire his own death. Such a request must therefore be regarded as a 'cry for help', an expression of the patient's fear of impending death or a submission to pressure from his family or his doctor. If he accedes to the request, the doctor's behavior can be disqualified in the same way as being based not on the considerations he believes are important - beneficence or respect for the patient's autonomy - but rather on his own anxieties about death, loss of control, and so forth. Hendin (1997) is a prime example of this sort of psychological reductionism. Throughout his book, he claims to 'know' better than the Dutch doctors who were directly involved (and who are his only source of information) what the 'real' reasons were for their patients' requests and what the 'real' reasons are that they did what they did. Such *a priori* knowledge liberates him from the necessity of considering carefully and open-mindedly what actually is going on. Hendin is also breathtakingly arrogant: the views of the greater part of his professional colleagues in the Netherlands (see chapter 3.5.1) are treated, in effect, as professionally incompetent, as mere psychological symptoms not worthy of serious consideration."

(3) A few critics seem to accept in principle many of the arguments in favor of Dutch euthanasia practice, but reject it ultimately on the grounds that it is not, and cannot be, adequately controlled, so that its dangers outweigh its benefits. Gomez (1991) and Keown (1992, 1995) are the most responsible exponents of this position.

Gomez' general description of Dutch practice seems to have been inspired by a genuine interest in the facts, and it was at the time not far off the mark, although he was not well-informed about some crucial aspects of the Dutch situation (for example, the predominant role of general practitioners in euthanasia practice). His central theme is that euthanasia in the Netherlands is not as unproblematic as its protagonists (in the United States) would sometimes have us believe. He concludes from his study and the literature available in English in 1990 that the rules that are supposed to regulate euthanasia are

- 16 Toward the end of his book, Hendin gives away his ideological *parti pris* when he observes that "if the advocates of legalization prevail, we will lose more lives to suicide (although we will call the deaths by a different name) than can be saved by the efforts of the American Suicide Foundation and all the other institutions working to prevent suicide" (1997: 223). Hendin, who at the beginning of his book (1997: 13), had proclaimed the open-mindedness with which he undertook his study, seems here at its end to reveal its hidden agenda. One of the authors of this book (Griffiths) was among those with whom Hendin spoke when he was conducting his research in the Netherlands. The sentence quoted is especially striking if one remembers having been reassured that the American Suicide Foundation, of which Hendin is Executive Director, is a purely scientific organization, with no position one way or the other on the issues involved in the public discussion of euthanasia.

"not only ... not enforced, they are probably unenforceable":¹⁷ The most important findings on which this conclusion is based are that the reporting requirement was not being complied with (which at the time was certainly true and in fact still is) and that the voluntariness of the patient's request is questionable because of the fact that doctors are "instrumental in helping to form that volition'." The empirical basis for this latter conclusion, however, is far too flimsy to support it.¹⁸ But the most essential weakness of Gomez' argument is the absence of an explicit comparison between the Netherlands and elsewhere: without a comparative analysis there is simply no basis for his (implicit) notion that there is *less* control over this sort of behavior in the Netherlands than elsewhere and, if so, that the limited legalization of euthanasia is the *cause* of this.

17 1991: 122.

18 1991: 123.

19 Gomez' description of the interaction between doctor and patient is based on information concerning 24 cases, collected long after the fact by a person (himself) whose grasp of the context was limited and who apparently did not speak Dutch, by means of interviews with a highly unrepresentative group of doctors who themselves were operating on the basis of memory and trying to describe subtle and complex interactions that had taken place as long as 5 years earlier, and whose English was probably not muscular enough for the task. That Gomez draws firm conclusions about the influence of the doctor on the patient's decision on the basis of this sort of information can only be described as scientifically irresponsible. The American reader who is inclined to dismiss such criticism of Gomez' research methods as exaggerated would do well to ask himself how much confidence he would have in the conclusions of - say - a Japanese doctor who studied some controversial medical procedure in the United States by interviewing a handful of American doctors with whom he happened to come in contact about a small number cases these doctors had been involved in several years earlier (and covering only cases in which the doctors had carried out a particular procedure, not the far larger group of cases in which they had not done so). Not speaking any English, our hypothetical Japanese researcher conducted the interviews through an interpreter. Based on the interviews (and without being able to read the American literature on the subject) the Japanese researcher felt able to make vigorous assertions not only about what American doctors generally do in such cases but also about what influence this has on the patients involved (none of whom, of course, he had talked to). And from these 'findings' he came to the conclusion that American policy in the area concerned was dangerously defective. To lend his account authenticity, he larded it with local color such as the information that the 'Bibel Beld' runs across the United States from New York to San Francisco. Despite his ignorance of English, he informed his Japanese readers about the etymology of the word 'autonomy': when Americans speak of the autonomy of the patient, they refer to the patient's continued ability to drive a car (Cauro'). See Gomez 1991:91 [*Ranstaad, sic*]; 155 n. 96 [*ontluisteren!*] for examples of the same sort of amusing errors.

Keown gives a useful and reasonably accurate short summary of Dutch euthanasia law and of the findings of some empirical research concerning actual practice and the effectiveness of legal control.²⁰ He shows convincingly what has been more extensively argued elsewhere," that euthanasia cannot be effectively distinguished from other sorts of medical behavior that shortens life, such as abstinence and pain relief, where the death of the patient is often an intended result. He concludes from this that the level of medical behavior that intentionally shortens life is far higher than is generally recognized and that in many such cases the patient is not (adequately) consulted. He also concludes that current legal control over euthanasia cannot be considered effective, partly because of the permeability of its borders with other forms of medical behavior that shortens life and partly because it depends on self-reporting by doctors. Up to this point, his argument can be considered painful for the Dutch, but it is otherwise a solid one; our own conclusions in chapter 6 are much the same.

Keown then turns to the question he thinks is critical: whether the Dutch experience confirms the fear of a 'slippery slope' toward non-voluntary termination of life, a fear expressed in British and Canadian reports opposing the legalization of euthanasia. **In** order to make such a claim plausible, he would have to show that the total of such behavior has *increased after legalization* of euthanasia, or that it is *higher in the Netherlands than elsewhere*. Then he would have to confront the difficult task of establishing a *causal* relationship between legalization of euthanasia and increasing non-voluntary termination of life. Citing the total of non-voluntary termination of life, as revealed by Dutch research, in itself proves nothing at all. We pause to consider his argument because it is so typical of foreign criticism that claims to base itself on Dutch data.

Keown's repeated suggestion that the frequency of non-voluntary termination of life has increased in the Netherlands since partial legalization appears to be unfounded. He gives no evidence for the claim that there is "growing condonation" of non-voluntary termination of life (there is at least as much reason to suppose that under the influence of growing openness and control, such practices are becoming *less* acceptable and *less* frequent-"l.

20 While the argument in Keown's two articles is essentially the same, that of 1992 relies primarily on Van der Wal's early research (ultimately published in Van der Wal 1992), that of 1995 on Van der Maas, Van Delden & Pijnenborg 1992.

21 See Griffiths 1994.

22 For example: the Government and the Medical Association (KNMG) have set themselves the task of reducing the frequency of such behavior (see chapter 6.2.5 and 6.2.6), and the 1995 research seems in fact to suggest a modest decline (see table 5.2); furthermore, as far as abstinence (which Keown rightly considers equally relevant) is concerned, there are increasing indications of concern at the hospital level to ensure that the patient is involved in the decision-making (cf. Blijharn & Van Delden 1996).

Keown might alternatively have supported his claim of a 'slippery slope' with an international comparison. Although he does not in fact undertake such a comparison, doing so would probably not have bolstered his argument. Although reliable data for other countries are hard to come by, as they gradually become available it seems increasingly apparent that the real difference between Dutch euthanasia policy and the situation elsewhere is not that medical behavior itself is very different: the rate of 'physician-negotiated death' seems to be roughly comparable and there is evidence of widespread, if hidden, euthanasia practice elsewhere." The real difference is that in the Netherlands this behavior to a considerable extent takes place in the open and is subject to at least some legal control. And as for non-voluntary shortening of life, as far as one can tell there is nothing very unusual about the Dutch situation: abstinence and pain relief without consulting the patient seem to be widely practised elsewhere." Keown's claim of a slippery slope requires him to show that the total rate of death due to these 'normal medical practices' - which he himself insists are not significantly different from what the Dutch call 'termination of life without an explicit request' - are higher in the Netherlands than they are in countries where euthanasia is entirely forbidden. He in fact does not even suggest that this is the case.

Keown's argument, which he apparently thinks condemns the Dutch approach by demonstrating a high level of non-voluntary shortening of life, is actually a boomerang. It is precisely the idea that abstinence and pain relief are *fundamentally and unproblematically different* from euthanasia and intentional termination of life without an explicit request that underlies legal policy in all other countries. If, as Keown argues, such a distinction cannot be made, then he ought to be looking closer to home for the horrors he claims to have found in the Netherlands."

- 23 Recent research in the United States gives rates of assistance with suicide roughly comparable to the Dutch figure for euthanasia (see the sources cited in Dworkin et al. 1997). 'Physician-negotiated death' is estimated at about 70% of all deaths in the United States (see Kass 1993: 34; cf. Quill 1996: 199). Recent Australian research using the methods of earlier Dutch studies shows rates of euthanasia and assistance with suicide very similar to the Dutch rates (Kuhse et al. 1997).
- 24 Much of the 'physician-negotiated death' referred to in note 23 must involve patients who are not competent or not conscious. Studies such as Anspach (1993) and Zussman (1992), and Quill's (1996) autobiographical account of end-of-life medical practice seem to confirm this inference. See Kuhse 1997 for Australian evidence to this effect.
- 25 The first sentence of Keown's 1995 article reveals all the shortcomings of his position: "There is only one country in which euthanasia is officially condoned and widely practised: the Netherlands." Apart from the obvious fact of official condonation, everything in this sentence is tendentiously wrong. Almost nothing is known about the frequency of what the Dutch call euthanasia in other countries (the little that is known suggests that its frequency may not differ much from that in the Netherlands - see note 23). And much of what Keown himself regards as essentially the same as euthanasia is both officially condoned and widely practised all over the world.

In short, Keown is so anxious to prove his point that he seems to lose sight of the implications of what he is saying. He has not uncovered evidence of a slope in the Dutch data, let alone of a slippery one. What he really calls attention to is quite a different problem, namely that both in the Netherlands and elsewhere the widespread use of abstinence and administration of pain relief to shorten life calls for much more adequate regulation than it currently receives."

The charges from abroad raise some fundamental questions, in particular with respect to the problem of adequate legal control, about which the Dutch themselves, as we will see, are very concerned. Unfortunately, on the whole (with the partial exception of writers like Gomez and Keown) the charges have not been made in a way which invites serious response. Imprecision, exaggeration, suggestion and innuendo, misinterpretation and misrepresentation, ideological *ipse dixitism*, and downright lying and slander (not to speak of bad manners) have taken the place of careful analysis of the problem and consideration of the Dutch evidence. It is perhaps understandable that the Dutch reaction has tended to be dismissive, since such critics do not seem to deserve respectful attention.

To a large extent, the Dutch tend simply to ignore foreign criticism." The more or less 'official' Dutch reaction, when there is one, amounts essentially to denial." Denial in the

- 26 An argument essentially similar to Keown's and subject to exactly the same fundamental criticisms is made by Hendin, Rutenfrans and Zylicz (1997). Where Keown is reasonably accurate with regard to Dutch law and respectful of empirical data, however, these authors seem untroubled by whether what they say is true or not. They find evidence of a 'slippery slope' in the progression from legally sanctioned assistance with suicide to legally sanctioned euthanasia, and thence "from euthanasia for terminally ill patients to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to nonvoluntary and involuntary euthanasia" (1997: 1720). As we will see in chapters 2 and 3.1, the first two steps on this mythical slippery slope are, as a matter of legal history, simply untrue; the third rests on a very imprecise rendition of the distinction between somatically based and not somatically based suffering (Dutch law never having permitted euthanasia for an 'illness' as such and never having required 'physical' suffering); the last suggests that 'involuntary' euthanasia has ever, under any circumstances, been sanctioned in the Netherlands, which is untrue. It is also untrue (see chapter 3.2) that the reporting procedure (either before or after the legislation of 1993) "ensur[ed] ... physicians [that they] will not be prosecuted if guidelines were followed" (1997: 1721). A substantial part of these authors' 'evidence' for a slippery slope is based on anecdotes of dubious reliability or representativeness (1997: 1721-1722). In short, yet another missed opportunity to engage in serious debate.
- 27 Although Hendin did receive some attention in the daily press, neither Gomez nor Hendin, for example, were reviewed in Dutch professional journals except by the authors of this book (see Griffiths 1993 and Weyers 1997).
- 28 See e.g. Rigter, Borst-Eijlers and Leenen 1988; Rigter 1989; Aartsen et al. 1989; Van der Kloot Mijburg 1989.

first place that there has been major legal change in the Netherlands: euthanasia, it is insisted, remains 'illegal'. This position is essentially disingenuous: it relies on the fact that the articles of the Criminal Code prohibiting euthanasia and assistance with suicide have not been amended and ignores the fact that another article of the Code has been interpreted to afford a defence of justification, so that if the relevant conditions are met, the behavior concerned is effectively *not* illegal. Denial, in the second place, that 'non-voluntary euthanasia' is taking place. In light of the evidence (see chapter 5), such a denial is only possible by insisting on the narrow Dutch conception of euthanasia, which must by definition be voluntary. Nothing is said about the large number of cases of non-voluntary termination of life that are not, in this sense, 'euthanasia' (most of them being abstinence or pain relief). Denial, most importantly, that there are problems of control. It is insisted that 'carefully and precisely drafted rules' make abuse impossible. But even a passing acquaintance with the applicable rules (see chapter 3) shows that they can hardly be described as watertight, and in any case a precise rule is quite a different matter from an effectively enforced one. It is well known in the Netherlands, and since the early 1990s this has become a subject of increasing concern, that the existing control system, depending as it does on self-reporting, cannot be regarded as adequate. This fact is simply not mentioned when foreign criticism is summarily dismissed; nor is the fact that the system, by its very nature, covers only a small part of the whole problem of medical behavior that shortens life.

Whatever the provocation, the Dutch dismissive reaction is unfortunate. The charges relating to the problem of legal control do go to the heart of the matter, even if, as levelled by most foreign critics, they do not seem to deserve the time of day. They can only be properly discussed after, in the chapters to come, we have described Dutch euthanasia practice and the legal norms and enforcement processes that regulate it. Our assessment of the strengths and weaknesses of the Dutch approach to legal control and of possibilities for improvement, will be presented in chapter 6, and in chapter 7 we will consider the relevance of all this for other countries grappling with the same underlying problems.

Intermezzo: The Dutch Health-Care System and the Care of the Terminally III

In this *intermezzo* we describe some features of the Dutch health-care system that are essential to an understanding of Dutch euthanasia practice and the problems associated with its regulation.¹ After a brief general introduction to the Dutch health-care system (section A) we will deal specifically with the institutions in which people in the Netherlands die (section B) and with the health-care professionals responsible for such patients (section C).

A The Dutch health-care system

PUBLIC HEALTH

The Dutch are relatively healthy compared with the inhabitants of other countries.² Life expectancy at birth in 1993 was 74.0 years for men and 80.1 years for women. With an average life expectancy of 77.1 years, the Netherlands belong in Europe's top quartile. Both men and women can expect to spend about 60 years of their lives in good health.³

ACCESS TO HEALTH CARE

Social policy in the Netherlands reflects the country's cultural commitment to social equity and solidarity. Virtually everyone in the Netherlands is covered by health insurance.⁴ In the funding of this insurance a distinction is made between 'normal' medical expenses and the 'exceptional' costs associated with long-term care or other high-cost medical treatment. Such exceptional costs are covered by a compulsory national health insurance scheme. Every person living in the Netherlands is covered by the scheme. Benefits include long-term residential and nursing care for the elderly, comprehensive psychiatric care, home-based care, and comprehensive care for the physically and mentally handicapped.

1 Except where otherwise noted, Schrijvers 1997 is our source.

2 SCP1990:21.

3 RIVM 1993: 206.

4 Recent estimates show that less than 1% of the population has no health insurance. In life-threatening situations, medical care would never be refused because the patient was not insured.

For 'normal' medical expenses, there is a compulsory public health insurance scheme applicable to all employees earning less than about 80,000 guilders per year, to social security recipients and to certain groups of the elderly. Those insured pay income-related premiums and a relatively low flat-rate premium; employers also contribute on behalf of their employees. The benefits package consists of regular medical and other care not covered by the statutory scheme for 'exceptional' care. Hospitalization and medical care by specialists, the services of GPs, paraprofessional services such as physical therapy, speech therapy, midwifery and dental care for youth, are all covered.

About 35% of the population are covered neither by the public health insurance scheme nor by specific schemes for public employees. This group includes employees earning more than the maximum amount mentioned above, self-employed persons, and owners of small businesses. Private health insurance is available for these persons; there is a standard benefit package that is almost the same as that under the public health insurance scheme.

THE COST OF HEALTH CARE

The total cost of health care in the Netherlands was 58 billion guilders in 1993, or about 10% of gross national product. In international terms, this is not particularly high: the Netherlands occupies a middle position among Western industrialized countries.⁵ Intramural care accounts for about 60% of the costs of health care, the rest being divided over extramural care, pharmaceuticals, preventive care, etc."

About 10% of the total cost of health care is paid for out-of-pocket by the patient; another 10% is paid by the government with funds raised through taxation. The remaining 80% is covered by insurance premiums, of which 65% are in the context of the public health insurance scheme and 15% are for private insurance.

THE ORGANIZATION OF HEALTH CARE

For purposes of health-care policy, facilities are divided into three groups: basic, primary and secondary. For our purposes primary and secondary care are the most relevant." In the category of primary care are GPs, dental care, pharmaceuticals, maternity nursing

5 Maas & Mackenbach 1995: 261. Such comparisons are only of limited significance, since in some countries the state exercises direct influence over the total, for example because it pays for a great deal of the costs of health care or fixes the incomes of medical professionals.

6 Maas & Mackenbach 1995: 263.

7 Basic health care covers a wide variety of facilities, from school dentists to organizations occupied with labor conditions, whose activities are mainly preventive.

services, health-related social services and drug-addiction aid. Secondary facilities include hospitals and specialist care, nursing homes, psychiatric hospitals, old-age or residential homes, institutions for the mentally handicapped and foster homes and day-care facilities for the handicapped.

B Institutions for health care and care of the elderly

Health-care institutions in the Netherlands derive historically from the activities of churches, later taken over by private organizations affiliated with the various 'pillars' of Dutch society. There were, and still are, non-denominational, Catholic, Protestant, Jewish and Humanist institutions. The recent history of Dutch health care is one of a changing relationship between government and these originally private institutions. The 'pillarization' of health care continued long after the state assumed responsibility for the financing and regulation of health care and some remains are to be found in the institutional organization of the health-care system. These can be quite important in connection with euthanasia, as we will see in chapter 5.4.2 when we examine the policies of hospitals and nursing-homes.

There are almost 750 health-care institutions that provide 24-hour nursing care in the Netherlands. Leaving aside institutions such as nursing homes for children and special institutions for the sensorily disabled, these include, in addition to hospitals and nursing homes, also mental hospitals (83 institutions with some 25,000 beds) and institutions for the mentally handicapped (139 institutions with some 35,000 beds),"

HOSPITALS

There were 149 hospitals with over 60,000 beds in 1995. There are 9 university hospitals in various parts of the country, 110 general hospitals providing various forms of specialist treatment and 30 specialized hospitals which limit their care to certain illnesses or sorts of patient."

Originating largely in private and often charitable initiatives, almost all hospitals are still private, and all are non-profit organizations. Merger and cooperation between hospitals has been important during the last two decades with the number of general hospitals declining from 212 in 1963 to about 150 now. Since mergers often take place between two or more hospitals originally founded on different denominational principles, the 'pillarization' of hospital institutions has been declining.

8 *Vademecum Gezondheidsstatistiek* 1996: 224.

9 *Vademecum Gezondheidsstatistiek* 1996: 224.

Because hospitals are private institutions, they have a certain degree of freedom in determining their own policy with regard to euthanasia or other medical behavior that shortens life. However, most doctors who practise in a hospital are not employees of the hospital, and the degree of control a hospital has over doctors in private practice who have patients there is limited.

NURSING HOMES (*VERPLEEGHUIZEN*)

Nursing homes are institutions for the care and nursing of persons who no longer require hospital care but who cannot be taken care of at home, the costs being born by the public insurance scheme for exceptional medical expenses.

In 1991 there were 333 nursing homes in the Netherlands with 52,000 beds, 52% for somatic patients and 48% for psychogeriatric patients (most of them suffering from dementia). More than 90% of the persons admitted to nursing homes are over 65 years old. The average age of somatic patients is 79 and of psychogeriatric patients 83.¹⁰ Of patients who die in a nursing home, somatic patients have spent on average 616 days there, psychogeriatric patients 1055.¹¹

Like hospitals, nursing homes determine their own policy with regard to abstinence, euthanasia and related medical behavior that shortens life. Since the doctors who are responsible for patients in a nursing home are usually employed by the institution, nursing homes can generally exert far more control over life-shortening behavior than hospitals are able to do.

RESIDENTIAL HOMES (*VERZORGINGSHUIZEN*)

Admittance to a residential home (publically financed old-age homes and the like) is possible for (usually elderly) persons who because of a disability, lack of social contacts, or anxieties are not capable of living independently. Residents must, however, be able to carry out most daily tasks for themselves. They have a private home, with locked doors and a doorbell, three meals a day served at home or in the institution's restaurant, some social assistance and an alarm system. Residents pay a small income-related share of the costs of stay.

There are 1,485 residential homes in the Netherlands with about 135,000 beds. The average age of residents is 84; 80% are single, and three-quarters are women. The average length of stay is 4.5 years. Such an institution is the last home for most of its inhabitants:

¹⁰ Muller 1996: 11.

¹¹ *Geriatric Informatorium* }-4005: 17-18.

80% die in the institution, 15% are transferred to a nursing home, the remaining 5% are transferred to a hospital or elsewhere and die there."

People who live in residential homes have their own personal GP (which means that in any given home a number of GPs have patients). The residents are free to organize their lives as they please, which in principle means that euthanasia or assistance with suicide is a matter between a resident and his GP, although a residential home with a strong religious orientation may find euthanasia so objectionable that it is difficult for a GP to carry it out there.

WHERE DO PEOPLE DIE?

Of the 2 million persons over 65, 180,000 (9%) live in a residential home or a nursing home. The living situation of the rest does not differ much from that of the rest of the population. More than 80% live in an ordinary house. Some, however, move into special housing for the elderly, which comes in a variety of forms, often with some degree of common facilities. A third of this special housing is associated with a residential home or a community center.^P

Only a rough estimate can be given of the place where people in the Netherlands die. It is assumed that more than 70% die in an institution, usually a hospital (40%), a nursing-home (15%) or a residential home (17%). About 26% are believed to die at home and 2% elsewhere."

More is known about the place where persons 65 or older die. In 1995, 35% died in a hospital, 21% in a residential home, 18% in a nursing home and 26% at home or elsewhere. The change from 1970 is spectacular. In that year, 58% died outside a health-care institution and only 19% in a hospital. Most of the change took place before 1985, when 37% died in a hospital and 29% outside a health-care institution."

C Health-care professionals

The professionals involved in the care of dying patients, and the nature of their relationships with one another, vary widely from one setting to another.

12 Van Loveren-Huyben 1995: 11.

13 Timmermans 1997: 100-105.

14 Munnichs 1989: 10.

15 Timmermans 1997: 138.

In hospitals, apart from doctors and nurses, social and pastoral workers are usually involved, sometimes also a psychologist or psychiatrist, occasionally a physiotherapist or GP. Other specialists (e.g. anesthesiologists) are called in when needed. These various professionals tend to regard each other as a 'team' and to discuss and coordinate the various aspects of terminal care of a patient with each other; final decision-making responsibility rests, however, with the 'doctor responsible for treatment' (*behandelend arts*: attending physician).

In nursing homes, the principal professionals involved are nursing-home doctors and nurses, pastoral workers and physiotherapists. Here, too, the working relationship is conceived of as 'teamwork'; coordination of care is the responsibility of the nursing staff but ultimate responsibility for decisions concerning care is with the doctors. There is little contact with specialists (hospitals) or a patient's former GP.

In residential homes the principal professionals as far as terminal care is concerned are the home's nursing and service personnel and the inhabitants' own GPs. Coordination of care is the responsibility of the nursing home's own staff, medical treatment (including all contacts with specialists) is the responsibility of a patient's GP. Since there may be many GPs with patients in a given home, coordinating the activities of the various participants involved in the division of responsibility can be problematic and the communication of doctors with the home's staff is often considered by the latter quite inadequate.

In the case of patients who die at home, the primary professionals are the GP and the visiting nurse. Although they usually work closely together, visiting nurses often criticize GPs for excluding them from the decision-making on questions such as euthanasia. Physiotherapists, social workers and pastors are sometimes also involved, but often not in coordination with the GP, who 'just happens to come across them' when he visits the patient."

DOCTORS

In 1995 there were about 28,000 doctors engaged in clinical practice (GPs, specialists and nursing-home doctors)." About 60% of all Dutch doctors are members of the Royal Dutch Medical Association (KNMG).¹⁸ All practicing doctors are subject to medical disciplinary law.

¹⁶ Benjaminsen 1988: 22-40.

¹⁷ *Vademecum Gezondheidsstatistiek* 1996: 232.

¹⁸ See Dillmann 1996: 65.

GENERAL PRACTITIONERS (HUISARTSEN)

In 1995 there were about 7000 GPs in private practice, or about 2200 inhabitants per GP.¹⁹ About half of all GPs are in solo-practice, 30% in duo-practice, 10% in group practice; about 5% work in a multi-disciplinary health center." The proportion of partnerships, group practices and health centers is increasing rapidly. GPs who are in solo- or duo-practice always have more or less intensive contact with a number of other GPs in the immediate surroundings, with whom they form a 'substitution group' so that access to primary medical care is guaranteed for their patients 24 hours a day throughout the year regardless of an individual doctor's absence on weekends, vacations, illness, etc.

Dutch primary medical care has three major system characteristics: 'listing', 'gatekeeping, and 'family orientation'. 'Listing' means that in principle every Dutch inhabitant is registered with a GP. This guarantees patients continuity of care. Dutch GPs see three-quarters of their patients annually, averaging 4.5 contacts per patient per year. The 'gatekeeping' function refers to the fact that patients generally do not have direct access to specialists or hospital care but must be referred by their GP. The impact of gatekeeping is reflected in the low referral rate: 90% of all complaints are treated by GPs. The third characteristic, 'family orientation', refers to the fact that a Dutch GP generally serves as the personal physician for a patient's entire family. Moreover, GPs make many home visits: 17% of all contacts are visits to the patient's home.

Since the beginning of the 1990s, the relationships between GPs have become gradually more organized. In the past, apart from duo- or group practices (a recent phenomenon) the only formal contact between them was in 'substitution groups'. Recently, however, both the government and the National Association of GPs have been promoting a national organizational structure at the base of which are 'GP-groups' (in which several 'substitution groups' participate). These are responsible for the organization of substitution, continuing education, contacts with other professionals, etc.; they are also supposed to arrange for intercollegial quality control." Nevertheless, GPs remain highly individualistic, and they have considerable freedom in conducting their practice. Formal control is limited, and implementation of what control there is, is weak.

GPs are the responsible doctor in about 43% of all deaths, including those of people who die at home and those of persons in residential homes."

19 *Vademecum Gezondheidsstatistiek* 1996: 232.

20 *Vademecum Gezondheidsstatistiek* 1996: 240.

21 In J. Zaritsky's film *An Appointment with Death* (see chapter 1, note 2), there is a scene in which a GP discusses a request for assistance with suicide with his colleagues in such a 'GP-group'.

22 Compare Van der Maas et al. (1996: 1701): a GP is the responsible doctor in the case of about 40% of all deaths.

SPECIALISTS

In 1995 there were more than 13,000 specialists." About three-quarters of all specialists are in private practice; 90% are connected with intramural institutions." Because few of them are salaried employees, the degree of control that the intramural institutions where they work can exercise over the way they practice is limited. In particular, specialists have considerable room for policy discretion concerning terminal care, and institutional rules on the subject either respect this discretion or are not really effective (see chapter 5.4.2).

Specialists are the responsible doctor in about 40% of all deaths.

NURSING-HOME DOCTORS

'Nursing-home doctor' is a medical specialty. In 1995 there were about 800 specialized nursing-home doctors." (There are, however, other doctors than nursing-home specialists who treat patients in nursing homes.)

More than most GPs and many other specialists, nursing-home doctors function as members of a treatment team, usually as its head. Most of them are employed by the institutions where they work. In particular with regard to euthanasia and other medical treatment that shortens life, their treatment discretion is more limited than that of GPs or specialists who work in hospitals.

Nursing-home doctors are the responsible doctor in about 15% of all deaths.

NURSES

In 1993 there were about 325,000 nurses working in the Netherlands. Almost 66,000 nurses work in hospitals, more than 47,000 in nursing homes and more than 54,000 in residential homes.

Nurses are also active in 'home care', a collection of support services provided partly by professionals, partly by volunteers, and intended to enable people to remain at home as long as possible. Home-nursing organizations offer a package of services, comprising nursing, support, and counselling related to illness, recuperation, disability, old age and death. About 5% of the Dutch population receive nursing care or other help at home. The elderly (70 years of age and over) are the largest group of home-nursing recipients.

23 *Vademecum Gezondheidsstatistiek* 1996: 232.

24 Maas & Mackenbach 1995: 256.

25 *Vademecum Gezondheidsstatistiek* 1996: 232.

Most of the costs of home-nursing care are born by the public insurance scheme for exceptional medical costs, the rest by individuals.

The nursing profession has a long tradition of professional organization. As in many areas of Dutch society, 'pillarization' plays an important role, and nurses are still largely organized along religious lines. Nurses' organizations are increasingly concerned to promote professionalization, concentrating on the following three areas: autonomy in professional practice, a voice in policy-making processes and organization of the professional group. However, in actual practice autonomy and professional responsibility are limited. The content and pace of work are largely determined by third parties. In the case of euthanasia and other life-shortening behavior, the role of nurses remains marginal.

Nurses are subject to medical disciplinary law.

PHARMACISTS

When a doctor prescribes or proposes to administer a controlled drug (which includes all drugs used as euthanatica), the drug must be supplied by a pharmacist (*apotheker*). Pharmacists are expected not to supply blindly whatever the doctor orders but to exercise some marginal control. Thus, for example, pharmacists are supposed to make sure that the proper instructions for use, warnings about side-effects, etc. are given to the patient, and to keep tabs on the various drugs prescribed for a patient (sometimes by different doctors) to ensure that the combinations are pharmacologically responsible.

There are 1500 self-employed pharmacists in pharmacies directly accessible to the public. In addition, there are some 700 pharmacists employed by the self-employed pharmacists, and another 300 who are responsible for the pharmacies of hospitals. Dutch pharmacists are organized in the Royal Dutch Society for the Advancement of Pharmacy (KNMP) and are subject to medical disciplinary law.

About 600 GPs, especially those in areas where no pharmacy is available, function as their own pharmacist."

CORONERS

The Law on the Disposal of Corpses requires, before burial or cremation can take place, that a doctor attest that a person's death was due to a natural cause. If the patient's own doctor cannot do this, he must report this fact to the municipal coroner, who examines the body and decides himself whether the death was a natural one; if not, he must report

the case to the local prosecutor (see further chapter 3.2). Every municipality in the Netherlands has at least one coroner. Persons authorized to practise medicine are eligible for appointment and in small municipalities a local GP in private practice is usually appointed, with several colleagues as his deputies. In larger municipalities, coroners are usually doctors in the municipal health service.

The fact that the coroner himself is a doctor can give rise to problems in connection, for example, with the reporting procedure for euthanasia. On the one hand, the coroner is required to satisfy himself of the cause of death and to provide the prosecutorial authorities with all information about the case that bears on a possible criminal prosecution. On the other hand, as a doctor he is in principle bound by the duty of confidentiality that covers the practice of medicine. When the coroner is a doctor in private practice, the independence of his judgment can be problematic (see chapter 5.3.5). There is a general consensus among those responsible for medical policy that in the future coroners should be public employees.

THE MEDICAL INSPECTORATE AND MEDICAL DISCIPLINARY LAW

The Medical Inspectorate is responsible for the enforcement of legal provisions relating to public health and the health-care system and for giving advice and information to the Minister of Health. Among other things, the Inspectors are authorized to initiate medical disciplinary proceedings.

All doctors in the Netherlands who are authorized to practice medicine, as well as other professionals involved in the health-care system (including nurses and pharmacists) are, as we have seen, subject to medical disciplinary law." The primary purpose of this law is

- 27 The formulation here of the coverage of medical disciplinary law and the primary disciplinary norm is based on a new law (Law on Professions Concerned with Individual Medical Care, *Staatsblad* 1993 no. 655) that only becomes formally effective on 1 December 1997. The old law was limited to doctors, pharmacists, dentists, and midwives, and the disciplinary norm was formulated in terms of 'undermining public confidence in the profession', engaging in negligence which causes great harm to a patient, and evidencing gross incompetence. In addition to medical disciplinary law, both civil law (malpractice and breach of contract) and criminal law bear on the behavior of medical practitioners. It is possible that for a single incident, a doctor is liable under two or even three of these bodies of law. There are agreements between the Medical Inspectorate and the prosecutorial officials concerning the division of responsibility between them. In euthanasia and related cases this means in practice that a disciplinary proceeding is held in abeyance until possible criminal proceedings are terminated. If the doctor is not prosecuted, or after his acquittal or conviction, the Inspectorate may decide to pursue disciplinary proceedings. This in fact happened in the *Chabot* case (see appendix 11-2).

to guarantee the quality of medical care. Disciplinary measures can be imposed for actions or omissions that are inconsistent with the care to which others are entitled or with the demands of good medical practice. Complaints can be lodged by an Inspector, by the governing body of the institution in which the professional works, or by a person directly affected by the behavior in question. The complaint is judged in the first instance by one of the five regional Medical Disciplinary Tribunals, and appeals are to the Central Medical Disciplinary Tribunal." The following measures can be imposed: a warning; a reprimand; a fine of up to *f*10,000; suspension from practice for at most one year; revocation in whole or in part of the authority to practice."

28 Until the new law mentioned in note 27, some appeals were to a Court of Appeals and thence to the Supreme Court.

29 See on Dutch medical disciplinary law and its functioning: Verkruijsen 1993.

2 Legal Change 1945-1997'

Recent developments in the Netherlands regarding the legality of euthanasia and other medical behavior that shortens life are extraordinarily interesting. The subject is fundamental and it has profound existential, philosophical, and political implications. But the process itself is fascinating, too, partly because it has been so complex and partly because it has been so open. The legal norms that currently seem to be valid have not emerged from legislation nor in any simple way from judicial decisions, but from interaction between the medical profession (in particular the Medical Association), interest groups (in particular the Association for Voluntary Euthanasia), the Government, Parliament, the Health Council, the State Commission on Euthanasia, the Rummelink Commission (appointed to carry out empirical research concerning euthanasia and related practices), several groups of empirical researchers and other academic participants in the public discussion, the judiciary, the prosecutorial authorities, the medical disciplinary tribunals, the Medical Inspectorate, several political parties, a variety of social and religious organizations, the media and 'the public'.

The process of change is described in this chapter in four phases." In the first period (1945-1970), euthanasia is not yet a subject of public discussion. We describe the factors that played a role in preparing the ground for the later public debate. In the second phase (1970-1982) the public becomes aware of the fact that doctors sometimes give their patients 'support in the dying process', in the sense that they either cease trying to prolong life or give death a helping hand. The idea of 'euthanasia' enters the public discussion, but it is used to refer to a variety of different sorts of behavior whose legality remains unclear to the participants in the discussion. The third phase (1982-1986) sees a fundamental legal breakthrough on two fronts. In the first place, it becomes clear that only active termination of life at the explicit request of the person concerned constitutes 'euthanasia' in the Dutch sense and that a variety of other sorts of medical behavior that shortens life fall within the scope of 'normal medical practice' and are legally unproblematic. In the second place, 'euthanasia' itself becomes generally accepted if performed

1 Translation by M. Griffiths.

2 Needless to say we have had to be selective in choosing what to discuss. Although this historical overview deals only with broad outlines, our aim has been to treat all the important legal cases and publications that influenced the definition and the legal treatment of euthanasia and other medical behavior that shortens life, including the formulation of the 'requirements of careful practice'.

under circumstances carefully defined both by the courts and the Medical Association. The fourth phase (1986-1997) is one in which (unsuccessful) efforts are made to codify the legal change that has taken place. Despite the failure of legislative efforts, this phase does see consolidation of the legal change, application of the new legal insights to some related problems and two major national studies of actual practice. It also sees a shift in the public discussion from the question of legitimacy to that of effective regulation.

2.1 1945-1970: How room for public debate became available

INTRODUCTION

On 11 March 1952 a doctor from Eindhoven stood trial for killing his brother, who had been suffering from advanced tuberculosis. During the weeks preceding his death the sick man had on several occasions strongly urged his brother to put an end to his misery. Eventually the doctor agreed. He told the District Court that "it was impossible for him, and he could not be expected, to ignore the claims of his conscience, which compelled him to comply with the explicit wish of his brother." He gave his brother Codinovo tablets and injected him with morphine, which led to the brother's death.

The District Court found the doctor guilty of killing on request (article 293 of the Criminal Code). Although considerations of general prevention suggested a jail sentence, the court decided to sentence the doctor to one year probation "because, as far as the Court is aware, this is the first time that a case of euthanasia has been subject to the ruling of a Dutch judge." The case did not cause much commotion. The newspapers confined themselves to sober reports and the journal of the Medical Association noted but did not comment on the case.³

By the end of the 1960s this lack of interest had vanished entirely. A leading psychiatrist/neurologist published a book in which he sharply criticized doctors who prolong the lives of their patients at all cost. Support in the dying process in different forms was

3 *Nederlandse Jurisprudentie* 1952, no. 275. Before 1952 there had been three cases in which 'killing on request' was of some importance. In 1908 a man had been convicted for attempted murder of his girl-friend although he claimed she requested him to do so. In 1910 a man shot his girl-friend at her request, he said, but he was convicted for murder (Herbergs 1984: 151). In 1944 the Supreme Court nullified the ruling of the Court of Appeals, Amsterdam in a case of a man who strangled his girl-friend. In the opinion of the Supreme Court the Court of Appeals had not paid sufficient attention to the explicit request of the woman involved (*Nederlandse Jurisprudentie* 1944, no. 314).

4 *Medisch Contact* 7: 288 (1952).

the subject of radio programs and TV shows, and it was discussed in Parliament. In short, passive and active termination of life had become a topic of medical, ethical, legal, and public debate. The question to be addressed in this section is what accounts for the change.

Support in the dying process was not the only topic pitting traditional views against more modern, in particular individualistic and secular, ideas that got onto the public agenda in this period. Starting in the 1950s, sexual morality, for instance, was the subject of a great deal of public discussion. Legislation was enacted legalizing the free sale of contraceptives (1970), repealing the crime of adultery (1971), and repealing a restrictive provision on homosexuality (1971). In the same period abortion was the subject of extensive public discussion. Because the debate on the legalization of abortion shows great similarities with the later debate on euthanasia, we discuss it here in some detail.⁵

THE LEGALIZATION OF ABORTION

Articles 295 through 298 and article 251b of the Criminal Code made abortion a crime. However, in the Parliamentary debates on these articles," the responsible Ministers had stated explicitly that a doctor who performs an abortion on medical grounds and does so in a medically sound fashion is not covered by their provisions.

During the 1960s social acceptance of abortion increased. In 1966 Enschede, a prominent criminal law scholar (later a member of the Supreme Court), published a very influential article. Enschede argued on the basis of the legislative history that a doctor who terminates a pregnancy on the basis of a medical indication falls within an implicit 'medical exception' to the abortion prohibition and is not guilty of a criminal offence. He argued further that the definition of 'medical indication' is subject to change, and that in 1966 non-medical grounds could be included within its scope." This view in effect decriminalizes abortion, so long as it is carried out in a medically responsible way.

Enschede's views were widely shared. In 1969 a parliamentary debate took place on whether or not the legislation on abortion needed to be adjusted to the changed social reality. The Government proposed setting up a commission to study the issue. The Labor Party (PvdA) was not willing to await the conclusions of this study and submitted a bill

5 The following discussion is based on Ketting 1978; De Bruijn 1979; Outshoorn 1986.

6 The debates mentioned are those on the introduction of the new Criminal Code between 1879 and 1881 (articles 295 through 298) and on legislation of 1910 by which article 251b of the Criminal Code was amended in order to amplify the ban on abortion.

7 See further on the idea of the 'medical exception': chapter 3.1.1.

8 Enschede 1966.

to legalize abortion. In the meantime a sort of legal vacuum had come about, in which abortion was still formally illegal but freedom of abortion was a fact. To satisfy the demand for abortion, special abortion clinics were set up.

In 1971 the Medical Association, which in 1969 had still been rather opposed to abortion, published new guidelines. These held that "the doctor's duty to give medical assistance can entail the decision to perform an abortion when he is asked to assist in an unwanted pregnancy"? The Association's change of direction, treating abortion on non-medical grounds as a form of 'normal medical practice' falling within the 'medical exception', meant that for practical purposes enforcement of the ban on abortion was no longer feasible.¹⁰ After 1971, therefore, only very exceptional cases have been prosecuted, for example when abortion is performed by a non-doctor or there are special circumstances, such as a medical complication or death. There have been no convictions based on article 251b - the provision normally used - since 1974.¹¹ Although abortion had thus in practice been decriminalized by the early 1970s, it took five legislative proposals and a number of political crises before the legal change was finally ratified in legislation in 1982.

CHANGES IN MEDICAL PRACTICE IN THE 1960s

The general context of changing societal values, evidenced particularly in developments concerning abortion, is not the only explanation for the fact that in the early 1970s euthanasia became a topic of public debate. Developments in medical technology were also important. These developments led to questions of a medical and ethical nature fundamentally different from any that had ever been asked before. In effect, doctors had come to have the means to postpone death even when recovery is impossible. But prolonging life does not always go hand in hand with making it more bearable. Doctors found themselves increasingly confronted with the question whether they should do everything within their ability to preserve life. In medical journals this question was initially asked with regard to resuscitation: Should someone who is suffering severely and has no prospect of recovery be kept alive? Doubts concerning an unconditional 'duty to preserve life' became more and more insistent. If the answer to the duty-question is 'no', if a doctor therefore may sometimes decide not to engage in treatment that would prolong the patient's life because it would not be in the patient's interest to do so, the question soon arises whether there is difference in principle between acting and refraining from action.

9 KNMG 1971: 1025.

10 The Association's acceptance of abortion elicited objections from a few doctors. Their opinion was that the Board of the Association could not speak for all doctors and that terminating a life violates a doctor's fundamental duty. In 1973 some of these doctors founded the Dutch Association of Physicians (NAV), a 'pro-life' organization.

11 De Bruijn 1979: 239.

Apart from the changes that doctors were faced with due to developments in medical technology, the 1960s also brought about changes in views concerning the doctor-patient relationship, including the general idea of 'informed consent' and the specific question whether a dying patient should be told the truth about his condition. Because of the role of pastors, the debate on 'truth at the deathbed' was mainly conducted in confessional medical journals. Pastors were sometimes more inclined than doctors to tell a patient the truth about his condition. The pastor's role as a spiritual guide, and the Roman Catholic ritual of 'Extreme Unction', could make openness concerning the situation necessary. This openness clashed with the widespread medical opinion at the time that most people cannot accept the truth regarding their own death, and that to be open with them would cause them to lose the confidence needed to keep up the struggle for life.

THE CASE OF MIA VERSLUIS: BEFORE TERMINATING LIFE-SUPPORT A DOCTOR MUST CONSULT OTHER DOCTORS AND INFORM THE PATIENT'S FAMILY

In March of 1967 the Dutch were for the first time publicly confronted with the situation of a patient in a long and irreversible coma. The question whether such a patient should be thought of as dead or alive was widely discussed in the media. Many commentators tried to imagine whether they would want their own treatment to be continued in such a case or if they would prefer having an end put to their life.

The 21-year-old patient's name was Mia Versluis. She had had an operation under complete anesthesia on 14 April 1966 for excessive growth of the bone on her heels. During the course of the operation she probably had had a cardiac arrest, after which she was resuscitated. After the operation was over, Mia Versluis was in coma, and it appeared that she had suffered severe brain damage. Since she required artificial respiration, a breathing tube was inserted in her windpipe.¹²

Initially, the anesthetist had been optimistic about the possibility of recovery. By September 1966, however, he had lost all hope and, according to the parents of Mia Versluis, proposed to remove the tube, which was expected to lead to her death. To the outraged father this was a proposal to perform what he called 'euthanasia'. He filed a complaint with the Medical Disciplinary Tribunal against the anesthetist, who, in the father's opinion, had made mistakes during the course of the operation.¹³ In the final judgment in the case the Court of Appeals, Amsterdam,¹⁴ held that when termination of life-support is

¹² *Nederlandse Staatscourant*; 1969 no. 55: 3-8.

¹³ Versluis 1970: 29-38.

¹⁴ The case had been referred to this Court of Appeals by the Supreme Court after it had ruled on the case. None of the earlier rulings was ever published.

considered, other colleagues must first be consulted on the matter, and the situation must be discussed with the family. The doctor was found guilty of behavior that undermines confidence in the medical profession. He was fined 1000 guilders and the Court of Appeals ordered that the ruling be made public in the *Official Gazette*.¹⁵

THE FORMULATION OF NEW IDEAS ON THE DOCTOR-PATIENT RELATIONSHIP

In 1969 the issues involved in the general debate on resuscitation and in the case of Mia Versluis in particular were formulated in an unusually provocative way by 'H. van den Berg, a psychiatrist/neurologist.' Van den Berg divides the history of medical technology into three periods: one of 'medical powerlessness', during which doctors had few options; one of transition; and one of medico-technical power'. This last period began, according to Van den Berg, in 1965. Van den Berg's argument is that medical ethics must adjust to such changes in medical technology.

The ethical motto from the time of medical powerlessness ran thus: 'It is the doctor's duty to preserve, spare and prolong human life wherever and whenever he can.' ... The new technical power makes a new code of ethics unavoidable. This is the motto of the new ethical code: 'It is the doctor's duty to preserve, spare, and prolong human life whenever doing so has any sense,'¹⁶?

According to Van den Berg, a doctor may passively or actively shorten life that is no longer 'meaningful'.

Van den Berg's book responded to widely felt concerns and was reprinted twenty-one times within seven years and endlessly discussed in magazines and other media. The general opinion was that Van den Berg had seriously confronted a problem of major importance. But many reviewers could not agree with the legitimacy of active termination of life. Many also found defining 'meaningful life' problematic.

Van den Berg was not the only person who expressed views in the late 1960s on the question whether or not shortening of life should be permissible. Almost simultaneously books were published by the Catholic ethicist Sporken and the lawyer Van Till. The first, dealing with the permissibility of shortening a patient's dying process, argued that

¹⁵ *Nederlandse Staatscourant* 1969 no. 55: 7. These are relatively heavy sanctions in Dutch medical disciplinary law (see Verkruijsen 1993). Mia Versluis died on 10 November 1971 in another hospital without ever having regained consciousness.

¹⁶ An English translation of Van den Berg's book was published in 1978.

¹⁷ Van den Berg 1978: 63. This and the following quotation from Van den Berg are taken from the English translation of his book.

"active intervention leading to the termination of life" and "non-intervention when a life-threatening complication occurs" are ethically speaking not significantly different from one another. Both can be defended from a moral standpoint." Van Till argued that medical actions necessary to assure the humane end of a person's life can be justified from a medical-ethical and from a legal point of view.¹⁸

A second issue raised by Van den Berg and by many others concerns the rights of the patient. The notion that doctors know best what is good for their patients was considered self-evident until the end of the 1950s. In the 1960s this idea was no longer unquestioned, and the balance of power between doctor and patient was increasingly a public issue. Van den Berg entitled his book *Medical Power and Medical Ethics* and ended with these words:

My last word is for the patient himself, for in these pages I have been writing for him. With him lies the decision of in what way he is sick: knowing or not knowing. With him lies the decision of how he wants to die, nobly or unworthily. He must have the courage to say what he wants. If he perseveres he will find the doctor on his side. Yes, the doctor is for the patient and for nobody and nothing else.¹⁹

TO SUM UP

Two kinds of change played an important role in getting euthanasia onto the agenda for public debate: a cultural change and a change in medical technology. The cultural change can be characterized with the words secularization, individualization, and democratization. The medical-technological change greatly increased the doctor's ability to postpone death and had as a consequence that the medical imperatives 'do whatever is possible' and 'relieve suffering' no longer always went hand in hand. The ethical questions to which this technological development gave rise on the one hand, and the greater cultural emphasis on personal autonomy on the other hand, helped create the space on the public agenda within which debate on the patient's role in determining the time and manner of his death could take place.

18 Sporcken 1969: 221-222.

19 Van Till 1970: 105.

20 Van den Berg 1978: 64-66.

2.2 1970-1982: The early stages of public debate

INTRODUCTION

Around 1970 questions concerning the sense and the legitimacy of prolonging life and the permissibility of terminating it became the subject of public debate in the Netherlands. In addition to the extensive readership of Van den Berg's book, many people watched TV shows or listened to radio programs about dying and being told the truth at one's deathbed. Symposia were organized, and 'support in the dying process' became a familiar concept.²¹ The term 'euthanasia' was also heard, and starting in 1972, various organizations began ventilating their opinions on the matter. Opinion polls showed that a growing proportion of the population thought that life may sometimes (actively) be terminated and that 'euthanasia' should be legal.²²

The term 'euthanasia' was initially used to describe a large and varied range of behavior. No consensus existed on which actions were covered by the term and which were not. This lack of conceptual consensus accounted at least in part for differences of opinion regarding the permissibility of 'euthanasia', since such opinions often concerned quite different sorts of behavior. During the period 1970-1982 a process of conceptual clarification took place, dividing behavior that generally came to be characterized as 'euthanasia' from other behavior, most of which came to be regarded as 'normal medical practice'. The process of formulating the requirements for permissible euthanasia also got under way.²³

THE FIRST ADVISORY REPORTS ON EUTHANASIA

Medical Power and Medical Ethics inspired a member of Parliament to propose setting up a commission to study the issues Van den Berg had raised. This proposal led the Government to request advice from the Health Council, which referred the matter to its Committee on Medical Ethics.

Before the Health Council could report, the General Synod of the Dutch Reformed Church adopted a report which concluded that 'passive euthanasia' - abstaining from life-prolonging measures for medical reasons - can be legitimate. The report also stated that if a competent patient, at the beginning of the dying process requests the doctor to stop further treatment, this wish should be respected.²⁴

21 Ten Kroode 1982.

22 See chapter 5.1 for a summary of the results of opinion polls.

23 Generale Synode 1972.

The Committee on Medical Ethics of the Health Council did not deal with the whole issue of medical power and medical ethics but limited itself to the question of euthanasia because this topic "appears to be the most urgent". After some discussion it defined euthanasia as

acting with the deliberate intention to shorten a patient's life or refraining from action with the deliberate intention not to prolong a patient's life, whenever this is in the patient's best interest and the patient's condition is incurable."

The Committee distinguished between voluntary and non-voluntary, and between passive and active euthanasia. According to the Committee, 'voluntary euthanasia' entails the express consent of a competent patient. The Committee defined 'passive euthanasia' as "euthanasia that is performed by ceasing or not initiating life-prolonging measures and treatment" and 'active euthanasia' as "euthanasia that is performed by the use of life-shortening measures and treatment'." In the Committee's judgment 'active euthanasia' should not be permissible. However, it did address a few remarks to the situation of a conflict of duties. A doctor who feels he has an obligation to accede to the patient's request to use measures that will terminate the patient's life must be prepared to account for his behavior in the context of a criminal prosecution.

With regard to 'passive euthanasia' the Committee took the view that under certain circumstances a doctor can refrain from employing life-prolonging measures. The Committee had two specific situations in mind: 'voluntary passive euthanasia', when it is the patient who refuses treatment, and 'non-voluntary passive euthanasia', when the doctor considers it his medical-ethical duty to refrain from further treatment.

The Committee did not find it necessary or desirable that the law concerning euthanasia be amended."

THE *POSTMA* CASE AND OTHER CASES INVOLVING VIOLATION OF ARTICLES 293 AND 294

The Committee on Medical Ethics of the Health Council had not yet completed its report when, on 27 November 1972, articles appeared in several Dutch newspapers reporting on the preliminary hearing in a criminal prosecution for euthanasia. It

24 Gezondheidsraad 1972: 12.

25 Gezondheidsraad 1972: 13.

26 In 1975 the Committee on Medical Ethics produced a second report, dealing with the problem of severely defective newborn babies. Again the Committee advised against amending articles 293 and 294 of the Criminal Code, but recorded its conviction that this does not imply that 'active euthanasia', in cases in which 'passive euthanasia' would be indicated, can never be justified.

appeared that Ms. Postma, a doctor, had terminated her mother's life with an injection of morphine. Ms. Postma had done this in the presence of her husband, also a doctor. The director of the nursing home where Ms. Postma's mother lived brought the matter to the attention of the Medical Inspectorate, which in turn alerted the prosecutorial authorities.

Ms. Postma's mother, a widow of 78, had been in a nursing home since a cerebral hemorrhage had left her paralyzed on one side a few months earlier. On several occasions she had asked her daughter to end her life, and she had also spoken of not wanting to live any more to her other daughter and to the nursing home's staff.

On 7 February 1973 Ms. Postma stood trial in Leeuwarden for 'killing on request' (article 293 of the Criminal Code). The Medical Inspector testified that the average doctor in the Netherlands no longer considered it necessary to prolong a patient's life endlessly. In his opinion it had become widely accepted in medical circles that when a patient is given pain relief the risk of the patient dying sooner because of this treatment can, under certain conditions, be accepted. The conditions mentioned by the Inspector were:

the patient is incurably ill;
 he finds his suffering mentally or physically unbearable;
 he has expressed the wish to die;
 he is medically speaking in the terminal phase of his illness;
 the person who accedes to the request is a doctor, preferably the doctor responsible for treatment."

The District Court pronounced sentence on 21 February 1973. It largely agreed with the Inspector's opinion. The only condition it did not accept was that the patient must be in the terminal phase of his illness." The Court ruled that even though the remaining conditions had been met, it was wrong of Ms. Postma to have used an injection that was immediately lethal." In the Court's opinion this was not a reasonable means to achieve Ms. Postma's goal of putting an end to her mother's suffering. Ms. Postma was given a conditional jail sentence of one week with one year probation.

27 *Nederlandse jurisprudentie* 1973, no. 183: 558.

28 The Court rejected this condition because it knew of the existence "of many cases of incurable illness or accident-caused disability, combined with serious physical and/or mental suffering, where the patient is otherwise healthy and can continue living in this state for years. It is not the court's view that such suffering should be denied the relief described by the expert witness" (*Nederlandse jurisprudentie* 1973, no. 183: 560).

29 Although it does not specifically mention the point, the ruling of the Court seems to be based on the difference between 'indirect euthanasia' (which is what the Medical Inspector had in mind) and 'direct euthanasia' (what Ms. Postma actually did).

The *Postma* case attracted a great deal of attention. It was covered extensively in the regular press. The journal of the Medical Association, *Medisch Contact*, which had ignored the earlier case of euthanasia in 1952, now devoted space to the *Postma* trial and to a general discussion about euthanasia. The Medical Association's Executive Board adopted a tentative policy position on the issues raised by the *Postma* case and by the Health Council's report. The Executive Board's position was generally the same as that of the Health Council."³⁰

Aside from heightened media attention to euthanasia, opponents and advocates of the liberalization of euthanasia were starting to organize themselves. Advocates focussed mainly on societal acceptance of euthanasia. The largest organization and the only one that still exists was founded in 1973: the Dutch Association for Voluntary Euthanasia (NVVE). The Association's goal is to work toward societal acceptance of voluntary euthanasia and its legalization. The Association emphasizes the importance of the voluntary character of euthanasia. One of its most important tasks is the formulation and distribution of 'euthanasia statements' (advance directives) in which a person declares that, should an illness or accident cause such physical or mental damage that recuperation to a reasonable and dignified standard of life is impossible, he or she refuses medical treatment and wishes to have euthanasia performed.

Opponents organized themselves in associations such as the Dutch Association of Physicians and the Dutch Association of Patients. Aside from these 'pro-life' organizations there were a number of religious groups, in particular the strict Calvinist churches and the Roman Catholic Church, that opposed legalization of euthanasia. Although a few books and articles were published arguing against legalization of euthanasia, the opponents hardly ever attracted much sustained public attention.

The *Postma* case was the best known prosecution in this period of a person who killed another person at the latter's request, but it was not the only one. There were at least three other prosecutions for violations of article 293 or 294.³¹ In 1969 a man strangled his incurably ill wife to death at her request. He was sentenced to seven months in jail, with a deduction of half a year for the time he had been held in pretrial custody, and the remaining month subject to probation. In 1978 a foster son was prosecuted for strangling his stepmother to death after she had attempted to commit suicide several times without success. He was given a jail sentence of one and a half years. In 1980 the husband of a psychiatric patient who did not want to be institutionalized again was tried for having built a device that enabled her to take her own life. On appeal he was sentenced to six months in jail.

30 KNMG 1973.

31 Information from Herbergs 1984 and Enthoven 1988.

In none of these three cases was there any doubt that the defendant acted at the request of the person killed or that his intentions had been honest. However, in the last two cases the courts specifically ruled that it had been wrong not to call on the assistance of a doctor. The difference between these three cases and those of the Eindhoven doctor in 1952 and the *Postma* case is that the defendants in the latter cases were doctors and had access to 'gentle means'; presumably as a consequence they were punished significantly less severely.

THE REPORT OF THE MEDICAL ASSOCIATION OF 1975

In 1975 a working group of the Medical Association issued a new report on euthanasia." The working group's definition is: acts or omissions intended to cause a patient's death, in his interest. The working group concluded that euthanasia in this sense can only be considered when it is voluntarily requested by the patient and there is no hope of recovery. The doctor responsible for treatment should discuss the matter with a colleague, but he must decide for himself whether and how to perform euthanasia. In most cases passive euthanasia will be the appropriate way of honoring the patient's request, and the working group considers it legitimate. But, according to the working group, "under very exceptional circumstances it can be necessary purposely to administer palliative treatment in a dosage that is too high"; "Such active euthanasia is only acceptable in the rare situation where passive euthanasia would be permissible, but waiting passively would result in suffering that cannot be relieved in any other way. In the opinion of the working group, there is no room in the doctor-patient relationship for assistance with suicide. It also warned against the Medical Association taking an official opinion on euthanasia, "because on this subject there are as many opinions as there are doctors"³⁴

A CASE OF 'INDIRECT EUTHANASIA'

In the same period a decision of the Medical Disciplinary Tribunal of Amsterdam received public attention. The doctor's behavior was labeled 'euthanasia' by the media. The case concerned a woman who had cancer and had been hospitalized because it was no longer possible to take care of her at home. The woman was increasingly short of breath and in danger of suffocating due to blockage of her tracheo-stoma. In order to avoid suffocation the blockages had to be removed many times a day. This had gone on for a long time and made it impossible for the woman to sleep normally. The doctor against whom disciplinary charges were pressed had spoken with the woman on the day she was admitted to the hospital. From that conversation it had become clear that she

32 KNMG 1975.

33 KNMG 1975: 10.

34 KNMG 1975: 15.

was well aware of her fatal condition. Later, the doctor had discussed the use of sleep-inducing drugs with the woman and her daughters. In the course of those discussions, explicit attention had been given to the fact that she might never awaken, since she would not notice if she began to suffocate. The woman insisted that the drugs be administered. The doctor did so. The woman fell asleep and died.

The woman's husband had, partly at the woman's own request, never been involved in the decision-making. He decided to press disciplinary charges against the doctor for having administered the drugs and for having failed to discuss the matter with him. The Medical Disciplinary Tribunal ruled that the doctor's behavior had not been incorrect, and that he was not to blame for not consulting the husband since this had been at the patient's request. This ruling was confirmed on appeal by the Central Medical Disciplinary Tribunal.³⁵

THE POSITIONS TAKEN BY VARIOUS ORGANIZATIONS

The period 1970-1982 saw, in addition to some early criminal and medical disciplinary cases, the publication by various associations and political parties of their positions on euthanasia. The Humanist Society's Executive Board argued that the law should allow room for doctors to give support in the dying process in accordance with medical professional standards." The right-of-center liberal party VVD took the position that both passive and active euthanasia at the patient's explicit and well-considered request should in principle be permissible, but it thought that the time was not yet ripe for amending article 293.³⁷ A commission of the three major Christian Democratic parties (united as CDA in 1981) deemed active euthanasia unacceptable but recognized that exceptional circumstances exist in which a doctor may feel obliged to perform it.³⁸

In 1978 the NVVE's Committee on Legislation also issued a report. The Committee distinguished between passive and active, voluntary and non-voluntary euthanasia (categories recognized by the Health Council) as well as between direct and indirect euthanasia. With regard to this last distinction, it made the following remarks:

Active euthanasia requires intentional behavior by a doctor that, whether indirectly or directly, leads to an earlier death of the patient. The distinction between active indirect and active direct euthanasia concerns the intended goal of the doctor's actions. The primary goal of indirect euthanasia is relief of the patient's suffering....

35 *Tijdschrift voor Gezondheidsrecht* 1978, no. 52.

36 Hoofdbestuur Humanistisch Verbond 1976.

37 Volkspartij voor Vrijheid en Democratie 1981.

38 Schroten 1979.

The primary goal of direct euthanasia is the termination of the patient's life, in cases where this is the only way in which the doctor can put an end to his patient's suffering."

As far as the permissibility of euthanasia goes, the NVVE's Committee was of the opinion that both "passive and active indirect [i.e., pain relief] voluntary euthanasia are, under certain circumstances, as a matter of actual practice and as an ethical matter quite generally accepted!"³⁹ The Committee considered direct, active euthanasia by a doctor permissible when three conditions have been met: a fully-informed patient must have made it clear in a voluntary, well-considered, and unequivocal request that he wishes euthanasia; the patient's condition must be in the terminal phase; and the euthanasia should be performed by the doctor responsible for treatment. The Committee argued that under these circumstances direct, active euthanasia is not illegal because "voluntary euthanasia under certain circumstances is to be considered normal medical practice!"⁴⁰ The Committee proposed to add to article 293 of the Criminal Code a provision that the legal doctrine of 'absence of substantial violation of the law' is applicable in such a case.

DOCTORS AND EUTHANASIA

Although the general opinion was that doctors are most qualified to perform euthanasia, doctors often did not consider themselves adequately prepared to do so. In a letter to the editor of *Medisch Contact* in 1973, for example, a doctor asked for information about the most appropriate drugs to use. Spreeuwenberg concluded from his research among GPs that those who were prepared to perform euthanasia were finding their way through "trial and error": "At that time the only existing source of information was Admiraal, an anesthetist who described his experiences with certain euthanatica in a chapter of a book on euthanasia" and in a brochure for doctors published in 1980. (See section 2.3.1 for Admiraal's trial in 1985.)

39 NVVE 1978: 12. The report assumes that the behavior at issue is that of the doctor responsible for treatment, or someone acting under his direct responsibility. The preference for the doctor responsible for treatment is due to the fact that only he is capable of judging whether or not the patient's condition is curable and whether or not it is in its terminal phase (NVVE 1978:21). But the authors of the report explicitly reject the implication that euthanasia performed by someone other than the doctor responsible for treatment is impermissible under all circumstance (NVVE 1978:6).

40 NVVE 1978: 13.

41 NVVE 1978:7-8.

42 Spreeuwenberg 1981:259.

43 Admiraal1977.

During this period euthanasia in all of the varieties that were currently recognized was presumably taking place, but there was very little quantitative or qualitative information about actual practice. Some quantitative information was available from the 'Continuous morbidity registration project'. This project registered information from the practices of approximately 60 GPs. Beginning in 1976 it included requests for euthanasia. The number of such requests grew in fits and starts from 15 in 1976 to 30 in 1981.⁴⁴ Extrapolated to all Dutch GPs, this would have meant that on average a GP was confronted with a euthanasia request once every two years.

A first impression of the practice of medical behavior that shortens life was provided by some exploratory qualitative studies in the early 1980s. Spreeuwenberg (1981) interviewed 30 GPs concerning (among other things) their experience with 'support in the dying process'. Verhoef and Hilhorst (1981) did direct observation in two nursing homes. Hilhorst (1983) interviewed 42 doctors, 32 nurses and 8 pastoral workers in 8 hospitals, and Kenter (1983) described 'euthanasia' in his own practice as a GP over a period of 5 years (1976-1981).⁴⁵

Hilhorst, the most important investigator in this period, concluded that 'euthanasia' played, as a concept, practically no role in the professionals' 'definition of the situation'; "the word euthanasia was and is taboo in hospitals." Clearly defined decision-making criteria or procedures were essentially non-existent. The relevant legal norms were hardly known or applied. The behavior of those interviewed and observed seemed dominated by the experience of moral tension ('the doctor helps' versus 'the doctor promotes life and not death') and by the exigencies of the concrete situation. Active, direct euthanasia was practically unanimously rejected by those interviewed, but other sorts of medical practice that shortens life (terminating or not initiating treatment; administering high doses of pain relief) were generally accepted." Consultation with a second doctor took place more regularly in the hospital context than in the practice of GPs. The latter acted independently (incidentally consulting a colleague or a pharmacist), whereas in a hospital the further treatment of a patient who had expressed a wish for termination of life was discussed in a staff meeting or between the responsible doctor and the head nurse.

ATTENTION FOR ASSISTANCE WITH SUICIDE

The growing importance attached to the idea of personal autonomy brought with it interest not only in euthanasia but also in assistance with suicide. The NVVE's Committee on Legislation acknowledged in 1978 that the ethical and practical problems of

44 *Medisch Contact* 3?: 1653 (1982).

45 Kenter 1983. 11 of III deaths in his practice were due to 'euthanasia'. In the ensuing five years the frequency was essentially the same (Kenter 1989).

46 Hilhorst 1983: 35

47 Hilhorst 1983: 87-89.

euthanasia in many ways resemble those of 'rational suicide'. But the Committee considered the subject of assistance with suicide outside its mandate. Two years later, however, both the NVVE and the Foundation for Voluntary Euthanasia (SVE) published reports in which assistance with suicide received attention. The NVVE stated that assistance with suicide should be permissible

when the assistance is given to someone who has requested it explicitly and voluntarily, who is *compos mentis* at the time of the request, whose suffering is unbearable, and whose desire to die is of a permanent nature."

The SVE argued that "rational suicide should be recognized as a worthy alternative to active euthanasia and, under certain circumstances, even as more desirable." In the SVE's opinion a person who is capable of suicide should as a rule not request euthanasia but assistance with suicide.⁵⁰ Such a preference was occasionally heard from doctors as well:

The choice of means [for the termination of life] is determined by the patient's physical condition... In order to emphasize the mutual responsibility of the patient and myself, I always try to use oral medicines."

THE WERTHEIM CASE AND PROSECUTORIAL POLICY

In the Spring of 1981 a voluntary-euthanasia activist, Ms. Wertheim, was arrested for having assisted the suicide of a 67-year-old woman. The woman, who suffered from many ailments of both a mental and a physical nature, had on many occasions expressed her wish to die. Her GP refused to accede to her request and referred her to Ms. Wertheim. After a few meetings Ms. Wertheim agreed to help her. On the night of 19 April 1981, she mixed approximately 30 Vesparax tablets into a bowl of chocolate custard and fed it to the woman. She then gave her an alcoholic drink because she knew that this would enhance the effect of the Vesparax. Shortly thereafter the woman died.

The trial took place in Rotterdam on 17 November. The prosecutor argued that this was a case of murder, but Ms. Wertheim's lawyer claimed that only assistance with suicide had been proven, and the District Court agreed. The lawyer further argued that, even though Ms. Wertheim's conduct had violated the letter of the law, she could not be convicted, because she had not violated the purpose of the law - protection of life - the

48 NVVE 1980: 17.

49 SVE 1980: 61.

50 SVE 1980: 60.

51 Spreeuwenberg 1982: 268.

deceased having wanted to be released from life. Should this argument fail, her lawyer further argued, Ms. Wertheim could not be convicted because the woman had been so insistent in her desire to die that this had put Ms. Wertheim in a situation of duress. The Court's ruling on 1 December 1981 rejected both arguments.

The District Court observed that suicide is not necessarily unacceptable in all situations and that the assistance of others can sometimes be indispensable. However, in light of the prohibition of assistance with suicide in article 294 of the Criminal Code, such assistance can only be justifiable if certain requirements are met. In the Court's view, to justify assistance with suicide it must appear that:

- the physical or mental suffering of the person was such that he experienced it as unbearable;
- this suffering as well as the desire to die were enduring;
- the decision to die was made voluntarily;
- the person was well informed about his situation and the available alternatives, was capable of weighing the relevant considerations, and had actually done so;
- there were no alternative means to improve the situation;
- the person's death did not cause others any unnecessary suffering.

The assistance itself must in the Court's view meet the following requirements:

- the decision to give assistance may not be made by one person alone;
- a doctor must be involved in the decision to give assistance and must determine the method to be used;
- the decision to give assistance and the assistance itself must exhibit the utmost care, which includes: discussing the matter with other doctors if the patient's condition is in the terminal phase, or, if the patient has not yet reached this phase, consulting other experts such as a psychiatrist, psychologist or social worker"

The District Court held that Ms. Wertheim had not met these requirements, and found her guilty of the offence of assisting suicide. Because a jail sentence would have been too much of a mental and physical burden for the 76-year-old Ms. Wertheim, she was given a conditional sentence of six months subject to one year probation. As a special restriction, the court ordered that she be put under house arrest for the first two weeks of her probation.

The prosecution initially filed an appeal, but after having conferred with the Procurator-General of the Court of Appeals in the Hague and the Minister of Justice, the appeal was

withdrawn. Following this incident, the national Committee of Procurators-General decided that every case of euthanasia (article 293) or assistance with suicide (article 294) that came to the attention of a prosecutor was to be referred to the Committee for a decision on whether to prosecute. The object was to achieve national uniformity in prosecutorial policy. The conditions as formulated in the *Postma* and *Wertheim* cases were to serve as guidelines for the decisions of the Committee of Procurators-General"

Soon after the decision in *Wertheim* a new case of assistance with suicide reached the courts. This case concerned a man who had brought Vesparax tablets from Switzerland for his wife, who suffered from severe facial pain from an unknown cause. The man helped his wife to take the tablets and she died. The District Court, Utrecht concluded that the conditions of permissible assistance with suicide had not been met. Among other things, other possibilities for dealing with his wife's suffering had not been adequately explored. The man was given a conditional jail sentence of six months with one day probation. "By fixing probation at one day the Court expresses its view that the conditional sentence should not be executed."?"

TO SUM UP

In the period 1970-1982, euthanasia had become the subject of social and legal discussion and several criminal and medical disciplinary cases. Distinctions were initially made between passive, active, voluntary, non-voluntary, direct and indirect euthanasia. But the public discussion seemed to exhibit a trend towards reducing the number of meanings of the term 'euthanasia'. The central characteristic of this reduction process was that behavior that was not problematic from a moral and legal standpoint was increasingly no longer called 'euthanasia'.

A consensus was reached in this period that indirect and passive euthanasia - pain relief and abstaining from treatment - are legitimate medical behavior: they came to be regarded as 'normal medical practice'. The *Postma* case confirmed that administration of pain relief in a dosage known to be likely to cause death does not constitute a violation of article 293 of the Criminal Code. No such explicit confirmation took place with regard to abstaining from life-prolonging treatment. However, while the frequent occurrence in medical practice of such life-shortening behavior was a well-known fact, no case of passive euthanasia reached the courts. This seems indirectly to confirm that passive euthanasia was not considered a criminal offence. Aside from narrowing down the meaning of the term 'euthanasia', this decade saw the growth of a general consensus that the legitimacy of assistance with suicide depends on essentially the same criteria as that of killing on request.

53 *Second Chamber of Parliament, appendix*, 1981-1982, 1757.

54 *Nederlandse jurisprudentie* 1983, no. 264.

The requirements that the person giving assistance must meet in order to avoid being guilty of the crimes of articles 293 and 294 were broadly discussed. It was generally thought that the suffering of the person requesting assistance must be permanent and irreversible and that the euthanasia request must be durable, voluntary, and well-considered. Although according to many commentators it was a prerequisite for permissible euthanasia that the patient be in the 'terminal phase', this view was not shared by the courts. There seemed to be consensus that only doctors may perform euthanasia or give assistance with suicide, and that in principle the person rendering assistance must consult with other doctors.

2.3 1982-1986: The breakthrough

As we have seen, in 1982, following the *Wertheim* case, the Committee of Procurators-General established a national prosecutorial policy on euthanasia and assistance with suicide. Prosecutions would not be brought under articles 293 and 294 if rather generally formulated requirements were met. However, it was not clear what the substantive legal grounds were for this policy. In the following period, 1982-1986, the legal basis for the legitimacy of euthanasia and the requirements for legal euthanasia were settled. The period also saw an end to uncertainty concerning the scope of the term 'euthanasia'.

2.3.1 *The justification of necessity and the 'requirements of careful practice'*

LEGAL DOCTRINES AVAILABLE FOR LEGITIMATING EUTHANASIA

A number of doctrinal approaches were in theory available to legitimate behavior that on its face violates articles 293 and 294 of the Criminal Code (see chapter 3.1 for a more complete discussion). In our discussion of the history of abortion, one of these has already been mentioned, namely the 'medical exception'. Enschede repeated for the case of euthanasia the argument that had been successful during the abortion debate: articles 293 and 294 are simply inapplicable to doctors."

A second defence against a charge under articles 293 and 294 could be based on the doctrine of 'absence of substantial violation of the law'; the idea that behavior that violates the letter but not the purpose of the law does not constitute an offence. The NVVE had proposed in 1978 to use this doctrine in cases of euthanasia. Ms. Wertheim had invoked this defence, but the District Court, Rotterdam had rejected it.

A third defence that could be used to justify euthanasia is that of *overmacht* (article 40 of the Criminal Code, see appendix I-A). This defence has two variants in Dutch law: the excuse of duress and the justification of necessity. Ms. Postma, for example, invoked the defence of duress. The District Court, Leeuwarden, rejected it on the ground that a doctor can be expected to withstand pressure from patients. The justification of necessity can be invoked by a person who finds himself in a situation of conflict of duties. If a person in such a situation chooses to prefer the value that from an objective standpoint is more important, even if this means doing something that in itself is forbidden, his conduct is justifiable.

THE *SCHOONHEIM* CASE: EUTHANASIA CAN BE JUSTIFIABLE

The first euthanasia case that reached the Supreme Court concerned the GP Schoonheim who, on 16 July 1982, had performed euthanasia on a 95-year-old patient who on several occasions had asked him in a serious and insistent manner to do so. The patient was bedridden because of a fractured hip for which she had refused an operation. She could no longer walk or sit and her eyesight and hearing were deteriorating. Mentally she was in excellent shape and thus fully aware of her situation, which she found humiliating." On 16 July Schoonheim talked one last time with the patient in the presence of her son, her daughter-in-law, and Schoonheim's assistant. It was obvious that she had only one desire: to die as soon as possible. Following this conversation Schoonheim acceded to her request. He injected her first with a drug that made her partly lose consciousness and then with a muscle relaxant which caused her death. That same day Schoonheim reported his actions to the police.

At the trial in April 1983 Schoonheim's lawyer argued that there was an 'absence of substantial violation of the law' and that Schoonheim had acted in a situation of *overmacht*." The first defence was accepted by the District Court, Alkmaar, and Schoonheim was acquitted." The prosecution appealed. The Court of Appeals, Amsterdam, rejected all of Schoonheim's defences and found him guilty, but used its discretion not to impose any punishment.⁵⁹

On 27 November 1984 the Supreme Court ruled on Schoonheim's appeal (see appendix II-1). The Supreme Court affirmed the holding of the Court of Appeals that the doctrine of 'absence of substantial violation of the law' was not available as a defence. However,

56 Enthoven 1988: 95.

57 The lawyer also argued that the defendant's behavior could not be seen as 'taking someone's life' since he had been requested to act. The Court rejected this defence.

58 *Nederlandse Jurisprudentie* 1983, no. 407.

59 *Nederlandse Jurisprudentie* 1984, no. 43.

the Supreme Court concluded that the Court of Appeals had not properly considered the appeal to *overmacht* in the sense of the justification of necessity." It vacated the verdict of the Court of Appeals and referred the case to the Court of Appeals, the Hague."

The Supreme Court explained its decision as follows:

[O]ne would have expected the Court of Appeals to have considered ... whether, according to responsible medical opinion, subject to the applicable norms of medical ethics, this was, as claimed by the defendant, a situation of necessity.

The Supreme Court specifically referred to the patient's "unbearable suffering", including the prospect of increasing "loss of personal dignity", the risk that it might become impossible for the patient to "die in a dignified manner": and the existence of alternative ways to relieve her suffering as relevant considerations. It concluded that the approach of the Court of Appeals had not excluded

the possibility that the euthanasia performed by defendant, according to objective medical opinion, must be considered justified, as having been performed in a situation of necessity'?

After securing additional evidence, the Court of Appeals, the Hague ruled that Schoonheim's defence of necessity was well-founded and acquitted him.s" For the first time, a doctor who had performed euthanasia was found not to be criminally liable.

THE POLS CASE: EUTHANASIA DOES NOT FALL WITHIN THE 'MEDICAL EXCEPTION'

A second euthanasia case soon reached the Supreme Court. On 5 August 1982 Ms. Pols, a psychiatrist, had killed her friend at the latter's explicit request. The friend was 73 years old and suffering from multiple sclerosis. Ms. Pols gave her a fast-working tranquillizer in combination with a glass of port. After waiting a few hours she injected her three times

60 Half a year passed between the hearing of the appeal and the Supreme Court's judgment. Rummelink (Advocate-General who submitted the brief to the Supreme Court arguing that the Court should reject Schoonheim's appeal) later explained the difference between the conclusion of his brief and the Court's decision by referring to the fact that in the interim the Executive Board of the Medical Association had adopted a new policy in which it for the first time recognized the legitimacy of euthanasia performed by a doctor (Rummelink 1992).

61 *Nederlandse jurisprudentie* 1985, no. 106. See note 6 of appendix II concerning referral to a second Court of Appeals.

62 *Nederlandse jurisprudentie* 1985, no. 106:459-460.

63 *Nederlandse jurisprudentie* 1987, no. 608.

with morphine after which the friend died. That same night she delivered letters to the friend's GP and the prosecutor to inform them about her conduct. She also notified the institution where the friend had been staying."

The case was tried in February 1984 in Groningen. Ms. Pals' lawyer invoked the defences of 'absence of substantial violation of the law' and of *overmacht*. The first defence was rejected, but its supporting argumentation was interpreted by the District Court as invoking the idea of the 'medical exception'. According to the Court such a defence was in theory available, but the Court rejected it here because Ms. Pals had not consulted another doctor. In the Court's opinion neither necessity nor duress had been proved. Ms. Pals was found guilty, but no punishment was imposed."

On appeal all of Ms. Pals' defences were rejected. The Court of Appeals, Leeuwarden, held that the defence of *overmacht* must fail since she had put herself in *the* difficult situation she sought to invoke. The Court of Appeals found her guilty and imposed a conditional jail sentence of two months subject to two years' probation."

On appeal to the Supreme Court, the idea of a 'medical exception' was explicitly rejected. The Court held that (by contrast with the case of abortion) it did not appear that the prohibition of euthanasia in article 293 had been intended as subject to an exception for doctors. Furthermore, contrary to the defendant's claim, there was no settled social consensus that euthanasia is a form of 'normal medical practice' that can be considered to fall within the 'medical exception'. The Supreme Court did not, however, agree with the Court of Appeals' rejection of the defence of *overmacht* in the sense of necessity'"

The Supreme Court referred the case to the Court of Appeals, Arnhem. This Court rejected the defence of necessity because Ms. Pals should have discussed the matter with colleagues since, among other things, she had ties of friendship with the deceased. The Court imposed the same sentence as had the Leeuwarden Court." On a second appeal to the Supreme Court it was argued that the fact that Ms. Pals had not consulted colleagues should not automatically have led to rejection of the defence of necessity. The defence argued that Ms. Pals had had enough reason to believe that she had made a justifiable choice. The Supreme Court let the decision of the Court of Appeals stand."

64 Enthoven 1988: 112-113.

65 *Nederlandse jurisprudentie* 1984, no. 450.

66 *Nederlandse Jurisprudentie* 1985, no. 241.

67 *Nederlandse Jurisprudentie* 1987, no. 607.

68 *Tijdschrift voor Gezondheidsrecht* 1987, no. 35.

69 *Nederlandse jurisprudentie* 1989, no. 391.

The *Schoonheim* and *Pots* cases brought much clarity with regard to the legality of euthanasia." This clarity primarily concerned the grounds on which a defence could be based. The Supreme Court explicitly rejected the defences of 'medical exception' and 'absence of substantial violation of the law', but it held that a doctor can invoke the defence of *overmacht* in the form of the justification of necessity based on a conflict of duties.

THE REPORT OF THE MEDICAL ASSOCIATION OF 1984: FORMULATION OF THE 'REQUIREMENTS OF CAREFUL PRACTICE'

Aside from the fact that the doctrinal basis for legal euthanasia and assistance with suicide was settled in this period, there was also considerable clarification of the conditions with which doctors must comply. This clarification was heavily influenced by the new policy adopted by the Medical Association's Executive Board in 1984. The Executive Board explicitly stated that it was not its intention to address the question of the permissibility of euthanasia." It considered euthanasia to be a fact of life. Euthanasia was defined by the Board as: "conduct that is intended to terminate another person's life at his or her explicit request", " As a consequence of this definition the Board was inclined to drop the distinction between euthanasia and assistance with suicide" and to use the same terminology and criteria for both." The Board emphasized that only doctors

- 70 The Foundation for Voluntary Euthanasia (SVE) decided in 1985 to disband since its aim, securing recognition for legal euthanasia within the context of existing law, had been achieved.
- 71 During the discussion in the general membership meeting on the new policy, the chairman stated that the Board did not want to take a standpoint for or against euthanasia. The purpose of the guidelines was to assist those doctors who consider performing euthanasia. Debate was closed with the observation that the new policy was that of the Board, not necessarily of all Dutch doctors (*Medisch Contact* 40: 438 (1985)). The schism in the Medical Association caused by the Medical Association's position on abortion (see footnote to) will have influenced this prudent approach.
- 72 KNMG 1984:991.
- 73 In the 1975 report a working group of the Medical Association had, as we have seen, argued that there is no room in the doctor-patient relationship for assistance with suicide (see section 2.2).
- 74 The Board of the Association also decided to prepare a position paper with regard to termination of life of patients who are either not able to express a request for euthanasia or whose competence to make a request is questionable. The Board mentioned minors, prisoners, severely defective newborn babies, patients in coma and persons suffering from a mental disorder. The Board appointed the Commission on the Acceptability of Medical Behavior that Shortens Life (CAL) which delivered four reports in the period 1990-1993 and a final report in 1997 (see chapter 3.3, 3.4 and 3.5).

should be allowed to engage in actions that terminate life. The question of euthanasia was seen by the Board as one that should be dealt with within the doctor-patient relationship. It recognized that the medical profession has a collective obligation to make a "socially acceptable solution" of the euthanasia issue possible."

The Board considered euthanasia performed by a doctor acceptable when the doctor has taken adequate steps to meet five 'requirements of careful practice':

- 1 the request for euthanasia must be voluntary;
- 2 the request must be well-considered;
- 3 the patient's desire to die must be a lasting one;
- 4 the patient must experience his suffering as unacceptable for him. (The Board emphasized that there are only limited possibilities for verifying whether suffering is unbearable and without prospect of improvement. The Board considered it in any case the doctor's task to investigate whether there are medical or social alternatives that can make the patient's suffering bearable.);
- 5 the doctor concerned must consult a colleague."

THE *ADMIRAAL* CASE: A DOCTOR WHO MET THE 'REQUIREMENTS OF CAREFUL PRACTICE' WILL BE ACQUITTED

In June 1985 a doctor who had followed the 'requirements of careful practice' stood trial in the Hague for euthanasia. The case concerned the anesthetist *Admiraal* who on 4 November 1983 had put an end to the life of a patient who suffered from multiple sclerosis. The patient had been admitted to a nursing home in 1981 and had been in need of constant nursing care since June 1983. She had expressed her desire to end her life, but the doctor-superintendent of the nursing home refused to help her. *Admiraal*, who was approached through the Association for Voluntary Euthanasia, talked with the patient a number of times about her desire to die. Life was nothing but torture to her, mainly because of her complete dependency on others. After having discussed the matter with the terminal-care team of the hospital where he worked, *Admiraal* decided to hospitalize her there so that he could carry out the termination of life. Before *Admiraal* actually did so, he informed the city's Health Service and the Medical Inspector of his plans.

One of the questions raised at the trial was whether *Admiraal's* conduct had failed to meet the 'requirements of careful practice' since he had failed to consult an expert on multiple sclerosis, a neurologist. The District Court ruled that *Admiraal* had been con-

75 KNMG 1984,993.

76 KNMG 1984: 994-995. In 1992 the requirement of a fully-documented written record was added (KNMG 1992: 30).

fronted by a situation of necessity, that he had carefully weighed the conflicting duties and interests against each other, and that in doing so he had made a justifiable choice. The Court saw no reason for requiring him to have consulted yet another doctor, and Admiraal was acquitted."

From the *Admiraal* case it became clear that a doctor who complies with the 'requirements of careful practice' cannot be convicted for performing euthanasia. This was confirmed by the Minister of Justice who notified the Medical Association in September 1985 that doctors who comply with the 'requirements of careful practice' published by the Board of the Association in *Medisch Contact* would not be prosecuted." However, the formulation of prosecutorial policy was still in a fairly primitive state. It is true that in 1982 it had been decided that every case of euthanasia and assistance with suicide that came to the attention of the prosecutorial authorities would be discussed by the Committee of Procurators-General. But since doctors did not generally inform prosecutors about such cases, the PG's were only very rarely able to assess whether a doctor had conformed to the requirements (see further chapter 5.3.5, table 5.17).

The prosecutor in the judicial district of Alkmaar seems to have been the first to design a procedure by which doctors could report euthanasia. After consultation with local doctors, the prosecutor promised that police and prosecutorial authorities would be very reticent, investigating reported cases in a reserved and low-visibility way," that doctors who had abided by the 'requirements of careful practice' did not have to fear prosecution, and that a doctor who reported would be informed within 14 days if the prosecutor saw any reason for further investigation. The results of this strategy were quickly apparent. In the district of Alkmaar doctors reported eight cases of euthanasia in the last three months of 1985; in 1986 they reported 38 cases and in 1987 31. The 31 reports in 1987 amounted to a quarter of all reports nationally!"

77 *Nederlandse jurisprudentie* 1985, no. 709.

78 A prosecution in 1987 settled beyond doubt that a doctor can indeed count on not being prosecuted as long as he has met the 'requirements of careful practice', and that a failure to consult another doctor is in itself insufficient ground for a criminal prosecution. The prosecuted doctor had given a patient lethal injections at her explicit request. When criminal charges were brought, the doctor requested the Court of Appeals, Arnhem to quash the indictment. The Court did so. In the Court's view the undisputable facts required the conclusion that prosecution of the doctor for euthanasia could not succeed, since if there were a trial it would soon become evident that the defendant had acted in a situation of necessity. The Supreme Court rejected the prosecution's appeal on the ground that the arguments given by the Court of Appeals formed a sufficient basis for its conclusions (*Nederlandse jurisprudentie* 1988, no. 157).

79 There had been complaints in medical circles about policemen arriving at hospitals with sirens screaming, bursting in uniform into hospital wards or offices, and about the needlessly long and aggressive interrogations to which both doctors and patients' relatives were subjected.

80 See Iosephus [itta 1987, 1997; Enthoven 1988: 277.

2.3.2 *The definition of euthanasia and initial proposals for legislation*

INTRODUCTION

In the period 1970-1982 a general consensus had already been reached concerning the legal acceptability of so-called 'passive' and 'indirect' euthanasia. The term 'euthanasia' was less and less used to describe these sorts of medical behavior that shortens life. In the period 1982-1986 euthanasia proper came to be more precisely defined and reserved for behavior covered by article 293: termination of life at the request of the person concerned.

THE HEALTH COUNCIL REPORT OF 1982

The first step in this process was a new report of the Health Council in 1982. This report was the result of a motion adopted by the Second Chamber of Parliament in 1978 requesting that a state commission be set up to give advice on future national policy concerning euthanasia.⁸¹ The Health Council was asked to advise on the assignment to be given this state commission. After summarizing the sorts of behavior that so far had been labeled 'euthanasia', the Council concluded that only "intentionally terminating or shortening a patient's life at his request or in his interest?" constitutes euthanasia. Ceasing a treatment that only postpones the moment of death, pain relief with the unintended but accepted effect of shortening life, and refraining from treatment at the patient's request are, according to the Health Council, 'normal medical practice'. The Council saw no reason to emphasize the distinction between euthanasia and assistance with suicide. "The context in which the treatment takes place seems far more important than the form assumed by the assistance in a specific case"⁸²

The Council did not advise on the desirability of legislative change regarding euthanasia and assistance with suicide, limiting itself to an outline of the advantages and disadvantages of such legislative change. It did, however, call attention to the problem faced by a doctor who has performed euthanasia: is it permissible for him to file a certificate of natural death (in which case burial or cremation can take place without further ado) or must the doctor inform the coroner that death was not due to a natural cause (in which case criminal investigation is to be expected)? The Health Council observed that doctors sometimes have reasons of a practical nature for submitting a certificate of natural death, since a criminal investigation can heavily burden both the doctor and the patient's family. The Council advised that the State Commission should address this problem.

81 This motion implemented the European Council's recommendation (29 January 1976) that a national commission be set up by each member state to investigate the euthanasia question.

82 Gezondheidsraad 1982: 15.

83 Gezondheidsraad 1982: 16.

THE WESSEL-TUINSTRA BILL

Before the State Commission had finished its work, a member of the Second Chamber of Parliament, Ms. Wessel-Tuinstra of the left-liberal party D66, decided that awaiting the Commission's report would mean putting off legislative change that she considered urgent. In her opinion both the person who requested euthanasia and the doctor who agreed to carry it out, were exposed to a degree of legal insecurity that was no longer acceptable. She also found it unacceptable that the whole issue of euthanasia had been left to judges and prosecutors. Regulation of euthanasia, in her view, is a responsibility of the legislature. In April 1984 she submitted a bill providing for changes in articles 293 and 294 of the Criminal Code."

Her bill (for its final form see appendix I-C-2) proposed to make euthanasia and assistance with suicide legal, as long as assistance was given in a responsible fashion "to a patient whose condition is terminal or to a patient whose physical or mental suffering is unbearable!" A number of conditions were formulated in the bill. The request must be voluntary and well-considered. The decision to end the patient's life must be made by a doctor who has convinced himself that the patient and his request meet the various requirements. The doctor must keep a written record of the case and must report his act to the proper authorities. Parliamentary action on the bill was postponed until after the State Commission's report.

THE STATE COMMISSION ON EUTHANASIA

On 19 October 1982 the State Commission on Euthanasia was installed (its chairman Leukens was a member of the Supreme Court). Its assignment was to report on future national policy concerning euthanasia and assistance with suicide, with an emphasis on legislation and its implementation." The Commission's installation had been opposed in advance by advocates of euthanasia. In their opinion the only purpose of the Commission was to postpone needed legislative reform. Whether these fears were justified at the time or not, the fact is that the State Commission succeeded in moving euthanasia to the top of the political agenda.

In the summer of 1985 the State Commission produced its report." The Commission defined euthanasia as "intentionally terminating another person's life at the person's

84 *Second Chamber of Parliament* 1983-1984, 18331, no. 2 and 3.

85 In 1986 this text was changed to make its terms congruent with those of the State Commission: 'a situation of hopeless necessity' (compare appendix I-C-2).

86 Staatscommissie 1985: 12.

87 The report consisted of a majority report and a minority report in which two members rejected any legalization of euthanasia. The majority report included minority views on some subjects, such as the requirement that the dying process have commenced (see below).

request", " For the Commission the patient's request was essential. This definition makes the term 'euthanasia' congruent with the behavior prohibited in article 293.

The State Commission organized public hearings where interested persons and organizations could state their views on euthanasia and assistance with suicide. During these hearings there was practically unanimous agreement with the distinction made by the Health Council between 'euthanasia' and other medical behavior that shortens life and with the position that abstinence and pain relief, even when death is the expected result, constitute 'normal medical practice'. Such agreement certainly did not exist with respect to the question whether euthanasia and assistance with suicide are morally or legally acceptable. Views on possible changes in articles 293 and 294 varied widely.

The transcripts of the hearings show the range of arguments current at that time. The statements of advocates of legalizing euthanasia and assistance with suicide generally rely on the right of personal autonomy. Opponents can be divided into two categories. There are those who invoke religious authority (the most important claim is that life belongs to God and is only given temporarily to human beings). And there are opponents who advance secular arguments against liberalization: euthanasia and assistance with suicide are in conflict with medical ethics; the 'right to life' imposes on the state a duty to protect human life; it is impossible to determine whether a request is voluntary; and liberalization of voluntary euthanasia will lead inexorably to social practices we all abhor (the 'slippery slope'). (See chapter 4.2 for a more extensive treatment of these arguments.)

The Commission urged the Government and Parliament to clarify the legal situation concerning euthanasia and assistance with suicide. In its opinion legislation was essential to accomplish such clarification. Like the Supreme Court, the Commission considered the 'medical exception' and the doctrine of 'absence of substantial violation of the law' not applicable to the case of euthanasia. As far as the justification of necessity was concerned, the Commission sought to define criteria to determine when a patient's situation is such that it would be reasonable and acceptable for a doctor, faced with the patient's request to terminate his life, to claim that he was confronted with a conflict of duties. The Commission was unable to reach a complete consensus on what the nature of the patient's situation must be. A majority agreed on the requirement that the patient must be suffering 'hopelessly' (*uitzichtloos*: without prospect of improvement; senseless), although this suffering could be either physical or mental. A minority wanted to add the requirement that "the dying process must irreversibly have set in".⁸⁹ After formulating these requirements concerning the patient's situation, the Commission emphasized that

88 This definition is much like the one Leenen, a member of the State Commission, had already formulated in 1977 (Leenen 1977: 80).

89 Staatscommissie 1985: 59.

"the termination of life must be performed by a doctor in the context of careful medical practice, and sufficient procedural control must be guaranteed."?"

The Commission saw no significant difference between killing on request and certain forms of assistance with suicide. If a doctor gives the patient lethal medication which the patient himself takes, the case should, in the Commission's view, be treated in the same way as killing on request.

The State Commission proposed a legislative revision of article 293 (see appendix I-C-I for the text of the State Commission's proposal). The revised article provides that euthanasia is legal when performed by a doctor in a medically responsible way, at the request of a patient who is in a situation of 'hopeless necessity' and when certain 'requirements of careful medical practice' have been met. The Commission formulated the following requirements:

- 1 the patient must be informed about his condition;
- 2 the doctor must have convinced himself that the patient's request was made voluntarily and after serious consideration;
- 3 the patient and the doctor must agree that there are no alternative ways of dealing with the patient's condition;
- 4 the doctor must consult with a doctor designated by the Minister of Health.

The Commission proposed that a doctor who fails to comply with the requirement of consultation or who files a certificate of natural death after performing euthanasia or assistance with suicide should be guilty of a specific criminal offence, the remaining requirements being conditions of legal euthanasia. The Commission further proposed that the doctor should report having performed euthanasia or assistance with suicide to the district prosecutor. Such a report should be accompanied by a statement in which the doctor explains how he has met the criteria and a statement by the doctor who was consulted.

The State Commission also proposed adding a new section to article 293 in which euthanasia proper would be distinguished from the so-called 'false forms of euthanasia'. Four such 'false forms' were specified in the State Commission's proposal: not initiating or stopping treatment either at the request of a patient or in a situation in which the treatment is medically futile, not treating a secondary illness or disorder in case of a patient who has permanently lost consciousness, and hastening the moment of death as a subsidiary effect of treatment that is necessary to relieve suffering.

Besides recommending changes in article 293, the State Commission proposed to add a new article. This article (292b) would provide that termination of the life of a person who cannot make his wishes known is forbidden, except in the case of a doctor who in a medically responsible way terminates the life of a person who is in an irreversible coma and whose medical treatment has been stopped because it was futile. Here, too, the doctor is required to consult with a doctor designated by the Minister of Health.

EUTHANASIA IS NOT A 'NATURAL' CAUSE OF DEATH

The reports of the Health Council and of the State Commission called attention to the need to create an adequate system of control over euthanasia practice. This problem, which later on came to dominate the entire public debate, was first addressed by asking whether a doctor can properly file a certificate of natural death after performing euthanasia." The majority opinion was that euthanasia cannot be considered a 'natural' cause of death.

In 1985 a criminal case began in Rotterdam which definitively settled this issue. The case concerned a doctor who on 15 December 1983 had ended a patient's life in a nursing home at her explicit request. He filed a death certificate stating that the cause of the patient's death had been natural. The doctor was tried for euthanasia and for submitting a false certificate (article 228(1) of the Criminal Code, see appendix I-A). The doctor's defence to the euthanasia charge was based on the justification of necessity. The District Court agreed and found him not guilty of euthanasia. The doctor's lawyer also invoked the justification of necessity as a defence to the second charge. She argued that the doctor was in a situation of conflict of duties: on the one hand his duty to the surviving relatives and the other patients in the nursing home for whom reporting the death as a non-natural one would have entailed additional grief and agitation, on the other his duty not to file a false certificate. Confronted with the choice of two unattractive options, he chose the less harmful one. The Court did not agree. In its opinion, filing a false certificate undermines legal control of termination of life. The doctor was sentenced to a fine of 500 guilders, half of which was made conditional.⁹² On appeal, the Court of Appeals, the Hague agreed with the District Court. It also rejected the defendant's reliance on his oath of secrecy: this oath gives a doctor the right to remain silent, but not to give false infor-

91 Enschede had argued that a certificate of natural death may be filed in situations where the cause of death is not a criminal offence. To this he added the consideration that a doctor must sometimes file such a certificate since he would otherwise violate his obligation of professional secrecy (Enschede 1985).

92 *Tijdschrift voor Gezondheidsrecht* 1985, no. 44.

mation." In December 1987 the Supreme Court upheld the decision of the Court of Appeals." As we will see in chapter 5.3.5, there have subsequently been a number of prosecutions and convictions for this offence.

TO SUM UP

In the period 1970-1982 there had been considerable discussion about how to define 'euthanasia'. This question was given a definitive answer in the period 1982-1986. In the same period important steps were also taken to legalize euthanasia and assistance with suicide under specific conditions. It became established in a series of court decisions that, when a patient who is suffering unbearably and hopelessly makes a voluntary and well-considered request, a doctor who accedes to the request, if he conforms to the 'requirements of careful practice' and makes his behavior controllable by not filing a certificate of natural death, is not guilty of a crime. The specific contents of the 'requirements of careful practice' had also been worked out in some detail. However, this clarification work did not end the public discussion on euthanasia. Legislation had still not been adopted to regularize a practice that had come to be considered legally acceptable, and the problem of termination of life without the patient's request, put on the agenda by the State Commission, remained to be seriously addressed.

2.4 1986-1997: Efforts to codify emerging practice in legislation; broadening the subject of debate

INTRODUCTION

By 1986 it had become clear what 'euthanasia' means as a matter of Dutch law and what legal doctrine is available to legitimize behavior by doctors that on its face violates articles 293 and 294 of the Criminal Code. Moreover, a bill had been submitted to Parliament which proposed to legalize euthanasia subject to a number of requirements and the State Commission had recommended legislation along the same lines. Such legislation was supported by a substantial majority in Parliament. One might have thought that the legalization of euthanasia by doctors was imminent. As we will see, this expectation did not materialize.

93 *Nederlandse jurisprudentie* 1987, no. 756.

94 *Tijdschrift veer Gezondheidsrecht* 1988, no. 13.

The State Commission had put an end to the discussion about the definition of 'euthanasia'," but at the same time it put termination of life without an explicit request onto the public and political agenda. Termination of life without an explicit request had also emerged as a subject of discussion within the Medical Association. The legitimacy of assistance with suicide to patients whose suffering is not physical but mental also received attention in the period 1986-1997.

POLITICAL RESPONSES TO THE REPORT OF THE STATE COMMISSION

In early 1986 the Government, a coalition of the Christian Democrats (CDA) and the right-of-center liberal party VVD reported to Parliament its tentative conclusions in light of the State Commission's report. The Government was inclined to the view that the time was not yet ripe for legislation concerning euthanasia. Nevertheless, should Parliament be of a different view, the Government indicated in a 'tentative draft of a bill' (*de Proeve*) what sort of legislation would be acceptable to it. In effect, the Government proposed to add to Wessel-Tuinstra's bill the additional limitation that euthanasia would only be legal in a situation in which there was "a concrete expectation of death': The Government thereby adopted the position of the minority within the majority of the State Commission." An explicit if limited role was accorded to the immediate family of the patient: added to the 'requirements of careful practice' was the requirement that the doctor must consult with the patient concerning their inclusion in the decision-making. The Government also proposed to add a new section to article 293 specifying, as the State Commission had advised, those forms of medical behavior that shortens life that do *not* fall under its prohibition."

Parliament, confronted with the Wessel-Tuinstra bill, the Government's alternative, and a number of more or less fundamental proposed amendments, decided to refer the matter to the Council of State for advice. The Council of State advised that the public discussion on euthanasia had not yet reached the point at which it was desirable to try to specify in the Criminal Code when euthanasia is permissible." The Council nevertheless did advise adding to the Criminal Code a provision making explicit that abstention and pain relief are not covered by articles 293 and 294 and, in separate legislation outside the

95 Which is not, of course, to say that other uses disappeared from popular discourse. There, the term 'euthanasia' sometimes has an astonishingly extensive meaning. The city of Groningen recently distributed a poster concerning the local tax on dogs, advising owners that one way of establishing that one no longer has a dog is by submitting a veterinary's "euthanasia statement':

96 See footnote 87 above.

97 *Second Chamber of Parliament* 1985-1986, 19359, no. 2.

98 *Second Chamber of Parliament* 1985-1986, 18 331, no. 43.

Code, specifying a number of minimum procedural and administrative requirements that a doctor would have to meet before being allowed to invoke the defence of necessity.

In January 1987 the Government notified Parliament that it would look into the possibility of a limited bill as advised by the Council of State. But first it proposed to ask the Health Council for advice concerning the 'requirements of careful practice'. The Council answered in March 1987. It re-emphasized the importance of fully informing the patient, of ensuring that his request is voluntary, well-considered and durable, of consultation, and of full record-keeping. The Council suggested that an advance directive could replace the patient's current request if the patient was no longer able to express his wishes. The family should be involved in the decision-making, unless the patient had a serious and well-founded objection that was regarded as valid by the doctor and the consulted expert. In the case of patients under 16, still subject to legal guardianship, the Council regarded it as essential that the doctor discuss the request with the immediate family, but even in such cases recognized that there might be exceptional situations."⁹⁹

The Government also asked the Committee of Procurators-General for its views concerning the advice of the Council of State, from the point of view of effective law-enforcement and doctrinal consistency with the rest of the criminal law. On 28 April 1987 the Procurators-General reacted very negatively to the advice of the Council of State and the Government's draft bill.¹⁰⁰ They objected to the device of a 'negative definition of an offence' (the specification of behavior *not* included in article 293) and to specifying requirements for the defence of necessity outside the Criminal Code. They also pointed out that so long as euthanasia remains a criminal offence, the proposed requirement that the doctor must file a certificate of non-natural death seemed to violate the privilege against self-incrimination.

At the very end of 1987 the Government submitted a revised bill under which essentially nothing in the Criminal Code would be changed.¹⁰¹ Instead of changing articles 293 and 294 the bill would have added two provisions to the Law on Medical Practice:¹⁰² (1) the exclusion of death due to termination or non-initiation of treatment and to pain relief from the scope of articles 293 and 294, and (2) minimum procedural and record-keeping requirements that a doctor who performs euthanasia would have to meet. According to these requirements the doctor should assure himself that the patient's request is explicit and serious, informed and voluntary, he should consult with the

⁹⁹ Gezondheidsraad 1987:6.

¹⁰⁰ *Second Chamber of Parliament* 1986-1987,19359, no. 8.

¹⁰¹ *Second Chamber of Parliament* 1987-1988,20383, no. 2 and 3.

¹⁰² This law was replaced in 1993 by the Law on Professions Concerned with Individual Medical Care (see the *Intermezzo*).

patient's family or other intimates (unless the patient objects to this) and with another, independent doctor, and he should keep a complete, written record.¹⁰³ It would be up to the prosecutors and the courts to determine to what extent these provisions outside the Criminal Code were relevant to the defence of necessity.

THE REACTION OF THE DUTCH ASSOCIATION FOR VOLUNTARY EUTHANASIA

In April 1989 the Dutch Association for Voluntary Euthanasia (NVVE) published an extra-parliamentary bill as an alternative to the Government's bill. The gist of the NVVE bill was that euthanasia and assistance with suicide by a doctor would be removed from the Criminal Code.¹⁰⁴ A provision was to be added to the Law on Medical Practice to the effect that medical care requires a doctor to limit the physical and mental suffering of the patient. Within the framework of this limiting of suffering, a doctor would be entitled, at the request of the patient, to assist him to die. The usual 'requirements of careful practice' were provided. The NVVE bill also provided that a doctor need only certify that the patient died from a cause that according to the doctor did not give rise to any objection to giving permission for burial or cremation.¹⁰⁵ The NVVE bill sought in effect to provide a legislative foundation for the 'medical exception'.¹⁰⁶

PRELUDE TO A NATIONAL STUDY OF MBSL

In May of 1989, before Parliamentary consideration of the Wessel-Tuinstra bill and the most recent version of the Government's alternative was complete, the center-right Government (CDA and VVD) fell and was replaced by a center-left Government (CDA and PvdA). During the formation of the new Government, the parties agreed that further legislative treatment of euthanasia should await the findings of a Commission appointed to conduct research into the extent and characteristics of current euthanasia practice.¹⁰⁷

103 There were also special provisions permitting the honoring of a written request (not more than 5 years old) of a patient no longer capable of expressing his wishes, and dealing with euthanasia requests by minors (whose legal representatives must be included in the decision-making and must agree to euthanasia).

104 The NVVE proposed to add to the articles 293 and 294, after the words "a person who;" the words "other than as the doctor responsible for care". Article 293, for example would read: "A person who, other than as the doctor responsible for care, takes the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than four years or a fine of the fourth category." (NWE 1989)

105 NVVE 1989.

106 Compare De Wit 1989: 1.

107 *Second Chamber of Parliament 1988-1989*, 21 132, no. 8 (coalition agreement): 47.

The Commission Appointed to Carry out Research Concerning Medical Practice in Connection with Euthanasia (referred to as the 'Rommelink Commission' after its chairman, who at the time was Advocate-General at the Supreme Court) was installed on 18 January 1990. Its research was supposed to provide insight into "the state of affairs with respect to acts or omissions by doctors which shorten the life of a patient, with or without an explicit and serious request".¹⁰⁸

In November of 1990 the Minister of Justice announced a reporting procedure for euthanasia.¹⁰⁹ This had been arrived at after negotiations with the Medical Association, which had conditioned its support for the intended research of the Rommelink Commission on clarification of the procedure to be followed by doctors for reporting cases in which they have carried out euthanasia. In broad terms the new reporting procedure was based on the assumption that a doctor who has performed euthanasia or assistance with suicide may not file a certificate of natural death but must notify the coroner of what he has done (see further chapter 3.2.)¹¹⁰ At the same time, the Procurators-General issued instructions governing the investigation by the police of reported cases. The gist of these instructions was that the whole investigation should be as discrete as possible. Thus, for example, when visiting a doctor in the course of an investigation, the police should not be in uniform nor drive a marked police car. They should also be as considerate as possible of the feelings of the next of kin.!'

THE *STINISSEN* CASE: ARTIFICIAL FEEDING IS MEDICAL TREATMENT

At the end of 1990 the Dutch were confronted again with a dramatic case of a person in irreversible coma (see section 2.1 on the earlier case of Mia Versluis). In June 1987 Gerard Stinissen had brought a civil action in the District Court, Almelo asking for a judgment that further treatment of his wife Ineke could be stopped. Ineke Stinissen had been in coma since March 1974 as a result of a medical mistake during a Caesarian delivery. Already in 1976 Gerard Stinissen had asked the nursing home where his wife was being kept alive to allow her to die. The nursing home refused, first because they were opposed to taking an 'active' decision to let a patient die, but later on because they were unsure of their legal position.

Stinissen requested the Court to order that the artificial feeding of his wife be stopped, that possible complications not be treated, and that the nursing home confine itself to care aimed at the relief of suffering. Stinissen argued that medical treatment was futile

¹⁰⁸ *Second Chamber of Parliament 1989-1990*, 20 383, no. 13: 2.

¹⁰⁹ *Second Chamber of Parliament 1990-1991*, 21 800, no. 23: 2.

¹¹⁰ *Medisch Contact*45: 1303 (1990).

III *Medisch Contact*45: 1304 (1990); compare section 2.3 and note 79 on the earlier policy in Alkmaar.

and that the patient could not be considered to have given consent to it. The Court ruled that the artificial feeding of Ms. Stinissen should be considered medical treatment and therefore fell within the authority of a doctor to terminate futile medical treatment. But it considered the doctor's decision to keep Ineke Stinissen alive legitimate and refused to intervene.¹¹²

In 1989, on appeal, the Court of Appeals, Arnhem likewise rejected Stinissen's request that the artificial feeding be stopped. The Court argued that judgments concerning medical treatment should be made by doctors. The Court of Appeals did however confirm the ruling of the District Court that the artificial feeding should be considered medical treatment.¹¹³

After the Court of Appeals' decision, Ineke Stinissen's doctor decided to stop the artificial feeding.¹¹⁴ Ineke Stinissen died on 19 January 1990.

THE REPORT OF THE REMMELINK COMMISSION AND THE GOVERNMENT'S REACTION

The Rummelink Commission delivered its report in September 1991. The research of Van der Maas, carried out under the authority of the Rummelink Commission, finally put an end to more or less wild speculations concerning the extent of euthanasia. It appeared from this research that about 1.7% of all deaths (2300) per year were due to euthanasia and 0.2% (400 deaths) to assistance with suicide. The research also revealed that in 0.8% (1000 deaths) the life of a patient was ended without the patient having made an explicit request for this (see further chapter 5.3 on the findings of this research).

Politically speaking, the essential function of the Rummelink Commission was the same as that which the State Commission had failed to perform: to pacify the euthanasia discussion. Whether or not such a pacificatory function was consciously intended,¹¹⁵ it was certainly fulfilled. Although the results of the research can support a variety of interpretations and conclusions, the Commission's report consistently chooses the politically unproblematic interpretation and draws the politically reassuring conclusion. The general tenor of its report is that - leaving aside some lapses in observance of the 'requirements of careful practice' - the current situation in the Netherlands gives no occasion for

¹¹² *Tijdschrift voor Gezondheidsrecht* 1987, no. 50.

¹¹³ *Nederlandse Jurisprudentie* 1989, no. 909.

¹¹⁴ The Dutch Association for Patients (a 'pro-life' organization) brought a civil action to force the doctor to continue the artificial feeding of Ms. Stinissen. The District Court ruled that the plaintiff had no standing to sue (*Kort Ceding* 1990, no. 32). The Court of Appeals confirmed this ruling (*Nederlandse Jurisprudentie* 1990, no. 470).

¹¹⁵ There is no reason to attribute any such intent to the members of the Commission, let alone to the researchers.

political concern. The reception of the report can best be characterized as a collective sigh of relief that there was apparently no real problem. The Labor Party (PvdA) -long supporters of the Wessel-Tuinstra bill- were promptly able to agree with the Christian Democrats (CDA), with whom they had formed a Government in 1989, that no substantial legislative change was required.

The Government gratefully seized the opportunity offered it by the report of the Remmelink Commission. On 8 November 1991 it published its formal reaction to the report.¹¹⁶ The research done for the Commission had demonstrated, the Government concluded, that "medical practice in connection with the end of life is characterized by great conscientiousness and responsibility".¹¹⁷ With very rare exceptions, doctors exhibit the "greatest possible care" before coming to the decision that the situation of necessity that justifies euthanasia is present. Such decisions take place in circumstances in which "medically speaking the patient must be considered beyond hope".¹¹⁸ The Government noted the Commission's conclusion that however good the treatment of pain is, this will not always replace the need for euthanasia, among other things because pain is not always the most important kind of suffering that leads to a request for euthanasia.

For the sake of the necessary external control over medical decisions concerning euthanasia, the Government proposed to maintain the existing provisions in the Criminal Code, as interpreted by the courts. The nature of the defence of necessity as a justification for departure from the general norm precludes, the Government argued, the formulation in legislation of the conditions under which the defence will succeed.

The Government proposed to withdraw the bill of 1987 and to substitute a new one, which did no more than put a legal foundation under the reporting procedure in effect since 1990.¹¹⁹ As the Remmelink Commission had advised, this procedure would now also be applicable to cases of terminating life without an explicit request. The 'requirements of careful practice' would be incorporated in the reporting procedure.^F

THE LEGISLATION OF 1993

The legislation ultimately adopted in 1993 and currently in effect was an amendment to the Law on the Disposal of Corpses.¹²⁰ It makes a technical change in the legal status of the forms to be used for reporting the death of a patient. Pursuant to the new Law a

¹¹⁶ *Second Chamber of Parliament* 1991-1992, 20 383, no. 14.

¹¹⁷ *Second Chamber of Parliament* 1991-1992, 20 383, no. 14: 2.

¹¹⁸ *Second Chamber of Parliament* 1991-1992, 20 383, no. 14: 2

¹¹⁹ *Second Chamber of Parliament* 1991-1992, 22 572, no. 2 and 3.

¹²⁰ The Government also proposed to continue support for research into the treatment of pain and to strengthen the support services for patients who choose to die at home.

¹²¹ Wet op de lijkbezorging, art. 1, *Staatsblad* 643, 1993.

special form was prescribed for cases of euthanasia, assistance with suicide and termination of life without an explicit request. This form¹²² consists largely of a list of 'Points requiring attention' to be covered in the doctor's report, which more or less correspond to the various elements of the 'requirements of careful practice' laid down in the case law. In this indirect way the Dutch Parliament can be said to have addressed itself to the legitimacy of euthanasia and, via a back door, to have ratified what the courts had long since done. Technically speaking, the legislation does not affect the legality of euthanasia at all. (See appendix I-B for the text of the Law and the 'Points requiring attention')

THE *CHABOT* CASE: ASSISTANCE WITH SUICIDE IN CASES OF NON-SOMATIC SUFFERING

The next important legal development was in 1994, when a case of assistance with suicide given to a person whose suffering was not based on a somatic condition reached the Supreme Court.¹²³

¹²² *Staatsblad* 688, 1993, effective 1 June 1994.

¹²³ Two earlier cases deal with the question of legitimacy of assistance with suicide to patients whose suffering is not somatic. The first case concerned a woman who for many years suffered from severe depressions. Medical treatment appeared to be pointless, and her doctors, a psychiatrist and a GP, decided to assist her with suicide. They supplied her with lethal drugs and were prosecuted for assistance with suicide. They moved to dismiss the indictment, arguing that they had followed the 'requirements of careful practice'. The Court of Appeals, the Hague, held that it was not dear if in cases of non-somatic suffering the 'requirements of careful practice' are the same as in cases of physical suffering, but that in any event the doctors had not consulted an independent doctor. The Supreme Court affirmed this decision (*Nederlandse jurisprudentie* 1991, no. 789). The doctors stood trial in Rotterdam. The District Court found that the request of the woman had been voluntary, well-considered and lasting. The Court ruled that the doctors could invoke the defence of necessity and acquitted them in spite of the Court's opinion that it would be desirable in cases of non-somatic suffering to consult another independent doctor (*Nederlandse Jurisprudentie* 1992, no. 664). The Court of Appeals, the Hague, also acquitted the doctors (*Tijdschrift voor Gezondheidsrecht* 1993, no. 52).

In the second case a pediatrician was prosecuted in 1991 for supplying lethal drugs to a 25-year-old patient suffering from *anorexia nervosa* (the case is known from John Zaritsky's film *An Appointment with Death*, see chapter I, note 2). The pediatrician moved to dismiss the indictment arguing that he had followed the 'euthanasia protocol' of his hospital. He also invoked the defence of necessity. The District Court, Almelo considered the patient's suffering unbearable, saw no hope for recovery and judged the patient's request voluntary and well-considered. In the Court's opinion the doctor had followed the 'requirements of careful practice' and had been in a situation of necessity. The indictment was dismissed. (*Tijdschrift voor Gezondheidsrecht* 1992, no. 19.)

On 28 September 1991 the psychiatrist Chabot, at her request, supplied Ms. B with lethal drugs. She consumed the drugs in the presence of Chabot, a GP and a friend and died shortly thereafter. Chabot reported her death the same day to the local coroner as a suicide which he had assisted.

Briefly, the facts were as follows (see appendix 11-2 for the decision of the Supreme Court and a fuller statement of the facts). Ms. B was 50 years old. Over a period of several years she had undergone a series of traumatic experiences that had deprived her of all desire to continue living. Psychiatric treatment had had little effect, and she had made one serious suicide attempt. She was referred to Chabot by the Association for Voluntary Euthanasia. After extensive discussions with her, he concluded that there was no question in her case of a psychiatric disorder or a major depressive episode. Her psychic traumas were in principle susceptible to psychiatric treatment (which would, however, have been long-term and with limited chance of success), but Ms. B consistently declined therapy. In Chabot's opinion, Ms. B was experiencing intense, long-term psychic suffering, the suffering was unbearable and hopeless for her, and her request for assistance with suicide was well-considered. He consulted a total of seven experts. Most of them agreed with his assessment of the situation and of the treatment perspectives (none of them considered it necessary to examine Ms. B).

The District Court, Assen,¹²⁴ and the Court of Appeals, Leeuwarden,¹²⁵ found the defence of necessity well-founded. On appeal, the Supreme Court reaffirmed its earlier judgments that euthanasia and assistance with suicide can be justified if

the defendant acted in a situation of necessity, that is to say ... that confronted with a choice between mutually conflicting duties, he chose to perform the one of greater weight. In particular, a doctor may be in a situation of necessity if he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care.¹²⁶

The Court rejected the argument of the prosecution that this justification is not available in the case of assistance with suicide given to a patient whose suffering is non-somatic and who is not in the 'terminal phase'. It agreed with the holding of the Court of Appeals "that the wish to die of a person whose suffering is psychic can be based on an autonomous judgment": However, the Court concluded that in the circumstances of the case there was insufficient proof to support the defence of necessity, since there was no

¹²⁴ *Tijdschrift voor Gezondheidsrecht* 1993, no. 42.

¹²⁵ *Tijdschrift voor Gezondheidsrecht* 1993, no. 62.

¹²⁶ *Nederlandse Jurisprudentie* 1994, no. 656: 3154.

statement from an "independent medical expert who has at least seen and examined the patient himself". Although, the Court observed, failure to consult a colleague - whether or not the latter examines the patient - does not in an ordinary case foreclose the defence of necessity, in the case of suffering that is not somatically based, evidence of consultation including actual examination of the patient is essential. The judgment of the independent colleague should cover the seriousness of the suffering and the prospects for improvement, the alternatives to assistance with suicide, and the question whether the patient's request was voluntary and well-considered, "without [the patient's] competence being influenced by his sickness or condition". In passing, the Court observed that "there can in principle be no question of lack of prospect of improvement if there is a realistic alternative to relieve the suffering which the patient has in complete freedom rejected."¹²⁷ Chabot was found guilty of the offence of assistance with suicide (however, no punishment was imposed).

REPORTS ON PROBLEMATIC CATEGORIES OF MBSL

Between 1990 and 1994 the Commission on the Acceptability of Medical Behavior that Shortens Life (CAL) of the Medical Association (see footnote 74 above) produced four provisional reports on the legitimacy of terminating life without an explicit request or in cases where the patient's competence is questionable. Two of these reports concern patients who are not able to make a request at all: severely defective newborn babies (CAL 1, 1990) and patients in a long-term coma (CAL 2, 1991). The third report concerns demented patients who are not entirely competent during the entire course of the decision-making (CAL 3, 1993), and the fourth report considers the legitimacy of assistance with suicide in the case of psychiatric patients (CAL 4, 1993). (See chapter 3.3, 3.4 and 3.5 on these reports.) A fifth problematic category was put on the public agenda in the same period by a former member of the Supreme Court, Drion. He argued for the right for persons over 75, under very limited circumstances, to be supplied with a 'pill' with which they could choose their own moment of death and thus avoid being exposed to a situation of physical or mental deterioration (see further chapter 3.5.2).

Except for including it in the reporting procedure, the Government had addressed no attention to the problem of patients not capable of expressing their will, put on the political agenda by the State Commission and the *Stintssen* case, and dealt with in the early 1990's in the CAL reports. In 1994, however, the Minister of Justice decided, against the advice of the Committee of Procurators-General, to prosecute two doctors for having actively terminated the lives of severely defective newborn babies.

¹²⁷ See chapter 3.5.1, notes 179 and 192, on the difficulty of interpreting the expressions "complete freedom" and "realistic alternative".

THE *PRINS* AND *KADIJK* CASES: TERMINATION OF LIFE WITHOUT AN EXPLICIT REQUEST IN THE CASE OF SEVERELY DEFECTIVE NEWBORN BABIES

On 26 April 1995 the gynecologist Prins stood trial in Alkmaar for murder, for having on 22 March 1993 terminated the life of a three-day-old severely defective baby. The medical team responsible for the baby, in consultation with her parents, had earlier decided to cease further medical treatment and in particular not to operate on her *spina bifida* because such surgery was considered medically futile. This decision made the baby's death inevitable, but it was not certain how long her dying would take. The baby was suffering unbearable pain which could not effectively be treated. The doctors and the parents decided to give the baby a lethal injection. Prins properly reported his act to the local coroner.

Prins acknowledged at his trial that he had put an end to the baby's life but he argued that this could not be called 'murder'. Further, he invoked the defence of absence of substantial violation of the law. In case these defences should fail, he invoked the defence of necessity. The District Court rejected the first and the second defences but held that active termination of life without an explicit request by the person concerned can be justifiable if certain requirements are met. Prins' defence of necessity was accepted because

- a. the baby's suffering had been unbearable and hopeless, and there had not been another medically responsible way to alleviate it;
- b. both the decision-making leading to the termination of life and the way in which it was carried out had satisfied the 'requirements of careful practice';
- c. the doctor's behavior had been consistent with scientifically sound medical judgment and the norms of medical ethics;
- d. termination of life had taken place at the express and repeated request of the parents as legal representatives of the newborn baby.¹²⁸

Prins was acquitted. On appeal, the Court of Appeals, Amsterdam, agreed with the holdings of the District Court.¹²⁹

On 26 April 1994 the GP Kadijk ended the life of a baby who had lived for 24 days. The baby suffered from an incurable congenital disorder that was bound to prove fatal, and her parents had decided, in consultation with her doctors, to care for her at home until she died. It was decided to omit all further medical treatment except for relief of suffering. When the baby's suffering grew worse and it became apparent she would probably

¹²⁸ *Nederlandse jurisprudentie* 1995, no. 602: 2878.

¹²⁹ *Nederlandse jurisprudentie* 1996, no. 113. The Court of Appeals did not discuss requirement (d).

die in an unacceptable way, Kadijk decided together with the parents to give the girl a lethal injection. Kadijk reported the death of the child as 'not natural' to the coroner.

Kadijk stood trial for murder in Groningen on 13 November 1995. The District Court rejected the request of the prosecutor to dismiss the case on the ground that the reporting procedure is in violation of the privilege against self-incrimination. It also rejected the defendant's request to dismiss the case on the ground of abuse of the power to prosecute to secure legal development rather than to secure a conviction. After having also rejected other defences (Kadijk claimed that the behavior was not 'murder', and he invoked the defence of the 'medical exception'), the Court accepted the defence of justification due to necessity.¹³⁰ The District Court's decision was affirmed on appeal (see appendix 11-3 for the judgment of the Court of Appeals).

A SECOND NATIONAL STUDY OF MBSL

In 1994 a new Government (PvdA, VVD and D66) had been formed in which, for the first time in modern Dutch political history, none of the confessional parties was represented. It came as a great disappointment to many when the Government announced that it did not intend

to introduce legislation to delete euthanasia from the Criminal Code. The way in which the Law on the Disposal of Corpses is working will be carefully assessed, with special attention to the reporting procedure; the relationship between the reporting procedure in the case of termination of life on request and of termination of life without a request, and prosecution policy, will also be examined. This evaluation will be completed within two years.¹³¹

In light of the Government's position, the NVVE decided it was necessary to keep up the pressure for legislative reform. In April 1996 it published a new proposed bill on euthanasia (see appendix I-C-3 for the text of the NVVE bill). The gist of the proposed revisions of articles 293 and 294 of the Criminal Code is that euthanasia and assistance with suicide by a doctor are not illegal when performed in accordance with the 'requirements of careful practice', which are to be included in the Criminal Code. The NVVE bill would also add a new article which makes it legal to supply a person who is not currently suffering, but who does not want to undergo physical or mental deterioration, the means for a 'gentle death': The NVVE seeks hereby to legalize the so-called 'Drion pill'.

¹³⁰ *Medisch Contact* 51: 199-203 (1996).

¹³¹ *Second Chamber of Parliament* 1993-1994, 23 715 no. 11 (coalition agreement): 32.

The results of the research promised by the Government in 1994 became available at the end of 1996. As we will see in chapter 5.3, the results generally confirm the picture presented by the research for the R Emmelink Commission in 1991, and the political message - that with regard to medical practice in connection with euthanasia and assistance with suicide there is not much reason for great public concern - was essentially the same. However, the new research directly addresses the question of the effectiveness of the reporting procedure, and here the burden of the findings, as we will see in chapters 5 and 6, is more problematic: the rate of reporting, while improved, is still rather low, and it seems that the more dubious cases (and in particular cases of termination of life without an explicit request) are hardly being reported at all. The problem of effective enforcement of the legal rules concerning euthanasia thereby became a central concern in the public debate. The Medical Association and the NVVE argued that legal insecurity resulting from the failure to adopt legislation legalizing euthanasia is the cause of the problem. The Government, on the other hand, argued that the problem lies in the distaste of doctors for having their behavior assessed by lawyers, and proposed that cases reported by doctors should be examined, in the first instance, by regional assessment committees composed largely of doctors. All these proposals are discussed extensively in chapter 6.

TO SUM UP

In the period 1986-1997 a variety of efforts were made to codify the results reached in the courts in an earlier period. All of these stranded, not always for want of majority support in Parliament but as a result of the exigencies of forming coalition governments. In the end, the only legislation that could be passed did nothing more than place the already functioning reporting procedure on a firmer legal footing. When for the first time a Government was formed in 1994 that consisted exclusively of parties that had earlier supported legislative legalization, this Government nevertheless turned out to have little enthusiasm for burning its fingers on the issue and proposed to postpone legislation until after new national research, including an evaluation of the reporting procedure.

In the same period, and as a direct consequence of the legislative stalemate, two major national studies were made of euthanasia and other medical behavior that shortens life. The results will be extensively discussed in chapter 5. Stimulated in part by the findings of this research, the public debate - having in an earlier period been narrowed down to euthanasia and assistance with suicide - was widened again to include other sorts of medical behavior that shortens life. First in reports of several medical professional bodies and shortly thereafter in the case law, the problems of assistance with suicide in the case of psychiatric patients and of shortening of life of severely defective newborn babies and of long-term coma patients began to receive serious attention. Toward the end of this period, in particular after the results of the second national survey became available,

the public discussion focussed increasingly on the problem of effective regulation, a matter that receives extensive attention in chapter 6.¹³²

2.5 Concluding remarks on the process of legal change

At the end of the 1960s euthanasia and assistance with suicide, which never before had received much public attention in the Netherlands, had become subjects of public debate. In section 2.1 we concluded that two kinds of change played an important role in bringing this about: a cultural change and changes in medical technology. These two changes alone, however, cannot account for more recent developments in the Netherlands regarding the legality of medical behavior that shortens life.

The lack of ideological confrontation between opponents and advocates of legalization of euthanasia is remarkable and is reflected in the fact that in this chapter almost no attention has been paid to the opponents. Partly this is because only a few opponents wielded the pen, and those few were mostly ignored. But more important is the political atmosphere in the Netherlands. Even though the period of 'pillarization' has come to an end, the solution generally sought for dealing with political disagreement over a matter of fundamental principle remains one of avoidance of frontal conflict whenever possible. Avoidance is accomplished by postponement of decision-making or by 'depoliticizing' the issue involved as much as possible (see the *Prologue*). Political decisions can often be postponed by appointing advisory commissions, and as we have seen, much use has been made of this technique by successive Dutch Governments.

'Depoliticizing', the art of representing political questions which risk polarization as if they can be solved in an objective, politically neutral way, is reflected in the early separation of euthanasia and assistance with suicide from the whole complex of medical behavior that shortens life. The effect of this separation was that political and legal decisions could be taken in stages. First the less controversial sorts of MBSL were recognized as 'normal medical practice'. Then MBSL that could be justified in terms of the principle of autonomy were liberalized. And finally the limits of shortening life without an explicit request were explored. We are not suggesting that 'depoliticization' is a conscious strategy. It is rather that the characteristic way the Dutch political system operates avoids

132 A recent institutional development should be mentioned here. In 1993 the KNMG had made a number of proposals for experimental projects intended to increase the willingness of doctors to report cases of euthanasia. One of these proposals was for a 'support center' in Amsterdam to which doctors can turn for information and advice in advance from a specially trained doctor, who is also available for formal consultation. This center recently began operation. See Dillmann et al. 1997.

frontal confrontations wherever possible and requires politicians to try to find some common ground that is widely shared on which to base important political decisions. Frequently that common ground can be found in a small part of some larger problem.

'Depoliticising' has not only been a feature of public, political debate: professional groups have also avoided ideological discussions. They have focussed their attention on procedures and rules of careful practice. The Medical Association, which has played an important role in the process of change, has been very cautious. For a long time the Association took no position on euthanasia. Even in 1984, when it stated that euthanasia was part of the doctor-patient relationship, it avoided the question whether it was permissible. As a result of this careful policy, euthanasia and assistance with suicide were made subjects of open discussion within the profession. The Association's recognition in 1984 that the profession was responsible for euthanasia and assistance with suicide opened the way for a measure of decriminalization. This recognition was also very important for the public debate because it was made by a professional group in which the Dutch in general have great confidence.

One consequence of the tendency toward conflict avoidance has been that the process of change has gone rather slowly. Successive Governments never put much pressure for quick results on the Health Council or other advisory commissions. The motion requesting a state commission, for example, was adopted in 1978. The Government decided first to ask the Health Council to give advice on the assignment to be given this commission. This advice took three years, and then the work of the State Commission took another three years. However frustrating it has been for some participants in the public debate, this slowing down has not been without its benefits. The State Commission still had not finished its work when the Supreme Court ruled on the *Schoonheim* case. In this way the State Commission's advice and the judgment of the Supreme Court were mutually reinforcing. In the meantime the public, the medical and legal professions and the political elite were given time to adjust to changes which, at least partly as a result of the passage of time, had in the meantime acquired wide support throughout Dutch society.

The legal vacuum created by the deliberate pace of political decision-making has been filled by the courts, which have accepted the task of reconciling the conflict between the explicit prohibition of euthanasia and assistance with suicide in the Criminal Code and the increasingly apparent fact that these MBSL are widely practiced and enjoy general public support. In a sense, the courts have thereby usurped the constitutional role of the legislature, but the latter has not protested. On the contrary, the Government itself (which in a parliamentary system is directly answerable to the legislature) has frequently and openly made use of the courts to secure legal development. And Parliament itself has exhibited only respect for what the courts have done.

Looking back on the process of legal development, it is remarkable to see that already in the *Postma* and *Wertheim* cases the conditions under which euthanasia is legitimate and the essential contents of the 'requirements of careful practice' were already in place. Limitations that were later proposed and then abandoned, such as the 'terminal phase' and the assumption that non-somatic suffering cannot justify euthanasia or assistance with suicide, had already been rejected in those first decisions.

Exploiting the possibilities of the casuistic approach made available by the justification of necessity, Dutch courts and prosecutors have been able to emphasize the uniqueness of each individual case, thereby leaving a maximum of legal room within which doctors can make decisions in situations where shortening of life is at issue and be open about what they are doing. Both the courts and the prosecutorial authorities have from the beginning made it clear that they are inclined both to follow the medical profession itself in fashioning rules concerning justifiable euthanasia and to leave a great deal of latitude in individual cases to professional judgment.

In addition to professional groups, advisory bodies and the Association for Voluntary Euthanasia (which, because of its very moderate approach, has often been able to exercise considerable influence behind the scenes), there are also some individuals whose role has been important. It is thanks to individual doctors that the practice of shortening of life came out of the closet and subjected itself to public scrutiny, debate and, ultimately, control. Doctors came forward of their own accord, made the facts of their life-shortening behavior public, and subjected their behavior to the hazards of criminal prosecution. Without their idealism and courage it seems unlikely that Dutch legal development in this area would have progressed as quickly and effectively as it has.

3 The Current Legal Situation

In chapter 2 we have described the process of public debate and legal change that has led, over a period of almost 30 years, to the current state of affairs in Dutch law concerning euthanasia and related forms of medical behavior that shortens life. The purpose of the present chapter is to describe in a detailed and accurate but non-technical way what that law is.'

The chapter consists of two parts. The first two sections deal with matters on which legal development has fairly run its course and the applicable legal rules can be stated with some certainty. After dealing in section 3.1 with the substantive legal rules concerning various sorts of medical behavior that shortens life, we will describe in section 3.2 the existing system of legal control over this sort of medical behavior - the so-called 'reporting procedure' - together with the problems that the technical legal basis of that regime implies with respect to the scope and the effectiveness of control.

The second part of the chapter (sections 3.3, 3.4, and 3.5) deals with unsettled questions, with the law in motion. Here, there are many points on which it is not easy to formulate current law in terms of settled rules, although the general contours of emerging law are on the whole quite clear. The treatment is therefore different: more discursive and more dependent on what appear to be the fundamental values and concerns underlying the course of legal development. On many questions we can predict with some confidence what the law 'is' (is becoming), but to do so we must often rely on a certain amount of legal hunch. An example of this is our prediction that the law governing medical behavior that shortens life in the case of coma patients (in the absence of an advance directive or other indication of the patient's wishes) will generally follow the development that has already taken place in the case of severely defective newborn babies, relying heavily on the 'priority principle' according to which 'active' termination of life can usually only be justified after - and as an extension of - a decision to let the patient die by abstaining from further treatment.

Needless to say, at a number of places such a division between the law that is settled and the law that is coming breaks down, either because there is an unsettled issue in a context

For general introductions in English to Dutch (criminal) law, see Blankenburg & Bruinsma 1994; Chorus et al. 1993. For a translation of the Dutch Criminal Code see Rayar & Wadsworth 1997.

of legal rules that have otherwise become well settled, or because there is a fixed point in a context that is otherwise in a state of rapid development. Whether and under what circumstances a legal preference for assistance with suicide as against killing on request will emerge is an issue of the first sort; making a prediction depends on how one interprets things happening at the cutting edge of legal development. The requirement of consultation is an example of the latter sort of issue: under what circumstances 'active' termination of life without an explicit request will ultimately be regarded as legal is not yet entirely clear, but it is quite clear that consultation of a second, independent doctor who himself examines the patient will in any case be required.'

A note to the reader. To a non-lawyer, especially the first part of this chapter (section 3.1) may seem about as dense as a tax code. That is because the subject is complicated and the Dutch have been engaged for a number of years in a kind of national project to regulate it carefully and in all of its aspects. The detail is important in itself - there is after all nothing trivial about the subjects dealt with. But it is in particular important as part of the overall argument of this book: the evidence assembled in this chapter shows as no generalization possibly could, how earnestly the Dutch have taken the task of regulating medical behavior that shortens life. If nothing else it puts the lie to the suggestion sometimes heard to the effect that the Dutch have substituted a sort of 'sloppy tolerance' and a naive faith in doctors for serious legal control (often thought by such critics to reside *par excellence* in criminal codes). We would like to ask you to bear with us, to do your best, and to feel entitled to skip a footnote once in a while.

- 2 A. Iosephus Iitta observes (letter of 26 May 1997) in this connection that, based on his prosecutorial experience with some 500 cases in the period 1988-1994, the medical situation of the patient is almost never a matter of doubt and therefore not of discussion between the consulting and the consulted doctor, and furthermore is usually well documented. Consultation therefore concerns primarily the voluntariness and well-consideredness of the request. To the extent that this is the case (compare chapter 5.2 and 5.3.1), consultation might seem *less* indicated in cases where there is no request. However, in our view the principal function of consultation is not the 'second opinion' but rather control: another (expert) person knows what the situation was before the patient died. From that point of view, consultation is *more* essential in the case of termination of life without an explicit request.

3.1 A summary of current law concerning medical behavior that shortens life

3.1.1 *'Normal medical practice; the 'medical exception' and a 'natural death'*

In principle, intentionally causing injury or death is an offence under one or more of a number of provisions of every criminal code. Nevertheless, in everyday medical practice behavior regularly occurs that is more or less certainly known and expected - and in that legal sense, 'intended' - to have such a result: the dentist who causes pain by drilling in one's teeth, the surgeon who amputates a leg, the oncologist who gives one chemotherapy. While such behavior violates the literal terms of the criminal law, it also falls within the scope of the legal authority to practice medicine. As such it constitutes 'normal medical practice' and is taken to be covered by an implicit 'medical exception' to the criminal offences that protect life and bodily integrity. The death of a patient due to such 'normal medical practice' - for example, during open-heart surgery or as a result of intensive use of pain-killing drugs - is considered a 'natural death' and can be reported as such to the coroner by the responsible doctor (which means in practice that no further official investigation of the death will be undertaken). These three legal terms - medical exception, normal medical practice, and natural death - are the foundation stones of the Dutch system of legal control over medical behavior that shortens life.

The concepts themselves will be discussed extensively in the course of this book, especially in chapter 6 in connection with the effectiveness of legal regulation of medical behavior that shortens life. But it is important to be aware that - while remaining largely implicit - they afford the underlying structure of the legal analysis presented in this chapter. The essence of that structure is as follows. The 'medical exception' applies to that behavior of doctors that constitutes 'normal medical practice', that is to say, behavior that doctors are generally authorized to perform based on medical indications and according to professional (technical and ethical) norms. However, there are other sorts of behavior that doctors are also legally authorized to perform, behavior based not on 'medical' indications nor regulated by professional norms but defined and regulated directly by the law. In the past, abortion was believed to be an example of both sorts of medical behavior. Medically-indicated abortion fell within the category of 'normal medical practice' and thus within the 'medical exception'. As the demand for abortion for non-medical reasons grew, legal standards applicable to such abortions had to be sought outside the

- 3 Indirectly, of course, all professional norms - at least, all those that derive from the legal authority to practice medicine - are 'legal', but much of their formulation and enforcement is in practice delegated to some extent to the profession itself (although Dutch medical disciplinary law, for example, is predominantly 'legal' both substantively and procedurally). It is incorrect to describe professional control as 'turning the matter over to doctors',

scope of 'normal medical practice'. The abortion reform law of 1984 permits doctors to perform such abortions under specified (non-medical) conditions. Similarly, euthanasia (and termination of life without an explicit request) falls at present outside the category of 'normal medical practice' (and the 'medical exception') and therefore, to the extent it is legal at all, the standards applicable to its performance are legal and not medical standards."

3.1.2 *The concept 'medical behavior that shortens life' (MBSL)*

With the benefit of hindsight it is clear that one of the most important contributions of the report of the State Commission on Euthanasia (1985) was to clarify the definition of 'euthanasia' (see chapter 2.3.2). In the Dutch public and legal discussion 'euthanasia' now refers exclusively to *behavior that terminates the life of another at the request of the person concerned*.

A solution to the resulting problem of defining the larger category of behavior, within which euthanasia is a distinct sort, has been worked out over the last few years in a sort of dialogue between Van der Maas and his colleagues, appointed by the Government to carry out the first national survey in 1990,⁵ and the Commission on the Acceptability of Termination of Life of the Medical Association (CAL - see section 3.3 of this chapter on the CAL reports). In its first report the CAL had defined the general category of 'behavior that terminates life' in terms of the *purpose of the interventions* Van der Maas and colleagues found a definition in terms of behavior whose purpose is the death of the patient too narrow. They proposed, instead, the term 'medical decision concerning the end of life' (MDEL), defined as including "all decisions of doctors where the purpose is to hasten the death of the patient or where the doctor takes account of the likelihood that the death of the patient will be hastened".⁷

4 See Leenen 1994: 135ff, 278-279; 1996: 35ff, 99ff, for this analysis of the concept of 'normal medical practice' and application of the analysis to abortion and euthanasia. Enschede's argument - successful in the case of abortion (see chapter 2.1) - took a different position: he argued that 'social indications' could, under modern conditions, be taken to fall within the scope of the concept of a 'medical indication'.

5 Van der Maas et al. 1991.

6 CAL: 4.

7 Van der Maas et al. 1991: 13-14. A number of objections can be made to the term MDEL: what needs to be defined is not *decisions* but *behavior*; the relevant decisions are only partly 'medical' (e.g. when the patient refuses further treatment); the behavior does not 'concern' the end of life, it brings it about; the behavior does not necessarily take place in the context of the 'end of life' - the patient need not necessarily have been 'dying':

Starting with its second report, the CAL has emphasized not the doctor's purpose but his *responsibility for the results of the intervention*: 'behavior that terminates life' was defined in the second report as "behavior of doctors that causes the death of the patient"⁸ In the third report, 'behavior that shortens life' takes the place of 'behavior that terminates life' (the latter being restricted to the situation in which a euthanaticum is used). Death is not necessarily the reason the doctor does what he does, but having "foreseen and accepted" that result, the doctor is responsible for bringing it about.⁹ Since most of the patients involved are near to death anyway, the improved definition of the whole family of behavior of which euthanasia is a part emphasizes precisely what it is that the doctor is responsible for: not so much the fact of death as the moment at which it occurs, not so much his purpose as what he has reason to expect.

The concept of 'medical behavior that shortens life' (MBSL) that emerges from the process of conceptual development just sketched covers the following legal categories. (Quantitative data on the various sorts of MBSL is to be found in chapter 5.)

THE PATIENT REFUSES (FURTHER) LIFE-PROLONGING TREATMENT

A competent patient¹⁰ has the legal right, for whatever reason, to refuse (further) treatment, even if the treatment is (in the opinion of the doctor) indicated and necessary to continued life. It is not relevant that the patient exercises this right in order to shorten his life; nor is it relevant that the doctor (or anyone else) agree with the patient's decision.

In the not very distant past Dutch doctors tended to be rather authoritarian and the law accepted this, but as in other countries where the idea of 'informed consent' has acquired general acceptance, the patient's essentially unqualified right to self-determination in this regard is no longer subject to doubt. It may be a right whose exercise is not always made easy for the patient, but as a matter of legal principle the doctor who imposes treatment on a patient without his consent is without question guilty of a number of medical disciplinary, civil and even criminal offences.

Because of the limited conditions under which euthanasia is legal and a variety of other difficulties that may stand in the way of a person who wishes to die, it has recently been noted by several observers in the Netherlands and elsewhere that cancer patients and

8 CAL2: 3.

9 CAL3:9.

10 CAL 3 and 4 consider the problem of refusal of treatment by only partly competent persons (in the case of senile dementia and psychiatric patients) - see sections 3.4 and 3.5.1 below. Blijham & Van Delden (1996) argue for a presumption of competence in connection with the role of the patient in decision-making with respect to reanimation. See also note 174 (p. 145).

elderly people suffering from dementia can and do 'let themselves die' (*versterven*) by starvation and dehydration (abstaining from food and/or drink). Especially when done in cooperation with a sympathetic doctor and with appropriate symptomatic relief, the method is alleged to be a not unpleasant one, at least for the elderly. It is probably in fact a way that many people in the past have died."

It is when it is not the patient himself but someone else who seeks to exercise the right to refuse treatment on his behalf that legal difficulties arise. The fact that a person is not at the relevant moment himself capable of exercising the right to refuse treatment does not necessarily entail a forfeiture of its benefit. For one thing, he may have done so in the past by means of an 'advance directive'. Recent legislation in which the autonomy of the patient with respect to medical treatment is guaranteed provides explicitly that a written 'advance directive' binds the doctor, although it is not entirely clear what the exact scope and limitations are of this binding force.¹² The same legislation provides that appointed representatives and close relatives of the patient can exercise the right on his behalf.¹³ presumably they must thereby take account of the known wishes and general outlook of the person concerned. There is still much room for legal clarification and refinement of basic principles that are now generally accepted. Some of the issues are discussed further at various places in this chapter.

The doctor who, at the request of the patient (or his surrogate), abstains from treatment that is necessary for the preservation of life is not regarded as having killed the patient, in the sense of the homicide offences mentioned above. The patient's death is considered

11 On 'letting oneself die' see Chabot 1996; see also section below. For an indication of the magnitude of the phenomenon, see chapter 5.3.1 note 49. See also notes 10 and 16.

12 *Wet op de geneeskundige behandelingsovereenkomst* [Law on Contracts for Medical Treatment], which became effective on 1 April 1995 as artt. 7:446 ff. of the Civil Code. Art. 450 section 3 provides that if a patient 16 or older, who "cannot be considered capable of coming to a reasonable assessment of his interests" has made a written declaration to the effect that he refuses treatment under certain circumstances at a time when he was competent to do so, both the doctor and a representative of the patient are bound to follow his instructions. The doctor may only override the patient's refusal if he considers that there are 'well-founded reasons' for doing so (that is, substantial reason to suppose that the patient himself would have wanted the treatment in question). See generally on this law: Sluyters & Biesart 1995.

13 Art. 465 of the law referred to in the previous footnote accords such representatives a substantial status in the decision-making with regard to treatment. As in the United States, there have been a number of cases concerning the right of the family of coma-patients and of severely defective babies to refuse treatment on behalf of the person concerned. For discussion of these cases see Leenen 1994: 314-322. See section 3.3.1 on 'surrogates'.

due to a 'natural' cause, which means that, by contrast with euthanasia, no special legal controls obtain.¹⁴

'NORMAL MEDICAL PRACTICE'

Two other sorts of medical behavior that shorten life are likewise essentially non-controversial. They are deemed to fall within the scope of the 'normal medical practice' that a doctor is authorized to perform. The death of the patient is considered 'natural', with the consequences for control just mentioned. Outside the medical profession itself there has not been much debate on these sorts of MBSL and the complex issues of control that they involve. As we will argue in chapter 6.3.3, it seems important that the 'requirements of careful practice' that have been worked out over the last decade for euthanasia also come to apply, *mutatis mutandis*, to these less controversial sorts of MBSL.

Use of drugs to alleviate pain or other symptoms even though the dose used will more or less certainly hasten the moment of death.

It is generally accepted that shortening the dying process in a way that leads to a 'death without suffering' (*zachte dood*) can be a legitimate subsidiary objective of the administration of pain relief.

- 2 Not initiating, or terminating, life-prolonging treatment when this is 'medically futile' [*medisch zinloos*], either in the sense that the treatment has no chance of success or that it would be (or has become) disproportionate to any benefit for the patient.

The only real controversy concerns the extent to which the doctor's decision to abstain can be based on 'quality-of-life' considerations (see further section 3.3.1).

What constitutes 'medical treatment' in this connection has in recent years been the subject of considerable discussion. It is now clear that artificial administration of food and drink is 'medical care' that can be terminated."

14 Civil and general medical disciplinary law does, of course, apply. Thus doctors are subject to general requirements of informed consent, record-keeping and the like. See Sluyters & Biesart 1995: 33ff, 62ff.

15 See the *Stinissen* case (chapter 2.4); Leenen (1994: 315-317) distinguishes between the case in which giving a patient food and drink are part of normal nursing care (the withholding of which would be the offence defined in article 255 of the Criminal Code) and the case, as in *Stinissen*, in which the artificial aspect of administration of food and drink is predominant.

A doctor is not required to accede to a patient's (or his representative's) insistence on treatment the doctor considers futile. On general principles it would seem that he must at least inform the patient or, in the case of a non-competent patient, the family or others responsible for the patient, of the fact that he proposes to abstain from treatment he considers futile, if only so that they can seek a second professional opinion."

Unless based on the patient's request, 'Do Not Resuscitate' instructions and other advance decisions not to administer life-prolonging treatment under specified conditions also fall in this category. It has recently been argued in connection with a hospital protocol for such decisions that the greater the role that proportionality or 'quality-of-life' considerations play, the greater the role of the patient (or his representative) in the decision-making should be."

TERMINATION OF LIFE

The final category of MBSL is termination of life, which encompasses what used to be called 'active, direct euthanasia' (see chapter 2.2, 2.3.2). 'Termination of life' could be operationalized as the use of euthanatica" were it not for the residual possibility of non-pharmacological methods of terminating life (such as the 'plastic bag method') and the continuing if declining use of morphine."

Termination of life is either voluntary or non-voluntary, depending on whether or not it is done at the explicit request of the person concerned. As we will see in section 3.3.1 and chapter 5.3.2, in many cases of non-voluntary termination of life there is reason to sup-

16 See Leenen 1994: 312-313. In 1994 the family of an Alzheimer patient complained to the prosecutorial authorities that a doctor had ceased artificial administration of food and drink without consulting them, allegedly in violation of article 255 of the Criminal Code (failure to care for a person for whose care one is responsible); the treatment was recommenced (see Leenen 1994: 317, n. 155). A recent case involving an Alzheimer patient who almost died in a nursing home as a result of application of the home's policy of abstaining from further artificial hydration under certain circumstances, but who recuperated when his family had him transferred to a hospital, has called national attention to the frequency of such practice and to the importance of good communication with the family. The man's daughter complained to the prosecutorial authorities who, after consulting the Medical Inspector, decided not to prosecute. See NVVE 1997 for a collection of newspaper reports concerning this case and, more generally, the phenomenon of 'letting oneself die' [*versterven*] (see also note 11 above).

17 Blijham & Van Delden 1996.

18 Compare CAL3:9 for such an operationalization.

19 The view that the use of morphine for termination of life is unprofessional is based in part on the resulting confusion as to what the doctor 'really' did: termination of life or pain relief.

pose that the person concerned would have wanted it if he had been able to express a will at the critical time; in the remaining cases, nothing is known about the will of the patient and termination of life is based on what are taken to be his interests. Although the expression 'involuntary euthanasia' (meaning: involuntary termination of life) is sometimes tendentiously used by critics of Dutch law to describe situations in which the termination is non-voluntary, there is in fact no room in Dutch law for termination of life *contrary to* the will, express or presumed, of the person concerned. Such behavior by a doctor would be simple murder and is no more tolerated in the Netherlands than anywhere else. There seems no reason to suppose it in fact occurs more frequently in Dutch practice than elsewhere. It does not fall within the category MBSL.

Voluntary termination of life is either euthanasia or assistance with suicide. It is a crime under articles 293 and 294 of the Criminal Code. The circumstances under which it may nevertheless be legally justifiable are discussed in the following section. Non-voluntary termination of life is known in the Dutch discussion as 'termination of life without an explicit request'. It amounts to murder or manslaughter (articles 289 and 287 of the Criminal Code). The circumstances under which it may nevertheless be legally justifiable are discussed in sections 3.3 and 3.4.

Figure 3.1 summarizes the various categories of MBSL:

Figure 3.1 The different sorts of MBSL

sort of MBSL		legal category	basis of legitimacy	legal status
refusal of treatment		refusal of treatment	autonomy of patient	criminal and civil prohibitions on invasion of bodily integrity
'normal medical practice'		abstinence	futility; interest of patient; (presumed) <u>will of patient</u>	authority to practice medicine
		pain relief	interest of patient; (presumed) will of patient	
'termination of life'	voluntary	euthanasia	autonomy of patient	justification of necessity
		assistance with suicide	autonomy of patient	
	non-voluntary	termination of life without an explicit request	interest of patient; (presumed) will of patient	

3.1.3 'Euthanasia'

Article 293 of the Dutch Criminal Code (see appendix I-I) provides that a "person who takes the life of another person at that other person's express and earnest request" is guilty of a serious offence. This is what is considered 'euthanasia' in the Netherlands. 'Euthanasia' is thus on its face illegal but, as we have already seen in chapter 2, it can under specific conditions be legally justifiable. Killing a person *without* his 'express and earnest request' (non-voluntary termination of life) may or may not be justifiable, but it is not 'euthanasia'. It is known in the Dutch discussion as 'termination of life without an explicit request'. Prosecutions in such cases (a number of which will be considered later on in this chapter) are generally for murder or manslaughter.

By contrast with euthanasia, assistance with suicide would not be an offence at all but for article 294, since suicide itself is not an offence. Nevertheless, despite their distinct treatment in the Criminal Code—" and the fact that they carry rather different penalties, Dutch law, as we have seen in chapter 2, generally makes no distinction between the two as far as the justification available to a doctor is concerned. As elsewhere in this book, we will in this chapter often use the term 'euthanasia' for both except where the difference is relevant. Section 3.1.4 considers the question whether distinct legal treatment would be desirable.

As we have seen in chapter 2, the older Dutch literature made a distinction between 'passive' and 'active', and between 'direct' and 'indirect' euthanasia. The State Commission, however, successfully insisted on the distinction between euthanasia proper and what it called 'false forms of euthanasia'. Abstaining from treatment that the patient does not want or that is medical futile (passive euthanasia) and death due to pain relief ('indirect euthanasia') are no longer considered 'euthanasia' at all.

The well-known Dutch criminal law scholar and former Supreme Court judge Enschede argued some years ago that euthanasia, like other *prima facie* violations of the criminal offences protecting life and bodily integrity, is subject to an implied 'medical exception;' But as we have seen in chapter 2.3.1, this argument was rejected by the Dutch Supreme Court in 1986.²²

- 20 Their legislative histories are in fact quite different (see Smidt 1891), and neither of them was enacted with an eye to medical practice, which was for Enschede an important argument in favor of recognizing a 'medical exception' (see chapter 2.1, 2.3.1).
- 21 See chapter 2.1 (abortion), 2.3.1 (euthanasia). See Leenen 1994: 278-279 for criticism of this position.
- 22 *Nederlandse Jurisprudentie* 1987, no. 607. Compare the decision of the Court of Appeals in the *Kadijk* case (appendix 11-3), similarly rejecting the 'medical exception' in the case of termination of life without a request.

The Dutch courts had, apart from the 'medical exception', only a limited number of doctrinal tools available to them by means of which some opening for legal euthanasia could be created. One was the idea of 'absence of substantial violation of the law' [*ontbreken van de materiele wederrechtelijkheid*], of which the essence is that the legislator, in defining the offence, had another sort of situation in mind. Although the Supreme Court once accepted such a defence (in 1933²³), the Dutch courts have been loath to honor it, its invocation by a defendant generally being regarded as an invitation to judicial legislation. Although euthanasia defendants have regularly raised the defence, arguing that in the circumstances of euthanasia or assistance with suicide by a doctor the essential purpose of the criminal prohibition is not violated, the courts have resolutely rejected the appeal."

Another doctrinal tool that defendants have invoked is the excuse of duress: the patient's appeal to the doctor, it being argued, having overwhelmed the latter's ability to conform to the law. The courts have made short shrift of this defence, dryly observing that it is precisely the task of the doctor to be able to resist this sort of pressure from patients.

The doctrinal tool finally accepted by the courts is that of justification due to necessity, as provided for in article 40 of the Criminal Code." Article 40 provides that an actor is not guilty of an offence if it was "the result of a force he could not be expected to resist [*overmacht*]". Since 1923 this provision has been interpreted to include the defence that the act took place in a situation of necessity in which the actor made a justifiable choice between two conflicting duties. (The text of article 40 can be found in appendix I-A.) The doctor confronted by the request of a patient who is unbearably and hopelessly suffering can, the courts have held, be regarded as caught in a situation of conflict of duties. On the one hand, there is the duty to respect life, as formulated in articles 293 and 294. On the other hand, there is a duty that has been variously formulated as one to reduce suffering or to respect the 'personality' (autonomy) of the patient." If, in this situation of conflict of duties, the doctor chooses a course of action that, considering the norms of medical ethics, is 'objectively' justifiable, the Supreme Court held in 1984 in the *Schoonheim* case (see appendix II-1) that he is not guilty of an offence.

The requirements of a substantive and of a procedural or professional character that must be met by a doctor who carries out euthanasia or gives assistance with suicide have become fairly clear. Some of these have been formulated by the courts in the context of

23 *Nederlandselurisprudentie* 1933, no. 918.

24 See e.g. the opinion of the Supreme Court in the *Schoonheim* case (appendix B-1).

25 Confusingly, both the justification of necessity (conflict of duties) and the excuse of duress are based on article 40, which on its face seems only to deal with duress in the sense of an excuse.

26 See appendix II-2, note 29.

criminal prosecutions," others in a variety of other legal sources, in particular proposed legislation, existing legal rules, and the reports and position-papers of various organs of the medical profession." Since our interest here is in the whole of the law (including the law that is in the process of emerging), the minor differences between the various sources are not essential. The following requirements are now generally accepted:

SUBSTANTIVE REQUIREMENTS

The essential substantive conditions of legal euthanasia concern the patient's request, the patient's suffering, and the doctor-patient relationship.

The patient's request must, in the terms of article 293, be 'express and earnest'. Absent such a request, the behavior concerned is not euthanasia but murder. The request requirement is operationalized as follows:

the request must be explicitly made by the person concerned;"
 the request must be voluntary (not the result of undue external influence):"

- 27 See Leenen (1994: 291-294) for treatment of the requirements specifically rooted in this case law.
- 28 The most important current sources for the law with regard to euthanasia are the decisions of the Supreme Court in the *Schoonheim* and *Chabot* cases (appendix 11-1 and 11-2), the 'Points requiring attention' included on the form to be used in reporting euthanasia (see appendix 1-E), and the most recent version of the official guidelines of the Medical Association (KNMG 1995, which includes the 'Points requiring attention' in an appendix).
- 29 This requirement is to be found in all formulations of the law concerning euthanasia since the report of the State Commission in 1985 (see chapter 2.3.2). For an example of its application in practice, see the decision of the District Court, Haarlem, in which the Court rejects the defence that not murder (as charged) but euthanasia was involved, emphasizing the difference between a patient's expression of a desire for the end of life and an explicit request to the doctor to terminate life. *Tijdschrift voor Gezondheidsrecht* 1986, no. 34.
- 30 This requirement is included in all formulations of the requirements for euthanasia (cf. the decision of the Supreme Court in the *Chabot* case, appendix 11-2). See NVP 1997 (discussed in section 3.5.1 below) for consideration of voluntariness as a requirement distinct from that of well-consideredness; see also KNMG 1995.

it must be well-considered: informed, made after due deliberation and based on an enduring desire for the end of life (evidenced for instance by its having repeatedly been made over some period of time);"
the request should preferably be in writing or otherwise recorded."

The requirement of a voluntary and well-considered request is actually only a variant of the general requirement of informed consent required in the case of a competent patient for all medical treatment. If there is a difference in the case of euthanasia, it lies in the oft-heard suggestion that the initiative should come from the patient himself, whereas in the case of other MBSL the doctor can suggest and even recommend a given course of action."

- 2 The patient's suffering must be 'unbearable' [*ondraaglijk*] and 'hopeless' [*witziichtsloos*] (in the sense of 'without hope for improvement' L)." This requirement is further operationalized as follows:

the suffering need not be physical (pain etc.) nor is a somatic basis required;" non-physical suffering can include such things as the prospect of inhuman deterioration [*ontluistering*] and the possibility of not being able to die in a 'dignified' way;"

- 31 See, e.g., the 'Points requiring attention'; KNMG 1995. See CAL 3 and 4 and NVP 1997 (discussed in sections 3.4 and 3.5.1 below) for extensive consideration of the requirement of well-consideredness in the case of patients suffering from dementia or a psychiatric disorder. The problem of competence of patients suffering from a somatic disorder has received relatively little attention (but see NVP 1997, §§ 6.4 and 6.5).
- 32 See the 'Points requiring attention'; KNMG-afdeling Enschede 1987: 667 ('preferably recorded in writing or with a dictaphone'). See however NVP 1997 for the position that a written request may sometimes be undesirable.
- 33 From time to time, however, one also sees suggestions that a conscientious doctor may make a patient aware of the possibility of euthanasia (compare chapter 5.3.1 note 54). However this may be, considering the complexities of human communication and the fact that in most cases no one else will have been present, it seems doubtful that a strict rule requiring patient initiative would be enforceable.
- 34 On the whole, these are treated together as a single requirement, and the patient's subjective experience of his suffering is regarded as largely determinative (although it must be 'understandable'). In 1995 the Committee of Procurators-General proposed to 'objectify' the suffering requirement by separating the two components, but the Minister of Justice refused to allow this (see chapter 5.3.5).
- 35 See Leenen 1994: 293-294. The Medical Association earlier took the position that non-physical suffering must at least be based on a somatic condition (KNMG 1992). In light of the Supreme Court's decision in the *Chabot* case (appendix II-2), it seems clear that this is not required (see also KNMG 1995).
- 36 See e.g. the decision of the Supreme Court in the *Schoonheim* case, appendix II-1.

if the patient's suffering is based on a somatic condition, other possibilities? for treating the condition or relieving the suffering must have been exhausted or have been rejected by the patient (it is well-established that in such a case the patient's exercise of the right to refuse treatment does not preclude a request for euthanasia based on the resulting suffering");
 if the patient's suffering is not based on a somatic condition, there must be no realistic possibility of treatment.³⁹

It is not clear to what extent anticipation of a fate one does not want to undergo (e.g. confinement to a nursing home, or further mental deterioration) can by itself meet the requirement of unbearable suffering, nor whether euthanasia can be carried out on a demented patient who is not currently suffering from the dementia but who in an earlier advance directive requested it in such circumstances (see section 3.4).

- 37 See note 192 below for the possibility that these are not necessarily limited to *medical* possibilities.
- 38 Leenen 1994:292. In one case, for example, the defence of necessity was allowed (in a situation of somatic suffering) despite the patient's refusal of treatment with psychopharmaca (Supreme Court, 27 November 1984, *Nederlandse jurisprudentie* 1985, no. 106; Court of Appeals, The Hague, 10 June and 11 September 1986, *Nederlandse jurisprudentie* 1987, no. 608). This situation seems in fact to be fairly common in practice, patients refusing life-prolonging treatment (e.g. cytostatic treatment) and requesting euthanasia; some patients apparently refuse palliative treatment, on the ground that they do not want to endure the diminished awareness that accompanies it, and request euthanasia instead. See however note 193 for a limiting case in which refusal of treatment may stand in the way of euthanasia.
- 39 See section 3.5.1 and the decision of the Supreme Court in the *Chabot* case (appendix II-2) on the question of refusal of treatment in the case of non-somatically based suffering.

- 3 Only a doctor may legally perform euthanasia.⁴¹ In principle this should be a doctor who has an established treatment-relationship with the patient [*behandelendarts*].⁴¹ No individual doctor is under an obligation to perform euthanasia, but a doctor who is conscientiously opposed should refer the patient to another doctor.

It was until recently sometimes supposed that the patient must be in the 'terminal phase' of his illness, although the Medical Association has since 1984 rejected such a requirement as medically meaningless, and the courts rejected it from the very beginning (see the *Postma* case, discussed in chapter 2.2). The former Minister of Justice's more or less one-man insistence on this limitation led to a number of prosecutions in late 1993 which were at the time generally believed to have significantly reduced the willingness of doctors to report euthanasia as such. However this may be, it is clear since the decision in the *Chabotcase* (see chapter 2.4, 3.5.1 and appendix 11-2) that no such limitation applies." In fact, it is possible that the person requesting euthanasia may not necessarily have to be 'ill' at all (see section 3.5.2).

If for legal purposes, within the context of the defence of justification to a criminal charge, the requirement of a 'terminal phase' plays no role, it does not follow that it is irrelevant as a matter of legal policy. As we will see in chapter 6.3.2, one of the advantages

-
- 40 This restriction is included in all statements of euthanasia law - see, e.g., the legislative proposals of the State Commission on Euthanasia, Wessel-Tuinstra and the NVVE (appendix 1-C). The KNMG guidelines of 1992 (KNMG 1992 - incorporated by reference in KNMC 1995) provide that the euthanasia must be carried out by or (if it takes place over a longer period) under the direct responsibility and supervision of the responsible doctor. A number of cases hold the defence of justification not available to lay persons (see chapter 2.2; *Tijdschrift voor Gezondheidsrecht* 1986, no. 22; 1990 no. 5). It is also not available to nurses (*Tijdschrift voor Gezondheidsrecht* 1988, nos. 1, 65; *Nederlandse jurisprudentie* 1995, no. 477; 1996 no. 61).
- 41 This restriction is generally accepted although it is difficult to find specific authority for it (see e.g. Lccn 1994: 292). In 1994 there was a small political tempest in connection with several 'travelling euthanasia doctors', as they were disparagingly called, who made their services available through the Association for Voluntary Euthanasia to patients whose own doctors had failed to honor their requests. The Minister of Justice answered parliamentary questions about the practice by reporting the results of research both in prosecution files and by the Medical Inspectorate. It appeared that only a very small number of doctors were involved and that in some of these cases either criminal or medical disciplinary proceedings had been brought. The Minister expressed the view that in the case of a doctor other than the patient's own doctor, there is no doctor-patient relationship and it "would be difficult to invoke the defence of necessity". *Second Chamber of Parliament* 1994-1995, appendix, no. 301.
- 42 See also Leenen 1994: 293.

of a decriminalized approach to control over euthanasia is that it would permit a more fine-tuned approach to the considerations relevant to a doctor's behavior. In such a context, the extent to which the patient's life is shortened by euthanasia may well influence the extent, for example, to which he should insist on exploring treatment alternatives or should engage in more than the minimum consultation.

A final substantive requirement that is sometimes suggested but appears not yet to have been accorded any legal status is that euthanasia should not be performed if the patient is receiving life-prolonging treatment that has not yet been discontinued. In other words, abstinence should have priority over administration of euthanatica." The idea is essentially the same as the 'priority principle' that has been proposed in the case of termination of life without an explicit request (comatose patients, newborn babies, etc. - see section 3.3.1).

PROCEDURAL AND PROFESSIONAL REQUIREMENTS ('REQUIREMENTS OF CAREFUL PRACTICE')⁴⁴

In addition to the substantive conditions of legal euthanasia, the doctor who performs euthanasia must meet a number of procedural requirements.

The doctor must take adequate steps to satisfy himself with respect to the substantive requirements set out above. (Although often so formulated, it is not clear that this is really an additional requirement.)

- 2 He must formally" consult at least one other doctor with respect to the patient's condition and life-expectancy, the available alternatives, and the adequacy of the request (voluntary, well-considered, etc.)."

⁴³ Compare KNMG 1975: 11; see the similar suggestion in Zwaveling 1994.

⁴⁴ See generally KNMG 1995; 'Points requiring attention: See the Glossary for the Dutch term *„zorgvuldigheidseisen*,

⁴⁵ The Medical Association distinguished as early as 1984 between informal discussion with other doctors (especially those with whom one works or who are involved in treating the patient concerned) and a "formal assessment in advance of the merits of the request for euthanasia," for which it proposed the creation of local committees of 3-5 doctors to carry out such assessments (KNMG 1984). Nevertheless, it has only recently become clear that what the requirements of careful practice contemplate is not merely an informal discussion of the case but a formal 'consultation' (see KNMG 1995).

⁴⁶ See Leenen 1994: 292; 'Points requiring attention'; various legislative proposals (appendix 1-e). Compare note 2 above for the subjects actually dealt with in consultation.

the consultant should in principle be 'independent' (not a subordinate, a member of a joint practice, a colleague in a group practice of specialists, or a doctor involved in the treatment of the patient):"

in the case of a patient apparently suffering from a psychiatric disorder the consultant doctor should be a psychiatrist;"

if the patient's suffering is of non-somatic origin, the consultant must himself examine the patient," and **in** other cases he should do so;⁵⁰

the consultant should make a written report, that becomes part of the medical dossier of the patient."

It seems in effect to be part of the consultation requirement that the consultant agree with the decision of the responsible doctor.^{52 53}

47 See 'Points requiring attention'. The Medical Association (KNMG 1995) further expresses a preference for a doctor who does not work in the same institution, especially in the case of smaller hospitals. From time to time the opinion is heard that in the case of GPs, the consultant ought not to be a fellow-member of a local substitution-group of GPs. The KNMG observes that if the case involves problems requiring special expertise, more than one consultant may be required (KNMG 1995).

There have been a number of proposals over the years to formalize the consultation procedure, for example by appointing specially qualified doctors to perform the function (see the State Commission's proposal for doctors appointed by the Minister of Health, appendix I-C-1; the KNMG's proposal for assessment committees, note 45 above).

48 See CAL 4: 36-37; NVP 1997; §4.1; 'Points requiring attention'; NVVE-bill (appendix I-C-3).

49 See the decision of the Supreme Court in the *Chabat* case (appendix II-2).

50 See KNMG 1995; 'Points requiring attention'.

51 See KNMG 1995.

52 See KNMG 1995, which regards it as necessary, if the consultant disagrees, to consult a second doctor (who should be apprised of the negative judgment of the first doctor). If the judgment of the second consultant is also negative, a doctor should not approach still other consultants until one of them agrees with him, but should reconsider his own opinion. NVP 1997 takes a similar position.

53 A case currently under investigation by the prosecutorial authorities and the Medical Inspectorate raises a new issue in connection with consultation: how long before the euthanasia can this take place, and in particular can it take place when the patient's suffering is not yet unbearable (in the case concerned, the consultation took place two months before the euthanasia)? The doctor involved considers such a practice preferable to consultation at the last minute when the patient is already suffering unbearably, since the patient is in a better position to express his wishes clearly to the consultant. See *Het Paraol*, 19 July 1997; 'Open letter to the Medical Inspector, South Holland,' *Medisch Contact* 52: 776-777 (20 June 1997).

- 3 The doctor should discuss the matter with the immediate family and intimate friends [*naasten*] of the patient (unless the patient does not want this or there are other good reasons for not doing so).⁵⁴
- 4 The doctor should discuss the matter with nursing personnel responsible for the patient's care and, if a nurse is involved in the request for euthanasia or in carrying it out, she should be included in the decision-making.⁵⁵
- 5 The doctor should keep a full written record of the case (including information concerning the above elements)."
- 6 The termination of life should be carried out in a professionally responsible way and the doctor should stay with the patient continuously – or be immediately available – until the patient dies (except possibly, for good reasons, in the case of assistance with suicide if careful arrangements are made, including the availability of the doctor if needed)."
- 7 Death due to euthanasia may not be reported as a 'natural death' (in effect, the doctor must report himself as having committed what *prima facie* is a serious criminal offence) (see section 3.2).

If the above requirements for the legally permissible performance of euthanasia have been clear for about the last 10 years, there has been less clarity over how, exactly, they are to be enforced. The substantive requirements for justifiable euthanasia are enforced

- 54 See 'Points requiring attention'; KNMG 1995; but cf. Leenen 1994: 292.
- 55 See 'Points requiring attention'; in the case of psychiatric patients, at least, this requirement has a "mandatory character" (CAL 4: 37). For the situation in which a nurse is somehow directly involved, see KNMG 1992, 1995.
- 56 See 'Points requiring attention'; KNMG 1995. See for a recent case in which one of the failures of which the doctor was accused was failure to maintain an adequate dossier, District Court, Amsterdam, 1 April 1997 (*Makdoembaks*).
- 57 See Leenen (1994: 294); 'Points requiring attention'; KNMG 1985. Among the failures of which the doctor was accused in a recent case was the use of an inappropriate euthanaticum (insulin) and failure to remain with the patient until her death (District Court, Leeuwarden, 8 April 1997 (*Schat*)). The requirement of continuous presence, as formulated by the KNMG, does not seem to take account of the use of 'slow' methods of euthanasia such as morphine in which some part of the execution must necessarily be in the hands of nurses, it being hardly feasible for the doctor to be present the whole time. In a recent disciplinary case the tribunal was of the opinion that the doctor must maintain control over the euthanaticum until the moment of administration (Leenen 1994: 294) but presumably this does not apply in some cases of assistance with suicide.

through the criminal law. Without the patient's voluntary and well-considered request, the behavior is not a potentially justifiable case of 'euthanasia' but a *prima facie* (though, as we will see in sections 3.3 and 3.4, possibly justifiable) case of murder or manslaughter. Recent prosecutions for termination of life without an explicit request (newborn babies, coma patients, and 'help in dying' - see sections 3.3.2, 3.3.3 and 3.3.4) have in fact been prosecutions for the latter two offences. If the euthanasia is not performed by a doctor, the case falls under articles 293 or 294 but is not justifiable (except perhaps under extreme circumstances). Euthanasia in the absence of unbearable and hopeless suffering is not presently regarded as legally justifiable (see however section 3.5.2).

It was for some time unclear to what extent conformity with the 'procedural' requirements ('requirements of careful practice') is necessary for a successful defence to a criminal charge. It seems now to be settled that deviation from these requirements does not necessarily stand in the way of an appeal to the justification of necessity. Such a development was to be expected, since it would be disproportionate to convict a doctor for homicide when the euthanasia itself was otherwise unobjectionable and what he is really accused of is inadequate consultation, record-keeping or the like. The 'requirements of careful practice' are generally enforced in medical disciplinary proceedings (although it seems that in a case of multiple violations of the 'requirements of careful practice' the courts will hold that the defence of justification is not available").

THE PATIENT'S RIGHT TO EUTHANASIA

As we have seen, the legal regulation of euthanasia has taken the form of a justification, available only to doctors, for what otherwise is a violation of two explicit provisions of the Criminal Code. A consequence of this is that the patient, even when his case meets all of the legal requirements, has no 'right' to euthanasia: if he finds a doctor willing to perform it, the doctor can legally do so, but no doctor has any obligation to accede to his request, however well-founded. In fact, all participants in the public debate have been insistent from the beginning that no doctor can ever be required to carry out euthanasia, and a small number of Dutch doctors are in fact for various reasons unwilling to do so.

In these circumstances the availability of euthanasia to a patient is largely a function of who the doctor responsible for his treatment happens to be. It is presumably rare that this doctor was specifically selected for his willingness to perform euthanasia." However, the doctor responsible for treatment does have a duty to give his patient accurate and

58 See the *Makdoembaks* and *Schatcases*, referred to in notes 56 and 57.

59 Furthermore, as Van Overbeek (1996) has shown, a patient may have very good reasons for not changing his doctor despite the fact that the doctor makes clear that he is not willing to perform euthanasia.

full information and, if he himself is unwilling to accede to a legitimate request, to make this clear to the patient and to cooperate in a referral of the patient to another doctor. The Medical Association describes these duties as 'requirements of careful practice', putting them on the same footing as the requirements applicable to a case in which euthanasia is carried out.⁶⁰

Given the monopoly of the medical profession over euthanasia - a position the Medical Association has insisted on from the outset - it has been argued that even though no individual doctor is obliged to perform it, the profession as a whole is bound to ensure the availability of euthanasia to eligible patients.⁶¹ In this context, the existence of institutional policies prohibiting euthanasia (see chapter 5.4.2) is particularly problematic. It seems pretty clear that a patient whose request meets all the legal criteria sometimes experiences great difficulty in finding a doctor willing and - in light of the limitation to doctors with an established treatment relationship - legally able to carry it out.⁶² The whole complex of problems surrounding the availability of euthanasia has yet to receive adequate legal attention.

THE LEGAL POSITION OF THIRD PARTIES

The legal position of nurses is in a highly unsatisfactory state. The only thing that is quite clear is that they may not perform euthanasia or other MBSL on their own.⁶³ Straight-forward application of the criminal law rules relating to accessories would seem in some cases to make the liability of a nurse who participates in carrying out euthanasia dependent on the justifiability of the doctor's behavior. If the doctor's behavior is justified, so is that of the nurse. But if what the doctor did is a crime, the nurse may well fulfill the requirements for being an accessory?⁶⁴ To the extent they do not ignore nurses altogether, proposals for legislative legalization tend to treat the liability of the nurse in the same

60 See KNMG 1995; compare Staatscommissie Euthanasie 1985: 104. See Van der Wal, Siemons & Verhoeff 1994 on the problem of referral after refusing a request for euthanasia, including the suggestion (earlier made by the chief Medical Inspector) that the requirements of informing the patient and cooperating in a transfer can, if necessary, be enforced through medical disciplinary proceedings. The NVP (1997: § 2.2) takes the position that a psychiatrist who has conscientious objections does not have to refer a patient himself, but he must explain his position to the patient and inform him of the possibility of being referred back to his GP.

61 See Griffiths 1987: 691; cf. mad 1996: 425-428.

62 See e.g. Van Overbeek 1996.

63 See note 40 above.

64 See Leenen 1994: 295.

way.⁶⁵ Such a situation seems legally intolerable since a nurse's independent responsibility for what takes place will generally be quite limited.

The extent to which a nurse can carry out some or all of the actual administration of euthanatica (or, for that matter, of other MBSL, such as discontinuing life-support) is quite unclear. As we will see in chapter 5.3.1, the practice was fairly common, at least until recently, especially in hospitals. The Medical Association takes the position that nurses should not be involved in the actual administration of euthanatica but qualifies this if the method used takes a considerable amount of time.⁶⁶

In 1995 a nurse was prosecuted for her role in a case of euthanasia that met all the requirements except that the doctor, while present and supervising, acceded to the patient's request that the nurse (a personal friend of the patient) be allowed to administer the euthanaticum. The doctor was not prosecuted, but the nurse was convicted of unjustifiable euthanasia and sentenced to probation.⁶⁷ Perhaps this conviction is an anomaly, but as things stand it seems that a nurse can be convicted of euthanasia when the substance of the matter is that the doctor violated one of the rules of careful practice - assuming, that is, that it was wrong for the doctor to have delegated the actual administration.

Pharmacists (*apothekers*) are likewise involved in euthanasia, in the sense that they are the source of the lethal drugs used by doctors. They have, however, been assured by the prosecutorial authorities that if a doctor is prosecuted for illegal euthanasia the pharmacist who supplied the means will under normal circumstances not be prosecuted as an accessory; and the Pharmaceutical Inspectorate has taken the position that the pharmacist must discuss the matter with the doctor concerned, but he does not have to investigate whether the doctor is acting in conformity with the legal requirements.⁶⁸ The Royal Dutch Association for Pharmacy (KNMP) has for some years had a number of 'requirements of careful practice' that a pharmacist who is asked by a doctor to supply euthanatica should follow. These include:

there must be a written request from the doctor and this must meet the requirements of and be maintained in the pharmacist's records in the same way as a request that falls under the legislation concerning narcotic drugs;

65 See the legislative proposals of the State Commission and of the NVVE; article 293b in the bill of Wessel-Tuinstra is a notable exception (all of these are in appendix I-C).

66 KNMG 1992. The Medical Association and the professional organization of nurses agree that a nurse is entitled to decline any involvement in euthanasia if she has conscientious objections.

67 *Nederlandselurisprudentie* 1996, no. 61 (Court of Appeals, Leeuwarden).

68 See KNMP 1994: 18.

the request must include the patient's name unless there are very clear reasons for not doing so and anonymity does not undermine the possibility of tracing the euthanaticum or otherwise pose a danger of misuse;

the pharmacist must secure from the doctor information on those aspects of the case that are relevant for the pharmacist;

the pharmacist may consult another pharmacist so long as he does not thereby breach the confidentiality owed to doctor and patient;

he must not permit his staff to be involved in the preparation or delivery of the euthanaticum;

the euthanaticum must be properly labelled and the label should include the instruction to the doctor to return the container and any unused drug to the pharmacist;

a pharmacist may refuse to supply euthanatica, but if he does this as a matter of principle it would be wise for him to inform the doctors in his vicinity of this."

Apart from criminal liability, pharmacists are subject to medical disciplinary law and to the disciplinary rules of their Association. So far as is known, there has never been any sort of proceeding against a pharmacist in connection with euthanasia."

There is no doubt that lay persons cannot legally perform euthanasia or give assistance with suicide," but the possibility of their involvement under the responsibility of a doctor has received little or no attention." In the case of involvement in suicide by non-doctors, the issue can arise as to what constitutes 'assistance: In a recent case involving the 'plastic bag' method, the defendant" advised the deceased as to the method, was present at the time, and told him when to pull the bag over his head. The courts held that while the assistance prohibited by article 294 does involve actual presence at the time of the

69 KNMP 1994: 18-19. These criteria were first formulated in 1984 and revised in 1987. From a journalistic account of an informal 'network' of pharmacists and GPs in Amsterdam in the mid-1980s, it appears that many of these requirements were being rather systematically violated. In particular, everything was done secretly, outside of working hours, with no prescription or other written registration of what transpired. As was common at that time, the death was reported as a natural one. See A. Scherphuis, 'Artsen en apothekers zijn met hun euthanasic 'netwerk' de politiek allang voor [Doctors and pharmacists are with their euthanasia 'network' way ahead of politicians],' *Vrij Nederland*, 14 February 1987.

70 Information received from the KNMP.

71 See note 40 above.

72 The NVVE-bill provides for euthanasia "done by or in dose consultation and cooperation with a doctor"; assistance with suicide, however, is only legal if done by a doctor (see appendix I-C-3).

73 Defendant was a doctor but maintained that she had not acted as such.

suicide, more than that is required. Even 'moral support' or 'merely giving information' are in themselves not enough. The defendant, however, was considered to have gone further than this: what she did amounted to giving the deceased an 'instruction.'

3.1.4 *Euthanasia versus assistance with suicide*

Unlike the situation elsewhere in the world, one of the most characteristic features of euthanasia practice in the Netherlands is that from the beginning of the public discussion until very recently there has been no suggestion of a legal preference for assistance with suicide over euthanasia in the narrow sense of killing on request." The justification defence worked out by the courts does not distinguish between killing on request and assistance with suicide, and as we will see in chapter 5.3.1, killing on request is much more common than assistance with suicide.

The Dutch preference for killing on request reflects the way in which euthanasia law has developed in the Netherlands (see chapter 2). By contrast with the situation in, for example, the United States, this development began not so much with a demand for 'patients' rights' as with the insistence by doctors, supported after some initial hesitation by the Medical Association, that under limited circumstances euthanasia is a legitimate medical procedure. The issue was legally formulated not so much in terms of what patients have a right to demand as in terms of what doctors are authorized to do." For many doctors it has seemed an integral part of the doctor's responsibility, once he has decided that the life of a patient should be terminated, to carry out the decision himself.

The possibility that the requirements for the justification of necessity in the two cases may be different has received little explicit attention in the Dutch public discussion. From time to time there have been suggestions in the literature of a preference for assis-

74 The decision to this effect by the Court of Appeals, The Hague, was upheld by the Supreme Court (*Tijdschrift voor Gezondheidsrecht* 1993, no. 24; 1994 no. 65; *Nederlandse jurisprudentie* 1996, no. 322).

The proposed legislation of the NVVE (see appendix I-C-3) retains only 'incitement' and 'procuring the means' in article 294, thereby eliminating the criminal liability of lay persons who merely 'assist'.

75 See Leenen 1994: 296 (the two are "essentially the same" and despite the fact that two different articles of the criminal code are involved, "there is no reason to distinguish between them in a case of assistance due to severe suffering"). The State Commission proposed to treat them as one (Staatscommissie Euthanasie 1985: 62-63) and legislative proposals since then (with the partial exception of that of the NVVE) have followed suit (see appendix 1-C).

76 See Griffiths 1987: 690-691.

tance with suicide, but this is probably a minority view and in any case has had little effect on practice." The fact that there may be important reasons for affording assistance with suicide a preferred position has only recently begun to attract attention. It can be argued that there is an extra guarantee of the voluntariness and seriousness of the patient's request when he has to perform the final act himself, and less emotional burden on the doctor when a patient capable of administering the lethal drug to himself does not impose the moral burden of doing so on his doctor."

Recently there have been some signs of change that may be harbingers of a future preference for assistance with suicide. To begin with, committees of the Medical Association and of the Netherlands Association of Psychiatrists, in reports on the situation of psychiatric patients who want a doctor to help them die (see section 3.5.1 below), assume without discussion that in such a case what would be involved is assistance with suicide. The decision of the Dutch Supreme Court in the *Chabot* case seems to share this assumption. The discussion of various forms of euthanasia for the non-'sick' and the non-'suffering' (see section 3.5.2) is likewise in terms of assistance with suicide.

The Medical Association has recently adopted new guidelines in which a careful preference is expressed for assistance with suicide whenever this is possible." If one may hazard a guess, it would be that over the course of the coming years assistance with suicide

- 77 See chapter 2.2. An early report of the Health Council (Gezondheidsraad 1982) is an exception to this generalization, but the proposal there to decriminalize assistance with suicide and to retain the prohibition of euthanasia except in cases in which the patient is not capable of carrying out suicide had no influence on subsequent legal development. Compare Benjaminson 1988 (the research in Utrecht referred to in chapter 5 note 1): a number of doctors interviewed and the one hospital with a formal policy had a preference for assistance with suicide where possible, but in fact it hardly ever took place. See chapter 5.2, note 18, for an apparent preference among GPs for assistance with suicide if the patient's suffering is less 'unbearable'.
- 78 Doctors are occasionally heard to complain of the moral pressure put on them by patients who are perfectly capable of carrying out their desire to die themselves, for example by ceasing to take medications that they know are essential to keep them alive. Van der Wal and Van der Maas (1996: 173) report that about half of all doctors say they are of the opinion that if a patient is capable, assistance with suicide is to be preferred, among other things as less emotionally burdensome for the doctor. Zwaveling (internist on an intensive care ward of a university hospital) argues that "euthanasia may be good for the patient but it is bad for the doctor" because of the psychological burden it involves (1994). He also argues that the autonomy of the patient's desire for death is better assured if the patient carries out the final act himself. He suggests that decriminalization of assistance with suicide and a more extensive use of abstinence could help keep the rate of euthanasia to a minimum.
- 79 KNMG 1995: 7-9.

will come to be regarded as preferred practice whenever there is not a clear reason for euthanasia (e.g. the inability of the patient to administer the fatal drugs himself). So far, however, there are no signs of this in actual practice; in fact, as we will see (table 5.2), the frequency of assistance with suicide relative to euthanasia actually *declined* slightly between 1990 and 1995.

It would probably be a mistake, moreover, to exaggerate the brightness of the line between the two sorts of behavior and to put too much weight on it as a ground for substantially different sorts of legal treatment. Assistance with suicide varies from, on the one end of the spectrum, behavior scarcely distinguishable from euthanasia (in the presence of the doctor, the patient opens the valve on a lethal intravenous drip), through the intermediate 'normal' situation in which the doctor prepares the drugs to be used and gives them to the patient to take in his presence, to the opposite extreme of a situation in which the doctor makes pills available to a patient who may or may not use them at some future time. It is doubtful that this whole range can be dealt with as one regulatory category, distinct from euthanasia. In other words, it is probably wiser to retain the current legal situation in which killing on request and assistance with suicide are, from the point of view of the justification of necessity, not distinguished, and to seek via professional protocols - or perhaps simply by way of advice and education - to promote a general preference for letting the patient take as much as possible of the responsibility not only for the decision but also for actually carrying it out. In a system of decriminalized control, as we will see in chapter 6.3.2, it would be possible to make subtler distinctions than are now possible within the criminal law justification of necessity, and to encourage the use of assistance with suicide whenever, considering all the circumstances, it is to be preferred.

Assistance with suicide can, as we have seen, pose problems with respect to one of the 'requirements of careful practice': the requirement that the doctor be present at the moment the patient uses the drugs the doctor has supplied. There are some obvious considerations in support of such a requirement: maintaining control over the availability of euthanatica, ensuring the effective and humane carrying out of the suicide and timely reporting of the death to the coroner." On the other hand, there are also some important reasons for not (always) insisting on the presence of the doctor. Some doctors, for example, have described their own practice of giving dying cancer patients a supply of lethal drugs to keep next to their bed in case their suffering should become unbearable, the doctor's position being that the mere availability of such control is such a relief to the patient that he can concentrate his thoughts and his energy on other matters and in fact

80 See note 57 above for the general rule requiring presence.

usually never uses the drugs at all." In such circumstances, insistence that the doctor be present may in fact work unnecessarily to increase the number of cases of assisted suicide." The whole idea of a 'pill' for the elderly, to allow them to decide for themselves when they no longer wish to go on living (see section 3.5.2), is of course inconsistent with a general requirement that the doctor be present.

3.2 The reporting procedure

The system of legal control over euthanasia and termination of life without an explicit request, which we will examine with an eye to its actual functioning in chapter 5.3.5 and will analyse with regard to its effectiveness in chapter 6, is based on the doctor's duty to report a patient's death as the result of a non-natural cause.

As we have seen in chapter 2.3.2, beginning as early as 1985 at the local level, and since 1990 at the national level, the prosecutorial authorities, in cooperation with the Medical Association, have worked out a special procedure for investigating cases in which a doctor reports a death as euthanasia. The prosecutorial authorities have also over the years made it increasingly clear that a doctor who reports a case of euthanasia as such and whose behavior meets the criteria for permissible euthanasia as developed by the courts will not be prosecuted; the result of this policy is that very few reported cases are in fact prosecuted (see chapter 5.3.5).

Elsewhere in this book we speak rather loosely of the doctor's 'duty' to report the death as a 'non-natural' one. This is what the legal situation amounts to in substance. However, this is the place to describe the applicable legal rules more precisely.

The Law on the Disposal of Corpses (*Wet op de lijkbezorging*³) requires the city clerk's permission for a funeral or cremation. Such permission is granted if the doctor responsible for treatment files a death certificate on which he certifies that the patient died from

81 See Schaepman & Scherphuis, 'Euthanasic' (*Vrij Nederland* 1a and 17 October 1987) for such a practice of a specialist in cancer of children (the patients involved were adolescents). Although there was some public commotion resulting from his revelation, so far as we know no prosecution or disciplinary complaint was brought against him.

82 Compare the argument for not requiring presence in the case of patients suffering from a psychiatric disorder, section 3.5.1 below.

83 *Staatsblad* 1991: 133.

a 'natural cause'.⁸⁴ If the doctor is not convinced that the death was a natural one, he must notify the coroner, who inspects the body of the deceased, and makes his own judgment about the cause of death. If the coroner is convinced that the death was a natural one, he files a death certificate; otherwise, he reports the case to the local prosecutor, who must decide whether to notify the city clerk that he has no objection to burial or cremation.

Certifying a death due to euthanasia or termination of life without an explicit request as a 'natural' death is a distinct criminal offence (under article 228(1) of the Criminal Code - see appendix I-A), for which there have been a number of prosecutions."

Based on these legal requirements, what is generally referred to as the 'reporting procedure' (*meldingsprocedure*) was agreed upon in 1990 between the Ministry of Justice and the Medical Association (see chapter 2.3.2). In 1993 the reporting procedure acquired a statutory basis in an amendment to the Law on the Disposal of Corpses and an accompanying Order in Council. (See appendix I-B for the text of the Law and the Order in Council.)

What the 1993 legislation, in a technical legal sense, does is authorize the Ministers of Justice and of Health to provide by Order in Council for the form on which euthanasia, assistance with suicide and termination of life without an explicit request are to be reported by the coroner to the local prosecutor." The form issued pursuant to this legislation includes a list of 'Points requiring attention' *iaandachtspunten* on which the doctor who

84 What exactly amounts to a 'natural cause', is a matter of some confusion and disagreement. In the legislative history of the relevant provisions of the Law on the Disposal of Corpses, an acknowledgement that the term 'natural cause of death' cannot be precisely defined is followed by the reassurance that in practice it will be sufficiently clear."Not only death due to intentional or negligent acts of others is not-natural, but also death due to suicide, even if this is the natural result of mental illness, as well as death due to an accident or external violence, even if this is not attributable to human fault." (*Second Chamber of Parliament 1951-1952*, 2410, no. 3:7). The operational definition in prosecution practice is said to be that a 'natural' death is 'one that comes from within', in which case not only euthanasia but a large number of other medically caused deaths would have to be considered 'non-natural'; deaths due to pain relief or to abstention are, under such a criterion, arguably not 'natural', although they are universally so regarded.

85 In 1987 the Supreme Court rejected the idea that the justification for euthanasia also applies to violation of this article (see chapter 2.3.2). See chapter 5.3.5 for some incidental prosecution data.

86 Actually, the legislation does even less than this, since such authority to promulgate the reporting forms already existed. The new law merely gives this authority a higher legal status accompanied by a slightly different procedure for exercising it.

brings such a death to the attention of the coroner must supply information (see appendix I-B for the text of the 'Points requiring attention'). On the whole, these follow the existing substantive and procedural requirements. On a few points the 'Points requiring attention' suggest requirements that do not entirely correspond to existing formulations of the 'requirements of careful practice' (for example, that the request should be in writing). The exact status of the items about which the form requires information is not entirely clear, and in any case the courts and prosecutors will not necessarily regard these items as defining the contours of a successful defence of necessity.

In reaction to the findings of the 1990 research, the new reporting procedure was made applicable not only to euthanasia but also to termination of life without an explicit request. This was much to the dismay of proponents of legal euthanasia, who have always insisted on voluntariness as the essence of euthanasia and did not want it to become confused with non-voluntary practices. The Government emphasized that the research had revealed the extent of this sort of MBSL and that it was important to subject it to control, but that the fact it was covered by the reporting procedure in no sense implied that it would not be criminally prosecuted." In fact, as we will see in chapter 5.3.5, hardly any such cases have been reported; the Government has recently proposed to separate the two reporting procedures (see chapter 6.2.5).

One final aspect of the reporting procedure requires attention: its uneasy relationship to the privilege against self-incrimination.⁸⁷ Serious concerns about this were raised in 1987 by the Committee of Procurators-General in connection with the advice of the Council of State on pending legislative proposals concerning euthanasia (see chapter 2,4). During the Parliamentary consideration of the legislation of 1993 similar concerns were voiced.⁸⁸ But until recently the question was not raised by defendants in criminal prosecutions, apparently because they sought vindication on the merits.⁸⁹ As far as we are aware, the issue was first raised in court by the prosecutor in the *Chabot* case, but because he did not do so formally the court did not deal with the matter. The same prosecutor took the unusual step in the *Kadijk* case of formally requesting the court to dis-

87 See *First Chamber of Parliament* 1992-1993, 22 572, no. 275a: 4ff.

88 The privilege - known in continental legal discourse as the *nemo tenetur* principle - is binding on the Dutch legislator and courts as an aspect of the right to a 'fair trial' guaranteed by article 6 section 1 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. See Woretshofer 1996.

89 See *First Chamber of Parliament*, 1992-1993, 22 572, no. 275a: 23-24; *First Chamber of Parliament* 1993-1994, *Proceedings*, 10-392.

90 Information from E.Ph.R. Sutorius, lawyer for the defendant in many recent cases concerning medical behavior that shortens life.

miss the prosecution for violation of the privilege." The District Court regarded the question as immaterial since at the time the doctor had reported, the statutory reporting procedure was not in place (the Court appeared to ignore the fact that the requirement of reporting was not created by the new legislation but had always been immanent in the doctor's duty to report a case of euthanasia as a 'non-natural death'). The Court of Appeals (see appendix 11-3) made equally short and unsatisfying shrift of the matter, holding that since the defendant had "made clear from the beginning ... that he wished to account for his behavior" no problem of self-incrimination was involved.

The result of all this is that the problem of self-incrimination, unmistakably involved in the reporting procedure, has still to receive authoritative legal attention. In the public discussion it tends to get brushed off by those who defend the procedure with the observation that if the doctor has met the various requirements, reporting does not involve incriminating himself - which is true, but irrelevant, since it is the doctor who has *not* met all the requirements who is at issue. If the issue is cleanly raised," the solution will presumably depend on the extent to which an administrative requirement connected with the disposal of corpses and imposed upon doctors in connection with their professional activities falls under the exception for general bookkeeping and record-keeping measures even though (1) it has a central place in the process of criminal investigation and enforcement of a specific crime, and (2) it involves a potential defendant supplying not merely some information that might be used at some time in a criminal prosecution but all the elements of a crime that the authorities have committed themselves to prosecute if it is brought to their attention. The seriousness of the offence involved is presumably also relevant. In situations in which the doctor's behavior does not clearly fall within the established terms of the justification of necessity, the reporting procedure thus

- 91 This led to an unfortunate but revealing incident. When her attention was called by a question in Parliament to what the prosecutor had done, the Minister of Justice took the position that his behavior was in violation of her instructions to prosecute the case. He later received a formal ministerial reprimand. The incident received considerable attention in the press at the time, in which the central point of contention was the Minister's assertion of authority to control the course of individual criminal prosecutions all the way down to the level of the legal position asserted by a prosecutor in court.
- 92 This is not as easy as one might think. The doctor who reports and is prosecuted can be met with the reaction of the Court of Appeals in the *Kadijk* case (in effect, that he waived the privilege by reporting). The doctor who falsely reports euthanasia as a natural death is prosecuted for filing a false death certificate (article 228(1) of the Criminal Code); if he then raises the issue of self-incrimination he can expect to be told that the privilege gives no license to lie. The theoretical possibility of not reporting at all is dealt with in note 93.

seems vulnerable to serious legal challenge." As we will see in chapter 6, the procedure is fundamentally ineffective anyway, so a court decision holding it in violation of the European Convention should be welcomed as an invitation to the Government to come up with a more serious way of enforcing the law in this area.

3.3 The CAL and NVK reports: *law in statu nascendi*

To this point we have been treating matters on which the law is generally fairly well settled. Now we turn to matters on which it is not. Here, the law is in a state of becoming, and judgments about what it *is* are necessarily based to some extent on judgments about what it *will be*.

In 1985 the Medical Association appointed a Commission on the Acceptability of Medical Behavior that Shortens Life (CAL) to report on the legitimacy of various MBSL in the case of not (entirely) competent patients. The CAL issued four interim reports in the period 1990-1993 (CAL 1_4).⁹⁴ In the same period, the Dutch Association for Pediatrics (NVK) issued a report on MBSL in the case of severely defective newborn babies (NVK 1992). Recently, the Dutch Association for Psychiatry (NVP) issued a report on assistance with suicide in the case of psychiatric patients (NVP 1997). In the complex interaction process characteristic of legal developments concerning MBSL in the Netherlands (see chapter 2), these reports, while perhaps not possessing formal 'legal' status, almost certainly point the way in which legal change can be expected to occur. In some cases (severely defective newborn babies and psychiatric patients) the central ideas of the reports have already been confirmed in judicial decisions. While the details of the ultimate legal regime may differ from the position taken in the reports, it seems safe to assume that the general tenor of emerging law is to be found there.

93 Compare Worethofer 1996. Knigge (1997), however, argues that there is no self-incrimination problem because, while there is a duty not to report falsely, a doctor has no affirmative duty to report anything more than his own inability to file a certificate of natural death (any further duty would involve breach of the doctor's duty of confidentiality, which is why the legislator chose a construction that does not impose an affirmative duty). If the doctor so notifies the coroner, it is up to the latter and the prosecutorial authorities to investigate the case themselves. In Knigge's view, all the reporting procedure does is give the doctor an opportunity to avoid such further investigation. A doctor might thus in theory be able to avoid the problem of self-incrimination by not reporting the death as a 'natural' one but also not qualifying it as euthanasia (or termination of life without an explicit request). In most cases, however, his moral duty toward the family of the deceased (who need a death certificate in order to bury or cremate the body) will preclude this course.

94 A final, comprehensive report integrating the four interim reports was recently adopted: KNMG 1997. Since it is the interim reports that have played a role in legal development to date, we have used them as the basis for the discussion in this chapter.

This section deals first with the general approach of the reports, then with the specific situations of severely defective newborn babies and coma patients, and finally with the more general idea of 'help in dying' that seems to emerge from these reports and other recent developments. The special problems of the demented elderly will be dealt with in section 3.4. Section 3.5 discusses the CAL and NVP reports on assistance with suicide in the case of psychiatric patients, as part of a discussion of the more general problem of non-somatically based suffering.

3.3.1 *The legitimacy of decisions to shorten life in the absence of a competent request*

In the case of euthanasia and of abstaining from life-prolonging treatment at the request of the patient, the legitimacy of the doctor's behavior depends upon the patient's request. It is the absence of this source of legitimation that is troublesome in the case of non-competent patients such as babies and the comatose. If the life of the patient is dependent upon initiating or continuing a life-prolonging treatment and the patient has not (competently) declined further treatment, how can a decision to withhold or terminate such treatment be legitimate? In many cases more or less objectively 'medical' criteria supply the answer: further treatment would have no chance of success, would involve a burden to the patient disproportionate to any possible benefit, or (because of other medical problems from which the patient suffers) cannot succeed in restoring a minimal level of functioning. Decisions grounded on the idea of 'medical futility' (*medisch zinloos handelen*) in this narrow sense can be regarded as being bound by medical-professional standards." But can a decision to forego treatment be based on the essentially non-medical judgment that the patient's future 'quality of life' will be so limited that he is better off dead? On what basis could anyone, particularly a doctor, be authorized to make such a decision for a patient?

In the American literature a basic structure for the analysis of this question has emerged, one that is also latent in emerging Dutch law. A non-competent patient enjoys the same fundamental right to refuse (further) treatment that accrues to a competent patient. For the exercise of this right, however, resort must be had to a 'surrogate decision-maker', who can be either the doctor or a representative (family or friend or appointed representative) of the patient. This surrogate can base a decision on behalf of the non-competent patient on one of two grounds: evidence concerning what the patient himself would have wished in the circumstances ('substituted judgment') or a judgment as to the 'best interests' of the patient." There is growing room in Dutch law for the 'substituted judg-

95 See Leenen 1994: 309-310.

96 The 'substituted judgment' and 'best interests' approaches merge into one another to the extent that specific evidence concerning what the patient would have wanted is not available and recourse must be had to what a 'reasonable person' in his position would have wanted.

merit' approach with a representative, family member or close friend of the patient as preferred surrogate decision-maker;" but on the whole, the legal discussion to date has largely been within the framework of a 'best interests' approach with the doctor as surrogate decision-maker."

The problem of the doctor's authority to ground a MBSL in 'quality of life' considerations can be avoided in many cases by means of a substituted judgment approach or, when that approach is not available (newborn babies), a 'best interests' approach with the family (parents) as surrogates. Nevertheless, there remain cases in which the doctor of necessity must decide. To exclude 'quality of life' considerations in such cases would imply that the law requires the doctor - in the absence of authorization by the patient or a representative - to act as if blind to all but the medical consequences of his behavior. Such an interpretation of the idea of medical futility seems remote from reality. No sensible person would want a doctor to devote himself exclusively to biological life with no consideration for the things that make life worth living, so it can safely be assumed the law does not require any such thing.

The reports of the CAL and the NVK share a common approach to the problem of the legitimacy of medical behavior that shortens life, one that puts the problem of the relationship between 'quality-of-life' considerations and the concept of medical futility in a different light. Their argument is premised on a fundamental point of departure. In effect, the reports stand the ethical problem of non-treatment on its head. The problem of legitimacy concerns not the artificial *shortening* of life but rather its artificial *prolongation*. If (further) treatment that is essential to prolong life cannot be legitimated, no additional legitimation for 'shortening' it by abstaining from the treatment is necessary. And in the case of a non-competent patient, the legitimacy of such treatment cannot be based, as is usually required, on the patient's consent.

Once having posed the question of legitimacy in this way, the reports invoke a time-honored principle of medical ethics: *in dubio abstine* (when in doubt, abstain). The doubt that brings this principle of non-intervention into play can derive from the limited chance of success of an intervention, from a lack of proportionality between intervention and result, or from the limited value to the patient of the additional life to be won. Quality-of-life considerations can give rise, in other words, to sufficient doubt about the legitimacy of (further) intervention that a doctor ought not to engage in it, at least not on his own authority.

97 See the provisions of the new Law on Contracts for Medical Treatment (note 12 above).

98 See Kooij 1996 for this analysis. She shows that American courts have, on the whole, preferred the 'substituted judgment' approach, with family, etc., as the surrogate decision-maker (differing on such things as the sort of evidence required) while the English courts have opted for the doctor as surrogate and the 'best interests' approach. Dutch law, she argues, is in the process of moving from the English to the American approach.

In particular, in the case of very premature babies and comatose patients the dramatic increases over the past decades in the technical possibilities for keeping a patient artificially alive have led, the CAL and NVK reports argue, to a systematic departure from the principle *in dubio abstine*. For a number of reasons - most importantly, to win time in order to make a fully informed diagnosis - doctors have come to apply the contrary principle: *in dubio fac* (when in doubt, act). If there seems to be any chance at all of a favorable outcome, the doctor initially deploys all available means to keep the patient alive. If the patient does not die but the medical intervention leads to a situation that, if it had been foreseen from the beginning, would not have been thought to justify a decision to intervene, then the doctor is confronted with a choice between continuing treatment that (with the benefit of hindsight) has been without legitimation from the beginning and ought not to have been commenced, or applying *in dubio abstine* retroactively, as it were. The latter course often implies that one cannot limit oneself to 'passive' non-intervention; one must 'actively' intervene to put an end to life-prolonging treatment.

Only on the condition that an intervention with which one has begun ... can later be stopped, is it possible to assure that it is not medical technology, but medical-ethical norms that have proved their value over the years ('in dubio abstine' and 'primum non nocere'), that define the character of medicine and ... guarantee the well-being of the individual patient."

Medical intervention on the basis of *in dubio factus* entails a special responsibility, and the doctor who begins a life-prolonging treatment on this basis must be prepared to take the responsibility for discontinuing it when it becomes clear that further treatment cannot benefit the patient. The CAL and NVK reports regard the line of thought to this point as essentially non-controversial.

The CAL and NVK next argue for the less well-settled position that artificial administration of food and drink are medical interventions that require legitimation. This sort of intervention, they conclude, is not significantly different from other forms of artificial prolongation of life. The consequence of this position for comatose patients and for most severely defective newborn babies is clear: the absence of legitimation for prolonging life may justify abstaining from (further) artificial administration of food and drink, which will inevitably lead to the patient's death.

The CAL further insists on the 'priority principle': life-terminating treatment (use of euthanatica) should only be considered *after* life-prolonging treatment has been termi-

nated. If the patient does not die in a humane way after life-prolonging treatment has been stopped, the doctor should intervene to ease the process of dying. Since,

the death [of the patient] has already been accepted [when the decision to terminate treatment was made] ... administration of drugs in a fatal dosage can be indicated ... as a form of 'assistance in dying' [*stervensbegeleiding*] [For some doctors the death of the patient is] part of the intention with which one began the process (terminating treatment and then giving adequate 'help in dying' [*stervenshulp*]).¹⁰⁰

The combined implication of these points of departure is that in almost all cases the patient will die quickly, and (except for possible 'help in dying') there will be no occasion for 'active' administration of euthanatica. The situations in which the legitimacy of 'active' termination of life – as to which, by contrast with discontinuing life-prolonging treatment, the medical profession is described by the CAL as divided – needs to be considered, are thereby reduced to a minimum.

Abstaining from (further) life-prolonging treatment because of serious doubt as to the benefit for the patient meets far fewer ethical or legal objections, at least in the Netherlands, than using euthanatica to terminate the life of a patient whose prospects are unacceptable. Standing the problem of legitimation on its head, as the CAL and NVK reports do, seems an effective way to defuse an area of medical ethics and law that otherwise could give rise to the same kind of political controversy as has characterised euthanasia. Putting the emphasis on the legitimacy of prolonging life also focusses the discussion where it on the whole belongs: on the ethical and practical consequences of the increasing medical-technical possibilities for prolonging biological life long beyond the point that doing so is sensible or humane.

But is standing the problem of legitimation on its head anything more than a rhetorical trick? The whole argument stands or falls with the status of the principle *in dubio abstine* and the underlying idea that (passive) non-intervention requires less legitimation than (‘active’) intervention (compare chapter 4.1.1). The reports say nothing about the ethical foundations of the principle; it is simply invoked as a sort of medical-ethical axiom. One might support its application here by arguing that the prospect of a 'life not worth living' is an insufficient basis for 'presumed consent' to further treatment'?' or, alternatively, for concluding that the patient's 'interest' justifies it. However this may be, so long as people

¹⁰⁰ CAL 2: 35. As we have seen in chapter 2.3.2 (see also section 3.3.3 of this chapter), the State Commission on Euthanasia adopted the same principle in its treatment of the problem of coma patients. Unlike the Rummelink Commission (see section 3.3.4), the CAL does not draw the seemingly inescapable conclusion of its argument: that 'help in dying' constitutes 'normal medical practice' and the death of the patient is a 'natural' one that can be reported as such (see CAL 1: 23, CAL 2: 45). See the Glossary for the terms *stervensbegeleiding* and *stervenshulp*.

¹⁰¹ Compare CAL 2: 39.

of otherwise conflicting views on the legitimacy of medical behavior that shortens life can find common ground in the principle, it affords a basis for the development of norms to govern medical practice in this area.¹⁰² As we will see in the following sections, the position of CAL and NVK seems in fact to underlie current legal developments with regard to the regulation of decisions to terminate or not to initiate life-prolonging treatment and, in that connection, to administer 'help in dying', both in the special cases of severely defective newborn babies and coma patients, and for non-competent patients more generally (see section 5.3.4).

3.3.2 Severely defective newborn babies (and late abortion)

Two of the reports mentioned above deal with the problems of medical behavior that shortens life in the case of severely defective newborn babies. One was prepared by the Commission on the Acceptability of Termination of Life of the Medical Association (CAL 1, 1990), the other by the Dutch Association for Pediatrics (NVK, 1992). Both are the fruit of intensive discussion with and among neonatologists and are intended to reflect the views of the entire professional group. The positions taken in the two reports are very similar.¹⁰³

As we will see in chapter 5.3.3, of slightly over 1000 babies per year who die in their first year, more than half die as the result of abstinence, about half the time accompanied by

¹⁰² It is clear from the CAL reports that the extent to which the *in dubio abstinere* principle can give rise to specific treatment protocols with a more or less binding character varies from one medical situation to another. For some situations - such as long-term coma - criteria for abstaining from (further) life-prolonging treatment can be given in concrete, quantitative terms (see section 3.3.3). This is not (now) the case for senile dementia, which is presumably the reason that the CAL in that situation relies primarily on the figure of the 'presumed will' of the patient (see section 3.4). Both the CAL and the NYK treat the situation of seriously defective newborn babies as comparable in this respect to that of the senile demented (see section 3.3.2). There are, however, neonatologists who argue that specific quantitative criteria should determine whether life-prolonging treatment of premature babies is appropriate (duration of pregnancy and body weight); below this limit, any life-prolonging treatment would require special legitimation. A weak point in both reports is the failure to consider this possibility. The information collected by the CAL reveals that Dutch academic hospitals set varying minima, from 23-24 to 26 weeks, despite the fact that the prognosis for these babies is extremely poor. The ethical and legal problems with which the CAL is concerned would presumably be far less frequent if neonatologists were restrained by clear-cut norms in the application of *in dubio fac*.

¹⁰³ The NVK report is one of the most careful and thorough contributions to date to the Dutch political and legal discussion on the legitimacy of medical behavior that shortens life.

pain relief expected to hasten death and quite regularly including what seems to amount to 'help in dying' (some 80 cases per year).

The discussion in neonatology essentially concerns the question whether and when a life-prolonging treatment can be discontinued. Abstinence from the beginning - according to the principle *in dubio abstinere* - is rare, at least in neonatal intensive care units. At the outset all available technical possibilities are used to save the life of the baby until a reliable diagnosis can be made.

The reports recognize two basic reasons for abstaining from or discontinuing life-prolonging treatment: the prognosis that the baby has 'no real chance of survival' (treatment would have no chance of success: *kansloos medisch handelen*) and the prognosis that the baby has a 'limited chance of a life worth living' (treatment would be pointless: *zinloos medisch handelen*).¹⁰⁴ In both cases the legitimation for (further) artificial prolongation of life is absent. The idea of a 'life worth living' is further operationalised in terms of the child's expected ultimate level of functioning in a number of distinct respects: the possibility of communication (verbal and non-verbal); suffering (physical and otherwise); dependency on others; autonomy; and personal development.¹⁰⁵ According to the reports, Dutch pediatricians are virtually unanimous in the view that refraining from further prolongation of life is legitimate if the baby's prospect is one of a 'life not worth living' (*anleefbaar leven*).¹⁰⁶

The only point of disagreement among neonatologists concerns 'active' termination of life with lethal drugs. The NVK report distinguishes three situations: (a) as a result of life-prolonging treatment that is no longer necessary the child has survived, but in a condition that, if it had been foreseen at the beginning, would have led to abstaining from life-prolonging treatment; (b) discontinuation of life-prolonging treatment has led to a situation of unacceptable suffering; (c) independently of any earlier life-prolonging treatment the baby has serious defects that are consistent with life but not with a life worth living. In situations (a) and (b), some neonatologists would consider the use of euthanatica legitimate while others would not, but both positions are generally considered legitimate. The CAL itself considers use of lethal drugs morally acceptable in situation (b) even when this is done preventively to avoid unnecessary suffering.¹⁰⁷ Situation

104 The NVK proposes this pair of concepts as an improvement on the established term 'medically futile' (*medisch zinloos*) that confusingly lumps the two rather different situations together (NVK: 23-24, 29-39). See also CAL I: 6-7. Van der Wal and Van der Maas, in their recent report on research carried out at the behest of the Government, explicitly adopt the terminology of the NVK (1996: 182-183).

105 CAL: 15; NVK: 31-32.

106 CAL: 11.

(c) is highly exceptional, among other things because of the possibility of abstaining from fairly routine forms of life-prolonging treatment such as artificial administration of food and drink. The profession is divided on the question whether termination of life with euthanatica can ever be legitimate in this situation."⁹⁷

Both reports emphasize the importance of the views of the parents. According to the CAL, if the prognosis is that the baby has no real chance of survival, there is "no real problem of choice and the views of the parents can therefore play only a marginal role": Nevertheless, careful practice requires "that in all cases the wishes of the parents [with respect to 'help in dying' or the moment of death] ... be ascertained, and if possible honored" If the prognosis is of a 'life not worth living' - in which case the capacity of the family to deal with the situation is relevant - "the views of the parents must receive much more weight ... than seems currently in many cases to be accorded". This "of course" does not mean "that the parents can dispose freely over the life of their child [T]he decision¹⁰⁸ should primarily be based on the expected physical and/or mental handicaps of the newborn baby and the minimum values that have been established therefor." In cases in which these 'minimum values' do not unequivocally indicate the proper course of action, it is appropriate for the doctor to adopt a "modest" position and "in principle to give the views of the parents a very important role" in the decision-making.¹⁰⁹

The role of the parents and the importance of careful communication with them receives even greater emphasis in the report of the NYK. The wishes of

thoughtful parents for whom the interests of the child are a central consideration... [should] be taken very seriously. A doctor who thinks parents are not being sufficiently careful or are not serving the best interests of the child (which after all is primarily entrusted to them), bears the burden of proof!"¹¹⁰

If the doctor is of the opinion "that the parents' wish (for example: not to operate) is clearly inconsistent with the child's interests" and there is consensus in the profession on this, then the procedure for temporary removal of parental custody should be used.¹¹¹ Subject to that legal outer limit, the NVK seems (almost) to recognize parents as holders of decisive *rights and powers* and not merely as sources of *important considerations* to be taken into account by the doctor.

107 NVK: 48-53.

108 Reference is apparently to the decision of the doctor.

109 CAL I: 16-17.

110 NVK: 39.

111 NVK: 55. As in other legal systems, Dutch law provides for temporary assignment of custody to a guardian if a parent's refusal of medical care is not in the 'best interests of the child'. See Leenen 1994: 147.

Neither report explicitly considers the implications of the legal capacity of the parents as guardians of their child. At least as far as decisions to abstain from (further) life-prolonging treatment are concerned, it would seem that the parents, deciding on behalf of their child, can in principle refuse treatment for any reason the child itself would be entitled to consider, subject to the outer limits of parental authority. This argument from legal principle is reflected in the new Law on Contracts for Medical Treatment!¹¹² article 465(4) of which requires a doctor to comply with the parents' instructions unless to do so would be incompatible "with the care expected of a good [doctor]". The historical paternalism of the medical profession does not seem to have caught up with the law on this matter.

Two recent cases (see chapter 2.4; see appendix 11-3 for the judgment in the *Kadijk* case) have clarified the controversial issue of 'active' termination of life in the case of severely defective newborn babies. In each case, the baby suffered from very serious defects and was not expected to live long; in each case a decision to abstain from further life-prolonging treatment had already been taken; in each case the doctor, in consultation with the parents, had decided to administer euthanatica to save the baby from a painful and inhumane death. The doctors concerned (one gynecologist and one GP) had scrupulously followed all of the 'requirements of careful practice' and had reported the deaths as 'not natural'. The Minister of Justice ordered prosecutions (for murder), deeming the two cases suitable vehicles for securing legal clarification. In both cases, the doctors were acquitted by both the respective District Courts and Courts of Appeals. The responsible prosecutorial officials saw no grounds for an appeal to the Supreme Court. The upshot of these cases seems to be that the law on the matter is essentially that recommended by CAL and NVK: if the parents agree, 'active' termination can be justifiable to put an end to further suffering in the case of a severely defective newborn baby, where essential life-prolonging treatment has been stopped in order to let the baby die, but death (while imminent) does not take place immediately.¹¹³

A closely related sort of MBSL that has not played much of a role in the public discussion deserves mention here, namely that of last-trimester abortion. Dutch abortion law permits abortion only until the foetus can reasonably be considered capable of surviving outside the womb, and this is interpreted to mean 24 weeks (minus an uncertainty factor of 2-4 weeks); once the foetus is in that sense viable, killing it is considered killing a person.¹¹⁴ If serious, non-treatable defects are first diagnosed later in the pregnancy than

112 See note 12 above.

113 It is arguable that the baby's death could be reported as a 'natural' one in such a case (see note 100 above); the CAL, however, insists that reporting as a non-natural death is required in all cases in which euthanatica are used to terminate life.

114 See Leenen 1994: 138-139.

this and the woman urgently requests an abortion, the responsible doctor is confronted with a dilemma similar to that of termination of the life of a newborn child.

The Dutch Association for Obstetrics and Gynecology (NVOG) has adopted a position paper for such situations that is largely derived from that of the NYK.¹¹⁵ If the foetus can only be expected to survive after birth for a short time or not at all, the criterion of viability is not met, and abortion is in the opinion of the NVOG probably legal. If the foetus has a chance of survival, but only if given life-prolonging treatment, and this would lead to a 'life not worth living', or if the baby might live without life-prolonging treatment but in circumstances such that active termination of life would be considered legitimate, the NVOG considers abortion acceptable.¹¹⁶ The NVOG proposes a number of procedural rules of careful practice generally similar to those for other MBSL. The NVOG takes the position that the doctor must report the death as a 'non-natural' one.

Although there have been a number of cases reported to the prosecuting authorities (see chapter 5.3.3), we know of no court decisions clarifying the law on this point.

3.3.3 *Coma (PVS) patients*

The second CAL report (CAL 2,1991) deals with long-term coma (often referred to as 'persistent vegetative state' - PVS), defined as a severe form of loss of consciousness in which all communication and normal movement are impossible.¹¹⁷

In the Netherlands, about 1000 patients per year experience a coma that lasts longer than 6 hours; of these, about 100 per year ultimately fall into a long-term coma.¹¹⁸ The longer the condition lasts (the age of the patient and the traumatic or non-traumatic cause of the coma also being important variables) the greater the chance that the coma will prove to be irreversible or that it will be followed by permanent and serious physical and mental handicaps.

¹¹⁵ NVOG 1994.

¹¹⁶ If the foetus survives the abortion, the NVOG observes that the NVK guidelines suggest that life-prolonging treatment should not be commenced, and recommends that gynecologist and pediatrician should have agreed on this course of action before the abortion.

¹¹⁷ CAL2: 5-7. In 1994 the Health Council issued a thoughtful and carefully-researched report on patients in a 'vegetative state' (Gezondheidsraad 1994); on the whole, the positions taken are very similar to those of the CAL

¹¹⁸ CAL2:9.

The CAL describes current treatment policy in the case of long-term coma on the basis of the literature and discussions with a number of those directly involved. Treatment is primarily directed at keeping the patient alive. By contrast with seriously defective newborn babies, treatment policy is generally not influenced by the unfavorable prognosis. A number of factors seem to be responsible for this, among them the personal opinions of those directly concerned (the attachment of nursing personnel and family members to the patient can be important) and the religious principles of the nursing homes involved. The CAL observes that "non-medical and subjective motives ... [appear to play an important role] in connection with life-prolonging behavior" and "there does not appear to be any consensus concerning ... the applicable criteria,!" But the nature of the medical situation is also an important explanation for the fact that putting an end to life-prolonging treatment is so rare. As time passes, the certainty of the prognosis increases, but often also the patient's independence of the more intensive forms of life-prolonging treatment (such as artificial respiration). Only ceasing artificial feeding remains as an option, and the acceptability of this is sufficiently controversial that it seldom occurs. Termination of life with euthanatica encounters even greater resistance from those involved in treatment decisions. At most they wait for an unrelated medical problem such as an infectious disease to present the opportunity for abstinence.

Apart from an unfavorable prognosis, the most important reason, in practice, for abstaining from (further) life-prolonging treatment is the presence of a written 'advance directive' [*schriftelijke wilsbeschikking*] or information concerning the 'presumed will' of the patient. These are accorded significant weight, especially in non-religious institutions (although if there are objections on the part of the family to carrying out the patient's will, these apparently often prevail). The opinion of the Commission is that the will of the patient should be accorded a "crucial and determinative role" in the decision-making, whether or not the "personal opinions" of family and close friends, or of the doctors, happen to concur. If the patient has not explicitly consented to life-shortening treatment in advance, a doctor may justify his intervention on the basis of the patient's 'presumed will', for instance by consulting family and close friends about this, but the express will must take precedence.¹¹⁹

For cases in which no 'will' of the patient can be ascertained, the CAL argues that the point of departure in the decision-making should be "the question whether continued life-prolonging treatment is legitimate": The Health Council justifies reversing the question of legitimacy in this situation as follows: life-prolonging treatment requires the consent of the patient, but this can in the circumstances only be a 'presumed consent'; the assumption that the patient would consent is no longer reasonable when further treat-

¹¹⁹ CAL: 20.

¹²⁰ CAL: 15-20; 37-40.

merit serves no "convincing purpose that is relevant for the patient" (i.e. prolongation of a vegetative state without hope of recovery).": The CAL's approach is slightly different. It argues that "a continuing (limited) biological life without consciousness ... is an insufficient condition to legitimate further treatment,"!" Since the preceding medical treatment is partly responsible for the patient's situation,

one cannot invoke as a justification for continued treatment the mere presence of life.... For one has oneself contributed to the specific situation in which this life now is. One is therefore at least partly responsible for that situation. That the patient is alive is of course relevant and of great importance, but it is not a sufficient reason for continuing treatment.¹²³

Continuing treatment simply to prolong a limited biological life is inconsistent with "human dignity", both because "one [thereby] may be doing something that the person in question would not have wished" and "because one prevents the dying process from coming to an end"!"

Waiting for a complication or an unrelated medical problem from which one can let the patient die implies - incorrectly, in the view of the CAL- that maintaining the patient in a comatose situation does not itself entail intervention. "The question whether the life-prolonging treatment should be continued always comes first. 'Waiting' (that is, continuing treatment) is only acceptable as the outcome of an explicit decision, based on the meaningfulness of the treatment"!"

The CAL suggests a limit of about 1 month for traumatic and 6 months for non-traumatic coma as the point at which the chance of recovery is too slight and the risk of permanent serious handicap in the case of recovery too great to justify further life-prolonging treatment.!"

The 'priority principle' implies that use of euthanatica to terminate life should only be considered once it has been decided to discontinue the existing treatment, including artificial feeding. One has thereby in fact already accepted the death of the patient, so

121 Gezondheidsraad 1994: 46.

122 CAL 2: 22.

123 CAL 2: 25; boldface in original.

124 CAL 2: 25-26.

125 CAL 2: 28.

126 In the final, integrated report (KNMG 1997), guidelines of 12 months in the case of trauma and 3-6 months in the case of non-trauma are proposed, based on more recent international studies. Compare Gezondheidsraad 1994: 37-39.

that, as we have seen above, use of euthanatica to avoid further suffering in the dying process may be legitimate. The State Commission on Euthanasia had proposed in its 1985 report to make an exception for the case of irreversible coma to the "central principle" that "intentional termination of life without a request therefor from the person concerned cannot be allowed": The Commission reasoned on the basis of the priority principle: termination of life is only possible after "treatment that according to current medical knowledge is futile" (that is, "cannot lead to any improvement in the situation of the patient") has been stopped. The legitimacy of active termination of life lay, in the Commission's view, in the <inhuman deterioration' [*ontluistering*] that the patient would undergo once artificial feeding is stopped. It is not clear why the State Commission did not recognize a similar legitimization in the case of severely defective newborn babies and other unconscious patients.

When the medical situation of the patient does not itself indicate the appropriate course of action, the views of the family are as important as those of parents in the case of severely defective newborn babies. The CAL recognizes that nursing personnel, too, can be "an important source of information" and can play a "valuable role" in a careful decision-making process; they should be included in all discussions in the medical team. If, once the views of all parties involved are known, the conclusion to be reached is not clear, it is "essential" that the responsible doctor consult an experienced, independent colleague.¹²⁷ These passages concerning the role – both procedurally and substantively – of the family, nursing personnel and an independent colleague are rather vague. Sometimes it seems that if the decision to be taken is clear, the responsible doctor can act without consulting anyone: that the participation of the others is only necessary in cases of doubt. At other places one reads that the participation of the other parties is of great importance. The general approach of the CAL would seem to imply that the doctor is in any event bound to ascertain from the family and nursing personnel information relevant to the 'will' of the patient. However this may be, the 'requirements of careful practice' are becoming so well-settled throughout MBSL practice that it seems highly unlikely that they will be any less stringent here than in other situations.

In early February of 1992 the Committee of Procurators-General announced its decision, with which the Minister of Justice agreed, not to prosecute a specialist who had ended the life of a 20-year-old, irreversibly comatose patient. The man had been found lying unconscious on the street, brought to hospital and reanimated (*in dubio fac*). It

127 State Commission 1985: 44-46. The Health Council assumed that cessation of artificial administration of food and drink generally leads to a 'peaceful death' (Gezondheidsraad 1994: 13); this is presumably the reason that it did not consider the legitimacy of use of euthanatica in such cases.

128 CAL2: 39-42.

then appeared that he had had a heart attack that had resulted in severe brain damage from which the chance of recovery was negligible. Since continuation of treatment was considered futile, artificial respiration was stopped in the expectation that the patient would quickly die. This did not happen, but the man's breathing was irregular and in the opinion of the doctor he was suffering severely. After extensive consultation with colleagues, the doctor came to the conclusion that 'active' termination of life with a euthanaticum was unavoidable. In answering questions in Parliament about the decision not to prosecute, the Minister of Justice said that this was based on "the combination of concrete, special circumstances, which in this case would have led to a successful defence of [necessity]". The PGs were of the view, the Minister emphasized, that their decision in this case created no "precedent":¹²⁹

In light of the recent cases dealing with 'active' termination of life in the case of newborn babies (see section 3.3.2), it seems very likely - despite the Minister's insistence that no precedent was being set - that the decision not to prosecute accurately reflects current Dutch law. The 'priority principle' seems to have been applied precisely as intended, and the decision to allow the patient to die by abstaining from further treatment was thus the essential decision, the administration of euthanatica a merely derivative one.

3.3.4 'Help in dying'

'Intentionally' and 'actively' shortening the life of a person without his explicit request is *prima facie* murder. Until recently, all participants in the Dutch public discussion seemed to agree on two propositions: such behavior is surely criminal, and it has nothing to do with euthanasia. At most the possibility of a justification in truly extraordinary circumstances was grudgingly acknowledged. Nevertheless, as we have seen in the preceding two sections, the realities of medical practice have recently overtaken the public discussion.

While anticipated as far as coma patients are concerned in the State Commission's report of 1985,¹³⁰ the problem only really entered the public debate with the publication of the results of the first national survey of MBSL in 1990. It appeared that Dutch doctors were

¹²⁹ *Second Chamber of Parliament* 1991-1992, *appendix*; no. 394. From a newspaper account of the case (*de volkskrant* 14 February 1992) the following additional facts appear: The decision was preceded by intensive discussions with the family and the patient's GP to ascertain what his wishes would have been. Two independent doctors were consulted, and the responsible doctor discussed the case with nursing personnel and with the deceased's 'spiritual advisor'. He informed the coroner of his proposed action beforehand and reported the case afterwards.

¹³⁰ See appendix I-C-1. See also the brief of R Emmelink as Advocate-General in the *Pals* case (Supreme Court, 21 October 1986, *Nederlandse jurisprudentie* 1987, no. 607: 2126-2127).

terminating life without an explicit request at a rate of about 1000 cases per year. In 1995 the rate was about the same. (See chapter 5.3.2 for the relevant data.)

The Rummelink Commission (see chapter 2.4), which supervised the 1990 research, came to the conclusion that at least some part of this practice should be regarded as 'help in dying': administration of euthanatica to speed up the dying process in the case of a patient whose bodily functions are successively and irreversibly failing.¹³¹ The Commission regarded 'help in dying' as 'normal medical practice, so that the patient's death can be reported as a 'natural' one (that is, due to the condition from which the patient was already dying). It seems likely that 'help in dying' has long been rather standard medical practice. However, the suggestion was received in Parliament with expressions of outrage,¹³² and nothing much has been heard of it in the public discussion since.

Nevertheless, as we have seen in the preceding two sections, there is growing acknowledgement that some forms of termination of life without an explicit request can indeed be justified under specified circumstances and subject to a regulatory regime ('requirements of careful practice') similar in most respects to that for euthanasia. In the early 1990s, authoritative reports from within the medical profession began to suggest this. Recently, in court decisions described in sections 3.3.2 and 3.3.3, the position taken in these reports was confirmed with regard to severely defective newborn babies and coma patients.

In a recent case, the principles involved in the case of newborn babies and coma patients received a more general application, perhaps signalling a rebirth of the idea of 'help in dying'. The defendant, a urologist, was prosecuted for manslaughter for having ended the life of a patient with a euthanaticum. The defence was necessity in the sense of conflict of duties. The patient had been admitted to hospital for optimal pain relief while awaiting death from prostate cancer that had spread to the bones and was no longer treatable. He was suffering continuously, seriously and without prospect of improvement and himself considered the situation unbearable and hopeless. From the outset, a non-reanimation decision was taken. To relieve the patient's pain, increasing doses of various drugs were tried, but without success. Use of morphine was decided upon after discussion with the family (in light of the risk that this would hasten the moment of death), but this, too, proved insufficient even after the dosage was greatly increased. An anesthetist was consulted and advised using another drug to keep the patient unconscious until he died. Shortly after this was administered, the patient ceased breathing for several minutes and appeared to be dying. When the patient nevertheless recommenced breathing, the doctor administered a euthanaticum: he considered it inhumane to allow the patient to

¹³¹ Commissie Rummelink 1991: IS, 32, 37.

¹³² See Gevers 1992.

regain consciousness (especially since brain damage might have occurred in the period in which breathing had stopped), and it was not possible at short enough notice to get a new dose of the drug used to render the patient unconscious. The District Court concluded that the defendant had acted in a situation of necessity in which "after balancing the conflicting duties and interests, he had made a choice that objectively considered, and in light of the specific circumstances of the case, could reasonably be regarded as justifiable."The doctor was acquitted of the charge of manslaughter.¹

In short, current law is that at least some part of the practice of termination of life without an explicit request, revealed in the surveys of 1990 and 1995, can legally speaking be regarded as justifiable. Without explicitly referring to it, the courts seem to have adopted the 'priority principle' argued for in the reports mentioned above: the essential decision that the patient should be allowed to die is taken in the context of abstinence from (further) life-prolonging treatment, and only thereafter is 'active' intervention with lethal drugs justifiable as a form of 'help in dying'. If such help in dying were to become accepted as 'normal medical practice', application of the priority principle could considerably reduce the frequency of euthanasia and termination of life without an explicit request.

3.3.5 *Assessment of the approach of the CAL and NVK reports*

The most important contribution of the CAL reports to legal development concerning medical behavior that shortens life probably lies in the insistence that the question of the legitimacy of *life-prolonging* behavior has priority over the question of the legitimacy of *life-terminating* behavior. Intractable problems concerning the role of 'quality of life' considerations in the decision-making become much less intractable when the question of legitimacy is stood on its head in this way. The 'priority principle' based on this approach has begun to bear fruit in court decisions. The distinction made by the NVK between life-prolonging treatment that has no chance of success and treatment that can-

133 District Court, Almelo, 28 January 1997. He was also acquitted for lack of evidence of a subsidiary charge of euthanasia. He was convicted for having submitted a false report of a natural death and fined f 5000. The Court explained this relatively heavy fine by observing that defendant had violated the trust that doctors enjoy in such cases, suggesting that the false report was intended to avoid a possible criminal prosecution. This latter suggestion seems dubious in light of the evidence (see chapter 5.3.2) that many doctors consider the death in such circumstances a 'natural' one, as indeed did the Rummelink Commission. In a somewhat similar case, also in Almelo, almost 10 years earlier, a doctor was convicted of murder and given a suspended sentence, but in that case the doctor had violated most of the 'requirements of careful practice' (consultation, investigation of alternatives, administration by the doctor himself) (*'Tijdschrift voor Gezondheidsrecht* 1988, no. 43).

not lead to a 'life worth living' (as operationalized by the NYK), together with its insistence that life-prolonging treatment can be as lacking in legitimacy in the latter as in the former case, has proved very influential. Apart from developments in the case law, these reports are the most important contributions to the public discussion of MBSL since the report of the State Commission in 1985.

3.4 The demented elderly

About 8500 persons are admitted per year to psycho-geriatric institutions and about 8000 per year die there. In 1990 there were more than 15,000 persons in nursing homes with dementia as primary diagnosis. The total number of persons in the Netherlands with a demential syndrome is estimated at 100,000.¹³⁴ Both in a quantitative sense and, as we will see, substantively as well, the problem of MBSL in the case of senile dementia raises problems of a dramatically different order of magnitude from those we have considered so far.

The patients concerned are not entirely non-competent during the entire course of the decision-making. Rather, they gradually, and with periods of remission, but nevertheless inexorably and irreversibly, lose competence. The large number of patients involved, their age,¹³⁵ and the institutional setting likewise have profound consequences for medical practice and for its legal regulation.

In describing current treatment practice in the case of severely demented patients, the CAL (by contrast with its two earlier reports on severely defective newborn babies and on coma patients), was not able to provide more than vague generalizations. The absence of clear criteria and established procedures is striking. Written protocols hardly exist and, to the extent that institutions have treatment policies, these are not generally available and are not made known at admission.¹³⁶

Two forms of life-prolonging treatment are of particular importance in the case of severely demented patients: use of antibiotics and artificial feeding. The crucial point in the decision-making concerns the initiation of treatment for a life-threatening condition.

134 See CAL 3: 14-15. On MBSL in the case of demented patients, see also NVV 1997, which discusses many of the same issues as CAL 3. The possibility of 'letting oneself die' (*versterven*) is, however, not discussed, and as far as competence is concerned this report argues that competence to refuse life-prolonging treatment should have to meet a stricter standard than competence to consent to it - which seems a peculiar position when one considers that one and the same decision is involved.

135 Alzheimer's disease is responsible for 50-70% of all dementia. Alzheimer's is primarily a disease of the elderly. Its incidence is about 3.2% of persons 70 or older and 10.8% of persons 80-89. (CAL 3: 14)

136 CAL3: 21.

The considerations taken into account are the chances for recovery or improvement, the additional burden of the treatment itself, the views of the family and (if ascertainable) the views or wishes of the patient. Life-prolonging treatment is discontinued on the basis of similar considerations, but some doctors limit such discontinuance to the 'dying phase'. Most doctors consider artificial feeding a medical intervention that can be discontinued. Pain relief is only used when medically indicated, although accelerating the dying process is accepted as a secondary effect. Active termination of life does not occur.¹³⁷

In current practice, the patient's wishes play only a limited role in the decision-making, although the wish of a patient who, for example, repeatedly pulls out the feeding tube is generally respected. 'Advance directives' are still rare and are usually couched in general terms. The doctors concerned are of the view that such a document "can never take the place of the doctor's judgment about the patient's situation", although they are prepared "to take its contents into consideration": In practice, advance directives play essentially no role in the decision-making.¹³⁸

In the Commission's view, two questions are of central importance in assessing the acceptability of life-shortening treatment for these patients: Under what circumstances is life-prolonging treatment no longer legitimate? And what is the relevance of the remaining capacity of the patient to participate in the decision-making, and how can the wishes of the patient be ascertained? In connection with the second question there is also the problem of patients who "in an early stage of dementia make requests that are consistent with their preceding way of life and personality" but who, when the dementia is more severe, resist effectuation of their earlier request!" or do not appear to be suffering unbearably.¹⁴⁰

The Commission takes the position that the competence of the patient is not a matter of all or nothing. The remaining autonomy of the patient should be respected as much as possible, and in this regard the patient's determination and the family's judgment should be taken into account. The mere fact that his wishes seem unwise is no reason to ques-

137 CAL 3: 19. According to the national surveys of 1990 and 1995 (see table 5.4) about two-thirds of all deaths for which nursing-home doctors are responsible involved a MBSL, roughly equally divided over abstinence and pain relief. The CAL makes no comment on the fact that there is apparently a far higher level of death due to MBSL in nursing homes than one would expect from the Commission's findings.

138 CAL 3: 22-23. Compare the findings for the United States of Teno et al. 1997a, 1997b.

139 The CAL seems with this offhand reference to suggest that it is conceivable that an earlier euthanasia request be carried out on a resisting patient. As far as we are aware there is no one in the Dutch euthanasia discussion who would defend such an idea.

140 CAL 3: 24-25.

tion a patient's competence. The balance of positive and negative effects of the patient's choice is important: when a patient whose remaining life expectancy is limited refuses food and drink, this should be respected even if the patient has hardly any remaining competence. Refusal of pain-killers or of food by a patient whose dementia is still only moderate could lead to the opposite conclusion. "The criterion used to determine competence ... should be more demanding to the extent that the consequences are more serious,"!

The legitimacy of life-prolonging treatment should, according to the Commission, be judged from a number of perspectives. In the first place, the patient's express wishes should be "determinative" if the patient is competent to indicate what he or she wants. If not, the question whether medical treatment is legitimate must be answered on other grounds. The "presumed will" of the patient is in that connection the most important "guideline". This can be ascertained either from an 'advance directive' or, if none is available, the patient's "concept of his life as a whole" can be reconstructed with the help of his family and close friends and nursing personnel.!

If an express or 'presumed' will does not give a decisive answer, then a judgment concerning the legitimacy of life-prolonging treatment must be based on the burden for the patient of the treatment in question and the expected positive effects: in other words, on what the doctors and the close relatives and friends of the patient consider to be in his interest. The Commission considers these factors a specific operationalization of the concept of 'futile medical treatment' in the context of treatment decisions with respect to severely demented patients.!" Elsewhere, the Commission observes that a decision based on such factors does *not* imply a "judgment about the quality of life of the patient concerned, but primarily one concerning the added value or the point of medical treatment!"! In the last phase of severe dementia,

the legitimacy of further treatment ... ceases. The demented patient would be reduced ... to a number of still intact physiological functions. Since improvement can no longer be achieved, the dying process would simply be drawn out: treatment in such circumstances brings the patient into an inhumane situation and keeps him in it longer than necessary.:"

As in its report on long-term coma patients, the Commission emphasizes the importance of the 'priority principle' in the decision-making: consideration of the legitimacy

141 CAL3:26-31.

142 CAL3: 32-33, 60.

143 CAL3: 32-35.

144 CAL3: 50.

145 CAL 3: 36-38.

of life-terminating treatment is only appropriate after the conclusion has been reached that (further) life-prolonging treatment is not legitimate and it has been stopped.":

The Commission appears to attach far more weight to an 'advance directive' or appointed representative than is common in current practice, and it expects an increasing use of such instruments in the near future."? But the Commission's support for this way of involving the patient's own will in the decision-making is qualified. The "opinion" of the appointed representative, for example, "should be accorded ... great weight," but the representative must be able to "make it plausible that his/her instructions really represent the patient's wishes": And if the patient has provided that "he or she does not want to be subjected to certain treatments ... then *in general* this wish should be respected" [italics added]. Elsewhere the Commission observes that at the moment of writing such an 'advance directive', a person can hardly "imagine what the later situation will be like" (but qualifies this remark with the observation that the same applies to doctors and relatives and friends who are called upon to take decisions for the patient). At the end of its treatment of 'advance directives', the Commission is not prepared to go further than the proposition that if such a written request is clear and current enough, "and in addition ... the appointed representative (if any) of the patient confirms its contents, then a doctor is obliged to respect it."¹⁴⁸ In this, it seems to fall short of the requirements laid down in the Law on Contracts for Medical Treatment, that became effective in 1995 (see section 3.1.3).

The legitimacy of euthanasia pursuant to an 'advance directive' in which the patient requests it in the case of severe dementia - something the Commission expects to occur more frequently in the future - raises two questions: whether serious dementia meets the criteria for euthanasia (as these have been worked out in the Dutch case-law), and how the doctor is to decide that the moment has come for carrying out the request.

The key problem with respect to the criteria for euthanasia is that the patient's request in an 'advance directive' is not based on contemporaneous suffering but on the prospect of becoming severely demented. In all probability a severely demented patient does not suffer from the dementia itself. Unlike the case of euthanasia there is thus no situation of 'necessity' arising out of a "direct and intensive contact with the patient, who experiences his/her situation as unbearable". If dementia is accompanied by some other condition that does cause serious suffering, or if carrying out an 'advance directive' to terminate

146 CAL3: 50.

147 CAL3: 35.

148 CAL 3: 38-43. The Commission also notes that positive requests for a particular form of treatment - for example, generous use of pain relief - should be honored so long as they do not conflict with the professional standard.

artificial feeding places the patient in an unacceptable situation, then some members of the Commission consider euthanasia legitimate; others would "want to limit themselves to relieving the patient's suffering, accepting as a secondary effect that this might lead to an earlier death":¹⁴⁹

Despite its reservations, the Commission concludes by observing that, if the prospect of severe dementia did not satisfy the criteria for euthanasia, it would never be possible to honor an 'advance directive' requesting it. The Commission considers such a «categorical conclusion - considering the extent of the loss of dignity [*ontluistering*] associated with advanced dementia - not easy to defend!"?

The second problem with an 'advance directive' requesting euthanasia is that it requires the doctor to decide *when* to carry out the patient's request. In a normal case of euthanasia, it is the patient's 'concrete request' that determines the time termination of life takes place. But carrying out euthanasia on the basis of an 'advance directive' requires the doctor to determine the moment at which the patient's criteria have been met. "The doctor becomes responsible for a not unimportant part of the patient's decision." The CAL considers that this "cannot necessarily be expected of a doctor": In fact, the objection is probably fatal to the prospects of euthanasia pursuant to advance directive on any significant scale."¹⁵¹ The situation is perhaps less difficult - at least for the doctor - if the patient has appointed a representative who can determine when the moment has come."¹⁵²

As far as termination of life with euthanasia on the basis of a 'presumed will' is concerned, the Commission does not go further than the observation that it is not impossible for such a will to be "convincingly reconstructed". Whether termination of life can be legitimated on such a basis the Commission leaves to further discussion. However, if the reconstruction satisfies the strictest demands and, apart from severe dementia, the patient is also apparently suffering severely from other disorders, the Commission considers termination of life legitimate (it does not expect the situation to occur frequently).¹⁵³

In the absence of an 'advance directive' or a 'presumed will', termination of life can only be legitimated in terms of the seriousness and duration of suffering: there would have to be a situation of necessity "in which the patient's situation is inconsistent with human

149 eAL3: 45-46.

150 CAL3: 42-48.

151 See also Keizer, cited in Holsteyn & Trappenburg (1996: 10-11), for the virtual impossibility that a doctor could honor an 'advance directive' requesting euthanasia under specified, future conditions.

152 CAL3: 46-47.

153 CAL3: 48.

dignity': The dementia itself is in any event an insufficient condition. It would have to be demonstrated that termination of life is not in violation of the '(presumed) will' of the patient. Family and friends would have to consider termination of life acceptable. The Commission concludes that the legitimacy of terminating life under such circumstances is so complex a question that it does not feel able to take a position on it at present. If, however, the conditions stated are not met, then it is certainly not legitimate.t"

In short: it is much too early to predict with any confidence how the law is going to develop on this matter. It seems unlikely that in the case of senile dementia 'active' termination of life with euthanatica, except in the form of 'help in dying' after the termination of life-prolonging treatment, will ever play more than a marginal role: the patient who requests it is of doubtful competence, 'advance directives' (even when accompanied by appointment of a representative) present too many seemingly insuperable problems, and termination of life with no request at all is hard to justify except under exceptional circumstances. The most important MBSL in these cases will continue to be abstinence. The most important legal developments will therefore probably concern the binding force of 'advance directives' or of instructions from an appointed representative in which life-prolonging treatment (including artificial feeding and hydration) is refused.':"

3.5 Euthanasia in the absence of somatic suffering

Much of the discussion further on in this section assumes that for purposes of the regulatory regime applicable to euthanasia and assistance with suicide a distinction can be made between somatically based and not somatically based suffering. It is generally recognized that a distinction between 'physical' and 'mental' suffering would be untenable, since all suffering is 'mental' and all of it involves impairment of functioning. The question here is a slightly different one: whether suffering can be differentiated in terms of its source.

The question is less important than it once seemed,"? since its relevance for regulation was significantly reduced by the holding of the Supreme Court in the *Chabot* case (see sections 2.4, 3.5.1 and appendix 11-2) to the effect that not somatically based suffering

154 eAL3: 49.

155 Sec note 11 on refusal of food and drink [*versterven*].

156 See the position of the KNMG of 1984 and the nurses' organization 'Nicuwe Unie' of 1992 (KNMG 1992:47), rejecting euthanasia in the absence of a somatic source of the patient's suffering.

can support a valid request for assistance with suicide. However, as the *Chabot* case also makes clear, the distinction does remain relevant for the consequences of the patient's refusal of treatment and for the substance of the consultation requirement and the consequences of inadequate consultation. It is therefore worth raising the issue whether the distinction deserves the status still accorded it.

What ultimately is the intrinsic significance of the somatic/non-somatic distinction? Euthanasia or assistance with suicide in a case of suffering of somatic origin usually involves a shortening of life on the order of days or weeks (see table 5.11), although in the case of a few conditions such as MS, AIDS, and paraplegia, it may be much more than that. The shortening of life involved in a case of non-somatic suffering will usually be far greater. The Supreme Court in *Chabot* presumably had this in mind in referring specifically to the requirement of 'proportionality' in the case of a patient whose suffering is non-somatic and who has refused a realistic alternative to assistance with suicide: the burden for the patient of treatment less easily outweighs the benefits when the life to be won is significant. Is this, then, a reason to distinguish cases of somatic and of non-somatic suffering so far as the defence of necessity is concerned?

Not all cases of non-somatic suffering involve a substantial remaining life expectancy. It is not clear that this was true in the *Chabot* case. The various experts Dr. Chabot consulted were agreed that Ms. B was likely to attempt suicide again within a month if not given assistance. The argument that a patient's life expectancy should be considered in isolation from his suicidality was specifically rejected by one of these experts as irrelevant, since in that case the patient would be a different person."? So the distinction somatic/non-somatic is not necessarily congruent with the problem of proportionality.

The idea that in cases of non-somatic suffering there is more reason to doubt whether the patient's request is voluntary and well-considered does not, on further inspection, support the distinction: a patient suffering from somatic causes may also suffer from diminished competence, and the competence of patients whose suffering is non-somatic need not necessarily be in question at all. In short, the distinction is not congruent with the problem of competence.

Euthanasia or assistance with suicide in the case of non-somatically based suffering may entail serious problems of establishing after the fact that the patient was suffering unbearably, was competent, and wanted to die. This seems an obvious reason for wanting to impose special procedural requirements in cases of non-somatic suffering. Cancer is the main occasion for euthanasia in the Netherlands, and cancer leaves a substantial

trail of corroborating evidence behind. Where x-rays, laboratory reports and autopsy evidence of (probable) suffering and a (likely) request are lacking, the reports and the testimony of other doctors who examined the patient can be particularly important. Nevertheless, as the *Chabot* case illustrates, the distinction somatic/non-somatic is not always congruent with the need for such corroborating evidence: there was in fact a wealth of corroboration concerning the situation of Ms. B.

Finally, whatever the merits or demerits of the distinction between somatic and non-somatic suffering, it seems questionable whether it can be made to stick in practice. Increasingly, psychiatric conditions that used to be considered entirely non-somatic in origin are being found to include biological factors in their etiology. Instead of a sharp line there seems to be a considerable grey area that is gradually effacing the formerly distinct categories on either side. In short, it seems unlikely that the distinction somatic/non-somatic can be made to do the major work that its role to date in the public discussion and in legal development demands.!"

3.5.1 Persons whose suffering is due to a psychiatric disorder

As we have seen (section 3.1.4 above), Dutch law has generally made no distinction between killing on request and assistance with suicide as far as the justifiability of the doctor's behavior is concerned and the 'requirements of careful practice' that apply. Nevertheless, in connection with suffering not based on a somatic condition it is almost universally assumed that what is at issue is assistance with suicide.!"

Of a total of about 1600 suicides per year in the Netherlands, about half are by persons with some psychiatric history (45% have been institutionalized at some time); about 250

158 As we will see in chapter 6.3.2, a system of decriminalized control could deal with differences in proportionality and the other differences of degree that may sometimes be associated with the difference between somatically and not somatically based suffering far better than can a system of criminal control.

159 See CAL4; NVP 1992; Van der Wal & Van der Maas 1996: 202; *Chabot*, appendix II-2.

of these are persons who are institutionalized at the time.¹⁶⁰ Psychiatric disorders are reported by doctors as the most important illness of the patient in about 1% of all cases of euthanasia (and in 14% of the cases in which euthanasia is refused). Psychiatrists are regularly consulted by non-psychiatrists in connection with requests for euthanasia, usually in cases involving a somatic disorder. Dutch psychiatrists receive some 320 serious requests for assistance with suicide per year; some 2 to 5 of these are granted, in more than half of which the patient is also suffering from a fatal somatic disorder (see chapter 5.3.4).

The terminological confusion that suffuses the preceding paragraph is characteristic of the legal and ethical discussion.¹⁶¹ Under the misleadingly simple label 'psychiatric patients' lurk situations that pose some quite different problems: (1) *psychiatric patients*¹⁶² who seek assistance with suicide *from a psychiatrist* because of *suffering due to their psychiatric disorder*, including as a special case persons *voluntarily or involuntarily institutionalized* with a psychiatric disorder; (2) persons who seek assistance with suicide *from a non-psychiatrist* because of a *psychiatric disorder*, (3) persons who seek the *assistance of a psychiatrist* in committing suicide although they have *no psychiatric disorder and also are not suffering based on a somatic condition*; (4) persons who request assistance with suicide *from a psychiatrist* because of *suffering due to a somatic condition*; (5) persons who request euthanasia because of a somatic disorder, but whose *competence is in doubt* because of a (suspected) psychiatric disorder.

In this section we are concerned with persons whose suffering is due to a psychiatric disorder, whether or not they are 'patients', whether or not they are under treatment by a psychiatrist, whether or not they are institutionalized, and whether or not it is a psychia-

160 CAL 4: 9; for data on total suicides per year see CBS, *Statistisch Jaarboek* 1997: 439. Psychiatric patients account for far more than their share of suicide: their frequency is 10 times that of the population as a whole, and 30-40 times higher if only institutionalised patients are considered. About half of all suicides are by persons who have some psychiatric history. Only an estimated 5% of all suicides appear free from serious psychiatric disorder.

The CAL data are a decade old and in some respects the situation is now different; for the most recent data on suicide see Kerkhof 1996. Among other things, it appears that by 1993 half of all suicides were by persons currently under treatment for a psychiatric condition and 75-80% had had such treatment at some time. Since the total number of suicides has been declining in the Netherlands, Kerkhof interprets these data as indicating greater success on the part of the institutions and doctors concerned in coming in contact with the population at risk.

161 See e.g. Van der Wal & Van der Maas 1996: 202-203.

162 Both the CAL and the NVP identify a 'psychiatric patient' as someone being treated by a psychiatrist for a 'psychiatric disorder' (CAL 4: 3-6; NVP 1997: § 1.5).

trist who is asked to render the assistance. The possible importance of the latter questions will emerge in the course of the discussion. The special situation of persons with no disorder at all who approach a psychiatrist (or another doctor) for assistance with suicide is considered in section 3.5.2. The problem of persons whose suffering is somatic but whose competence is in question was touched on in section 3.1.3.

Until the beginning of the 1990s (despite indications to the contrary in some early judicial decisions - see for example the *Wertheim* case discussed in chapter 2.2) it was quite widely supposed that legitimate euthanasia or assistance with suicide requires 'physical suffering' and a 'terminal illness' and that it is not available for persons whose suffering is based on a psychiatric disorder. The Health Council's *Advice on Suicide* of 1986 observed that the competence of a psychiatric patient is not always problematic, but the Council was divided on the question whether non-somatically based suffering alone could afford sufficient legitimation for assistance with suicide.¹⁶³ The Medical Association concluded in its policy statement of 1991 that "a somatic condition or pain" is generally required and that it is "doubtful whether a [psychiatric] patient can be considered capable of making a well-considered and entirely voluntary request".¹⁶⁴ After the Medical Association and the Ministry of Justice had agreed, in late 1990, on a procedure for doctors to report cases of euthanasia, the National Inspectors for Public Health and for Mental Health stated in 1991, in a joint letter to all doctors, that this procedure was not applicable to psychiatric patients because a psychiatric condition could never afford a basis for assistance with suicide.¹⁶⁵

The letter of the Inspectors led to a great deal of criticism, including questions in Parliament. In its answer to these, the Government disavowed the categorical position of the Inspectors. In 1993 the Inspector for Mental Health brought out a report concluding that exceptional situations are possible in which assistance with suicide at the request of a psychiatric patient could be legitimate; the letter of 1991 was withdrawn.¹⁶⁶ In the meantime, the Dutch Association for Psychiatry (NVP) had issued a report rejecting the idea that a psychiatric disorder necessarily affects the patient's competence and adopting the position that assistance with suicide for such patients does not differ in principle - and need not be judged in a different way - from euthanasia in all other cases.¹⁶⁷

Beginning in the mid-1980s, the courts had been confronted with a number of cases in which these issues were presented. With the exception of one decision of the Central

¹⁶³ Gezondheidsraad 1986.

¹⁶⁴ KNMG 1992: 30.

¹⁶⁵ See Legemaate 1993: 758-759.

¹⁶⁶ See Legemaate 1993: 759.

¹⁶⁷ NVP 1992.

Medical Disciplinary Tribunal that led to the letter of the Medical Inspectors mentioned above, the judgments seemed to allow room for assistance with suicide in the case of psychiatric patients (see chapter 2.4). By 1994 all these developments appeared to have arrived at a tentative resolution. In November 1993 the CAL published the fourth in its series of discussion-papers: *Assistance with Suicide in Psychiatric Practice* (CAL 4), in which it accepted the legitimacy of assistance with suicide for psychiatric patients. In May 1994 the Dutch Supreme Court rendered its decision in the *Chabot* case, which resolved various questions in favor of the legitimacy of assistance with suicide for persons whose suffering is based on a non-somatic disorder. Finally, the Dutch Association for Psychiatry recently produced a tentative draft of a report, *Assistance with Suicide in the Case of Patients with a Psychiatric Disorder* (NVP 1997); its arguments and conclusions are generally similar to those of the CAL.¹⁶⁸

From the foregoing sketch of recent Dutch developments it is clear that there are two specific questions involved in the legitimacy of assistance with suicide at the request of a psychiatric patient: the question of competency to make a request and the question of non-somatic suffering. The reports of the CAL and the NVP deal with both questions.

COMPETENCE

The CAL rejects the "categorical approach" of the Inspector for Mental Health to the question of competence: "The position that psychiatric patients in general are not competent is ... untenable." The CAL argues that the patient's "actual present competence, not the psychiatric disorder" should be decisive. However, if psychiatrists question the competence of their patients, this is not a matter of "prejudice" but of experience in practice that "treatable conditions ... can give rise to temporary suicide wishes or attempts": The doctor must try to distinguish between "a request that is really meant as such, and one that may well be the symptom of some temporary or treatable condition": The CAL thus situates the problem of assistance with suicide at the request of psychiatric patients at the point of tension between two competing objectives: promoting the welfare of the patient (which may sometimes require paternalistic measures) and respect for the autonomy of the patient.¹⁶⁹

The CAL takes the same position as in the case of dementia (see section 3.4): competence is a matter of more or less. Furthermore, in the case of some conditions, relatively 'good'

168 Because the version available to us at the time this book went to press was not yet the final published version, all references are to section numbers in the final report. See the list of literature at the end of this book for further information on this report.

169 CAL 4: 3-8.

periods may alternate with relatively 'bad' ones.?" The patient's competence can be assessed with the help of a number of criteria, varying from being able to 'express a choice' to being able to 'make a decision on the basis of a rational thought-process' The Commission's position is that if "there is no longer a treatment perspective, the patient is suffering severely and unpreventably, and the patient emphatically and repeatedly expresses the wish to die," it is not necessary that the patient meet "the strictest possible standards of competence": The patient must, however, meet the criterion of "actual understanding of information with respect to the choice":¹⁷¹

The approach of the NVP is slightly different. It is presented as an exegesis of the requirements for justifiable euthanasia in the specific case of psychiatric patients: the patient's request must be 'voluntary and well-considered: A 'voluntary request' is defined as one "free from coercive influence by others"¹⁷² and a 'well-considered' request is one that involves a 'clear choice' for death and in which the patient is able to receive and understand the relevant information, to assess the considerations for and against the choice and to give an explanation for that choice and to take account of the consequences his suicide will have for others. The NVP observes that a psychiatrist must be alert to the danger that "primitive inclinations and drives" that the patient is not consciously aware of may play a role in his choice, but it rejects the idea that all psychiatric patients lack the normal human capacity for a well-considered request."¹⁷³ The patient's request must also be based on an "enduring desire for the end of life", and in the case of a psychiatric patient this means that the request must be made "over a period of *at least several months*, in a well-considered way, repeatedly, and in the presence of others".¹⁷⁴

170 This gives rise to the problem - similar to that in the case of 'advance directives' - that the competent decision (during a 'good' period) and the unbearable suffering (during a 'bad' one) may not occur at the same time. The CAL considers assistance with suicide during a 'good' period in principle legitimate (CAL 4: 14). But carrying out a written request, made during a 'good' period, during a period that the patient is not competent is "in general" not acceptable: one must wait until the patient is competent again (CAL 4: 38-39).

171 CAL 4: 14-15, 18-21.

172 NVPI997, §3.1.1.

173 NVP 1997: § 3.1.2.

174 NVP 1997: § 3.2 (italics in original). The NVP rejects a requirement of a written request, out of concern that such a request might tend to commit the patient to the request (*ibid.*).

The District Court, Assen (10 October 1997) was recently confronted with the case of a man of 81, in a nursing home recovering from a hip fracture, whose wife had died while he was in the home, and who as a result of refusing to eat was expected to die. A proceeding for involuntary commitment to a psychiatric institution was brought and the evidence showed that although the man knew perfectly well what he was doing, his wish to die was the result of a treatable psychiatric disorder. The Court ordered commitment for the unusually short period of 3 months to see whether he could be helped by treatment.

SUFFERING

The CAL argues that it is "not meaningful to distinguish between types and causes of suffering": What is important is "the individual (psychic) experience" and the possibility of "influencing actual suffering with the help of appropriate medical-therapeutic means". In the CAL's view, it is the treatment perspective that is the central factor in the legitimation of assistance with suicide at the request of psychiatric patients. If there is no longer a treatment perspective, the principal legitimation of medical treatment - "alleviating ... suffering or eliminating it through cure" - is absent.¹⁷⁵ Under these circumstances it

becomes meaningless ... to interpret the patient's wish for death as the result of a psychiatric condition. That may well in fact be the case, but since we have no further possibility of letting the patient continue to live without the condition, and without the wish for death, we will have to change our perspective. The patient, his life-history, his condition and his wish for death are ultimately one existential whole. It is this actual person who must be our measure when we consider what action is appropriate.¹⁷⁶

TREATMENT PERSPECTIVE

The CAL and the NVP are agreed that the requirement that the patient's suffering be 'without prospect of improvement' requires the absence of a 'realistic possibility of treatment', which is taken to exist when, according to current medical opinion, there is a treatment that offers hope of improvement, within a reasonable time, and with a reasonable balance between the expected results and the burden for the patient.¹⁷⁷ The NVP seems to be slightly more restrictive than the CAL in specifying that a 'reasonable time' in any case must be long enough to carry out a "complete psycho-pharmacological protocol together with a protocolled psychotherapeutic treatment directed at a specific complaint": The NVP is emphatic that a patient can only be considered untreatable when every realistic possibility of treatment that "current medical-scientific opinion deems indicated" has been tried without success, and these treatments must reflect the "state of the art";¹⁷⁸

The psychiatric patient's refusal of treatment, unlike that of a patient whose suffering is based on a somatic condition, thus precludes assistance with suicide if the proffered

175 CAL4:36.

176 CAL4: 14.

177 CAL 4: 20; NVP 1997: § 3.3.3.

178 NVP 1997: § 3.3.3.

treatment offers" a reasonable chance of success within a reasonable period!" The CAL does remark in this connection that "expectations with respect to treatment may be based more on hope than on knowledge and experience," with the possible consequence that "the suffering of the patient is pointlessly prolonged". The NVP notes that an improvement in psychiatric terms will not necessarily always be experienced by the patient as reducing his suffering, and in such a case refusal may be acceptable.¹⁵⁰ Ultimately, the existence of a treatment perspective must weigh more heavily than the suffering of the patient.¹⁵¹

Why a patient whose suffering is somatically based but perfectly treatable - for example, a patient with diabetes - should be allowed to refuse treatment and still qualify for euthanasia, whereas a patient whose suffering is non-somatically based cannot, has nowhere been satisfactorily explained. Nevertheless, almost everyone (CAL, NVP, Supreme Court) seems to be agreed on the distinction.¹⁵²

INSTITUTIONALIZED PATIENTS

The CAL and the NVP are agreed that an involuntarily committed patient should in principle be discharged before assistance with suicide is given.¹⁸³

The NVP considers particularly difficult the problem of institutionalized suicidal patients for whom there is no treatment perspective but only one of continued physical

179 CAL 4: 21, 40; NVP 1997: § 3.3.4; *Chabot*, appendix II-2. The *obiter dictum* of the Supreme Court, that treatment refused "in complete freedom" would preclude assistance with suicide, is endorsed by the NVP. The expression is peculiar: in the first place because in human affairs there is no such thing as 'complete freedom', and in the second place since it seems paradoxically to imply that a patient whose rejection of treatment is *less* than free does *not* thereby disqualify himself for assistance with suicide.

180 It does insist, however, that "when indicated, biological psychiatric treatments, because of their relatively quick effects and the fact that side-effects are seldom serious, can in no case be refused":

181 CAL 4: 39-40.

182 The NVVE is an exception: it rejects the requirement that a psychiatric patient must accept treatment (NVVE 1996: 29). See chapter 6.3.2 for the possibilities of fine-tuning the relevance of refusal of treatment in the context of a decriminalized control regime.

183 CAL 4: 42; NVP 1997: § 6.1. Neither the CAL nor the NVP consider whether it is necessary to inform the committing court of the proposed release, although prevention of suicide may have been the main reason the court ordered the commitment in the first place. The NVP also considers the case of persons involuntarily confined as a result of a criminal conviction: for a variety of reasons assistance with suicide can only be contemplated after their involuntary confinement is at an end.

restraint and who are suffering unbearably from a psychiatric disorder that precludes a well-considered request. "One is confronted by the limits of what psychiatry has to offer." The choice, in the view of the NVP, is between giving assistance with suicide even though not all the requirements have been met (and thus running the risk of a criminal prosecution), or following the "less official route" and letting the patient leave the institution, knowing that he will probably commit suicide. The NVP regards the former course as 'preferable'; for the CAL the latter course is "indefensible": the risk is too great that such a suicide will take place in a way that the patient and those exposed to it ought not to have to undergo.¹⁸⁴ The CAL in fact considers this risk a specific legitimating factor in the case of psychiatric patients. There is a group of patients who "with great conviction and tenaciousness seek death" and who "end their lives in a hard and violent way that can be traumatic for those confronted with it." "The chance of such an outcome should be taken into account in deciding how to react to a request for assistance with suicide by a psychiatric patient."¹⁸⁵

NON-PSYCHIATRISTS

Neither the CAL nor the NVP considers it in principle impossible that a non-psychiatrist - for example, the patient's GP - give assistance with suicide in the case of a psychiatric patient. If the doctor who receives the request is not himself a psychiatrist, he should discuss the case intensively with the patient's psychiatrist(s) (in particular to establish that further treatment is regarded by them as futile) and consult two independent psychiatrists.¹⁸⁶

CONSULTATION

Because of the special susceptibility of psychiatric patients to suggestion and influence, and the danger that the psychiatrist, too, may be influenced in his judgment by unconscious motives.¹⁸⁷ CAL and NVP argue that an especially high degree of care is required in these cases. In the case of a psychiatric patient there should be consultation with one, and in difficult cases more than one, independent psychiatrist (or other doctor); the consulted doctors must have examined the patient themselves.¹⁸⁸

184 NVPI997:§6.1;CAL4:21-22.

185 CAL4: IS.

186 CAL4: 36-37; NVP 1997: § 6.4.1.

187 The NVP discusses at some length the problem of unconscious motives that can affect the judgment of the psychiatrist (NVP 1997:§ 3.4).

188 CAL4: 37;NVP 1997:§4. The 'Points requiring attention' pursuant to the reporting procedure (see appendix I-B) contemplate consultation with one doctor and at least one other person "with knowledge of the psychological condition of the patient", both of whom have examined the person concerned, in a case of a "patient ... suffering from a psychiatric disorder".

The most important questions to which the consultant(s) should address themselves are "the patient's competence, the treatment perspective, and the problem of counter-transference"; the NVP adds to this the patient's enduring desire for death and the unbearability of his suffering.¹⁸⁹

OTHER 'REQUIREMENTS OF CAREFUL PRACTICE'

Other health professionals (GPs, nursing personnel, psychologists) should, according to CAL and NVP, be included in the decision-making. There must be "good and convincing reasons ... not to inform the family and close friends" (in order to limit their suffering as much as possible), and their judgment can in particular be of importance in connection with the question of competence.¹⁹⁰

The NVP argues that there can be good reasons for the psychiatrist not to insist on being present when the patient commits suicide; and giving the patient the euthanaticum for use within a prescribed period (such as a week) can be a way of keeping the patient from feeling 'obliged' to go through with the suicide. In such cases, however, specific agreements must be made covering the continued availability of the psychiatrist, the place the suicide is carried out, etc., and the GP and close relatives or friends must be notified.

The NVP devotes extensive attention to the importance of careful and complete record-keeping and in this respect goes further than the 'Points requiring attention' pursuant to the reporting procedure, covering all aspects of the case from the initial request through the ultimate carrying out of the suicide.¹⁹¹

THE *CHABOT* CASE

In its decision in 1994 in the *Chabot* case (see chapter 2.4 and appendix 11-2), the Dutch Supreme Court addressed several of the issues involved in the foregoing discussion. The Court's decision answers four important questions:

- a. Can assistance with suicide be legally justifiable in the case of a patient whose suffering does not have a somatic basis and who is not in the terminal phase? The Court holds that it can be.
- b. Can the wish to die of a person suffering from a psychiatric sickness or disorder legally be considered the result of an autonomous (competent and voluntary) judgment? The Court holds that it can be.

189 CAL 4: 42-43; NVP 1997: § 4.2. See note 52 above on the question how binding the consultant's opinion is on the doctor who requests it.

190 CAL4: 15, 19, 28, 33, 36-7, 37-8, 41; compare NVP 1997: §§ 5.1, 5.2.

191 NVP 1997: § 7.

- c. Can the suffering of such a person legally be considered 'lacking any prospect for improvement' if he has "in complete freedom" refused a "realistic alternative to relieve the suffering"?' The Court holds that in principle it cannot be.¹⁹³
- d. What are the legal requirements of consultation in such a case, as far as the defence of necessity is concerned? The Court holds that in the case of not somatically based suffering, the requirement of consultation (specifically, that the consultant examine the patient) is not merely a 'procedural' rule enforceable in disciplinary proceedings, but a condition of the justification of necessity. The different treatment of the consultation requirement in the situation of non-somatic suffering follows, in the view of the Supreme Court, from the "extraordinary care" required in such cases.

We have purposefully included the term 'legal' in each case to emphasize something that non-lawyers tend to forget: the decision of the Court concerns a number of legal terms and norms (in particular, those of the criminal law), not psychiatric or other terms or theories. There are, of course, psychiatrists who as a matter of professional opinion deny the very possibility of a 'voluntary' or 'balanced' request for suicide. As far as the criminal law is concerned, the Court follows the CAL and the NVP in rejecting such a categorical approach. The Court's holding does not address the more specifically professional concern, discussed below, for the delicate and dangerous nature of the psychiatrist-patient relationship, with its problems of transference and counter-transference (misplaced anger, need for control), of blackmail ('If you don't agree to help me, I will do it in a horrible way'), etc.'?"

- 192 The Court's opinion is not entirely clear on whether the "realistic alternative" to which it refers is limited to *medical* possibilities. The brief of the Advocate-General had in fact suggested that 'social' possibilities should be explored. Both CAL and NVP share this view: "Other than medical possibilities ... of reducing the suffering" should also be exploited; but in that case "responsibility for [dealing with the suffering] ... is entirely outside the competency of the doctor" (CAL 4: 36); the NVP includes among the interventions that must be tried: "social interventions that could make the suffering more bearable" (NVP 1997: §3.3.3). The implications of these remarks for what the doctor must do are not entirely clear. See also note 179 on the idea of refusal in 'complete freedom'.
- 193 In the *Chabot* decision this was *obiter dictum*. The rule was applied shortly thereafter in another case which suggests how complicated the question can be. In that case, the District Court, Haarlem (*Tijdschrift voor Gezondheidsrecht* 1994, no. 48), concluded on the basis of expert testimony that there were realistic possibilities for dealing with the patient's suffering which, while it was due to paralysis caused by several strokes, was treated by the Court as essentially non-somatic in character. The Court held that the doctor had too readily accepted the patient's refusal of any alternative to assistance with suicide.
- 194 The risk of transference and other psychological threats to the medical integrity of the psychiatrist's decision-making is of course equally present when the decision is to *refuse* assistance with suicide, a point often overlooked in arguments against assistance with suicide by psychiatrists.

After the decision in the *Chabot* case, the Ministers of Justice and of Health promptly announced a revision of the prosecutorial guidelines to reflect the holdings of the Supreme Court, and 11 of the 15 pending prosecutions (involving non-somatic suffering or patients not in the 'terminal phase') were dropped.¹⁹⁵

KILLING ON REQUEST OR ASSISTANCE WITH SUICIDE?

Strictly speaking only assistance with suicide, not euthanasia, was at issue in the *Chabot* case and, while it does not suggest any difference in the justifiability of the two, the Court does seem to take for granted that in the case of psychiatric patients assistance with suicide and not euthanasia would be at issue. Both the CAL and the NVP similarly assume, as we have seen, that only assistance with suicide is appropriate in the case of psychiatric patients.

If, as we have argued in section 3.1.4, assistance with suicide should (and will) enjoy a preferred status, especially because of the additional guarantee of voluntariness that it affords, this may afford an explanation for the implicit assumption that psychiatric patients should be given assistance with suicide and not euthanasia. From the point of view of societal control over what the doctor does, the most troubling aspect of these cases is, after all, the problem of the lack of material evidence to support the doctor's assertion that the patient's request, right up to the last moment, was voluntary and based on 'unbearable and hopeless' suffering. If to this consideration we add the unspoken assumption that persons suffering from a psychiatric disorder are generally capable of carrying out the act themselves, whereas persons suffering from a somatic disorder frequently are not, we seem to have an adequate explanation for at least a general rule of thumb. If correct, such an explanation would seem to entail that the rule applies not only to psychiatric patients but to all cases of non-somatically based suffering. The explanation also implies that in the case of a psychiatric patient *not* capable of carrying out a suicide!" the law will accept euthanasia as legitimate.

WHY PSYCHIATRISTS?

The CAL and the NVP have addressed the questions, whether assistance with suicide should be available for persons suffering from a psychiatric disorder and whether and how psychiatrists should be involved in the decision-making. What neither the CAL nor

195 See *Staatscourant* no. 179, 19 September 1994:1. In a recent case, the District Court, 's Hertogenbosch (31 July 1997), applied the criteria of the *Chabot* case and acquitted a psychiatrist. The psychiatrist was, at the explicit request of the patient, not present at the time she took the euthanaticum, but was continuously available.

196 See NWE 1997 for some anecdotal evidence concerning cases of persons whose mental disorder deprived them of the capacity for the necessary planning. A.J. Tholen has suggested to us the example of a psychiatric patient who is paraplegic after a suicide attempt.

the NVP address is the question why a psychiatrist should be involved in rendering the assistance. There seem to be opposing professional views on this question. On the one hand there are those who emphasize the importance of a psychiatrist being able honestly to assure a (potential) patient that he is in principle willing to give such assistance, as a necessary condition of getting a treatment relationship established, on the basis of which it may be possible to forestall a suicide. On the other, there are those who argue that entertaining the possibility of assistance with suicide would be fatal to a therapeutic relationship. As, for example, with the possibility of a sexual relationship, it is something that must be categorically excluded lest it corrupt the therapeutic possibilities not only of the psychiatrist who permits it in his own practice but also (by affecting the expectations of patients) of those of his colleagues who do not. On the latter view, there is not necessarily anything wrong with assistance with suicide, but it must be given by anyone *excepta psychiatrist*.

The medical and psychiatric professions in the Netherlands have, as we have seen, on the whole taken a less restrictive view of the limitations of the relationship between psychiatrist and patient than some psychiatrists (especially outside the Netherlands) consider appropriate. Nevertheless, by contrast with other developments in connection with MBSL, the decision in the *Chabot* case – and more particularly, what Chabot had done – provoked a rather polarized debate among psychiatrists in the Netherlands.¹⁹⁷ What is involved here seems not so much a legal issue as one of competing professional views among psychiatrists. It does not seem necessary for the law to take a position on one side or the other of an internal professional debate.

3.5.2 *The legal horizon: assistance with suicide by the non-'sick' and the non-'suffering'*

The legitimacy of a doctor giving assistance with suicide to a person whose non-somatic suffering is not due to a psychiatric disorder has much in common with the case of a person whose suffering is based on a psychiatric disorder, except that the competence of the person concerned is not at issue. If assistance with suicide in the case of a psychiatric patient can be legitimate, this would seem to apply *a fortiori* in the case of a 'rational suicide', unless the presence of an 'illness' is considered critical.

Assistance with suicide in a case of non-somatic suffering such as that of Ms. B in the *Chabot* case is only in a residual sense 'medical'!¹⁹⁸ Although Chabot himself is a psychia-

197 See Koerselman 1994; articles collected in NWE 1995; appendix 11-2, note 45.

198 The Supreme Court did apparently regard Ms. B as in some sense 'sick', although Chabot himself makes it quite clear that he did not (see *Chabot*, appendix 11-2, part 2; Chabot 1996: 153). He himself raises the question whether help of the sort he gave need be restricted to doctors.

trist and the Supreme Court obviously considered it essential that he was a doctor, nevertheless the principled basis on which Dutch euthanasia law rests seems with the decision in the *Chabot* case to have taken a hesitant step away from the doctor-centered approach that has dominated legal development up to now and toward giving somewhat greater weight to the *principle of autonomy* (see chapter 4.3 on the balance between the various principles underlying legal policy concerning euthanasia).

Looked at in this way, the decision in *Chabot* may later be seen as having opened the way to a legal development that accepts assistance with suicide to persons who are not 'sick' at all (e.g. very elderly persons who are incapacitated in various ways and simply 'tired of life') and to persons who are not suffering at the time the request is made but, in anticipation of future deterioration, want to be in a position to choose the time of their death in advance of becoming incapacitated and dependent. There is, of course, nothing inevitable about such a development, and the mixture of partly conflicting legal principles on which Dutch euthanasia law (and the decision in *Chabot*) rest (see chapter 4.3), affords more than enough basis for choosing not to go that route. But the argument from autonomy wins unmistakably in weight from the Supreme Court's decision in *Chabot*.

'Rational suicide' has begun over the past few years to occupy a place in the Dutch public discussion concerning medical behavior that shortens life. This seems likely to be an area of important legal development in the future. A number of situations can be distinguished:

A person who is not psychiatrically 'sick' suffers unbearably as the result of a traumatic experience, and there is no treatment acceptable to the person concerned or with so favorable a prognosis that its benefits can be considered to outweigh the burden to the patient. (This was the situation in the *Chabot* case, at least on Chabot's view.)

As a result of old age, with the accompanying physical deterioration, dependency, loneliness, etc., a person is 'tired of living': life as such has become unbearable. Such cases - in which the prosecuting authorities decided not to prosecute doctors who rendered assistance - have been described in the literature.¹⁹⁹

Although a person is not currently suffering, the prospect of dementia, physical deterioration, dependency, confinement to a nursing home, etc. is unacceptable; the person concerned wishes to choose his or her own moment of death in order to

199 See Chabot 1992 and Weisz 1994. See sections 3.1.2 and 3.4.4 on the possibility that such persons can make use of the absolute right of the patient to refuse all treatment (including administration of food and drink) and hence 'let themselves die' (*versterven*).

avoid being exposed to such a situation. As we have seen in chapter 2.4, Drion has suggested that, under very limited circumstances, elderly persons should have the right to be supplied with a 'pill' with which they could accomplish this at a time of their own choosing.²⁰⁰"

It would be foolhardy to wager a prediction on the direction or the speed of legal development in these cases.²⁰¹ So far, it does not seem that Drion has succeeded in helping to de-medicalize assistance with suicide by shifting the focus of attention away from the doctor and toward the right of an individual to decide for himself. However, it is worthy of note that the newest draft euthanasia bill of the Dutch Association for Voluntary Euthanasia (NVVE 1996) allows for assistance with suicide (by a doctor!) on no other condition but that the request be well-considered.

3.6 Conclusion

The substance of Dutch law concerning MBSL is pretty well settled on most of the major problems that have been subjects of public discussion and legal development, with the important exception of 'advance directives' requesting euthanasia in the case of dementia and the whole area of not somatically based suffering. Leaving aside for a moment the huge category of 'normal medical practice' (abstinence and pain relief), not currently regarded as problematic, the essential structure of legal control consists of the following elements:

- a prohibition (euthanasia, murder, etc.);
- a justification, available only to doctors, under clearly-defined circumstances (unbearable and hopeless suffering plus a request, or application of the 'priority principle');
- procedural 'requirements of careful practice' (consultation, proper administration, record-keeping, etc.);
- the duty to report the death as a non-natural one (except, perhaps, in the case of 'help in dying'),

There are some residual problems concerning the way in which the 'requirements of careful practice' are enforced (criminal or disciplinary proceedings), the scope of the

²⁰⁰ Drion 1992. For a variety of practical reasons, Drion proposed to limit this to single persons over 75.

²⁰¹ One technical problem to be solved is the requirement that the doctor involved be responsible for the patient's treatment. In the case of a person who is not 'sick', there can in the nature of things not be such a doctor.

idea of 'help in dying', the application of the notion of a 'natural death', the liability of nurses and other non-doctors for their participation in euthanasia or assistance with suicide, the precise contours of the role of parents, family and friends, etc.

As far as legal regulation is concerned, it is abstinence and pain relief - not euthanasia, assistance with suicide or even termination of life without an explicit request - that seem to present the most pressing problems. These sorts of medical behavior that shorten life are, as we will see in chapter 5.3.1, every bit as 'intentional' as euthanasia, they often are not at the request of the person concerned (who frequently, for example, is unconscious), and they involve vastly larger numbers of patients. Furthermore, they are distinguished from the controversial sorts of MBSL in terms of legal concepts (action versus omission; intentionality) that, as we will see in chapter 4.1, are intrinsically problematic, and as we will further see in chapters 5 and 6, make effective control over 'active, intentional termination of life' essentially impossible. Despite such good reasons to subject them to public control, they remain largely unregulated, both substantively and procedurally.

However, the biggest problem with which the Dutch are now confronted does not so much concern the legal rules as their effectiveness in practice. This is partly because of the conceptual inadequacies just mentioned and the exclusion of abstinence and pain relief from the scope of legal control, but more importantly it is a consequence of the very structure of the current control regime, based on a criminal prohibition and self-reporting. This problem will be addressed directly in chapter 6, after we have looked at the conceptual difficulties of the present control regime and the conflicting principles on which it is based in chapter 4, and the available empirical information in chapter 5.

4 The Terms of Debate since 1982

The central question around which the political euthanasia debate revolves is: to what extent and on what basis should the state become involved in the relationship between someone who wishes to die and someone who, at the request of this person, brings about his death or provides assistance to this end? More specifically, should the state legally prohibit a doctor from honoring a patient's request for help to end his life? Within the Dutch euthanasia debate, a variety of arguments for and against the legalization of euthanasia have been advanced. The most important of these will be presented in section 4.2. This will be followed in section 4.3 by an analysis of the Dutch euthanasia debate in which we will consider the various arguments and examine whether there is common ground in terms of which the opposing positions might be reconciled.

But first, attention must be given to a fundamental presupposition of the euthanasia debate: the idea that there are valid reasons to distinguish 'euthanasia' from shortening of life as a result of 'normal medical practice'. This idea has, as we have seen in chapter 3, led to two different legal control regimes, applicable to the two sorts of life-shortening behavior. In section 4.1 we will conclude that the basis for the distinction is not adequate to support such widely different legal treatment.

4.1 Distinguishing euthanasia from other MBSL

As we have seen in chapter 2.3.2, during the early 1980s the Dutch debate concerning the shortening of life in a medical context concentrated on euthanasia in a narrow sense: intentional life-shortening behavior by someone other than the person involved, at his request. Euthanasia proper was distinguished from the so-called 'false forms of euthanasia'. Not euthanasia but 'normal medical practice' was said to be involved if death is a result of (a) not beginning or ceasing a treatment that is 'medically futile', (b) not beginning or stopping medical treatment because the patient does not want it, or (c) administering pain-killing drugs.

Euthanasia is prohibited by article 293 of the Criminal Code while 'normal medical practice' with life-shortening consequences is uncontroversial as far as both criminal and medical law are concerned. When such shortening of life is the result of not beginning or ceasing treatment because the patient refuses (further) treatment, the doctor's behavior is not criminal because a patient who is of sound mind has the right to refuse treatment.

The other two forms of 'normal medical practice' with life-shortening consequences fall under the heading of the 'medical exception' and are therefore not subject to the criminal law (see chapters 2.2, 2.3.1, and 3.3.1). It is thus very important that the dividing line between euthanasia on the one hand and 'normal medical practice' with life-shortening consequences on the other can be clearly drawn. If this is not possible, it will not be clear which life-shortening behavior is criminal and which is not. This section will examine whether or not a distinction can be made and whether or not the basis for the distinction is morally relevant.

The distinction between euthanasia and 'normal medical practice' has become generally accepted in the context of the Dutch euthanasia debate, but in fact there has been little discussion devoted to it.¹ Discussion of the foundations of the distinction has occurred primarily in the international philosophical literature. In this literature the possibility and the importance of the distinction between euthanasia and normal medical practice with life-shortening consequences are founded on two underlying dichotomies: the first is between *killing* and *letting die* and the second between the *intentional* and the *non-intentional shortening of life*. The importance of these two underlying distinctions is defended as follows:

shortening of life as a result of not beginning or ceasing treatment that is medically futile or not (any longer) desired by the patient is classified as 'letting die' and is, by contrast with euthanasia (a form of 'killing'), morally less objectionable or even acceptable; and

shortening of life as a result of administering pain-killing drugs is distinguishable from euthanasia by the absence of an intention to cause death, and is therefore morally less objectionable or even acceptable.

In the following sections we examine these two claims closely.

4.1.1 *Killing versus letting die*

The distinction between 'killing' and 'letting die' is based on the so-called *acts and omissions doctrine*. This doctrine holds that

failure to perform an act, with certain foreseen bad consequences of that failure, is morally less bad than to perform a different act which has identically foreseeable bad consequences.²

¹ See however Van Till 1970; Staatscommissie 1985: 201ff De Beaufort & Dupuis 1988; Dupuis 1994.

² Glover 1977: 92.

This idea has an honorable pedigree.' Nevertheless, its moral relevance can be questioned. The arguments for the distinction are as a general matter untenable, or they do not apply in the medical context. The five most important of these arguments will be reviewed here.

(1) The first argument in defense of the distinction is that in the case of killing the death of the patient is 'caused' by the doctor. Letting die, by contrast, allows Nature to take its course, which leads to a 'natural death' (in which some recognize the hand of God)." This argument has the plausibility of popular wisdom and, as is often the case with such wisdom, cannot stand up to analysis. There is no such thing as 'the cause' of a particular state of affairs. Any given occurrence is always the outcome of a complex intermingling of circumstances. Excluding omissions from such a complex is completely arbitrary and assumes exactly what needs to be proved.'

(2) A second argument is to the effect that 'killing' always implies that death is a desired result, at least as a means of reaching some further goal (for example, relieving the patient's suffering), while this need not be the case in a 'letting die' situation. But in fact any motive a person can have for killing can equally well be a motive for letting die. The thought that in the case of letting die death, in itself or as a means to an end, is not desired is incorrect: there are, for example, each year in the Netherlands some 17,600 such deaths, the intended results of abstinence from life-prolonging treatment (see table 5.2).⁶

(3) A third argument refers to a supposed difference in moral weight between two general duties everyone in principle has: the duty not to harm and the duty to help. It is argued that killing is a violation of the duty not to harm and letting die is at worst a violation of the duty to help (premise 1). Because our moral intuition is that the first duty is of

3 See Rachels 1986: 106.

4 The Dutch criminal law scholar Enschede has observed that preoccupation with euthanasia and neglect of the other MBSL seems to reflect a latent Christian objection to suicide: the supposed 'intention' of the doctor permits the patient's death in the case of the other MBSL to be ascribed to a terminal condition that was already present rather than to human agency (Enschede 1986a).

5 Compare Rachels 1986: 115. Most actions that are part of the complex of factors leading to a particular result can easily be described as omissions. A pedestrian may die from being hit by a motorist who was not looking where he was going and did not brake on time because he did not see the pedestrian soon enough, and the City Council may have contributed by allowing the motorist's visibility to become limited by postponing cutting back bushes growing along the side of the road.

6 Compare Kuhse 1987: 123ff.

greater moral weight than the second (premise 2), it can be concluded that killing is morally worse than letting die.

Both premises of the third argument are problematic. As far as the first premise is concerned, it is unclear why letting die can never be considered as inflicting harm (especially if we accept that omissions can be a cause of a person's death - see above). The doctor who lets Mr. X die because he has confused him with another patient Mr. Y for whom a non-reanimation decision had been taken certainly does inflict harm on Mr. X. It is therefore possible that letting die involves violation of the duty not to harm. Furthermore, it is possible that shortening of life, regardless of whether it is regarded as killing or as letting die, does not always amount to inflicting harm. It may be regarded as in the patient's interest if, for example, it is the only way to relieve unbearable suffering.⁷ Finally, there are situations conceivable in which letting die inflicts more harm than killing: for example in the case of a dying patient suffering serious untreatable pain, when letting die would prolong his misery.

The second premise is based on the assumption that the duty not to harm weighs more heavily than the duty to help. However, the reason more weight is often attributed to the duty not to harm lies in the fact that fulfillment of the duty to help often asks more of the actor than fulfillment of the duty not to harm. The duty not to murder your neighbor, for example, is more absolute than the duty to help provide food for children in the Third World because the latter is much more demanding.

In the case of shortening of life in a medical context, the argument that the duty not to harm outweighs the duty to help is particularly unconvincing. The moral weight of the duty to help is determined by whether or not there is a special relationship between the person who is able to offer help and the person in need of help. In a medical context there most certainly is such a special relationship. Whether looked at as a matter of the contractual relationship between doctor and patient or as a general obligation resting on doctors as a consequence of the authority to practice medicine,⁸ the essence of the doctor-patient relationship is the doctor's duty to treat the patient. Furthermore, the burden for a doctor in fulfilling the duty to help a patient is far less than it would be for a lay person, since the doctor possesses the necessary medical expertise.⁹

It follows that the third argument also fails.

7 The *principle of beneficence* is in fact one of the most important arguments in favor of the legalization of euthanasia: see section 4.2.2.

8 See also article 255 of the Criminal Code in appendix I-A.

9 Compare Peinberg 1984: 164; Rachels 1986: 116.

(4) The next argument is that there is a distinction of certainty of outcome between killing and letting die: by contrast with killing, someone who allows a patient to die leaves open the possibility, for example, that a third party may intervene, which is supposed to reduce the first actor's responsibility for the death.¹⁰ This argument may be generally true. But it is not a good reason for making the distinction in a medical context. A doctor who lets a patient die does so in the expectation that a third party will not intervene. The doctor responsible for a patient's care knows that in principle only he is authorized to make treatment decisions." And, in general, those in a doctor's immediate surroundings will, at least as far as the sorts of 'abstinence' that are broadly accepted as legitimate are concerned, share his view of the case and therefore not be inclined to intervene.

(5) Finally, it is frequently stressed that the aim of medicine and therefore a doctor's first duty is to preserve life and that killing a patient directly conflicts with this duty.¹² Only in a case where further medical treatment would be futile is allowing a patient to die not considered to be in conflict with this duty because in such a case the doctor has done all he could reasonably have done to save the patient's life. It is, however, not clear that any such basic 'aim of medicine' can be defined. Preventing inhuman suffering and respecting the autonomy of the patient could equally well be considered basic aims of medicine. Such considerations do not amount to an independent argument for the distinction between killing and letting die. What a doctor's duty is, is precisely what is at issue. Now that the idea is increasingly accepted that in certain circumstances death may be in a patient's interest, it is dogmatic simply to assert that a doctor should strive for continuation of life."

The conclusions concerning the distinction between killing and letting die that can be drawn from this discussion are as follows. It is doubtful whether the distinction has general moral relevance. But however that may be, within the medical context its importance is limited. This has to do mainly with the duty a doctor has to his patient. This duty makes the doctor morally accountable for everything that happens to the patient for whose care he is responsible. It is the doctor's ability to influence the situation which

10 A variant of this fourth argument points out that death is the *certain* result of killing, whereas it is only a *possible* result of letting die.

11 To ensure that his decision to let the patient die is not frustrated, a doctor may inscribe 'NTBR' (not to be reanimated) on the patient's chart, with the express purpose of preventing life-extending treatment from being administered by someone else.

12 The Hippocratic Oath is often invoked in this connection: see Amundsen 1987.

13 Compare Veatch 1981: chapter I; Rachels 1986: 118ff.

constitutes his responsibility, not the nature (killing or letting die) of what he does." In all cases of life-shortening treatment the possibility and the duty to exert influence are in principle present. Whatever sort of life-shortening behavior is involved, a doctor has to do *something*, even if that something is limited, for example, to giving instructions to nursing staff. And a doctor, even if he chooses to abstain (and hence let die), always remains responsible for what happens to the patient after this decision, for example for administering pain killers if needed. He may never use the idea of a 'mere omission' as an excuse for abandoning a patient to his fate.

In short, the distinction between killing and letting die cannot be clearly drawn and does not afford sufficient ground for the argument that there is an important moral or practical difference between euthanasia and 'normal medical practice' resulting in the shortening of life.

4.1.2 *Intentionally shortening life*

The third form of death due to 'normal medical practice' from which euthanasia is generally thought to be clearly distinguishable is death as a result of the use of pain killers. This is not regarded as controversial, since it is assumed it is not the doctor's intention to cause the death of the patient but rather to alleviate pain; the death of the patient is considered an 'undesired side-effect'.¹⁵ This approach raises two questions. First, how must the distinction between the intentional and the non-intentional shortening of life be understood? And second, is the distinction morally relevant?

The idea that in the case of a death as the result of administering pain killers the doctor's intention is not to cause the death of the patient, which is merely an undesired side-effect, is linked with the so-called *doctrine of double effect*. The roots of this doctrine originate in the teachings of Thomas Aquinas and to this day form part of the moral teachings of, for example, the Roman Catholic Church." Because medical ethics have historically *been* strongly influenced by Roman Catholic moral teaching, the doctrine of double effect has played a major role in medical ethics.

The doctrine of double effect developed in connection with the Judeo-Christian *principle of the sanctity of human life*. This principle absolutely forbids the intentional termina-

14 Compare Hart 1968: 122; Harris 1985: 30. See also Staatscommissie 1985: 205; Fahner 1988: 817; Leenen 1994: 276.

15 Compare Staatscommissie 1985: 27. See also Van der Wal & Van der Maas 1996: 41.

16 Compare Fisher 1995.

tion of innocent human life." The so-called *doctrine of innocence* can be used to justify the death penalty and killing in self-defence or in wartime." But there are other cases where causing death is also considered permissible. The doctrine of double effect keeps cases that, on grounds of moral intuition, are not considered morally reprehensible outside the scope of the principle of the sanctity of human life.¹⁷

The doctrine of double effect holds that behavior that has both a good and a bad effect can, despite the bad effect, be morally permissible provided

- the behavior itself is not intrinsically wrong (that is: considered separately from its consequences);
- 2 the actor intends only the good effect, not the bad one;
- 3 the bad effect is not a means used to bring about the good effect; and
- 4 the good effect outweighs the bad effect.²⁰

In order to ensure that the outcome of the doctrine of double effect corresponds with moral intuition, the term 'intention' in the second condition is interpreted in a special, narrow way. This can be understood as follows. Behavior can have three sorts of consequences: consequences desired for themselves; consequences desired as a means toward a result that is desired for itself; and consequences that are side-effects of the behavior. According to the narrow conception of the intentional, only the first two are to be considered 'intended', while side-effects are 'merely foreseen'.²¹ The doctrine of double effect rests, therefore, on the distinction between 'intention' and 'foresight of consequences'.

Adherents of the doctrine of double effect conclude that shortening life as a result of alleviating pain is morally permissible because, although it can be foreseen, death *in* such a case is not desired either for itself or as a means of achieving the goal of alleviating suffering." What is desired is the alleviation of the patient's suffering. His death is not a

17 See Kuhse 1987: 7. Compare Ferngren (1987: 34) on the 'Christian concept of imago Dei' that "provided the basis for the belief that every human life has absolute intrinsic value as a bearer of God's image and an eternal soul for whom Christ died":

18 Compare Rachels 1986: 12: "[A] person is 'innocent' unless he has by his own misconduct forfeited his right that others should not kill him. Using this criterion we can understand why criminals, murderers, and enemy soldiers are said not to be innocent."

19 The applicability of the doctrine of double effect is not limited to behavior that shortens life. In this sense the doctrine is more general than the principle of the sanctity of human life.

20 See Rachels 1986: 16; Kuhse 1987: 91. In connection with problematic aspects of the doctrine of double effect, several different versions have been developed: see Marquis 1991.

21 See Hart 1968: 120; Kuhse 1987: 89.

22 See, for example, Finnis 1995: 27.

means to achieve that goal, and administering the same drug to cause the patient to die *in order to put an end to his suffering* would not be permissible."

There is an important objection to the distinction between 'intention' and 'foresight': it is questionable whether the distinction can be made in the clear-cut way that adherents to the doctrine of double effect suppose. There are two problems: first, it seems on careful analysis to be impossible to distinguish those results of an act that are merely 'foreseen' side-effects from those that are a 'means to an end'; and second, the idea that 'intent' requires more than mere 'foresight' makes intentionality a purely subjective concept.

The problem of distinguishing side-effects from means can be illustrated by two well-known abortion cases, the *hysterectomy case* and the *craniotomy case*. Abortion performed by removing the cancerous uterus of a pregnant woman with the aim of saving her life (the first case) is considered morally permissible by adherents of the doctrine of double effect. Crushing the skull of a foetus caught in the birth canal with a view to the same life-saving goal (the second case) is not. In the latter case, the argument goes, the death of the foetus is a means of saving the woman's life, while in the first case it is only an unavoidable and undesired side-effect.

But why should we consider the foetus' death from a crushed skull in the craniotomy case a (desired) 'means' of saving the pregnant woman's life, but not its death from the removal of the mother's uterus in the hysterectomy case? At this point, the argument for the doctrine of double effect boils down to the opinion that what the doctor does in the first case, but not in the second, 'is' the actual killing of the foetus." This argument is a pure *ipse dixit*. The two cases have in common the only two apparently relevant circumstances: the death of the foetus is a *foreseeable consequence* of what the doctor does and a *necessary condition* for his success in saving the woman's life."

That the way the actor's behavior is described plays a crucial role in the application of the doctrine of double effect becomes even clearer if we consider another case, that of the hero who throws himself onto an exploding grenade in order to save other human lives. Sacrifice of his own life leads to no reproach from adherents of the doctrine of double effect. His death is not considered a means of preserving the lives of others (in which case it would be a reprehensible suicide, a violation of the principle of the sanctity of human

23 Ceasing treatment that is disproportionately burdensome, even if this will probably cause the patient to die is, according to adherents of the doctrine of double effect, also morally permissible. Shortening the patient's life is not considered a means of ending the burden to the patient but as a merely anticipated side-effect.

24 See Kuhse 1987: 100.

25 See Hart 1968: 123.

life) but a 'mere side-effect'.²⁶ They believe that what the hero in fact 'does' must be described as 'throwing himself on the grenade' and not 'killing himself to save others'. It thus appears that the *way an act is described* determines which of its effects are to be considered means and which side-effects. If the sacrifice is to be sanctioned by the doctrine of double effect, then the act of sacrifice must be described in such a way that the result-that-may-not-be-desired (the hero's death) does not figure. That the hero could be sure that under the circumstances his death was inevitable does not matter.

The fact that the way behavior is described is so determinative undermines the doctrine of double effect since behavior can always be described in several ways, depending on which effects one is concerned with. Like the heroic soldier, what a doctor 'does' can be described as 'putting the patient out of his misery' (with death as a side-effect) or as 'killing him to end his suffering' (with death as a means). It is in principle arbitrary to regard either of these possible descriptions as preferred. That which in a particular description of a case is presented as a means to an end thus cannot be conclusive with respect to the 'intention' of the actor. The relationship between what an actor intends and what is to be regarded as a 'means' or a 'side-effect' is precisely the reverse of what the doctrine of double effect assumes. It is not whether something is a 'means' that determines what an actor intends, but what he intends (as an end) that determines the appropriate way of describing his behavior and hence those consequences of his behavior that can be designated as means or as mere side-effects. Which of all the effects foreseen by the actor are 'intended' can therefore not be ascertained independently of what he has in mind. To be tenable, the doctrine of double effect would have to distinguish permissible and impermissible actions not on the basis of what the actor *does*, but on the basis of *a mere interior state of mind*/?

Could the adherents of the doctrine of double effect accept the conclusion that the moral permissibility of behavior that, as a foreseeable effect, involves the death of another person, depends on what the doctor considers to be his motive at the moment he causes the patient's death? A doctor would then be able to determine the permissibility of his behavior simply by reassessing his own motives." Such a position has two drawbacks. In the first place it judges not the permissibility of behavior but the *character of the actor*. In the second place it is impossible for *human beings and human institutions* to establish what

26 Compare this case with that of the person who commits suicide in order to escape from depression, for example. This is not considered permissible: death is 'desired' as a 'means' to relieving suffering.

27 Compare Kuhse 1987: 159.

28 Compare Williams 1957: 322: If the doctrine of double effect "means that the necessity of making a choice of values can be avoided merely by keeping your mind off one of the consequences, it can only encourage a hypocritical attitude towards moral problems."

the actor's motive is. This is possibly not an issue from the point of view of Roman Catholic teaching; after all, God sees everything. However, for purposes of secular morality and legal control, making the responsibility of an actor dependent on his motive is unacceptable. It would undermine every possibility of effective control by making those responsible for control dependent on information possessed only by those whose behavior is to be controlled. It comes as no surprise that the criminal law rejects the idea of liability based on motives and subjective intentions known only to the actor, taking instead all consequences of his behavior that the actor could foresee as constituting his 'intention.'

Ultimately, only the proportionality criterion of the fourth condition of the doctrine of double effect seems capable of withstanding analysis." The moral permissibility of a course of action depends on the relation between its good and its bad consequences. An actor is responsible for all of those consequences that for him were foreseeable.³¹ As far as the doctor's intention is concerned it is unclear why 'normal medical practice' in the form of pain killing with shortening of life as a foreseeable result should be considered in itself morally less problematic than euthanasia. The same applies to abstinence that will foreseeably lead to death.

4.1.3 Conclusion

In this section we have seen that the moral distinctions that are supposed to underlie the different legal treatment of euthanasia and of other forms of intentional shortening of life (distinctions between 'killing' and 'letting die' and between the 'intentional' and the 'non-intentional' shortening of life) seem to be both untenable and morally irrelevant.

The conclusion to be drawn from the foregoing discussion, at least as far as the public debate over the regulation of euthanasia is concerned, is as follows. The distinction

29 Compare Hart 1968: 117ff; Enschede 1986b: 39; Hazewinkel-Suringa & Rummelink 1996: 20ff.

30 Applying the narrow conception of the intentional to the second condition of the doctrine of double effect makes the third condition redundant: compare Marquis 1991: 520. The same objection that is fatal to the second condition also undermines the first condition: there is no such thing as 'the behavior itself', distinguished from its consequences: there are only *different descriptions* of behavior. Compare Davis 1991.

31 Compare CAL 3: 8, quoted in chapter 3.3; Rachels 1986: 95: "Remember that the rightness or wrongness of an act is determined by the reasons for and against it.... The intention you would have, if you decided to cease treatment, is not one of the things you need to consider. It is not among the reasons for or against the action."

between euthanasia and intentionally causing death as a result of 'normal medical practice' is not a good starting point for a system of legal control of life-shortening behavior in a medical context. Both euthanasia and intentional death resulting from 'normal medical practice' must in principle be judged according to the same criteria. In this section we have shown that the responsibility of a doctor for shortening the life of a patient should not depend on the 'nature' of his behavior nor on the subjective 'intention' he has, but on his responsibility for what happens to the patient. Whether behavior that shortens life violates his duty to the patient depends on the reasons for or against the behavior, and in particular the advantages and disadvantages it has for the patient. Apart from that, the responsibility of the doctor should depend on whether he could have foreseen the patient's death and on the extent to which he was in a position to influence the processes that led to that death.

4.2 The most important arguments since 1982

We have seen in chapter 2 that at the end of the 1960s euthanasia became a topic of public debate. In the first phase of that debate, the argument concentrated on the moral permissibility of shortening of life by doctors. In the 1970s the discussion focused on defining and distinguishing different sorts of life-shortening behavior. It was not until the end of the 1970s that discussion turned to the question of legal policy. From that last perspective the primary question is not whether euthanasia is to be considered an acceptable course of action for an individual and his doctor, but whether it is legitimate for the *state* to permit or to restrict euthanasia, and if so how and under what circumstances.

This latter question was first posed in the political forum when in 1978 Parliament asked the Government to

request advice about future government policy with regard to euthanasia from a State Commission set up for this purpose.³²

As we have seen in chapter 2.3.2, this request resulted in a preparatory report of the Health Council and, ultimately, in a report of the State Commission on Euthanasia.³³ The subject of these reports was whether it would be advisable to amend articles 293 and 294 of the Criminal Code that specifically forbid euthanasia and assistance with suicide.

The reports of the Health Council and the State Commission seemed to offer excellent starting points for a debate of high quality on legal policy. However, such a debate never

³² *Second Chamber of Parliament 1978-1979*, 15 300, no. 26.

³³ *Cezondheidsraad 1982; Staatscommissie 1985*.

actually took place. Instead, politics were more or less overtaken by judicial decisions: halfway through the 1980s the Supreme Court interpreted the existing provisions of the Criminal Code in a way that left room for euthanasia under specific conditions. The discussion of legal policy thereafter stayed more or less within the bounds of the legal solution adopted by the Supreme Court.

The question of the legal permissibility of euthanasia having been solved in a way that proved generally acceptable, attention shifted in the second half of the 1980s to more practical matters. From that time on, the question was not so much whether or not euthanasia should be legally permissible, but how it can best be *regulated*. The focus of concern has been, in particular, on the question how conformity with the 'requirements of careful practice' can be achieved. The debate on fundamental matters of legal principle was thereby pushed to the background.³⁴

In this section we confine ourselves to a presentation of the arguments that have in fact been made. Attention will first be paid to the three arguments of principle that have figured in the public discussion: the *principle of autonomy*, the *principle of beneficence*, and the *right to life*. After that two practical arguments that have played a role in the public discussion will be dealt with: the *slippery-slope argument* and *control arguments*. A critical assessment and exploration of the various positions in the context of the question whether they can be reconciled with each other will be postponed to section 4.3.

4.2.1 *The principle of autonomy*

The principle of autonomy is one of the most important arguments of those who are in favor of the legalization of euthanasia. At first sight, this seems strange. The issue in the euthanasia debate is not whether an individual has the freedom to end his own life (suicide never having been illegal in Dutch law), but whether a *doctor* can legally give him assistance in doing so. On closer examination, the appeal to the principle of autonomy involves a slightly more complex argument than appears at first sight. Threatening the doctor with criminal punishment puts an obstruction in the way of a patient who wants (or needs) his doctor's help to end his life. The appeal to the principle of autonomy thus amounts to the claim that the state must not do anything that obstructs the exercise of what is regarded as a fundamental freedom.

Appeal to the principle of autonomy is not meant as an appeal to an existing legal right. Those who make use of the argument use it either as a moral principle considered to be

34 This generalization is less applicable to problems of termination of life of persons considered not (fully) competent than it is to euthanasia proper.

of such heavy weight that it must be taken as a starting point for the regulation of euthanasia, or as a legal principle already implicit in the law as a whole. As a moral principle the principle of autonomy is widely accepted in medical ethics." As a legal principle it has been frequently invoked in the Dutch euthanasia debate. The Health Council regards it as a "basic idea of a modern legal system" that the autonomy of every adult member of society must be respected as much as possible. A "legitimate public regulation ... must be directed toward the realization of individual interests as defined by those concerned." According to the Health Council this principle entails that, leaving aside the necessity of guarding against abuses, the state is not entitled to protect legal rights (such as the right to life) when the individual concerned does not want such protection. The state should restrict itself to creating conditions under which individuals can exercise their autonomy. One of these is the opportunity to die a good death and to receive help if one wants it."

The legal philosopher Soeteman endorses this argument. He observes that human dignity is invoked by both supporters and opponents of the principle of autonomy, but that they interpret human dignity differently. Supporters of autonomy think that an individual should be entitled to define his own conception of human dignity: Soeteman refers to this as a 'tolerant' interpretation of human dignity. Opponents, on the contrary, want to impose a particular conception of human dignity on their fellow citizens. Soeteman argues that only the tolerant interpretation of human dignity corresponds to Dutch law, while the 'moralistic' interpretation of the opponents has no legal support. A tolerant interpretation of human dignity can, Soeteman believes, be the foundation for a principle of autonomy that applies, among other things, to euthanasia."

Leenen, author of the influential *Handbook of Health Law*, is emphatic on this point. According to him, the principle of autonomy is a natural right of human beings, not derivative from the state or the community:

The foundation of the right to decide for yourself is the principle of the free, autonomous human being who has an inherent dignity that deserves unconditional respect, and who is entitled to dispose over his own life.

Leenen argues that the principle of autonomy is reflected in a number of fundamental rights laid down in the Dutch constitution, such as for instance the freedom of religion,

35 Beauchamp & Childress 1989:68ff; Dupuis 1994:47-64.

36 See Gezondheidsraad 1982: 64-68 and 74-77. The arguments quoted here and elsewhere in this chapter are not the position of the Health Council itself. In its preparatory report the Health Council did not formulate a final conclusion of its own, but limited itself to an inventory of different arguments for and against euthanasia.

37 Soeteman 1986:61ff.

the right to privacy and the right to inviolability of the body. This last right includes the right to refuse medical treatment." Leenen argues that,

The individual right of autonomy is the basis of the right to make decisions about the end of one's life. That fundamental value would be violated if others (the state, the doctor) could continue a person's life against his will, which would make that life one without freedom and autonomy. That would entail a lack of respect for the person concerned and would force him to violate the dictates of his conscience."

The proposed amendment to articles 293 and 294 of the Criminal Code submitted by Wessel-Tuinstra in 1984 was largely based on the principle of autonomy. The accompanying Memorandum included the following passage concerning the task of the state with regard to euthanasia:

[The state] must, departing from the generally accepted norm of protection of life, create space for an individual's decision to determine the limits of that protection as far as his own life is concerned, subject to the state's specific responsibility to strengthen the legal position of the vulnerable and the quality of medical and other assistance [*hulpverlening*].⁴⁰

Wessel-Tuinstra's bill had the support of the majority of the Second Chamber of Parliament halfway through the 1980s, but as we have seen in chapter 2.4 it was, for reasons having to do with coalition politics, never adopted.

In the case law, the principle of autonomy plays a more limited role than it does in the public debate. That is understandable in light of the fact that the courts cannot simply ignore articles 293 and 294 of the Criminal Code, articles that seem on their face inconsistent with such a principle. Nevertheless, in 1983 the District Court in Alkmaar held that in connection with the increasing societal acceptance of autonomy with regard to the ending of one's own life, euthanasia (by a doctor) fell within the doctrine of 'absence of substantial violation of the law'. However, the Court of Appeals reversed this decision,

38 That the right to inviolability of the body must be seen as based on the principle of autonomy is reflected, according to Leenen, among other things in the legislative history of the most recent constitutional revision of 1983 (Leenen 1994: 38).

39 Leenen 1994: 31, 22ff, 43, 262. Leenen observes (*id.*, 260) that opinions concerning euthanasia differ, but that "in the case of moral disagreement on a subject such as euthanasia legal rules should respect everyone's opinion to the extent this is possible.... The current prohibitions of euthanasia and assistance with suicide in the Criminal Code are inconsistent with [this fundamental principle]."

40 *Second Chamber of Parliament* 1983-1984, 18331, no.3: 12-13.

and on this point the Supreme Court agreed. In the *Schoonheim* case, the Supreme Court held that the principle of autonomy cannot support the conclusion that euthanasia is not a substantial violation of the law (see chapters 2.3.1 and 3.1.3, and appendix 11-1). In the same judgment the Court concluded that euthanasia by a doctor may, under certain circumstances, be justifiable as a correct choice between conflicting duties. But it is not clear that respect for the autonomy of the patient is one of those conflicting duties: in the *Chabot* case the Court referred explicitly to the duty concerned as one requiring a doctor to do everything possible to alleviate the intolerable and incurable suffering of a patient in his care."

The supporters of autonomy with regard to the termination of life do not assert that autonomy is without its limits. Their view is that its exercise should not lead to damage to others, and they believe that the legalization of euthanasia will not have this as a consequence, provided that sufficient legal protections are in place. They accept, for example, that the law must ensure that a request for euthanasia is truly voluntary. In the words of Leenen:

The legislator should ... not impose a particular moral opinion on the population, but when a decision has such far-reaching consequences as the termination of life with the assistance of another, he must enact rules to guarantee the voluntariness of the request and to eliminate the risks due to the fact that another person, the doctor, is involved."

According to Soeteman, the requirement of 'unbearable and hopeless suffering' offers the necessary protection:

41 See appendix 11-2, section 3.1. Schalken concludes, however, in his note to the *Chabot* judgment (see appendix 11, note 3): "It would be more accurate to describe the emergency situation as a conflict between the duty to preserve life and respect for the wishes of the patient to end his life." This interpretation is linked to a note by Mulder (*Nederlandse jurisprudentie* 1987, no. 6(8) that expressed the view that the doctor must "weigh the respect owed to the personality of the patient against [the duty to preserve life, as provided for in article 293]. In extreme cases respect for the personality of the patient will weigh more heavily than respect for [the preservation of life] and in this way [the patient's] wish for termination of life will be honored." According to Den Hartogh (1996: 167), however, a duty to respect the autonomy of the patient can never result in a conflict of duties because "the duties that correspond to the principle of autonomy are all negative duties, duties of a non-interfering nature, none of them requires provision of positive help".

42 Leenen 1994: 300.

It can function as part of a pragmatic operationalization of the condition that it must be reasonably clear that there was nothing wrong with the request. ... The requirement of unbearable and hopeless suffering is a plausible one in this connection because it ties the permissibility of euthanasia to situations in which the wishes of the person involved can be reasonably understood."

4.2.2 *The principle of beneficence*

A second argument in support of the legalization of euthanasia is based on the principle of beneficence.⁴³ This principle imposes a duty, within limits, to act on behalf of another. Applied to suffering, and in this variant sometimes called the *principle of mercy*, the principle imposes the duty to alleviate pain or ease suffering. The principle of beneficence can be considered an independent ground for legalization of the termination of life, but it can also be invoked in support of autonomy. In the latter case it is argued that patients in general know best whether or not continuation of life is in their interest. The duty to act on behalf of the patient is thus best served by allowing him to decide for himself.

The principle of beneficence is not recognized as a general proposition in Dutch law. But because the Dutch Supreme Court has accorded medical-ethical norms a prominent place in its euthanasia decisions, beneficence has played an important role in the process of legal change with regard to termination of life. The duty of a doctor to alleviate 'unbearable and hopeless suffering' has, via the justification of necessity recognized by the Supreme Court, become the principal legal basis for the legalization of euthanasia and assistance with suicide."

As a medical-ethical principle beneficence is fairly non-controversial. From ancient times the principle has been given great weight in medical ethics, more so than the principle of autonomy." Prevention of damage to the patient and the promotion of his interests are a doctor's central duties, and if necessary he may be quite paternalistic in effectuating them." Traditionally, it has been regarded as a corollary of the principle of beneficence that a doctor must do everything possible to postpone death."

43 Soeteman 1986: 69. See also Leenen 1994: 301.

44 The principle of beneficence is here interpreted as including the *principle of non-maleficence*. It has been argued (for example by Beauchamp & Childress 1989: 121) that these two principles must be distinguished, the latter weighing more heavily than the former. For discussion of that idea see section 4.1.1.

45 Most recently in the *Chabot* case: see appendix II-2.

46 See Beauchamp & Childress 1989: 112.

47 See Brennan 1991: 36.

48 See Veatch 1981: chapter 1; CAL 1: 10, CAL 2: 23; Dupuis 1994: 28.

Despite this history, the principle of beneficence has recently begun to play an important role in arguments in support of the legalization of euthanasia. The traditional interpretation of beneficence has come under pressure in recent decades. As we have seen in chapter 2.1, as a result of medical-technological developments there has since the 1960s been growing awareness that medical treatment does not always serve the patient's interest. Strict adherence to the aim of preservation of life is, therefore, not always desirable. Doing everything possible to postpone death amounts to submission to the 'tyranny of technology' by which it is not the patient's interest but medical-technical possibilities that determine how the patient is treated."⁴⁹ When the (continued) use of medical technology entails damage to the patient, life-prolonging medical treatment is increasingly seen as in conflict with the principle of beneficence.⁵⁰

Such a position inevitably raises the question whether there are criteria that could be used to determine whether continued life is in the patient's interest. As mentioned above, it is generally accepted that a patient in general knows best whether continued life is in his interest. This is why there are in principle no such criteria needed for patients who are competent. As regards patients who are not (fully) competent, a distinction must be made between those patients who previously were competent (comatose or senile patients) and patients who have never been competent (seriously defective newborn babies). In the first case, life-shortening decisions can often be made on the basis of an explicit expression of will, for example in the form of an advanced directive, made when the patient was competent. If such an explicit expression of will cannot be relied on, one must work with the idea of the presumed will of the patient.⁵¹

If there is no indication of any (presumed) will of the patient, the situation of formerly competent patients and of patients who were never competent is similar: the so-called *best interests standard* must be brought into play. As we have seen in chapter 3.3.2, the CAL and the NVK argue that life-prolonging treatment is no longer in the best interests of a severely defective newborn baby when such treatment cannot lead to a 'life worth living'. With regard to long-term comatose patients, the CAL argues that continuation of treatment is only justified if there is a chance of a return to consciousness and if a minimum quality of life is then to be expected (see chapter 3.3.3).

Apart from abstinence from (further) life-prolonging treatment that is not in the patient's interest, the principle of beneficence can be invoked to justify termination of life, although such use of the principle is much more controversial. Continued life may arguably not be in the interest of the patient either when the patient, although not

49 Dupuis (1994: 41) refers to this as the moral fallacy that 'What can be done, must be done.'

50 Compare CAL 1:10.

51 Compare Jacobs 1987.

dependent on life-support, is still alive as a result of medical treatment that did not lead to an acceptable situation, or when the patient's situation is not the result of any medical intervention but nevertheless involves hopeless suffering or (the prospect of) an unacceptably low quality of life. In both cases it can be argued that the principle of beneficence supports termination of life in the patient's interest. An example of the former situation is a newborn baby whose life has been saved by heroic medical intervention, but whose prospects in life are so poor that if one had foreseen this outcome from the outset one would not have regarded intervention as justifiable. As we have seen in chapter 3.3.2, the CAL and the NVK argue that in such a case beneficence may justify (active) termination of life. But this conclusion can also obtain where the doctor bears no responsibility at all for the patient's deplorable situation. The CAL suggests, for example, that if a very senile patient is in a situation of extreme distress, and termination of life does not conflict with an earlier express will nor with a presumed will, "a reason for terminating life can possibly be based on the intention to end a situation that obviously conflicts with human dignity?"

4.2.3 *The principle of the sanctity of life*

The idea of an inalienable right to life derives from the principle of the sanctity of human life, the ancient and originally religious principle that forbids the intentional termination of life, regardless of whether or not this is requested (see section 4.1.2).

The appeal to a 'right to life' is the most important argument of principle raised against the legalization of the termination of life in a medical context in the Dutch euthanasia debate. The right to life is not only a fundamental moral right, it is specifically guaranteed in article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms and article 6 of the International Covenant on Civil and Political Rights. These international treaties are fundamental law in the Netherlands, binding both the courts and the legislator.

The idea that the right to life, protected in these treaties, sets limits on the scope of the principle of autonomy can be expressed in different ways. The Health Council argued, for example, that the right to life implies a lack of duty on the part of the state to promote autonomy at the expense of life because

[i]n a democratic state the government has a duty to guard and protect the inviolability of human dignity.... Human life cannot be considered in isolation from human dignity. One of the fundamental rights of a human being is the right to life. The government's responsibility is to protect human life from invasion by third parties."

52 CAL 3: 51-52; compare chapter 3.3.4.

53 Gezondheidsraad 1982: 78ff.

In 1984, the legal philosopher and later Minister of Justice Hirsch Ballin went further than this. Dropping the restriction to 'invasion by third parties', he contended that there "definitely is an opposition between ... a right to dispose of one's own life and the right to life" guaranteed in the two treaties just mentioned. Hirsch Ballin's view is that autonomy with respect to the ending of life would be inconsistent with the 'integrity of the person'. He concludes with this rhetorical question:

With other fundamental rights, such as freedom of movement, freedom of the press and freedom of religion, there are good reasons why, even if one does it out of free will and thinks that this is in one's best interest, a person cannot legally alienate these rights as against other persons. Should one be able to do so with the right to life?⁵⁴

The most extensive consideration of the relevance of the right to life is to be found in the minority report of the State Commission. In the majority report attention to article 2 of the European Convention was limited to the observation that the article requires "great care ... in making euthanasia no longer a crime": It is partly for this reason that the State Commission advised limiting legalization to cases in which the doctor judges that there is a 'situation of hopeless necessity'⁵⁵

In response to this, the minority of the State Commission argued that authorizing a doctor to perform euthanasia necessarily implies authorizing him to act on the basis of a quality-of-life judgment, which would be inconsistent with the human dignity protected by the right to life:

A decision ... to terminate a life and/or the request to do so includes, logically and necessarily, *another* judgment, namely that because of the suffering *life itself*... has, everything considered, if it is not ended, become pointless.

A doctor may not make such a judgment, because

the dignity of the human being [does] not allow others to accept a person's judgment on the pointlessness of his remaining life.... People must refrain from such a judgment because it would deny ... *the dignity of the human person* ... as expressed by the Universal Declaration of the Rights of Man.⁵⁶

54 HirschBallin 1984: 183ff.

55 Staatscommissie 1985: 37-38; see appendix I-C-I for the text of the State Commission's proposed legislation.

56 Staatscommissie 1985: 243ff. Compare Klijn 1985; *Second Chamber of Parliament* 1984-1985, 18331, no. 6:9.

The idea that the right to life sets limits on autonomy is also reflected in the legislative history of article 293 of the Criminal Code. The Government observed at the time (1886) that, while the patient's consent cannot make a killing legitimate, it does fundamentally change its character:

[T]he law ... no longer punishes the assault against a certain person's life, but the violation of the respect due to human life in general- no matter what the motive for the act may be. Crime against human life remains, crime against the person is absent"

Many different arguments have been made against appeals to the right to life. Leenen argues that a human person is more than a mere biological creature and therefore

respect for life means respect for humanness in all its aspects, thus also for the autonomy of the person and human dignity.

As far as article 2 of the European Convention is concerned, Leenen argues that

The individual fundamental rights such as article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms protect against the state, and also, if we assume horizontal working, against other individuals. Individual rights do not limit a person's autonomy with regard to himself. Fundamental rights do not limit the freedom of the person concerned.⁵⁸

The legal philosopher Soeteman, among others, argues that the comparison made by Hirsch Ballin between the right to life and other basic rights as a basis for his position that the right to life is inalienable is a lame one.

The duty to live does not follow automatically from the right to life. Inalienability does not change this, because inalienability means essentially that one may not and cannot dispose of the right, which is something different from disposing of life itself.⁵⁹

57 Smidt 1891: 463; this passage was cited by the Supreme Court in the *Schoonheim* case (appendix 11-1). Mulder (*Nederlandse jurisprudentie* 1987, no. 607) observed in connection with this passage: "The legislator obviously attached value to life, even if it no longer has any value for the individual. A doctor is obliged to protect life as a public good. His treatment of the patient is in part in service of the community."

58 Leenen 1994: 261.

59 Soeteman 1986: 59. See also Alkema 1978: 47ff; Van Haersolte 1985: 68; Van Dijk & Van Hoof 1990: 245.

Finally, in light of the discussion in section 4.1 it would seem that a consistently applied right-to-life argument would require the conclusion that 'normal medical practice' with intended life-shortening results is not permissible. However, those who invoke the right to life do not draw this conclusion.

4.2.4 *The slippery-slope argument*

A practical argument frequently raised against the legalization of euthanasia is that even if euthanasia itself is perhaps acceptable, legalizing it will inevitably lead to practices that are not. There are two versions of this 'slippery-slope' argument: a logical or conceptual version and an empirical or causal version.

According to the logical version, legalization of euthanasia logically implies the legalization of other forms of termination of life that are morally unacceptable. It is argued, for example, that those who argue for the legalization of euthanasia on the basis of the principle of autonomy have no argument against legalization in cases in which the patient is not suffering, or that those who argue for legalization of euthanasia on the basis of the principle of beneficence must also support termination of the lives of patients who have not requested it, such as severely deformed and acutely suffering newborn babies. It is also argued that the criterion of 'unbearable and hopeless suffering' is an insufficient barrier against euthanasia at the request of a patient whose suffering has a non-somatic cause. These examples make clear that the logical version of the slippery-slope argument presupposes that the forms of termination of life allegedly implied by legalization of euthanasia are obviously unacceptable.

The logical version of the slippery-slope argument is invoked in the minority report of the State Commission to counter the standpoint of the majority that euthanasia can be legalized provided it is limited to a 'situation of hopeless necessity'. In the eyes of the minority, the majority (which considered the patient's request a necessary condition for, but not the legitimizing basis of euthanasia) could not answer

the question why free will, if this is not really the source of legitimation, must always be a condition *sine qua non*. There seems to be no reason why the situation of necessity would not be allowed to 'overrule' this condition under certain circumstances.

In addition, there is the problem of operationalising the idea of a 'situation of hopeless necessity':

The problem of discriminating between suffering and suffering, between 'not yet serious enough' and 'just serious enough', and of answering the patient's question how bad it has to be and how long he has to wait, cannot be solved by those respon-

sible for treating him and thus leads to erosion [of the norm]. It calls into being a dynamic process that will lead, willy nilly, to a greater and greater expansion of direct termination of life.

This argument strengthened the conviction of the authors of the minority report that euthanasia can never be permissible."

Although its conclusions can be disputed, the minority report does call attention to the fact that confusion about the foundations of legalization of a particular form of termination of life can lead to difficult situations. De Beaufort emphasizes this problem:

Proponents of euthanasia who, under certain circumstances, also consider non-voluntary euthanasia to be justified, can get themselves into a predicament. They obviously cannot rely on the principle of autonomy but must appeal to the principle of beneficence. If, at the same time, they maintain that voluntariness is *always* a necessary condition for the permissibility of euthanasia, or even for being able to speak in terms of 'euthanasia' - as they sometimes seem to do - they are inconsistent."¹

The empirical version of the slippery-slope argument holds that the legalization of a desirable form of termination of life will lead in fact to a sort of erosion of norms, so that ultimately forms of termination that are currently considered undesirable will come to be accepted as more or less unproblematic. legalization of euthanasia will, for example, so undermine our sense of the sanctity of human life that we will eventually not object to certain sorts of non-voluntary termination of life. And where termination is now still linked to the interests of the person involved (as for instance in the case of defective newborn babies), later on the interests of others will come to be decisive. The Health Council formulates this concern as follows:

A danger lurks in the possibility that the freedom to engage in euthanasia will lead to a certain routine and habituation, which raises the danger that required standards of care will not always be adhered to in making judgments whether or not euthanasia or assistance with suicide is in fact indicated. Even those who have a high regard for the medical profession do not suffer from the illusion that every doctor will always be able to resist the direct or indirect pressure that can be inflicted on him by third parties.v-

In short, we will adhere less and less precisely to our norms with regard to matters of life and death."

60 Staatscommissie 1985: 251-252.

61 De Beaufort 1987: 18.

62 Gczondheidsraad 1982: 72.

63. Compare Dessaur & Rutenfrans 1986: 109ff; Keown 1995.

In this connection De Beaufort points out that

the big problem in discussing the empirical version of the slippery-slope argument about euthanasia is that hard evidence for these predictions, or for the denial thereof, cannot be given. The discussion frequently amounts to little more than an exchange of contradictory assertions, many recriminations and few arguments.⁶⁴

According to Leenen there is

no basis for the assumption that by permitting euthanasia society will come to accept the termination of life without a request as normal. Reference is often made in this connection to Nazi Germany during the Second World War. The situation under German fascism cannot be compared with that of the democratic Netherlands. In the Netherlands euthanasia is a matter of human rights, and the [patient's] request is crucial; in Nazi Germany human rights were denied, and lives were terminated in large numbers without the request and against the will of those involved." Murder under the pretense of euthanasia cannot be treated as if it were the same thing as a person's own decision to end his life because of acute suffering. Experience does not lend much support to the risk of a slippery slope. The argument was, for example, often used in the discussion concerning the legalization of abortion. The domino theory proved unfounded. The Netherlands has a law permitting abortion, and one of the lowest abortion rates in the world."⁶⁵

One variant of the empirical version of the slippery-slope argument is the claim that legalization of euthanasia will undermine public confidence in the medical profession. The concern is that a patient will no longer feel secure that a doctor for whom it is (legally) possible to administer life-terminating treatment can be counted on to do everything possible to preserve the patient's life.⁶⁶ According to others, however, there is no indication whatever that legalization will undermine the doctor-patient relationship. On the contrary, Leenen argues:

64 De Beaufort 1987:21.

65 Compare Griffiths 1987 for the observation that the slippery-slope argument based on the Nazi experience is paradoxical: the danger in that case was from the state, whereas it is that same state to whom opponents of legalization look for *protection* of human life. He suggests that budgetary concerns of the state are probably the source of the greatest danger to the norms concerning medical treatment of dying patients.

66 Leenen 1994: 262-263. See also De Beaufort 1987: 25ff. It is often argued that the approximately 1000 cases of non-voluntary termination of life that take place annually in the Netherlands are proof of the slippery slope. In fact, however, as we argue in chapter 7 (see also Leenen 1994: 270), closer examination of this category shows that this is not the case.

67 See, for example, the State Commission's minority report: Staatscommissie 1985: 262.

The possibility of open communication about euthanasia contributes to the relationship between patients and doctors. The doctor's promise that if the time arrives he will administer euthanasia often brings peace of mind to the patient who is contemplating his death; fear of having to endure a horrible death is thereby reduced. It is doctors pulling out all the stops to preserve patients' lives against their will that has undermined confidence in medicine.s"

The empirical version of the slippery-slope argument assumes that the values that are at stake are better protected by a *criminal* prohibition of euthanasia than they can be by other (legal or non-legal) means.⁶⁹ It is therefore important to consider the slippery-slope argument in conjunction with the cluster of arguments to be discussed in the next section: the control arguments.

4.2.5 Control arguments

An important argument against the legalization of life-terminating behavior claims that it is in practice not possible to ensure that the rules designed to guard against abuse will be adhered to. It is argued, for example, that it is not possible to know for certain whether the request of the patient was truly voluntary:

An important question concerning the voluntariness of the request to die is how such a condition for euthanasia or assistance with suicide is to be interpreted. There are two possibilities: (1) the voluntary nature of the request is assumed, unless there are good reasons to doubt it, and (2) the voluntary nature must be proven. In the first case it is hard to see how a watertight arrangement can be designed, such that no single case of non-voluntary euthanasia can occur. In the second case the condition of voluntariness becomes a practically insurmountable obstacle, because there can always be some doubt whether the person involved made a completely free decision."

The conclusion often drawn from such uncertainty is that the 'safest' choice should be made and the categorical prohibition of any sort of termination of life maintained. Euthanasia may, on this view, sometimes be morally acceptable, but the instruments of

68 Leenen 1994: 263-264.

69 Compare the minority report of the State Commission (Staatscommissie 1985: 271): "Criminal law is not the only means of legal protection, but can in certain circumstances be necessary. If a law has ceased to be effective, it can be a good idea to look for other means." The entire minority report is, however, permeated by the thought that the criminal prohibition of euthanasia is actually effective.

70 Gezondheidsraad 1982: 71. Compare *Second Chamber of Parliament* 1984-1985, 18331, no. 6: 8.

the criminal law are too crude to be able to make the moral distinctions required, so it is better not to legalize it at all:

Legalization of euthanasia and similar decisions means that the state must try to formulate something that cannot be expressed in legal terms. A whole complex of subtle and interdependent factors and motives cannot be transformed into general rules."

Proponents of legalization have not been convinced by this argument. They have countered that there can be effective guarantees (a written request, waiting periods) that confirm the autonomy of the patient's request." Furthermore, they argue that it is wrong to assume that it is always necessarily a greater evil wrongly to let someone die than it is wrongly to make him go on living. Nor can it be assumed that in the case of legalization the number of the former sort of mistake will be bigger than the number of the latter sort in the case of continued prohibition, while it is precisely the ratio between the two that is relevant.

Finally, as with the empirical version of the slippery-slope argument, the control arguments take for granted the effectiveness of the criminal prohibition of euthanasia. But since the 1980s it has been clear that euthanasia has in fact been practised for a long time. To quote the Health Council once again:

The state forbids euthanasia and assistance with suicide, but in practice doctors do perform euthanasia under certain circumstances, and they do in certain cases supply the means with which a person can kill himself, without in fact exposing themselves to criminal prosecution. This situation is objectionable in several respects. The fact that doctors who, in certain cases, are prepared to perform euthanasia and to assist with suicide, and who actually do so, are not exposed to criminal prosecution is simply a result of the fact that they give their help 'behind closed doors', so that no charges can be filed against them. All this leads to disingenuous representations of what has taken place that are completely uncontrollable. When medical practice takes place out of public view, furtively, it is impossible to know whether the doctor acts conscientiously.

[Such a] situation is also confusing and uncertain for those seeking help. It is not clear what is and is not allowed and to whom they can ultimately turn. It is the doctor who decides when a request for help is a cry of distress and when it is a well-considered request for a humane death; the uncontrollability and arbitrariness of the decision-making can continue unchecked."

71 Trappenburg 1991: 532.

72 See Gezondheidsraad 1982: 77; Leenen 1994: 264.

73 Gezondheidsraad 1982: 86-88.

The bill introduced in Parliament in 1984 by Wessel-Tuinstra was motivated in significant part by the need to do something about feelings of insecurity caused by the uncontrollability to which the Health Council called attention:

The bill submitted by the undersigned only proposes to bring something that (at least in the Netherlands) has been taking place for a long time and that is regarded as acceptable both by large groups in the population and by the judiciary, out of the criminal context, to make it controllable, and at the same time to increase the legal security of all those involved. Also for those who do not want euthanasia."

This interpretation of the Dutch situation was confirmed by the research of Van der Maas in 1991 and that of Van der Wal and Van der Maas in 1995 (see chapter 5.3). The chasm between the criminal prohibition and actual practice makes clear that the criminal law is not an effective control regime in the case of euthanasia and other life-shortening behavior of doctors. In short, there is an important control argument *for* decriminalization: this is desirable, not so much because it is 'in principle' better but because it is a necessary condition of a more effective system of control, one that will do a *better* job than the criminal law in protecting values shared by the proponents and opponents of euthanasia. In chapter 6 we pursue this line of thought further.

4.3 A fundamental difference of opinion?

Notwithstanding the divergent views discussed in the previous section, there is general consensus in the Netherlands as to the legal permissibility of euthanasia. Although the foundation for this consensus is not clear, the Dutch euthanasia controversy is in fact substantially settled. In this section we attempt a closer evaluation of this consensus. The most important opposing arguments in the debate will be reconstructed, and we will examine on what basis the opposing positions could be reconciled.

4.3.1 *The nature of a question of legal policy*

The central question in the euthanasia debate - the authority of the state to regulate (or not regulate) euthanasia - is one of legal policy. Such questions must be distinguished from moral and from legal questions. A moral question is concerned with what an individual or group 'may' (or 'may not') do, and although law may be relevant to such a question, it is not finally determinative. The questions whether (assuming euthanasia is not a criminal act) a patient may request euthanasia and whether a doctor may in such a case

co-operate in performing it are moral in nature. The answer is dependent on moral theory. A legal question concerns the content of currently valid legal rules. Whether the proper interpretation of the relevant provisions of the Criminal Code is that a doctor who performs euthanasia at the request of a dying patient is guilty of a criminal offence is a legal question. The answer depends on what sources of law are considered authoritative and how these are to be understood. Questions of legal policy, finally, are concerned with what the law *should be*. The opinion that the prohibition of euthanasia, as set out in the Criminal Code, should be revised to make euthanasia by doctors legal is an opinion on a question of legal policy.

The importance of these distinctions becomes clear in the context of two fundamental principles on which Dutch constitutional law is based: the *separation principle* and the *principle of the rule of law*. The separation principle holds that the 'public domain' and the 'private domain' must be kept separate and that considerations relevant within a person's private domain cannot be simply transferred to the public domain as a basis for legal policy. The principle of the rule of law holds that the judiciary, among other agents of state power, must base its decisions exclusively on existing law.

Both political and legal practice show that these distinctions are not without their difficulties. The creation of law in the political arena is not a value-free enterprise. It always presupposes an underlying moral position. Something similar applies to adjudication. What in a concrete case is 'law' is not always clear. Sometimes the law offers no definitive answer and judges have to take refuge in what were previously 'non-legal' norms."

The euthanasia debate shows how difficult it can be to honor the two principles. The positions adopted by participants in the legal policy debate have often been based on considerations of personal morality. And the norms of medical ethics have played an important role in judicial decisions concerning the legality of euthanasia (see chapter 2.3.1 and appendix II-1 and II-2). It seems that moral and legal questions (and answers) can be distinguished but not *kept separate* from questions of legal policy. This raises the question which normative standpoints are and which are not relevant to the creation of legal rules. In other words: what restrictions apply to the considerations invoked in the formulation of a standpoint on a question of legal policy?

The first requirement of legal policy is one of coherence. The way in which euthanasia is legally regulated must not be purely *ad hoc* but must be grounded on general principles of legal policy. This approach has the advantage that the conclusions reached derive their weight in part from the fact that they have a certain general validity, because they are based on considerations that are not only relevant for the regulation of euthanasia but also for other problems of legal policy.

