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EUTHANASIA IN THE NETHERLANDS: SLIDING DOWN THE SLIPPERY SLOPE?

JOHN KEOWN*

INTRODUCTION

There is only one country in which euthanasia is officially condoned and widely practiced: the Netherlands. Although euthanasia is proscribed by the Dutch Penal Code, the Dutch Supreme Court held in 1984 that a doctor who kills a patient may in certain circumstances successfully invoke the defense of necessity, also contained in the Code, to justify the killing. In the same year, the Royal Dutch Medical Association (K.N.M.G.) issued its members guidelines for euthanasia. Since that time the lives of thousands of Dutch patients have been intentionally shortened by their doctors.

Both the legal and medical guidelines include a central requirement that the patient make a free and explicit request. Defenders of the guidelines have claimed that the guidelines permit voluntary euthanasia but not euthanasia without request. They also claim that the guidelines are sufficiently strict and precise to prevent any slide down a "slippery slope" to euthanasia without request, and that there has been no evidence of any such slide in the Netherlands.

The question addressed in this paper can be simply put: does the Dutch experience of euthanasia lend any support to the claims of supporters of voluntary euthanasia that acceptance of voluntary euthanasia does not lead to acceptance of non-voluntary euthanasia, or does it tend to support the claims of opponents of voluntary euthanasia that it leads down a "slippery slope" to euthanasia without request?

The "slippery slope" argument is often thought of as one argument but it is more accurately understood as comprising two independent yet related forms: the "logical" and the "empirical." In its logical form, the argument runs that acceptance of voluntary euthanasia leads to acceptance of at least non-voluntary euthanasia (that is, the killing of patients incapable of requesting

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euthanasia such as newborns or those with advanced senile dementia). Arguments for voluntary euthanasia rest on the judgment that some lives are not "worth" living. Doctors are not automata who simply execute their patients' wishes, however autonomous. They are professionals who form their own judgment about the merits of any request for medical intervention. A responsible doctor would no more euthanatize a patient just because the patient autonomously asked for it any more than the doctor would prescribe anti-depressant drugs for a patient just because the patient autonomously requested them. The doctor, if acting professionally, would decide in each case whether the intervention was truly in the patient's best interests. Consequently, the alleged justification of voluntary euthanasia rests fundamentally not on the patient's autonomous request *but on the doctor's judgment that the request is justified because the patient no longer has a life "worth" living*. If a doctor can make this judgment in relation to an autonomous patient, he can, logically, make it in relation to an incompetent patient. Moreover, if death is a "benefit" for competent patients suffering certain conditions, why should it be denied incompetent patients suffering from the same conditions?

In its "empirical" form, the "slippery slope" argument asserts that even if a line can in principle be drawn between voluntary and non-voluntary euthanasia, a slide will occur in practice because the safeguards to prevent it cannot be made effective. A common illustration of the argument in this form is the experience of legalized abortion in England, where the law allowing therapeutic abortion has conspicuously failed to prevent widespread abortion for social reasons.¹

The empirical argument is, of course, dependent on empirical evidence. Invaluable evidence about euthanasia in the Netherlands has of late been provided by a large-scale survey carried out on behalf of a Commission appointed by the Dutch Government to investigate medical decision-making in the Netherlands at the end of life. This article makes comprehensive use of this evidence.

The paper comprises three parts. Part I outlines both the relevant law as laid down by the Dutch Supreme Court and the guidelines for euthanasia prescribed by the K.N.M.G., and con-

1. For excellent expositions of the "slippery slope" argument against euthanasia, see Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958); Luke Gormally, *Walton, Davies and Boyd and the Legalization of Euthanasia*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* (John Keown ed., forthcoming 1995).

siders their alleged precision and strictness. Part II summarizes the evidence, including that contained in the above survey, which indicates widespread breach of those guidelines (especially the practice of euthanasia without request). Part III examines the slide from voluntary to non-voluntary euthanasia in Dutch practice and the shift in Dutch opinion towards condonation of non-voluntary euthanasia. The paper concludes that there is ample evidence from the Dutch experience to substantiate the relevance of the "slippery slope" argument in both its forms.

First, an important word about terminology. A standard definition of "euthanasia" is "[t]he intentional putting to death of a person with an incurable or painful disease."² It is common to refer to euthanasia carried out by an act as "active" euthanasia and euthanasia by omission as "passive" euthanasia. Common definitions further distinguish between "voluntary," "non-voluntary," and "involuntary" euthanasia, which refer, respectively, to euthanasia where the patient requests it, where the patient is incompetent, and where the patient is competent but has made no request.

Dutch definitions of "euthanasia" are, typically, markedly narrower, such as "the purposeful acting to terminate life by someone other than the person concerned upon request of the latter."³ It will be apparent that this is narrower than the usual definition in two respects: it is limited to cases of *active*⁴ killing, and there must be a *request by the patient*. In short, the Dutch definition corresponds to what is normally called "active, voluntary euthanasia."

I. STRICT SAFEGUARDS?

A. *The Legal and Professional Guidelines*

Taking the life of another person at his request is an offense contrary to Article 293 of the Penal Code (as amended in 1891),

2. STEDMAN'S MEDICAL DICTIONARY 544 (25th ed. 1990). See also *infra* note 72.

3. P. J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 22 HEALTH POL'Y 1, 5 (1992) (special issue containing the English language translation of a survey conducted by the Erasmus University Department of Public Health and Social Medicine)[hereinafter *Survey*]. A summary of the *Survey* appears in 338 LANCET 669 (1991).

4. A Report of the K.N.M.G. on euthanasia, though, states: "All activities or non-activities with the purpose to terminate a patient's life are defined as euthanasia." VISION ON EUTHANASIA 15 (a translation by the K.N.M.G. in 1986 of its report STANDPUNT INZAKE EUTHANASIE published in 39 *Medisch Contact* 990 (1984)).

and assisting suicide is prohibited by Article 294. In 1984, however, in the *Alkmaar* case, the Dutch Supreme Court allowed a doctor's appeal against conviction for intentionally killing one of his elderly patients at her request. The Court held that the lower courts had wrongly failed to consider whether he had been faced with a "conflict of duties"⁵ (his duty to obey Article 293 on the one hand and his duty to relieve his patient's suffering on the other), whether "according to responsible medical opinion"⁶ measured by the "prevailing standards of medical ethics"⁷ a situation of "necessity"⁸ existed, and whether he had, therefore, been entitled to the defense of necessity, contained in Article 40.⁹

This decision is remarkable for a number of reasons. First, the necessity defense has traditionally been understood as justifying an ostensible breach of the law in order to *save* life (as by pushing someone out of the path of an oncoming car), not to take it. Second, the judgment fails to explain *why* the doctor's duty to alleviate suffering overrides his duty not to kill. Finally, the Court appears to abdicate the power to determine the circumstances in which killing attracts the necessity defense to medical opinion.

In a series of decisions following this landmark case, lower courts have laid down a number of conditions which have hitherto been understood as being required for a doctor to avail himself of the necessity defense, though there is increasing uncertainty as to which, if any, are required. Subject to this important caveat, these conditions were listed in 1989 by Mrs. Borst-Eilers, then Chairman of the Dutch Health Council, as follows:

1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.
2. The patient's request must be well-considered, durable and persistent.
3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.
4. Euthanasia must be a last resort. Other alternatives to alleviate the patient's situation must have been considered and found wanting.
5. Euthanasia must be performed by a physician.

5. 106 NJ 451, 452 (H.R. 1985). See also I.J. Keown, *The Law and Practice of Euthanasia in The Netherlands*, 108 L.Q. REV. 51, 51-57 (1992).

6. 106 NJ at 453.

7. *Id.*

8. *Id.*

9. *Id.*

6. The physician must consult with an independent physician colleague who has experience in this field.¹⁰

Moreover, having performed euthanasia, the doctor should *not* certify death by "natural causes," which would involve the offense of falsifying a death certificate, but should call in the local medical examiner to investigate. The medical examiner should carry out an external inspection of the corpse, interview the doctor, and file a report with the local prosecutor, who should decide whether to investigate further or to allow the body to be handed over to the next-of-kin.

Three months before the landmark Supreme Court decision in 1984, the K.N.M.G. published a report setting out its criteria for permissible euthanasia.¹¹ They are substantially similar to the conditions just listed and require a voluntary request by the patient which is well-considered and persistent, unacceptable suffering by the patient, and consultation by the doctor with a colleague working in the same institution and with an independent doctor.¹² The K.N.M.G. subsequently formulated, in collaboration with the National Association of Nurses, certain "Guidelines for Euthanasia"¹³ which embody the above criteria.

B. "Precisely Defined" and "Strict"?

Before considering the evidence which indicates the extent to which the practice of euthanasia conforms to the above requirements, some comment is called for on the nature of those requirements and particularly on the extent to which they are capable of closely regulating the practice of euthanasia.

A leading Dutch defender of euthanasia has claimed (a claim reproduced with uncritical, almost robot-like repetition in many newspaper articles on this subject) that the Guidelines are "strict" and "precise."¹⁴ However, even a cursory examination indicates that this is not the case. For one thing, it is not even possible precisely to identify the legal criteria, let alone define them: the Supreme Court did not lay down a precise list and lower courts have issued sets of criteria which are far from congruent. For another, as Professor Leenen, a leading Dutch health lawyer (and supporter of legalized euthanasia) has

10. Keown, *supra* note 5, at 56.

11. VISION ON EUTHANASIA, *supra* note 4.

12. *Id.* at 8-11.

13. *Guidelines for Euthanasia*, 3 ISSUES IN L. & MED. 429 (Walter Lagerwey trans., 1988) [hereinafter *Guidelines*].

14. Henk Rigter, *Euthanasia in the Netherlands: Distinguishing Facts from Fiction*, 19 HASTINGS CENTER REP. 31 (1989). For an example of uncritical reference to "strict" guidelines, see INDEPENDENT, June 30, 1994, at 25.

observed, concepts such as "unbearable pain" (*a fortiori*, one might add, "suffering") are open to subjective interpretation and are incapable of precise definition.¹⁵ As for the assertion that the *Guidelines* are "strict," this too is difficult to sustain, not only because of their imprecision but also because of the absence of any effective independent check on the doctor's decision-making to ensure that they are satisfied.

A hypothetical case may help highlight their inherent vagueness. A leading, respected Dutch practitioner of euthanasia has said that he would be put in a very difficult position if a patient told him that he wanted euthanasia because he felt a nuisance to his relatives who wanted him dead so they could enjoy his estate. Asked whether he would rule out euthanasia in such a case, the doctor replied:

I . . . think in the end I wouldn't, because that kind of influence - these children wanting the money now - is the same kind of power from the past that . . . shaped us all. The same thing goes for religion . . . education . . . the kind of family he was raised in, all kinds of influences from the past that we can't put aside.¹⁶

If such a leading practitioner of euthanasia, who has delivered many lectures on the subject inside and outside the Netherlands (including lectures to Dutch police on how to handle euthanasia cases), can interpret the *Guidelines'* requirements of "entirely free and voluntary request" and "unbearable suffering" as possibly extending to such a case, little more need be said about their inherent vagueness and elasticity. In short, because of the *Guidelines'* vagueness and the fact that they entrust the decision-making to the individual practitioner, they are simply incapable of ensuring that euthanasia is carried out only in accordance with the criteria they specify. The empirical evidence which confirms the inability of the *Guidelines* to regulate euthanasia effectively is set out in Part II.

II. EUTHANASIA IN PRACTICE: THE EMPIRICAL EVIDENCE

A. *The Origins of the Rummelink Commission and the van der Maas Survey*

The Dutch coalition government which assumed office in 1989 decided to appoint a Commission to report on the "extent

15. H.J.J. Leenen, *The Definition of Euthanasia*, 3 MED. & L. 333, 334 (1984).

16. Interview with Dr. Herbert Cohen (July 26, 1989).

and nature of medical euthanasia practice."¹⁷ A Commission under the chairmanship of the Attorney-General, Professor Remmelink, was appointed on January 17, 1990 by the Minister of Justice and the State Secretary for Welfare, Health and Culture, and was asked to report on the practice by physicians of "performing an act or omission . . . to terminate [the] life of a patient, with or without an explicit and serious request of the patient to this end."¹⁸

To assist the discharge of this responsibility, the Commission asked P.J. van der Maas, Professor of Public Health and Social Medicine at Erasmus University, to carry out a survey which would produce qualitative and quantitative information on the practice of euthanasia. The Commission and van der Maas agreed that the survey should embrace all medical decisions affecting the end of life so that euthanasia could be seen within that broader context. The umbrella term "Medical Decisions Concerning the End of Life" ("MDELs") includes "all decisions by physicians concerning courses of action aimed at hastening the end of life of the patient or courses of action for which the physician takes into account the probability that the end of life of the patient is hastened."¹⁹ MDELs comprise the administration, supply, or prescription of a drug, the withdrawal or withholding of a treatment (including resuscitation and tube-feeding), and the refusal of a request for euthanasia or assisted suicide.²⁰ The Commission's *Report*²¹ and the *Survey*²² were published in Dutch in September 1991. One year later, the *Survey* was published in English.²³

17. *Survey*, *supra* note 3, at 3.

18. *Id.* at 4.

19. *Id.* at 19-20.

20. *Id.* at 20.

21. MEDISCHE BESLISSINGEN ROND HET LEVENSEINDE, RAPPORT VAN DE COMMISSIE ONDERZOEK MEDISCHE PRAKTIJK INZAKE EUTHANASIE (1991) [hereinafter REPORT].

22. MEDISCHE BESLISSINGEN ROND HET LEVENSEINDE, HET ONDERZOEK VOOR DE COMMISSIE ONDERZOEK MEDISCHE PRAKTIJK INZAKE EUTHANASIE (1991).

23. *Survey*, *supra* note 3. Oddly, the Report has not been translated, though a brief English summary has been produced by the Ministry of Justice. OUTLINES (sic) REPORT COMMISSION INQUIRY INTO MEDICAL PRACTICE WITH REGARD TO EUTHANASIA 1991 [hereinafter OUTLINE]. Dr. Richard Fenigsen, First Reactions to the Report of the Committee on Euthanasia (1991) (unpublished), contains a translation of key passages of the Report. I am grateful to Dr. Fenigsen for permission to rely on his translation. See *Report of the Dutch Governmental Committee on Euthanasia*, 7 ISSUES IN L. & MED. 365 (H. Jochemsen trans., 1991).

A previous paper of mine²⁴ suggested that the Dutch experience lends support to the "slippery slope" argument in both its "logical" and "empirical" forms.²⁵ Do the *Report* and *Survey* require that suggestion to be qualified? The answer on an uncritical reading of the *Report* would be yes. But a reading of the *Report* in the light of its *Survey* yields a contrary answer. Indeed, taken together, the *Survey* and *Report* tend forcefully to confirm the application of the argument in both its forms.

B. *The Findings of the Survey and the Conclusions of the Commission*

After an outline of the *Survey's* findings about the incidence of euthanasia, consideration will be given to the light the *Survey* and the *Report* shed on the extent to which doctors observe the criteria laid down by the courts and the K.N.M.G. in practice. Attention will focus on the *Survey* rather than the *Report* because the *Report* contains the Commission's conclusions in the light of the *Survey*, while the *Survey* is a comprehensive empirical study which stands independent of the *Report*. The conclusions drawn in the *Report* are frequently difficult to square with the findings of the *Survey*.

1. Methodology

Before turning to the *Survey's* findings, a summary of its methodology is appropriate. The *Survey* comprised three studies.

a. *The Retrospective Study*²⁶

A sample of 406 doctors was drawn from general practitioners (G.P.s), specialists (concerned with MDELs), and nursing home doctors, of whom 91% agreed to participate. The doctors were interviewed on average for two and a half hours, almost always by another doctor.²⁷ The respondent was asked about relevant types of decisions. If he or she had made a decision of a

24. Keown, *supra* note 5.

25. *Id.* at 61-78.

26. See *Survey*, *supra* note 3, at Part II (chapters 4-10).

27. *Id.* at 14-17, 191. The authors considered whether those who refused to participate formed a select group which could lead to serious bias and concluded that, in the light of the total number of refusals (41) and the variety of reasons for refusing (mainly lack of time), this could hardly be so. The 15 who refused to participate because they disapproved of the *Survey*, did not wish to comment, or opposed euthanasia could only have introduced a "very modest" bias. *Id.* at 228. This reasoning is unpersuasive: does the conclusion excluding bias not depend on answers which are unverified? Is it not possible that some of the 41 who declined to participate frequently performed

given type, the last occasion on which he or she had done so was discussed in greater detail. At most, ten cases were discussed with each doctor.²⁸

*b. The Death Certificate Study*²⁹

This study examined a stratified sample of 8,500 deaths occurring in the Netherlands from July through November 1990. The treating doctor was identified from each death certificate and was sent a short questionnaire which could be returned anonymously. The response rate was 73%.³⁰

*c. The Prospective Study*³¹

Each of the doctors interviewed in the retrospective study was asked at interview if he or she would complete a questionnaire about each of their patients who died in the following six months. This study had several advantages: there would be little memory distortion because the questionnaire would be completed soon after the death, it would provide additional information to strengthen the quantitative basis of the interview study, and the carefully planned selection of respondents meant that the responses were representative of 95% of all deaths. The study ran from mid-November 1990 to the end of May 1991. 80% of those involved in the first study participated, completing over 2,250 questionnaires.³² In all, each of some 322 doctors supplied information about, on average, seven deaths.³³ The method of collection of data in all three studies was such that anonymity of participants could be guaranteed.³⁴

2. The Incidence of Euthanasia

In 1990, the year covered by the *Survey*, there were almost 130,000 deaths in the Netherlands from all causes, of which 49,000 involved a MDEL.³⁵ The *Report* adopted the Dutch definition of euthanasia as "the intentional action to terminate a person's life, performed by somebody else than the involved person

euthanasia and equally possible that some of these cases fell outside the guidelines?

28. *Id.* at 33.

29. *Id.* at Part III (chapters 11-13).

30. *Id.* at 15, 121-125, 191.

31. *Id.* at Part IV (chapters 14-15).

32. *Id.* at 15, 149-151, 192.

33. *Id.* at 160.

34. *Id.* at 16.

35. REPORT, *supra* note 21, at 14.

upon the latter's request."³⁶ How many cases of "euthanasia" so defined were there in 1990?

The three studies differed as to the incidence of euthanasia, yielding respective figures of 1.9%, 1.7%, and 2.6% of all deaths. The researchers felt that the difference between the second and third estimates was "probably due to the existence of a boundary area between euthanasia and intensifying of the alleviation of pain and/or symptoms"³⁷ and to the probability of the third study counting cases of pain alleviation as cases of "euthanasia," thereby exaggerating its incidence.³⁸

Of the three studies it is, however, arguably the third which produces the most accurate estimate of "euthanasia." As the authors of the *Survey* point out, the respondents in the second study had no information other than the questionnaire and an accompanying letter. Those in the third, however, had participated in the physician interviews, discussing one or more cases from their practice and the crucial concepts in the questionnaire for over two hours with a trained interviewer. The authors, noting that a "great number"³⁹ of interviewees commented that the interview had clarified their thinking about MDELs, suggest the possibility of a learning effect: familiarity with the questionnaire, in which the question about euthanasia followed those relating to other MDELs, may have led the respondents to reply negatively to the earlier questions knowing that the question about euthanasia was to come. The authors conclude that the most important fact was that the respondents in the third study "changed their approach with respect to their intention when administering morphine due to their recent intensive confrontation with thinking about this complex of problems."⁴⁰ If the thinking of participants in the third study had been clarified by their participation in the first study, their responses are surely more likely to have been reliable than those in the second study, particularly since there was an increased risk of memory distortion in the second study because it was retrospective.

36. *Id.* at 11; see also *OUTLINE*, *supra* note 23, at 2. The Dutch define euthanasia as "the purposeful acting to terminate life by someone other than the person concerned upon request of the latter." *Survey*, *supra* note 3, at 5, 23 (quoting STATE COMMITTEE ON EUTHANASIA, REPORT ON EUTHANASIA (1985)). In accordance with this definition it has been argued that 1.8% of the deaths in the Netherlands are attributable to a physician's conscious contribution to euthanasia through prescribing, supplying, or administering drugs. See *id.* at 193 and *infra* note 41 and accompanying text.

37. *Survey*, *supra* note 3, at 178.

38. *Id.*

39. *Id.* at 162.

40. *Id.*

The authors' conclusion, however, is that in light of all three studies, "euthanasia" occurred in about 1.8% of all deaths, or about 2,300 cases,⁴¹ and that there were almost 400 cases of assisted suicide, some 0.3% of all deaths.⁴² More than half of the physicians regularly involved with terminal patients indicated that they had performed "euthanasia" or had assisted suicide and only 12% of the doctors said they would never do so.⁴³

These figures document euthanasia in its narrowest sense: intentional, *active* termination of life *at the patient's request*. But the authors of the *Survey* themselves go on, rightly, to consider euthanasia in a somewhat wider but still precise and realistic sense. They estimate that in a further 1,000 cases (or 0.8% of all deaths) physicians administered a drug "with the explicit purpose of hastening the end of life without an explicit request of the patient."⁴⁴

Beyond this, the authors' commentary does not adequately consider the additional range of evidence yielded by the *Survey*. Many other MDELs also involved an intent to hasten death. In 17.5% of the cases (or 22,500 cases)⁴⁵ palliative drugs were administered in "such high doses . . . that [they] almost certainly would shorten the life of the patient."⁴⁶ In 65% (or 14,625) of these cases the doctors administered the medication merely "[t]aking into account the probability that life would be shortened."⁴⁷ However, in 30% (or 6,750) of the cases, the medication was administered "[p]artly with the purpose of shortening life."⁴⁸ In an additional 6% (or 1,350) of the cases the doctors acted "[w]ith the explicit purpose of shortening life."⁴⁹

Moreover, doctors withdrew or withheld treatment without request in another 25,000 cases, and by the time of the *Survey*, some 90%, or 22,500, had died.⁵⁰ In 65% (or 16,250) of the cases the treatment was withdrawn or withheld "[t]aking into account the probability that life would be shortened."⁵¹ In 19%

41. *Id.* at 178.

42. *Id.* at 179.

43. *Id.* at 40 (Table 5.3).

44. *Id.* at 182. The third study returned a figure of 1.6%. *Id.* at 181.

45. *Id.* at 183.

46. *Id.* at 71. The authors were not concerned with cases where palliative drugs were used which had no chance of shortening life. *Id.* at 72. Life was shortened by up to one week in 70% of cases and by one to four weeks in 23%. *Id.* at 73 (Table 7.3).

47. *Id.* at 72 (Table 7.2).

48. *Id.*

49. *Id.*

50. *Id.* at 85, 90 (Table 8.14).

51. *Id.* at 90 (Table 8.15).

(or 4,750) of the cases, however, doctors acted “[p]artly with the purpose to shorten life,”⁵² and in a further 16% (or 4,000) of the cases “[w]ith the explicit purpose to shorten life.”⁵³

Further, physicians received some 5,800 requests to withdraw or withhold treatment when the patient intended at least in part to hasten death.⁵⁴ In 74% of these cases the doctor withdrew or withheld treatment partly with the purpose of shortening life but in 26% “[w]ith the explicit purpose of shortening life.”⁵⁵ By the time of the interview, some 82% (or 4,756) had died.⁵⁶ The above figures are reproduced in the following table.

52. *Id.*

53. *Id.*

54. *Id.* at 81.

55. *Id.* at 84 (Table 8.7).

56. *Id.* at 82 (Table 8.6).

TABLE: MEDICAL DECISIONS CONCERNING
THE END OF LIFE IN 1990

Acts or omissions with intent to shorten life
(cases of "explicit" intent to shorten life in bold)
(cases without explicit request in parentheses)

Total deaths (all causes)	129,000	
"Euthanasia" [^]		2,300
Assisted suicide		400
Intentional life-terminating acts without explicit request ⁺		1,000 (1,000)
Alleviation of pain/symptoms~	22,500	
with the "explicit purpose" of shortening life		1,350 (450)
"partly with the purpose" of shortening life		6,750 (5,058)
Withdrawal/withholding of treatment without explicit request*	25,000	
with the "explicit purpose" of shortening life		4,000 (4,000)
"partly with the purpose" of shortening life		4,750 (4,750)
Withdrawal/withholding of treatment on explicit request**	5,800	
with the "explicit purpose" of shortening life		1,508
"partly with the purpose" of shortening life		4,292
SUB-TOTAL#		10,558 (5,450)
TOTAL##		26,350 (15,258)

[^] No shortening of life occurred in 1% of these cases. *Survey, supra* note 3, at 49 (Table 5.13).

⁺ No shortening of life occurred in 4% of these cases. *Id.* at 66 (Table 6.10).

[~] No shortening of life occurred in 8% of these cases. *Id.* at 73 (Table 7.3).

* 90% of these patients (22,500) had died by the time of the interview and there had been no shortening of life in 20% of these cases. *Id.* at 90 (Table 8.14).

** 82% of these patients (4,756) had died by the time of the interview and there had been no shortening of life in 19% of these cases. *Id.* at 82 (Table 8.6).

This sub-total refers to cases where doctors "explicitly" intended to shorten life by act or omission.

This total refers to cases where doctors intended ("explicitly" or "partly") to hasten death by act or omission. Both it and the preceding sub-total therefore include (as does the *Survey*) cases where life may not in fact have been shortened and cases in the asterisked categories where patients had not died by the time of the *Survey*.

Thus, it becomes clear that, while the Commission stated that the figure of 2,700 cases of "euthanasia" and assisted suicide "does not warrant the assumption that euthanasia in the Netherlands occurs on an excessive scale . . .,"⁵⁷ the total number of euthanasiast acts and omissions in 1990 was in reality far higher than the Commission claims. To clarify and confirm this conclusion it is necessary to look more closely at the definitions used by the authors of the *Survey* in classifying their data to produce the figure of 2,700.

The commission defined euthanasia as the "*intentional* action to terminate a person's life, performed by somebody else than the involved person upon the latter's request."⁵⁸ Similarly, the definition adopted in the *Survey* was "the *purposeful* acting to terminate life by someone other than the person concerned upon request of the latter."⁵⁹ These definitions echo the one embraced by the central committee of the K.N.M.G. in its 1984 report on euthanasia as all actions "aimed at"⁶⁰ terminating a patient's life at his explicit request. This report added that a majority of the committee had rejected a sub-division of "active" and "passive" euthanasia as "morally superfluous"⁶¹ and undesirable: "All activities or non-activities *with the purpose to terminate a patient's life* are defined as euthanasia."⁶²

The authors of the *Survey* distinguished the following states of mind:

- 1) (acting with) the explicit purpose of hastening the end of life;
- 2) (acting) partly with the purpose of hastening the end of life;
- 3) (acting while) taking into account the probability that the end of life will be hastened.⁶³

They explained that the first category, unlike the third, applied where the patient's death was the intended outcome of the action. The second category was used because sometimes an act was performed with a particular aim (such as pain relief) but the side effect (such as death) was "not unwelcome."⁶⁴ The authors felt that such an effect should be categorized as intentional

57. REPORT, *supra* note 21, at 31; OUTLINE, *supra* note 23, at 2.

58. REPORT, *supra* note 36 (emphasis added).

59. *Survey*, *supra* note 3, at 36 (emphasis added).

60. Keown, *supra* note 5, at 15.

61. *Id.*

62. *Id.* (emphasis added).

63. *Survey*, *supra* note 3, at 21. They state, confusingly, that death "may not" have been intended in the third category.

64. *Id.*

because in order to count as *unintentional* a death "should not in fact have been desired."⁶⁵ The category related to a situation in which the "death of the patient was not foremost in the physician's mind but neither was death unwelcome,"⁶⁶ this was regarded by the authors as a "type" of intention.⁶⁷

As the Table reveals, doctors intended to accelerate death in far more than the 2,700 cases classified by the Commission as "euthanasia" and assisted suicide. The Commission total ignores the 1,000 cases of intentional killing without request and three further categories where there is said to have been some intention to shorten life: first, the 8,100 (1,350 + 6,750) cases of increasing the dosage of palliative drugs; second, the 8,750 (4,000 + 4,750) cases of withholding or withdrawing treatment without request; and third the 5,800 (1,508 + 4,292) cases of withholding or withdrawing treatment on request.⁶⁸ Adding these 23,650 cases to the 2,700 produces a total of 26,350 cases in which the *Survey* states that doctors intended, by act or omission, to shorten life. This raises the incidence of euthanasia from around 2% to over 20% of all deaths in the Netherlands.

It could be argued that the 23,650 cases are not "euthanasia" because they are not cases of intentional killing at the patient's request. There are, however, two counter-arguments. First, some of them clearly *are* intentional killing at the patient's request. In relation, for example, to the 1,350 cases in which it was the explicit purpose of the doctor to shorten life by increasing the dosage of palliative drugs, the *Survey* discloses: "In all these cases the patient had at some time indicated something about terminating life and an explicit request had been made in two thirds of the cases."⁶⁹ Indeed, the authors comment: "This

65. *Id.*

66. *Id.*

67. *Id.*

68. By no means were all of the patients from whom treatment was withdrawn on request terminal. Life was shortened by one to four weeks in 16% of the cases, by one to six months in 43%, and even longer in 13%. *Id.* at 82 (Table 8.6). Moreover, three of the four reasons most frequently given by the patient for requesting withdrawal ("loss of dignity" (31%), "tiredness of life" (28%), and "dependence" (24%), *id.* at 82 (Table 8.4)) appear (unlike the remaining reason - "burden of treatment" (43%)) quite consistent with a suicidal intent. However, as the respondent doctors were not given the opportunity of stating that they withheld or withdrew treatment merely foreseeing that life would be shortened, the figures indicating that doctors intended to shorten life in *all* cases should be treated with some caution, and their categorization here as cases of euthanasiast omissions is subject to this caveat.

69. *Id.* at 72.

situation is therefore rather similar to euthanasia."⁷⁰ It is unclear, then, why the Commission does not regard these as cases of "euthanasia;" they seem to fall squarely within its definition. Interestingly, a member of the Commission (in fact, the member who wrote the *Report*) has subsequently agreed that those cases where doctors had, with the explicit purpose of shortening the patient's life and at the patient's explicit request, administered palliative drugs could properly be categorized as euthanasia.⁷¹

The second counter-argument is that the true scale of euthanasia can properly be gauged only when the Commission's abnormally narrow definition of "euthanasia" is replaced by a standard definition such as "when the death of a human being is brought about on purpose as part of the medical care being given to him."⁷² If this more realistic definition is applied, then the presentation of the data in the *Survey* suggests that there were a further 23,650 deaths by euthanasia.

However, there remains a further question about the proper interpretation of the *Survey*'s definitions, and thus of its figures. Is it appropriate to include the 15,792 cases in which hastening death was only "partly" the doctor's intention? These cases were distinguished in the *Survey* from those where the doctor merely foresaw the acceleration of death (where he proceeded "[t]aking into account the probability that life would be shortened"⁷³). If the doctor's purpose in these cases was, albeit partly, to hasten death, then it seems quite appropriate to regard these cases as instances of euthanasia. By analogy, if racial discrimination is the intentional (purposeful) treating of one person less favorably than another on racial grounds and, say, an employer takes advantage of a need to make cutbacks in order to get rid of his black workers, he may be said to have acted partly with a view to firing black workers, even though his primary purpose is to save his company by reducing employment costs.

On the other hand, it is arguable that these are not necessarily cases in which the doctor's purpose was to hasten death. Notwithstanding the researchers' treatment of these cases as

70. *Id.*

71. Interview with Mr. A. Kors, Ministry of Justice, The Hague (Nov. 29, 1991).

72. THE LINACRE CENTRE, EUTHANASIA AND CLINICAL PRACTICE 2 (1982). See also DICTIONARY OF MEDICAL ETHICS 164 (A.S. Duncan et al. eds., 1981) (" 'mercy killing', the administration of a drug deliberately and specifically to accelerate death in order to terminate suffering."); STEDMAN'S MEDICAL DICTIONARY, *supra* note 2, at 544.

73. *Survey*, *supra* note 3, at 73 (Table 7.2), 90 (Table 8.15).

ones of purposeful killing, their explanation of this category, and in particular their apparent understanding of the concept of "purpose," in fact leave the matter unclear. The implication in their explanation that death in these cases was "desired" does indeed suggest that the doctor intended to shorten life, but the reference to death as a "not unwelcome" consequence suggests that death, while not regretted, may not, in some of these cases, have been any part of the doctor's purpose or goal.

Although it may well be that the doctor's intention in most, if not all, of these cases was to shorten life (a conclusion which would be consistent with the finding that no fewer than 88% of Dutch doctors had performed euthanasia or would be willing to do so⁷⁴) the possibility that it was not cannot be ruled out. These cases are, therefore, regarded in this paper as cases of intentional shortening of life subject to this caveat. However, the force of the following critique of Dutch euthanasia in no way depends on their inclusion. For even if they are discounted, the total number of life-shortening acts and omissions where the doctor's *primary* intention (more graphically but less precisely called "explicit purpose" by the *Survey*) was to kill, and which are therefore indubitably euthanasiast, is 10,558. This figure is almost four times higher than the number of cases categorized as "euthanasia" and assisted suicide by the Commission and amounts to over 8% of all deaths in the Netherlands. In other words, almost 1 in 12 of all deaths in the Netherlands in 1990 was intentionally accelerated by a doctor.

3. "Dances With Data?"

The authors of the van der Maas *Survey* recently argued that I (and a number of other commentators on Dutch euthanasia) have misinterpreted their findings.⁷⁵ One of their main criticisms (to which I shall limit myself in the interests of conciseness) is that I have inaccurately inflated the number of cases of euthanasia and assisted suicide disclosed by their *Survey*. I respectfully demur.

It will be recalled that van der Maas and his colleagues concluded that there were 2,300 cases of euthanasia and 400 cases of assisted suicide⁷⁶ and that the discrepancy between their total of 2,700 and my total of 10,558 stems largely from their peculiarly narrow definition of "euthanasia" as "*active, voluntary* euthanasia," in contrast with my standard definition of "euthanasia" as

74. *Id.* at 40 (Table 5.3).

75. P.J. van der Maas et al., *Dances with Data*, 7 *BIOETHICS* 323 (1993).

76. *See supra* notes 41-42 and accompanying text.

the intentional shortening of a patient's life, by act or omission. Their arguments for rejecting my total are quite unpersuasive. Their main argument is that "intentions cannot carry the full weight of a moral evaluation on their own"⁷⁷ because "intentions are essentially private matters. Ultimately only the agent 'decides' what his intentions are, and different agents may describe the same actions in the same situations as performed with different intentions."⁷⁸ And, they add, the agent's purpose may change over time, so what is to count as the "definitive description?"⁷⁹

This line of argument is remarkable. They agree that euthanasia is to be distinguished from other MDELs in that it involves the intentional (purposeful) shortening of life; indeed, one of the welcome features of their meticulous *Survey* is the care they took to ascertain the doctors' state of mind when hastening death. They specifically *asked* whether the doctors acted with the "explicit purpose" of shortening life, or "partly with the purpose" of shortening life, or merely "taking into account the probability" of shortening life, and the doctors *replied* that in some 10,558 cases it had been their *explicit intention to shorten life*. Why are the doctors' own answers not taken as the "definitive description" of their intention? If the authors thought it impossible to discern the doctors' intention, why did they bother asking them?

The authors add that no doctor who performs euthanasia does so with the sole intent to kill: "His or her intention can always be described as trying to relieve the suffering of his or her patient. This is exactly what infuriates Dutch physicians when, after reporting the case they are treated as criminals and murderers."⁸⁰ However, while the doctor's ultimate intention may be to relieve suffering, he intends to do so by shortening the patient's life, which is precisely why, in most jurisdictions, the doctor who performs euthanasia is liable for murder. If an heir kills his rich father by slipping a lethal poison into his tea, would they deny that this was murder on the ground that the heir's intention was not to kill and "can always be described as" trying to accelerate his inheritance?

The authors continue that it is wrong to rest the moral evaluation entirely on intention: "For a moral evaluation, more is to be taken into account, such as the presence of a request of the patient, the futility of further medical treatment, the sequelae of

77. Van der Maas, *supra* note 75, at 325.

78. *Id.*

79. *Id.*

80. *Id.*

the decision to stop treatment (e.g. will this cause heavy distress?), the interests of others involved such as family and so on."⁸¹ This muddles the argument still further. The question at issue here is not the *moral evaluation* of cases of euthanasia but their *incidence*, and this is a matter of definition, not evaluation. And standard definitions of euthanasia include cases where the doctor, by act or omission, intentionally shortens life.

A further argument they advance is that if the "context" is taken into account, it can be questioned whether the intentions were euthanasiast. As an example they cite the 6% of cases of alleviation of pain and symptoms in which doctors stated that their explicit intention was to shorten life. The authors seek to distinguish these cases from euthanasia on the ground that they involve a failure of palliative care followed by the use of higher doses which may lead to a point at which "the physician realizes that he or she actually hopes that the patient dies."⁸² His or her intention is "not necessarily"⁸³ the same with respect to euthanasia. A physician performing euthanasia would surely try another lethal drug if the first failed, whereas a physician administering opiates would "never" do so.⁸⁴

This argument, too, fails. First, in these cases doctors stated it was their *explicit*, not partial, intention to shorten life; the authors give no reason to doubt the accuracy of this response. Second, the argument appears to rest on the unsubstantiated speculation that, had the higher dose failed to shorten life, the doctor would not have resorted to another method. Even if this were so, the argument is specious, resting on a patent *non sequitur*. If A attempts to kill B by method M1, which fails, his decision not to resort to method M2 in no way establishes he did not intend to kill by method M1.

In sum, the arguments advanced by van der Maas and his colleagues against my total of 10,558 cases of euthanasia backfire, succeeding only in highlighting the inaccurate basis on which they have calculated their own total of 2,700.

C. *Conformity with the Guidelines?*

How many of the 10,558 (or, if partly intended life-shortening is included, 26,350) euthanasiast acts and omissions satisfied the *Guidelines* laid down by the courts and the K.N.M.G.? More specifically, in how many cases was there a "free and voluntary"

81. *Id.* at 325-26.

82. *Id.* at 326.

83. *Id.*

84. *Id.*

request which was "well-considered, durable and persistent?" In how many was there "intolerable" suffering for which euthanasia was a "last resort?" And in how many cases did the doctor consult with a colleague and report the case to the legal authorities, whether prosecutor, police, or local medical examiner?⁸⁵

1. An "Entirely Free and Voluntary" Request Which Was "Well-Considered, Durable and Persistent"

Doctors stated that in the 2,700 cases of euthanasia and assisted suicide there was an "explicit request"⁸⁶ in 96%; the request was "wholly made by the patient"⁸⁷ in 99% of all cases and "repeated"⁸⁸ in 94%; and in 100% of the cases the patient had a "good insight"⁸⁹ into his disease and its prognosis. Oddly, no specific question was asked about the voluntariness of the request and there is no evidence of any mechanism to ensure that the request was voluntary. Moreover, the request was purely oral in 60% of cases⁹⁰ and, when made to a G.P. in cases where a nurse was caring for the patient, the G.P. more often than not failed to consult her.⁹¹

There is no way of gauging the accuracy of the doctors' uncorroborated statements about the patients' requests. Even if they are true, however, the *Survey* data shows that in the 10,558 cases in which it was the doctor's primary purpose to hasten

85. 98% of the doctors stated that they were aware of the "rules of due care" formulated by the K.N.M.G., the Health Council, and the Government. *Survey, supra* note 3, at 95. When asked what they were, 89% mentioned consultation, but only 66% the need for a seriously considered request; 42% a voluntary request; 37% "unacceptable" suffering; and 18% a long-standing desire to die. *Id.* at 95-96 (Table 9.1). When shown 14 guidelines, however, and asked to rank them in importance, 98% mentioned voluntariness and only 67% consultation. *Id.* at 96 (Table 9.2).

A smaller, postal survey of euthanasia by nursing home physicians between 1986 and 1990 revealed that, in over one in five cases, euthanasia was administered less than a week after the first discussion with the patient and in 7% of the cases, in less than a day. In 35% of the cases, euthanasia was administered less than a week after the first request. M.T. Muller et al., *Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?*, 42 J.A.M. GERIATRICS SOC'Y 624, 626 (Table 2) (1994).

86. *Survey, supra* note 3, at 50 (Table 5.15).

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.* at 43.

91. *Id.* at 108 (Table 10.3). By contrast, 96% of specialists and nursing home doctors consulted nursing staff. *Id.* Further, two thirds of G.P.s said they felt it was up to the doctor in certain circumstances to raise the topic of euthanasia. *Id.* at 101.

death, there was in the majority (52%) no explicit request from the patient. Similarly, in a majority (58%) of the 26,350 cases in which it was the doctor's primary or secondary intention to shorten life, the doctor shortened life without the patient's explicit request.

a. *"Life-Terminating Acts Without the Patient's Explicit Request"*

In the light of the three studies, the *Survey* concludes: On an annual basis there are, in [t]he Netherlands, some thousand cases (0.8% of all deaths) for which physicians prescribe, supply or administer a drug with the explicit purpose of hastening the end of life without an explicit request of the patient.⁹²

In over half these cases, the decision was discussed with the patient or the patient had previously indicated his wish for the hastening of death, but in "several hundred cases there was no discussion with the patient and there also was no known wish from the patient for hastening the end of life."⁹³ Virtually all cases, state the authors, involved seriously ill and terminal patients who obviously were suffering a great deal and were no longer able to express their wishes, though there was a "small number"⁹⁴ of cases in which the decision could have been discussed with the patient.

The fact that doctors administered a lethal drug without an express request in 1,000 cases - almost half as many as they did on request - is striking. So too is the Commission's reaction to this statistic. The Commission observes that the ("few dozen"⁹⁵) cases in which the doctor killed a *competent* patient without request "must be prevented in [the] future,"⁹⁶ and that one means would be "strict compliance with the scrupulous care"⁹⁷ required for euthanasia "including the requirement that all facts of the case are put down in writ[ing]."⁹⁸ However, the Commission *defends* the other cases of non-requested killing, stating that "active intervention"⁹⁹ by the doctor was usually "inevitable"¹⁰⁰ because of the patient's "death agony."¹⁰¹ That is why, it explains,

92. *Id.* at 182.

93. *Id.*

94. *Id.*

95. OUTLINE, *supra* note 23, at 3.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

it regards these cases as "care for the dying."¹⁰² It adds that the ultimate justification for killing in these cases was the patient's "unbearable suffering."¹⁰³

The Commission's assertion that most of the 1,000 patients were incompetent and in their "death agony" should not pass unchallenged. The physician interviews indicate that 14% of the patients were totally competent and a further 11% partly competent,¹⁰⁴ that 21% had a life expectancy of one to four weeks and 7% of one to six months¹⁰⁵ (the *Survey* classed patients as "dying" if their life had been shortened only by "hours or days," not by "weeks or months"¹⁰⁶) and that doctors did not list "agony" as a reason for killing these patients. The reasons given by doctors were the absence of any prospect of improvement (60%); the futility of all medical therapy (39%); avoidance of "needless prolongation" (33%); the relatives' inability to cope (32%), and "low quality of life" (31%).¹⁰⁷ Pain or suffering was mentioned by only 30%.¹⁰⁸ And, even in relation to these 30%, if they were essentially cases of increasing pain or symptom treatment to shorten life, why did the doctors not classify them under that heading?¹⁰⁹

In short, the Commission's defense of these 1,000 cases would appear to be based on a shaky factual foundation and its attempted ethical justification amounts to little more than a bare assertion that killing without request, a practice in breach of cardinal criteria for permissible euthanasia, is morally acceptable.

102. *Id.*

103. *Id.*

104. Seventy-five percent of the patients were "totally unable to assess the situation and take a decision adequately." However, 14% were totally and 11% partly ("not totally") able to do so. *Survey, supra* note 3, at 61 (Table 6.4). The authors describe a person "not totally able" as "partially able to assess the situation and on this basis adequately take a decision." *Id.* at 23. According to the death certificate study, 36% were competent. Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1197 (1993) (Table II).

105. *Survey, supra* note 3, at 66 (Table 6.10).

106. *Id.* at 24. According to the Survey's definition, then, only 29% of the 2,700 cases of euthanasia and assisted suicide involved "dying" patients. *Id.* at 49 (Table 5.13).

107. *Id.* at 64 (Table 6.7).

108. *Id.* Note that in the instruction to the interviewer it was not specified as a constraint that the cases involved in the study must be cases in which the explicit purpose was hastening the end of life. Furthermore, and surprisingly, no question was asked about the doctor's intention which, as the authors note, "complicates the interpretation of the results." *Id.* at 57.

109. Henk Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. MED. ETHICS 212, 213 (1994).

On the basis of this assertion, the Commission proceeds to recommend that doctors should report such cases in the same way as they report cases of voluntary euthanasia.¹¹⁰

The Government has implemented the Commission's recommendation that euthanasia without request should be reported by incorporating the reporting procedure into the law regulating the disposal of the dead. The procedure makes it clear that it applies whether or not the patient requested euthanasia.¹¹¹

b. Other Cases of Intentional Life-Shortening Without Explicit Request

In addition to the 1,000 cases of active life termination without explicit request there were many more in which the patient made no explicit request that his life be shortened.

In 59% (or 4,779) of the 8,100 cases in which doctors are said to have intended to hasten death by pain-killing drugs, the patient had "never indicated anything about terminating life,"¹¹² and there had been no explicit request in a further 9% (or 729),¹¹³ making 5,508 cases in which there had been no explicit request.¹¹⁴

Additionally, in 8,750 cases treatment is said to have been withheld or withdrawn without explicit request with the intent to shorten life.¹¹⁵ The Commission would have it that these were cases of omitting to provide futile treatment. It states:

After all, a doctor has the right to refrain from (further) treatment, if that treatment would be pointless according

110. OUTLINE, *supra* note 23, at 6. The Commission excepted from this recommendation cases where "the vital functions have already and irreversibly begun to fail" on the ground that in such cases a natural death would have ensued anyway. *Id.* The Government has rejected this exception. See J.K.M. Gevers, *Legislation on Euthanasia: Recent Developments in the Netherlands*, 18 J. MED. ETHICS 138, 140 (1992).

111. Gevers, *supra* note 110, at 139-40. See also *infra* note 163 and accompanying text.

112. *Survey*, *supra* note 3, at 76 (Table 7.9).

113. *Id.*

114. In 17% of the cases, the patient had indicated something about life termination but the "request was not strongly explicit." *Id.* If these cases are included, the number of cases of life shortening without explicit request becomes 6,885. Thus, in only 15% of the cases was there a "strongly explicit" request. *Id.*

115. See *supra* notes 52-53 and accompanying text. In 18% of cases the patient had "indicated something at some time about terminating life" and in a further 13% there had been some discussion with the patient. *Survey*, *supra* note 3, at 88 (Table 8.11).

to objective medical standards. The commission would define a treatment without any medical use as therapeutic interference that gives no hope whatsoever for any positive effect upon the patient. To the application of this kind of futile medicine, no one is entitled. It is undisputed that the medical decision whether a particular action is useful or not, belongs to normal medical practice.¹¹⁶

The Commission appears confused. First, the concept of "futile treatment" was not used in the *Survey* in relation to withdrawal of treatment, because the authors felt that its meaning was open to "variable" interpretation.¹¹⁷ Second, the preamble to the relevant questions suggests that they were not asking about the withdrawal of futile treatment, that is, treatment which was unlikely or incapable of achieving its normal therapeutic purpose, but rather about the withdrawal of treatment which was preserving "futile" lives, that is, lives which were not thought to be worth preserving:

[In most instances this] decision to withhold or to withdraw . . . treatment . . . concerns situations in which the treating physician does not expect or does not observe sufficient success. However, there are situations in which a considerable life-prolonging effect can be expected from a certain treatment while the decision can nevertheless be made to withhold such treatment or to withdraw it. This implies that under such circumstances considerable prolongation of life is considered undesirable or even futile. "Considerable" is taken to mean more than one month.¹¹⁸

That the questions were concerned with "futile" lives rather than ineffectual treatment is further suggested by the authors' explanation of this series of questions:

Briefly, two types of situations are discussed here. On the one hand therapies are involved which will probably meet with little or no success. Such treatment can be withdrawn or withheld for this reason. On the other hand there are cases in which therapies which can have a considerable (more than one month) life-prolonging effect but in which

116. OUTLINE, *supra* note 23, at 3-4.

117. There is no uniform definition of the concept of "medically futile therapy." The term "futile" depends too much on what is considered to "have a point," i.e., to make sense. This concept was therefore not used in the questionnaires because its interpretation is too varied. *Survey*, *supra* note 3, at 24.

118. *Id.* at 84-85.

prolongation of life is undesirable or pointless and treatment is withdrawn or withheld for this reason.¹¹⁹

They add that doctors were asked to discuss "only the second type" of situation.¹²⁰

Third, it seems clear that the question was so understood by at least some of the respondents. Thirty-five percent of the doctors replied that their (primary or secondary) intention was to hasten death, not to withdraw a futile treatment.¹²¹

That the lives of so many patients were shortened without explicit request is striking. Hardly less striking is the fact that by no means were all of the patients killed without request incompetent. It will be recalled that of the 1,000 actively killed without request, 14% were (according to the physician interviews) totally competent and a further 11% partly competent. Van der Wal has aptly commented that in these cases the right to self-determination was "seriously undermined."¹²² Moreover, of the 8,100 patients whose deaths are said to have been intentionally accelerated by palliative drugs, 60% (or 2,867) of those who had never indicated anything about life termination were competent.¹²³ Finally, the patient was totally competent in 22%, and partly competent in a further 21%, of all the cases where treatment was withheld or withdrawn without request.¹²⁴

The Commission concludes that the *Survey* "disproves the assertion often expressed, that non-voluntary active termination of life occurs more frequently in the Netherlands than voluntary termination."¹²⁵ However, if intentional termination by omission is included, as it should be if an accurate overall picture is to be presented, the *Survey* indicates that non-voluntary euthanasia is in fact more common than voluntary euthanasia. As the above Table illustrates, the *Survey* discloses that in 1990 doctors intentionally sought to shorten more lives without than with the patient's explicit request. It was their primary aim to kill 10,558 patients, 5,450 (52%) of whom had not explicitly asked to have their lives shortened. If one includes cases in which the patient's death is referred to as part of what the doctor aimed to achieve, then the total number of intentional killings by doctors may not

119. *Id.* at 85.

120. *Id.*

121. *See supra* notes 52-53 and accompanying text.

122. Gerrit van der Wal, *Unrequested Termination of Life: Is it Permissible?*, 7 *BIOETHICS* 330, 337 (1993).

123. *Survey, supra* note 3, at 77.

124. *Id.* at 88 (Table 8.12). The *Survey* does not appear to provide separate figures for those whose lives were intentionally shortened.

125. *OUTLINE, supra* note 23, at 3; *REPORT, supra* note 21, at 33.

be far short of 26,350, in 15,258 (58%) of which the patient had not explicitly asked for death to be hastened.

2. "Intolerable Suffering With No Prospect of Improvement" When Euthanasia Was a "Last Resort"

a. "Intolerable Suffering"

The *Survey* throws considerable doubt on whether euthanasia was confined to patients who were "suffering unbearably" and for whom it was a "last resort."¹²⁶ For example, doctors were asked in interviews which reason(s) patients most often gave for requesting euthanasia. In 57% of the cases, patients cited a "loss of dignity;" in 46% "not dying in a dignified way;" in 33% "dependence;" and in 23% "tiredness of life."¹²⁷ Only 46% mentioned "pain."¹²⁸

A recent case concerned a fifty year old woman who had lost two sons, one to suicide, the other to cancer and who repeatedly asked her psychiatrist, a Dr. Chabot, to help her die. Dr. Chabot assisted her to commit suicide and was prosecuted but acquitted. The prosecution's appeal to the Court of Appeal was unsuccessful but an appeal to the Supreme Court resulted in the doctor's conviction on the ground that the doctor should have ensured that one of the doctors he had consulted had personally examined the patient. A novel and disturbing feature of the case is that the woman was not terminally or, indeed, even physically ill. The suffering which was considered sufficient to warrant assisted suicide was purely mental, resulting from a "depression in a narrower sense without psychotic characteristics in the context of a complicated grieving process."¹²⁹

126. The Commission states that Dutch doctors regard the "intolerable suffering of the patient and/or his natural desire for a quiet death" as the only grounds on which to perform euthanasia. REPORT, *supra* note 21, at 32. The reference to these grounds in the alternative, without disapproval, is revealing: it confirms that neither all doctors nor the Commission regard both as essential for euthanasia to be permissible.

127. *Survey*, *supra* note 3, at 45 (Table 5.8).

128. *Id.* Doctors gave similar reasons for killing without request. See *supra* notes 106-08 and accompanying text. Similarly, Muller found that the most common reason for requesting euthanasia was not "unbearable suffering" but "fear of/avoidance of deterioration of condition." Muller, *supra* note 85, at 626 (Table 3).

129. "[E]en depressie in engere zin, zonder psychotische kenmerken, in het kader van een gecompliceerd rouwproces." Hoge Raad, STRAFKAMER, nr. 96.972., June 21, 1994, at para. 4.5. The Supreme Court rejected the prosecution's submissions that necessity required somatic pain and that a psychiatric patient could not make a genuine request for death. It held, however, that in cases where the suffering was not somatic, a proper factual

In relation to cases of withholding or withdrawal of treatment without explicit request and with intent to hasten death, the basis for the decision appears to have been simply a belief that, in the words of the preamble to the question put, "considerable prolongation of life" was considered "undesirable or even futile."¹³⁰ That Dutch doctors regard "unbearable suffering" as an essential criterion is, moreover, hardly confirmed by the agreement of two thirds of those interviewed with the proposition that "[e]veryone is entitled to decide over their own life and death."¹³¹

b. A "Last Resort"

Nor does it appear that euthanasia was invariably a "last resort." Doctors said that treatment alternatives remained in one in five cases (21%) but that, in almost all of these cases, they were refused.¹³² One in three G.P.s who decided that there were no alternatives had not sought advice from a colleague.¹³³ When asked to rank the *Guidelines* in order of importance, only 64% of respondents said absence of treatment alternatives was "(very) important."¹³⁴

Moreover, even in the four out of five cases in which the doctors said there were "no treatment alternatives," they apparently meant that there were no "alternatives to the current treatment," rather than no "alternatives to euthanasia." The question

basis for the necessity defense could be laid only where the patient had been examined by an independent doctor who had assessed the gravity of the suffering and possibilities for its alleviation. As the Court of Appeal had not made such a finding in this case it had not been in a position to conclude that a situation of necessity existed. Although the doctor's conviction was restored, he was not punished. For commentaries on the case see T. Schalken, 656 N.J. 3256-59 (1994); J.H. Hubben, *Hulp bij zelfdoding en psychiatrie; het arrest Chabot*, 27 NJB 912 (July 15, 1994); H.J.J. Leenen, 1 TIJDSCHRIFT VOOR GEZONDHEIDSRECHT 48 (1994).

130. *Survey*, *supra* note 3, at 85. For example, the evidence in relation to the 8,750 cases in which doctors stated that they withheld or withdrew treatment without request with intent to shorten life does not indicate that all the patients were suffering unbearably and that euthanasia was a last resort. For one thing, given that 58% of the patients were unable to "assess the decision and take a decision adequately," how could the doctor assess the extent of the patients' suffering (if any), particularly as the patients' conditions varied? *Id.* at 88 (Table 8.12).

131. *Id.* at 102 (Table 9.7).

132. *Id.* at 45 (Table 5.7).

133. *Id.* at 43. Even in those cases where the doctors (two-thirds of G.P.s and 80% of specialists) did consult, there is nothing to suggest that the colleague consulted was a specialist in palliative medicine.

134. *Id.* at 96 (Table 9.2).

asked of the doctors ("Were alternatives available to the treatment given? Here I consider other therapeutic possibilities or possibilities to alleviate pain and/or symptoms."¹³⁵) supports this interpretation. Also, in response to a question about the aim of the treatment at the time when the decision to carry out euthanasia or assisted suicide was made, 77% of the doctors replied that the aim was palliative, 10% that it was life prolonging, and 2% that it was curative. Only 14% said there was no treatment.¹³⁶ In other words, just because there might have been no treatment alternatives to the existing treatment does not mean that the existing treatment was not an alternative to euthanasia.

But even if the palliative treatment given in 77% of cases was not preventing intolerable suffering and was so ineffectual that euthanasia was thought to be the only alternative, does this (and the fact that in 46% of cases pain was one of the reasons most frequently given by patients as a reason for wanting euthanasia) not raise questions about the quality of the palliative care that the patients were receiving? A report on palliative care published in 1987 by the Dutch Health Council concluded that a majority of cancer patients in pain suffered unnecessarily because of health professionals' lack of expertise.¹³⁷ Similarly, more recent research into pain management at the Netherlands Cancer Institute, Amsterdam, contains the "critical and worrisome overall finding . . . that pain management was judged to be inadequate in slightly more than 50% of evaluated cases."¹³⁸

135. *Id.* at 43.

136. *Id.* at 45 (Table 5.6). Why 14% were receiving no treatment is unexplained.

137. Keown, *supra* note 5, at 65. The British Medical Association Working Party on Euthanasia commented that palliative care in the Netherlands is not as advanced as in Britain. THE BRITISH MEDICAL ASSOCIATION WORKING PARTY ON EUTHANASIA 49 (1988).

138. Karin L. Dorrepaal et al., *Pain Experience and Pain Management Among Hospitalized Cancer Patients*, 63 *CANCER* 593, 598 (1989). Referring to this study, Zbigniew Zylic, Medical Director at the newest hospice in the Netherlands, comments that it does not warrant a general judgment about terminal care in the Netherlands but should be taken as a warning and a stimulus for further studies. He notes that "cancer pain treatment and symptom control does not receive enough attention and in many places, it is practiced at a very poor level. As yet, there is no specific training available in palliative care." Zbigniew Zylic, *The Story Behind the Blank Spot*, 10 *AM. J. HOSPICE & PALLIATIVE CARE* 30, 32 (1993). He adds that there are no comprehensive hospices in the Netherlands because the high standard of care in hospitals and nursing-homes and the Government's policy to reduce institutional beds have combined to discourage the hospice system. While hospitals are officially encouraged to provide hospice care, the necessary resources are not provided. Zylic urges the establishment of more hospices. *Id.* at 33-34.

Interestingly, 40% of the Dutch doctors interviewed in the van der Maas Survey expressed agreement with the proposition that “[a]dequate alleviation of pain and/or symptoms and personal care of the dying patient make euthanasia unnecessary.”¹³⁹ Yet the Commission concludes that its total of 2,700 cases of “euthanasia” and assisted suicide shows that “euthanasia” is not being used as an alternative to good palliative medicine or terminal care.¹⁴⁰ This observation is quite unsupported by the data which reveals not 2,700 but over 10,500 unambiguously euthanasiast acts and omissions. It also sits uneasily with the Commission’s later observation about the inadequacy of such care in the Netherlands:

The research report shows that the medical decision process with regard to the end of life demands more and more expertise in a number of different areas. First of all medical and technical know-how, especially in the field of the treatment of pain, of prognosis and of alternative options for the treatment of disorders that cause insufferable pain.¹⁴¹

It adds:

Especially doctors, but nurses as well, will have to be trained in terminal care. . . . Optimal care for someone who is dying implies that the doctor has knowledge of adequate treatments for pain, of alternatives for the treatment of complaints about unbearable pain and that he is aware of the moment when he must allow the process of dying to run its natural course. Doctors still lack sufficient knowledge of this care. . . . In a country that is rated among the best in the world when it comes to birth care, knowledge with regard to care for the dying should not be lacking.¹⁴²

If there is such a lack of knowledge, does this not confirm and help to explain the *Survey* evidence which indicates that euthanasia is being used as an alternative to appropriate palliative care?¹⁴³

139. *Survey*, *supra* note 3, at 102 (Table 9.7).

140. *OUTLINE*, *supra* note 23, at 2; *REPORT*, *supra* note 21, at 31.

141. *OUTLINE*, *supra* note 23, at 7.

142. *Id.*

143. An expert committee of the World Health Organization has concluded: “now that a practicable alternative to death in pain exists, there should be concentrated efforts to implement programmes of palliative care, rather than a yielding to pressure for legal euthanasia.” *WORLD HEALTH ORGANIZATION, CANCER PAIN RELIEF AND PALLIATIVE CARE, TECHNICAL REP. SERIES NO. 804 (1990)*. Dr. Pieter Admiraal, one of the leading practitioners of euthanasia in the Netherlands, has written that “in most cases, pain can be

3. Performed By a Doctor Who Has Consulted an Independent Colleague and Reported the Case to the Legal Authorities

a. Consultation

A K.M.N.G. - proposed scheme of consultation with two colleagues, one of whom is independent, has never been put into effect. Doctors stated that they had consulted a colleague in 84% of cases of euthanasia and assisted suicide.¹⁴⁴ The *Survey* does not explain the form, substance or outcome of the consultations. Again, in respect to the 1,000 acts of life termination without request - cases where presumably consultation would assume special importance - only a minority (48%) of doctors consulted a colleague.¹⁴⁵ Moreover, 40% of G.P.s stated that they did not think that consultation was very important.¹⁴⁶

b. Reporting

Only a minority of cases of "euthanasia" were duly reported to the legal authorities. In almost three out of four cases (72%) doctors (three out of four G.P.s and two out of three specialists) certified that death was due to "natural causes."¹⁴⁷ By so doing, they not only failed to comply with one of the *Guidelines* whose importance has been continually stressed by the K.N.M.G., but they also committed the criminal offense of falsifying a death certificate.

The three most important reasons doctors gave for falsifying the certificate included the "fuss" of a legal investigation (55%), a desire to protect relatives from a judicial inquiry (52%), and a

adequately controlled without the normal psychological functions of the patient being adversely affected." Pieter Admiraal, *Justifiable Euthanasia*, 3 ISSUES IN L. & MED. 361, 362 (1988).

144. *Survey*, *supra* note 3, at 47 (Table 5.9).

145. *Id.* at 64 (Table 6.8). In 68% of the cases the doctor felt that there was no need to consult a colleague because "the situation had been clear." *Id.* at 65. Before withholding or withdrawing a treatment without request, doctors consulted a colleague in 54% of the cases. *Id.* at 89 (Table 8.13). When there was a request, the figure was 43%. *Id.* at 82 (Table 8.5). Before administering palliative drugs in such doses as might shorten life, doctors consulted a colleague in 47% of the cases. *Id.* at 73 (Table 7.4). Muller's survey revealed that, of the doctors consulted, only two thirds talked with the patient, only half studied the medical records, and only 17% physically examined the patient. Muller, *supra* note 85, at 627.

146. *Survey*, *supra* note 3, at 97.

147. *Id.* at 49 (Table 5.14). Muller found that in 57% of the cases doctors certified a natural death. Muller, *supra* note 85, at 628 (Table 7).

fear of prosecution (25%).¹⁴⁸ Similarly, virtually all of the 1,000 acts of life termination without request were certified as natural deaths. The most important reasons given by the doctors were the "fuss" of a legal investigation (47%), the (remarkable) opinion that the death was in fact natural (43%), and the desire to safeguard the relatives from a judicial inquiry (28%).¹⁴⁹

Interestingly, only 64% of doctors thought that each case of euthanasia should somehow be examined, and the most favored form of review was by other doctors.¹⁵⁰

III. THE SLIDE IN PRACTICE AND THE SHIFT IN OPINION

My earlier article suggested that the slippery slope argument in both its logical and practical forms applies to the Dutch experience of euthanasia.¹⁵¹ The *Survey* and the *Report* serve amply to reinforce that contention. The examination of the *Guidelines* in Part I of this paper concluded that they are vague, loose and incapable of preventing abuse. The *Survey* bears out this conclusion by indicating that cardinal safeguards - requiring a request which is free and voluntary; well-informed; and durable and persistent - have been widely disregarded. Doctors have killed with impunity. And on a scale previously only guessed at: the *Survey* discloses that it was the primary purpose of doctors to shorten the lives of over 10,000 patients in 1990, the majority without the patient's explicit request.

How the Rummelink Commission can so confidently conclude, in the light of the evidence unearthed by the *Survey*, that the "medical actions and decision process concerning the end of life are of high quality"¹⁵² is puzzling. The Commission's assessment is based solely on the doctors' uncorroborated replies,

148. *Survey*, *supra* note 3, at 48. The authors add that 23 doctors actually stated that they had regarded the death as natural.

149. *Id.* at 65. Deaths hastened by withholding or withdrawing a treatment without request were almost all certified as natural deaths. *Id.* at 89. All deaths hastened by the administration of palliative drugs also were certified as natural deaths; in over 90% of the cases the doctor felt that the death was natural, but in 9% the doctor felt that reporting an unnatural death would be "troublesome." *Id.* at 74.

150. *Id.* at 97 (Table 9.3). See also *id.* at 98. It merits mention that in a small number of cases, the lethal drug was administered by someone other than the doctor, nurse or patient. See *id.* at 140 (Table 13.10), 143, 193.

151. Keown, *supra* note 5.

152. OUTLINE, *supra* note 23, at 6. Remarkably, van der Maas also regards them of "good quality." *Survey*, *supra* note 3, at 199. According to the replies to Muller's survey, all the safeguard requirements were met in only 41% of the cases. Muller, *supra* note 85, at 628. Even this figure, based as it is on self-serving replies, may well be too high.

replies which disclose, surely far more reliably, wholesale breaches of the *Guidelines*. In particular, the scale of intentional life-shortening without explicit request and of illegal certification of death by natural causes must cast grave doubt both on the Commission's conclusion that decision-making is of "high quality" and on van der Maas's opinion that the *Survey* shows that doctors are "prepared to account for their decisions."¹⁵³ As the 1,000 cases of unrequested killings vividly illustrate, the existing system cannot realistically hope to detect the doctor who ignores the *Guidelines* since it essentially relies on him to expose his own wrongdoing.

Moreover, the Rummelink Report's narrow categories of "euthanasia" and "intentional killing without request" may suggest to those who have not considered it before a neat way of side-stepping the reporting procedure. A doctor might kill not by a lethal drug, which he would be required to report, but by an overdose of morphine or by withdrawing treatment, which he could claim with at least some show of legitimacy (in the unlikely event of being challenged) to be "normal medical practice."

Even though recent statistics indicate a significant increase in the number of cases reported (1,424 in 1994¹⁵⁴) it seems clear that the reporting procedure will continue to provide a wholly inadequate mechanism for regulating euthanasia and that the reports filed will continue to provide no more accurate a picture

153. *Survey*, *supra* note 3, at 205.

154. This number is over three times the number for 1990, and it is 120 more than for 1993.

YEAR	NON-PROSECUTION	PROSECUTION	NON-PROSECUTION AFTER JUDICIAL INVESTIGATION	PROSECUTION TAKEN FURTHER
1984	16	1	0	0
1985	26	4	1	0
1986	81	0	1	2
1987	122	2	1	1
1988	181	2	1	0
1989	336	1	1	0
1990	454	0	0	0
1991	590	1	0	0
1992	1,318	4	1	0
1993	1,303	15*	1	0
1994	1,417	7	12	2

JAVERSLAAG OPENBAAR MINISTERIE 1994 (1995). The Table also indicates that only 14 cases were prosecuted in 1993. In a dozen of these cases the prosecution was brought because the patient had not been terminally ill. After the decision of the Supreme Court in the case of Dr. Chabot (*see supra* text accompanying note 129) that a terminal illness was not required to justify euthanasia, the prosecution in these cases was discontinued.

of the reality of euthanasia than they have hitherto done. Reports of killing without request promise to be particularly unrepresentative: how many doctors are likely to report a practice which has not (yet) been declared lawful by the courts?¹⁵⁵ Further, even if all cases were reported, this would still provide no guarantee of propriety; indeed, were all to be reported, it is doubtful whether prosecutors would have the resources to subject them even to the limited check which reports currently receive.

The *Report* uses the finding that doctors refused some 4,000 serious requests¹⁵⁶ to argue that "euthanasia" is not used excessively and as an alternative to good palliative care.¹⁵⁷ Leaving aside the evident shortcomings in Dutch terminal care, this is simply illogical, particularly when viewed against the 10,500 occasions on which it was the doctor's primary purpose to shorten life.

That statistic suggests rather the pertinence of the slippery slope argument. The argument's relevance is indeed quite strongly suggested by the fact that doctors had as their primary aim the shortening of the lives of some 5,500 patients without their explicit request (and are represented in the Survey as having had as their subordinate aim the shortening of the lives of upwards of a further 10,000 without their explicit request). The relevance is sufficiently striking even if one focuses simply on the 1,000 cases involving the administration of a lethal drug without explicit request. Nor were these patients killed by a minority of maverick doctors: a majority of doctors admitted that they either had killed without request or would be prepared to do so.¹⁵⁸

In any event, it is now evident that some of the leading authorities in the Netherlands openly condone non-voluntary euthanasia in certain circumstances. The Rummelink Report defends, it will be recalled,¹⁵⁹ the vast majority of the 1,000 killings without request as "care for the dying."¹⁶⁰ Stating that the absence of a request only serves to make the decision more difficult than when there is a request, it adds:

155. Gevers, *supra* note 110, at 140.

156. *Survey*, *supra* note 3, at 52.

157. OUTLINE, *supra* note 23, at 2.

158. *Survey*, *supra* note 3 at 58 (Table 6.1).

159. See *supra* notes 99-103 and accompanying text.

160. A member of the Commission informed me that these killings came as a "terrible shock" to its members, who had hoped that they did not exist. Interview with Mr. A. Kors (Nov. 29, 1991). This makes the Commission's defense of the bulk of these killings all the more puzzling.

The ultimate justification for the intervention is in both cases the patient's unbearable suffering. So, medically speaking, there is little difference between these situations and euthanasia, because in both cases patients are involved who suffer terribly. The absence of a special request for the termination of life stems partly from the circumstance that the party in question is not (any longer) able to express his will because he is already in the terminal stage, and partly because the demand for an explicit request is not in order when the treatment of pain and symptoms is intensified. The degrading condition the patient is in, confronts the doctor with a case of force majeure. According to the commission, the intervention by the doctor can easily be regarded as an action that is justified by necessity, just like euthanasia.¹⁶¹

The classification of killing without request as "care for the dying" could be criticized as tendentious euphemism and is inconsistent even with established Dutch terminology.¹⁶² Moreover, in view of the importance which has long been attached by many Dutch proponents of euthanasia to the need for a request by the patient, it is remarkable that the Commission, rather than setting out a reasoned ethical case to substantiate its opinion that killing without request can be justified, should do scarcely more than assert that a request is no longer essential in all cases.

Nevertheless, the Dutch Parliament has implemented the Commission's recommendation that the reporting procedure for euthanasia should clearly allow for such cases. It has amended the Burial Act of 1955 to set out the reporting procedure in statutory form, a form which makes it clear that the procedure is to be followed even in cases of euthanasia without request.¹⁶³ The amendment, which was passed in 1993 and came into force in June 1994, has not made euthanasia lawful but has enshrined the reporting procedure in statutory form.

Similarly, a committee of the K.N.M.G. set up to consider non-voluntary euthanasia has condoned the killing, in certain circumstances, of incompetent patients including babies and patients in persistent coma and has canvassed opinion on the killing of patients with severe dementia.¹⁶⁴ It is surely only a matter of time before such "responsible" medical opinion receives

161. OUTLINE, *supra* note 23, at 3.

162. See *infra* note 173 and accompanying text.

163. See REPORT OF THE SELECT COMMITTEE ON MEDICAL ETHICS (H.L. 21-I of 1993-94) Appendix 3 at 65.

164. Henk Jochemsen, *Life-Prolonging and Life-Terminating Treatment of Severely Handicapped Newborn Babies*, 8 ISSUES IN L. & MED. 167 (1992); *Doen of*

judicial approval. Indeed, if the criterion for the availability of the defense of necessity is what accords with "responsible" medical opinion, it is difficult to see how the courts could deny it. The authors of the van der Maas Survey, referring to the 1,000 killings without explicit request, state that legally speaking there is no question that these cases should be seen as anything but murder but that "the possibility that a court will accept an appeal to force majeure cannot be ruled out."¹⁶⁵ Similarly, Leenen has recently expressed the opinion (which seems to contradict his earlier opinion,¹⁶⁶ to which he does not refer) that in "exceptional" cases non-voluntary euthanasia attracts the necessity defense.¹⁶⁷ The approval of the courts may not even be necessary: the Chief Prosecutors have already declined to prosecute in a number of cases of killing without request.

One such case involved a patient in a permanent coma after a heart attack. The local Chief Prosecutor, mindful of the Remmelink Commission's recommendation that such cases should be dealt with in the same way as killing on request, decided against prosecution; after questions had been raised in Parliament, his decision was affirmed at a meeting of all the Chief Prosecutors in February 1992.¹⁶⁸

Another case concerned a dying, comatose seventy-one year old man who had not asked for his life to be shortened. At a meeting in November 1992 the Chief Prosecutors decided against prosecution since "the action taken . . . amounted to virtually the same as suspending ineffectual medical treatment,"¹⁶⁹ even though they regarded the case as "potentially extending the boundaries of current practice."¹⁷⁰

Laten? (Utrecht: Nederlandse Vereniging voor Kindergeneeskunde, 1992) 13; *Dutch Doctors Support Life Termination in Demetia*, 306 B.M.J. 1364 (1993).

165. Johannes J.M. van Delden et al., *The Remmelink Study: Two Years Later*, 23 HASTINGS CENTER REP. 24, 25 (1993); cf. Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1199 (1993) (where they write that, when all the "safeguards" are respected and "only the best interests of the patient are taken into account" such killings are "certainly not murder.").

166. See *infra* notes 172-75 and accompanying text.

167. H.J.J. Leenen & Chris Ciesielski-Carlucchi, *Force Majeure (Legal Necessity): Justification for Active Termination of Life in the Case of Severely Handicapped Newborns after Forgoing Treatment*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 271, 274 (1993).

168. Personal communication with the Staff Office of the Public Prosecutor, The Hague, Feb. 12, 1993.

169. *Id.*

170. *Id.* A third case involved the killing of a 4 year-old handicapped child who was dying. Charges were dropped "in view of the specific and unusual circumstances of the case, despite the fact that the patient had not

The current and growing condonation of non-voluntary euthanasia contrasts markedly with earlier pronouncements on euthanasia. There was little support for non-voluntary euthanasia in 1984. As has been seen, the very definition of "euthanasia" adopted by the Dutch incorporated the need for a request. Moreover, the K.N.M.G. Report of that year was careful to confine itself to euthanasia on request and three of its five Guidelines were concerned with ensuring not only that there was a request but that it was free, well-considered and persistent. In 1985, a State Commission on Euthanasia concluded that third parties should not be permitted to request euthanasia on behalf of (incompetent) minors and "other persons incapable of expressing their opinion, such as the mentally handicapped or senile elderly people."¹⁷¹ Its Vice-Chairman, Professor Leenen, has since written that the Commission proposed an amendment to the Penal Code to prohibit the intentional termination of an incompetent patient's life on account of serious physical or mental illness and did so in order to "underline the importance of the request of the patient."¹⁷² In 1989, Leenen reaffirmed that a request was "central" to the Dutch definition, adding:

Without it the termination of a life is murder. This means that the family or other relatives, parents for their children, or the doctor cannot decide on behalf of the patient. *People who have become incompetent are no longer eligible for euthanasia, unless they have made a living will prior to their becoming incompetent, in which they ask for the termination of life.*¹⁷³

He added that Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which provides that everyone's right to life shall be protected by law, does not (in his view) prohibit the killing of a patient who freely wishes to die but that it "*prohibits the State and others from taking another's life without his request.*"¹⁷⁴ Rejecting the argument that euthanasia would undermine the public's trust in doctors, he

expressly requested intervention." *Id.* It has since been reported that two doctors who allegedly killed gravely ill newborns are to be prosecuted by order of the Minister of Justice in order to ascertain the law relating to non-voluntary euthanasia. THE TIMES, Dec. 23, 1994.

171. H.J.J. Leenen, *Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands*, 8 HEALTH POL'Y 197, 204 (1987).

172. *Id.*

173. H.J.J. Leenen, *Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands*, 8 MED. & L. 517, 520 (1989) (emphasis added).

174. *Id.* at 519 (emphasis added).

stated: "People's trust in health care will not decrease if they are sure that euthanasia will not be administered without their explicit request."¹⁷⁵

Leenen was echoed in the same year by Henk Rigter, who wrote in the *Hastings Center Report*: "In the absence of a patient request the perpetrator renders him or herself guilty of manslaughter or murder."¹⁷⁶ An array of leading Dutch advocates of voluntary euthanasia wrote endorsing the accuracy of Rigter's paper, adding that "problems concerning the termination of life of incompetent patients, either comatose or newborn, are *not* part of the euthanasia problem."¹⁷⁷ One, the Director of the National Hospital Association, wrote that "euthanasia" meant killing on request, adding:

Consequently, it is impossible for people who do not want euthanasia to be maneuvered or forced into it. The requirement of voluntariness means no one need fear that his or her life is in danger because of age or ill health, and that those who cannot express their will, such as psychogeriatric patients or the mentally-handicapped, shall never be in danger as long as they live.¹⁷⁸

But how much longer will they be allowed to live in view of the common practice of, and growing support for, non-voluntary euthanasia? The argument that euthanasia cannot be forced upon competent or incompetent people, and that such conduct is not part of the euthanasia problem because it does not fall within the definition of "euthanasia" is hardly convincing. If an advocate of abortion were to define abortion as "therapeutic" and dismiss arguments that its legalization might lead to abortion for social reasons, or to women being pressured into abortion, on the ground that they would not be "abortion" and are not, therefore "part of the abortion problem," he or she would rightly be given short shrift. The suggestion, by leading Dutch advocates of euthanasia, that the moral debate about euthanasia can be resolved by definitional *fiat* serves only to illustrate the intellectual poverty of the case for euthanasia which has come to prevail in their country.

The widespread readiness to kill without any request contrasts starkly with the refusal of many serious requests for euthanasia, and serves further to underline the dispensable role of patient autonomy in the reality, if not the rhetoric, of the Dutch experience. As ten Have and Welie shrewdly point out, accept-

175. *Id.* (emphasis added).

176. See Rigter, *supra* note 14, at 31.

177. *Letters*, 19 HASTINGS CENTER REP. 47-48 (1989).

178. *Id.* at 48.

ance of euthanasia is not resulting in greater patient autonomy but in doctors "acquiring even more power over the life and death of their patients."¹⁷⁹

In 1990 Professor Leenen observed that there is an "almost total lack of control on the administration of euthanasia" in the Netherlands.¹⁸⁰ The *Report* and the *Survey* serve only to confirm the accuracy of that observation.¹⁸¹ The Commission sought to paint a reassuring picture of the euthanasia landscape revealed by the *Survey*, but the scene it depicts is grossly misleading. As Dan Callahan has pointed out, the reality is quite different: "The Dutch situation is a regulatory Potemkin village, a great facade hiding non-enforcement."¹⁸² The hard evidence of the *Survey* indicates that, within a remarkably short time, the Dutch have proceeded from voluntary to non-voluntary euthanasia. This is partly because of the inability of the vague and loose *Guidelines* to ensure that euthanasia is only performed in accordance with the criteria laid down by the courts and the K.N.M.G. It is also because the underlying justification for euthanasia in the Netherlands appears not to be patient self-determination, but rather acceptance of the principle that certain lives are not "worth" living and that it is right to terminate them. Indeed, the authors of the van der Maas Survey recently lent support to this thesis when they wrote:

[Is] it not true that once one accepts euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? In our view the answer to this question must be affirmative.¹⁸³

Might it not be argued that the number of cases has remained static and that the evidence reveals not a slope but a

179. Henk A.M.J. ten Have & Jos V.M. Welie, *Euthanasia: Normal Medical Practice?*, 22 HASTINGS CENTER REP. 34, 38 (1992). See also Jos V.M. Welie, *The Medical Exception: Physicians, Euthanasia and the Dutch Criminal Law*, 17 J. MED. & PHIL. 419, 435 (1992).

180. Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients 6 (Dec. 2-4, 1990) (unpublished paper delivered at a conference on euthanasia held at the Institute for Bioethics, Maastricht, the Netherlands).

181. The author of the Rummelink Report agreed that there was no control over cases which had not been reported and that, even in relation to the reported cases, the prosecutor did not know whether the doctor was telling the truth. He maintained that euthanasia occurred even if the law prohibited it, as was the case outside the Netherlands, and that it was preferable to try to control it. Interview with Mr. A. Kors, Nov. 29, 1991.

182. DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* 115 (1993).

183. See van Delden, *supra* note 165, at 26 (footnote omitted).

plateau? This argument would, however, fail to dent the slippery slope argument in its logical form. Indeed, even the empirical form of the argument is, arguably, not dependent on showing a statistical *increase* in non-voluntary euthanasia over time. Even if the proportion of non-voluntary euthanasia cases remained stable from the time voluntary euthanasia gained approval, this would hardly disprove either the logical connection or the ineffectiveness of the safeguards; quite the contrary. There would, in any event, appear to be no empirical evidence to support the possible suggestion of a plateau. Further, any such suggestion would seem particularly implausible in the light of the available statistical evidence and the clear shift in opinion since 1984 in favor of the non-voluntary termination of life.

That the evidence from the Netherlands lends support to the slippery slope arguments should come as no surprise. Some twenty years ago a perspicacious warning about the dangers of venturing onto the slope was sounded by Dr. John Habgood, now Archbishop of York and a member of the House of Lords Select Committee on Medical Ethics which reported early in 1994.¹⁸⁴

Legislation to permit euthanasia would in the long run bring about profound changes in social attitudes towards death, illness, old age and the role of the medical profession. The Abortion Act has shown what happens. Whatever the rights and wrongs concerning the present practice of abortion, there is no doubt about two consequences of the 1967 Act:

(a) The safeguards and assurances given when the Bill was passed have to a considerable extent been ignored.

(b) Abortion has now become a live option for *anybody* who is pregnant. This does not imply that everyone who is facing an unwanted pregnancy automatically attempts to procure an abortion. But because abortion is now on the agenda, the climate of opinion in which such a pregnancy must be faced has radically altered.

One could expect similarly far-reaching and potentially more dangerous consequences from legalized euthanasia.¹⁸⁵

184. REPORT OF THE SELECT COMMITTEE ON MEDICAL ETHICS H.L. Paper 21-I (1993-94).

185. J.S. Habgood; *Euthanasia - A Christian View*, 3 J. ROYAL SOC'Y HEALTH 124, 126 (1974). The Abortion Act of 1967 decriminalized abortion where, in the opinion of two registered medical practitioners, the continuance of the

However, the patent reality of the slide in the Netherlands may not yet be fully appreciated outside (or, indeed, inside) that country. The slide was not *explicitly* identified and criticized by the House of Lords Select Committee on Medical Ethics, even though a delegation from the Committee visited the Netherlands in October, 1993. Perhaps the delegation was influenced by the statement made to them by a Ministry of Justice spokesman that "the government held strongly to the position that euthanasia was not possible for incompetent patients."¹⁸⁶ This statement was made eight months after the proposed change in the law to provide a mechanism for the reporting of non-voluntary euthanasia had been approved by the Second Chamber of the Dutch Parliament and one month before its approval by the First Chamber. If euthanasia was "not possible" for incompetent patients, why was the government providing for its reporting?

A welcome recognition of the slide is, however, clearly implicit in the Committee's rejection of the legalization of euthanasia, in the light of the Dutch experience, on the ground, *inter alia*, "that it would not be possible to frame adequate safeguards against non-voluntary euthanasia. . . ." ¹⁸⁷ Moreover, in the debate on the motion to receive the *Report* in the Lords, the Committee's Chairman, Lord Walton, observed that those members of the Committee who had visited the Netherlands returned from the visit "feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia . . . was commonly performed. . . ." ¹⁸⁸ He added that they were "particularly uncomfortable"¹⁸⁹ about the case of the woman of 50 suffering from mental stress who had been assisted in suicide by her psychiatrist. His Lordship could, of course, have gone much further but took the view (without saying why) that it would not be proper for him to criticize the decisions of the "medical and legal authorities in another sovereign state."¹⁹⁰

Another member of the Committee to comment unfavorably on the Dutch experience, Lord Meston, said:

it did not seem possible to find any other place beyond the existing law for a firm foothold on an otherwise slippery

pregnancy involved risk to the life, or to the physical or mental health of the mother, greater than if the pregnancy were terminated, or where there was a substantial risk that if the child were born it would be seriously handicapped.

186. See REPORT OF THE SELECT COMMITTEE ON MEDICAL ETHICS, *supra* note 184, Appendix 3, 68.

187. *Id.* at 49.

188. 554 Parl. Deb., H.L. (5th Ser.) 1345, 1346 (1993-94).

189. *Id.* See *supra* note 129 and accompanying text.

190. *Id.* at 1346.

slope. The evidence of the Dutch experience was not encouraging: in the Netherlands, which apparently lacks much in the way of a hospice movement, there seems to be a gap between the theory and practice of voluntary euthanasia. One cannot escape the fear that the same could happen here, with pressures on the vulnerable sick and elderly, who may perceive themselves to have become a burden on others, and pressures on the doctors and nurses from relatives and from those who are concerned with resources.¹⁹¹

Of course, the reality of the slippery slope may not have been lost on at least some Dutch advocates of voluntary euthanasia, who may have thought it tactically desirable to maintain a discreet silence about it. Professor Alexander Capron, reporting on a euthanasia conference in the Netherlands at which this point was conceded, has written that the Dutch proponents of euthanasia began with a narrow definition of euthanasia "as a strategy for winning acceptance of the general practice, which would then turn to . . . relief of suffering as its justification in cases in which patients are unable to request euthanasia."¹⁹² He adds: "It was an instance, or so it seemed to me, when the candour of our hosts was a little chilling."¹⁹³

IV. CONCLUSION

This paper began by asking if the Dutch experience shows that acceptance of voluntary euthanasia does not lead to acceptance of euthanasia without request. The evidence presented, which is consistent with evidence unearthed by a number of other commentators on the Dutch experience,¹⁹⁴ suggests the contrary. Those who thought that euthanasia could and would be confined to the lucid, rational patient who makes a free and informed decision to be killed because he or she is terminally ill

191. *Id.* at 1398. In a recent decision of the Canadian Supreme Court rejecting an alleged right to assisted suicide in Canadian law, Mr. Justice Sopinka, delivering the majority judgment, noted the "worrisome trend" in the Netherlands toward euthanasia without request, which supported the view that "a relaxation of the absolute prohibition takes us down the 'slippery slope.'" *Rodriguez v. Attorney-General*, 107 D.L.R.4th 342, 403 (1994).

192. Alexander M. Capron, *Euthanasia and Assisted Suicide*, 22 HASTINGS CENTER REP. 30, 31 (1992).

193. *Id.*

194. See, e.g., CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); *Colloquy*, 22 HASTINGS CENTER REP. (1992); cf. Margaret Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?*, 20 L. MED. & HEALTH CARE 133 (1992).

and suffering unbearable pain beyond alleviation by the best palliative care available, have been shown to be quite mistaken. The Dutch experience lends weighty support to the slippery slope argument in both its forms. Within no more than a decade, the so-called "strict" safeguards against the slide have proved signally ineffectual; non-voluntary euthanasia is now widely practiced and increasingly condoned in the Netherlands. For inhabitants of such a flat country, the Dutch have indeed proved remarkably fast skiers.