Why euthanasia should not be legalized - a reflection on the Dutch experiment

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1. Introduction

The experience of the Netherlands continues to be cited as an illustrative example in the euthanasia debate that is going on in many countries. In that country a regulation of euthanasia has been adopted in the beginning of the nineties and before and after that extensive surveys into the practice of euthanasia have been carried out. The fact that the Dutch example is cited both by those who favor the legislation of euthanasia and those who reject that demonstrates that empirical data in themselves do not settle an ethical or juridical issue.

In this chapter I will argue against legalization of euthanasia, largely on the basis of the Dutch experience. I will follow two approaches: a juridical and an ethical. The juridical argument is based on the assumption that any form of legal regulation of euthanasia is only acceptable if it would guarantee that the state, i.c. the legal authorities, would in principle be able to assess each case.[2] The crucial question is whether the Dutch have succeeded in establishing a regulation of euthanasia that permits its application in individual cases under certain conditions, while at the same time maintaining a strict control of the practice as a whole. This paper will analyze the available data on Dutch euthanasia practice in the light of that question.

The ethical approach will discuss a number of medical ethical and social ethical problems that are raised by a legal regulation of euthanasia.

This chapter is divided into the following paragraphs. Paragraph 2 contains the clarification of some concepts that play a crucial role in the euthanasia debate. Paragraph 3 presents information on the regulation and the practice of euthanasia and considers whether the requirements are followed. Paragraph 4 discusses new developments after the publication of the second main survey (1996), considering the question whether they involve an improvement of the situation. In paragraph 5 the ethical approach against (legalization of) euthanasia is developed. Paragraph 6 contains the conclusion of the chapter.

2. Clarification of concepts

In the Netherlands euthanasia is narrowly defined as "the intentional shortening of a patient's life at the patient's explicit request". In other words, ‘euthanasia’ is defined to mean only ‘active, voluntary euthanasia’ and does not include intentional life-shortening by omission (‘so-called passive euthanasia’) or euthanasia without the patient's request (whether ‘non voluntary’ if the patient is incompetent or ‘involuntary' if the patient is competent). For ease of exposition, I will follow the Dutch definition. Apart from the request of the patient this definition of euthanasia, as well as most others, contains two crucial elements. First, that the shortening of life, in other words the death of the patient, is intended, that is wanted, if not as an end in itself at least as a means to an end (normally the ending of suffering). Second, that this intention leads the person to an action that he would not otherwise have performed and that indeed aims at the shortening of the patient’s life. Hence, in my opinion euthanasia is not solely defined by the particular intention to shorten life. That would mean that medical care informed by the acceptance that the patient will die and that is provided by a physician who personally feels that for the patient it would be desirable to die soon, could hardly be distinguished from euthanasia, whereas it could be normal medical treatment. Nor is euthanasia just defined by a shortening effect on the life of the patient. That would bring any course of action that would not maximally stretch the life of the patient under the definition of euthanasia. This would either lead to an inhuman medicine that would essentially aim at the

[1] Published as: Henk Jochemsen. “Why euthanasia should not be legalized. A reflection on the Dutch experiment”, in: Weisstub DN, Thomasma DC, Gauthier S, Tomossy GF. *Aging: Decisions at the end of life.* Dordrecht: Kluwer Academic Publishers 2001, p.67-90.

prolongation of the physical life of patients, or broaden the meaning of the term euthanasia to the extent of becoming virtually meaningless.
The important elements of the definition of euthanasia can be clarified further by discussing the differences between euthanasia and other actions of physicians that may seem to be euthanasia but are not. It has been agreed in the Netherlands that the following three categories of actions should not be considered as euthanasia.[3]:
a) stopping or not beginning a treatment at the request of the patient,
b) withholding a treatment that is medically useless,
c) pain and symptom treatment with the possible side-effect of shortening life.
These courses of action will briefly be discussed.

Ad a) On the basis of the rule of informed consent, the patient is entitled to refuse treatment or to withdraw consent. When the physician respects the refusal of treatment of a fully competent patient and the patient dies soon after the withdrawal of life-supporting treatment, this is not to be classified as euthanasia. This does not mean that such situations cannot become at least ambiguous. Firstly, because decisions of patients are often very much influenced by the information that the physician provides on the burden of the possible treatment, its prognosis etc. and by *the way* in which this information is provided. Hence, the performance of the physician can provoke the refusal of a medically useful treatment when in the opinion of the physician it would be better for the patient if he were 'allowed to die'. Secondly because the patient can be suicidal, e.g. because of a depression, and refuse a proportional medical treatment in order to die. If the physician thinks this would be better indeed for the patient he could go along too easily with the patient's decision, without assessing whether the decision of the patient is really a voluntary and free choice. This is not to deny the legal right of a competent patient to refuse any treatment, but to point out that a non-treatment decision by a physician *can* be morally ambivalent if not highly problematic.

Ad b) Treatment that is medically useless should not be provided and can or should be withdrawn when it is provided. Medically useful treatment fulfills the following criteria:
- the treatment is effective and proportional, which means that the expected benefits of the treatment outweigh its expected or possible risks and burdens for the patient,
- the evaluation of benefits, risks and burdens for the patient should only take into consideration medical criteria and should not be an evaluation of the value of the life of the patient.

Good medical practice has always included stopping disproportional medical treatment. Calling this in general passive euthanasia is confusing. If the term passive euthanasia can be applied usefully at all it is to indicate situations in which a physician does not offer or provide a medically proportional treatment to a competent or an incompetent patient respectively, with the intention that the patient will die. In such cases the intention to shorten life has informed the action (in this case an omission) of the physician that resulted in a sooner death than otherwise (probably) would have been the case. On the other hand, the withdrawal of disproportional medical treatment does not (necessarily) intend the death of the patient, but intends not to cause discomfort that is not outweighed by benefits for the patient. (These considerations from the point of view of the caregiver do not deny the fact that a patient or his proxy has to give consent for any treatment. But (a) the requirement of consent does not rule out the professional responsibility of the physician, (b) the physician is not obliged to provide treatment that by the profession is clearly considered futile, and (c) the decision of the patient/proxy is often highly influenced by the physician, see above).

The fact that in practice there is a grey area between clearly proportional and clearly disproportional treatment, in which patients and physicians would decide differently, does not rule out the importance of this principle for medical practice.

Ad c) Pain treatment aims at the alleviation of the patient's suffering. It may, and in certain cases almost certainly will shorten the life of the patient. However, actions must be defined according to their aims and not according to their side-effects. So, the shortening of life as an unavoidable side-effect of proportional pain and symptom treatment is morally acceptable on the basis of the principle of double-effect and should not be classified as euthanasia.

Here again the conceptual distinction between this course of action and euthanasia does not rule out that in practice the distinction may seem vague. It is obvious that in practice pain treatment can shift to

euthanasia by increasing the medication beyond doses needed to effectively treat the pain and symptoms with the intention to shorten the patient's life. Yet this distinction is crucial in the evaluation of medical care at the end of life. I will come back to some of these points in paragraph 5.1

3. The regulation and the practice of euthanasia

3.1 The present regulation of euthanasia

In order to be able to interpret the data on the fulfillment of the requirements for euthanasia it is necessary to know the legal regulation of life terminating actions that form the framework for the requirements.

The basis of the present legal regulation of euthanasia is the decision of the Supreme Court (in 1984) that a physician who has committed euthanasia can, in cases of an objectively established 'conflict of duties', appeal to a defence of 'necessity' (Penal Code art. 40). This conflict concerns on the one hand the duty to obey the law that forbids euthanasia and assisted suicide (Penal Code art. 293, 294), and on the other hand to alleviate suffering. The government approved the Supreme Court's decision, thereby accepting euthanasia under certain circumstances.[4] The conditions establishing a 'conflict of duties' were essentially: a free, well-considered request, unacceptable suffering with no other reasonable possibilities to alleviate the suffering, and consultation by the physician with a colleague.[5]

In 1990 the government established a new legal regulation on the basis of the courts' decisions. The prohibition of euthanasia and assisted suicide was maintained in the Penal Code. At the same time the procedure by which physicians *report* death in cases of euthanasia, assisted suicide and life-terminating actions without an explicit request, was given a statutory basis by amending the law on the Disposal of the Dead.[6] In terms of this procedure, a physician who has terminated a patient's life informs the local medical examiner, who inspects the body externally and takes from the attending physician a statement which contains the relevant data (the patient's history, request, possible alternatives, consultation with a second physician, intervention etc.). This report, together with an evaluation by the local medical examiner, is checked by the Public Prosecutor who considers if the termination of the patient's life was contrary to the Penal Code as interpreted by the courts. So, to the conditions mentioned above was added the requirement of reporting each case of euthanasia, assisted suicide and life terminating action without an explicit request.

3.2 The data on euthanasia practice

In 1991 the results were published of an important survey, by P.J. van der Maas et al., into end-of-life decision-making by Dutch doctors in the year 1990.[7] In 1996 Van der Wal and Van der Maas published the results of another extensive survey dealing with end-of-life decisions by Dutch doctors in the year1995.[8] This latter survey sought particularly to ascertain the incidence of intentional life-shortening by doctors; the extent to which they complied with their duty to report such cases and the quality of their reporting. The most important quantitative data are summarized in table 1.

These data (with minor differences) are presented and discussed by Kimsma and a critical discussion has been published elsewhere.[9] Here I will only use these and some additional data in order to answer the question whether euthanasia practice is well under control of the legal authorities. This will be done by examining to what extent the requirements have been fulfilled.

3.3 Fulfillment of the requirements

The criteria that should be fulfilled by a physician who performed euthanasia in order to successfully appeal to necessity are: the request must be voluntary and well-considered and persistent, there must be unacceptable suffering that cannot be alleviated by reasonable medical means, and consultation and reporting.

3.3.1 Voluntary, well-considered and durable request

It is clear that in a substantial number of cases doctors intentionally terminate or at least shorten the lives of patients. There are 900 cases of terminating the patient's life without an explicit request. But in addition, doctors increase pain medication explicitly with the intention to shorten life in about 2000 cases; in a few hundreds of cases without an explicit request.[10] Furthermore, in about 14000 cases treatment was withhold or withdrawn with the explicit intention of shortening life. It is very well possible, though we do not know for sure, that in a considerable percentage of these cases the treatment

had become disproportional. Yet, taking into account a statement of L. Pijnenborg, a co-author of Van der Maas in the 1991 report, those data should be taken seriously. Pijnenborg writes in her thesis: "If a physician administers a drug, withdraws a treatment or withholds one with the explicit purpose of hastening the end of life, then the intended outcome of that action is the end of the patient's life".[11] According to this statement the death of patients should be considered the result of a physician's action in 14.200 + 2000 cases (categories 6a and 7b1 of table 1), in addition to the 4.500 cases (categories 2+3+4 of table 1). In many of these cases there was no explicit, well-considered request.
It must be concluded that this criterion is not fulfilled in a considerable part of life-terminating actions.

Tabel 1) Main quantitative data on end-of-life actions by physicians in The Netherlands

	1995	1990
1. Death cases in the Netherlands	135.500 (100%)	129.000 (100%)
2. Requests for euthanasia	9.700 (7,1)	8.900 (7)
3. Euthanasia applied	3.200 (2,4)	2.300 (1,8)
4. Assisted suicide	400 (0,3)	400 (0,3)
5. Life terminating action without specific request	900 (0,7)	1.000 (0,8)
6. Intensification pain and symptom treatment:	20.000 (14,8)	22.500 (17,5)
a. explicitly intended to shorten life	2.000 (1,5)	1.350 (1)
b. partly to shorten life	2.850 (2,1)	6.750 (5,2)
c. taking into account a probable shortening of life	15.150 (11,1)	14.400 (11,3)
7. Withdrawing or withholding treatment (including tube feeding):	27.300 (20,1)	22.500 (17.5)
a. at the explicit request of the patient	5.200 (3,8)	5.800 (4,5)
b. without explicit request of the patient		
b1. Explicitly to shorten life	14.200 (10,5)	2.670 (2,1)
b2. Partly to shorten life		3.170 (2,5)
b3. Taking into account a probable shortening of life	7.900 (5,8)	10.850 (8,4)
8. Intentional termination of life of newborn babies	10	
a. without withdrawing/withholding treatment	80	
b. withdrawing or withholding treatment plus administration of medication explicitly to shorten life.	2 - 5	
9. Assisted suicide of psychiatric patients		

Incompetent patients
Here it should be pointed out that both by the medical profession and by the courts, life terminating actions with incompetent patients have been accepted. The clearest examples are two severely handicapped and ill babies whose lives were intentionally ended. The attending physicians reported the case and were prosecuted and brought before a District Court (Alkmaar[12] and Groningen[13]) and later before a Court of Appeal (Amsterdam[14] and Leeuwarden[15], respectively). We will briefly present these cases.[16]
In the Alkmaar case the baby had spina bifida, hydrocephalus, a spinal cord lesion and brain damage. The specialists decided not to operate on the spina bifida, because of the bad prognosis. The baby appeared to be suffering severe pain which was difficult to treat. The parents did not want the baby to suffer and asked for the termination of her life. Three days after the baby was born, she was killed by the attending gynecologist, P., after consultation with other specialists who had examined the baby. She died in the arms of her mother.
The Groningen case concerned a newborn baby with trisomie-13, a syndrome that manifested itself in a number of disorders (deformities of skull, face and hands, heart and kidney malfunction and brain damage). The baby was diagnosed to be non-viable; death was to be expected at most within a year, and probably within six months. After the situation had stabilized to a certain point, the baby was taken home and looked after by the parents, who had learned to supervise the tube-feeding. After a week some tissue (meninges) came out through an opening in the skull. This appeared to be very sensitive

and the baby appeared to be in pain. The family physician, K., gave pain treatment, but that did not appear to be fully effective. After a number of days, with the explicit consent of the parents (though whether it was at their request remains unclear), and after consulting the pediatrician who had seen the baby before, the life of the baby was ended by lethal injection.
Both doctors appealed to the defense of necessity. All four courts accepted this and released the physicians without punishment.[17]
In the court decisions two lines of reasoning can be traced, not uncommon in discourses that defend euthanasia. First, in cases of short life expectancy, stopping or not starting treatment while accepting that the patient will die, is virtually morally equated with intentionally killing the patient. A decision not to treat is regarded as an intention to shorten the life of the patient. The second main reasoning of the courts is that proportional pain and symptom treatment with has as a side-effect a shortening of life is morally equated with intentional killing by the administration of lethal substances. So, the moral significance of the principle of 'double effect' is rejected. We will come back to these reasonings in paragraph 5.1.
The 1995 survey reports that over 1000 newborns die in the Netherlands before their first birthday and estimates that the lives of about 15 are actively and intentionally terminated by doctors.
I conclude that under specific circumstances the intentional shortening of life of incompetent patients is supported by the KNMG, is practiced to a certain extent and is justified by the courts. Therefore, the practice of intentional shortening of life is not following the condition of a voluntary, well-considered, free request.

3.3.2 Unacceptable suffering without prospect
According to the physicians this clearly is the most important reason for patients to ask for euthanasia. It is, however an 'open' criterion, i.e. not clearly defined and in no way objectivized so far. It is the doctor who decides whether the suffering has become sufficiently unacceptable to give in to a request for euthanasia.[18] With about two-thirds of the 9700 requests for euthanasia the physicians did not comply, probably because in their opinion the situation had not yet become intolerable.

On the other hand, according to the attending physicians there were medical alternatives to alleviate the suffering in about 17% of the cases of euthanasia and assisted suicide, but the patients rejected them and the doctors complied with the request. This is at odds with the requirement that there must be no (reasonable) alternative to alleviate the suffering. Euthanasia should only be used as a last resort. This condition (an application of the subsidiarity principle) was supported by the former Cabinet and by the KNMG (Royal Dutch Medical Association).[19] However, the present Cabinet appears to have reversed this position. The bill that is now before the Dutch parliament (see paragraph 4.2) establishes that the refusal by the patient of available treatment alternatives does not render euthanasia unlawful.[20] Furthermore, the integral terminal palliative care is not very well developed in the Netherlands. Only in recent years the hospice movement is really gaining importance.[21]

I conclude that this requirement (a) is interpreted differently by different physicians, (b) is not always fulfilled in the sense that euthanasia is only used as a last resort. With respect to the latter two contradictory movements can be distinguished. On the one hand the acceptance that this condition can also be fulfilled when a patient refuses a reasonable medical alternative to alleviate the suffering and on the other hand the increasing possibilities and availability of integral palliative care that could take away a request for euthanasia. If both movements will gain force, euthanasia will become less and less a last resort and more and more a choice for a certain kind of death. This will put society even more urgently before the question how to regulate this and avoid abuse, and will confront the medical profession with the question whether it want to be the executor of such deaths.

3.3.3 Consultation
The guidelines for permissible euthanasia and assisted suicide require the doctor, before agreeing to either, to engage in a formal consultation (*consultatie*), and not merely an informal discussion (*overleg*), with a colleague.
In cases of euthanasia and assisted suicide 92% of doctors had, according to the survey, discussed the case with a colleague[22] but in 13% of these cases the discussion did not amount to a formal consultation. Hence, consultation took place in 79% of cases. However, other figures of the survey indicates that consultation occurred in 99% of the reported cases but in only 18% of unreported cases.[23] Since almost

60% of all cases of euthanasia and PAS were not reported (see next section) it can be calculated that consultation occurred in only around half of all cases. The discrepancy between this 50% and 79% is not exactly clear, but seems to be related to a certain bias in responses to some questions.[24]
In 97% of the cases of life-termination without explicit request there was no formal consultation, though in 43% the case was discussed with a colleague. Even when consultation did take place, it was usually with a physician living locally and the most important reasons given for consulting such a physician were his views on life-ending decisions and his living nearby: expertise in palliative care was hardly mentioned.
I conclude that even this relatively easy condition did not reach a truly high level of compliance.

3.3.4 Reporting
In 1995 41% of cases of euthanasia and assisted suicide were reported to the local medical examiner, as required by the reporting procedure (cf. paragraph 3). While this is an improvement on the figure of 18% reported in 1990, it means that a clear majority of cases, almost 60%, still go unreported. Furthermore, the increase in reporting from 18% (1990) to 41% should not lead to optimism, since the numer of euthanasia cases increased between 1990 and 1995 (900 cases) with almost the same number as the reported cases (980 cases). Moreover, the survey confirms that the legal requirements are breached more frequently in unreported cases, in which there is less often a written request by the patient; a written record by the doctor; or consultation by the doctor.[25]
The most important reasons given by doctors for failing to report in 1995 were (as in 1990), the wish to save oneself and/or the patient's relatives the inconvenience of an investigation by the authorities, and to avoid the risk of prosecution (though, as the consistently tiny number of prosecutions indicates, this risk is very small indeed.
The purpose of the reporting procedure is to allow for scrutiny of the intentional termination of life by doctors and to promote observance of the legal and professional requirements for euthanasia. *The fact that a clear majority of cases still goes unreported confirms the failure of the procedure to fulfill its purpose and belies any claim of effective regulation, scrutiny and control.*

4. Developments after 1996

4.1 A new procedure
In 1998 the Parliament accepted a new regulation of euthanasia reporting that became effective on November 1, 1998.[26,27] This does not contain a change of the Penal Code prohibition of euthanasia, but a change of the procedure by which euthanasia should be reported. According to the new procedure, the report of every euthanasia case as well as the filled out form of the medical examiner, should no longer be sent directly to the public prosecutor, but should be sent to one of five regional euthanasia review committees. This committee, consisting of a physician, a lawyer and an ethicist, should evaluate the case in the light of the courts' decisions on life-terminating actions thus far. The committee's opinion on the case is sent to the public prosecutor, together with the reports of the attending physician and of the medical examiner. The prosecutor has the freedom and duty to form his own opinion on the case, but the opinion of the committee will be of major importance in the decision of the prosecutor to prosecute or not.
Since in this procedure the legal authorities find themselves at larger distance from the euthanizing physician, the government hope that a higher percentage of cases will be reported. However, the first year report of these review committees indicate that so far this new procedure has not resulted in a substantial increase of the number of reported cases.[28] Furthermore, this report indicates that in the reported cases the information of the attending physician on the existence of alternatives and on the quality of the consultation was not always sufficient. In some cases, additional information was requested from the physician. Ultimately in all cases the euthanasia or assisted suicide was approved by the committee concerned.
A second change in the reporting procedure is that euthanasia (at the request of the patient) and life-termination without explicit request should be reported by different procedures. In this way the government want to stress that the two kinds of acting should not be morally equated. This does not mean, however, that unrequested life-termination is ruled out altogether. Actions of this kind should be reported to a national committee, that will give its evaluation and then send the case to the public

prosecutor who will decide whether the case should be brought before court. Also in these cases the opinion of the national committee as well as the court decisions on such cases (cf. paragraph 3.3.1) will significantly influence the decision of the prosecutor. But also in these cases there is no guarantee that they will be reported in the first place. So far, this national committee has not yet been established.

4.2 A new bill

In 1999 the Cabinet introduced a new Bill on euthanasia and assisted suicide. The Bill provides[29]:

1) Euthanasia must be performed in accordance with 'careful medical practice'. Requests must be voluntary, well-considered, persistent, and emanate from patients who are experiencing unbearable suffering without hope of improvement. More than one doctor must be involved, and the doctor and the patient must agree that euthanasia is the only reasonable option.

2) All cases must be reported to and evaluated by the established regional euthanasia review committees consisting of a lawyer, a doctor, an ethicist, and others. So this law would give the committees mentioned above a legal basis.

3) Euthanasia and physician-assisted suicide will not be punishable if performed by a doctor who has complied with the requirements listed in (1) and who has reported the case to the local medical examiner.

4) The local medical examiner must send his or her report to the prosecutor as well as to the regional committee. The report must demonstrate that all the requirements have been met. In the event of any serious infringement, the prosecutor will not give permission for burial or cremation until a further investigation has been conducted.

In addition to these criteria, the Bill contains the following provisions concerning children and advance directives:

5) Children between 12 and 16 must normally have their parents' consent to euthanasia. However, in 'exceptional' cases - those involving serious and incurable disease or intolerable and unrelenting suffering, a doctor may agree to such a child's request even without parental request. Requests by children aged 16-17 do not require parental consent, though parents should be involved in the decision-making process.

6) Competent patients may request euthanasia, by way of advance directive, even if they later become incompetent.

In response to critical questions by members of parliament the Cabinet announced in July 2000 that the provision that euthanasia requests of minors between 12 and 16 years in exceptional cases could be granted without the parents' consent will be dropped.

Would the Bill, if enacted, be likely to ensure effective control of voluntary euthanasia? The acceptance of this Bill would not imply a major change in the requirements and circumstances under which euthanasia will be approved. But it can be interpreted as a further acceptance and institutionalization of euthanasia in society. The relaxation of the reporting procedure by the introduction of interdisciplinary committees as a buffer between the doctor and prosecutor, as well as the enactment of the Bill, which would remove any lingering doubts about the legal permissibility of voluntary euthanasia, may assuage the fear of prosecution and encourage reporting. Yet it is doubtful whether this regulation would lead to a far higher reporting rate of euthanasia and assisted suicide. Also under the new legislation euthanasia be allowed only under certain conditions and circumstances. When the physician has not fulfilled the requirements, the case has to be investigated and possibly brought before court. Physicians show themselves quite reluctant to legal control. There is no reason to expect why this would change. Hence, it is to be expected that precisely those cases in which the requirements have not been fulfilled, will still not be reported. Government and physicians have brought themselves into a prisoner's dilemma. When all the reported cases will be scrutinized critically, physicians will hesitate to report precisely those cases in which the requirements were not fully observed. To obtain a higher reporting rate legal scrutiny should be relaxed, but then one may wonder what its value is. Therefore, the fundamental problem that the legal authorities are not able to effectively control the life-terminating actions by physicians, is not likely to be solved in the new legal situation. It might well increase the permissiveness towards euthanasia among physicians and society at large and further an increase in the number of cases.

Furthermore, the legal approach will be different. So far euthanasia is prohibited in the Penal Code and in individual cases the physician must be able to prove that he fulfilled the requirements in order to successfully appeal to the defense of necessity. But under the proposed regulation of euthanasia in the Penal Code the public prosecutor must be able to prove that the physician has *not* fulfilled requirements in order to start prosecution. So the burden of prove will be shifted from the physician to the prosecutor. This may be a reason for public prosecutors to forego prosecution in doubtful cases in which they foresee difficulty in proving noncompliance with the requirements. Probably effective control and prosecution of unacceptable euthanasia will become even more difficult.

5. Ethical critique of euthanasia

5.1 Conceptual clarifications revisited

In the presentation of the three categories of actions that may have an impact on the moment of death of the patient but should be distinguished from euthanasia and assisted suicide the concepts of proportional, or medically useful treatment, the principle of double effect and the distinction between 'bringing about death' and 'letting die' have been used. These concepts constitute complicated and much debated issues involving philosophical problems with respect to causality and the relation between a natural course of events and technical interventions. It is not possible in this context to discuss these issues extensively. But they often play an important role in the debate as was apparent in the reasoning of the courts in the cases of the two babies whose life was ended intentionally (cf. paragraph 3.3.1). Therefore, I want to briefly present my view on these issues which, I think, is very much in line with traditional medical ethical reasoning and with the way many physicians experience their practice.

A central question is the relation between life and health and human (technical) intervention. It is important to recognize that human life and health are natural phenomena that have an existence and dynamic of their own. Health is a regulative idea, indicating a state of wholeness that cannot be fully objectified and can never be *produced* by medicine. Disease is to be understood as a disturbance of a state of (better) health. Medical interventions try to stop, to push back or take away pathological processes that constitute the disturbance in order to facilitate the natural processes of life to restore the ill person to a state of equilibrium that underlies health.[30] Today's medicine, no doubt, has enormous possibilities to (temporarily) control physiological processes making it possible to maintain patients alive that would otherwise have died. Yet these interventions cannot produce health. Their possibilities are limited. They entail, on the contrary, always the risk and often the certainty that they will cause damage and more suffering to the patient. The principle of proportionality states that a medical intervention can be justified only if for the patient the benefits of that intervention outweigh its burdens and risks. It is important to note that this principle involves the assessment of the positive and negative effects of the intervention for the patient. It should not involve a value judgment of the life of the patient as a basis for a decision of the value of a treatment.

What do these observations mean? The observation that medicine cannot fully control life and health implies that the physician cannot be hold responsible for whatever happens to the patient. The course of the disease and the dying process can be and ultimately always will lie beyond medical possibilities and often even sooner beyond ethically justifiable medical intervention. Therefore, a decision to let a patient die when no proportional treatment exists any longer, cannot be considered in any morally meaningful way a decision to *bring about* death.[31] The former decision implies the acceptance that the justifiable possibilities to maintain life are exhausted and that the death of the patient is unavoidable. The position that stopping disproportional life-prolonging treatment and letting a patient die is morally equal with actively bringing about death presupposes a degree of control over life that does not exist. From an ethical perspective such reasoning evaluates an action solely on the basis of its outcome, since those two kinds of action are only equal in the outcome: the death of the patient. But such a narrow consequentialist reasoning neglects the moral importance of the nature of the act itself and of the intention of the actor. It is possible that a physician experiences the condition and the care for a dying patient as a whole in which 'natural processes' and his interventions can hardly be distinguished. This does not rule out the importance of maintaining those distinctions in order to prevent intentional killing becoming a medical solution to difficult situations. For if this occurs, effective protection of patients' lives becomes impossible, as we saw above.

The principle of double effect, which has a long history in western ethics, is a central ethical principle in medicine.[32] It is based on the distinction between the intended and unintended foreseen results of an action. This distinction is common in medicine. The intended result of the administering of cytostatics is the healing of the patient from cancer. A foreseen but unintended result can be the loss of hair. This is accepted because of the (expected) intended effect on the cancer. A condition for an acceptable treatment is that the intended effects outweigh the foreseen unintended effects.

In the case of pain and symptom treatment sometimes the shortening of life can be an unintended side effect. The principle of double effect can be used to explain why this can be ethically justifiable.[33] The administering of palliative drugs is not bad in itself - otherwise it would not be acceptable in spite of possible good results. Second the intention of the physician is (or should be) the relieve of pain, the (possible) shortening of life is an unintended side effect. This should be clear from the dosages that are administered: these are appropriate for the situation and not 'overdoses'. Third the good effect (relieve of pain) is not produced by the side effect (shortening of life). Fourth, there is a good reason to allow the bad side effect: the suffering of a patient in the last phase of life.[34] In other words, the intended effects morally outweigh the side effects. The objection that it is impossible to distinguish between the intended and foreseen unintended effects of a physician is not convincing. Physicians constantly make this distinction in their treatment decisions and these decisions are justified with the use of this distinction. Denying the possibility to make this distinction would mean that physicians are intending the negative side effects of their treatments in the same way as the positive effects. In the care for terminal seriously suffering patients physicians may find it difficult to clarify their intentions. But this does not deny the importance of the distinction under discussion for the moral assessment of physician's actions. Furthermore, we have seen that Van der Wal and Van der Maas categorize the different kinds of 'medical decisions near the end of life' partly on the basis of the intention of the physician to shorten life, thus underlining the importance of it in the moral evaluation of medical actions.

In the following I will present and criticize some of the main arguments in favor of euthanasia and present some additional arguments against euthanasia.

5.2 *Arguments for euthanasia presented and discussed*

5.2.1 Autonomy

A major argument of those who approve of euthanasia is the principle of autonomy or human self-determination. Autonomy is seen as a fundamental anthropological characteristic and respect for autonomy as an ethical principle. In both meanings of the concept man is considered as an individual agent who on the basis of rational deliberation is able to choose his values and norms as well as voluntarily behave in accordance with them. Because the human being is viewed as an autonomous being each individual's autonomy should be respected. The important principle of informed consent is based on the principle of autonomy.[35]

These considerations on autonomy also apply to the euthanasia issue, because an important argument used in favor of euthanasia is the respect for the autonomy of the patient who asks for it. More and more the right to self-determination is extended to the moment and the way one is going to die.[36] Death should not be awaited with fear and trembling while one's physical and mental condition is deteriorating, but death may be brought about willfully by a 'free decision' of an autonomous person who has chosen to 'step out of this life'.[37] The relatively wide support for a proposal from an elderly, well-respected man of law illustrates the rise of this mentality in the Netherlands. According to this proposal, people from a certain age should be able to obtain a 'euthanasia-pill' from their GP by request. This would allow the elderly to terminate their life at a self-chosen moment.[38]

Autonomy revisited

A number of objections can be raised against the use of the autonomy concept as an argument for euthanasia.

a) The before-mentioned concept of autonomy forms part of a very individualistic view of mankind. Society is considered to be a collection of individuals in which relationships are accidental and peripheral to human existence. What makes a human being really human is, in this view, his reasoning. This anthropology fails to recognize the importance of the spiritual, historical and social dimensions of

mankind. It reasons in terms of rights and duties and not in terms of care and responsibility. This view implies an impoverishment of human life and relationships. It threatens to throw the individual back on himself and tends to further loneliness.

It should be pointed out here that the interpretation of self-determination as a ground for physician assisted death is not broadly supported internationally.[39]

b) The concept of man as an autonomous individual who freely and rationally chooses his norms and values and decides to act according to them, is unrealistic. And particularly so in health care. It is unlikely that a person who would fulfill the criteria for euthanasia would at the same time reach the high ideal of autonomy that would have to justify euthanasia. Illness, as soon as it gets serious, always implies a reduction of the freedom of reasoning and of choice because of the discomfort, pain and anguish the illness involves. A Dutch neurologist has argued that the very fact of being in a terminal state, as well as the medication that is often given in those situations, make a clear and normal functioning of the brain almost impossible.[40] Furthermore, the patient is completely dependent on others, who through their attitude, gestures, tone of voice, etc. can suggest the patient to ask for euthanasia. This is especially true for the physician and can even happen unconsciously if in the doctor's opinion euthanasia is considered to be a good 'solution' in some cases. [41]

One need not deny the theoretic possibility of a truly voluntary request by a seriously ill patient to have his life ended, to realize that in practice it would be difficult to make sure that only such requests will be granted, once euthanasia is accepted and legalized. Recent research demonstrated that 58.8 % of patients with a persistent wish to be killed, had a depression, whereas of a comparable group of patients who did not have a depression 7.7 % had such a death wish. Such a depression is often not recognized while once diagnosed it demonstrates to be well treatable in many cases.[42]

The above is not to deny the importance of the agency and the wishes and needs of the patients and to respond to them, on the contrary (se further). It is to argue that the principle of respect for autonomy is a very feeble basis for intentionally ending the life of a patient.

c) The autonomy of the *patient* cannot logically be the main reason for accepting euthanasia or assisted suicide, simply because the *physician* is performing it. Euthanasia also requires the autonomous consent of the physician. When performing euthanasia the physician freely and intentionally kills the patient. But the free and intentional killing of another person, even with good intentions, cannot fail to influence the attitude of the physician towards people, life and death in general, and to very ill patients, competent and incompetent, in particular. Our acts influence our attitude (e.g. think of the phenomenon of cognitive resonance). This also applies to physicians. Performing and justifying euthanasia will make them different people. This will affect medical care and therefore society as a whole.

d) The whole system of review and control that is necessary to restrict legalized euthanasia to the permitted cases contradicts the ideal of euthanasia on the basis of individual autonomy.[43]

5.2.2 *Mercy*

In modern medicine there is a tendency to gain control over life and health. The intention is to maintain life and health as much as possible.[44] This has led to formidable results in medical possibilities to treat diseases and disorders. However, the enormous technological facilities and the lure of technological control also make it possible to prolong patients' lives until a situation is generated which turns out to be unbearable for the patient.[45] Terrible suffering and agony near the end of life (which, of course is not only generated by medical technology) is experienced as dehumanizing. It should not be tolerated. Humans have a right to die with dignity, it is stated. Ending the patient's life is then considered an act of *mercy* of the physician and of *beneficence* towards the patient. (Note that a traditional term for euthanasia is mercy-killing).

Mercy revisited

Many who accept euthanasia do so in the name of mercy or compassion. And mercy, without doubt, will in general be a motive when euthanasia is performed. I find this understandable and wherever any kind of hastening death would be allowed it would be on the basis of compassion. I also realize that in the course of the ages (some) in extreme cases physicians have consciously given high doses of drugs knowing that death would thereby be hastened. Whether they had the clear intention to bring about death is difficult to know and whether it was the right thing to do remains to be seen. But apart from that I think that today's

euthanasia practice in the Netherlands clearly extends beyond such extreme cases, particularly in view of the modern possibilities of palliative medicine.[46]

In addition to mercy euthanasia in my opinion is motivated by a pursuit for control on the part of the patient and of the physician. This aspiration for control pervades modern medicine. It primarily concerns control over the quality of life, but under circumstances this requires control over death. For when the *quality of life* cannot be maintained at the desired level, the *situation* can be brought back under control by ending the patient's life.[47] Therefore, I see euthanasia as the culmination and not so much as a correction of a medicine that is becoming more and more an instrument for control by technical means. The acceptance of euthanasia may well further such a medicine, because if the efforts to control the quality of life fail but leave the patient in a miserable condition, euthanasia still provides a way out. This is not to say that physicians consciously experience that aspiration for control. It has become part of the ethos of modern society and therefore also of medicine.

It may be granted that when the life of a patient is intentionally terminated, death itself is not the good sought for but the elimination of suffering. However, ending a patient's life to stop the suffering, implies the judgment that such a life is fully marked by the suffering and that the good of eliminating suffering justifies the elimination of the good of the person's life. Medical ethically I find this unacceptable. Medicine should fight suffering because of the person and should not turn against the person because of his suffering. In practice this distinction may seem to become vague, e.g. in situations in which the suffering can only be made tolerable by such high doses of drugs that the patient's consciousness is pushed back and his life is (almost certainly) shortened. Yet it maintains its fundamental ethical importance because of the fundamental goods of the patient's life and of the physician's position in society (see further). The general acceptance of euthanasia may cause to atrophy our ability to deal with our human condition of vulnerability and openness to suffering in another way than by medical technology.

5.3 Some additional arguments against euthanasia.

5.3.1 Palliative care

A request for euthanasia is very often a sign of insufficient or inadequate care or attention. The patient feels uncomfortable, has pain, is afraid of what still may happen, worried about relatives or relationships. Such a request should be taken as an appeal to our responsibility to provide the care that is needed. This is precisely what hospice care intends to do. Good care and attention by physicians and nurses, attention by relatives, adequate pain treatment (nowadays almost always possible) in most cases by far make a request for euthanasia disappear.[48] Exceptions to that rule may exist, but exceptions should not determine morality nor legislation.

5.3.2 Life termination without request

Voluntary euthanasia will provoke 'non voluntary euthanasia'. From the data of Dutch euthanasia practice, it can be concluded that not so much the request, but rather the condition of the patient is the fundamental reason for physicians to terminate a patient's life (cf. paragraph 3.2). Yet, in cases where the condition of the patient gives reason to perform euthanasia on request, the patient will often no longer be able to make a free request (cf. paragraphs 5.2.1 and 5.2.2; I forego the complicated issue of advanced directives). However, when the patient's condition functions as the fundamental ground for euthanasia, the fact that there is no request could then be considered insufficient reason *not* to perform euthanasia. In this way the ideological background of voluntary euthanasia also provides a justification for life termination without request.

5.3.2 Doctor-patient relationship

The acceptance of euthanasia will in the long run seriously change the doctor/patient relationship for the worse.[49] "There is an inherent conflict of interest between the beneficent healing and comforting role in which life and wholeness is sought, and one in which death is caused intentionally".[50] This same concern is expressed by the AMA and other American organizations of health care professionals: "The ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics. Its roots are as ancient as the Hippocratic Oath that a physician 'will neither give a deadly drug to anybody if asked for it, nor ... make a suggestion to this effect' and the merits of the ban have been debated repeatedly

in this nation since the late nineteenth century. (….). Physician-assisted suicide remains 'fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks'".[51]

The acceptance of euthanasia as part of medical practice will change the attitude of health care workers to terminally ill patients, both competent and incompetent. Fenigsen has given several examples of that new mentality that is becoming manifest in the Netherlands (giving up patients unnecessarily, or withholding medically indicated treatment since the patient is "just living by himself", or is already 70 years of age etc.).[52] When euthanasia is a generally accepted option, then for terminal patients who get into difficulty it will be more and more just an option *not* to ask for euthanasia.[53] When such patients do not feel really appreciated and respected they may start asking for euthanasia, maybe in the first place to get the care and attention they would appreciate. Such a society would become an inhabitable place for patients who need permanent care. We should avoid our society developing into that direction. I am not saying that acceptance and legalization of euthanasia would immediately produce such a society. In the Netherlands there are still many people and institutions committed to care for care-dependent people. Yet, precisely these days a read about very long waiting lists for psycho-geriatric patients.[54] And I notice that it is becoming more difficult to explain to the new generations of medical students why euthanasia would be a moral problem at all.

6. Conclusion

6.1 Juridical evaluation

The empirical evidence on euthanasia practice in the Netherlands, not least that of the two major surveys, is far from reassuring. Advocates of voluntary euthanasia have long claimed that tolerating it subject to 'safeguards' would allow it to be 'brought into the open' and effectively controlled. The data discussed above prove this to be only partly true. The reality is that an increasing number of cases of euthanasia and assisted suicide is indeed reported. But it is not certain that all the reports contain complete and correct information on the case in question. And, more seriously, most cases of intentional life terminating actions - at least until very recently a clear majority - have gone unreported and unchecked. In view of the undisputed fact that in these cases there has not been even the opportunity for official scrutiny, claims of effective regulation are unwarranted. The way in which euthanasia has been brought into the open and been dealt with by political and legal authorities and leaders of the medical and ethical elite has in my opinion led to quite a permissive attitude towards intentional life-terminating actions in a situation of seriously inadequate control.

In the light of the assertion made in the introduction that any form of legal regulation of euthanasia is only acceptable if it would guarantee that the state would in principle be able to assess each case, this development constitutes a strong argument against legalization of euthanasia.[55]

6.2 Ethical evaluation

In addition to the before-mentioned juridical argument I see several serious medical and social ethical arguments against the legalization of euthanasia. They mainly circle around a concern for a health care and a society in which all human beings, independent of their capacities and condition are protected, respected and cared for. Even in our age with a technologically advanced medicine our human condition may confront us sometimes with appalling suffering for which there seems to be no alleviation. I realize very well that *only* saying that euthanasia is or should be forbidden, is unconvincing. Those situations present a real challenge to our societies and health care. Only some remarks have been made in this respect, since this is not the place to elaborate this topic. But I am convinced that so far the Dutch have not found the right answer to those challenges.

Notes and references

[1] Henk Jochemsen is director of the Prof.dr. G.A. Lindeboom Institute, centre for medical ethics, and holder of the Lindeboom chair for medical ethics, Amsterdam; website https://www.lindeboominstituut.nl/

[2] This requirement can be founded on the European Convention on Human Rights (1950), especially art. 2 which requires the state to protect the life of every citizen by law. So even if the law would allow for the intentional termination of the life of a citizen it can do so only under the condition that the legal authorities have the possibility to control in each case whether the requirements that the law demands had been fulfilled. The Belgian jurist Prof. Velaers, concludes his thorough study of this issue as follows:
"Only when it is demonstrated that medical deontology and the control system of the judiciary and of the disciplinary court can guarantee satisfactorily that euthanasia will be kept within acceptable limits, the lawgiver can take its responsibility. However, if it is not possible to provide that guarantee, in our view the lawgiver is not allowed to create any space, even not under very restrictive conditions". See: Velaers J. Het leven, de dood en de grondrechten - juridische beschouwing over zelfdoding en euthanasie [Life, death and fundamental rights - juridical discours on suicide and euthanasia]. In: *Over zichzelf beschikken? Juridische en ethische bijdragen over het leven, het lichaam en de dood [self determination? Juridical and ethical essays on life, the body and death].* Reeks: Het recht in de samenleving, van het Centrum Grondslagen van het Recht, Universiteit Antwerpen. Antwerpen: Maklu uitgevers 1996, p. 573. Translation from the Dutch by H. Jochemsen.

[3] Leenen HJJ. Dying with dignity: developments in the field of euthanasia in the Netherlands. *Medicine and Law* 8 (1989) p.520.

[4] Standpunt van het Kabinet inzake medische beslissingen rond het levenseinde [Position of the Cabinet with respect to 'Euthanasia and other medical decisions concerning the end of life'] (Den Haag: Ministerie van Justitie, 8 Nov 1991).

[5] Leenen, *op cit* n 2; also: WR Kastelein. *Standpunt hoofdbestuur KNMG inzake euthanasie*, [Position General Committee KNMG on Euthanasia]. Utrecht, august 1995.

[6] The new legal regulation (bill no. 22 572) amends the law on the Disposal of the Dead (article 10) which provides the legal basis for a form used by physicians to certify natural death. The law as amended provides that both the form to certify natural death and the form to notify all cases of euthanasia, assisted suicide and a life-terminating action without request will be set out in an enactment ['Algemene Maatregel van Bestuur', AMvB]. This AMvB has been published in the Staatsblad [official publication of the government] of 28 Dec 1993, as: *Besluit van 17 Dec 1993, Stb 688*. This law became formally effective on June 1, 1994.

[7] Van der Maas PJ, et al. *Medische beslissingen rond het levenseinde*. Den Haag: SDU Uitgeverij 1991. (Published in translation as Euthanasia and Other Medical Decisions Concerning the End of Life. Amsterdam: Elsevier 1992.

[8] Van der Wal G, Van der Maas PJ et al. *Euthanasie en andere medische beslissingen rond het levenseinde. De praktijk en de meldingsprocedure.* [Euthanasia and other medical decisions concerning the end of life. Practice and reporting procedure.] Den Haag: SDU uitgevers 1996, (to this publication will be referred by 'survey'). For summaries of the research in English see: Paul J van der Maas. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands 1990-1995. *New England Journal of Medicine* 335 (1996), p.1699; Gerrit van der Wal. Evaluation of the notification procedure for physician-assisted death in the Netherlands. *Ibid*, p.1706.

[9] Jochemsen H. Euthanasia in Holland: an ethical critique of the new law. *Journal of Medical Ethics* 20 (1994), p. 212; Jochemsen H & Keown J. Voluntary euthanasia under control? Further empirical evidence from the Netherlands. *Journal of Medical Ethics* 25 (1999), p.16-21; see also: Keown J. Euthanasia in the Netherlands: sliding down the slippery slope? in: John Keown (ed.) *Euthanasia Examined*. Cambridge University Press 1995, ch.16

[10] The report does not give exact data at this point, but from the data that are given it can be estimated that in at least a few hundreds of those cases there was no explicit request. (cf. Survey p. 77,78, 80, 92, 93).

[11] Pijnenborg L. *End-of-life decisions in Dutch medical practice*. Thesis. Rotterdam 1995, p.18.

[12] Vonnis Arrondissementsrechtbank te Alkmaar d.d. 26 april 1995 in the case against P. *Tijdschrift voor Gezondheidsrecht* No.5 (1995) p.292-301.

[13] Vonnis Rechtbank te Groningen d.d. 13 november 1995 in the case against K. *Pro Vita Humana* 3, no.1 (1996) p.29-32.

[14] Arrest Gerechtshof te Amsterdam d.d. 7 november 1995 in the case against P. *Pro Vita Humana* 3, no.1 (1996) p.25-28.

[15] Arrest Gerechtshof te Leeuwarden, d.d. 4 april 1996 in the case against K. *Tijdschrift voor Gezondheidsrecht* No.5 (1996) p.284-291.

[16] For a more extensive discussion of these cases, see: Jochemsen H. Dutch court decisions on non voluntary euthanasia critically reviewed. *Issues in Law & Medicine* 13, no.4 (1998) p.447-458.

[17] The Leeuwarden court formulated the following conditions that at least must be fulfilled by the physician to be able to successfully appeal to the defence of necessity (see *op cit* n 15, section 12.10):
- no doubt must exist about diagnosis and prognosis,
- the doctor must consult colleagues,
- death must be brought about in a careful and correct way,
- the doctor must report the case.
- the parents must consent to the killing of the baby

[18] In a recent publication dr. Dillmann, secretary of the KNMG medical ethical committee, argued that indeed the physician must make a judgement on the suffering of the patient and conclude that this is unbearable before he can perform euthanasia. The moral justification of euthanasia is not just the request of the patient but as much his suffering, according to Dillmann. Dillmann RJM. Euthanasie: de morele legitimatie van de arts [Euthanasia: the moral legitimation of the physician]. In: Legemaate J, Dillmann RJM (red.) *Levensbeëindigend handelen door een arts: tussen norm en praktijk [Life terminating acting by a physician: between norm and practice].* Houten: Bohn Stafleu Van Loghum 1998, p.11-25.

[19] See: Sorgdrager W, Borst-Eilers E. Euthanasie. De stand van zaken. *Medisch Contact* 50, no.12 (1995) p.381-384) and Kastelein WR, 1995, op cit n 8, resp.

[20] *Wet Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Legal assessment of life termination on request and assisted suicide*]. Tweede Kamer 1998-1999, 26691, nr. 3, 10.

[21] I speak of hospice *movement* since it is rather a kind of approach to terminal care than recognizable institutions or the availability of certain medical 'know how' as such. I do not deny that palliative care and palliative medicine is practiced in the Netherlands for many years. However, the application of the most modern pain and symptom control in the context of integral palliative care according to the hospice philosophy is not widespread and still depends very much on local initiatives. An inventory in 1997 demonstrated that there were 35 initiatives in palliative care, six of which are (mostly small) hospice institutions and the others concern intramural palliative care within other health care institutions like nursing homes. In addition to these 35 there were about 120 initiatives of activities that show some overlap with hospice care, like the functioning of a special pain team or specific caring facilities for terminal patients; see: Francke AL, et al.. *Palliatieve zorg in Nederland.* Utrecht: Nivel 1997. More recently the government and the medical profession are making considerable efforts to improve the situation (cf. www.palliatief.nl).

[22] Survey, Table 10.1

[23] *Ibid*, Table 10.2

[24] *Ibid*, p.113

[25] *Ibid*, Table 11.6.

[26] These changes are announced and described in: Kabinetsstandpunt naar aanleiding van de evaluatie van de meldingsprocedure euthanasie. *Brief van Minister van Justitie en van de Minister van Volksgezondheid, Welzijn en Sport aan de Tweede Kamer, d.d. 21 januari 1997 (kenmerk 603400/97/6)*. [*Position of Cabinet with respect to evaluation of reporting procedure of euthanasia. Letter of Ministers of Justice and of Health, Welfare and Sports, d.d. January 21, 1997].*

[27] *Staatscourant 1998*, 101 and 103.

[28] Regionale toetsingscommissies euthanasie. *Jaarverslag 1999*. [Regional euthanasia review commitees. *Year report 1999*]. Den Haag 1999, p.8ff. This report indicates that in 1999 2216 cases of euthanasia or assisted suicide were reported, whereas in 1998 2241 cases were reported. (Jaarverslag Openbaar Ministerie 1998 inzake euthanasie en hulp bij zelfdoding. *ProVita Humana* 7, no 1 (2000), p.34).

[29] See Jochemsen H. Legalizing Euthanasia in the Netherlands. *Dignity: the Newsletter of the Center for Bioethics and Human Dignity* 5 (1999), p. 1.

[30] Schipperges H. Motivation und Legitimation des Arztliche Handelns, in: Schipperges H, Seidler E, Unschuld PU (red.), *Krankheit, Heilkunst, Heilung,* Freiburg/München 1978, pp. 447-489, esp. p. 487. See also: Gadamer H-G. *The enigma of health- the art of healing in a scientific age.* Stanford: Stanford University Press 1996, p. 31-44, 70-82, 103-116.

[31] Callahan D. When self-determination runs amok. *Hastings Center report* 22, no.2 (1992) p.52-55; and Callahan D. Can we return death to disease? *Hasting Center report* 19, no.1 (1989) p.4-6.

[32] Cf. Reich W. (ed.). Acting and refraining, in: *Encyclopedia of Bioethics.* New York: Free Press, 1978, p.33-35.

[33] The American Medical Association in this context explicitly refers to this principle as well as to the distinction between withdrawing or withholding a treatment and assisted suicide, in its statement presented at the Hearing before the Subcommittee on Health and Environment of the Committee on Commerce of the House of Representatives of the USA, d.d. March 6 1997 (Serial No. 105-7), p. 55.

[34] Keown J. Double effect and palliative care: a legal and ethical outline. *Ethics & Medicine* 15, no2 (1999), p.53-54.

[35] Beauchamp TL, Childress JF, *Principles of biomedical ethics*, 4nd Ed. Oxford: Oxford University Press 1994, Ch 3.

[36] Leenen HJJ, op. cit. no 3; Willems JHPH. Euthanasie en noodtoestand. *Ned. Juristenblad* 22 (1987), pp.694-698.

[37] Interesting in this context is that according to the Survey of 1995 52 % of the attending physicians, 83 % of the medical examiners and 73 % of the public prosecutors (fully) agree with the statement that "Everyone has the right to self-determination about one's own life and death"; op cit n 8, p.174.

[38] Drion H. Het zelfgewilde einde van oude mensen [The selfchosen end of elderly people]. Amsterdam: Balans 1992.

[39] Cf. The Appleton International Conference: developing guidelines for decisions to forgo life-prolonging medical treatment. *Journal of Medical Ethics* 18 (1992, supplement), pp. 3-5. See also Recommendation 1418

on ‘The protection of the human rights and dignity of the terminally ill and the dying’, adopted by the Assembly of the Council of Europe on 25 June 1999. This recommendation states: “..recognizing that a terminally ill or dying person’s wish to die cannot of itself constitute a legal justification to carry out actions intentionally to bring about death”. *Pro Vita Humana* 7, no 1 (2000), p.34

[40] Schulte BPM. Over euthanasia en in het bijzonder over de relatie tussen hersenfunctie en vrijwilligheid bij euthanasie. *Vita Humana* XV (1988) nr.1, p. 9-12.

[41] Cf. the opinion of a number of American medical and nurses’ organizations: "....experience to date provides little basis for confidence that health care professionals can reliably determine whether patients have provided truly informed consent for assisted suicide. Frank, sensitive, and extended conversations between physicians and patients are presumptively antecedents to such a determination" (p.15). "The well-established phenomena of transference and countertransference further complicate the problem of relying upon physicians and nurses to identify voluntary requests" (p.15,16). See: Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, et al. as Amici Curiae in support of Petitioners. *In the Supreme Court of the United States, October term 1996; State of Washington, Christine O. Gregoire (petitioners) versus H. Glucksberg, A. Halperin, T.A. Preston, P. Shalit (respondents). Doc. No.96-110,* d.d. 12 november 1996. See also: Muskin PR. The request to die. Role for a psychodynamic perspective on physician-assisted suicide. *J Am Med Ass* 279, no 4 (1998), p.323-328.

[42] Verhagen S. Behandeling depressiviteit: altijd zinvol, vaak effectief [treatment of depression: always useful, often effective]. *Pallium* 2, no.2 (2000), p.13-17.

[43] Cameron NM de S. Autonomy and the ‘right to die’. In: Kilner JF, Miller AB, Pellegrino ED(Eds*.) Dignity and dying- a christian appraisal*. Grand Rapids (MI): Eerdmans 1996, p.23-33.

[44] Jaspers K. The physician in the technological age. *Theoretical Medicine* 10 (1989), p. 262. Editorial. A new ethic for medicine and society. *California Medicine* 113 (1970) nr.3, pp. 67, 68. Callahan. *What kind of life- the limits of medical progress*. New York: Simon & Schuster, ch. 2.

[45] Cassell EJ. The sorcerer’s broom. *Hastings Center report* 23, no 6 (1993), p.32-39.

[46] See e.g. the antropological study of Pool R. *Vragen om te sterven. Euthanasie in een Nederlands ziekenhuis. [Asking to die. Euthanasia in a Dutch hospital]*. Rotterdam: WYT Uitgeefgroep 1996.

[47] "Health care professionals also experience great frustration at not being able to offer the patient a cure. For some, the ability to offer the patient the `treatment' of assisted suicide may provide a sense of `mastery over the disease and the accompanying feelings of helplessness". Brief of the AMA etc. d.d. 12 nov 1996, op cit n 41, p.16.

[48] Just a few references who affirm this. Zylicz Z. Palliative care: Dutch hospice and euthanasia. In: Thomasma et al. (Eds.) *Asking to die: Inside the Dutch debate about euthanasia*. Dordrecht /Boston/London: Kluwer Acad Publ. 1998, p.187-203; Dutch oncologist J van Turnhout, in: *Pallium* 1, no 5 (1999), p.14; Baar FPM. Palliatieve zorg voor terminale patienten in verpleeghuizen [palliative care for terminal patients in nursing homes]. *Pro Vita Humana* 6, no 6 (1999), p.169-175; Twycross R. Where there is hope, there is life: a view from the hospice. In: Keown J (Ed.) *Euthanasia examined. Ethical, clinical and legal perspectives*. Cambridge University Press 1995, ch 11.

[49] Singer PA, Siegler M. Euthanasia - a critique. *New Engl J Med* 32 (1990) nr.26, pp. 1881-1883.

[50] Reiche W, Dijck A. Euthanasia: a contemporary moral quandary. *The Lancet* ii (1989), pp.1321-1323; quote p.1322.

[51] Brief of the AMA etc. d.d. 12 nov 1996, op cit n 41, p.5.

[52] Fenigsen R. A case against Dutch Euthanasia. *Hastings Center report* 19 (1989) nr.1, special suppl., p. 22-30.

[53] Cf. “Were physician-assisted suicide to become a legitimate medical option, then a decision not to select that option would make many patients feel responsible for their own suffering and for the burden they impose on others”. Brief of the AMA etc. d.d. 12 nov 1996, op cit n 41, p.17.

[54] Te weinig zorg voor dementen. [shortage of care for demented]. *Nederlands Dagblad*, 11 July 2000, p.1.

[55] Cf. the conclusion of the British Select Committee of the House of Lords on the question whether euthanasia should be legalized: "Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. (...) We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions". *Report of the Select Committee on Medical Ethics*. House of Lords, Session 1993-94. London: HSMO 1994, p.48. This report received remarkably little attention in the Netherlands.