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An Outsider's View of Dutch Euthanasia Policy and Practice

Raphael Cohen-Almagor, D.Phil.*

ABSTRACT: This article provides a critical analysis of Dutch euthanasia policy and practice. The research benefited from twenty-eight interviews conducted in the Netherlands during the summer of 1999 with some of the leading figures who dictate the decision–making process and take an active part in the debates. The discussion begins with a review of the two major Dutch reports on euthanasia and the conflicting views and interpretations offered by the literature. Next, I provide some data about the interviews, and then analysis indicating that the Dutch Guidelines on the policy and practice of euthanasia do not provide ample mechanisms against abuse. I argue that the Dutch Guidelines are insufficient, do not provide adequate control over the practice of euthanasia, and that the entire policy should be revised and made more coherent and more comprehensive.

The Dutch experience has influenced the debate on euthanasia and death with dignity around the globe, especially with regard to whether physician-assisted suicide and euthanasia should be legitimized or legalized. Review of the literature reveals complex and often contradictory views about this experience. Some claim the Netherlands offers a model for the world to follow; others believe the Nether-

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lands represents danger rather than promise, that the Dutch experience is the definitive answer why we should *not* make active euthanasia and physician-assisted suicide part of our lives.

Given these contradictory views, fieldwork is essential to develop a fully informed opinion. Having investigated the Dutch experience for a number of years, in the summer of 1999 I went to the Netherlands to visit the major centers of medical ethics as well as some research hospitals, and to speak with leading figures in euthanasia policy and practice. This article reports the main findings of my interviews and provides detailed accounts of the way in which some of the Netherlands' leading experts perceive the policy and practice of euthanasia in their country. These accounts are quite fascinating.

The discussion begins with a review of the two major Dutch reports on euthanasia and the conflicting views and interpretations offered by the literature. Next, I provide some data about the interviews, and then analysis indicating that the Dutch Guidelines on the policy and practice of euthanasia do not provide ample mechanisms against abuse. Virtually every guideline has been breached or violated. This finding reiterates Hendin's finding.[1] I conclude by recommending that the Netherlands amend its policy and remedy its troubling practice. The findings should compel us to conduct further investigation and research. The Netherlands should overhaul its policy and procedures to prevent potential abuse.

Background

Since November 1990, prosecution is unlikely if a doctor complies with the Guidelines on euthanasia and physician assisted suicide set out in the non-prosecution agreement between the Dutch Ministry of Justice and the Royal Dutch Medical Association. These Guidelines are based on the criteria set out in court decisions relating to when a doctor can successfully invoke the defense of necessity.

The substantive requirements are as follows:

- The request for euthanasia or physician-assisted suicide must be made by the patient and must be free and voluntary.
- The patient's request must be well considered, durable and consistent.
- The patient's situation must entail unbearable suffering with no prospect of improvement and no alternative to the end of suffering.[2] The patient need not be terminally ill to satisfy this requirement and the suffering need not necessarily be physical.
- Euthanasia must be a last resort.[3]

[1] HERBERT HENDIN, SEDUCED BY DEATH 23 (1997).

[2] The Medical Association Executive Board emphasized that there are only limited possibilities for verifying whether suffering is unbearable and without prospect of improvement. The Board considered it in any case the doctor's task to investigate whether there are medical or social alternatives that can make the patient's suffering bearable. JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN THE NETHERLANDS 66 (Amsterdam: Amsterdam University Press, 1998).

[3] John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 L. Q. REV. 51, 56 (1992).

The procedural requirements are as follows:

- No doctor is required to perform euthanasia but if he/she is opposed on principle the doctor must make his/her position known to the patient early on and help the patient get in touch with a colleague who has no such moral objections.
- Doctors taking part in euthanasia should preferably and whenever possible have patients administer the fatal drug to themselves, rather than have a doctor apply an injection or intravenous drip.[4]
- A doctor must perform the euthanasia.
- Before the doctor assists the patient, the doctor must consult a second independent doctor who has no professional or family relationship with either the patient or doctor. Since the 1991 *Chabot* case,[5] if the patient has a psychiatric disorder the doctor must cause the patient to be examined by at least two other doctors, one of whom must be a psychiatrist.
- The doctor must keep a full written record of the case.
- The death must be reported to the prosecutorial authorities as a case of euthanasia or physician-assisted suicide (PAS), and not as a case of death by natural causes.[6]

In 1990, the Dutch government appointed a commission to investigate the medical practice of euthanasia. The Commission, headed by Professor Jan Remmelink, Solicitor General to the Supreme Court, was asked to set up an inquiry research team to conduct a comprehensive nation-wide study of "medical decisions concerning the end of life" (MDEL). The following broad forms of MDEL were studied:

- Non-treatment decisions: withholding or withdrawing treatment in situations where treatment would probably have prolonged life;
- Alleviation of pain and symptoms: administering opioids in such dosages that the patient's life could be shortened;
- Euthanasia and related MDEL: the prescription, supply or administration of drugs with the explicit intention of shortening life, including euthanasia

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[4]THE ROYAL DUTCH MEDICAL ASSOCIATION'S REFINEMENTS OF THE 1984 GUIDELINES ON EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE (Dutch Ministry of Justice & Royal Dutch Medical Association, Aug. 25, 1995); *cf.* Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, Sept. 11, 1995, at A3.

[5]Supreme Court of the Netherlands, Criminal Chamber, June 21, 1994, no. 96.972 [Nederlandse Jurisprudentie 1994, nr 656; Tijdschrift voor Gezondheidrect 1994/96 nr 47]. For translation, *see* John Griffiths, et al., *Euthanasia and Law in the Netherlands, The Chabot Case*, 58 MOD. L. REV. 232, 232-39 (1994); and GRIFFITHS, *supra* note 2, App. II (2).

[6]<http://www.euthanasia.org/dutch.html#remm>. *See also* Marcia Angell, Editorial, *Euthanasia in the Netherlands - Good News or Bad?* 335 NEW ENG. J. MED. 1676, 1676-78 (1996); Adriaan Jacobovits, *Euthanasia in the Netherlands*, WASH. POST, Jan. 23, 1997, at A16; GENERAL HEALTH COUNCIL, A PROPOSAL OF ADVICE CONCERNING CAREFUL REQUIREMENTS IN THE PERFORMANCE OF EUTHANASIA (The Hague, 1987).

at the patient's request, assisted suicide, and life termination without explicit and persistent request.[7]

The study was repeated in 1995, making it possible to assess for the first time whether there were harmful effects over time that might have been caused by the availability of voluntary euthanasia in the Netherlands. It was difficult to make valid comparisons with other countries, not only because of legal differences but also because similar studies have not been done.[8]

The two Dutch studies were said to give the best estimate of all forms of MDEL (i.e., all treatment decisions with the possibility of shortening life) in the Netherlands as around 39% of all deaths in 1990, and 43% in 1995. In the third category of MDEL, the studies gave the best estimate of voluntary euthanasia as 2300 persons each year (1.9% of all deaths) in 1990,[9] and 3250 persons each year (2.4%) in 1995. The estimate for physician-assisted suicide was about 0.3% in 1990 and in 1995. There were 8900 explicit requests for euthanasia or assisted suicide in the Netherlands in 1990, and 9700 in 1995. Less than 40% were proceeded with. The most worrisome data is concerned with the hastening of death without the explicit request of patients. There were 1000 cases (0.8%) without explicit and persistent request in 1990, and 900 cases (0.7%) in 1995.[10]

In 1990, 30% of the general practitioners (GPs) interviewed said they had performed a life-terminating act at some time without explicit request (compared with 25% of specialists and 10% of nursing home physicians).[11] Performing a life-terminating act without explicit request occurred, on the average, with older patients than did euthanasia or physician-assisted suicide.[12] There were still treatment alternatives in 8% of cases in which a life-terminating act was performed without explicit request of the patient. The physician did not use these alternatives because the patient had indicated she/he no longer wanted it, because it "only would pro-

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[7]*Cf.* P.J. VAN DER MAAS, et al., EUTHANASIA AND OTHER MEDICAL DECISIONS CONCERNING THE END OF LIFE, HEALTH POLICY MONOGRAPHS (Amsterdam, Elsevier 1992).

[8]For further discussion, *see* Chris Ciesielski-Carlucci & Gerrit Kimsma, *The Impact of Reporting Cases of Euthanasia in Holland: A Patient and Family Perspective*, 8 BIOETHICS 151, 151-58 (1994); J.K.M. Gevers, *Physician Assisted Suicide: New Developments in the Netherlands*, 9 BIOETHICS 309, 309-12 (1995); Henk Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. MED. ETHICS 212, 212-17 (1994); Tony Sheldon, *Euthanasia Law Does Not End Debate in the Netherlands*, 307 BRIT. MED. J. 1511, 1511-12 (1993); Johannes J.M. van Delden et al., *Deciding Not to Resuscitate in Dutch Hospitals*, 19 J. MED. ETHICS 200, 200-05 (1993).

[9]P.J. VAN DER MAAS, ET AL., *supra* note 7, at 41.

[10]Gerrit van der Wal & Paul J. van der Maas, *Empirical Research on Euthanasia and Other Medical End-of-Life Decisions and the Euthanasia Notification Procedure*, *in* ASKING TO DIE 171 (David C. Thomasma, et al. eds., Dordrecht, Kluwer Academic Publishers 1998). *See also* Bill Mettyear, South Australian Voluntary Euthanasia Society, *Advocating Legalising Voluntary Euthanasia* (Feb. 1997), <http://www.on.net/clients/saves/>.

[11]P.J. VAN DER MAAS, ET AL., *supra* note 7, at 58.

[12]*Id.* at 61.

long suffering," or because the expected gain was not enough to make the treatment worthwhile.[13] It should be noted that the level of consultation was significantly lower in life-termination acts without the patient's explicit request compared with euthanasia or physician-assisted suicide. A colleague was consulted in 48% of the cases (compared with 84% in euthanasia and assisted suicide cases).[14] Relatives were consulted in 72% of the cases (compared with 94% in euthanasia and assisted suicide cases). In 68% of the cases, the physician felt no need for consultation because the situation was clear.[15] Van der Maas and colleagues note that this should be considered in light of the very brief period by which life was shortened.[16]

About a quarter of the one thousand patients had earlier expressed a wish for voluntary euthanasia.[17] The patient was no longer competent in almost all of those cases. In 67% of cases in this group death was hastened by a few hours or days; in 21% of cases the patients' lives were shortened by one to four weeks; in 7% of cases by one to six months, and in 1% of cases by more than half a year.[18] A small number of cases (approximately fifteen) involved babies who were suffering from a serious congenital disorder and were barely viable; the doctor decided, in consultation with the parents, to hasten the end of life.[19]

The Remmelink Commission regarded these cases of involuntary termination of life as "providing assistance to the dying." They were justified because the patients' suffering was unbearable, standard medical practice failed to help and, in any event, death would have occurred within a week.[20] The Commission added that actively ending life when the vital functions have started failing is indisputably normal medical practice: "It deserves recommendation that the reporting procedures in place...will in the future also cover the active termination of life by a doctor in the framework of help-in-dying without an explicit request by the patient," except if it concerns a situation where there is "the beginning of irreversible, interrelated failure of vital functions." In this last case "natural death would very

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[13]*Id.* at 62.

[14]The 48% figure has been cited as the *total* percent of cases on which there had been consultation when the reported and unreported cases are taken together. Virtually none of the cases whose lives are ended without request are reported. *See* P.J. VAN DER MAAS, ET AL., *supra* note 7, at 65.

[15]In another study among family doctors, one quarter of the physicians said that they did not ask for a second opinion before administering euthanasia or assisted suicide. Twelve percent of the General Practitioners had no kind of consultation with any professional health worker. *Cf. generally* G. van der Wal, et al., *Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?* 9 FAM. PRAC. 140 (1992).

[16]P.J. VAN DER MAAS ET AL. *supra* note 7, at 65.

[17]Henk A.M.J. ten Have, *Euthanasia: The Dutch Experience*, CXII ANNALS DE LA REAL ACADEMIA NACIONAL DE MEDICINA 429 (Madrid, 1995).

[18]P. J. VAN DER MAAS, ET AL., *supra* note 7, at 65.

[19]*See* FOREIGN INFORMATION DEPARTMENT, NETHERLANDS MINISTRY OF FOREIGN AFFAIRS, 1996 STUDY FINDINGS, EUTHANASIA AND OTHER DECISIONS CONCERNING THE END OF LIFE IN THE NETHERLANDS (1996).

[20]One of the referees notes that estimations by physicians that patients have only a week or two to live have been demonstrated to be grossly inaccurate.

quickly occur even if the doctor did not actively intervene. . . ." The recommendation goes on to say that this is not the case with patients whose vital functions are still intact and who are subject to life-shortening treatment without explicit request. Such cases should be reported.[21]

On the basis of the 1995 report, the government decided to decrease the influence of the criminal law in cases of euthanasia by instituting regional review committees. These committees will review each case of euthanasia reported to the medical examiner and advise whether to dismiss the case or prosecute the physician involved. By introducing this mechanism, the government thought the willingness of physicians to report would increase.

Methodology

Before arriving in the Netherlands, I wrote to some distinguished experts in their respective fields: medicine, psychiatry, philosophy, law, social sciences and ethics, asking to meet with them in order to discuss the Dutch policy and practice of euthanasia. These individuals are known nationally and internationally. Most of them I know through their writings. The others were recommended to me by Dutch colleagues as experts whom I should meet. Only one—Dr. Chabot—explicitly declined my request for an interview.[22]

The interviews took place during July-August 1999, in the Netherlands. They lasted between one to three hours each. Most interviews went on for more than two hours during which I asked more or less the same series of questions.[23] During the interviews I took extensive notes that together comprise some 200 dense pages. Later the interviews were typed and analyzed.

The interviews were conducted in English, usually in the interviewees' offices. Four interviews were conducted at the interviewees' private homes, and four interviews in "neutral" locations: coffee shops and restaurants. Two interviews were conducted at the office kindly made available to me at the Department of Medical

[21]Remmelink Commission, *Rapport Medische Beslissingen Rond het Levenseinde* 37 (The Hague, SDU, 1991). *See also* Henk A.M.J. ten Have, *supra* note 17, at 429. In his comments on the first draft of this study, Leenen wrote that the proposal of the Remmelink Commission was rejected by nearly all the Dutch commentators and also by the government. Letter from H. J. J. Leenen, former Prof. of Social Medicine and Health Law, Medical Faculty and Faculty of Law, University of Amsterdam, to author (July 25, 2000) (on file with author).

[22]In his letter dated June 5, 1999, Dr. Chabot wrote: "After four years waiting for the final court judgment (1991-1995) and discussing the case with many people from abroad, I hope you will understand that I prefer to remain in the background now and not to make an appointment with you." Letter, Dr. Chabot to author (June 5, 1999) (on file with author). He, however, agreed to answer via e-mail some specific questions relating to his conduct that brought about the charges against him. I am in the process of writing a detailed analysis of the *Chabot* case.

[23]My questionnaire was comprised of fifteen questions. The Dutch comprehensive study of 1995 consisted of 120 pages and the interviews lasted for an average of two and a half hours. The pace of questioning was, apparently, frantic. *Cf. generally* Paul J. van der Maas, et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1700 (1996).

Ethics, Free University of Amsterdam. To have a sample of different locations I traveled from Groningen in the north to Maastricht in the south, making extensive use of the Dutch efficient train system.

The interviews were semi-structured. I began with a list of fifteen questions but did not insist on all of them when I saw that the interviewee preferred to speak about subjects that were not included in the original questionnaire. With a few interviewees—most notably the GPs performing euthanasia and the De Boer family, who openly discussed their own personal experience with euthanasia—I spoke only about their direct involvement in the practice of euthanasia. Because I was interested in the problematic aspects of the euthanasia practice, after some general questions I addressed the troublesome aspects reiterated in the Remmelink report. This line of questions disturbed some of the interviewees, who wanted to know my own opinion on the subject matter before continuing to answer my questions. Others seemed eager to bring the interview to a close.

I was struck by the defensiveness expressed by some of the interviewees. Gomez also reported suspicion and guardedness on the part of his interviewees.[24] The attitude of some of my interviewees reminded me of my own initial reaction when I attended debates of post-Zionists outside of Israel during the late 1980s and early 1990s. At that time I felt that the 'dirty laundry' should not be taken out; that the debate should be restricted to Israelis who are familiar with the intricate aspects of the debate, and that all who take part in the dispute should show responsibility when they address the issue before non-Israelis and non-Jews who might then exploit the information to harm Israel's interests. In the Netherlands I sensed that the interviewees did not like the idea of a foreigner asking these questions. Their attitude spurred me to entitle this article *An Outsider's View of Dutch Euthanasia Policy and Practice*. Although they realize the euthanasia policy is imperfect, they tried to defend it to the best of their abilities.[25] As a matter of fact, I was somewhat troubled by their lack of criticism and their readiness to accept the euthanasia policy and practice with all their flaws.[26] I presume some of the interviewees identify with their

[24]CARLOS F. GOMEZ, REGULATING DEATH 59-60 (1991).

[25]In her remarks on the first draft of this essay, Heleen Dupuis wrote: "We do not want to defend our views, nor do we want to persuade others to adopt them. We are just very weary when a hundred and umpteenth foreigners come with questions we already have discussed the same number of times. Personally I am very tired by the endless interrogations, whereas I feel that euthanasia is a private matter, such as abortion, and even more so. I also feel that there is a certain exaggeration when it comes to the gravity of the problem." Letter from Prof. Heleen Dupuis, Dep't of Metamedicine, University of Leiden, to author (July 25, 2000) (on file with author).

[26]In his comments on the first draft of this study, Leenen wrote that he doesn't agree that there is a lack of criticism in the Netherlands: "We have for more than 25 years discussed euthanasia publicly and between all kinds of opinions in a good atmosphere. Nobody was excluded. I personally lectured in meetings of opponents who invited me. I don't know of a country where this is possible." Leenen maintained that gradually a kind of consensus has grown "within a majority" and the problem is that 'people like Fenigsen' never took part in this debate and only ventilated their opinions elsewhere. Letter from H.J.J. Leenen, former Prof. of Social Medicine and Health Law, University of Amsterdam,

government's decisionmaking to the extent of defending the system and suspecting foreigners like me who press them with difficult questions.[27] I also suspect that after the publications of Gomez,[28] Keown[29] and Hendin,[30] they were not enthusiastic about cooperating with me. One interviewee was candid enough to tell me this directly. When I asked why he was willing to sit with me and answer my questions, he replied that he felt obliged as a researcher and scientist to cooperate and wanted his viewpoint to be heard.

Some of the interviewees were nominated by the Dutch government to conduct research on the policy and practice of euthanasia and to submit their recommendations for changes. Science commissioned by the state might be a tricky issue. The researcher might become identified with the project to the extent of becoming "the voice of the state" and forgoing impartiality. It is preferable that research on controversial matters be funded by non-partisan foundations rather than by an interested government.[31]

This article reports the answers to the question concerning two breaches of the Guidelines: lack of consultation and lack of reporting. For limitations of space I cannot possibly report the extensive answers to my fifteen questions. This is done in my forthcoming book *Euthanasia in the Netherlands.*

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to author (July 25, 2000) (on file with author). One referee remarked that this statement is incorrect. Before publishing an article on Dutch euthanasia in *The Hastings Center Report* (1989), Fenigsen had tried for nine years to alert the Dutch doctors and public opinion of the dangers involved in the practice. Fenigsen submitted a memorandum to the staff of Willem-Alexander Hospital (1980) and to the Board of the Royal Society of Medicine (1984). Fenigsen also published in Dutch a book and two articles opposing euthanasia, delivered public lectures to that effect, and expounded his views in interviews given to Dutch newspapers and periodicals.

[27]One referee questioned my statement, arguing that in the Netherlands, as in the United States, there is no particular reverence for "the central government," nor is the Dutch government the source or a creator of the euthanasia policy. If it acts, it's to investigate or to confirm the consensus already reached by the majority of the public, the medical profession, and the judiciary. The referee maintained that the Dutch assume a defensive attitude when this national consensus and the practice in which they have a stake are questioned.

[28]GOMEZ, *supra* note 24.

[29]John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 L.Q. REV. 51-78 (1992); *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?* NOTRE DAME J.L. ETHICS & PUB. POL'Y 407-48 (1995).

[30]HENDIN *supra* note 1.

[31]This statement spurred Van der Maas to react by saying: "I consider myself as an independent researcher, with a primary responsibility in collecting reliable data and basing impartial estimates and interpretations on that empirical information. I see no position for myself in a pro versus contra euthanasia debate and I think such kind of debate is entirely unproductive. As a researcher I think my responsibility is to find out what people do and how that might fit in high quality end of life medicine. During the last years part of our study has been replicated in Australia and Belgium and we have obtained funding from the European Union for an international collaborative study in order to establish empirical comparisons between countries." Personal communication of Professor Paul van der Maas, Dep't of Public Health, Erasmus University, Rotterdam (Amsterdam, Sept. 18, 2000) (notes on file with author).

Breaches of the Guidelines

Consultation

The physician practicing euthanasia is required to consult a colleague with regard to the hopeless condition of the patient. I asked: Who decides the identity of the second doctor? I also asked about the common practice in small villages in rural areas where it might be difficult to find an independent colleague to consult. One prosecutor told John Keown that in the countryside there were towns with only two or three doctors. He therefore asked rhetorically: "What's the use of asking one of those two or three to judge the handling of a euthanasia case by the other one? How objective can that be? I don't see it."[32]

The Dutch movie, *Death on Request,* presented on Dutch television in October 1994, showed that the doctor performing the euthanasia was careful to call a colleague to consult with him about his patient.[33] It is unclear why the GP picked this specific consultant. Was it because of his particular field of expertise or because the physician knew this doctor and assumed he would back his decision without too many questions? Did they know one another and were they on friendly terms? What worries me is that the requirement to consult could become a dead dogma, only to fill the papers, and that, in essence, one hand helps the other: you approve euthanasia for my patients, I will approve it for yours. And obviously, a doctor who approves euthanasia would not call a colleague that is against it or is hesitant about the practice. Indeed, one study shows that the consultant was nearly always a partner in the practice or a locum. At least sixty percent of the 'independent consultants' giving the second opinion already knew the patient before the consultation. The family doctor sought a second opinion from a doctor he did not know personally in only five percent of the cases.[34] Another study showed, unsurprisingly, that almost all consultants regarded the request of the patient to be well-considered and persistent, that there were no further alternative treatment options, and that almost all of them agreed with the intention to perform euthanasia or assisted suicide. In general, the GPs did not need to change their views or plans after consultation took place.[35] Two hypotheses may be offered to explain this finding, a positive one and a negative one. The positive one is that the GPs are very careful in their practice and agree to perform euthanasia only in clear-cut cases. The negative hypothesis is that the procedure is formal, to fill out the papers, and that the consultant does not take

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[32]John Keown *supra* note 29, at 68.

[33]*Death on Request*, IKON, Interkerkelijke Omroep Nederland, Postbus 10009, 1201 DA Hilversum. I thank IKON for sending me a copy of this film. For deliberation and critique of the content of this film, *see* HENDIN, *supra* note 1, at 114-20.

[34]G. van der Wal, et al., *supra* note 15, at 113, 115.

[35]Bregje Dorien Onwuteaka-Philipsen, Consultation of Another Physician in Cases of Euthanasia and Physician-Assisted Suicide 29, 31 (unpublished doctoral thesis, Dep't of Social Medicine, Vrije Universiteit, Amsterdam 1999) (on file in Vrije Universiteit Library).

great care to examine the patient in concern because s/he doesn't wish to refute the GP's decision: "you wash my hand, I wash yours."

Consultation takes place in about ninety-nine percent of reported cases of euthanasia and assisted suicide (to reiterate, only 41% of cases are reported). It is estimated that consultation takes place in 37% of unreported cases. In 88% of the cases the consultant had also seen the patient.[36] Physicians mainly consult colleagues of their own specialty. Recent research shows that familiarity and accessibility are very important factors in the choice of the consultant. Half of the physicians who had been consultants more than once had previously been consulted by the same physician who consulted them in their most recent case. In 24% of these cases, the treating physician and the consultant had previously acted as consultants for each other. Physicians who previously consulted or had been consulted by the same physician agreed more often with the intended euthanasia or assisted-suicide than physicians who did not (90% versus 80%).[37]

The interviews revealed sharply contrasting and contradictory opinions on this matter of consultation. I suspect that not all of the interviewees were completely candid in their answers, possibly because they were "protecting the system" and viewed me with suspicion as a "foreigner."

My first interviewee, John Griffiths, a law professor at the University of Groningen and one of the authors of a leading study in the field of euthanasia in the Netherlands, said the physician is supposed to discuss the matter with the patient's family and in his opinion should be required to explain in writing if he/she did not. If the patient does not wish the family to be included in the deliberations, the doctor should be required to have the patient put that refusal in writing. According to current Dutch law, the nursing staff should be included in the euthanasia discussions. In cases of euthanasia performed at the patient's home, the patient usually has home nursing care, and the on-site nurse should be included in the decision making process. As for the requirement to consult another doctor, Griffiths acknowledges that there are problems in the consultations of doctors with their colleagues. In rural areas it can be difficult to get hold of a colleague, especially an "independent" doctor, since doctors in rural areas are often members of the same substitution group. In Griffiths' opinion, the consultation requirement should be adhered to more strictly than now appears to be the case, although the complexities of concrete situations require a rule that can be applied in a flexible and casuistic way, something that is difficult in the context of criminal enforcement. Currently the courts are rather lenient with doctors who do not comply, but the regional

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[36]Bregje D. Onwuteaka-Philipsen, et al., *Consultants in Cases of Intended Euthanasia or Assisted Suicide in the Netherlands*, 170 MED. J. AUSTRALIA 360, 360-63 (1999).

[37]*Id.*

assessment committees seem to be trying to give the requirement more teeth.[38] In this context, Cuperus-Bosma *et al* examined the Minutes of the Assembly of Prosecutors General and note that if all requirements for accepted practice were met, except consultation, the physician was not prosecuted but the case was usually referred to the Health Inspector. But if there were doubts about other requirements for accepted practice being met, an inquest was held.[39]

Furthermore, according to Griffiths, some of the prosecuted cases involved a doctor who consulted another doctor, and then the consulted doctor performed the euthanasia, not the *first* doctor who asked for the consultation. The Guidelines say, however, that the physician who first recommended euthanasia, not the consulted doctor, should perform the euthanasia. When this "role reversal" occurs, the case is not reported for fear of prosecution. Griffiths added that it is wrong to suppose that all unreported cases are unjustified.

Griffiths estimated that 10% of physicians in the Netherlands oppose the practice of euthanasia on principle, and a further 6% would not perform euthanasia themselves, but refer patients who ask for it to another doctor.[40] Griffiths further said that consultation on somatic cases is sometimes quite inadequate, being performed for example over the phone or by a busy specialist who stops by a hospital ward and notes on the patient's status sheet that he agrees with the attending physician. He argues that consultants should always see the patient, but the prosecution and the courts do not regard this as an absolute requirement. The Supreme Court should broaden the requirement of consultation in person to all patients, and not limit it to psychiatric patients only.

Sjef Gevers, Professor of Health Law at the University of Amsterdam, reiterated the latter points in Griffiths' testimony. Until 1995, consultants did not need to see the patient. The Dutch Medical Association Euthanasia Guidelines of 1995 changed the picture, saying that the consultant needs to be an independent colleague, not part of the doctor's group and must talk with the patient himself and be

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[38]Henri Wijsbek reiterated this point of lenient courts saying he did not know of any prosecutions for lack of consultation, and that the duty to consult should be "observed and complied [with] closely." Leenen, on the other hand, wrote that it is incorrect to say that the courts are very lenient toward lack of consultation. Letter from Prof. H.J.A. Leenan (formerly Medical Faculty and Faculty of Law, University of Amsterdam) to author (July 25, 2000) (on file with author). But it is clear from the *Chabot* case, *see* note 5, *supra* and accompanying text, that the courts do not regard consultation (except in cases of non-somatic suffering) as an absolute requirement.

[39]Jacqueline M. Cuperus-Bosma, et al., *Physician-Assisted Death: Policy-Making by the Assembly of Prosecutors General in the Netherlands*, 4 EUR. J. HEALTH L. 225, 232 (1997).

[40]In his book, Griffiths writes that twelve percent of Dutch doctors are unwilling to perform euthanasia on principle and that most of them would refer a patient requesting it to another doctor. *See* GRIFFITHS, ET AL., *supra* note 2, at 253. According to Van der Maas *et al.*, 9% of all physicians would never perform euthanasia and assisted suicide but would refer patients seeking it to another physician. Three percent would never perform the practices or refer patients. *Cf.* Paul J. van der Maas, et al., *supra* note 23, at 1702.

informed of the patient's medical situation. Consultation over the phone or by looking at the patient's file is insufficient. The courts, however, do not insist that the consultant see the patient. Following the *Chabot* precedent, only in psychiatric cases is consultation required in person.

Several interviewees[41] explained that in hospitals the general practice is to consult the whole medical team, including nurses, not just another physician. Thus in hospitals consultants always see the patients; examining their medical files is conceived insufficient. In nursing homes, the standard procedure is to invite a consultant from another nursing home. As for GPs, many physicians have a trusted colleague whom they always consult in euthanasia cases. It was noted that it is important that the consultant not be from the GP's medical team or someone who fills in for the doctor on weekends. But often GPs consult colleagues on their own team. The consultant is perceived to be independent because he or she is not directly involved with the patient, but of course that is not total independence from the perspective of the best interest of the patient. The common view is that the physician needs to hear and see the patient, examine him, feel him, listen to what the patient wants. There were incidents, however, when consultation was done over the phone without seeing the patient. The interviewees emphasized that consultation might be a problem in small villages, where the GP may have to travel a relatively long distance to get an independent consultant, and that insisting on the consultant's independence is important in all euthanasia cases.[42]

On the other hand, Ron Berghmans, a bioethicist from Maastricht, and A. van Dantzig, a well-known psychiatrist, do not think that finding an independent doctor is a major problem. The Netherlands is a small country, and it is possible to find a consulting doctor who does not belong to the same medical team. Berghmans thinks the GP and the consultant might have other shared interests, but that they would not compromise the independence requirement. With regard to consultation over the phone, Berghmans contends that in the past too much respect was granted to maintaining privacy in physician-patient relationships, even to the ex-

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[41] Prof. Bert Thijs, Medical Intensive Care Unit, V.U. Hospital, Amsterdam (July 20, 1999); Dr. Rob Houtepen, Health Ethics and Philosophy, Maastricht University (Aug. 11, 1999); Arie van der Arend, Health Ethics and Philosophy, Maastricht University (July 26, 1999); Dr. Jaap Visser, Ministry of Health, Dep't of Medical Ethics, The Hague (Amsterdam, July 21, 1999); Prof. Ruud ter Meulen, Director, Institute for Bioethics and Professor, University of Maastricht (Aug. 11, 1999); and Prof. Henk Jochemsen, Lindeboom Institute (Ede Wageningen, July 27, 1999) (notes on file with author).

[42] Leenen maintained that consultation might be a problem in small villages. But in May 1999, following "Support and Consultation of Euthansaia in Amsterdam" (SCEA), *see* note 62, *infra* and accompanying text, the government initiated the organization of consultation teams all over the country. Consultants will travel to small villages to examine medical files and see patients. Hospital specialists are required to examine the files. The scheme is not fully worked out yet, and time will tell to what extent it will succeed, but Leenen thinks the consultation mechanism has gradually improved.

tent of allowing consultation over the phone. This picture is now changing, and the new law requires that the consultant see the patient.

Paul van der Maas, the principal investigator of the 1990 and 1995 studies on euthanasia, explains that "real consultation" means consultation with a colleague who is an expert in the field and who is able to verify that there are no available alternatives for treatment. The consultant should also verify that the patient really wants euthanasia, and that the decision–making process did not involve problems of transference and counter-transference between doctor and patient.[43] Van der Maas maintains that he and his team train consultants to see the patient and examine his condition first hand. Similarly, Van Dantzig argues that consultation involves seeing the patient, determining the motive for the will to die, and exploring avenues of treatment. Seeing the patient is required to verify that euthanasia is the only solution, and the most desirable solution.

Koerselman, another well-known psychiatrist who opposes the practice of euthanasia, was consulted in the past and objected to the practice. He testified that he felt pressure from his colleagues to sign the documents approving the euthanasia decision. At some point, his colleagues gave up on him and stopped consulting him. Now he is no longer consulted. Koerselman offered to serve as an expert witness in one court trial, but the court was not interested in hearing his expert testimony.

I asked how much time is needed for consultation. Van der Arend, a nurse and bioethicist from Maastricht, thought that a totally independent physician is unable to evaluate the condition of the patient within the customary one-half hour or hour of consultation. Ideally, the consulting physician should meet the patient several times. If there is only one short meeting, there may be a lack of communication. Van der Arend advised having three different meetings before the consultant writes the report.

George Beusmans and Gerrit Kimsma, who practice euthanasia, do not share this view. According to Beusmans, after several meetings with the patient, he asks for the patient's request for euthanasia in writing. At a certain moment, when the patient says: "I can't deal with the suffering, you can do it," Beusmans asks: "When?" This discussion takes place when the patient is in the final phase of life, having only about two weeks left. When the patient insists that he wants euthanasia, Beusmans arranges for a colleague to come and see the patient. At this stage, Beusmans also contacts a pharmacy to arrange for the lethal drugs. The colleague is a General Practitioner with whom Beusmans does not work. Beusmans has two colleagues with whom he cooperates on euthanasia matters, and these two colleagues also ask

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[43]Freud recognized that doctors' unconscious emotional responses may have an impact on their relations with patients. Counter-transference has been defined in the psychoanalytic literature as the emotional reactions in the therapist engendered by the patient. *Cf.* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 147 (1984).

Beusmans to serve as a consultant for their euthanasia cases. The consultant will see the patient, speak with him, and decide whether it is necessary to perform euthanasia. The consultant usually signs the papers after thirty minutes of conversation with the patient. Beusmans thinks thirty minutes is enough to verify that the patient qualifies for euthanasia.

Gerrit Kimsma who, *inter alia*, teaches at the department of Metamedicine at the Free University of Amsterdam, also insists that the consultant see the patient. He thinks one-half hour is enough when the consultant comes prepared with all the pertinent information. The consultant reads the patient's medical records, sees the patient, asks for the patient's view on his condition, and checks whether the patient knows why the consultant came. The consultant needs to see that the patient is of sound mind and is requesting euthanasia without pressure. He is required to verify that the Guidelines have been fulfilled and that Kimsma's approval of the euthanasia decision was correct.

Kimsma testifies that he consults an independent colleague for whom he covers during the weekends. In his opinion, the independence requirement is not compromised because the main concerns are to examine the issues of transference and counter–transference, and to determine that the GP has arrived at the euthanasia decision without pressure and without identifying with the patient to the point of obscuring his own medical judgment.

My interviews also included a meeting with the De Boer family who experienced the euthanasia decision–making process. K was a cancer patient who knew that death was inevitable. He could not adequately digest food and was very weak; he suffered great pain and consumed large doses of pain medication. K felt that his life had no quality and filled out the papers he had obtained from the Voluntary Euthanasia Society, in which he expressed a will to die. He reiterated his request to his personal doctor and at a later stage entered into a state of unawareness for a few days. The meeting with the consultant to approve the GP's decision was scheduled ahead of time, and on that day the consultant arrived an hour after K woke up. K was in a good mood and did not believe that he had slept for four days. The GP told K that he had arrived to discuss K's euthanasia decision, and K stated he did not believe the situation was that bad; he thought his family and the physicians had made this up. The consultant talked with K about euthanasia, but K found it difficult to comprehend why the consultant wanted to discuss euthanasia with him since he had had such a good sleep and was feeling quite happy. Clearly, the family testified, K was not ready for euthanasia though K still backed his euthanasia decision. I asked what the consultant decided after this confusing episode and was told that the consultant arrived again later and confirmed the decision for euthanasia.

Though I felt that K's family acted sincerely in a *bona fide* manner, this episode is disturbing and demonstrates the intricacy of this issue. It is unclear why the GP and the consultant arrived that day. If K had been unconscious for four days, the GP should have been aware of this. Surely, the consultant could not fulfill his responsi-

bility if the patient was unaware and unable to communicate. The consultant here was not satisfied by the first visit, during which the patient clearly wanted to live, and felt an obligation to visit the patient again. Additionally, it must have been quite a blow for K to see his beloved family and the physicians, including his trusted GP, around his bed discussing his mercy killing at a time when he felt well.

Bert Keizer tells the disturbing story of a cancer patient who arranged to end her life, but during the last days became increasingly muddled. On the evening of her death, when she heard the doorbell, she let the doctor in, greeting him with some bewilderment: "And what brings you here tonight, doctor?" The doctor and the other people present at her home refreshed her memory and later that evening the patient did take her dose. Before the doctor left he asked the patient's daughter: "This is what Mother wanted, isn't it?"[44]

Many interviewees spoke about the new "Support and Consultation of Euthanasia in Amsterdam" (SCEA) project that began in Amsterdam and became a Dutch project.[45] In 1997, the SCEA project was initiated to provide all GPs working in Amsterdam with a support group of about twenty especially trained GPs for consultation or advice on euthanasia and PAS. The purpose was not only to make it easier for GPs to find an independent and knowledgeable consultant, but also to make the consultation more professional.[46] Physicians were required to contact SCEA consultants before they performed euthanasia, in order to make consultation as accurate as possible. Van der Wal, one of the principal investigators of the 1995 study, said that most doctors did not like the idea that they did not select the doctor themselves, especially as long as euthanasia was officially illegal. They preferred to consult with someone they knew. Gerrit Kimsma saw no problem in choosing the consultant himself or, for that matter, in allowing every GP to choose his/her consultant. He said that there was good faith among physicians.

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[44]BERT KEIZER, DANCING WITH MISTER D 117 (London, Black Swan 1997).

[45]Interviews with Prof. Evert van Leeuwen, Dep't of Metamedicine, Free University of Amsterdam (July 19, 1999); Prof. John Griffiths, Dep't of Legal Theory, Faculty of Law, University of Groningen (July 16, 1999); Prof. J.K. Gevers, Prof. of Health Law, University of Amsterdam (July 19, 1999); Dr. Dick Willems, Institute for Research in Extramural Medicine, Dep't of Social Medicine, Amsterdam (July 20, 1999); Prof. Gerrit van der Wal, Institute for Research in Extramural Medicine, Dep't of Social Medicine, Free University of Amsterdam (July 21, 1999); Dr. Jaap Visser, Ministry of Health, Dep't of Medical Ethics, The Hague (Amsterdam, July 21, 1999); H.J.J. Leenen, former Prof. of Social Medicine and Health Law, Medical Faculty and Faculty of Law, University of Amsterdam (July 21, 1999); Prof. Henk Jochemsen, Lindeboom Institute (Ede Wageningen, July 27, 1999); Dr. Gerrit Kimsma, Dep't of Metamedicine, Free University of Amsterdam (Koog 'aan de Zaan, July 28, 1999); Prof. Paul van der Maas, Dep't of Public Health, Faculty of Medicine, Erasmus University, Rotterdam (Amsterdam, July 29, 1999); Prof. Govert den Hartogh, Faculty of Philosophy, University of Amsterdam (Aug. 10, 1999); and Dr. Johannes van Delden, Senior Researcher, Center for Bioethics and Health Law, Utrecht University (Aug. 10, 1999).

[46]Bregje Onwuteaka-Philipsen, *supra* note 35, at 91.

Four of the interviewees (Van Leeuwen, Kimsma, Van Delden and Den Hartogh) are members of the newly established regional committees whose role is to review euthanasia cases and see that the rules of carefulness are observed. Evert van Leeuwen, chairperson of the medical ethics department at the Free University of Amsterdam, testified that his committee did not review even one incident of consultation conducted over the phone. He thinks it is essential for the consultant to see the patient, to verify that he or she is competent and acting upon free will, and to review the patient's medical condition, by both physical examination and also examination of the medical files. The consultant usually spends thirty minutes with the patient during which he or she verifies that the patient wishes to die and that the medical condition is hopeless. Van Leeuwen thinks half an hour is sufficient for the purpose of consultation.

Govert den Hartogh, a respected philosopher from Amsterdam, explains that doctors who do not consult a colleague do not report to the Regional Committee. The Royal Dutch Medical Association (KNMG) advises consultants to see the patients, and the consultants have adhered to this requirement. The reports he reviewed said the consultation lasted one to two hours, but Den Hartogh testified that he was unsure about this. He is certain that the time for consultation is often shorter, especially in hospitals.

The consultant should not be involved in the treatment of the patient. S/he is required to visit the patient to determine that the request is voluntary and that the patient is helplessly suffering. Den Hartogh maintained that doctors in some islands in the south might find it difficult to find a consultant. In his comments on the first draft he wrote that in August 2000 his committee reviewed a case of a doctor from one of those southern islands with an orthodox Protestant majority, in which the doctor had consulted his own associated partner. The physician explained that he had tried to find another consultant but had not been able to find one. So this occurs, although probably rarely.[47]

Den Hartogh further wrote in his comments that one unfortunate side-effect of the fact that the rules for justifiable euthanasia are court-made and rely on the defense of necessity, is that the matter of consultation for some time has not been given sufficient attention. As a result of KNMG-policy and of the growing involvement of the government in the assessment of acts of euthanasia and assisted suicide, this matter has gradually been improved. In hospitals the report is often nothing but a short written note on the patient's state. But there is evidence that the SCEA project, which later became national and is now called SCEN, already has had good effects on the quality of both consulting and reporting. Den Hartogh believes that the training of SCEN consultants and of doctors generally will be far more effective in shaping the Dutch practice than any possible form of legal regulation.

[47]Written comments from Govert den Hartogh to author (Aug. 27, 2000) (on file with author).

Since the installation of the review committees, the requirement is that the consultant should be independent, that he/she should see the patient in person, and consider both the character of the request and the nature of the suffering. Den Hartogh clarifies that that doesn't mean that a doctor who failed to consult a colleague at all, or failed to consult an independent one, could not appeal to necessity. He/she can make that appeal even when the new law has formalized the new requirement.[48]

Johannes van Delden from Utrecht, a member of the 1990 inquiry team into the medical practice concerning euthanasia appointed by the Dutch government, holds that the consultant should see the patient for one hour after examining the patient's medical files and speaking with the GP, inquiring whether the doctor tried other medical alternatives prior to the euthanasia decision. The consultant is required to explain his reasoning; simply writing "I agree" on the form is insufficient. Van Delden's committee asks for detailed explanations. The role of the committee is also educational, explaining that the reports should be informative.[49] According to Van Delden's testimony, there was only one incident in hundreds of cases reviewed by his committee in which the GP consulted a colleague over the phone. The committee reported the case to the medical inspector. Van Delden does not think there is any problem with consultation in rural areas. Most doctors are willing to be involved in the practice of euthanasia, and it is not difficult to find an independent doctor.

Contrary to the testimonies of many medical and legal ethicists,[50] Dick Willems, a member of the 1995 inquiry team on euthanasia, argues that the KNMG 1995 directives prescribe that the consultant must see the patient *or* the files. He knows of cases in which consultation was done over the phone. The psychiatric guidelines are more detailed than the other medical guidelines because there are more doubts about the patient's competence and because psychiatrists might identify too much with their patients. Willems himself thinks that the consultant should see the patients. Like some of the other interviewees,[51] he opposes the practice of looking at

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[48] *Id.*

[49] As a nurse, Van der Arend is dissatisfied that nurses are not represented on the committees. In his mind, it would be better to have a balance of ideas before making the euthanasia decision by including nurses and independent physicians, and by following the rules of carefulness in detail.

[50] *Cf.* discussion of opinions of Prof. J.K. Gevers, Prof. of Health Law, University of Amsterdam (July 19, 1999); Prof. Govert den Hartogh, Faculty of Philosophy, University of Amsterdam (Aug. 10, 1999); Dr. Johannes J.M. van Delden, Senior Researcher, Center for Biotheics and Health Law, Utrecht University (Aug. 10, 1999); Dr. Jaap J.F. Visser, Ministry of Health, Dep't of Medical Ethics, The Hague (Amsterdam, July 21, 1999) as well as Prof. H.J.J. Leenen, former Prof. of Social Medicine and Health Law, Medical Faculty and Faculty of Law, University of Amsterdam (July 21, 1999) and Prof. Henk Jochemsen, Lindeboom Institute (Ede Wageningen, July 27, 1999).

[51] Prof. Evert van Leeuwen, Dep't of Metamedicine, Free University of Amsterdam (July 19, 1999); Prof. John Griffiths, Dep't of Legal Theory, Faculty of Law, University of Groningen (July 16, 1999);

the medical files in lieu of examining the patient. Willems explains that the consideration of unbearable suffering is first and foremost on his mind, and physicians cannot verify that by looking only at the files. With regard to consultation in small villages in rural areas, Willems thinks doctors usually consult the physician next door. It is difficult for them to find someone who is totally independent as required.

Margo Trappenburg, a political scientist who published works on public perspectives on euthanasia, spoke of Sippe Schat, a physician who was viewed as "a god in his village," who did not consult colleagues, and who did everything alone without consultation. Eventually he was prosecuted and found guilty for not consulting a colleague prior to performing euthanasia (District Court, Leeuwarden, April 8, 1997).[52]

Egbert Schroten, Director of the Center for Bioethics and Health Law at Utrecht University, said that—to the best of his knowledge—most doctors consult their colleagues, and at least until the early 1990s the consultation was done over the phone. When I asked whether this is sufficient to warrant euthanasia, Schroten answered that doctors apparently think they can approve euthanasia without seeing the patients, believing they have enough information to decide the matter. Schroten, like many of my interviewees, did not seem too concerned.

These testimonies are alarming. I question whether it is possible to conduct a reliable consultation over the phone. It should be obligatory to see the patient, to examine him or her, to confirm that the patient freely wishes euthanasia, and that all options for treatment were exhausted before resorting to medical killing. At first I was astonished by the interviewees' relaxed tone while speaking about consultation by telephone. In turn, they were somewhat surprised to see my alarm.

H.J.J. Leenen, an emeritus law professor from the University of Amsterdam, does not agree. He explains that during the 1980s, consultation was often conducted over the phone. Euthanasia was regarded as any other medical practice. Leading decision makers and policy consultants, among them Leenen himself, said that euthanasia was, is and should remain an exception. As a result, a view emerged

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J.K. Gevers, Prof. of Health Law, University of Amsterdam (July 19, 1999); Prof. Bert Thijs, Medical Intensive Care Unit, V.U. Hospital, Amsterdam (July 20, 1999); Dr. Rob Houtepen, Health Ethics and Philosophy, Maastricht University (Aug. 11, 1999); Henk Jochemsen, Prof., Lindeboom Institute (Ede Wageningen, July 27, 1999); Dr. Arie J.G. van der Arend, Health Ethics and Philosophy, Maastricht University (July 26, 1999); Prof. Govert den Hartogh, Faculty of Philosophy, University of Amsterdam (Aug. 10, 1999); Dr. Johannes J.M. van Delden, Senior Researcher, Center for Bioethics and Health Law, Utrecht University (Aug. 10, 1999); Dr. Jaap J.F. Visser, Ministry of Health, Dep't of Medical Ethics, The Hague (Amsterdam, July 21, 1999); and Prof. Paul van der Maas, Dep't of Public Health, Faculty of Medicine, Erasmus University, Rotterdam (Amsterdam, July 29, 1999).

[52]Griffiths *et al.* argue that the facts found by the District Court, involving multiple and serious failures to conform to the requirements of careful practice, seem to call for a serious medical disciplinary measure, perhaps revocation of the license to practice medicine. *See* GRIFFITHS, ET AL., *supra* note 2, at 293.

that euthanasia is not like other medical procedures which could be consulted about over the phone. Physicians now consult by looking at the medical files or by meeting patients in person. Although euthanasia is an exceptional medical procedure, Leenen does not think the consultant should always see the patient. In his view, consultation in person is often unnecessary, and he believes examination of the medical files is sufficient. Leenen does not agree with the KNMG 1995 directives that consultants see the patients, because most of those asking for euthansia are dying from cancer, and their evaluations can be done by reviewing their medical files. Many patients' families regard the consultation requirement as a bureaucratic stupidity, a redundant control mechanism. Leenen agrees that consultants need to see psychiatric patients, but feels there is no such need in what he terms to be "clear cases." He states that he trusts doctors and the experience he had working with doctors for the past twenty-five years has been positive: "Doctors are morally decent and competent people." Leenen criticizes them for not spending enough time with their patients, "but their intentions are good."

Heleen Dupuis, theologian and ethicist at the University of Leiden, contested the views of most of her colleagues. Unlike Leenen, she thinks the wish of the patient and his/her medical condition need to be confirmed by a second opinion; hence consultation in person is absolutely required. She was puzzled by my question and remarked that "Doctors want to help their patients, not to kill them." Doctors would jeopardize themselves by not consulting another doctor or compromise their duty by just sending the patient's medical files. Hence, consultation over the phone "is impossible." It is "not acceptable" and it "does not happen." As for the situation in rural areas, Dupuis asserted that those who request euthanasia are mainly cancer patients (who are examined by hospital doctors), and it doesn't occur often. The requirement of independent consultation is not compromised, and if there is no independent doctor, euthanasia is not performed.

Lack of Reporting

Next I asked about the worrisome data on the lack of reporting. The question was formulated as follows: Record-keeping of written requests for euthanasia has improved considerably since 1990; there are now written requests in about 60% and written record-keeping in some 85% of all cases of euthanasia. The reporting rate for euthanasia was eighteen percent in 1990, and by 1995 it had risen to 41%.[53] The trend is reassuring, but a situation in which less than half of all cases are reported is unacceptable from the point of effective control.[54] What do you think? I then added, how could the reporting rate be improved?

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[53]One referee noted that the percentage of cases of voluntary euthanasia and assisted suicide reported in 1990 is uncertain and might be 28%, not 18%.

[54]John Griffiths, Effective Regulation of Euthanasia and Other Medical Behavior that Shortens Life 10, 11 (Oct. 14, 1998) (unpublished manuscript on file with author); GRIFFITHS, ET AL., *supra* note 2 at 236-37.

Most interviewees are worried about the lack of reporting and would like to introduce changes to increase the level of reporting. John Griffiths thinks the criminal law on euthanasia is ineffective and that non-criminal control would be more appropriate.[55] Evidently, doctors do not report, and it is difficult to locate abuse. Griffiths thinks that a different system is needed. In his view, the only way to improve the situation is to leave the issue within the realm of the medical profession. Griffiths suggests a three-tier system: medical committees to review the euthanasia cases, plus medical inspectors, plus disciplinary committees. Instead of five regional committees, Griffiths suggests a low level of control in which each hospital would have its own review committee to examine the circumstances of death. What is needed is effective control of the "whole balloon," in Griffiths' terms. Griffiths explains that pressing the balloon on one side would increase it on the other side. The analogy being control of euthanasia might increase death as a result of pain relief and abstinence. Therefore, it is advisable to establish a committee in each hospital to review all cases of death and to refer questionable cases to medical disciplinary committees.[56]

Similarly, Bert Thijs who directs the Intensive Care Unit, V.U. Hospital in Amsterdam, and Dick Willems think the reporting rate will be improved if the threat of prosecution is lessened. They hope the introduction of the regional committees will improve the reporting rate, because the committees are closer to the medical profession and don't have legal authority. Previously, all cases went to the public prosecutor, but now the committees serve as a buffer. The role of the public prosecution will decrease.[57] Another means to improve reporting is medical education. Ending of life should be discussed more in medical schools and in society at large. Thijs and Willems believe in increasing social control through education and communication.

Some interviewees think that *the* major problem in the practice of euthanasia in the Netherlands is low level of reporting.[58] They said that 41% of reporting is

[55]In his comments on the first draft of this article, Griffiths denied saying that the criminal law is "ineffective." He wrote: "I do not regard it as perfect, the imperfections are a matter of concern, and something should be done about them. As a matter of fact, something is being done: unlike other countries, the Dutch are continually working on the adequacy of control of this sort of intrinsically dangerous medical behavior." Personal communication with Prof. John Griffiths, Dep't of Legal Theory, Faculty of Law, University of Groningen (GRONINGEN, July 10, 2000).

[56]For elaborated discussion, *see* GRIFFITHS, ET AL., *supra* note 5, chap. 6.

[57]*Cf.* Jacqueline M. Cuperus-Bosma, et al., *Assessment of Physician-Assisted Death by Members of the Public Prosecution in the Netherlands*, 25 J. MED. ETHICS 8, 8-15 (1999).

[58]Sjef Gevers, Prof. of Health Law, University of Amsterdam (July 19, 1999); Dr. Rob Houtepen, Health Ethics and Philosophy, Maastricht University (Aug. 11, 1999); Prof. Ruud ter Meulen, Director, Institute for Bioethics and Professor, University of Maastricht (Aug. 11, 1999); Dr. Margo Trappenburg, Dep't of Political Science, University of Leiden (July 22, 1999); Dr. Ron Berghmans, Institute for Bioethics, Maastricht University (Aug. 11, 1999); Prof. H.J.J. Leenen, former Prof. of Social Medicine and Health Law, Medical Faculty and Faculty of Law, University of Amsterdam (July 21, 1999); and Prof. Egbert Schroten, Director, Center for Bioethics and Health Law, Utrecht University (Aug. 5, 1999).

unacceptable. Several explanations for this finding were given: (1) euthanasia was under the Penal Code and doctors feared possible prosecution; (2) preference of secrecy, as part of doctor-patient relationship (physicians wish to maintain trust between them and their patients and feel euthanasia is a private matter); (3) laziness on the part of doctors who wish to avoid the paper work; and (4) many physicians are also willing to lie at the patient's/family's request or for their own personal reasons.[59]

While trusting doctors, the view is that doctors need to report because euthanasia should never become a routine action. Euthanasia should be considered an extraordinary measure to be employed in extraordinary circumstances. Doctors should discuss their conduct in the open and expose the practice of euthanasia to public scrutiny. Trappenburg, Van Leeuwen, Gevers, Schroten and Wijsbek emphasized that doctors need not worry if they follow the Guidelines. They think that the new proposal—to report to the regional committees—might bring some improvement.

G.F. Koerselman does not share the optimism of others[60] about the positive role of the regional committees. He thinks the regional committees would not change much. He believes the organization is secondary, and it is the value system that is important. At this point, almost no one contests the vital policy decisions that were made. Koerselman added that even if the regional committees improve the level of reporting, a change in the climate is what is really needed.

Henk Jochemsen, medical ethicist and Director of the Professor Lindeboom Institute, thinks the regional committees might improve the level of reporting, but like Koerselman he does not think this is the real issue. Physicians are now more aware of the Guidelines, there is more pressure on them to report, and we can assume this pressure will continue. Jochemsen's impression is that the committees are and will continue to be tolerant of the physicians. The committees also educate physicians on the proper performance of euthanasia, and in his view, this will help to make euthanasia even more a part of society. Similarly, Chris Rutenfrans, a journalist at *Trouw*, does not see great importance in the regional committees since they

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[59]I should note that Van der Maas and his colleagues stated that after performing euthanasia and assisted suicide, three quarters of the general practitioners and about two thirds of the specialists reported "natural death" in the declaration of death. The most important reasons for falsely declaring natural death were: the "fuss" of a legal investigation (55%), fear of prosecution (25%), the desire to safeguard relatives from judicial inquiry (52%) and bad experiences in the past with stating non-natural death (12%). P.J. VAN DER MAAS, ET AL., *supra* note 7, at 46-48. *See also* Gerrit van der Wal, *et al.*, *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706, 1707 (1996); Martien Tom Muller, Death on Request 73 (Amsterdam, Vrije Universiteit, 1996) (unpublished doctoral thesis on file at Vrije Universiteit Library).

[60]Most notably of Schroten and Trappenburg, *supra* note 58, Thijs and Van Leeuwen, *supra* note 51, Gevers, *supra* note 50, Dr. Henri Wijsbek, Dep't of Medical Ethics, Erasmus University of Rotterdam (July 23, 1999); and Dr. Dick Willems, Institute for Research in Extramural Medicine, Dep't of Social Medicine, Amsterdam (July 20, 1999).

receive only the politically correct cases, those performed according to the Guidelines. There are many more cases in which the doctors do not follow the Guidelines and do not report to the committees. Rutenfrans thinks the level of under-reporting is quite high.

Van der Arend would be surprised if the regional committees will substantially increase the level of reporting. He expects the level of reporting by the end of the year 2000 to be around 50%. He thinks the committees will generate more paper work, with meager substantive positive results and will not change the GP's inclination not to report euthanasia cases.

Many of the interviewees found it necessary to call other countries into their conversation, always with the purpose of apologetically arguing that the situation in the Netherlands is no worse than those countries. The same line of apologetic tone can be found in Dutch publications authored by scientists who fundamentally agree with the policy of euthanasia. Consider, for instance, the following concluding statement of an article compiling a very brief sketch of reports about incidence of euthanasia, assisted suicide and "actions intended to hasten a patient's death" in the Netherlands, Australia, the UK, the US, Denmark and Norway:

> the conclusion is that EAS [euthanasia and assisted suicide] is occurring in medical care at the end of life in all countries studied.... Most worldwide surveys on incidence of EAS show lower figures than those reported in the Netherlands, where there is a lenient policy for prudent practice. Yet, in the Netherlands the actual incidence of EAS is lower than the number of requests received; more requests are refused than granted.[61]

H.J.J. Leenen, a noted jurist who has been instrumental in his efforts to change the penal code so as to permit voluntary euthanasia, said that outside the Netherlands no one reports. Doctors perform euthanasia and the act is reported as a normal, natural death. If the Dutch want to conduct euthanasia in the open, it should be adequately controlled and the reporting needs to be full and complete. The Royal Dutch Medical Association accepted the new law proposal, which Leenen helped to formulate, stating that a physician who performs euthanasia but does not report it will be prosecuted for murder.

Although Leenen is skeptical about the work of the committees, he still thinks the number of reports is on the increase. He mentioned the SCEA project. According to Leenen's estimate, seventy percent of the Amsterdam cases were reported in 1999. Physicians know they will not be prosecuted if they follow the Guidelines. In this context I should mention that Jaap Visser of the Health Ministry also thinks there is an improvement in the level of reporting. He estimates, however, that only 55-60% of the euthanasia cases is now reported.

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[61]Martien T. Muller, et al., *Euthanasia and Assisted Suicide: Facts, Figures and Fancies with Special Regard to Old Age*, 13 DRUGS & AGING 190, 190 (1998).

Evert van Leeuwen and Govert den Hartogh provided insight about the regional committee of which they are members whose role is to examine whether the physicians observe the rules of carefulness, including reporting. Because so many interviewees feel these committees play a positive role in the policy and practice of euthanasia, let me say something about them. In November 1997, the Secretaries of Justice and of Healthcare, Well Being and Sports, published their intention to inaugurate five regional committees to supervise physicians in actively ending the lives of their patients. These committees have been functioning since December 1998 and evaluate retrospectively the reported cases of euthanasia and physician-assisted suicide. The committees' members are a physician, a lawyer and an ethicist, and their responsibility encompasses all cases where a voluntary request has been made by a competent patient. Cases of physician-assisted death without such a request are sent directly to the Office of the Prosecution. The primary goal of having regional committees is to evaluate the prudence of the practice of physician-assisted death, with the intent of public control of a highly sensitive medical practice and moral issue. The secondary goal is to increase the number of reported cases and thus make public control more effective.[62] Van Leeuwen explained that the KNMG thought there should be a control body between the law and the practice. Until the early 1990s, the police checked every incident of unnatural death. In some regions, the police arrived at both the home of the physician and the home of the patient; in other regions, the police arrived at the physician's home only. This was very disturbing, so those visits were stopped in the early 1990s.

Van Leeuwen, Den Hartogh and their colleagues go over the files and verify that the physician made a careful judgment according to the Guidelines. They assess the durable wish of the patient, the patient's willingness and suffering, the GP's consultation with a colleague, and the use of the proper drugs to perform euthanasia. The committee provides moral support to physicians who conduct euthanasia in a moral way.

Each month Van Leeuwen's committee examines fifty cases of euthanasia and physician-assisted suicide that took place in North Holland. In turn, Den Hartogh's committee reviews forty to fifty cases per month. Other regions have thirty-five cases on average. Each regional committee meets once a month, and each of the committee members reads all cases before the meeting. They try to reach a consensus on every case. If euthanasia has not been done according to the Guidelines, the committee asks the physician to provide clarification and more information. Each report should contain a declaration of will by the patient, the physician's report, a statement from the consultant, and the coroner's statement. Sometimes there is also a letter from the family.

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[62]Evert van Leeuwen & Gerrit Kimsma, *Problems Involved in the Moral Justification of Medical Assistance in Dying: Coming to Terms with Euthanasia and Physician Assisted Suicide*, in MEDICAL ETHICS AT THE DAWN OF THE 21ST CENTURY 151-73 (R. Cohen-Almagor, ed. 2000).

Van Leeuwen emphasizes that the committee is not a prosecutorial body. Its aim is to convince physicians to report. In his opinion, euthanasia is not only a medical act; it is an extraordinary act that physicians should report to the public. There are physicians, however, who think this is a private matter between themselves and their patients. The regional committees are trying to change this view. They also explain that if physicians perform euthanasia properly, there is no fear of prosecution. Members of the committees write letters to physicians, explaining the need for reporting and how they should perform euthanasia. But the letters are sent to physicians who report, not to those who don't. The committee gets their names from the files.

The committee's verdict on each euthanasia case goes to the District Attorney's (DA) Office, where the prosecutor checks whether the committee examined the case thoroughly. There have been a few cases in which the DA disagreed with the conclusion of Van Leeuwen's committee. Den Hartogh testified that there was no single case in which the prosecution overruled the decisions of his committee. Under the new law, the last word is given to the committees. Lawyers object to granting the committees the power to decide whether or not to prosecute because two-thirds of the committee members are not lawyers (each committee is comprised of one lawyer, one physician, and one ethicist). Van Leeuwen expects there to be discussions on this issue in parliament, and that this power will not be granted. He believes the parliament will seek a way for the DAs to retain their freedom to prosecute.

Most of the reported cases were cancer patients (95% of the cases reported to Den Hartogh's committee; 80-90% of the cases reported to Van Leeuwen's committee). Den Hartogh said that cancer patients are the accepted group for euthanasia and speculated that doctors might not report euthanasia of non-cancer patients because the committee might consider this conduct as unusual and, therefore, might ask the doctor questions. This is an interesting speculation. Is it the case that most euthanasia involves cancer patients, or that physicians who provided mercy killing to non-cancer patients did not report, and hence contributed indirectly to the data that associate euthanasia with cancer patients? This is a difficult and interesting question, which requires further empirical research and analysis.

Van Leeuwen's committee had reviewed some three hundred cases by the time of his interview, and in most of these cases the Guidelines had been observed. In a small number of cases, four to eight, the requests were very clear, the physicians could do nothing to help, and the patients were suffering, but were not on the verge of death; they still had four to six months to live. Van Leeuwen felt there were cases in which palliative care could have helped. This issue is something that still needs to be explored and developed. Indeed, patients who request euthanasia should be seen by palliative care experts before complying with their request. Govert den Hartogh testified that the problematic cases involved consultants who were not truly independent. Sometimes the patient did not form what Den Hartogh terms a

"categorical request" for euthanasia, or the practice was conducted too early. Nevertheless, the committee only "on occasion" asked physicians to clarify their actions, and only "rarely" concluded that the physician's action wasn't careful.

In his detailed comments on the first draft of this study, Den Hartogh elaborated his explanation by saying that the cases in which his committee asked for more information and/or clarification, were not cases in which the Guidelines had not been followed. Rather these were cases in which the information provided (by the doctor, the consultant or both) was insufficient to make a reliable judgment on the issue. Such questions were asked in 15-20% of the cases. Den Hartogh added that other committees did it less frequently. In 1 or 2% of the cases members of the committee were not satisfied with the replies and invited the doctor for an interview. In one case the committee decided after the interview that "the patient had not made a relevant request, so the committee was not competent to decide the case, and the report was sent to the public prosecutor." In three or four cases the committee had some doubts concerning the condition of unbearable suffering, "but having interviewed the doctor we finally decided that his action met the criteria." In three cases the committee found that the requirement of independent consultation had not been satisfied. In three cases the committee's final judgment was that the doctor had acted carefully on the whole, but that during the procedure some mistakes had been made, either by him/her or his/her colleagues, requiring the attention of the health care inspection agency.[63] These last cases have all been scrutinized by the public prosecutor, but this did not lead to actual prosecution. The committee never recommended prosecution; it only recommended investigation by the health care inspection agency.[64]

Sometimes the committee saw from the report that the request for euthanasia, the consultation with another doctor, and the act of euthanasia had been performed on the same day. Den Hartogh explained that this happened when the patient was suffocating and suffering severely. Ordinarily, this rapid decisionmaking should not take place. Nevertheless, these cases constituted, in Den Hartogh's view, "unavoidable exceptions."

Den Hartogh mentioned religion as a significant factor that might hinder reporting. In the orthodox Protestant communities, doctors are more reluctant to perform euthanasia. Some would refuse, and others would refer patients to another doctor. And those who are willing to perform it would do it secretly, and would fail to report. Den Hartogh said that when the regional committees were established he had hoped their existence might lead to improved reporting. This has not happened yet; however, it may occur in the future.

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[63]This is an agency, independent of the public prosecution. Its activities may lead to disciplinary law trials.

[64]Written correspondence from Prof. Govert den Hartog, Faculty of Philosophy, University of Amsterdam to author (Aug. 27, 2000) (on file with author).

Johannes van Delden is a member of a third regional committee. His response to my inquiry about his work was far more reserved. He said that almost all reported euthanasia cases "had something in writing," but he is "not allowed to say how many cases there were."[65] The documents, *inter alia*, clarified that the patient made the euthanasia request. Van Delden maintained it is too early to judge the regional committees' effectiveness. He explained that if the committees are too harsh on the doctors, they will not report. On the other hand, if the committees are too lenient, their work will have no real purpose. So the committees are required to preserve a delicate balance in their work. They tend to keep the process outside the realm of criminal law and to emphasize educating the doctors. If it appears that a doctor did not follow the Guidelines, discussions will be held with him or her and, if required, with the consultant as well, explaining what was lacking and how their practice of euthanasia should be improved.

George Beusmans, who practices euthanasia in Maastricht, revealed that his experience with reporting (which involved calling a coroner) was not very good. He explained that the practice of euthanasia is an intimate moment between himself and the patient's family; and when an intruder (the coroner) arrives, that intimacy is destroyed. When the patient has a family, he tells them it is not necessary to call a coroner. But Beusmans maintained that during the last few years he did call a coroner. Ten years ago, euthanasia was more the exception, but now it is practiced more often, and Beusmans has more experience now with euthanasia. He and his colleagues talk about it in their continuing education programs. Interestingly, Beusmans does not think the regional committees will make any difference.

Gerrit Kimsma, a bioethicist who also practices euthanasia in the Koog 'aan de Zaan area, said he did not report his first euthanasia case. He was convinced that he was doing the right thing and that the law lacked sensitivity. He claimed that his second case took place several years later and then he did report it. From then on Kimsma reported all his cases. He thinks physicians have a social role, with a professional obligation to society, hence the need to report. He believes it is unprofessional not to obey the Guidelines, and doctors should not fear prosecution if they conform. With regard to the regional committees, Kimsma is unsure whether they would increase the level of reporting. He testifies from his experience as a member of one regional committee that of three hundred to four hundred cases examined, there was only one case in which a physician was not careful enough in the euthanasia procedure.

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[65]In his comments on the first draft of this article Van Delden explained that his hesitation to disclose numbers at that point in time derived from the fact that these numbers were not public yet. He emphasized that he had "no inclination to hide anything." Written comments from Dr. Johannes J.M. van Delden, Senior Researcher, Center for Bioethics and Health Law, Utrecht University, to author (Aug. 4, 2000) (on file with author).

Van Dantzig and Heleen Dupuis were sympathetic about the physicians' lack of reporting. They both said that physicians performing euthanasia do not want to be bothered with filling out forms and waiting months to find out whether there would be prosecution. For this reason Van Dantzig is *worried about the need to report*. He regards the institution of the regional committees as an improvement, a preferred mechanism over the criminalizing of euthanasia. Dupuis exclaims that lack of reporting is the consequence of legal ambiguity. Physicians who feel their behavior was moral do not see why they need to comply with the bureaucracy. Van Dantzig and Heleen Dupuis think euthanasia should be in the realm of the medical practice, not of criminal law.

Conclusions

I came to the Netherlands with mixed feelings and left the same way, but with greater anxiety. The study shows that there is room for concern. Furthermore, it seems that the Dutch culture does not welcome a critical plurality of opinions regarding the legitimacy of euthanasia. Critics are regarded quite unfavorably.[66]

It was strange for me to discuss the issue of euthanasia in the Netherlands. Views that are extremely unpopular in other countries regarding euthanasia's place in society rule supreme in the Netherlands. These discussions were almost a mirror image of discussions I had in Israel, the United States, Britain, Canada and Australia. What was striking in my discussions with the Dutch experts was the prevailing acceptance of the euthanasia procedure. There were only a few dissenters, people who were willing to go against the system. My first fourteen interviewees were, on the whole, in favor of the policy, and I felt a growing unease encountering such unanimity of opinion. This conformity worried me. Plurality and diversity of opinion are good for society, leading to a more comprehensive understanding of the issues, as well as a higher level of truth, as John Stuart Mill used to say.[67]

A further concern is the way critics are treated in the Netherlands. The three dominant critical voices in the interviews, Koerselman, Rutenfrans and Jochemsen, complained about the atmosphere surrounding the policy and practice of euthanasia, and voiced their dissent against the institutional mechanisms that are used to de-legitimize them and undermine their position. Koerselman said that advocates

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[66]In his comments on the first draft of this study, Van Dantzig wrote that this assertion is fundamentally incorrect: "The whole of Dutch society is based on the cohabitation of people who fundamentally disagree on everything. The sometimes very creative solutions (soft drugs may not be bought by coffee shops, but their sale is not punished within certain limits) have given rise to the word 'poldermodel,' which expressly means living by compromise, or as I have once put it, the fair division of discontent. I write to you because such a fundamental misunderstanding may harm the quality of your paper." Written comments from Prof. A. van Dantzig, retired expert in pshychiatry (Amsterdam), to author (July 14, 2000) (on file with author).

[67]JOHN STUART MILL, UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT (London, J. M. Dent 1948) (Everyman's edition).

of euthanasia dismissed him as a Catholic fundamentalist. In fact, he is not a Catholic at all. He was brought up without any religious background, but his critics find it difficult to believe that a secular person would object to euthanasia with so much passion as Koerselman does. He also testified that he often felt treated like a clown. The media invited him to debate on euthanasia issues only because they needed to depict 'the other side,' not because they were really interested in exploring the anti-euthanasia arguments. Koerselman declared that he was fed up with this treatment and with the dismissive attitude that he received from scholars and colleagues.

Chris Rutenfrans, who used to teach at the Catholic University of Nijmegen and later in his life became a journalist, argued that it is bad for one's reputation to be against euthanasia in the Netherlands because it gives the appearance of being conservative, and it is not good to be conservative in the Netherlands. This is why Rutenfrans wants to disassociate himself from the subject and is inclined to write on other issues. In his view, the country is not very liberal, but rather is conformist in its liberalism. Its people do not want to hear ideas that clash with their liberal values.

Rutenfrans recounted that in 1986 he had co-authored a booklet against euthanasia, entitled *May the Doctor Kill,* with Caterina I. Dessaur, a novelist known under the pen name Andreas Burnier. This was a highly polemic, very controversial book. Rutenfrans maintained that Dessaur had been quite a famous novelist before publishing this book. After publication, Dessaur's consecutive novels were more harshly criticized than before, depicting her as a conservative reactionary. In effect, she was ostracized by the country's literary circles.[68]

Henk Jochemsen indicated that during the past twenty years, the general atmosphere has been in favor of euthanasia.[69] The mentality now is to stop treatment at an early stage when the patient is suffering. Quality of life has become the major principle at the expense of respect for life. Jochemsen claimed that physicians had told him about the difficulties they would face in finding a job in some institutions if they declared themselves to be opposed to euthanasia. The establishment view is pro-euthanasia, and one's professional advancement might be harmed if one takes a contrary view.

I found it troublesome that scholars and decisionmakers support a system that suffers from serious flaws while the stakes are very high; after all, we are deal-

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[68]For further deliberation, *see* HENDIN, *supra* note 1, at 105-107.

[69]A poll in 1996 showed that 84% of the population is in favor of euthanasia if a fellow human being is in an unacceptable and futureless situation. For further discussion, *see* The Voluntary Euthanasia Society, *The Debate*, <http://www.ves.org.uk/library/smook.htm>.

ing with life and death.[70] There were variants of opinion regarding specific questions and issues, but only a minority questioned the system *as such*. Many of the experts depicted a society in which it is the role of doctors to help patients. They didn't question the doctors' motives, and saw no reason why doctors would perform euthanasia without compelling reasons. They argued that, of course, criminals exist in every society, in every sphere of life, but policy is not built around this small number of criminals. They believed there is a need to install control mechanisms against the possibility of abuse, but that the system's rationale is good—to help people in their time of need. They emphasized that the two major reports of 1990 and 1995 indicate there is no slippery slope, yet ignored the fact that there is already too much abuse. Many of the interviewees failed to recognize that the system does not work because *all* the Guidelines, without exception, are broken time and time again.[71] It is not always the patient who makes the request for euthanasia or physician-assisted suicide. Often the doctor proposes euthanasia to his patient. Sometimes the family initiates the request. The voluntariness of the request is thus compromised. On occasion, the patient's request is not well considered. There were cases in which no request was made and patients were put to death. Furthermore, the patient's request is not always durable and persistent as required.

The Guidelines speak of "unbearable suffering," a term that evokes criticisms because it is open to interpretation.[72] Are dementia patients, for instance, suffering unbearably? Was Chabot's patient in an unbearable state of suffering?[73] The Guidelines require that doctors perform the euthanasia. There are cases in which nurses administered euthanasia. It is estimated that 10% of the nursing home physicians let the nurse or even the patient's members of family administer the euthanasia drug.[74] Before the doctor assists the patient the doctor must consult a second doc-

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[70]In his comments on the first draft of this essay, Griffiths reacted to this statement by writing: "Nowhere do you suggest that anywhere else there is a *better* system. The Dutch know about the system's defects and are working to improve it. Can you tell me about another country where that is true? In short, I think you need to think again, and a lot more carefully, about what you are writing about, before you can expect to be taken seriously." Written comments from Prof. John Griffiths, Dep't of Legal Theory, Faculty of Law, University of Groningen (July 10, 2000) (on file with author). Griffiths, it seems, finds a lot of comfort in comparative studies to the point of blurring his own careful thinking about the current situation in his country.

[71]In his remarks on the first draft of this study, Griffiths wrote that this assertion is "of course pretty silly." He asked: "Do you know of a single legal policy that 'works' 100%? The fact that the Guidelines are not yet effective *enough* does not mean they are having no effect at all. I would argue that the situation in the Netherlands is *much better* than elsewhere, that the difference is that here *we know* the extent to which control is not yet adequate." Written comments from Griffiths to author (July 10, 2000) (on file with author).

[72]For deliberation on the range of what "unbearable suffering" means, *see* CARLOS F. GOMEZ, REGULATING DEATH 99-104 (1991).

[73]*See* Griffiths' analysis in *Assisted Suicide in the Netherlands: The Chabot Case*, *supra* note 5, at 239-48.

[74]Martien Tom Muller, *supra* note 59, at 52.

tor. This Guideline has been breached many times. The doctor must keep a full written record of each and every case and report it to the prosecutorial authorities as a case of euthanasia or physician-assisted suicide, and not as a case of death by natural causes. This Guideline has also been violated very often.[75] Notwithstanding, many interviewees were quite content with the Guidelines.

Upon analyzing the interviewees' answers, we could group them accordingly:

1. People who believe that the option of euthanasia should be available for patients and are not willing to critically analyze the situation. They are avowed advocates of the system no matter what. This group includes A. van Dantzig[76] and Heleen Dupuis.

2. The majority of interviewees defend the practice despite its major flaws. Some of them work for government agencies and identify with the system. When the government commissions science, there is always a risk that the scientist will identify with the governmental policy to the point of compromising his or her critical capacity for impartial reflection. Other interviewees in this group are more critically open and think that some accommodations are needed, but that the system, on the whole, functions well. They think that euthanasia should be an option for patients in a liberal society and that, in any event, the Netherlands cannot go back. The public largely supports the policy and wishes it to be continued.[77] This group consists of Paul van der Maas, Gerrit van der Wal, H.J.J. Leenen, Johannes van Delden, Jaap Visser, Dick Willems, J.K. (Sjef) Gevers, Ron Berghmans, Bert Thijs, Henri Wijsbek, George Beusmans, Gerrit Kimsma, Margo Trappenburg, Egbert Schroten and Rob Houtepen.

3. There is a smaller group who recognize the flaws and would like to introduce changes, some of which are quite substantial: John Griffiths, Evert van Leeuwen, Govert den Hartogh, and Arie van der Arend. Like the two former groups, these people still support the practice.

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[75]For deliberation, *see* Jacqueline M. Cuperus-Bosma, et al., *Physician-Assisted Death: Policy-making by the Assembly of Prosecutors General in the Netherlands*, 4 EUR. J. HEALTH L. 225, 225-38 (1997).

[76]In his comments on the first draft, Van Dantzig wrote: "Please remove this, this is far from true." Written comments from Prof. A. van Dantzig, retired expert in psychiatry (Amsterdam) to author (July 8, 2000) (on file with author).

[77]The number of citizens who approve of euthanasia at the patient's explicit request grew from 40% in 1966 to over 60% (in some polls, almost 80%) in 1993. Likewise the number of opponents decreased steadily (21% in 1986, 17% in 1989, 12% in 1994). *Cf.* Joop van Holsteyn & Margo Trappenburg, *Citizens' Opinions on New Forms of Euthanasia: A Report from the Netherlands*, 35 PATIENT EDUC. & COUNSELING 63, 64 (1998). A 1998 poll indicated that 92% of the population supports the practice of euthanasia. *Cf. Dutch Might Legalize Euthanasia*, Associated Press (July 12, 1999), <http://dailynews.yahoo.com/headlines/ap/international/>.

4. Critics of euthanasia who would like to prohibit the practice are G.F. Koerselman, Henk Jochemsen[78] and Chris Rutenfrans.

5. Ruud ter Meulen, Director of the Institute for Bioethics and Professor at the University of Maastricht, Arko Oderwald who teaches at the Department of Metamedicine, Free University of Amsterdam, and James Kennedy who writes a book on the history of euthanasia in the Netherlands, recognize that the policy suffers from several serious flaws, some of which may not be correctable. They are struggling with the issue and have ambivalent views about the practice.

I was surprised during some of the discussions at the rosy pictures that were painted. I asked myself whether I was too cynical and suspicious, or my counterparts too optimistic; after all, they knew the situation in the Netherlands far better than I did. But the unanimity of opinion might suggest that there is not enough reflective thinking about this issue, that the practice of euthanasia is taken for granted;[79] therefore, there might be greater room for abuse because those who wish to abuse would find it easy to do so given this high level of trust and lack of critical investigation. Even issues that are acknowledged as problems are not conceived to be serious enough to press. The Dutch tend to argue and to accept highly troublesome contentions and to consider and allow euthanasia in cases where even the Guidelines are not satisfied. The surrounding culture around euthanasia makes the practice accessible within the confines of what is permissible. This culture has a chilling effect on open, critical debate.[80] In other parts of the world, under similar circumstances, in light of the justified critique, euthanasia would not be considered an option.

Some troubling questions have arisen as a result of my studying this Dutch phenomenon. The high number of unreported cases of euthanasia is alarming. The fact that some of the patients were put to death without prior consent is extremely worrisome. Society has to ensure ways that no abuse takes place and that the exist-

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[78]In his comments on the first draft, Jochemsen asked me to add that he does realize that in the present situation a simple reiteration of the prohibition would not improve the practice immediately. This would require a whole package of measures. Written comments from Prof. Henk Jochemsen, Lindeboom Institute (Ede Wageningen) to author (July 5, 2000) (on file with author).

[79]In his comments, Arie van der Arend contested my argument that there is not enough reflective thinking about euthanasia, arguing that (a) I cannot expect extensive and balanced reflective thinking during interviews that were taken from people who were busy with totally different tasks at that moment; (b) my study does not cover the extensive Dutch literature on the subject; (c) I did not interview one of the best 'reflective thinkers', Theo Beemer, Prof. of Moral Theology and Health Care Ethics, Catholic University of Nijmegen and (d) that such a value judgment could have been justified only after comparing the Dutch practice to the situation in other countries. Written comments from Dr. Arie J.G. van der Arend, Health Ethics and Philosophy, Maastricht University to author (July 3, 2000) (on file with author).

[80]Hendin reached a similar conclusion. *Cf.* HENDIN, *supra* note 1, at 100.

ing legal procedure does not open a window for abuse, or a way to get rid of 'unwanted' patients. More research should be done on what outside of the Netherlands is termed "passive euthanasia," the withholding or withdrawal of treatment. More attention should be given to demented patients, newborns and children. The Guidelines need to be clarified in detail, closing the door to possible misinterpretation that could lead to abuse.

I agree with most of the experts who contend that euthanasia should not be regarded as an integral part of the normal medical care. But the fact that many physicians do not wish to be bothered with the Guidelines is alarming. It shows that they have not internalized the idea that euthanasia is an exceptional medical procedure and, as such, requires social control. It is possible that the moral ambiguity surrounding the issue—allowing the practice while it was still prohibited under the Penal Code—made doctors feel that they had better conduct euthanasia in private, keeping it between the patients, their families and themselves only. The understanding of euthanasia and its importance should be changed for it to work without abusing the rules of carefulness.

I also think physicians should not suggest euthanasia to their patients as an option. By now, the Dutch people are fully aware that euthanasia is available. If patients wish, they can raise the issue themselves. Most of the euthanasia cases involve cancer patients, and at some time during the progressive course of their illness, they can take the initiative and discuss it with their physicians. If they don't, the physician can assume that the patient does not wish to have euthanasia.

I believe the medical profession should not turn its back on patients who clearly request to shorten their lives. But this issue should be open to a constant public debate. Wherever euthanasia is practiced, it should be subject to constructive criticism. It is preferable to draft a better legal framework than that of the Netherlands,[81] which was at the time of the interviews ambiguous and presented an illegal-yet-tolerated model. In the event a new euthanasia policy is introduced, and we see that it opens the way to abuse, then yet again we should pursue a public debate in which different sectors of society will take part. Respect for human life is and should remain the prime concern. Ending a human life without acquiring the patient's consent might be motivated by mercy—or, the motivation may be quite different. Because ending of patients' lives should be conducted in the light, not in shadowy areas where only selected people may enter, we should devise a better working framework to help patients in need.

On November 28, 2000, the Dutch parliament, by a vote of 104 for and forty against, made the Netherlands the first country in the world to legalize euthanasia. On April 11, 2001, the Senate also voted to legalize euthanasia by a majority of

[81] See R. COHEN-ALMAGOR, *A Circumscribed Plea for Voluntary Physician-Assisted Suicide*, in MEDICAL ETHICS AT THE DAWN OF THE 21ST CENTURY 127-49, especially 140-44 (2000).

forty-six to twenty-eight.[82] The law is expected to become effective within the next few months. The new law will make it legal to end a patient's life, subject to the following criteria: the patient must be suffering unbearable and unremitting pain. The patient must make a sustained, informed and voluntary request for help to die. All other medical options must have been previously exhausted. A second medical opinion must be sought to confirm diagnosis and prognosis. The termination of life must then be carried out in a medically appropriate manner.[83]

Doctors will be immune from prosecution for helping a patient to die, as long as they follow this set of Guidelines. They will still report cases of voluntary euthanasia to the coroner and a regional panel, who can recommend prosecution leading to a prison sentence of up to twelve years if the Guidelines have not been followed.

This new bill, while not amending the safeguards under which doctors practice voluntary euthanasia in the Netherlands, did change the emphasis on who should prove guilt or innocence if the code of practice is breached. Previously, the onus was squarely on the doctors to prove that they had followed the Guidelines and were therefore innocent of any offence. But the new law shifts the responsibility for proving guilt to the regional panels.[84]

Before coming to the Netherlands I supported euthanasia and published some articles calling attention to the need for euthanasia (in the active sense that is practiced in the Netherlands).[85] After my visit I changed my view. I no longer support euthanasia and restrict my plea for helping patients in need to physician-assisted suicide. This is in order to enable patients to have control over their lives, and death, until the very last moment, and provide a further mechanism against abuse. At the same time, I am willing to concede the need for euthanasia in two circumstances: (1) the patient who asked for euthanasia is totally paralyzed, from head to toe, unable to move any muscles that could facilitate assisted suicide; and (2) the patient took a lethal dose of oral medication but death is protracted over several hours.

The majority of Dutch scholars do not share my view. They lump euthanasia and physician-assisted suicide together and even invented an acronym for this purpose: EAS. It should be noted, however, that in August 1995, in an effort to improve the control mechanisms the KNMG refined its Guidelines to recommend that assisted suicide rather than euthanasia should be performed whenever possible.[86]

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[82]Tony Sheldon, *Holland Decriminalises Voluntary Euthanasia*, 322 BRIT. MED. J. 947 (2001).

[83]*Dutch Parliament Votes to Legalize Euthanasia*, REUTERS, Nov. 28, 2000.

[84]<http://www.ves.org.uk/news/wld_archive.htm>.

[85]*Cf.* R. Cohen-Almagor, *The Patients' Right to Die in Dignity and the Role of Their Beloved People*, 4 ANN. REV. L. & ETHICS 213, 213-32 (1996); *Reflections on the Intriguing Issue of the Right to Die in Dignity*, 29 ISRAEL L. REV. 677, 677-701 (1995); *Autonomy, Life as an Intrinsic Value, and Death With Dignity*, 1 SCI. & ENGINEERING ETHICS 261, 261-72 (1995).

[86]*Cf.* HENDIN, *supra* note 1, at 122.

I believe that the right to die with dignity includes the right to live with dignity until the last minute and the right to part from life in a dignified manner. There are competent, adult patients who feel that the preferable way for them to part from life is through physician-assisted suicide.[87]

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[87]I explain my view point in detail in THE RIGHT TO DIE WITH DIGNITY: AN ARGUMENT IN ETHICS, MEDICINE, AND LAW (Rutgers University Press, 2001).