

Why the Netherlands?

Raphael Cohen-Almagor

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 the Dutch experience. Some claim that the Netherlands offers a model for the world to follow; others believe that the Netherlands represents danger, rather than promise, and that the Dutch experience is the definitive answer regarding why we should *not* make active euthanasia and physician-assisted suicide part of our lives.

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 essay commences by providing some background information on the practice of euthanasia and on the legal framework, and then reports the main answers to my first question: Why the Netherlands? What are the reasons that prompted the Dutch to adopt their policy? For limitations of space, I do not report all the answers to my questions. This I have done in my forthcoming book, *Euthanasia in the Netherlands*.

PRELIMINARIES

The Dutch understanding of euthanasia is said to be marked by its precision. Unlike other countries that distinguish between active and passive euthanasia, between direct and indirect euthanasia, and between voluntary and involuntary euthanasia, the Dutch definition of the term is exact: the intentional taking of someone's life at his or her explicit

request. According to the law, only a competent patient's request can be accepted. This has several consequences.

First, what is termed "euthanasia" in the Netherlands is called "active euthanasia" in other parts of the world. In the Dutch conception, euthanasia is by definition active and there is no need to specify the act by the term "active," as other countries do.

Second, all other kinds of end-of-life ("terminal") care bear other names. Thus, for instance, withdrawal of treatment is not considered euthanasia. Elsewhere it is termed "passive euthanasia." In the Netherlands, this term is deemed illogical and useless insofar as passive euthanasia is self-contradictory because it concerns the omission of treatment to which the patient has not consented.¹ Within the law, the difference between acting and refraining from acting has no particular relevance, and such a legal consideration takes precedence over the psychological experience of the difference. The prevailing Dutch perspective regards as futile any treatment that has no clear medical benefit for the patient. The argument is that no patient should be subjected to useless medical interventions and that these treatments should not be offered as an option to patients. In a leading test case, a Dutch court ruled that contrary to the wishes of the next of kin, a hospital was not obliged to return an 80-year-old cancer patient to intensive care when his condition was deteriorating.²

Third, unintended shortening of life in the course of treatment to abate suffering is viewed in the Dutch discussion as a physician's duty to alleviate pain. Some term this as "indirect euthanasia," and others see it as coming within the "double effect doctrine."³ The possibility that a seriously ill patient might die as a result of such treatment does not constitute euthanasia.

Fourth, the decision to end a life without an explicit request is legally not termed euthanasia. This is considered

Journal of Law, Medicine & Ethics, 30 (2002): 95–104.

© 2002 by the American Society of Law, Medicine & Ethics.

to be killing a person, even though some physicians would disagree. Involuntary euthanasia is regarded as a contradiction in terms.

Fifth, the distinction between euthanasia and physician-assisted suicide hardly figures in the Dutch discussion. Although assisted suicide is considered to be a crime by law and the distinction may be seen as morally relevant, no relevance has been attributed to this distinction in the actual medical context in the cases of euthanasia that have been brought to trial. In both practices, the physician has to meet the same substantive and procedural requirements.⁴ Many of my interviewees said that euthanasia and physician-assisted suicide are considered in the Netherlands as one and the same, implying the same responsibility for the physician.

THE PRACTICE OF EUTHANASIA

The three relevant categories of Dutch doctors who are involved in the practice of euthanasia are general practitioners, nursing-home doctors, and specialists. Every person in the Netherlands has a more or less permanent relationship with a general practitioner, who provides primary health care and is the point of entry for specialist care. General practitioners have the most extensive experience with euthanasia insofar as they discuss it most frequently with their patients, they receive two-thirds of all requests, and they are generally the most willing to perform it (about 90 percent of Dutch doctors have either practiced euthanasia or would be willing to do so).⁵ The level of experience with euthanasia among specialists is about half that of general practitioners (with 3 percent of all deaths in their practice attributable to euthanasia). By contrast, euthanasia plays a small role in the practice of nursing home doctors, who receive relatively few requests (only a fifth of them have ever honored one).⁶

The euthanasia guidelines of the Royal Dutch Medical Association speak of persistent request. A request made on impulse or as a result of a temporary period of depression should not be honored. The request must have been discussed repeatedly and thoroughly a number of times during several conversations. However, van der Wal and colleagues conducted a survey among a random sample of family doctors, showing that in 22 percent of cases the request was made only once.⁷

The rate of recordkeeping⁸ and written requests⁹ in euthanasia cases improved during the 1990s, but the situation is still unsatisfactory. There are now written requests in about 60 percent of all euthanasia cases and written recordkeeping in some 85 percent.¹⁰ A most troubling phenomenon is the significant number of unreported euthanasia cases. Since November 1990, new state regulations require physicians to report cases of euthanasia to the local coroner and the public prosecutor. The number of reports rose from 454 cases in 1990 to 591 in 1991, then to 1,323 in 1992, to 1,318 in

1993, and to 1,424 in 1994. In 1999, the total number of reports was 2,216.¹¹ This considerable increase suggests that more physicians are willing to acknowledge and report their actions, having seen that their colleagues are not being prosecuted for performing euthanasia. At the same time, the Rummelink Commission, appointed in 1990 to investigate the practice of euthanasia, detected 2,300 cases of euthanasia, which means that about half are still unreported.¹² John Griffiths argues that the reporting rate for euthanasia¹³ was 18 percent in 1990, and that by 1995 it had risen to 41 percent. A situation in which less than half of all cases are reported is unacceptable from the standpoint of effective control.¹⁴

The Dutch approach to euthanasia is said to reflect an open attitude toward tackling a difficult moral issue. For the past twenty years, the debate has been discussed openly by all circles of society. It has been considered in the Parliament, addressed by the courts, debated in religious institutions, and has required the constant attention of the Royal Dutch Medical Association. It continues to be a focus of the media, and polls have been conducted from time to time to examine public attitudes on this issue.

Despite this apparent openness, the 1990 Rummelink study shows that 22 percent of physicians feel that they should not be required to always report euthanasia as unnatural death. The legal ambiguity that existed for twenty years made Dutch doctors feel uncomfortable with reporting euthanasia, citing prosecution as an objection. They emphasized that they would be prepared to report euthanasia as such, but they did not wish to be considered as a suspect in a criminal act. Thus, the uncertainty of what might happen to the physician was considered an obstacle to reporting an unnatural death.¹⁵ In order to address this issue, a careful, clearly stated procedure was needed, one which would be explicitly recognized under the law.

THE LEGAL FRAMEWORK

The legal ambiguity was the result of prohibiting euthanasia under the law while allowing the practice under certain circumstances. Two articles of the Criminal Code explicitly prohibit euthanasia: Article 293 prohibits killing a person at his or her request ("Any person who takes another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fine of NLG 100,000"); Article 294 prohibits assisted suicide ("Any person who intentionally incites another person to commit suicide, assists him in the act or provides him with the means to commit suicide shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fine of NLG 25,000").¹⁶

Despite these legal provisions, the courts have held that Article 40 of the Criminal Code ("Any person who was compelled by *force majeure* to commit a criminal act shall not be criminally liable")¹⁷ provides a defense to doctors charged

under Articles 293 and 294. The *overmacht* defense, which, like *force majeure*, translates as overpowering force, envisions a case of urgency whereby the accused is driven by his or her conscience to commit an offense that amounts to a lesser evil than would have ensued had events been permitted to run their course. As such, the accused decided to make the deliberate moral choice to break the law because the force of circumstances precluded delaying action. However, the defense does not stand if there was a reasonably available option whereby the accused could have avoided the commission of the offense.¹⁸

A major step was taken in 1990 on behalf of physicians practicing euthanasia. Soliciting for the approval and cooperation of the Royal Dutch Medical Association with the Rummelink study, the Ministry of Justice not only promised legal immunity to physicians participating in the national investigation, but it also agreed to proclaim a notification procedure that included the following elements:

- the physician performing euthanasia would not need to issue a declaration of a natural death, but would inform the local medical examiner by means of an extensive questionnaire;
- the medical examiner would report to the district attorney;
- the public prosecutor would decide whether a prosecution must be started. As a general rule, if a doctor had complied with the requirements for euthanasia, he or she would not be prosecuted.¹⁹

The notification procedure was granted a formal legal status by a procedural law that came into force on June 1, 1994. According to this law, a physician performing euthanasia in compliance with the criteria that had been developed in case law and medical ethics would not, as a general rule, be prosecuted.²⁰

On November 28, 2000, the Dutch Lower House of Parliament, by a vote of 104 to 40, approved the legalization of euthanasia. On April 10, 2001, the Dutch Upper House of Parliament voted to legalize euthanasia, making the Netherlands the first and at this time only country in the world to legalize euthanasia. The Senate had voted 46 to 28 (with one member not present) in favor of the Termination of Life on Request and Assistance with Suicide Act.

The new legislation made it legal to end a patient's life, subject to the following criteria: the patient must be suffering unbearable and unremitting pain, with no prospect of improvement. 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 with medically appropriate care and attention. The physician is obliged to report the death to the municipal pathologist, specifying whether the cause of death was euthanasia or assisted suicide.²¹

Doctors are immune from prosecution for helping a patient die as long as they follow these guidelines. If they do not, the coroner and a regional panel can recommend prosecution leading to a prison sentence of up to 12 years.

This new act, while not amending the safeguards under which doctors previously practiced voluntary euthanasia in the Netherlands, did change who has the burden of proof regarding whether the code of practice has been breached. Previously, the onus was squarely on the doctors to prove that they had followed the guidelines and were therefore innocent of any offence. However, the new law shifted responsibility for proving guilt to the five regional committees that examine the euthanasia reports.²²

The law contains special provisions for dealing with requests from minors for termination of life and assisted suicide. The most controversial aspect of the original act was that incurably ill minors between the ages of 12 and 16 could request and receive help to die if they had their parents' agreement. In exceptional circumstances, doctors could even help the child to die without parental consent, although such cases would likely have been rare. Persons aged 16 to 18 would be able to request euthanasia without recourse to their parents' approval.²³

In July 2000, in response to critical questions by members of Parliament, the Cabinet dropped the provision that euthanasia requests from minors between 12 and 16 could be granted without their parents' consent. Some analysts viewed this retreat as a maneuver to win approval for other controversial provisions of the new legislation, such as legalizing euthanasia for victims of Alzheimer's.²⁴ Still, allowing the euthanasia of minors 12 years and older seriously overestimates the capacity of minors to evaluate the meaning and consequences of a request to die. It places an unacceptable burden on these young people and may well disturb society's confidence in the relationship between physicians, parents, and children. Henk Jochemsen rightly says that unless we are prepared to give minors the right to do everything else in life that an adult can do, giving them the right to end their life seems out of place.²⁵

The new law also establishes a legal basis for advance euthanasia declarations via a type of living will in which competent patients can request euthanasia in the event they become mentally incompetent. Though such a statement does not imply that a physician has a duty to perform euthanasia, it provides the legal basis to end the life of an incompetent patient who has signed such a document.

Let me now proceed by outlining the methodology of my independent research in the Netherlands and the findings to my question: Why the Netherlands?

METHODOLOGY

Before arriving in the Netherlands, I wrote to some distinguished experts in the fields of medicine, psychiatry,

philosophy, law, social sciences, and ethics, asking to meet with them in order to discuss the Dutch policy and practice of euthanasia. Only one — Dr. Boudewijn Chabot — explicitly declined my request for an interview.²⁶

The interviews took place during July–August 1999 in the Netherlands. They lasted between one and three hours each. Most interviews went on for more than two hours, during which I asked more or less the same series of questions.²⁷ 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 in "neutral" locations (coffee shops and restaurants). Two interviews were conducted at the office kindly made available to me at the Department of Medical Ethics at the 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 efficient Dutch 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 an interviewee preferred to speak about subjects that were not included in the original questionnaire. With a few interviewees, 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 these aspects by reference to the Rimmelink report. This line of questioning disturbed some of the interviewees, who wanted to know my own opinion on the subject before continuing to answer my questions. Others seemed eager to bring the interview to a close.

This article reports the answers to the first question in my questionnaire. At the start of every interview, I pledged to my interviewees that I would send them the rough draft of the book I planned to write prior to submitting it for publication. After completing the first draft of the manuscript *Euthanasia in the Netherlands* in July 2000, I sent it to all twenty-eight interviewees, inviting their comments and criticisms. In my cover letter, I explained that I wished to give each interviewee an opportunity to verify that the references to our discussion adequately represented his or her views. I added that the issue at hand was not my analysis and interpretation. Rather, the aim was to ascertain whether the interviewee's views were characterized in a fair and honest manner and whether the opinions attributed to him or her were correct. The majority of interviewees commented on the first draft.²⁸

THE RESPONSES

The Netherlands was the first democracy to tolerate euthanasia. My questions on this point were "Why the

Netherlands?"; "Why does the Netherlands accept euthanasia *de facto* if not *de jure*?"; and "What are the significant factors that made the Dutch tradition and culture hospitable to the euthanasia movement?"

Some literature addresses these questions. Bert Gordijn argues that the Dutch policy is a typical example of a policy of pragmatic tolerance. To better understand this societal phenomenon, one should look at Dutch history. The historical roots can be traced to the Dutch republic of the seventeenth century, where two dominant and sometimes contradictory societal forces influenced Dutch mentality and policy. The merchants advocated peace and freedom through a policy of tolerance, exemptions, and compromises. The Calvinists, on the other hand, strove for normative regulation of all human behavior in accordance with their rigid moral standards. These two forces led to the Dutch policy of pragmatic tolerance; namely, certain criminal acts remained unpunished, and certain conditions for immunity from criminal prosecution were formulated in advance and in public by the authorities. Gordijn contends that the practice of tolerance of illegal deeds was normatively regulated and that its influence is significant in the present euthanasia policy.²⁹

Griffiths and his colleagues provide another layer of explanation. They emphasize the developments that took place since the 1960s, arguing that the 1960s and 1970s were a crucial watershed for Dutch society. From a conservative, tradition-bound country, the Netherlands was transformed into a society of social and cultural experimentation. The Netherlands took a prominent place in the sexual revolution, the legalization of abortion, the acceptance of drugs, the democratization of educational institutions, and the questioning of religious authority. The process of secularization that started in the 1960s gradually undermined the status of traditional institutions. In 1958, 24 percent of the population had no affiliation, 42 percent belonged to the Roman Catholic Church, and about 33 percent were affiliated with the Protestant churches. In the 1990s, the respective figures were 57 percent (no affiliation), 22 percent (Catholic), and a bit more than 20 percent (Protestant).³⁰

Societal relationships also changed, with the effect that the social distance between ordinary people and people in positions of power declined. As such, ordinary citizens developed expectations about their role and influence in society and their ability to affect matters concerning their lives. The political elite accommodated themselves to the new reality. In many cases, the elite supported the new ideas, and its members were even spokesmen for them. The political culture of conflict-avoidance and the traditional conviction that it is better to guide social developments than to try to stop them were instrumental in coping with the waves of change.³¹

Paul van der Maas brought to my attention a study conducted by Loes Pijnenborg, in which thirty-four experts (twenty-three from the Netherlands and the rest from the United States, Australia, Canada, the United Kingdom, and

Germany) were asked two questions: What is the explanation of the fact that the current discussion on euthanasia in the Netherlands differs from the discussion in other countries? Do you think that the current euthanasia practice in the Netherlands differs from that of other countries? According to the respondents, the most important factors influencing the Dutch policy and practice of euthanasia were the relationship between the physician, the patient, and health care (mentioned by 24 respondents); culture and society (22 respondents); legal aspects (15); history (11); church and religion (10); definition of euthanasia (6), and moral principles (5).³²

These issues were reiterated by my interviewees. Some preferred to answer “Why the Netherlands?” by delineating the historical process that brought about the practice of euthanasia.³³ They explained that up until the late 1960s, the Netherlands was a divided society, with Catholic pillars, Protestant pillars, liberal pillars, and socialist pillars. Each organized its own political party, schools, medical organization, newspaper, media, club, union, and so on. These pillars, especially the religious ones, eventually broke down and collapsed. The student revolution of 1969 had a profound effect on the country as the social movement rebelled against the traditional values, autocracy, and established hierarchies. After more than two decades of digesting the horrors of World War II, the time was ripe for change. The old morality based on religious perceptions had collapsed. Church values were no longer appealing to large sectors of the population, who were looking for a different set of morals upon which to base their lives.

Consequently, the Netherlands had to find a secular basis for morality. Some of the essential moral foundations established were that of individual choice, liberation from collective morality, autonomy, and individuality. The religious view of the sacredness of life was abolished and replaced by secular moral views. Since then, the discussion on morality has revolved around the rights of the individual, including issues like contraceptives, abortion (the law became liberal in 1969), suffering, and ending of life. The increased democratization of society and the emphasis on individual control made the practice of euthanasia more open and available.³⁴

Henk Jochemsen, director of the Professor Lindeboom Institute, a center for medical ethics, who also holds a privately funded chair for medical ethics at the Free University, further explained that Calvinism stressed personal responsibility and that there should be no contradiction between teaching and practice. When physicians realized that there were occasions when euthanasia should be performed, they started pressing for some accommodation to use this practice.³⁵

In 1969, Jan Hendrik van den Berg, a renowned psychiatrist, published his book *Medical Power and Medical Ethics*.³⁶ The book discusses the tragic conditions of various patients who are described as victims of medical power. Had they lived 100 or even 50 years ago, they would have been allowed to die in peace. These days, however, they are being

kept alive simply because the capacity to do so is available, regardless of the patients’ best interests. Van den Berg suggests granting these victims of medical power a dignified death.³⁷ James Kennedy, Egbert Schroten, and H.J.J. Leenen maintain that this book started the euthanasia discussion in earnest, focusing on life that had lost its purpose. Specifically, the thesis advocated putting an end to pointless suffering with the help of a doctor.³⁸ At the time, the medical establishment was very much against physician-assisted suicide and euthanasia. Some journals, including *Tijdschrift Voor Geneeskunde (Journal of Medicine)*, refused to discuss euthanasia for a long time. Another leading medical journal, *Medisch Contact*, was unique in allowing letters and articles to be published on this issue.

In 1972, the Council of Health commissioned its own study on euthanasia, concluding that euthanasia ought to remain illegal, but that public opinion was changing and that there was a need for reprisal.³⁹ In 1973, the first euthanasia court case occurred in Leeuwarden: the *Postma* case, which received a great deal of publicity, prompting certain groups to argue that euthanasia should be allowed.⁴⁰ Leenen and van der Maas see this court case as the most instrumental in paving the way toward tolerating euthanasia.

In the mid-1970s, the Dutch Euthanasia Society was formed and the discussion spread into different circles: media, literature, politics, and academia. The Conservatives, Socialists and Social-Liberals all included the issue of euthanasia in their political platforms. Long deliberations in the Parliament failed to result in concrete steps, as all initiatives were blocked by the ruling party, the Christian-Democrats.

Many physicians felt that the issue needed to be addressed carefully and sincerely. The Dutch Medical Society set up a committee in 1983 to examine the practice of euthanasia. The Society did not adopt a specific viewpoint, but nevertheless said that if physicians practiced euthanasia, they needed to follow the jurisprudential guidelines that Henk Leenen helped to formulate. This was a very important step in the process, and Leenen perceives those years as the formative years in the euthanasia debate. A social movement was created, involving a variety of different interests: physicians, patients’ groups, politicians, lawyers, courts, and religious organizations.

In 1987, a state committee, under a Catholic president, recommended legalizing euthanasia and thereby according it a legitimate status for the first time. However, the Christian-Democrats continued to block all legislative attempts. Leenen and Kennedy emphasize that during this period, physicians continued to practice euthanasia and more cases were brought before the courts. Arie van der Arend and Govert den Hartogh noted that patients’ groups and voluntary euthanasia advocates then gained strong influence.

John Griffiths, a professor at the University of Groningen Faculty of Law, explains that the Dutch have a history of tolerance and moral ambiguity — they tolerate things that

are illegal but that are not undesirable enough to stop. As Paul van der Maas puts it, the Dutch raise moral questions and try to settle them through pragmatic means. For instance, one of the problems faced by the Netherlands earlier in the twentieth century was that of squatters, people who illegally resided in empty buildings. According to Griffiths, the government understood that the problem might become worse if they evacuated the squatters by force. Hence, it tried to find them housing, and the squatters even formed their own organization to negotiate with the local municipalities.

A. van Dantzig, one of the nation's most well-known psychiatrists, pointed out another phenomenon that illustrates how the Dutch have their own way of dealing with moral questions. Their attitude of "live and let live" is exemplified by their policy on soft drugs. It is forbidden for coffee shops to buy drugs, but they are allowed to sell them and the authorities don't ask how the shops obtained the drugs. In essence, this is a politics of accommodation and compromise among the interests of each fragment of society as long as they recognize the authority of the State.

Not everyone is happy with the increased sense of secularization and the prevailing liberalism. G.F. Koerselman, another well-known psychiatrist, explains that the Netherlands shifted too rapidly from one extreme to another. Whereas before the 1950s, the country was very religious, since then the secularization process has brought about "totalitarian humanism." It is totalitarian because humanism cannot be discussed; it is self-evident, unquestioned, taken for granted.

This view has significant implications for public life. First and foremost, there is absolute respect for individual autonomy. It is almost dogma that people should be, and are, autonomous. Consequently, the prevailing view is that decisions, especially about life and death, should be left in the hands of individuals. Second, argues Koerselman, there is a societal battle against suffering. It is strongly believed that people should not suffer and, in the name of relieving suffering, it is thought that it is better to seek death. Euthanasia is one form of resolving the issue of suffering. Similarly, Henk Jochemsen says that the social climate in the Netherlands is one in which euthanasia seems a good solution for suffering, and that it is up to the doctor to provide this solution.

Interviewees emphasized "openness" as the trait that made euthanasia possible. Dutch people prefer to put things on the table and to discuss everything openly — from drugs, prostitution, and pornography to homosexuality, abortion, and euthanasia. Sex education is explicit and universal in Dutch schools. There are open debates on moral issues, a plurality of views, and an overall atmosphere of permissiveness.⁴¹ Indeed, in a comparative survey of fifteen countries, including the United States and Canada, the Dutch had by far the most permissive orientation.⁴²

Interviewees noted that the Dutch enjoy having the kind of theological discussion which includes probing norms and values. They further mentioned compromise as a basic mechanism by which resolutions are reached, explaining that the Netherlands has been in trade for centuries and consequently developed the necessary ability to compromise. The ambiguity of having euthanasia guidelines, yet prohibiting euthanasia under the penal code, is the result of compromise between the religious and secular circles of society, between the legalistic and the realistic, in trying to resolve the issue of suffering.⁴³ The Netherlands has a history of consensus governments based on compromise and mutual tolerance. The Dutch resent authority and have never had an authoritarian regime. As Gerrit van der Wal and Johannes J.M. van Delden have pointed out, the average Dutch citizen is liberal, pragmatic, and tolerant, and appreciates plurality. There is a sense of obligation in Dutch society to try to reach a consensus on controversial matters.

Another important consideration is the Dutch attitude toward the law. Some interviewees argue that one of the lessons of World War II relates to the limits of authority and the need to dissent when strong moral grounds are provided.⁴⁴ Many Dutch physicians during the war felt that the state should not intervene in the doctor-patient relationship and thus refused to participate in the German euthanasia program, openly defying an order to treat only those patients who had a good chance of full recovery.⁴⁵ In this context, Chris Rutenfrans of the *Trouw* newspaper spoke of a lack of sufficient safeguards against abuse as a result of historical shortsightedness. Unlike the United States, Germany, and other countries where the eugenics movement was active during the 1930s, the Netherlands did not have such a movement. While those countries were alarmed at how the Nazis implemented euthanasia, the Dutch collective memory is unaware of the Nazi experience in this regard. If one has compelling moral reasons, it is considered acceptable to break the law in compliance with one's conscience. The fact that the courts tended to be very lenient towards doctors who performed euthanasia reflects the prevailing positive attitude on this issue.

Many interviewees emphasized the importance of the Dutch health-care system. As previously mentioned, the Netherlands has all-inclusive health insurance based on general practitioners who have longstanding relationships with their patients. The result is that most patients trust their doctors.⁴⁶ Emphasis is put on the autonomy of patients, enabling them to have self-determination. At the same time, their strong trust in their general practitioners may lead patients to yield their autonomy or, ultimately, even their lives. This possibility exists especially when doctors suggest euthanasia to their patients.

The literature describes the strongly developed system of primary care in the Netherlands, with 6,300 general practitioners and additional nursing care at home. Many patients (40 percent) die at home, especially patients with cancer (48

percent of all cancer deaths). Almost all patients (99.4 percent) have health care insurance, and 100 percent of the population is insured for the cost of protracted illness.⁴⁷

When faced with the choice of going to the hospital to obtain the necessary health care or staying at home to receive care, the Dutch generally prefer the latter. The same is true for giving birth, and a high percentage of births take place at home. While women are aware of the possible risks involved in giving birth at home, many still prefer home delivery. Home is seen as the place to start life and to finish life. The general practitioner typically visits the patient at home and establishes a personal relationship that is discrete and private. In this realm of intimacy, outside control often does not exist and is conceived by both parties as interfering and damaging to the personal trust and special bond that have evolved over time. Many incidents of euthanasia happen at home and are not reported, given that this is considered a private matter, something between the patient, his or her family, and the doctor.

CONCLUSIONS

The aim of this essay was to describe the reasons interviewees gave to explain what prompted the Netherlands to adopt its policy and practice of euthanasia. Multiple reasons were mentioned: historical, social, cultural, religious, and political as well as the pivotal importance of the local health-care system. A complex combination of factors brought the Netherlands to adopt a very tolerant attitude regarding euthanasia and physician-assisted suicide.

In the United States, Oregon's Measure 16 that allows assisted suicide is facing a challenge.⁴⁸ In Australia, the Northern Territory Bill that allowed terminally ill patients to commit suicide with a doctor's help was declared void. The legislatures of Canada and England have resisted attempts to legalize assisted suicide and euthanasia. The Netherlands remains the only country in the liberal world (with the possible exception of Belgium) that generally accepts the policy and practice of both euthanasia and physician-assisted suicide, without seeing much difference between the two (unlike Switzerland), and whose legislatures advance more bills that would legitimize euthanasia further, while broadening the scope of the practice. Many Dutch scholars lump euthanasia and physician-assisted suicide together and have 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 guiding these procedures, the Royal Dutch Medical Association refined its guidelines to recommend that assisted suicide, rather than euthanasia, be performed whenever possible.⁴⁹

I believe that the medical profession should not turn its back on patients who clearly request to shorten their lives. However, 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 the one that governed the practice of euthanasia in the Netherlands until November 2000, which was ambiguous and presented an illegal-yet-tolerated model. If we see that the new euthanasia policy opens the way to abuse, then yet again we should pursue a public debate in which different sectors of society can take part.

While it is necessary to devise a better working framework to help patients in need, 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, alternatively, the motivation may be quite different. The ending of a patient's life should be conducted in the light, not in shadowy areas where only selected people may enter.⁵⁰

I also think that 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; at some time during the progressive course of their illness, they can take the initiative and discuss it with their physicians if they are so inclined. If they do not initiate such a discussion, then the physician can assume that the patient does not wish to move in this direction.

ACKNOWLEDGMENTS

The author is most grateful to the referees of the *Journal of Law, Medicine & Ethics* for their useful comments, to Evert van Leeuwen and Martine Bouman for facilitating the research, to Daren Jacobe for her research assistance, and to the interviewees for their kind cooperation.

APPENDIX

The names and affiliations of those interviewed (with the location and date of their interview in parenthesis) are as follows:

1. Dr. Arie J.G. van der Arend, Health Ethics and Philosophy, Maastricht University (Maastricht, July 26, 1999).
2. Dr. Ron Berghmans, Institute for Bioethics, Maastricht University (Maastricht, August 11, 1999).
3. Dr. George Beusmans, Maastricht Hospital (Maastricht, July 26, 1999).
4. Professor G.F. Koerselman, Sint Lucas Andreas Hospital, Amsterdam (Amsterdam, July 27, 1999).
5. Ms. Barbara de Boer, the widow of a man who was euthanized, and her three children (Amsterdam, August 2, 1999).
6. Professor A. van Dantzig, retired expert in psychiatry (Amsterdam, July 20, 1999).
7. Dr. Johannes J.M. van Delden, Senior Researcher, Center for Bioethics and Health Law, Utrecht University (Utrecht, August 10, 1999).

8. Professor Heleen Dupuis, Department of Metamedicine, University of Leiden (Leiden, July 22, 1999).

9. Professor J.K. Gevers, Professor of Health Law, University of Amsterdam (Amsterdam, July 19, 1999).

10. Professor John Griffiths, Department of Legal Theory, Faculty of Law, University of Groningen (Groningen, July 16, 1999).

11. Professor Govert den Hartogh, Faculty of Philosophy, University of Amsterdam (Amsterdam, August 10, 1999).

12. Dr. Rob Houtenpen, Health Ethics and Philosophy, Maastricht University (Maastricht, August 11, 1999).

13. Professor Henk Jochemsen, Director, Professor Lindeboom Institute (Ede Wageningen, July 27, 1999).

14. Dr. James Kennedy, Department of History, Hope College, Michigan. Visiting Research Fellow at the Institute for Social Research, Amsterdam (Amsterdam, July 29, 1999).

15. Dr. Gerrit K. Kimsma, Department of Metamedicine, Free University of Amsterdam (Koog aan de Zaan, July 28, 1999).

16. Professor H.J.J. Leenen, formerly professor of social medicine and health law, Medical Faculty and Faculty of Law, University of Amsterdam (Amsterdam, July 21, 1999).

17. Professor Evert van Leeuwen, Department of Metamedicine, Free University of Amsterdam (Amsterdam, July 19, 1999; Haarlem, July 28, 1999).

18. Professor Paul van der Maas, Department of Public Health, Faculty of Medicine, Erasmus University, Rotterdam (Amsterdam, July 29, 1999).

19. Professor Ruud ter Meulen, Director, Institute for Bioethics and Professor, University of Maastricht (Maastricht, August 11, 1999).

20. Dr. Arko Oderwald, Department of Metamedicine, Free University of Amsterdam (Amsterdam, July 30, 1999 and August 8, 1999).

21. Dr. Chris Rutenfrans, *Trouw* (Amsterdam, July 30, 1999).

22. Professor Egbert Schrotten, Director, Center for Bioethics and Health Law, Utrecht University (Utrecht, August 5, 1999).

23. Professor Bert Thijs, Medical Intensive Care Unit, VU Hospital, Amsterdam (Amsterdam, July 20, 1999).

24. Dr. Margo Trappenburg, Department of Political Science, University of Leiden (Leiden, July 22, 1999).

25. Dr. Jaap J.F. Visser, Ministry of Health, Department of Medical Ethics, The Hague (Amsterdam, July 21, 1999).

26. Professor Gerrit van der Wal, Institute for Research in Extramural Medicine, Department of Social Medicine, Free University of Amsterdam (Amsterdam, July 21, 1999).

27. Dr. Henri Wijsbek, Department of Medical Ethics, Erasmus University of Rotterdam (Rotterdam, July 23, 1999).

28. Dr. Dick Willems, Institute for Research in Extramural Medicine, Department of Social Medicine, Amsterdam (Amsterdam, July 20, 1999).

REFERENCES

1. G.K. Kimsma and E. van Leeuwen, "Dutch Euthanasia: Background, Practice, and Present Justifications," *Cambridge Quarterly of Healthcare Ethics*, 2 (1993): 19–35, especially at 24.

2. See T. Sheldon, "Doctors Not Obligated to Carry Out Treatment They Think 'Futile,'" *British Medical Journal*, 319 (October 23, 1999): 1088.

3. For a discussion of the double effect doctrine, see R. Cohen-Almagor, "Language and Reality at the End of Life," *Journal of Law, Medicine & Ethics*, 28, no. 3 (2000): 267–278.

4. See J. Legemaate, "Twenty-Five Years of Dutch Experience and Policy on Euthanasia and Assisted Suicide: An Overview," in David C. Thomasma et al., eds., *Asking to Die* (Dordrecht: Kluwer Academic Publishers, 1998): at 20; G.K. Kimsma, "Euthanasia and Physician Assisted Suicide in the Netherlands," *Medizin, Ethik, Recht* (1994): 161–69.

5. J. Griffiths, A. Bood, and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998): at 213.

6. J. Griffiths, "Effective Regulation of Euthanasia and Other Medical Behavior that Shortens Life," in E. Mackaay, ed., *Uncertainty and the Law* (Montreal: Editions Thémis, 1999): 61–94, especially at 72–73.

7. G. van der Wal, J.Th.M. van Eijk, H.J.J. Leenen, and C. Spreeuwenberg, "Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?," *Family Practice*, 9, no. 2 (1992): 135–40.

8. A doctor has an obligation to maintain a full dossier on every patient and to accurately record therein what he or she does and why. Keeping adequate records is a general requirement of medical practice, and is specifically one of the requirements of careful practice in the case of euthanasia.

9. Kimsma notes that written requests of euthanasia are preferable but not mandatory. Another acceptable solution is a witness.

10. Griffiths, *supra* note 6, at 74.

11. I thank Henk Leenen for this piece of information.

12. H.A.M.J. ten Have, "Euthanasia: The Dutch Experience," *Annals de la Real Academia Nacional de Medicina*, Tomo CXII (Madrid, 1995): 425–44, at 436–37.

13. Reporting, as opposed to recordkeeping, refers to the requirement that a doctor report a case of euthanasia to the authorities as an unnatural death.

14. Griffiths, *supra* note 6, at 74–75.

15. P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life*, Health Policy Monographs (Amsterdam: Elsevier, 1992): at 98.

16. For further reading, see H.J.J. Leenen, "Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands," *Health Policy*, 8 (1987): 197–206; J.K.M. Gevers, "Legal Developments Concerning Active Euthanasia on Request in the Netherlands," *Bioethics*, 1, no. 2 (1987): 156–162.

17. "Euthanasia and Physician Assisted Suicide in the Netherlands," at <http://www.nlembassy.or.kr/c_hlteuth.html> (last visited January 14, 2002). This website is a service of the Royal Netherlands Embassy in Seoul, Korea.

18. B. Sneiderman and M. Verhoef, "Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases," *Alberta Law Review*, XXXIV, no. 2 (1996): 374–415, at 376. In England and Canada, the defense of medical necessity has been recognized in abortion cases (see *R. v. Bourne* [1938] 3 All E.R. 615 and *R. v. Morgentaler* [1975] 20 C.C.C. (2d) 449), but it is not available in euthanasia cases. For England, see *R. v. Cox* [1992] 12

BMLR 38 (England); R. Porter, "Doctor Convicted of Attempted Murder," *Sunday Telegraph* (London), September 20, 1992. For Canada, see M. O'Malley and O. Wood, "'Cruel & Unusual': The Law and Latimer," CBC News, at <http://www.cbc.ca/news/indepth/background/latimer_robert.html> (last visited January 15, 2002), describing the Robert Latimer case, which involves a Saskatchewan farmer who killed his 12-year-old daughter, Tracy, who suffered from severe cerebral palsy and had the capacity of a three-month-old child. Latimer is currently serving a life sentence, which holds no possibility of parole until 10 years.

19. R.J.M. Dillmann and J. Legemaate, "Euthanasia in the Netherlands: The State of the Legal Debate," *European Journal of Health Law*, 1 (1994): 81–87, especially at 84.

20. A translation of the law can be found in Griffiths, Bood, and Weyers, *supra* note 5, at 308–13.

21. Reuters, "Dutch Parliament Votes to Legalize Euthanasia," November 28, 2000, available at <<http://www.worldrtd.org/dutchlaw.html#reuters>>.

22. On the regional committees, see E. van Leeuwen and G. Kimsma, "Problems Involved in the Moral Justification of Medical Assistance in Dying: Coming to Terms with Euthanasia and Physician Assisted Suicide," in R. Cohen-Almagor, ed., *Medical Ethics at the Dawn of the 21st Century* (New York: New York Academy of Sciences, 2000): 157–173; B. Onwuteaka-Philipsen, *Consultation of Another Physician in Cases of Euthanasia and Physician-Assisted Suicide*, Doctoral Thesis (Amsterdam: Department of Social Medicine, Vrije Universiteit, 1999).

23. "Minderjarige mag euthanasie vragen" (A minor may/is allowed to ask/request for euthanasia), *NRC Handelsblad* (New Rotterdam), July 10, 1999, at 3. See also M. Gardner, "Dutch Poised to Legalize Euthanasia," *Christian Science Monitor*, June 30, 2000, available at <<http://www.csmonitor.com/durable/2000/06/28/text/p1s4.html>>.

24. Associated Press, "Dutch Call Off Aided Suicide for Children," *International Herald-Tribune*, July 15, 2000.

25. H. Jochemsen, "The Legalization of Euthanasia in The Netherlands," *Ethics & Medicine*, 17, no. 1 (January 2001).

26. In his letter dated June 5, 1999, Dr. Chabot wrote: "After four years waiting for the final court judgement (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." He, however, agreed to answer via e-mail some specific questions relating to his conduct that brought about the charges against him.

27. My questionnaire comprised fifteen questions. The Dutch comprehensive study of 1995 consisted of 120 pages and the interviews lasted for an average of 2.5 hours. The pace of questioning was, apparently, frantic. See P.J. van der Maas et al., "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995," *N. Engl. J. Med.*, 335, no. 22 (1996): 1699–1711, at 1700.

28. Those commenting included Arie J.G. van der Arend, Rob Houtepen, Henk Jochemsen, Margo Trappenburg, James Kennedy, H.J.J. Leenen, A. van Dantzig, Heleen Dupuis, Johannes JM van Delden, John Griffiths, Sjeff Gevers, Ron Berghmans, Ruud ter Meulen, Govert den Hartogh, Arko Oderwald, Evert van Leeuwen, Paul van der Maas, and Gerrit Kimsma. Bert Thijs and George Beusmans read the draft and had no problem with my account of their views.

29. B. Gordijn, "Euthanasie: strafbaar und doch zugestanden? Die niederlandische Duldungspolitik in Sachen Euthanasie" (Euthanasia: Criminal offense and still allowed? The Dutch policy of permissiveness/tolerance in cases of euthanasia), *Ethik Med*, 10 (1998): at 12.

30. Proceedings of *Euthanasia and Assisted Suicide in the Neth-*

erlands and in Europe, Maastricht, June 10–11, 1994 (Luxembourg: Office for Official Publications of the European Communities, 1996): at 101.

31. Griffiths, Bood and Weyers, *supra* note 5, at 12–13.

32. L. Pijnenborg, "The Dutch Euthanasia Debate in International Perspective," in *End-of-Life Decisions in Dutch Medical Practice*, Doctoral Thesis (Rotterdam: Department of Public Health, Erasmus University, 1995): 119–132. I am most grateful to Paul van der Maas for sending me this work as well as some other publications.

33. These included James Kennedy, Govert den Hartogh, Heleen Dupuis, Henk Jochemsen, and A. van Dantzig.

34. Evert Van Leeuwen, Jaap Visser, Margo Trappenburg, Bert Thijs, and Gerrit van der Wal expressed similar views.

35. Ruud ter Meulen made a similar point. For further deliberation on Calvinism, see D.E. Holwerda, ed., *Exploring the Heritage of John Calvin* (Grand Rapids, Michigan: Baker Book House, 1976). See especially the chapter by T. Minnema, "Calvin's Interpretation of Human Suffering," at 140–162.

36. The book was translated to English and published by W.W. Norton in 1978.

37. J. van Holsteyn and M. Trappenburg, "Citizens' Opinions on New Forms of Euthanasia. A Report from the Netherlands," *Patient Education and Counseling*, 35 (1998): 63–73.

38. Van den Berg's book responded to widely felt concerns and was reprinted twenty-one times within seven years and endlessly discussed in magazines and other media. See Griffiths, Bood and Weyers, *supra* note 5, at 48.

39. On changes in public opinion from 1966 to 1991, see P.J. van der Maas, L. Pijnenborg, and J.J.M. van Delden, "Changes in Dutch Opinions on Active Euthanasia, 1966 Through 1991," *JAMA*, 273, no. 18 (May 10, 1995): 1411–14; D.J. Hessing, J.R. Blad, and R. Pieterman, "Practical Reasons and Reasonable Practice: The Case of Euthanasia in the Netherlands," *Journal of Social Issues*, 52, no. 2 (1996): 161–66. According to two consecutive polls, 70 percent of the Dutch people accepted active euthanasia in 1985, and 76 percent in 1986. See R. Fenigsen, "A Case Against Dutch Euthanasia," *Hastings Center Report*, 19, no. 1 (Supp. January/February 1989): 22–25. A 1998 survey showed that more than 90 percent of the population favors euthanasia. See S. Daley, "The Dutch Seek to Legalize Long-Tolerated Euthanasia," *New York Times*, June 20, 2000, available at <<http://www10.nytimes.com/library/world/europe/062000holland-mercy.html>>.

40. C.F. McKhann, *A Time to Die: The Place for Physician Assistance* (New Haven, Connecticut: Yale University Press, 1999): at 122. The *Postma* case was the best known prosecution during this period of a person who killed another at the latter's request, but it wasn't the only one. There were at least three other prosecutions for violations of Articles 293 or 294. See C.F. Gomez, *Regulating Death* (New York: The Free Press, 1991): at 28–32; Griffiths, Bood, and Weyers, *supra* note 5, at 53.

41. This is supported by my interviews with John Griffiths, J.K. Gevers, Bert Thijs, Arie van der Arend, Ron Berghmans, and Ruud ter Meulen.

42. P. Ester, L. Halman, and R. de Moor, *The Individualizing Society: Value Change in Europe and North America* (Tilburg: Tilburg University Press, 1994): at 56–60.

43. This is supported by my interviews with Jaap Visser, Dick Willems, and John Griffiths. This point was reiterated also by Frank Koerselman, Egbert Schroten, and Govert den Hartogh.

44. These include Evert van Leeuwen, John Griffiths, and Gerrit van der Wal.

45. L. Alexander, "Medical Science Under Dictatorship," *N.*

Engl. J. Med., 241 (July 14, 1949): 39–47, especially at 45.

46. This is supported by my interviews with J.K. Gevers, Jaap Visser, Heleen Dupuis, Margo Trappenburg, Gerrit van der Wal, Henk Jochemsen, Govert den Hartogh, Arko Oderwald, and Rob Houtepen.

47. G. van der Wal and R.J.M. Dillmann, “Euthanasia in the Netherlands,” *British Medical Journal*, 308 (1994): 1346–49. For further deliberation on the Dutch health-care system, see J. van der Made and H. Maarse, “Access to Health Care in the Netherlands,” in J. Lenaghan, ed., *Hard Choices in Health Care: Rights*

and Rationing in Europe (London: BMJ Publishing Group, 1997): 93–111.

48. See R. Cohen-Almagor and M.G. Hartman, “The Oregon Death with Dignity Act: Review and Proposals for Improvement,” *Journal of Legislation*, 27, no. 2 (2001): 269–98.

49. See H. Hendin, *Seduced by Death* (New York: W.W. Norton, 1997): at 122.

50. See R. Cohen-Almagor, *The Right to Die with Dignity: An Argument in Ethics, Medicine, and Law* (NJ.: Rutgers University Press, 2001).

Not for
Distribution