

EUTHANASIA PRACTICES IN THE NETHERLANDS

The public era of euthanasia in the Netherlands began in 1973,¹ when two significant events occurred. A government commission reported that the ban on active euthanasia should remain, and a doctor, after admitting killing her sick mother who wanted to die, was found guilty, and given a suspended sentence. Evidence was tendered that she had only done what was already commonly, though unofficially, done by many doctors. The court announced several conditions which, in its view, would justify the active killing of a patient.

In 1981 and 1983, two courts reached similar conclusions.

A State Commission on Euthanasia decided in 1982,² that 'a doctor who terminates the life of a patient at the latter's expressed and serious desire no longer should be punishable, providing that a number of conditions have been met', even though Article 293 of the Penal Code provided, as it still does, that taking the life of another person, even at that person's express and serious request, is a serious offence against human life, punishable by up to 12 years imprisonment.

The guidelines when carrying out euthanasia were formally published by both the government and the Royal Dutch Medical Association (KNMG) in 1984 and in 1987.³ They required that the request be voluntary, well-considered and durable, that there be unacceptable suffering and that a second doctor be consulted. For many years, all these provisions have been known to be often abused. For example, regarding a well-considered request, a study by van der Wal in 1990⁴ showed that the interval between the first request and euthanasia was no more than a day in 13% of cases, no more than a week in another 35% and had been as short as a few hours.

Since 1984, the courts have created increasingly liberal grounds for exempting doctors from prosecution after euthanasia, accepting psychological distress as a reason and no longer requiring terminal illness. To justify what was admittedly an offence, the courts decided that it was lawful for a doctor, faced with the alternative of leaving the patient in pain or giving relief by killing, to take the 'compassionate' option, by taking life. The doctor is said to be acting under a higher duty or 'force majeure'.

Many unsatisfactory court determinations followed. In 1985, a doctor was charged with being implicated in about 20 deaths in a nursing home, without the knowledge or consent of the victims. He was found guilty and sentenced to a year in prison but, following an outcry against the severity of the sentence, the verdict was overturned on a technicality. He was then awarded US\$150,000 damages by a civil court.⁵ In 1987, nurses killed three unconscious patients in an intensive care unit by injecting them with drugs. They admitted their guilt and were charged with murder, but discharged because of 'poor communication between the nurses and doctors over 'euthanasia policy'.'⁶

Courts accepted that some common practices outside the law could now be used to justify their legal recognition. The objective criteria normally required by criminal law were replaced by conformity with changing medical standards, and by subjective criteria which could not be tested at law. Prominent among those is 'unbearable and hopeless suffering', a criterion that has been shown by Dutch lawyers to be incapable of any consistent interpretation.⁷

The same reasons are invoked in the Netherlands as elsewhere to justify euthanasia, chiefly respect for self-determination, but only voluntary euthanasia is openly discussed. While some

regard Dutch euthanasia as the flowering of patient autonomy, others regard it as the domination of patients by doctors who have gained unprecedented power over patients' lives.

Public opinion polls are also used to justify policy, though the same polls that gain 70% support for voluntary euthanasia in the community encounter 90% opposition, when conducted in nursing homes.⁸

Official support for non-voluntary euthanasia is readily found. The State Commission on Euthanasia in 1987 recommended that non-voluntary euthanasia should not be an offence, if carried out in the context of 'careful medical practice', though that was not defined.⁷ In 1988, a KNMG working party condoned euthanasia for deformed infants, in some instances thinking it ought to be compulsory.⁷ In 1991, a KNMG committee condoned the killing of patients in persistent coma.⁷

The Rummelink Report and the van der Maas Survey

After years of uncertainty and argument, from within and without, about its euthanasia practices, the Dutch resolved in 1990 to set up a Commission, chaired by Attorney General Rummelink. It conducted an inquiry over a twelve month period and, in 1991, issued the Rummelink Report.⁹ The statistical Survey on which the Report was based was carried out by the Central Bureau of Statistics and published in English in 1992, under the name of Dr van der Maas.¹⁰ Though the Commissioners were surprised at some of the findings, especially non-voluntary killing, they at once excused such practices in their Report, but the statistics cannot be denied.

By adopting the narrow definition of euthanasia as 'active termination of life upon the patient's request', the Dutch reported there were 2,300 instances of euthanasia in the year of the survey, or 1.8% of all deaths. When, however, to these are added instances of killing patients without request and intentionally shortening the lives of both conscious and unconscious patients, the figures are dramatically altered. They now become: 2,300 instances of euthanasia on request; 400 of assisted suicide; 1,000 of life-ending actions without specific request; 8,750 patients in whom life-sustaining treatment was withdrawn or withheld without request, 'partly with the purpose' (4,750) or 'with the explicit purpose' (4,000) of shortening life; 8,100 cases of morphine overdose 'partly with the purpose' (6,750) or 'with the explicit purpose' (1,350) of shortening life; 5,800 cases of withdrawing or withholding treatment on explicit request, 'partly with the purpose' (4,292) or with the 'explicit purpose' (1,508) of shortening life.¹¹

Thus, there were up to 23,350 instances of doctors intending, by act or omission, to shorten life, lifting the incidence of euthanasia to over 20% of all deaths in the year. Because of lack of precision in some of the above categories, it is not possible to be certain about the exact incidence of the intentional taking of life without consent, that is, of non-voluntary euthanasia, but there can be no doubt that it was substantial.

Although the Report stated that the 1,000 instances of 'life-ending actions without request' were carried out on incompetent patients 'in their death agony', on the doctors' testimony at interview detailed in the Survey, 14% of those patients were competent and 11% were partly competent. According to the death certificate study, 36% of them were competent.¹²

In the preamble to its Guidelines for Euthanasia in 1987, the KNMG had stated: 'if there is no request from the patient, then proceeding with the termination of his life is juridically a matter of

murder or killing, and not of euthanasia'.³ By their own Society's definition then, Dutch doctors were then carrying out medical murder, and have continued to do so.

As the Report also noted, to these totals should be added unspecified numbers of handicapped babies, sick children, psychiatric patients and AIDS patients, whose lives were also terminated by doctors, but for whom there are no data. It is estimated that some 25% of deaths in AIDS patients in the Netherlands are now due to euthanasia.

The guidelines for careful practice were found to be frequently disregarded. 27% of respondents admitted they had killed patients without any request, and 72% reported that after euthanasia, they falsified the death certificate to make it appear that death was due to natural causes. On none of those occasions, therefore, was there any information about what, if any, guidelines had been observed. It is reasonable to conclude that this was because guidelines had been ignored, in whole or in part.

What has happened since 1991?

It may have been expected that uncovering these facts would bring calls for radical reform of some of these practices, chiefly failure to report euthanasia, falsification of death certificates and widespread neglect of the guidelines, and for the total prohibition of life-taking without request.

There ensued a period of official inactivity because some of the findings were so unexpected, and because euthanasia was well established and supported by the community. Euthanasia activists lobbied to have euthanasia formally legalised, without success. In particular, taking life without consent presented a semantic problem because it was not euthanasia according to the official definition. To meet this difficulty, the authorities abandoned their previous frankness of 1987 in favour of an innocuous-sounding acronym, LAWER, 'life-terminating acts without explicit request'.¹³ The topic could now be openly discussed as though it were morally, emotionally and socially neutral, and was soon to become a medical alternative acceptable to doctors and the community.

In 1993, authors from the Department of Public Health at the Erasmus University could write: 'But is it not true that once one accepts euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? In our view, the answer to this question must be affirmative'.¹⁴

In February 1993, new regulations about medical reporting of euthanasia were issued,¹⁵ but they have had little impact, either on reporting or on the practices themselves. The new rules 'required' the reporting of both voluntary and non-voluntary euthanasia (NVE) on the same form. This had the effect of confirming in many doctors the view that both were equally acceptable to the authorities. Indeed, in 1993 the Secretary of Health, referring to these practices, said 'For a physician, the considerations in these two cases are not essentially different; from the moral point of view the two actions are not of entirely different kind'.¹⁶

In 1995, the health authorities reviewed the effects of these 1993 changes in the reporting rules.¹⁷ They said the changes were to 'encourage' physicians to report and to 'promote' adherence to them, but they did not say they would be enforced, so that reform would be achieved. The reporting rate, which had been a mere 18% in 1990, was found in 1995 to be only 41%, still less

than half, indicating a continuing large pool of euthanasia practice about which nothing whatever is officially known, and about which little is intended to be done.

For that review, a number of doctors who had not reported cases of euthanasia were interviewed with a guarantee of indemnity, to try to open a window on these hidden practices. 70 doctors had not reported their last case of NVE and 36% said they would never report such a case, whatever the law might require. Only 44% had required a written patient request, only 11% had consulted with a colleague and only 57% had provided a written report after voluntary euthanasia. The incidence of NVE among those who had reported their practices was .09%, while among those who had not reported it was 19%, a staggering difference of 200 times. Despite this, the authors concluded that 'substantial progress in the oversight of physician-assisted death has been achieved', and that 'there were no major differences between reported and unreported cases, in terms of...whether there was an explicit request...'.

Visiting Australia in 1996, the then Dutch Minister of Health said that some doctors did not report their cases because they were afraid of prosecution.¹⁸ One may gauge their real level of concern when one reads, in the 1995 paper, of the fate of 20 doctors who were investigated for non-reporting - 9 were acquitted, 2 were discharged, 3 were found guilty but not punished and 6 were given suspended sentences of one week to six months. None were prosecuted.

Official moves are now being made to set up local committees of inquiry to receive reports of euthanasia, in order to exclude the law, and for automatic exemption from further oversight when the doctor reports having followed the guidelines. Of course, those who do not report their actions will also not be prosecuted, no matter what they have done.

In an official review in 1996 of developments since the Rummelink Report,¹⁹ it was concluded that 'euthanasia seems to have increased in incidence since 1990, and the ending of life without the patient's explicit request seems to have decreased slightly'. The latter is discussed with the cool statistical detachment that befits a practice about which the authors have no concerns, confirming that it has become just another option for doctors.

In 1993, a Dutch court established a new milestone by extending toleration for euthanasia to suicidal patients who are not physically ill. A psychiatrist had assisted a woman to die, because she was depressed following the breakdown of her marriage and the loss of a son. He did not treat her depression because she refused treatment, and he did not consult other doctors. He was originally found guilty of murder, but this finding was overturned on appeal.²⁰

Because a sustained wish for death is almost always associated with profound psychological disturbance, it is now accepted that every person who requests euthanasia should be referred to a psychiatrist. Surprisingly, a survey of 552 psychiatrists in the Netherlands, published in 1997, revealed that only one third of them had ever been asked by another doctor to see a patient for that reason.²¹

In 1995, two separate Dutch courts upheld the actions of doctors who had deliberately ended the lives of handicapped neonates with lethal injections, so providing the first legal endorsement of NVE. In one case, the judge said 'In the decision of active ending of life, Dr Kadjik had acted with scientific responsible insight and in accordance with the medical ethic and accepted norms and in consideration of due care resulting therefrom; he is entitled to an appeal of force majeure.'²²

Euthanasia in the Netherlands has gone from requiring terminal illness to no physical illness at all, from physical suffering to depression only, from conscious patients to unconscious, from those who can consent to those who cannot, and from being a measure of last resort to one of early intervention.

Although respect for patient autonomy is the main ethical argument in favour of euthanasia, power has passed almost exclusively into doctors' hands. Patient autonomy has been subverted by the unprecedented rights given by the courts to doctors to decide the fate of patients.

Euthanasia was widely developed in defiance of the statute law, though with apparent community approval, to be later rationalised by court determinations. This was followed by even more objectionable medical practices, again outside the official guidelines, with ethics and common law trying to catch up. Instead of principle being enunciated to inform both the law and ethical medical practice, principle has been taken captive by widespread abuse of them both.

Two important messages emerge. First, in legalising euthanasia, one has to contend with what has been described as 'the tendency of a principle to expand itself to the limit of its logic', and second, attempting to make law in the absence of a full understanding of its consequences is highly dangerous.

It has recently been announced (August 1999) that voluntary euthanasia will soon be legalised in the Netherlands. It is too soon to know what the structure of that law may be, but events there since 1973 give little hope to suppose that the law would pass scrutiny for safety, by the standards of British or Australian criminal law.

The Dutch government issued its draft for such a law in 1998, and while the final bill as presented in parliament may differ from that early draft, it provides the best clue to the government's thinking. Here are the first four sections of the 1998 draft:

A. The Penal Code Article 293 will read as follows:

1. He who intentionally takes another's life at his explicit and serious request, is to be punished with a prison term of, at the most, twelve years or a fine of the fifth category.
2. He who intentionally incites another to suicide, is to be punished if the suicide follows, with a prison term of, at most, three years or a fine of the fourth category.
3. He who intentionally assists another with suicide or offers him/her the means thereto if the suicide follows, is to be punished with a prison term of, at most, three years or a fine of the fourth category.
4. The first and the third section do not apply if the termination of life, or the assisted suicide, or the offering of the means thereto is done at the patient's explicit and repeated request on account of the hopeless emergency situation in which he finds himself, by a medical doctor who meets the requirements of carefulness and who informs the coroner accordingly as to what is proscribed in Article 7, Section.

The wording of the fourth section is so loose that it changes nothing about the circumstances of Dutch euthanasia over the past twenty years, namely that Dutch doctors have gained virtually

total control over the practice of euthanasia, when it will happen and to whom it will happen. The government will have caved in to the powerful medical lobby to confirm them in their position of dominance. The only change that MAY eventuate could be the incidence of honest reporting, but even the making of specific regulations about that in 1993 in the past brought little change for the better.

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