

EUTHANASIA, THE NETHERLANDS, AND SLIPPERY SLOPES

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1. INTRODUCTION

Voluntary euthanasia may be defined as “a medically assisted quick peaceful death at the request of and in the interests of a patient”¹, “the deliberate ending of a life in a painless manner *at the request* of the patient”², the “killing of someone where, on account of his distressing physical or mental state, this is thought to be in his own interests... done at the request of the person himself.”³ O’Loughlin and McNamara define euthanasia as the

intentional taking of a human life either by a deliberate act (as with a lethal injection) or by the deliberate neglect of reasonable care (as with not offering feeds to a newborn infant.)⁴

They observe that “the continuing use (by proponents of euthanasia) of the term voluntary euthanasia to specify a policy, shifts the emphasis from the objective nature of the act of killing to the intent or choice of the persons involved, be they doctor or patient. This pro-choice emphasis is similar to that used in the abortion debate.”⁵

Euthanasia advocates prefer the usage “voluntary euthanasia” because they believe that voluntary euthanasia can be kept separate from other acts of euthanasia which involve the killings of patients without their explicit request.⁶ The South Australian Voluntary Euthanasia Society (SAVES) believes that changes to the law to permit voluntary euthanasia represent a “clearly defined and unambiguous boundary”, and that such evidence as SAVES claims it has “does not support this escalation of fear.”⁷

¹ South Australian Voluntary Euthanasia Society, *vid. Second Interim Report of the Select Committee on the Law and Practice Relating to Death and Dying*, South Australian Parliament, 49

² Daniel Ch Overduin, *Euthanasia* (Adelaide: Lutheran Publishing House), 5

³ Jonathon Glover, *Causing Death and Saving Lives*, (Harmondsworth, UK: Penguin Books Ltd., 1987), 182

⁴ Kevin T. O’Loughlin and Laurence J. McNamara, *Caring, Living & Dying*, (Adelaide: Care For Life Inc., 1991), 7

⁵ *Ibid.*, 8

⁶ In 1989 Henk Rigter, executive director of The Health Council of The Netherlands (Gezondheidsraad), The Hague, declared that there was no evidence of widespread involuntary euthanasia, that “virtually all of the doctors brought to trial for performing euthanasia, or whose case was investigated by a public prosecutor, appeared to have followed the generally accepted rules of practice.” Henk Rigter, “Euthanasia in The Netherlands: Distinguishing Facts from Fiction”, in *A Special Supplement, The Hastings Center Report*, 19:1, January/February 1989, 31 and *cf* Richard Fenigsen, “A Case Against Dutch Euthanasia”, *loc. cit.*, 22-30

⁷ *The Right to Choose. The case for legalising Voluntary Euthanasia*, (Brighton, South Australia: South Australian Voluntary Euthanasia Society, 1986), 27

SAVES is “simply proposing” changes in the law to rectify the anomalies they see, and that, “as in The Netherlands, the circumstances in which v.e. is permissible should be carefully defined and the law changed accordingly.”⁸

2. CAN VOLUNTARY EUTHANASIA BE TAMED?

Supporters of voluntary euthanasia claim that voluntary euthanasia can be domesticated, that it will not lead to other forms of medical killing which violate the patient’s autonomy or right to choose. The Netherlands is frequently cited as the test case which proves the point. I shall assess the evidence available on the practice of euthanasia in that country shortly.

Invoking the principle of autonomy as the defining principle to decide the moral rightness or wrongness of euthanasia, Tristram Engelhardt and Helga Kuhse both recognise the qualification of avoiding harm to others. Like Jonathon Glover they hold that

To refuse to provide help [to commit suicide] is a very serious denial of the person’s autonomy over the matter of his own life and death, and is only to be justified by powerful arguments appealing either to the future quality of his life or to side-effects.⁹

None of these writers believe that we have cause to worry about deleterious social consequences.¹⁰

However Helga Kuhse and Peter Singer also believe that it is sometimes morally right to kill certain classes of humans without their knowledge and consent. Peter Singer can justify the killing of a “defective infant”.

When the death of a defective infant will lead to the birth of another infant with better prospects of a happy life, the total amount of happiness will be greater if the defective infant is killed. The loss of a happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would, according to the total view, be right to kill him.¹¹

Kuhse and Singer “think some infants with severe disabilities should be killed.”¹² They believe that

there is a limit to the burden of dependence which any community can carry. If we attempt to keep all handicapped infants alive, irrespective of their future prospects, we will have to give up other things which we may well regard as at least as important.¹³

⁸ *Ibid.*, 30

⁹ Jonathon Glover, *Causing Death and Saving Lives*, (Harmondsworth: Penguin Books Ltd., 1987), 184

¹⁰ Jonathon Glover says: “In my view thorough discussion should enable us to sort out the serious requests from the others, and the arguments from side-effects are not sufficiently strong enough to constitute an overriding objection.” *Ibid.*, 188. According to Tristram Engelhardt “the experience in the state of Texas suggests that a practice grounded in respect of free individuals does not lead to disasters.” *The Foundations of Ethics*, 317. Cf Helga Kuhse, *The Sanctity of Life Doctrine in Medicine*, (Oxford: Clarendon Press, 1987), 216-218

¹¹ Peter Singer, *Practical Ethics*, (Cambridge: Cambridge University Press, 1989), 134

¹² Helga Kuhse and Peter Singer, *Should the Baby Live?*, (Oxford: Oxford University Press, 1985), v

¹³ *Ibid.*, 170. Kuhse and Singer go on to deny that there is anything in their views that “in any way implies a lack of concern for disabled people in our community.” *Ibid.*, v. Despite this disclaimer, people with disabilities in Germany saw in Peter Singer’s expressed views the essence of eugenics, that distaste for lives afflicted by disability and a willingness to allow parents to have such children killed. Kuhse and Singer declare that they want improved services for “disabled people”. It should be noted that such people prefer to be called people with disabilities, to emphasise their personhood rather than

As far as adults who refuse euthanasia are concerned, Helga Kuhse proposes the following strategy to make the choice for death seem the only choice to make.

If we can get people to accept the removal of all treatment and care – especially the removal of food and fluids – they will see what a painful way this is to die, and then, in the patient’s best interests, they will accept the lethal injection.¹⁴

Kuhse is not proposing a policy of coercive “voluntary euthanasia”. Her view is that a public policy, which allows the withholding of food and fluids, is a cruel one and not in the patient’s best interest. She believes the public recognition that such a policy grossly disregards the interests of patients must lead to the acceptance of active euthanasia.¹⁵

Daniel Myen proposes suicide not just as a right but, in some circumstances, a duty.

The duty to suicide occurs when through my continued living lack of autonomy, misery, isolation, uniformity, unfruitfulness, incurability, lameness, pain, insensitivity, disgrace, madness, sin threaten to become the norm for humanity and my suicide is the only means available for me to prevent this.¹⁶

The New South Wales Humanist Society has suggested that “converting some forms of N.V.E. [non-voluntary euthanasia] to V.E. [voluntary euthanasia] is very desirable.” It suggested the possibility of a “senile degenerate” having signed prior consent to being killed “while still in full possession of his faculties”. They further suggest that the law could be changed to allow “the mentally ill, the right of consent to E. [euthanasia].” As for babies “born with severe mental or physical disabilities, such as are sure to make it a misery to itself or to those who have to look after it, its life should be terminable by legal process before any person becomes emotionally attached to it.” This could be done by “passing a law granting parents a right to assign certain discretion to a doctor”. The N.S.W. Humanist Society refers specifically to “babies grossly mentally or physically handicapped. The severe mentally afflicted. Senile degenerates. It does seem undesirable to keep these unfortunates alive. Their continued existence burdens relatives, friends and the community, and often, though not always, themselves.”¹⁷ This discussion of the non-voluntary killing of some “degenerates” occurs in a document which begins firstly with a discussion of suicide, assisted suicide, and voluntary euthanasia, a discussion which inexorably leads to the canvassing of the killings even of the mentally ill.¹⁸

their disability. Given Kuhse and Singer’s preference for defining personhood in terms of “self-awareness and a sense of the future” then there is some reason to understand why there is a concern for at least some adult persons with disabilities. Cf. *ibid.*, 138

¹⁴ Fifth Biennial Conference of the World Federation of Right to Die Societies; Nice, France; Sept. 20-23, 1984. From “Ethics Panel: The Right to Choose Your Death – ‘Ethical Aspects of Euthanasia’.” Remarks by panel member Helga Kuhse, Ph.D., lecturer in philosophy at Monash University and Research Fellow at the Centre for Human Bio-Ethics in Melbourne, Australia, Sept. 21, 1984 and cited in Rita L. Marker, “The Ethical Values That Civil Law Must Respect in the Field of Euthanasia”, *The Linacre Quarterly*, 56:3, August 1989, 26

¹⁵ Personal conversations with Helga Kuhse, 1992

¹⁶ Daniel Myen, “Zur ethischen Beurteilung der Selbsttötung (*Deutsche Gesellschaft für humanes Sterben*, 1982)

¹⁷ N.S.W. Humanist Society, *Euthanasia (Compassionate Death)*, prepared by a sub-committee of the N.S.W. Humanist Society and adopted, February 1973

¹⁸ It seems that Martin Luther approved of the killing of the degenerate. He “advised the Prince of Anhalt to drown a twelve-year old malformed and imbecile boy who ‘devoured as much as four farmers did and who did nothing else than eat and excrete’. (cf LW, American Edition Vol. 54, ‘Table

It appears, then, that many of the key proponents of voluntary euthanasia are committed, as well, to the non-voluntary killings of other classes of humans, some of whom they are disposed to define as non-persons to make the killings seem more “reasonable”. That being the case, there is every reason to question the claim that voluntary euthanasia can be quarantined from the non-voluntary killings of different groups of vulnerable human beings.

3. PETER SINGER, “THE AGE”¹⁹ DEBATE, AND THE NETHERLANDS

In the Melbourne newspaper “The Age”, of March 6 1992, Peter Singer advocated the legalisation of euthanasia in line with the court-sanctioned practice of The Netherlands. He referred to a study carried out by the Monash University Centre For Human Bioethics which purported to show that a quarter of the Victorian nurses who participated in the survey “had been asked by a doctor to do something that would, at the request of the patient, directly and actively end the patient’s life.” Of these, 85 per cent had engaged in the administration of death to their patients at least once, and 80 per cent “had done so more than once.” This was in line with an earlier survey of Victorian doctors “which found that 29 per cent of respondents had taken active steps to bring about the death of a patient who had asked for death to be hastened.”²⁰

The essential elements of Singer’s case were:

- a) The doctors and nurses are doing it anyway, it is better it is legal so that patients can have access to the services that “would put them in control of the last phase of their lives.”²¹
- b) The Netherlands system means that a second opinion will be required and strict conditions met.
- c) It will put the minds of doctors and nurses at ease that they will not be charged with murder.
- d) As in The Netherlands “voluntary euthanasia can be offered openly, in specified circumstances, and reported as the cause of death on the death certificate, without any fear of prosecution, as long as correct procedures were followed.”²²
- e) In The Netherlands about 2300 deaths each year result from voluntary euthanasia carried out by doctors.

A spirited correspondence and a series of other articles followed the Singer article and an earlier statement (March 3) by Ron Merkel. Merkel, the president of the Victorian Council for Civil Liberties claimed that the distinction between passive and active euthanasia was illusory.

Talk’, No. 5207, pp 396-7 and note 140).” Cited in D. Ch. Overduin, *Euthanasia*, (Adelaide: Lutheran Publishing House, 1980), 4. Luther’s view needs to be understood in the context of the prevailing mores of the time. The famous Dutch jurist Hugo de Groot (1583-1646) spoke of ‘bodies unsuitable to contain a rational soul.’ “Euthanasia (suffocation) of such malformed children was permitted in some countries until the first half of the 19th century.” *Ibid*

¹⁹ “The Age” refers to a newspaper in Melbourne, Victoria, Australia.

²⁰ Peter Singer, “The last rights”, *The Age*, March 6, 1992, 11

²¹ *Ibid*.

²² *Ibid*.

If you stand by and don't help a patient who therefore dies – or if you are standing by and you help that patient to die – there is no real difference.²³

Peter Coghlan responded by arguing that Merkel was mistaken, that there is a morally relevant distinction between intending to kill by act or by neglect, and engaging in acts or omissions without intending to cause death.²⁴ The South Australian Select Committee On the Law and Practice Relating to Dying has also refused to accept that “there is no moral distinction between letting someone die and bringing about that person's death.”²⁵ Dr Lloyd Morgan rejected the call for active euthanasia “because it is unnecessary in most cases”, and because the choices of dying in pain or being killed are not the only choices available given modern palliative care.²⁶

4. THE TRUTH ABOUT THE NETHERLANDS

The evidence from The Netherlands, now available in the official Dutch reports, and in a recently published research piece by the English legal academic John Keown, provides conclusive evidence of abuse, of the slippery slope that Singer, Kuhse and others have denied would be the case. The Dutch reports contain abundant evidence that doctors kill more without their explicit request than with their explicit request, and that euthanasia is not restricted by the so-called “strict medical guidelines” provided by the Dutch courts.

The first results of the Dutch nationwide study on “euthanasia and other medical decisions concerning the end of life (MDEL)” give pause for thought. The report, published in the British medical journal *The Lancet* and based upon larger reports published in Dutch, hereinafter referred to as *The Lancet Dutch Report*, acknowledges that “in cases of euthanasia the physician often declares that the patient died a natural death”²⁷. This amounts to a tacit admission that Dutch doctors are prepared to make false statements even when they kill patients according to the strict medical guidelines laid down by the judiciary. The study, which is a prospective survey, needs to be handled carefully given the fact that Dutch doctors who perform acts of euthanasia are not always very truthful. Nevertheless, *The Lancet Dutch Report* indicates that about 0.8% of the 38.0% of all deaths involving MDEL were “life-terminating acts without explicit and persistent request”.²⁸ The need for the request to come from the patient, for it to be well-considered, durable and persistent, as well as a free and voluntary request forms part of the strict medical guidelines laid down by the Dutch courts and summarised by Mrs Borst-Eilers, Vice-President of the Dutch Health Council.²⁹ This means that *The Lancet Dutch Report* acknowledges the deaths of about 1,000 Dutch

²³ “Nurses in call for euthanasia inquiry”, *The Age*, March 3, 1992, 6

²⁴ Peter Coghlan, “Deliberate killing of fellow human beings”, *The Age*, March 6, 1992, 11

²⁵ *Second Interim Report of the Select Committee On the Law And Practice Relating to Death and Dying*, (Adelaide: SA Parliament, May 1992), 51

²⁶ Lloyd Moran, “Means available to aid right to die”, *The Age*, March 9, 1992, 8

²⁷ Paul J. van der Maas, Johannes J.M. van Delden, Loes Pijnenborg, and Caspar W.N. Looman, “Euthanasia and other medical decisions concerning the end of life”, *The Lancet*, 338:8768, September 14, 1991, 669

²⁸ *Ibid.*, 670

²⁹ Else Borst-Eilers, “The Status of Physician-Administered Active Euthanasia in The Netherlands”, (Unpublished paper delivered at the Second International Conference on Health Law and Ethics, London, July 1989), and cited in John Keown, I.J. Keown, “The Law and Practice of Euthanasia in The Netherlands”, in *The Law Quarterly Review*, 108, January 1992, 7-8

citizens in a single year which were the result of the doctor hastening the death of the patient, without the patient's explicit request and consent. *The Lancet Dutch Report* summarises it in this way:

Sometimes the death of a patient was hastened without his or her explicit and persistent request. These patients were close to death and were suffering grievously. In more than half such cases the decision had been discussed with the patient or the patient had previously stated that he would want such a way of proceeding under certain circumstances. Also, when the decision was not discussed with the patients, almost all of there were incompetent.³⁰

In the light of the fact that Dutch doctors do not always tell the truth in these matters, that some 1,000 patients are killed outside of the 'strict medical guidelines', the lack of concern by the authors of *The Lancet Dutch Report* is noteworthy. Ten Have and Welie have suggested that the R Emmelink Committee's interpretation of the facts "reveals a political bias".

The committee clearly tried to remove any societal anxieties about the practice of euthanasia. Similar practices are brought under dissimilar headings to keep the numbers low. And at crucial places, particularly with the 1,000 non-voluntary cases, the committee uses fallacious rhetoric to emphasize that there is nothing to worry about.³¹

There are two other matters which also give cause for concern.

Firstly, the definition of euthanasia used in the report is a very narrow one: "active termination of life upon the patient's request." This definition does not include those who die of involuntary euthanasia, and so does not include the 1,000 patients to which I have already referred. If reference is then made to the two Dutch reports, available only in Dutch, and upon which *The Lancet Dutch Report* is based, then a very disturbing picture emerges. The real number of physician-assisted deaths, estimated by the R Emmelink Committee Report³² is, in reality, 25,306 which is made up of:

2,300 euthanasia on request³³

400 assisted suicide³⁴

1,000 life-ending treatment without explicit request³⁵

4,756 patients died after request for non-treatment or the cessation of treatment with the intention to accelerate the end of life³⁶

³⁰ Paul J. van der Maas *et al*, *loc. cit.*, 673

³¹ Henk A.M.J. ten Have and Jos V.M. Welie, "Euthanasia: Normal Medical Practice?" in *Hastings Center Report*, 22:2, March-April 1992, 36

³² *Medische Beslissingen Rond Het Levenseinde* – Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, (The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Dutch Euthanasia Survey Report*] and *Medische Beslissingen Rond Het Levenseinde* – Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie. The Hague, The Netherlands: Sdu Uitgeverij, 1991 [*R Emmelink Report*]. I am indebted to Dr Daniel Ch. Overduin for translating the relevant sections of the two reports, thereby making the detailed evidence contained in them accessible to the English-speaking but non-Dutch-speaking public.

³³ *R Emmelink Report*, 13

³⁴ *Ibid.*, 15

³⁵ *Ibid.*,

³⁶ There were 5,800 such cases, *cf Ibid.*, 15. However only 82% [i.e. 4,756] of these patients actually died. *Cf Dutch Euthanasia Survey Report*, 63ff

8,750 cases in which life-prolonging treatment was withdrawn or withheld without the request of the patient either with the implicit intention (4,750) or with the explicit intention (4,000) to terminate life³⁷

8,100 cases of morphine overdose with the implicit intention (6,750) or with the explicit intention (1,350) to terminate life.³⁸ Of these 61% were carried out without consultation with the patient, i.e. non-voluntary euthanasia.³⁹

This total of 25,306 physician-assisted deaths amounted to 19.61 per cent of total deaths (129,000) in The Netherlands in 1990.

To this should be added the unspecified numbers of handicapped newborns, sick children, psychiatric patients, and patients with AIDS, whose lives were terminated by physicians, according to the *Remmelink Report*.⁴⁰ The narrow definition of euthanasia masks the real number of individuals whose lives are ended by interventions from the medical profession, and also masks the fact that more people are killed by physicians without their consent than with their consent.⁴¹

Secondly, *The Lancet Dutch Report* blandly observes:

Many physicians who had practiced euthanasia mentioned that they would be most reluctant to do so again, thus refuting the “slippery slope” argument.⁴²

This begs the question as to why such physicians “would be most reluctant” to practice euthanasia again. Is it that they feel they have done something very wrong? Was it, all things considered, an unpleasant experience, and, if so, in what way? It further begs the question as to how the ‘slippery slope argument’ is refuted. To be “most reluctant” to do so again doesn’t mean that one will not do it again. And in the light of the actual information in the *Dutch Euthanasia Survey Report*, on which *The Lancet Dutch Report* is based, there is ample evidence of the slipperiest of slopes,⁴³ thereby giving support to Thomas Hobbes’ observation that to voluntarily agree to be killed threatens the right to life of other members of the community as well.

The *Remmelink Report*, in the context of dealing with the nature of medical decisions at the end of life,⁴⁴ does not effectively deal with the questions of palliative care⁴⁵,

³⁷ There were 25,000 such cases, *cf Ibid.*, 69. However, only 35% (8750 cases) were done with the intention to terminate life. *Cf Ibid.*, 72; *cf also Remmelink Report*, 16

³⁸ There were 22,500 patients who received overdoses of morphine, *cf Ibid.*, 16. 36 per cent were done with the intention to terminate life, *cf Dutch Euthanasia Survey Report*, 58

³⁹ *Dutch Survey Report*, 61, Tabel 7.7 [“Besluit niet besproken”]

⁴⁰ *The Remmelink Report*, 17-19

⁴¹ Other reviews of the evidence from the two Dutch reports supporting the present writer’s analysis may be found in Richard Fenigsen, “The Report of the Dutch Governmental Committee on Euthanasia”, *Issues in Law & Medicine*, 7:3, 1991, 337-344; Henk A.M.J. ten Have and Jos V.M. Welie, “Euthanasia: Normal Medical Practice?” *loc. cit.*, 34-38

⁴² Paul J. van der Maas *et al*, *loc. cit*, 673

⁴³ Helga Kuhse, referring to the “ ‘social experiment’ with active voluntary euthanasia” currently in progress in The Netherlands, has stated that “as yet there is no evidence that this has sent Dutch society down a slippery slope.” Helga Kuhse, “Euthanasia”, in *A Companion to Ethics*, ed. Peter Singer, (Oxford: Basil Blackwell Ltd., 1991), 302. The evidence cited together with I.J. Keown, *loc. cit.*, 70-77 suggests a less encouraging conclusion should be drawn from the facts.

⁴⁴ *The Remmelink Report*, 21ff. Part II, par. 6 deals with “De aard van medische beslissingen rond het levenseinde.”

patient depression, patient fears, and the subtle and not too subtle pressure brought to bear on patients to end it all now, rather than to continue being a burden on others. The *Rommelink Report* fails to give reasons why patients who were close to death “were suffering grievously”,⁴⁶ and why a wealthy country like The Netherlands does not offer patients effective means to relieve that suffering. “Good care is not cheap; it is much cheaper to kill people.”⁴⁷

Alexander Morgan Capron⁴⁸ attended a meeting at the Institute for Bioethics, Maastricht, The Netherlands, in December 1990, which brought together, by invitation, 14 experts to examine the practice of euthanasia in The Netherlands. Capron considered the two basic requirements for the justification of euthanasia in The Netherlands, self-determination and the relief of suffering.

Proponents of euthanasia began with a “narrow” definition (limited to voluntary cases) as a strategy for winning acceptance of the general practice, which would then turn to the second factor, *relief of suffering*, as its justification in cases *in which patients are unable to request euthanasia*.⁴⁹ [my emphases]

Capron went on to cite the evidence of one of the Dutch participants, a physician, who “mentioned that in perhaps thirty cases a year, patients’ lives were ended after they had been placed in a coma through the administration of morphia.”

When asked about the apparent discrepancy, she replied that the latter cases were not instances of euthanasia *because they weren’t voluntary*: discussing the plan to end to patients’ lives would be “rude”, she said, particularly as they know they have an incurable condition. Comments from several other physicians made clear that this practice is neither limited to one particular hospital nor of recent vintage. Nevertheless, a number of the Dutch participants were plainly discomfited to find that at least in some situations the number of instances of physicians causing death without consent overshadowed the number that met the Dutch definition of “euthanasia”.⁵⁰

In a recently completed research project carried out in The Netherlands, John Keown argues that the ‘guidelines’ for euthanasia in The Netherlands are not strict or precisely defined, and that there is no “satisfactory procedure, such as an effective independent check on the doctor’s decision-making, to ensure that they are met”.⁵¹ Dr. Keown is the Director of the Centre For Health Care Law, in the Faculty of Law in the University of Leicester, U.K.. Keown doubts that the requirement that the

⁴⁵ This stands in sharp contradistinction to the Report of the Committee on the Environment, Public Health and Consumer Protection on “care for the terminally ill” [European Communities – European Parliament, *Session Documents (English Edition)*, 30 April 1991 A3-0190/91] which contains a “Motion For a Resolution” on *care for the terminally ill* which refers in its preamble (“E”) to the proposal that “the right to a dignified death” be enshrined in the *European Charter on the Rights of Patients*. However, the emphasis in the motion itself is on *palliative care*, rather than on assistance in dying.

⁴⁶ Paul J. van der Maas et al, *loc. cit.*, 673

⁴⁷ Ian Maddocks, *The Advertiser*, (Adelaide, South Australia, November 2, 1991), 1. Professor Maddocks is the Professor of Palliative Care, Daw Park Repatriation Hospital in South Australia. He was referring to allegations that some doctors in South Australia help patients to die by lethal injection.

⁴⁸ Alexander Morgan Capron is the Henry W. Bruce University Professor of Law and Medicine, University of Southern California, and codirector of the Pacific Center for Health Policy and Ethics.

⁴⁹ Alexander Morgan Capron, “Euthanasia in The Netherlands. American Observations”, *Hastings Center Report*, 22:2, March-April 1992, 31

⁵⁰ Alexander Morgan Capron, *loc. cit.*, 31

⁵¹ I. J. Keown, *loc. cit.*, 62

request for euthanasia be “entirely free and voluntary” is met. “Although the K.N.M.G. Guidelines state that the request must not be the result of pressure by others, they do not prevent the doctor or nurse from either mentioning euthanasia to the patient as an option or even strongly recommending it.”⁵²

Having developed his case that the guidelines are not strictly enforced Keown goes on to remark that the “overwhelming majority of cases are falsely certified as death by natural causes and are never reported and investigated... a doctor who has acted in breach of the law is no more likely to admit having done so in his report than a tax evader is likely to reveal his dishonesty on his tax return.”⁵³ The fact that the “vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths itself casts doubt on the lawfulness of much of the euthanasia which is being carried out.”⁵⁴

Brian Pollard makes similar observations to Keown. He also refers to this statement by the Advocate General of The Netherlands: “The medical profession is in all likelihood the only academically trained group of professionals, who by virtue of their profession, are guilty of making false statements in writing with great regularity when, after a euthanasia procedure, they make inaccurate death declarations which conceal the unnatural death case.”⁵⁵

The naivety of Singer and Kuhse in imagining that the legalised killing of some would not lead to the unauthorised killing of others is noteworthy. It is naïve to imagine that people will always be “reasonable”, especially professional elites like physicians and nursing staff.⁵⁶ Yet Helga Kuhse and Peter Singer have already shown that some doctors and nurses will break the law and kill their patients in certain circumstances.⁵⁷ Kuhse and Singer appear willing to take doctors at their word, that they had killed patients “who had asked them to do so”,⁵⁸ without any independent corroborating evidence. Why doctors should be any more law-abiding if voluntary euthanasia were

⁵² *Ibid.*, 62-63

⁵³ *Ibid.*, 67-68

⁵⁴ *Ibid.*, 67.

⁵⁵ Brian Pollard, “Medical aspects of euthanasia”, *Medical Journal of Australia*, 154:9, 1991, 613-616

⁵⁶ Dan W. Brock exhibits the same kind of naivety in his recommendation that the practice of euthanasia be restricted to physicians. “Physicians whose training and professional norms give some assurance that they would perform euthanasia responsibly, are an appropriate group of persons to whom the practice may be restricted.” Dan W. Brock, “Voluntary Active Euthanasia”, *Hastings Center Report*, 22:2, March-April 1992, 21

⁵⁷ Helga Kuhse and Peter Singer, “Doctor’s Practices and Attitudes Regarding Voluntary Euthanasia”, *The Medical Journal of Australia*, 148:12, June 20, 1988, 623-627. Of the 369 doctors in the State of Victoria who answered the question, “Have you ever taken steps to bring about the death of a patient who asked you to do so?” 107 (29%) “replied that they had taken active steps to bring about the death of a patient who had asked them to do so.” *Ibid.*, 624. *Vid.* also Helga Kuhse and Peter Singer, “Euthanasia: A survey of nurses’ attitudes and practices”, *Australian Nurses Journal*, 21:8, March 1992, 21-22. In this article Kuhse and Singer conclude, on the basis of their survey that “of those nurses who had been asked by a patient to hasten death, 5% had taken active steps to do so without having been asked by a doctor. Almost all of the 25% who had been asked by a doctor to engage in active steps to end a patient’s life had done so.” *Ibid.*, 22

⁵⁸ Helga Kuhse and Peter Singer, “Doctors’ Practices and Attitudes Regarding Voluntary Euthanasia”, *loc. cit.*, 624

to be legalised is never clearly explained.⁵⁹ Perhaps it is the “belief” in utilitarianism, the “belief” in humanism, or faith in reason which obscures the truths about human nature so ruthlessly exposed by Hobbes, Augustine, Aquinas and Niebuhr.

5. CONCLUSION

The narrow definition of “euthanasia” in the Dutch report masks the real numbers of physician-assisted deaths, the majority of which have not been shown to be at the request of the patient. The so-called “strict medical guidelines”⁶⁰ are clearly not strictly followed or enforced. The encouragement by Peter Singer and Helga Kuhse to embrace these guidelines in Australia on the basis that they have been successfully employed in The Netherlands is simply not supported by the facts. Voluntary euthanasia cannot be quarantined from other acts of intentional killing as the Dutch experiment clearly demonstrates. Human rights are inalienable as well as inviolable. The right to life cannot be given up without threatening the right to life of other members of the community. When medical killing is allowed in some circumstances, the number of circumstances in which such killings occurs quickly increases. Repeated assertions of benign Dutch practice do not match the facts. And since, according to Kuhse and Singer, some doctors and nurses in Australia are already prepared to break the law and kill some patients, one wonders why they imagine that those same doctors and nurses would be any more law abiding even if the law were to allow medical killing in prescribed circumstances. Their own evidence of medical malfeasance and illegality suggests that such a confidence in medical professionals to obey a euthanasia law would be misplaced.

⁵⁹ Helga Kuhse endorses the principle summarised by Peter Singer, “If we sense an inconsistency in our beliefs and actions, we will try to do something to eliminate the sense of inconsistency...” One way of doing this is to make “our beliefs and actions both true and consistent.” Peter Singer, *The Expanding Circle*, (New York: Farrar, Straus & Giroux, 1981), 143 cited in Helga Kuhse, *The Sanctity-of-Life Doctrine in Medicine*, 28. Without the benefit of Revelation from God, about which not all are convinced, this would appear to be an impossible task, one which no moral philosophy has been able to achieve to the satisfaction of any except the disciples of a particular school.

⁶⁰ On November 8, 1991 the Dutch Minister of Justice and Secretary of Health presented to the President of the People’s House of the Parliament (“Tweede Kamer”) the “standpunt van het kabinet inzake medische belissingen rond het levenseinde” (position of the cabinet concerning medical decisions at the end of life). This “position” was critically examined by K F Gunning in *Vita Humana*, XVIII, 4 December 1991, 153ff. The Dutch Physicians Association is very concerned about the developments in this area of health care and opposes the proposed cabinet “position” which, it believes, endangers the life of patients and contradicts the European Declaration concerning Human Rights. *Ibid.*, 156. On April 1, 1992 it was reported that the Dutch Parliament endorsed the guidelines as presented in the cabinet “position” . Euthanasia is not yet legal in The Netherlands but this parliamentary action effectively guarantees the continuation of the current euthanasia practice in that country with all its attendant dangers.