

Euthanasia: law and practice in The Netherlands

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In The Netherlands, euthanasia is defined as the deliberate termination of the life of a person on his request by another person. Although, in this limited sense, euthanasia is only one of the issues raised by medical decision-making at the end of life, it is, in particular, the acceptance of euthanasia in this country that has attracted attention from abroad. Also, in The Netherlands itself, the toleration of the courts of euthanasia (if carried out by a physician under strict conditions) has given rise to much debate. This contribution surveys the developments in the law (including recent legislation), and in medical practice, and explores the relation between the two, with particular attention to the position of the physician.

Usually, 'euthanasia' is defined in a broad sense, encompassing all decisions (of doctors or others) intended to hasten or to bring about the death of a person (by act or omission) in order to prevent or to limit the suffering of that person (whether or not on his or her request). In The Netherlands, the word has a more limited meaning; it only refers to the deliberate termination of the life of a person on his request by another person (i.e. active, voluntary euthanasia)¹. This contribution deals with the regulation and practice of euthanasia in this limited sense. It is also in this sense that euthanasia in The Netherlands has attracted so much attention and raised so much controversy.

This is not to say, of course, that euthanasia is necessarily the most important, let alone the only, issue as far as medical decisions relating to the end of life are concerned. Due to an aging population, sociocultural developments and the increasing potential of medical technology to prolong life, physicians (in The Netherlands and elsewhere) have increasingly to face difficult dilemmas, first of all on whether or not to withhold (or refrain from) treatment. Also in The Netherlands (as in Britain, the USA, and other countries) there is much discussion on non-treatment decisions, in particular when incompetent patients (severely handicapped newborns, comatose patients, patients with severe dementia, or others) are concerned.

With regard to these decisions, however, the situation in The Netherlands would not seem to be basically at variance with accepted practice in most other countries. Therefore, this contribution will focus on (active, voluntary) euthanasia. It will deal first of all with the role of

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the courts and the profession in the regulation of euthanasia. Subsequently, medical practice will be discussed, with particular reference to recent empirical studies conducted in this field. Finally, an account will be given of the development of the notification procedure, of legislation and of prosecution policies.

The development of law

According to the Dutch Penal Code, euthanasia is a crime. However, it is not qualified as murder (as in some other countries), but dealt with in a separate section: according to Article 293, anyone who takes another person's life at his explicit and earnest request will be punished by imprisonment to a maximum of 12 years.

The Dutch debate on euthanasia was sparked by a court case in 1973 (the same year in which the Dutch Society for Voluntary Euthanasia was formed). In this case, a general practitioner was prosecuted for ending the life of her mother, who had suffered a cerebral haemorrhage, was partly paralysed, was deaf, and had trouble speaking. After the mother had repeatedly expressed the wish to die, the daughter ended her mother's life by giving her a lethal dose of morphine. The court (of Leeuwarden) found her guilty, not because she had hastened the death of her mother (who was incurably ill and suffered unbearably), but because she had directly ended her life instead of stepping up the doses of morphine with the secondary effect that the patient's life would have been shortened. The court gave her a suspended sentence of one week imprisonment and put her on probation for a year. In later decisions, the courts no longer exclude that a doctor may bring about the death of the patient in a direct way, but they have elaborated the criteria developed in the Leeuwarden decision and added other requirements.

Of the many other court rulings over the last two decades, I will only discuss the case which resulted in the landmark decision of the Supreme Court in 1984. This case (known as the Alkmaar case) concerned a 95-year-old woman who was seriously ill with no chance of recovery. The weekend before her death, she suffered substantial deterioration, was unable to eat or drink, and lost consciousness. She had pleaded with the doctor several times to put an end to her agony. After regaining consciousness, she declared that she did not want to go through such an experience again and urged her physician to end her life. Finally, the doctor decided to act according to her wishes as he was convinced that every single day would only be a heavy burden to the patient.

Doctors prosecuted for euthanasia have defended themselves in different ways. The only plea for acquittal which was not dismissed,

and which was also accepted by the Supreme Court in 1984, is the invocation of a situation of 'force majeure' (or necessity), resulting from a conflict of duties: the duty towards the patient to alleviate hopeless suffering and the duty towards the law to preserve the patient's life. A doctor will not be convicted if he or she has carefully balanced the conflicting duties and made a decision that can objectively be justified, taking into account the special circumstances of the case.

According to the Supreme Court in the Alkmaar case, the Court of Appeals of Amsterdam had not given sufficient reasons for its conviction of the doctor; in particular, it should have investigated whether, according to responsible medical opinion, a necessity (conflict of duties) had existed. In doing so, it should have taken into account, for instance, whether it could be expected that the patient would soon no longer be able to die with dignity in circumstances worthy of a human being. The case was referred to the Court of The Hague, which acquitted the doctor. In the same year, the Royal Dutch Medical Association issued an influential statement on euthanasia. While acknowledging the fact that in a pluralistic society there would never be consensus on matters such as abortion and euthanasia, including among doctors, the medical association stated that euthanasia might be acceptable in certain circumstances. In order to provide guidance to the profession as to under which conditions euthanasia could be permissible, it formulated a set of criteria that mirror the criteria developed by the courts:

- the request for euthanasia must come from the patient and be entirely free and voluntary, well considered and persistent
- the patient must experience intolerable suffering (physical or mental), with no prospect of improvement and with no acceptable solutions to alleviate the patient's situation
- euthanasia must be performed by a physician after consultation with an independent colleague who has experience in this field²

A year later (1985), the State Commission on Euthanasia (established in 1982 to advise the Government on its future policy with regard to legislation) proposed that Article 293 of the Penal Code be amended in such a way that the intentional termination of another person's life at the latter's express and earnest request would not be an offence, provided this is carried out by a doctor in the context of careful medical practice in respect of a patient who is in an untenable situation with no prospect of improvement³. As will be explained below, that proposal has never resulted in an amendment of the Penal Code.

In applying the aforementioned criteria, several other questions have been addressed by the courts in subsequent decisions. I will briefly comment on two of them.

Court decisions do not exclude the possibility that the patient's request is laid down in an advance directive drawn up by the patient while still competent. However, it is obvious that, in such a case, great caution is required, for instance with regard to the situation to which the statement is meant to apply. Until now, only one such case has been before a disciplinary court; in 1994, the Central Medical Disciplinary Court apparently accepted the written statement as a valid request. In a recent report on patients with severe dementia (1993), a commission of the Dutch Medical Association expressed strong reservations concerning euthanasia on the basis of such an advance directive at least as far as patients with dementia are concerned.

The courts do not require that the patient is terminally ill and that his death is imminent (see, for instance, the decision of the Court of The Hague in 1985, which acquitted an anaesthesiologist who had administered euthanasia on the request of a very ill patient suffering from multiple sclerosis). But if this is not the case, the physician will have to do more in explaining why the patient was in an untenable situation and why acceptable alternatives were not available. The same applies when the patient's suffering is of a psychological rather than of a physical nature (see also the Supreme Court decision of 21 June 1994 – Chabot case – on assistance in suicide of a mental patient).

Medical practice

The pattern of court decisions and the positions taken by the Dutch Medical Association and the State Commission of 1985, have facilitated an open discussion of medical practice in this field, both in medical journals and in the public press. Nevertheless, it has taken some time before more precise data on the practice of euthanasia became available.

The most extensive and important study was conducted under the auspices of an official committee of inquiry (Rommelink committee) set up by the Dutch Government in 1990; in September 1991, the committee published its report which included data not only on euthanasia, but also on other medical decisions concerning the end of life, such as withholding or withdrawing of treatment⁴. In the past, estimated numbers of cases of euthanasia had ranged between 2,000 and 8,000 a year. This study found 2,300 cases in 1990, which amounts to about 1.8% of the 129,000 deaths in The Netherlands in that year. Furthermore, 400 cases of physician assisted suicide were reported. Another study, published a year later and also based on self reports of doctors obtained in strict anonymity, yielded similar results and confirmed also most of the other findings of the Rommelink report⁵.

The number of initial requests for euthanasia or assisted suicide was around 3 times as high as the number of cases in which it actually took place. Obviously, in many cases alternatives are found, patients change their mind or die naturally, or the doctor turns down their request. Requests were made by patients for reasons of loss of dignity (mentioned in 57% of cases), pain (46%), being dependent on others (33%), or tiredness of life (23%); only in 6% was pain the only reason. When euthanasia was performed, life was shortened by at least 1 week in 70% of all cases, and in 8% by more than 6 months. In these cases, cancer was especially prominent (68% as opposed to 27% for all deaths).

One of the findings of the study, which has attracted much attention (in The Netherlands and abroad), is that in about 1,000 cases (0.8% of all deaths), doctors prescribed or administered a drug with the objective of shortening the life of the patient, without the latter's explicit request. In the large majority of these cases, death was imminent; in most cases, patients were in the end stage of a malignant disease and were dying; in almost all cases patients were suffering grievously. Most patients were incompetent at the time of the decision, but, in more than half of the cases, it had been discussed with him or her while still competent. These cases do not meet the strict criteria for euthanasia developed in jurisprudence. I refer to them because they have played an important role in the legal developments of the last few years (see below).

Euthanasia would seem to occur much more often in general practice than in hospitals (euthanasia in nursing homes is rare). According to a report published in 1994, euthanasia or assisted suicide is performed as much as 3 times more often by general practitioners than by other physicians. To a large extent, this can be explained by the generally long-standing relationship between the patient and his or her physician in general practice⁶.

Notification and prosecution

Under Dutch law, a physician can only issue a death certificate in the case of natural death; in other cases he has to notify the municipal medical examiner, who, after investigating the case, will report to the public prosecutor, that is the district attorney. Until 1990, this would frequently result in a police investigation; these investigations could be very burdensome for physicians and the police would often not limit themselves to interrogating the doctor. From 1982 onwards, reported cases were discussed at national level in the meetings of the attorneys general. They would decide on whether or not the physician in question would be prosecuted.

Before 1985, doctors usually did not report euthanasia. After several doctors had been convicted by the courts for writing a false death certificate, the number of reported cases of euthanasia started to increase. In 1989, 338 cases were officially registered, which is less, however, than 20% of the estimated total number in that year. Many doctors felt they were being unjustly criminalised by the existing notification procedure. Whereas, in some districts, agreements between the public prosecution and local physicians would result in respectful treatment, in other districts police officers would come close to arresting the physician⁷.

In 1990, a new procedure was agreed upon by the Minister of Justice and the Royal Dutch Medical Association, which argued that a less deterrent procedure would be much more effective. In entering into this official agreement, the Dutch Government took a small, but significant, step in the direction of not only tolerating, but also decriminalising the practice of euthanasia. That it was willing to do so cannot only be explained by the pressure exerted on it by the medical profession, but also by the fact that it needed the support and cooperation of the profession in conducting the nationwide study described in the preceding section.

The new procedure is as follows. The physician informs the local medical examiner by means of an extensive questionnaire; the medical examiner then reports to the district attorney. When he is satisfied that the criteria laid down by the courts are complied with, the public prosecutor will issue a certificate of no objection to burial or cremation; in other cases, he may order an investigation and decide to prosecute the case.

Since this procedure came into force, the number of reported cases has increased dramatically: from 454 in 1990, to 1,424 in 1994 (which is about 50% of the estimated total number of cases of euthanasia and assisted suicide). At the same time, the percentage of prosecutions has decreased. Whereas, in 1983, proceedings were instituted in two out of the ten cases reported in that year, in 1992, four cases were prosecuted only out of the total number of 1,322 reported cases. One may be tempted to conclude, that the unreported cases do not meet the standards; research indicates, however, that most of these cases meet the substantive requirements developed by the courts⁸.

The question whether the Penal Code (Article 293) should be changed to bring existing legislation more in accordance with medical practice has been a matter of extensive debate for many years⁹. Reference has already been made to the proposals of the State Commission in 1985 (see above). From 1984 onwards, various bills were introduced into Parliament but none was adopted. After receiving (in 1991) the results of the study on medical decisions concerning the end of life, the Government submitted a new proposal to Parliament which would modify existing legislation be it to a very limited extent. According to the Bill, Article 293 would not be changed, but the notification procedure agreed upon in 1990 would be

laid down in regulations under the Burial Act and thereby acquire formal legal status. At the same time—in particular, in reaction to the finding of 1,000 cases in which doctors would have shortened the life of patients without their explicit request—its scope would be extended: it would also apply to doctors ending the life of a patient without his or her request.

In particular, the latter element has been criticised: it would wrongly suggest that cases, in which there is no previous, unambiguous request, can be dealt with on the same basis as cases of euthanasia. In the parliamentary debate on the Bill, the Government has repeated time and again, however, that, in principle, such cases would be prosecuted. On the other hand, when the substantive requirements developed by the courts are met, in general no proceedings will be instituted. The Government also made it clear, however, that a doctor performing euthanasia would never be completely immune from criminal prosecution.

On the whole, the position taken by the Government would seem ambiguous: euthanasia will remain a crime even if it is carried out by a doctor who complies with all the restrictions elaborated in the court rulings. But at the same time, the modification of the Burial Act implies that a doctor will not be prosecuted if he or she carefully commits that crime. After long discussions in Parliament, the Bill was adopted; although quite a few Members of Parliament were not satisfied with the outcome of the debate, it turned out impossible to find a majority which would support a more straight-forward proposal. The new law came into force on 1 June 1994.

Conclusions

If one not only looks at the legislation, but tries to strike a more general balance of developments in The Netherlands, the following can be observed. Although euthanasia is by no means universally accepted in The Netherlands, there would seem to be less controversy over the present policy than there has been in the years before. A delicate balance has been achieved between statutory law that prohibits euthanasia, case law that stipulates conditions for non-prosecution, and controlled acceptance in practice. Empirical data are available on what doctors do, both in general practice and in hospitals. Orderly reporting has increased considerably. Some (like the Royal Dutch Medical Association) would prefer further legislation, mainly to enhance legal certainty for physicians performing euthanasia. Others are of the opinion that the complicated issues of medical decision-making at the end of life elude

attempts at legislation; such attempts would only result in political conflict or in unsatisfactory compromise.

The discovery of cases of ending of life without an explicit request is a matter of grave concern, but even that has a positive side: it makes it possible to address this issue and to reduce the number of such cases as far as possible¹⁰. The existence of these cases does not necessarily demonstrate that the Dutch are skiing down the 'slippery slope': we do not know whether these cases also occurred before euthanasia was openly accepted. Nor do we know to what extent doctors in other countries shorten the lives of desperately ill patients, with or without their explicit involvement¹¹.

If, in the future, other countries also leave some room for euthanasia, they will have to face similar problems as those which emerged in The Netherlands. In the solutions to these problems there will be differences from one country to another. One should be careful in transferring the Dutch experience to other countries. The delicate balance between prohibition and acceptance mentioned before cannot be completely disconnected from the social structure of Dutch society, the legal system and the cultural climate on the one hand, and the system of health care and insurance on the other¹².

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