Preface

Euthanasia is a controversial subject. Although the number of countries in which it is practiced is increasing, the Netherlands is still one of relatively few where it is allowed. In the Netherlands, euthanasia is permitted, provided certain very specific requirements are met. However, Dutch euthanasia policy and practice do give rise to various misunderstandings, which I will address in this Element. My main objective is to clarify.

Although the Netherlands is not the only country to have decriminalized euthanasia to a considerable extent, it does have the most experience in this area. In that respect, the Netherlands is unique. Because of the way it is regulated, the wealth of knowledge of the practice is overwhelming. Opponents of legalizing euthanasia usually have little regard for the benefits of transparency and the safeguards it provides. Because of its long-standing tradition, the Netherlands has also experienced (and is experiencing!) unique developments. Proponents of legalizing euthanasia tend to have a blind spot for the problematic aspects of some of those developments.

Euthanasia evokes strong moral sentiments as well. This Element is not an ethical pamphlet. I do not advocate the legalization of euthanasia nor make a plea for its criminalization. Although the Element aims, first and foremost, to inform the reader about how euthanasia as a practice has grown in the Netherlands and the direction it is taking, it is certainly not devoid of critical commentary.

Since the Dutch Euthanasia Act came into force on April 1, 2002, I have closely observed developments. I have written about many of them in articles that have appeared in academic and professional journals, as well as newspapers. This Element allows me to reflect on my earlier writings, sharpen my thoughts, and develop a comprehensive view of Dutch euthanasia policy, the direction in which the practice is evolving, and its challenges.

And finally, the chosen perspective of this Element may appear predominantly legal. Although I have taken great pains to avoid legal jargon, it must not be forgotten that the Dutch euthanasia policy came about by case law. Current issues are subject to judicial scrutiny as well. The story of euthanasia in the Netherlands simply cannot be told without referring extensively to law.

1 The Euthanasia Act and Its Genesis

To properly understand Dutch euthanasia practice, it is imperative to know how it came about. Numerous parties have contributed to the Dutch notion of euthanasia, but least of all the legislator. The genesis of the practice can best be described as a growing consensus among societal stakeholders on what counts as standard medicine and what as nonstandard medicine at the end of life.[1] Euthanasia is

a broad term that can be (and is) used to refer to a range of end-of-life practices. The Dutch understanding of euthanasia is very specific. It is important to realize up front that practices that could also be qualified as euthanasia, and might elsewhere pass for euthanasia, are considered standard medicine in the Netherlands (Section 1.5).

1.1 Before 1969

The Euthanasia Act (officially: the Act on the Assessment of Termination of Life on Request and Assistance in Suicide) came into force on April 1, 2002. Its enactment formally concluded a development that had begun many years before. As early as 1984, all the building blocks provided fell into place, making way for the practice as we know it today.

Until the 1960s, hardly any writings on euthanasia were published in the Netherlands. Although termination of life on request and assistance in suicide had been included as crimes in the Dutch Criminal Code since it came into force in 1886, no prosecution of these offenses took place until 1944. It was not until that year that the Supreme Court of the Netherlands issued a judgment in which euthanasia was the subject of dispute; but because the Supreme Court only dwelt on the duty of the criminal court to substantiate its decision, this ruling is generally not considered the first one on euthanasia in the Netherlands.[2]

In the so-called Eindhoven doctor case (1952), a sanatorium resident suffering severely from tuberculosis had repeatedly urged his brother – a physician – to end his life. The brother had finally complied by giving him Codinovo tablets and administering morphine in lethal doses. In court, he argued, inter alia, that he had no choice but to follow the voice of his conscience. In its judgment, upheld by the appellate court, the District Court ruled that no extralegal ground for impunity exists according to which a person may take another person's life following the voice of their conscience, not even when this person is suffering severely and explicitly requests that they wish their life to be ended. The brother was sentenced to a suspended prison term of one year.[3]

This was the first time a Dutch court ruled on a doctor's deliberate termination of life at the request of a patient who – in his own words – was suffering "almost unbearably." But there was no proper doctor–patient relationship, and even in the medical profession, the physician's actions were primarily seen as those of a brother.[4]

1.2 1969–2002

The change in mentality in the 1960s, characterized by secularization, emancipation, and increasing individualism, also made itself felt in the relationship between physicians and their patients. That decade saw the birth of the Dutch

patients' rights movement. Physicians' authority met with challenges, and respect for the patient's autonomy was claimed; this was later translated into legally enforceable rights regarding information, consent, surrogate decision-making, and so on.[5]

The 1960s were also a time of significant medical–technological progress, which raised new moral questions. Medical techniques made it possible to preserve life, even when recovery is no longer possible. Of considerable influence on Dutch understanding of euthanasia was the publication in 1969 of a booklet entitled *Medical Power and Medical Ethics*, written by physician, psychiatrist, and philosopher Jan Hendrik van den Berg.[6] The first edition caused a stir because of its plea for an ethics that no longer acknowledged the duty to preserve life unconditionally. "Physicians are duty-bound to preserve, spare, and prolong human life wherever and whenever that is meaningful," claimed the author.[7] But if it is no longer meaningful, he argued, they have the moral right to end their patients' lives, passively or actively.[8] In the Netherlands, Van den Berg is credited with firmly putting the topic of euthanasia on the public agenda, where it has remained ever since.

1.2.1 Postma (1973)

A family relationship also featured in the Postma case. The patient, a severely ill seventy-eight-year-old nursing home resident, was, among other things, partially paralyzed and incontinent, but mentally still quick-witted. A month before her death, she contracted pneumonia, intensely longed for death, and urged her physician and family members to end her life. The doctor was convinced of the severity of her suffering but thought he could not proceed to actively end her life due to the criminal prohibition of termination of life on request. In addition, he feared resistance from the nursing home staff. The patient's daughter, Mrs. Postma-van Boven, who happened to be a physician, ultimately administered a lethal morphine injection to her mother. She was sentenced by the District Court to only one week's suspended imprisonment "given the utter purity of her motives."[9]

The Postma case was a milestone because, for the first time, a court considered the possibility of impunity for termination of life on request. The District Court put the question of whether an exception to the ban could be justified to a physician, a healthcare inspector. In his expert opinion, several due care requirements of the later Euthanasia Act were clearly recognizable. He considered an exception to the ban conceivable if the following criteria were met:

- The patient is incurably ill because of a disease or an accident or is medically considered as such.
- The physical or mental suffering is subjectively unbearable or severe for the patient.

- The patient has expressed a wish to end their life or, in any case, to be relieved of their suffering, if need be, in advance in writing.
- The euthanasia is performed by a physician: either the attending physician or another in consultation with that physician.[10]

According to the inspector, the patient would also have to be in the process of dying, or the start of that process would have to be imminent.[11] The judges did not accept that requirement.[12] Nor is it mentioned in the Euthanasia Act.

The physician's appeal to *force majeure* was rejected because she had not first tried to alleviate her mother's suffering. Unlike the rulings in the Eindhoven doctor case, this verdict caused much public controversy. Times had clearly changed. The court case resulted in numerous publications on end-of-life decision-making. It also triggered the creation of advocacy organizations committed to the social acceptance and legalization of euthanasia.[13]

1.2.2 Wertheim (1981)

Another important court decision was made in the Wertheim case, involving a euthanasia activist (Mrs. Wertheim-Elink Schuurman) who had assisted another woman in suicide. At the latter's request, she provided a lethal drug, which resulted in the woman's death. Her life had been a series of tragedies. She was an alcoholic, lived in isolation, and thought she had cancer, which a later autopsy revealed she did not.

The District Court considered, inter alia, that "according to many nowadays – in contrast to the time when the Criminal Code was drafted – suicide is not necessarily unacceptable in exceptional cases,"[14] and referred to the criteria mentioned in the Postma ruling. These were strengthened by the Court's explicit acknowledgment that the request for assisted suicide must be voluntary, well-considered, and sustained, that there are no other options available to improve the situation and that the decision to end life was made after the person concerned was fully informed about this. The Court added that a physician must be involved in deciding whether to assist in suicide.[15] Again, these were requirements that ended up in the Euthanasia Act.

Because most of the requirements had not been met, Mrs. Wertheim's appeal to *force majeure* in the sense of emergency was unsuccessful. She was sentenced to a suspended prison term of six months with a probation period of one year.[16]

After the Wertheim ruling, the Procurators General decided that every case of termination of life on request or assisted suicide that would become known to the Public Prosecutor's Office should be referred to them for a prosecution decision.[17] Such a decision was made in the Schoonheim case (1984), in which the Supreme Court's ruling more or less definitively shaped Dutch euthanasia policy.[18]

1.2.3 Schoonheim (1984)

The patient was a ninety-five-year-old woman, permanently disabled, bedridden, and entirely dependent on others for her care. She had written an advance directive requesting euthanasia, was still fully competent, and, as her condition deteriorated, asked ever more pressingly for her life to be ended. After a severe breakdown, leaving her unconscious for days and unable to eat or drink, she again insisted on euthanasia to avoid a repeat of the horrible experience. According to Dr. Schoonheim, her family doctor, she found the experiences of everyday life extremely burdensome, causing her to suffer unbearably.

After consulting a junior doctor, the general practitioner decided to comply with his patient's wishes, whereupon he was prosecuted. Although the charges were initially dismissed,[19] Dr. Schoonheim was nevertheless found guilty on appeal.[20] Although no penalty was imposed, he appealed to the Supreme Court, arguing that the appellate court had not sufficiently addressed whether the patient's suffering was so unbearable that the doctor reasonably had no choice but to spare her that suffering by euthanasia. With respect to this point, the judges sympathized with Dr. Schoonheim. The Supreme Court considered that a physician could successfully invoke *force majeure* in the sense of emergency if:

- they have carefully weighed the relevant duties and interests at stake;
- they have done so in accordance with medical ethics and according to the medical-professional standard; and
- in doing so, and given the case's particular circumstances, they have made a choice that can be justified objectively.[21]

It also listed several factors that may be important in the assessment:

- whether, according to professional medical judgment, it was to be feared the person would suffer increasingly from loss of dignity or that their suffering, already experienced as unbearable, would worsen;
- whether it was foreseeable that the person would soon be unable to die with dignity;
- whether there were still possibilities to alleviate the suffering.[22]

It is tempting to associate the first two factors with the principle of respect for autonomy. Yet that would amount to an incorrect reading of the ruling. The Supreme Court did not discuss patient self-determination. It considered the factors mentioned primarily as elements of suffering. The Supreme Court overturned the appellate court's judgment and referred the case to the The Hague Court of Appeal, which upheld the appeal to *force majeure* and dismissed the charges against Dr. Schoonheim.[23]

A considerable period elapsed between the judgment of the Court of Appeal and that of the Supreme Court. More than likely, the decision had been postponed to take note of the position of the Royal Dutch Medical Association (KNMG).[24] That physicians' organization is another major contributor to Dutch euthanasia policy.

1.2.4 The Royal Dutch Medical Association

Euthanasia was on the agenda of the Association's general assembly meeting a week before the Supreme Court's ruling in the Schoonheim case. Its board had previously published its position on euthanasia in the Association's weekly magazine. The board had accepted that euthanasia was now practiced in medicine in the Netherlands, and it was also convinced that doctors were the only ones who should be allowed to perform euthanasia.[25]

The KNMG board wished to remove the legal uncertainty among physicians who may be considering performing euthanasia by formulating due care requirements. For the physician's action to be responsible, the patient's request had to be well-considered and based on their free will. The desire to die had to be sustained and the suffering unacceptable. In addition, the physician who was asked to perform euthanasia had to consult an experienced colleague. Finally, the board considered it fundamentally wrong to register a case of euthanasia as a natural death. The board not only argued that not filling out death certificates truthfully is unworthy of a medical professional, but it also felt that everything that takes place in medicine under the heading of euthanasia should be verifiable. In addition, the board was aware that obfuscating the cause of death in cases of euthanasia would only add to the existing tension between the law and medical practice.[26]

Dutch courts have always been clear about falsifying death certificates. The obligation to report unnatural deaths is strict. In the Rademaker case (1987), the Supreme Court ruled that euthanasia should always be regarded as a nonnatural cause of death, even if death is inevitable and the moment of dying naturally very near.[27]

At the assembly, the Association's President concluded the item by reiterating the board's explicit wish not to take a moral position on euthanasia. The intention was merely to offer guidance to individual members of the profession contemplating the performance of euthanasia.[28]

1.2.5 Chabot (1994)

The fact that the Dutch courts chose to be guided by the views of the medical profession was also evident in another case, involving a fifty-year-old woman who had ended her life by taking lethal drugs provided by her psychiatrist,

Dr. Chabot. For years, she had been suffering mentally because of past marital problems, the resulting divorce, and the death of both her young sons. After these events, and notwithstanding years of counseling, the woman was determined to die. Dr. Chabot found his patient to suffer continuously, unbearably, and hopelessly. Although she was physically healthy and her suffering was not the result of a psychiatric condition or disorder, there was a complicated grieving process with symptoms of depression. According to the psychiatrist, this condition was treatable, but the patient consistently rejected all further treatment. If she were not offered physician-assisted suicide, she would most likely try to commit suicide herself. The woman had previously saved up medication and attempted suicide. Everything indicated she could make another attempt. Following consultations in writing with seven experts (fellow psychiatrists and ethicists), Dr. Chabot agreed that the woman no longer had any realistic prospects for treatment.

The District Court and the Court of Appeal honored Dr. Chabot's appeal to *force majeure*.[29] However, the Supreme Court did not, and found the psychiatrist guilty without imposing a penalty.[30] Dr. Chabot was blamed primarily because none of the consulted experts had personally examined the patient. Therefore, the untreatability of the suffering had been insufficiently established. In particular, as the suffering was not somatic, the Court considered examination in person by a consultant to be essential.[31]

In addition, it also clarified the following points:

- Psychiatric patients can also request euthanasia voluntarily and well-considered.
- The cause of suffering does not affect the degree to which it is experienced. In other words, the hopelessness and unbearableness matter, not the cause (somatic, psychological, or other).
- Therefore, suffering caused by a psychiatric illness or disorder can justify euthanasia as well.
- In the event of such suffering, courts of law must assess the doctor's appeal to *force majeure* as an emergency with extra caution because (1) it must be ruled out that the illness or disorder influenced the patient's decision-making ability, and (2) it is more difficult to establish the unbearableness and the hopelessness of suffering stemming from a psychiatric cause.
- In principle, there can be no hopeless suffering if the patient freely refuses realistic alternatives for relief.[32]

1.2.6 Parliament and Government

The years 1984–1986 proved decisive for Dutch euthanasia policy. Although there was hardly any political input until that period, from 1980 onwards

political parties began to make their views known. In 1984, the first bill was introduced, a private member's bill by social liberal MP Mrs. Elida Wessel-Tuinstra.[33] However, this bill met with resistance from the then center-right government.[34]

In 1989, the subsequent center-left government ordered an inquiry into the practice of euthanasia.[35] Since this study could not be conducted without the cooperation of physicians, some of their wishes were granted: a notification procedure for euthanasia and guidelines for its judicial handling.[36] Subsequently, the study revealed that in 1990 euthanasia had been performed an estimated 2,300 times, and assisted suicide about 400 times. It also revealed that a life was ended about 1,000 times without the patient's request. In only 40 percent of cases had a report been made of the decision-making process; and in only 18 percent of cases had the doctor reported an unnatural death.[37]

Parliament agreed to the government's proposal to provide the notification procedure developed for the purpose of the study with a legal basis.[38] This was implemented in June 1994. Until the enactment of the Euthanasia Act in 2002, the legal prohibition of euthanasia existed alongside a regulation as to the method of reporting cases – a typical example of Dutch pragmatism.

In 1994, a government without Christian Democrats took office, which had not been seen since 1918, and another study was conducted. As it turned out, the number of euthanasia cases had increased to 3,200 in 1995, but the number of physician-assisted suicide cases had remained the same. The number of times termination of life had occurred without the patient's explicit request had dropped to 900. The proportion of cases in which peer consultation had taken place had increased to 92 percent, and the notification percentage had risen to 41 percent.[39] Because this percentage was considered too low, the government proposed that regional euthanasia review committees be placed between the notifying physicians and the Public Prosecutor's Office. These would have to assess whether a doctor reporting a case of euthanasia or assisted suicide had acted in accordance with the due care requirements. And if that were the case, the committee should advise not to prosecute.[40]

In 1998, the government introduced a bill.[41] The Act on the Assessment of Termination of Life on Request and Assistance in Suicide (the "Euthanasia Act") came into force on April 1, 2002. This Act formalized the notification procedure and the consultation requirement while strengthening the review committees' position. Since the Euthanasia Act came into force, they no longer have a purely advisory role. If a review committee rules that a notifying doctor has met the due care requirements, it does not inform the Public Prosecutor's Office (and the Healthcare Inspectorate) of the facts.[42] The case is then closed.

The Act added nothing to the due care requirements. But for a proper understanding of these requirements, we have one last court ruling to consider.

1.2.7 Brongersma (2002)

In April 1998, former senator Edward Brongersma ended his life by taking lethal drugs given to him by his family doctor. Eighty-six-year-old Mr. Brongersma had no severe physical illnesses, nor any psychiatric disease or disorder, apart from some age-related complaints such as dizziness and osteoporosis. However, he suffered tremendously from his deterioration, loneliness, dependence on others, and a great sense of futility. Mr. Brongersma also feared that if he delayed too long, he would no longer be physically able to commit his desired suicide.

His general practitioner, Dr. Sutorius, had many conversations with his patient, and he concluded that his wish to die was durable, well-considered, and had come about voluntarily. The doctor was empathetic to Brongersma's suffering. After consulting a psychiatrist and ruling out a psychiatric disorder, he concluded that no more treatment options were available. A fellow general practitioner and a psychiatrist confirmed the unbearableness and hopelessness of the patient's suffering. Thereupon, Dr. Sutorius assisted in Mr. Brongersma's suicide.

The District Court considered that there was no consensus in medical ethics as to whether a narrow or a broad definition should be used regarding the unbearableness of suffering. The judges opted for a broad one. Because all the due care requirements had been met, the physician could, according to the District Court, rightly invoke *force majeure* and the charges against him were subsequently dropped.[43]

The Public Prosecutor's Office questioned whether being "tired of life," being "done with living," or "suffering from life" fell within the medical domain. According to the prosecution, the due care requirements developed in case law and those of the forthcoming Euthanasia Act were limited to that domain. The Court of Appeal endorsed this view and found the general practitioner guilty but did not impose any penalty.[44] Dr. Sutorius appealed the Court's judgment in cassation. In December 2002, the Supreme Court decided that only suffering predominantly caused by a medically classifiable somatic or psychological illness or disorder can legitimize deliberate life-terminating acts by a physician. And in the case of Mr. Brongersma, it concluded, no such legitimization existed. Thus it revoked a core consideration of the Chabot judgment, according to which the cause of suffering is irrelevant.[45]

In its judgment, the Supreme Court referred extensively to the legislative history of the Euthanasia Act. And because it was rendered after the latter's