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**Editorial**

# **Euthanasia in the Netherlands - down the slippery slope ?**

Raanan Gillon *Imperial College School of Medicine, University of London*

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In this issue of the journal two staunch opponents of euthanasia take a searching look at the results of a survey into euthanasia in the Netherlands and conclude that "the practice of voluntary euthanasia remains beyond effective control". Among other criticisms, Drs Henk Jochemsen and John Keown point out that in the survey doctors admitted to intentionally shortening patients' lives in the absence of the patient's explicit request in twenty per cent of the 4,500 cases reported of intentional and active shortening of life, despite the fact that an explicit request from the patient is one of the preconditions of legal acceptance of euthanasia in the Netherlands.<sup>1</sup> In a commentary Dr Hans van Delden, a Dutch physician and bioethicist who accepts the need for euthanasia as a measure of last resort, also accepts that the criticisms may have some validity, though he cautions that interpretations of empirical findings depend crucially on the moral stance of the interpreter.<sup>2</sup> In a third paper Dr Cuperus-Bosma and other medico-legal social scientists find that in the legal assessment of those cases of euthanasia that are reported to the public prosecution service in the Netherlands - assessments which determine whether or not doctors will be prosecuted for murder - doctors are likely to be subject to quite variable assessments, more or less "lenient", depending on the particular assessor.<sup>3</sup> For instance two of the 47 legal assessors surveyed would have dismissed from further investigation nine of the twelve hypothetical cases presented to them, while at the other end of the spectrum two other assessors would have recommended a summons in six of the twelve cases. Despite one of the basic requirements of the euthanasia code of practice being an explicit request from the patient, as many as five of the 47 prosecution service assessors were ready to dismiss one or more cases of euthanasia in the absence of an explicit request from the patient.

The three papers repay careful attention. Jochemsen and Keown are concerned about the

various ways in which doctors in the Netherlands who in the survey admitted to intentionally shortening the lives of some of their patients did so outside the agreed criteria. Thus first, in 17 per cent of 3,600 cases of euthanasia or assisted suicide doctors stated that alternative palliative treatment options existed but in almost all these cases the patients did not want them. Yet, argue Jochemsen and Keown, the euthanasia guidelines and a Dutch Supreme Court decision forbid euthanasia when the alternative of palliative treatment is available. It should be noted that the issue here turns crucially on what is meant by "available" - it could be reasonably argued that a treatment rejected by a patient is not "available" - at any rate not to the doctor, who of course cannot treat a competent patient without that patient's consent. As Van Delden points out, this finding may simply be reflecting a shift towards recognising the importance of patients' own attitudes and decisions about the available treatment options and an acceptance that patients faced with the prospect of inevitable suffering, loss of dignity and decline, for example after a major stroke, should be given the option of choosing euthanasia rather than continuing down that path. And as Van Delden also points out, moral evaluation of this development will depend on one's moral views. Whether or not this represents, as Jochemsen and Keown assert it does, a slide down the slippery slope, or whether it represents a valuable extension of a patient's right to choose - and a doctor's right to assist in the decision - not to undergo the suffering (including the indignities) associated with certain incurable diseases, is not determined by the empirical finding.

The same recognition of a patient's right to choose does not, however, seem to underlie the survey's finding that 900 patients - twenty per cent of the 4,500 patients whose lives the doctors had said they had actively and intentionally helped to end by euthanasia or assisted suicide - had had their lives ended without their explicit request. In a third

of the 900 cases although there had been a previous discussion about possible termination of life, and although some fifty per cent of these patients were competent at the time of their death, their lives had been ended without their explicit request.

Jochemsen and Keown also point to cases where doctors admitted to administering palliative drugs at least partly with the intention of shortening life but without discussing it with patients, despite the fact that some of these patients were competent and able to have such discussion. In addition, of the many cases of withdrawal or withholding of life-sustaining treatment a small number were both explicitly intended to shorten life and did not involve discussion with patients who were admitted to be competent to have such discussion. And in 41 per cent of 1,000 deaths in the first year of life, life-prolonging treatment had been withheld or withdrawn with the explicit intention of shortening the baby's life. Where this had been done because the doctor thought the baby's life was unbearable, in 20 per cent of cases there had been no discussion with the parents. Finally, Jochemsen and Keown point out that many doctors, according to the survey, were failing to consult with colleagues as required by the euthanasia guidelines before carrying out euthanasia or assisting with suicide; and that almost 60 per cent of all cases of euthanasia and assisted suicide were not reported to the legally appointed authorities.

As Van Delden points out, these figures do not necessarily point to any slippery slope - they are not much different from the previous survey in 1990, and before that time we simply do not know how much euthanasia of various sorts was carried out in Holland any more than we know how much was - and is - carried out in other countries. Certainly it is reasonable to infer that very much more *voluntary* euthanasia is being reported to the authorities in the Netherlands than in most other countries. And it might be added, the sorts of cases in the non-voluntary euthanasia vignettes offered by Dr Cuperus-Bosma and colleagues indicate that if there is a slippery slope in the Netherlands it does not have Nazi-like atrocities at its foot.

None the less what is shown by the empirical findings is that restrictions on euthanasia that legal controls in the Netherlands were supposed to have implemented are being extensively ignored and from that point of view it is surely justifiable to conclude, as Jochemsen and Keown do conclude, that the practice of euthanasia in the Netherlands is in poor control; and in particular, that as well as voluntary euthanasia, which is explicitly legally acceptable there, involuntary and non-voluntary

euthanasia are also being carried out, despite their remaining illegal and officially uncondoned. On the other hand as Van Delden points out, this may always have been the case for we simply have no reliable evidence about its extent in the past and more than we have reliable evidence of its extent in most other countries. The culture of relative openness that has developed in the Netherlands is surely to be welcomed. In most of the rest of the world euthanasia is not legally accepted but almost certainly is surreptitiously practised.

More empirical studies of euthanasia would surely be useful, both in the Netherlands and in other countries. Such investigations would be particularly useful if the attitudes to euthanasia of the researchers could be rigorously prevented from affecting the design, performance and interpretation of their studies. One possible way of achieving such an objective might be for a multinational, multidisciplinary, multiattitudinal research project to be funded in the forthcoming round of European Union Biomed bioethics research projects. Among the social questions worth asking in such a project would be: what, in different countries, are people's real fears about what lies at the bottom of a slippery slope if euthanasia is legalised, and how much, if at all, are such fears being realised in the Netherlands? For example, one of the common worries in the UK about the legalisation of voluntary euthanasia is that people will feel pressured into "volunteering" either to avoid being a burden on the state, and/or to avoid being a burden on their families. It would be of great benefit to discover how much, if at all, this is occurring in the Netherlands. And so far as non-voluntary and involuntary euthanasia are concerned one obvious and major fear is that people will be killed without their consent in circumstances where they would otherwise have continued to live a life they considered worth living. Is that happening in the Netherlands? Were it possible to design studies that could offer some reliable answers to such questions, both in the Netherlands and in countries where euthanasia is illegal, then perhaps we could obtain information useful for policy-making about whether or not the Dutch social experiment with legalised euthanasia is or is not descending a socially dangerous slippery slope.

## References

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- 3 Cuperus-Bosma J, van der Wal G, Looman C, van der Maas A. Assessment of physician-assisted death by members of the public prosecution in the Netherlands. *Journal of Medical Ethics* 1999; 25:8-15.