Euthanasia across the North Sea

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The United Kingdom and The Netherlands are separated by a narrow stretch of sea but in terms of an understanding of euthanasia they seem to be light years apart. An attempt to bridge the information gap seems in order.

The position paper on euthanasia published by the Royal Dutch Medical Association contains 16 typed pages.¹ In contrast, the report on euthanasia issued by a working party of the British Medical Association is 80 pages in small print.²

BMA report

The Dutch report begins by stating that in a plural society thoughts and ideas about euthanasia—that is, active voluntary euthanasia—will always vary, in the medical profession as well as in society generally. No attempt is made to reconcile the irreconcilable. The BMA report, on the other hand, sets out to formulate general principles and a uniform policy. This in itself does not explain the length of the BMA report, however, for if the central principle articulated by the working party had been, for instance, “active voluntary euthanasia is morally wrong and utterly unacceptable,” a few pages would have sufficed. As it is, such straightforward language is not to be found in the report; the closest it comes is to claim that euthanasia is intuitively wrong. Instead, the working party seems to have chosen this approach: to refute arguments that support active voluntary euthanasia. Thus it suggests that patients seldom request euthanasia. Moreover, if such a request is made it should not be taken literally but rather as a cry for help. Furthermore, the working party argues, euthanasia is not a relevant option in view of the adequacy of good terminal care. Finally, the report intimates that the patient’s autonomy is limited; the wish of a patient to have his or her life ended must lead the doctor to question whether the patient is competent.

The Dutch experience

There is one awkward fact: the experience with euthanasia in The Netherlands runs counter to the arguments of the working party. Euthanasia is defined in The Netherlands in this restricted sense: the intentional termination of life by a doctor on the urgent request of the patient. What then, is the experience of the Dutch with euthanasia? Firstly, when euthanasia is no longer taboo some desperately ill patients do ask doctors to end their lives. According to the results of a survey of 25 general practitioners in The Hague, these doctors had received 17 requests in 1985. Euthanasia took place in nine cases.³ If these data are representative this would mean that a general practitioner will, on average, be asked to perform euthanasia once every three years. This would amount to about 2% of all deaths that occur in general practice in The Netherlands.

It may not be superfluous to emphasise that in the relatively well funded health care system of The Netherlands there is no economic incentive for hospitals, nursing homes, or general practices to have patients killed. Any suggestion that economic motives may play a part is repugnant.

Secondly, quite a few patients who are sound of mind persist in their requests even after they are repeatedly and truthfully assured that they will have full access to any necessary care. The BMA working party asserts without documentation that palliative care in The Netherlands is inferior to that in the UK, apparently implying that this would reinforce the need for euthanasia. Regrettably, it confuses organisation with quality of care. There are not many hospices in The Netherlands of the type that exist in the UK, but extensive, refined, and sensitive terminal care is universally available. The working party’s conclusion that “the techniques developed in The Netherlands means that the opportunity for reflection is unlikely to be available to a person when a doctor acts to terminate their life” is similarly unsubstantiated, and, we believe, no evidence could be found for this claim.

Euthanasia is not practised in The Netherlands, only,^{4,7} but it has been documented better there than in other countries. Since the early 1970s euthanasia has been publicly debated in ever wider social and political circles in The Netherlands, with strong views represented on both sides of the question. Public support for euthanasia has increased gradually over the years from two fifths in 1966 to two thirds of the population in 1986. This is not an idiosyncrasy of the Dutch, as shown by the findings of opinion polls abroad.^{6,9} The working party rightly points out that the moral value of a standpoint cannot be judged by the number of people who subscribe to it, but it goes to the other extreme when it casts doubt on the reliability of questionnaires in general.

Guidelines

The final message of the working party is that euthanasia should remain a criminal act, and that a doctor who follows the dictates of his conscience and intervenes should be prepared to have his action scrutinised as closely as the law might wish. Remarkably, this exactly reflects what now happens in The Netherlands. Euthanasia has not been legalised,¹⁰⁻¹³ and Dutch doctors practising euthanasia do so in violation of the penal code. In practice, however, they will not be prosecuted provided they can prove that they have followed certain circumscribed guidelines. Such immunity from prosecution applies only to doctors and to no one else. Three tiers of the Dutch judicial system—district courts, appeal court, and the supreme court—have handed down judgments in which these guidelines are defined with great care and

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precision. These have been affirmed and extended by the Royal Dutch Medical Association,¹ the State Commission on Euthanasia,¹⁴ and the Dutch government.

These conditions include a requirement that there must be an explicit and repeated request by the patient which leaves no reason for any doubt concerning his or her desire to die; that the mental or physical suffering of the patient must be very severe with no prospect of relief; that the patient's decision must be well informed, free, and enduring; that all options for other care must have been exhausted or refused by the patient; and that the doctor must consult another medical practitioner (and may also decide to consult nurses, pastors, and others).¹⁰⁻¹⁵ The doctor is advised to note down the course of events. If there is an infringement of these conditions charges of murder or manslaughter may be pressed. More and more nursing homes, hospitals, departments of the Royal Dutch Medical Association, and groups of general practitioners are incorporating these guidelines in protocols, which may be discussed with such authorities as the district public prosecutor.

Case study

A case study may be illustrative. The following report was published by a general practitioner in 1983.¹⁶

Mr A, aged 67, living alone, has a lifelong history of chronic obstructive pulmonary disease, with exacerbating severity. He is hospitalised with tightness of the chest and is in severe pain. He is losing his appetite and physical energy. On return home he emphatically and repeatedly tells his general practitioner, who visits him regularly, that he prefers euthanasia over further admissions to hospital. Nevertheless, he is again rushed to hospital during an attack some months later. Pleuritis carcinomatosa is diagnosed. The general practitioner, who continues to see his patient, consults a colleague about the possibility of euthanasia and decides that, if asked again, he will honour the patient's wish. After two weeks the patient has himself released from the hospital and is brought home. He removes the respirator tube, refuses to take medicines, and sends for the general practitioner to arrange for euthanasia. The patient says goodbye to his neighbour, who has taken care of him for many years. At 7 30 pm his mother, brother, and sisters and their partners assemble around his bed. At 10 30 pm the doctor returns. The patient, in high spirits, persists in his wish to die. His mother holds his hand while the doctor injects him with the drugs. The patient dies peacefully at 3 30 am. The members of his family thank the doctor and they continue to express their gratitude in later contacts.

This case is typical. Incidentally, euthanasia is not restricted to incurable malignancies. According to a public prosecutor, who reviewed the 85 cases of euthanasia reported in his district in one year, three quarters of the patients had cancer, a tenth had neurological disease, and a sixth had other serious afflictions.

What can be learnt from this and other cases? First of all, it is the patient who takes the initiative in suggesting euthanasia (not necessarily with the doctor first) and often with great determination. The doctor, of course, is completely free to refuse to perform euthanasia. Though family members are usually present at the deathbed, they have no say in the decision whether or not euthanasia will take place. The image of patients shying away from needle happy

doctors, which is sometimes evoked by the foreign popular medical press, has no basis in reality. If a doctor were to press euthanasia on a patient this would surely be discovered, and the doctor would have to face charges of murder or manslaughter. Indeed, to the Dutch "involuntary euthanasia" is a contradiction in terms. It may not be superfluous to emphasise that in the relatively well funded health care system of The Netherlands there is no economic incentive for hospitals, nursing homes, or general practices to have patients killed. Any suggestion that economic motives may play a part is repugnant.

The cases reported in Dutch publications illustrate that euthanasia is not performed on the spur of the moment but rather after long deliberation. The general practitioner in The Netherlands is a family doctor in the true sense of the word. Similarly, euthanasia in nursing homes or hospitals is not practised anonymously; there must be a bond of trust between doctor and patient.

Why, then, do some patients insist on euthanasia? It is not death they fear, it is continued degradation. "Dying should be a family affair," the BMA working party states. Some patients in The Netherlands are determined to make sure it is.

Splitting hairs

In critiques of the BMA report¹⁷⁻¹⁹ attention was drawn to the laborious distinction it makes between active and passive euthanasia. Passive euthanasia is described as "the withdrawal or withholding of some necessary treatment for the maintenance of human life." The distinction between active and passive euthanasia has been dropped in official documents in The Netherlands. In the eyes of the law acts of omission and commission directed at a hastening of death are the same. To doctors, of course, there may be a psychological difference. Is there also an ethical difference between active and passive euthanasia? To quote Kuhse: "It is sometimes suggested that a patient cannot rationally and autonomously choose euthanasia. But if opponents of active euthanasia really believed this, then they would also have to hold that no patient can ever autonomously and rationally refuse life-sustaining treatment. But this is not what most opponents of active euthanasia believe. Rather, they suggest—most implicitly—that a patient can rationally choose passive euthanasia. This is inconsistent."⁵ It is also inconsistent to hold that "sanctity of life" should be the doctor's unwavering guiding principle when rejecting active euthanasia but not in cases of passive euthanasia.

Whether one agrees or disagrees with the practice of euthanasia in The Netherlands it is essential to distinguish facts from fiction. Doctors who are "euthanasia enthusiasts" do not exist in The Netherlands any more than elsewhere. Euthanasia is regarded as a distressing process, to be avoided if possible but sometimes deemed acceptable. If Dutch doctors are exceptional at all it is perhaps in their wish to subject their actions to public scrutiny. Clearly, the last word on euthanasia has not been said,¹⁸ in the UK or in The Netherlands. Better communication across the North Sea could help to clarify the various positions on this most difficult issue.

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