

# RECURRING THEMES IN THE DEBATE ABOUT EUTHANASIA AND ASSISTED SUICIDE

Theo A. Boer

## ABSTRACT

During the past four decades, the Netherlands played a leading role in the debate about euthanasia and assisted suicide. Despite the claim that other countries would soon follow the Dutch legalization of euthanasia, only Belgium and the American state of Oregon did. In many countries, intense discussions took place. This article discusses some major contributions to the discussion about euthanasia and assisted suicide as written by Nigel Biggar (2004), Arthur J. Dyck (2002), Neil M. Gorsuch (2006), and John Keown (2002). They share a concern that legalization will undermine a society's respect for the inviolability and sanctity of life. Moreover, the Report of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill (2005) is analyzed. All studies use ethical, theological, philosophical, and legal sources. All these documents include references to experiences from the Netherlands. In addition, two recent Dutch documents are analyzed which advocate further liberalization of the Dutch euthanasia practice, so as to include infants (*Groningen Protocol*, NVK 2005) and elderly people "suffering from life" (*Dijkhuis Report*, KNMG 2004).

KEY WORDS: *euthanasia*, Dijkhuis Report, Groningen Protocol, *the Netherlands*, *physician-assisted suicide*, *slippery slope*

## 1. Introduction

DURING THE PAST FOUR DECADES, the Netherlands played a leading role in the debate about euthanasia and assisted suicide.<sup>1</sup> Expert committees in the field of politics, medical associations, and health care institutions, theologians, and courts of justice propagated the view that euthanasia should be made possible under strict conditions. A provisional legal arrangement in 1995 was followed by a euthanasia law in 2002. Whereas this law covers traditional euthanasia cases only, that is, euthanasia on

<sup>1</sup> For the sake of brevity (and unless indicated otherwise), the term "euthanasia" refers in this article to euthanasia and assisted suicide alike. Whereas in the Netherlands the term means only "voluntary" euthanasia ("nonvoluntary" euthanasia is called "life termination without a request"), I adopt the prevailing international usage of euthanasia so as to include both.

competent persons suffering from a medically classifiable disease, some recent expert reports advocate more far reaching options, such as euthanasia on infants (*Groningen Protocol*, NVK 2005) and euthanasia on elderly persons “suffering from life” (*Dijkhuis Report*, KNMG 2004).

During the decades of Dutch discussions, a frequently recurring claim is that other countries will eventually follow the good example. So far, only the American state of Oregon (in 1997) and Belgium (in 2002) have. In Switzerland, assisted suicide is possible, but this is due to a loophole in the law rather than a liberal political consensus.<sup>2</sup> Other attempts to legalize euthanasia failed. The Australian Northern Territories’ euthanasia law in 1996 was overruled in 1997, and the Assisted Dying for the Terminally Ill Bill in Great Britain was rejected in 2006. Concerns keep rising which, according to some, belong to times long past: questions about the intrinsic wrongness of intentional killing; questions as to whether killing really is the last resort in situations of unbearable suffering; concerns that palliative care in many Western countries is still inadequate; proposals for a community-based ethic as a counterbalance to an ethic based on individual autonomy; proposals to relocate the norms and values that govern end-of-life decisions within medicine itself; a lack of consensus as to who would apply for euthanasia and who would not in case of legalization; and fears (usually supported with data from the Netherlands) about slippery slopes. In this article, I look at some of these concerns as they are raised in, or provoked by, seven recent publications.

## 2. Who Enjoys Full Protection and Who Does Not?

Nigel Biggar’s study *Aiming to Kill: The Ethics of Suicide and Euthanasia* (2004) is concise and comprehensive at the same time. Biggar argues within the context of a natural law position which holds that the intentional killing of an innocent human being is always wrong. In line with modern elaborations of this “traditional position” Biggar stresses the equal value of all human beings. He elaborates—some may want to say challenges—this position by connecting the concepts of “value” and “human being” with the help of a theologically qualified notion of responsibility. The capacity to bear responsibility undergirds both the *value* of a person and the value of someone *as a person* (Biggar 2004, 166). The distinction between “biographical” and mere “biological” life as made by Harris, Dworkin, and others is pivotal. However, instead of adopting

<sup>2</sup> A similar loophole was identified by a Dutch court in January 2007, in the Vink case (Sheldon 2007). Vink, who helped a woman die, was acquitted since he “gave only general instructions,” did not “take the lead,” and was not present at the moment of the suicide. The case is considered to provide a shortcut to assisted suicide and may, if not followed by stricter legal regulations, have consequences for Dutch euthanasia practice.

their autonomy-based criterion, Biggar considers the capacity to bear responsibility to be the key indicator of biographical life (47–49). His wider concept includes persons with an impaired rationality and persons who are severely suffering. Humans with (strongly) impaired mental capacities may still be able to value the good around them. Referencing Pope John Paul II’s “theology of suffering,” he argues that human suffering may even have a theological significance in contributing to the reconciliation between God and human beings (50–53). Biographical life is “sacred.” Its intentional killing is not allowed, unless (in line with the Principle of Double Effect) as a foreseen and proportionate side effect (85, 167). However, mere biological life, that is, human life that “is forever beyond responsibility,” may be taken intentionally and, if necessary, nonvoluntarily (142–43).

Biggar remains opposed to legal arrangements for euthanasia: such arrangements carry the risk that responsible patients become victims of manipulation and abuse. If euthanasia becomes common practice, society’s high esteem for biographical human life may erode (167). Moreover, he points to difficulties in developing criteria for distinguishing biographical from biological life. For these reasons, he also advocates a general policy to provide care and treatment for persons in a Persistent Vegetative State (169). To support his rejection of societal acceptance of euthanasia, Biggar refers to data from the Netherlands. The Dutch law bears witness to the underdeveloped system of palliative care at the time of its origin: “It is surely one of the most damning features of Dutch policy that it has pursued the relaxation of the prohibition of euthanasia and assisted suicide during a time when palliative care services in the Netherlands have been so rudimentary” (170). In line with this criticism he advocates further investments in palliative care.

Biggar’s argument is well structured, open minded, fair, and compelling. The tone of his argumentation is mild yet at the same time his critique of hedonistic, rationalistic, and voluntaristic tendencies is prophetic. Through its theological depth (such as in Chapter 2), it is at times truly inspiring.

Given Biggar’s acceptance of intentional killing in some cases, his conclusion that legalization should be rejected is reached almost with a sense of relief—if not for its author, then at least for part of his readership. Why? Like most others who argue that some lives deserve protection and others do not, Biggar suggests the key features that make the difference: responsibility and the capacity to value good things. Others make different proposals: the capacity to will, or to act, to think rationally or to do so in the future; the capacity to sense and to suffer, to respond, or to engage oneself religiously; the capacity to contribute to the common good. Other criteria may be suggested that are acceptable to some, yet unconvincing to others. Personally, I find Biggar’s account more plausible than, for

example, Singer's or Papst Battin's. However, how plausible are criteria at all when there is not the slightest chance of unanimity? Who is to tell, amidst the plurality of these competing claims, the bad criteria from the good? Probably the only consensus that can ever be reached is a formal one: some humans may be killed and others may not.

Let us thus imagine a group of five colleagues who agree that the traditional position is rigid and too categorical. They agree that intentional killing is sometimes morally justified and that it perhaps even should be made legal. However, Andrew, who argues that only people who make autonomous requests for euthanasia may be killed, disagrees deeply with Barry, who advocates the killing of nonautonomous humans, because Andrew's younger brother has a severe mental disability. Barry, who holds that only nonautonomous human life may be taken, may be offended to hear Charlie defend a right to die for patients in great distress, because Barry himself suffers from ALS and needs all the support he can get to keep on living. Charlie, who condones the killing of people only when they are suffering severely, may be horrified to hear Diana support late abortions because Charlie's wife is pregnant and they already love the baby very much. Diana, in turn, may feel nauseated by Ethan's plea to grant patients suffering from depression the right to die, because she still has not gotten over the suicide of her mother. They all agree that *some* lives may be intentionally taken, but when it comes to the question of *which* lives, the "alliance" crumbles. (It sometimes seems as if those who challenge the traditional position form one front. This impression is probably stronger among those who defend the traditional position than among those who challenge it.)

Often a lack of unanimity is solved by an agreement to respect some formal guidelines, which are deliberately left ambiguous. In practice, it is assumed, the parties will find ways to deal with the remaining problems. However, Neil Gorsuch is probably more than right that such an ambiguity is intolerable when it comes to the question of who may live and who may not (Gorsuch 2006, 162). Once we allow exceptions to the rule that killing an innocent human being intentionally is wrong, who has the right and the authority to set the range of exceptions? Further, who will ever be fully sure that *his* full right to life will never be contested?

Biggar certainly sees the problem: "To endorse the distinction, then, is one thing, however; to accept the definition of its terms is another" (Biggar 2004, 39). And as mentioned, he opposes a law that allows innocent human life to be taken intentionally. What remain problematic, however, are the arguments for this categorical respect for all human lives. Does he not call to respect "lives beyond responsibility" only for the purpose of protecting biographical lives, rather than for their own sake? What if we would find crystal clear, effective, and broadly supported criteria to distinguish biographical and biological life? What if new data from

the Netherlands would show that slippery slopes can effectively be prevented? In that case, if I understand Biggar correctly, these lives would no longer deserve legal protection. How close then does his argument come to “purely instrumental protection” of human life?

It seems that total protection of all living human beings is, at least *prima facie*, the safest option. For Biggar, bodies are a necessary but not a sufficient condition for living persons (Biggar 2004, 34).<sup>3</sup> To be sure: bodies are necessary for the *existence* of personhood, so when a body is dead, we have reason to assume that the person is “gone.” However, when living bodies are no longer able to display *expressions* of personhood, can we really rule out the presence of personhood? It seems that such epistemic assumptions should be made with great reserve.

### 3. Reverence for Life as the Basis of Western Law and Morality

For those who need insight into the part played by legislators and courts of justice in recent euthanasia discussions, Neil M. Gorsuch’s book, *The Future of Assisted Suicide and Euthanasia* (2006) is an excellent source. This study describes a number of ground-breaking court cases in and outside the United States. It is comprehensive and well argued. Despite its legal focus, the book has a lot to say in the field of ethics. A delicate feature in Gorsuch’s argument is that he limits his scope to the intentional killing by private persons (Gorsuch 2006, 4). This has the advantage of excluding complex issues like just warfare and the death penalty. However, what if euthanasia were conceived as a responsibility of a state? Would that make it more justifiable? As we will see, the *Groningen Protocol* runs the risk of conceiving euthanasia on severely suffering infants as a societal rather than a private responsibility. If euthanasia takes place on behalf of the community, would that make it any less problematic? Therefore, why does Gorsuch confine the rule, “human life may not be taken intentionally” only to the level of private persons? Is it because in that case the death penalty would also have to be classified as wrong? (Justifying warfare would, with the help of the Principle of Double Effect, have better odds.)

The first of Gorsuch’s two goals in this book is to introduce and critically examine the primary legal and ethical arguments used in favor

<sup>3</sup> Biggar quotes James M. Gustafson’s discussion of suicide in *Ethics from a Theocentric Perspective* in which Gustafson remarks: “[Life’s] almost absolute value stems from the fact that it is the condition *sine qua non* for the individual to value anything else and to make contributions as a participant in life” (Gustafson 1984, 214, quoted in Biggar 2004, 104). In contrast to this rather Kantian approach, however, Gustafson seems to suggest in an earlier discussion that the mere presence of physical life itself is a “*sufficient* condition for a life to be valued at all” (Gustafson 1973, 554).

of the legalization of euthanasia. One of these, the argument from autonomy, will come back below. Gorsuch also discusses utilitarian claims that legalization would maximize social happiness and formulates two objections: the reality is much more complicated and simple balances of costs and benefits are hard to make; and there are other data (for example, from the Netherlands) that point in a different direction and which have led authorities to retain laws *against* euthanasia. But confronted with the possibility that a utility calculus may in fact support legalization, he makes this somewhat elusive reservation: "I submit that the utilitarian focus on competing costs and benefits . . . may help sharpen our thinking, but it will not—and, more fundamentally, cannot—resolve the debate" (142). This reveals a persistent tension in many arguments about euthanasia that is also found in Keown (2002) and Dyck (2002), as we will see below. First, arguments of a rather practical kind are invoked: "Voluntary euthanasia leads to nonvoluntary euthanasia," "Many euthanasia requests are caused by a depression," or "Good palliative care will drastically reduce the number of requests," and the like. When such practical arguments (which often include empirical claims) are not supported by evidence, when they appear to be outright false, or fail to be convincing for other reasons, authors point to the fact that, apart from practical considerations which may be true or not, euthanasia is intrinsically wrong. Such an argument sometimes makes it hard indeed to grasp why an author "really" opposes or endorses euthanasia. This flaw is probably the fate of any mixed deontology, since the relations between extrinsic and intrinsic goods here are complex by definition.

In the second part Gorsuch sets forth an argument for retaining existing laws banning euthanasia. His argument comes close to an argument that is also elaborated by Dyck (2002): the equal intrinsic value of all human beings. Instead of providing a philosophical foundation, Gorsuch refers to a common understanding of basic goods implicit both in secular moral and in legal theory, based on our practical human experience. "And this is as it must be. I do not purport that I can 'prove' the existence of basic goods or moral absolutes by reference to logical syllogism. Rather, I can and seek only to suggest their existence by reference to the practical, pragmatic experience of each of us in the world" (Gorsuch 2006, 158). He argues that our whole political system is premised on the notion and acceptance of such basic rights and wrongs. One of these is that all human beings are equally valuable and that no one is entitled to take human life intentionally.

#### 4. The History Test

Both Gorsuch and Biggar pay extensive attention to the disputed history of euthanasia. Interestingly, as Gorsuch shows, history may be used

both by advocates and adversaries of the legalization of euthanasia. The former will point to the fact that Greek philosophers and Roman law saw no reason to put constraints on the individual's choice for suicide. The rejection of this view, which came with the rise of Christianity, was retained in the laws of many Western, Enlightened States. Social Darwinism and Nazism brought a more positive view on the killing of people with handicaps or people who were suffering severely, both with and without their request. After the atrocities in Hitler's Germany, the movement toward a liberalization of the prohibition on euthanasia suffered a "backlash" (Gorsuch 2006, 36), but soon voices were raised again in favor of euthanasia. Although the great majority of current pleas for euthanasia renounces any sympathy with Nazi thinking, Gorsuch points to some striking parallels between pre- and post-Nazi pleas for euthanasia: "[I]t is hard to disagree with [the] conclusion that, 'though they may not know it, today's defenders of the right to die often echo the justifications of euthanasia first uttered' by early movement leaders [in the nineteen thirties]" (Gorsuch 2006, 43). Some of these parallels are, in fact, disquieting, such as the one between Peter Singer and William J. Robinson (36). Comparisons like these almost by definition are a form of "skating on thin ice." However, Biggar has a point in criticizing the other extreme, such as Margaret Battin's reassuring observation that "[a]fter Hitler, we are, I trust, beyond extermination of unwanted or dependent groups" (Battin 1981, 177, quoted in Biggar 2004, 158). That is hardly good news, Biggar suggests, for Cambodians, Rwandans, Iraqis, and Kosovans.

### 5. Last Resort in Unbearable Suffering: The Policeman's Dilemma

In 1993–94, the British Select Committee of the House of Lords on Medical Ethics issued a report which concluded that there was no reason for a change in the British prohibition of intentional killing, which it regarded as the cornerstone of law and social relationships (House of Lords 1994; see also House of Lords 2005, 3).<sup>4</sup> Among other things, the Committee was concerned about the risk of nonvoluntary euthanasia. Since then, three countries made legal arrangements for euthanasia or physician-assisted suicide. Public support for similar arrangements increased and there was a growing openness between patients and doctors about the wish of some to die. Moreover, some citizens traveled to Switzerland to have their wish fulfilled. For these reasons, Lord Joffe introduced the *Assisted Dying Bill* in 2003. Although given a Second Reading, it did not proceed further. With the wisdom resulting from these

<sup>4</sup> Citations from the House of Lords Report 2005 reference paragraph numbers.

discussions, Lord Joffe submitted the *Assisted Dying for the Terminally Ill Bill* in 2004 (House of Lords 2004). This bill regarded only terminally ill patients and required a discussion with applicants of the option of palliative care. In light of these restrictions, the Academy of Medical Royal Colleges adopted a neutral stance on the ethics of the Bill, while raising concerns on its provisions (House of Lords 2005, 4). The Bill was considered by a Select Committee of the House of Lords, which reported on April 4, 2005. The Committee does not reach a conclusion whether or not euthanasia should become legal, but takes the more modest role of identifying issues that need to be addressed in any future legislation, whatever the outcome. Since the practical requirements in the Bill are clear and solid, the Committee discusses the more basic normative assumptions underlying its recommendations. Careful mention is made of the many voices against and in favor of euthanasia. The Report stresses the value of patient autonomy but comments that it is not an absolute right and may need limitations, especially when others are affected (62). Moreover, it assents to the principle that may be described in terms of both sanctity and inviolability of life. The Report retains the difference between acts and omissions, which is central in British law.

The Report also addresses some more practical arguments. It discusses contested claims that assisted killing already happens covertly on a large scale and that a law helps to prevent misuse and creates legal security. It pays attention to slippery slope considerations and to the consequences of legalization for relations of trust between doctors and patients. In line with the bill itself, which requires a patient to have a person-to-person consultation with a medical specialist in palliative care, the Report makes critical remarks about the limited availability of palliative care and about its poor effectiveness. The underlying moral consideration in this careful discussion is: if we are at all to condone euthanasia, it should be a matter of last resort in a situation of unbearable suffering. To illustrate this, the Report makes a reference to the widely used example of the "policeman's dilemma" (47).

The policeman's dilemma is the story of a lorry driver who is trapped in the blazing cab of his vehicle following an accident. A policeman on the scene sees that the driver cannot be extracted before the flames get to him. As a last resort, the driver asks the policeman to shoot him.<sup>5</sup> The case is regularly invoked to justify euthanasia. If killing is the only way to prevent the lorry driver from burning to death, killing can be the right thing to do for physicians, too.

To be sure, the dilemma provides a compelling example of how a rule may have to be broken. However, as Robin Gill observes, "[i]t is a hugely

<sup>5</sup> See Harris 2003. Interestingly enough, a similar case occurred in Iraq in 2004 when a U.S. soldier killed a severely wounded Iraqi teenager who was stuck in his truck. The soldier was sentenced to three years in prison in December 2004.



compassionate case, and I would do exactly as the policeman did, and I hope you would too. But I would not expect the law to be changed to allow that" (House of Lords 2005, 68). Interestingly enough, some advocates of and some opponents to legalization seem to agree that a rule is a rule and knows no exceptions. If it can be successfully argued that euthanasia may sometimes be justified, they agree (gladly or grudgingly) that the rule itself is called into question. However, that is not the only possible conclusion. The mere concept of "exception" often serves as an affirmation of the normativity of rules!

Moreover, there is an essential difference: the policeman has only one option to end the suffering, but doctors often have more means, from painkillers and tranquilizers to full sedation. To increase the relevance of the lorry example, it should be so framed as to involve more than one option to end the driver's suffering, for example, that the policeman also carries a capsule which, when swallowed, brings the driver in an immediate coma without killing him. No doubt, doctors with a *prima facie* aversion to active killing would prefer to take away the suffering without having to kill. It may sound a bit rhetorical, but most doctors do have such an aversion, as do most other people. The question is thus: under what conditions can the claim be sustained that killing is really the only and last resort?

A case that was reported in 2006 to a Dutch review committee may serve to illustrate the moral complexity of the argument of "last resort in the case of unbearable suffering."<sup>6</sup> The case involves a physician who was to perform euthanasia on a terminally ill cancer patient. All the criteria set by Dutch law were met. The evening before the agreed term, the patient called the doctor in distress. He insisted that the euthanasia be performed right away. Since the physician did not yet have access to the lethal drug till the next morning, she administered a medication that induced a coma. The next morning she returned and, without waking the patient, performed the euthanasia as agreed. The committee decided to report the case to the prosecutor. It based its verdict on a report written for the Dutch Medical Association KNMG (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst), which suggests that a patient in a coma cannot experience unbearable suffering (Legemate 2005, 40). Moreover, the physician should either have awakened the patient and asked him, or should not have proceeded.

The verdict discloses a pivotal and ever recurring issue in almost any euthanasia discussion: if a patient can be made comfortable with the help of advanced palliative techniques, including terminal sedation, what justification is left to take the most radical measure and terminate both the suffering *and* the life of the patient? The committee's verdict may

<sup>6</sup> Not published. The details have been changed to protect the privacy of the case.

cause quite some discussion. In a technical sense, *most* cases of voluntary euthanasia in the Netherlands concern patients in a state of coma. Following KNMG guidelines, most physicians induce a coma (usually by using sodium thiopental) before the actual life termination takes place (usually through pancuronium bromide, a neuromuscular muscle relaxant). In the minutes between the administrations of the two drugs, the patient is in a coma and seems to be free from suffering.

Alleviation of suffering, of course, is more than just taking away some bodily symptoms. The British Committee admits that even if palliative care may be highly effective in dealing with symptoms such as pain, it will never be fully able to address some patients' concerns regarding their loss of autonomy, loss of control of bodily functions, and loss of dignity (House of Lords 2005, 88). These are "person-centered issues which most frequently lie at the heart of a request for help to die." Here, autonomy comes into the picture.

The Bill was defeated on its Second Reading in the House of Lords on May 12, 2006 by a margin of 148 votes to 100. There is no current Bill before parliament on either assisted suicide or euthanasia.

## 6. The Argument from Autonomy

Central to John Keown's book *Euthanasia, Ethics, and Public Policy: An Argument against Legalisation*, is the view that legalization of euthanasia yields a practice that cannot be controlled. For this purpose, extensive attention is paid to jurisdictions that have taken the step to permit euthanasia or assisted suicide. Examples give his argument a compelling clarity.

Both Keown and Gorsuch pay extensive attention to the role of autonomy in the euthanasia debate. Gorsuch (2006, 86–90) rejects two commonly held views about autonomy, which are used in support of euthanasia: the view that respect for individual autonomy requires a neutral state and the view that the state should only prevent its citizens from harming *each other*. Gorsuch endorses a third view, suggested by Robert George: a state should sometimes put paternalistic constraints on the choices of its citizens, but this leaves enough room for a meaningful exercise of individual autonomy. In support of this view he adduces examples from religious cults in which people commit suicide while explicitly excluding the possibility that they have been brainwashed. "The notion that such events could proliferate may seem remote, but how can we dismiss the possibility out of hand that we would see more 'choices' of this sort—or others like them?" (Gorsuch 2006, 100).

Keown argues in a similar way. The "right to choose" only makes sense in the context of a moral framework that enables us to discern what is *right* to choose (Keown 2002, 54). Keown's examples of practices that are prohibited by the state, however—sex with children, cruelty toward

animals, and female circumcision—are not as convincing as those explored by Gorsuch. Advocates of the “autonomy only” paradigm will object that the reason why these practices are prohibited is formal rather than material: they fail to meet the requirement of universalizability. Pedophilia and animal torture are against the “wishes” of children and animals. Female circumcision can hardly be said to be voluntary. More convincing examples, it seems, would be the prohibition against polygamy and the conviction in 2006 of a German man who ate a fellow citizen at the man’s own request. In the latter cases, no autonomy is violated and the universalizability requirement is fully met. Still, everyone loathes cannibalism and most reject polygamy.

Thus, Keown and Gorsuch may be right after all that there are reasons to confine human autonomy on more than formal grounds alone. And most people probably agree that a state has the responsibility to enforce limits to some autonomous choices. But under which conditions? Is euthanasia morally equal, or similar, to polygamy, or to horrific life-destructive acts based on autonomous choices? Does euthanasia even remotely belong to the same category as Waco? Or does it reside in a category that is morally much more acceptable, and would legal prohibitions be justified for slippery slope concerns rather than reasons of intrinsic wrongness?

Keown has doubts as to whether a euthanasia request can be really informed and autonomous (Keown 2002, 56). To be sure, anyone will see the relevance of this point, but it is doubtful whether it will convince those who do not believe in the intrinsic wrongness of euthanasia. Frequently recurring claims that euthanasia can never be fully voluntary invite the question: What if it can? Would euthanasia in that case be permissible? For Keown, it is not: “Even if all such requests were truly free there remains the argument that the principle of the inviolability of life is of such foundational importance to any civilized society that it should never be compromised” (63; see also section 3 above). He and others have powerful reasons for arguing that euthanasia is intrinsically wrong. Against that categorical background, the question is whether voluntary euthanasia is any better than nonvoluntary. Of course, even nonvoluntary euthanasia involves an autonomous choice, in this case made by others than the patient. When the intentional killing of an innocent human being is intrinsically wrong, does it matter whose intention is involved? In some religious traditions, suicide is worse than murder and may even be “unforgivable.” When someone is killed unexpectedly, some people are even more upset to hear that it was suicide. Thus, to some, voluntary euthanasia may be even *worse* than nonvoluntary.

We should probably understand Keown and others to make the following claims: (1) Voluntary euthanasia is *intrinsically* wrong because it means the intentional killing of an innocent human. If people really

knew what they were asking, and were truly free to choose, many of them would shy away. (2) Voluntary euthanasia is *extrinsically* wrong because it may lead to new acts of euthanasia, both voluntary, nonvoluntary, and even involuntary. Whether nonvoluntary and involuntary euthanasia are *intrinsically* more or less wrong than voluntary euthanasia is not made explicit.

## 7. The Wish to Die

Arthur Dyck's study *Life's Worth: The Case against Assisted Suicide* (2002), offers a composition of arguments against the legalization of euthanasia.<sup>7</sup> The book starts with the cogent story of Sidney Cohen, a patient in a terminal phase of cancer who is suffering severely and who requests euthanasia. The story is strikingly familiar to the dozens of stories I review monthly as a member of a regional review committee. Cohen's case, though, has a happy ending (Dyck 2002, 1–2).

Dyck's central contention is that unconditional respect for human life lies at the very basis of Western morality and law. This is a moral structure which people share as human beings and which forms the basis for laws both against homicide and against euthanasia. Dyck criticizes philosophers who claim that killing is wrong only when someone does not wish to be killed. He draws on concepts and affirmations found in both Christian thought and Western philosophy: "But the claims made in the *sources* of anyone's thinking are distinguished from *warrant* for one's claims, whatever their sources" (9).

Dyck dedicates a substantial part of his study to a criticism of the autonomy argument. A request for euthanasia usually implies convictions based on certain medical information, and there is always a theoretical chance that this information is wrong. Patients and their families may need the extra time to become prepared for their deaths. Patients' wishes may be subject to change. Euthanasia requests may be caused by depression. Some even wish euthanasia because fear of death amplifies the fear about what to expect from the dying *process*. Here, the fear of death itself needs to be addressed (17). Moreover, respecting patient autonomy does not guarantee that the physician's values in the clinical encounter are not imposed on the patient: a right to euthanasia is equally an imposition of liberal values on severely suffering people. Dyck's criticism becomes especially challenging when he suggests that the very idea that the value of human life can be calculated bears witness to a suicidal attitude (21). Those who do not despair rarely make such a calculation. In support of his point, Dyck contrasts Kant and Gewirth. The latter's equation of

<sup>7</sup> Despite the title, the book covers both euthanasia and physician-assisted suicide.

human dignity and absolute freedom has deep problems. In line with Kant, Dyck argues that it is rational to seek our self-preservation, and humans are naturally social and have the natural ability and proclivity to be morally responsible for their relations (25).

In Chapter 2, Dyck concentrates on the specific moral characteristics of euthanasia compared to “comfort-only-care.” He agrees with W.D. Ross that some moral dilemmas cannot be solved with the help of the Principle of Double Effect. Rather, they should be understood in terms of their “right making” and “wrong making characteristics.” In criticizing Beauchamp and Childress, Dyck argues that euthanasia and palliative care involve more characteristics than the right making characteristic of relieving suffering and the wrong making characteristic of ending a life: (1) Euthanasia carries the wrong making characteristic of introducing a “lethal agent,” different from administering painkillers which *may* hasten death. (2) Palliative care has the right making element of the wish that the patient lives. (3) Palliative care allows people to sustain the quest for a virtuous life and even to gain in virtue during one’s very last weeks (42).

In both chapters, the wish to die stands out as wrong making. The question is whether the author really needs to make this claim. To be sure, death wishes may be motivated by very obscure reasons. And yes, many death wishes can probably be prevented were the person to receive better care or more love and attention. Still, we all know persons whose wish to die we can understand—because they want to be with God, because they have had a fulfilled life, or because they are in extreme suffering. The moral question is not whether such a wish is good or not; from a pastoral and psychological viewpoint it would clearly be wise to allow people to speak freely about their wish to die. The essential question is whether such a wish justifies intentional killing. I may wish to be rich, but I will not rob the bank; I may want to marry the prettiest girl in town, but I will not try to talk her into a divorce. As elsewhere in life, there is a lot of space between “desires” and “actions.”

In Chapter 3, Dyck argues that the structure of life’s worth and protection expresses itself in at least three ways: as an individual, natural, and inalienable right to life, a right that cannot even be overruled by ourselves; as a natural love of life; and as a belief in life’s sacredness. These, he argues, are “naturally occurring phenomena.” He draws on different theological traditions (mostly Protestant) in support of natural responsibilities to protect life and respect its sacredness. This is a refreshing approach. Dyck is the only one of the authors reviewed here who makes extensive references to the existence of a natural morality. However, readers who are more practically oriented will look in vain for concrete proposals. What they need is a theory of “natural dying”—a theory which helps us to find ways to live with our wishes to die with “as

little killing as possible” and to rediscover ways to die “more naturally.” Ideally, such a theory would be a critique not only of euthanasia, but also of the many other ways in which medical technology influences, and sometimes obstructs, the conditions for dying naturally.

### 8. Acts or Omissions?

There is a continuing debate about the moral differences between acts and omissions when the intention and the effect are the same. Keown chooses the definition “by action or by omission” and part of his argument is that killing is widely practiced by (unjustly) withholding from a patient life-sustaining treatment. Gorsuch and Biggar concentrate on active killing but stress the implications of their positions for decisions to withhold treatment. Dyck chooses to stress the difference and speaks of (some) decisions to withhold treatment almost soothingly as “comfort-only-care.” His critique of Beauchamp and Childress, who abandon the distinction between foreseen and intended consequences (Dyck 2002, 35–39), is an implicit criticism of Keown and others, too.

Perhaps a few observations may suffice. (1) There seems to be agreement that at least in some cases acts and omissions become very similar morally, if not equal. This is especially the case when the effect of acts and omissions and the intentions behind them are the same. (2) It seems equally undisputed that in at least some instances there are moral differences between acts and omissions. As Gorsuch observes, only in acts do we have total certainty as to the intention (Gorsuch 2006, 62–65). Moreover, while in “acts” the primary actor is a human being (for example, by swallowing a poison or by giving an injection), in cases of omissions the primary agent is rather a nonhuman “cause,” to which humans may lend their cooperation. (This may be equally reprehensible as performing the act, but the difference is there.) There are also differences in directness: acts normally result in death right away, whereas in many cases of withholding or withdrawing life-sustaining treatment, death does not follow directly or does not incur at all. That there may be moral differences is, moreover, reflected by intuitive reactions when people learn that a death is caused by euthanasia rather than abstention. (3) It thus seems plausible to construe the relationship between acts and omissions in terms of overlapping circles rather than in terms of two manifestations of one and the same matter.

There is one additional reason for stressing the nonidentity of acts and omissions, which is taken from the Dutch discussion about euthanasia in the 1980s. Already in an early stage of that debate the existence of a moral difference between killing and letting die was contested. In 1981, the influential theologian Harry Kuitert defined euthanasia as “ending a human life intentionally, including the decision to withdraw

treatment” (Kuitert 1981, 29). The Gezondheidsraad, the statutory advising body to the government in health care issues, adopted a similar definition in 1982. The terminology was soon taken over in other contexts. The synodal report, *Euthanasie en Pastoraat* (1988) of the Protestant Church of the Netherlands (Gereformeerde Kerken in Nederland, GKN, and Nederlandse Hervormde Kerk, NHK) argues that “in spite of what many think, there is no moral difference between active life termination and the decision to withhold treatment” (GKN/NHK 1988, 4). It is not hard to imagine the impact of this redefinition. Since most people at some point may have supported decisions to refrain from giving additional treatment to a severely suffering patient in a terminal phase—treatment that could have preserved his or her life for days, weeks, or months—the suggestion is made that we *all* occasionally condone “euthanasia.” What is left, it seems, is the question of when euthanasia may be proper and when not. This shift in the discussion from “if” to “when” may have contributed to the early acceptance of euthanasia in the Netherlands.

## 9. Euthanasia or Assisted Suicide?

Biggar, Dyck, Gorsuch, and Keown work from the assumption that, despite circumstantial differences, euthanasia and physician-assisted suicide are morally identical. Both involve deliberate acts of killing an innocent human being. In legislation and jurisprudence, assisted suicide is often considered more tolerable than euthanasia. Switzerland and Oregon only allow assisted suicide. In the Dutch euthanasia law, the maximum penalty for unjustified euthanasia is twelve years whereas the penalty for unjustified assistance to suicide is three years. The main reasons for this legal preference seem to be formal: in the case of assisted suicide, the primary actor is no longer alive. Moreover, the chance that a suicide occurs without the person’s wish is relatively small.

Is assisted suicide therefore also morally preferable? Many physicians point to the fact that euthanasia is, for them, emotionally more burdensome than assisted suicide. In the case of assisted suicide, the physician is at liberty to depart after delivering the medication and giving the instructions and can be absent during the actual suicide. When the actual killing is performed by the patient, the physician has more certainty as to the patient’s preference. On the other hand the great majority of patients in the Netherlands—about nineteen out of twenty—request euthanasia and not assistance in suicide. The tragic fact that most of them are simply not able to perform the act due to symptoms such as extreme fatigue and nausea explains much, but not all of this preference. Even patients in a relatively good physical condition ask for euthanasia. Why? More than most other forms of intentional killing, euthanasia arouses

associations of a patient “going to sleep.” A patient in a Dutch documentary film explained her wish for euthanasia; “Wouldn’t it be wonderful to just go to sleep and be able to say, ‘This time I will not wake up?’” (Hof 2003). About 95 percent of the euthanasia cases in the Netherlands occur in the privacy of a home doctor–patient relationship. The injections are given by the same physician who is valued for her help and advice. Ideally, the patient has trusted her as a morally reliable and wise person who acts in the patient’s best interests. That the method for performing euthanasia is known from procedures to support life no doubt has a reassuring effect. Moreover, when a physician performs the killing, the circle of those who are responsible is widened. The heavy burden of deciding to terminate the patient’s life and of performing the killing is shared. For the patient, suicide, even under assistance, may be a lonelier and more emotionally burdening experience.

The question whether, other things being equal, euthanasia is to be preferred over assisted suicide, will thus be answered differently depending on whether a patient or a physician perspective is adopted. Neither will a broader societal and political ethic, which holds that human life deserves protection and that its intentional and active termination should be discouraged, give an unambiguous answer to the question. No doubt, assisted suicide is likely to provide better safeguards against nonvoluntary killing. This may be especially relevant in countries with a more paternalistic tradition of health care, as well as in countries in which physicians are under pressure to pursue the cheapest of alternatives. Moreover, Keown may be right that the distinction between the two is often a “matter of tactics”: “[Pressing for PAS] might more easily enable the campaign to distance itself from the uncomfortable historical baggage associated with euthanasia” (Keown 2002, 35). On a more fundamental level, assisted suicide may better reveal the persistently problematic character of acts of killing than its more concealing alternative, euthanasia, and in this way deter some from choosing death: not all who request euthanasia will have the courage to kill themselves. On the other hand, the active involvement of physicians, which is ideally typical of the process that precedes euthanasia, may provide an extra safeguard against poorly thought-out acts of suicide.

### 10. Euthanasia for Infants: *Groningen Protocol*

The much-debated *Groningen Protocol* (NVK 2005) takes its name from a city in the north of the Netherlands. In the Academic Hospital located here, physicians specializing in intensive care and life-sustaining treatment for premature infants regularly make end-of-life decisions. One of the options is the active termination of the life of an infant. Given the widely acclaimed transparency of decisions concerning active



euthanasia on *competent* patients in the Netherlands, and given the jurisprudence in the Prins and Kadijk cases, which acquitted doctors who terminated the life of severely suffering newborns, the Groningen physicians felt the time was right for a policy document on this matter. To increase the chances for consensus and to minimize the risk of legal prosecution, the document was made in consultation with the public prosecutor.

The *Protocol* commences by identifying three categories of newborns for whom end-of-life decisions are made. (See also Verhagen and Sauer 2005.) Group 1 comprises infants who will die shortly with or without the use of advanced medical techniques. At most, death can be postponed for a short period of time. Decisions to withhold or withdraw treatment are rarely contested here, neither for medical nor for ethical reasons. Group 2 comprises infants who could survive with the help of intensive treatment, but this treatment is considered futile on grounds that include quality-of-life concerns. When treatment is withdrawn, these infants are expected to die. Medication for the purpose of alleviating pain and suffering in the dying phase is generally accepted. Differences in opinion exist on the appropriateness of medication given with the intent to hasten death without directly killing the infant. The document concentrates on a third group of patients: "Stable infants with a hopeless prognosis, not dependent on technology." Here, the decision to withhold or withdraw life-sustaining treatment does not lead to the death of the infant. Although it may live for a longer period of time, there are no prospects of improvement over time and despite palliative care, its suffering cannot be alleviated. One option in these cases would be to wait for "nature to take its course," for example, in combination with withholding or withdrawing tube feeding. Since this strategy, albeit preferred by some physicians, implies the possibility that the infant will suffer severely and for a potentially long time, it is sometimes decided to terminate its life. In 2001, it was estimated that such decisions in the Netherlands occur about one hundred times a year (Van der Wal et al. 2003, 118–21). In 80 percent of these cases, medication is administered with the intention of hastening the process of dying; in the remaining 20 percent, drugs are administered with the explicit and direct intention to make the infant die. Since it is generally agreed that the death of these 20 percent of patients cannot be categorized as "a natural death," these decisions have to be reported and it is especially for this category that the *Groningen Protocol* was developed.

The *Protocol* argues that decisions in both categories 2 and 3 are, and should be, made on more than medical grounds alone. To begin, it must be clear that all treatment options are medically futile. That is, treatment does not contribute to the solution of the medical problem, the means are disproportionate in relation to the goal, and treatment does

not bring about a certain minimum level of life quality. Quality of life regards a variety of parameters such as:

1. The expected degree of communication;
2. The expected possibilities of autonomy/independence;
3. The degree of dependence on medical care;
4. The degree of suffering; and
5. The infant's life expectancy.

Of these criteria, suffering and the impossibility of reaching a minimum level of autonomy are the most important.

The *Protocol* then suggests a number of procedural "checklists." Section A contains some formal requirements for the physician, including the duty to consult the coroner beforehand and reporting to him afterward. Section B describes the interaction between the physician and the coroner in detail. Section C contains a list of due care criteria. The criteria include: (1) The physician must use *all* the diagnostic methods needed to make the diagnosis; (2) Diagnosis and prognosis have to be based not only on experience and knowledge of the doctor, but also on evidence from literature; (3) The doctor must base his prognosis primarily on the existing condition of the child; (4) The medical team must reach unanimity as to the diagnosis and prognosis; (5) The parents must be fully informed; (6) Both parents must consent; and (7) Physicians with moral objections to the life termination must be open about their point of view and refer to a colleague who has no such objections. Attached to the *Protocol* is a detailed questionnaire similar to those used for euthanasia on competent persons.

The *Protocol*, the first of its kind in the Netherlands, has met fierce criticism from many countries, most notably the United States and the Vatican. That the *Protocol*, despite its influential status, has as yet never been officially published, may have contributed to the allegations. Apart from comparisons to Nazi Germany, and suggestions that thousands of newborns are killed in the Netherlands each year, the *Protocol* does in fact give reason for some more serious concerns. First, the document lacks a moral argument and merely refers to preceding moral and medical discussions elsewhere (KNMG 1997; NVK 1992; NVK 2000; and Leenen 2000), which are more or less unanimous in their normative conclusions. The five quality-of-life criteria are not made explicit and leave room for new interpretations; despite the implicit assumption that decisions to terminate the lives of infants are rare exceptions, no reference is made to their consistently problematic character; the *Protocol* focuses on active termination of life and does not discuss other options, such as refraining from treatment, nor does it refer to the moral distinction between acts and omissions. To be sure, this focus rests on a practical necessity: since only *active* termination of life needs to be reported to the coroner, and

since in the Netherlands *nonvoluntary* euthanasia remains highly problematic, physicians need concrete and generally agreed upon guidelines. However, the problematic character of killing infants would be all the more reason to mention morally less problematic alternatives.

Despite these and other points of criticism, the *Groningen Protocol* was accepted by the Dutch Association of Pediatrics (NVK, Nederlandse Vereniging voor Kindergeneeskunde) as a national guideline in 2005. In a letter dated November 29, 2005, the government, a coalition of Christian Democrats and Liberals, embraced the *Protocol* and its acceptance by the Dutch Association of Pediatrics as a starting point for issuing nationwide guidelines on this matter (Ministerie van VWS 2005).

The Ministerial Guidelines show both similarities and differences in comparison to procedures regulating voluntary euthanasia. For reviewing the cases, the government announced the formation of a national review committee. Just like their regional colleagues who review euthanasia on competent patients, the national review committee assesses the termination of life in hindsight. It bases its verdict on five criteria: (1) the certainty of the diagnosis and prognosis based on solid empirical data; (2) the presence of hopeless and unbearable suffering; (3) the confirmation of the diagnosis, prognosis, and suffering by at least one doctor independent of the medical team; (4) the consent of both parents; and (5) the procedure's accordance with accepted medical standards.

From this list, a number of other differences in comparison to procedures surrounding euthanasia on competent patients can be found. Since newborns cannot make a request, the logical thing to assume would be that the parents make a request on their child's behalf. However, both the Ministerial Guidelines and the *Groningen Protocol* speak in terms of "consent," which suggests that others than the parents may take the initiative. This physician-centered reading is supported by the introduction to the *Protocol*: "The physician can decide to watch and wait until the child is relieved from its suffering. For most of the doctors, however, this is unacceptable." In the questionnaire that has to be completed after the euthanasia, one of the questions is: "Who was the first to suggest the intentional termination of life?" (II.1). Just once in the *Protocol* the term, "parental request" is used (A subsection 3b). The Ministerial Guidelines do not mention the term at all.

This apparent reversal of roles (the physician takes the initiative, the parents have the right to consent) is reinforced by another feature: the dominant role of medical criteria in the decision to end the life of the infant. The *Groningen Protocol* elaborates extensively on the medical conditions that may justify the termination of life. Among those who would qualify are infants with severe brain damage, spina bifida, or hydrocephalus. The *Protocol* does not require a detailed account of the severity of the suffering. It does not even speak of "unbearable suffering"

(its first author, Dr. Verhagen, did use the term at the presentation of the *Protocol*). Instead, the weaker term, "severe suffering," is used. The Ministerial Guidelines return to the term, "hopeless and unbearable suffering," a term current in procedures surrounding voluntary euthanasia. Moreover, the *Groningen Protocol* and the Ministerial Guidelines lack the common clause, "Physician and patient must together have reached the conclusion that there is hopeless and unbearable suffering that cannot be alleviated by other means." One would have expected a clause such as, "Physician and parents must together have reached the conclusion that there is hopeless and unbearable suffering that cannot be alleviated by other means."

A closely connected difference is that euthanasia on infants is preceded by stricter criteria concerning diagnosis and prognosis than is the case in voluntary euthanasia. The *Groningen Protocol* elaborates this requirement more extensively than the Ministerial Guidelines. The stress on the need for thorough medical examination is reflected by the members of the national committee: whereas the regional review committees for voluntary euthanasia consist of three members (a lawyer, a physician, and an ethicist), the national committee consists of a lawyer, an ethicist, and *three* physicians (although the opinion of the three doctors together counts as only one vote).

We may finally point to two rather contradictory features. Whereas the verdict of a regional euthanasia review committee that a physician has acted in accordance with the due care criteria is final, the verdict of the national committee has only advisory status and the final decision is up to the College of Attorneys General, a decision which, in turn, can be overruled by the Minister of Justice. This illustrates that the intentional and direct termination of the lives of infants continues to be anything but normal. The Ministerial Guidelines explicitly address this issue with a strong admonition: "Life ought to be protected, including the lives of people with a handicap" (Ministerie van VWS 2005, 4). On the other hand the physician who intends to terminate the life of an infant consults the coroner *before* the actual termination of life. Put somewhat bluntly, the "blessing" of a state official for such a highly controversial act raises questions about the independence of the state and is likely to reduce the chances of a successful prosecution in case of doubts about the rightness of a life termination.

Those who look at it from the bright side may stress that finally a much-disputed category of life termination has come out of the gray zone. The government has bridged the gap between covert practice and existing law, and has regained control. Moreover, physicians have greater legal security. Still, the skeptic may remonstrate that the guidelines create new gray zones, that the leading role of physicians is a threat to parental autonomy, and that the focus on medical criteria overlooks

the importance of concern for the suffering of an infant. In addition, the objection is made that the goal of alleviating the infant's suffering can in many cases be reached by making less problematic concessions to a society's duty to protect human life.

## 11. Suffering from Life

In the week after the euthanasia law passed the Dutch Senate in April 2001, Health Minister Else Borst declared in a newspaper interview her support for a right to die for elderly persons "who are bored stiff but, alas, not bored to death" (Boer 2003, 237). In that same year, the KNMG asked a committee presided by Professor Dijkhuis to explore the role of physicians with regard to patients who "suffer from life," that is, whose wish to die is not, or not primarily, based on the presence of a medically classifiable illness. The *Dijkhuis Report* was presented in 2004 (KNMG 2004). The Report identifies four alternative approaches to this issue: (1) Physicians have no special expertise with regard to "suffering from life" and should not engage in assisted dying under these circumstances. (2) Physicians can extend their expertise with regard to unbearable and hopeless suffering to patients who are "suffering from life." (3) "Suffering from life" requires expertise from more professionals than physicians alone. Helping such persons to die must be arranged in multidisciplinary teams. (4) Assisted suicide is not a matter for professionals. Anyone who helps a competent person to die at his request should have legal protection.

In 2002, the Supreme Court convicted a home physician, Sutorius, for helping one of his patients to die. The suffering of this patient, 88-year-old former senator Mr. Brongersma, fell within the category of "suffering from life." The Court ruled that the 2001 euthanasia law only covers suffering from medically classifiable illnesses. Despite this verdict, the Dijkhuis Committee recommends that the KNMG proceed along the lines of option 2. It argues that many of those with medical illnesses who receive euthanasia in fact suffer from other than medical causes alone. As an additional advantage, it is argued, the euthanasia law does not need further changes. Merely the jurisdiction should be extended so as to include this new category of suffering.

The Report has been met with skepticism. Right to die societies criticize its physician-centered approach and its "paternalistic" undertone: after all, it argues primarily from beneficence based on a physician's assessment of the seriousness of the suffering. While the largest Dutch Protestant Church in the 1970s and 1980s issued reports that were positive about liberalization (NHK 1972; GKN/NHK 1988), its standing advising committee on health care issues rejected the conclusions of the *Dijkhuis Report* (PKN 2003). One of the members of the Dijkhuis

Committee, Nico Mensing van Charante, declared in an interview a year after its publication: "According to my knowledge, nothing has happened with the report. . . . The KNMG reacted very reticently. . . . I think they were startled." Mensing van Charante explains this as follows: "[T]he issue does not occupy the minds of physicians. For most of them [euthanasia for patients who suffer from life] is a bridge too far. Some of them do get such a request, but they respond: 'Why ask me? Let people make arrangements for themselves'" (Peters 2005). This explanation is affirmed by a study by Mette Rurup, *Setting the Stage for Death: New Themes in the Euthanasia Debate* (2005). Rurup estimates that physicians in the Netherlands receive about four hundred requests for euthanasia per year in which "suffering from life" is the main reason for the request. In about one hundred of these requests there is no severe physical illness at all. Only forty out of these four hundred requests are granted (Rurup 2005, 26).

Also politically, the developments on this issue seem to have come to a pause. In February 2007, a new government was formed, based on a coalition of Christian Democrats, Social Democrats, and for the first time ever, the conservative Christian Union. The latter is strongly opposed to euthanasia and the other parties respect some of its concerns. The new government has announced that in the coming four years there will be no experimenting on further liberalization of euthanasia praxis; moreover, it announced investments in better palliative care. A further liberalization of the Dutch practice is unlikely.

## 12. Slippery Slope or Rocky Road?

According to Keown, Biggar, Dyck, and others the Dutch are on a slippery slope. The slippery slope argument holds that allowing A (which may or may not be intrinsically wrong), will inevitably (or very likely) lead to B, which is wrong (see Boer 2003, 229–32). The two most commonly debated slides are (1) the slide from voluntary to nonvoluntary euthanasia, and (2) the slide from assisted suicide to euthanasia. Other slides, not so frequently discussed, may be (3) the slide from nonvoluntary to voluntary euthanasia (if suicide is seen as a greater evil than murder, see Section 9), (4) the slide from euthanasia to assisted suicide, and (5) the slide toward the acceptance of an ever-increasing range of indications and reasons for euthanasia.

The Dutch preference for transparency yields a steadily growing number of surveys monitoring the occurrence of end-of-life decisions. Not all references to those surveys are convincing. Dyck, for example, bases his extensive discussion of the pros and cons of the Dutch experience solely on sources that are critical of the Dutch situation. Many of these date back to as early as 1989. For example, Dyck (2002) cites Twycross (1995), who cites George (1990), who in turn bases his findings on surveys

conducted in the late 1980s (Dyck 2002, 4 n. 5). The observation that “in the Netherlands, only about 25 percent of its doctors have received training in cancer pain management” (Dyck 2002, 4) is based on a survey published thirteen years earlier. It would have been fair to mention that the Dutch since then have taken initiatives to catch up with much of the rest of the civilized world. Such anachronisms with respect to Dutch surveys occur in other studies, too.

In 2003, a survey was published on the basis of data gathered in 2001–2002. This time, the increase in the number of euthanasia cases was very modest. Seen against the background of overall mortality rates, the data even justify the conclusion that the increase had come to a halt (Van der Wal et al. 2003). Most of the authors reviewed here did not yet have access to this survey. Only Biggar mentions it, and he sees no reason to revise his thesis about a slippery slope in the Netherlands (Biggar 2004, 197 n. 141). However, he and others may have to modify their conclusions in light of more recent data. A survey presented in May 2007 concludes that the number of voluntary euthanasia cases performed by a physician has decreased sharply in recent years: from 3,500 in 2001 to 2,300 in 2005, a decrease of 34 percent. The assisted suicide rates went down even more sharply: from 300 in 2001 to 100 in 2005. The number of requests for euthanasia or assisted suicide dropped from 9,700 to 8,400. The number of nonvoluntary euthanasia cases went down from 950 to 550. Since the number of cases reported to the regional review committees for euthanasia went down only slightly during those years (it amounts to approximately 1,900 cases annually), this means that the percentage of cases of voluntary euthanasia reported is now up to 80 percent, much higher than the 45 to 55 percent that was assumed earlier (Van der Wal et al. 2007a, 2007b).

There may be different explanations for these recent developments. First, palliative sedation has become increasingly common in the Netherlands as an alternative to euthanasia in cases in which it is assumed that a patient has no longer than one to two weeks to live. Between 2001 and 2005, the number of cases of palliative sedation went up from 8,500 to 9,700. Another reason may be found in the development of a well-functioning nationwide system of consulting physicians (“SCEN-doctors”), trained to operate on the basis of well-defined criteria. This extensive network may also explain the greater readiness to report: it promotes the view that “a good doctor is a doctor who reports when needed.” Last but not least, the decrease may in part have been caused by additional information in the newest questionnaire. Although the questions remained the same for statistical purposes, the 2005 questionnaire contains a more unambiguous definition of euthanasia. Physicians will be less prone to articulate a decision to increase the medication in which the primary purpose is palliation (but in which it is also hoped that the patient may die sooner) in the language of “euthanasia.”

However important these and other data may be for assessing the course that the Dutch practice is taking, the question arises as to why so many critics of the Dutch euthanasia law focus so much on the risk of a slippery slope. Let us imagine that there is *no* slide down the slope; or let us assume, as the 2007 survey suggests, that there are signs of a “climb up the slope.” Does that make the current euthanasia practice in the Netherlands more acceptable? To some, it may. However, we should not be blind to the problems inherent in the remaining numbers—even if they are stable. Of the 2,400 cases of voluntary euthanasia, only 80 percent are reported and there is reason to believe that in the remaining 20 percent or so, one or more of the due care criteria have not been met. That especially goes for the 550 cases of nonvoluntary euthanasia, which, almost by necessity, go unreported. And even in many of the 1,900 cases that *are* reported and are deemed legally correct, there may be reason for concern: Were there really no alternatives? Was there no undue pressure from family members? Has the patient not been too demanding? Should we not rather learn how to “let go” instead of “being in control”? So let us thus suppose, as I do, that the proofs for a slide downward are now very meager indeed. Would that render the arguments and concerns of Dyck, Gorsuch, Biggar, and Keown useless? No. With or without a slippery slide, the Dutch road with its many bumps and holes is rocky enough. Any fair argument that helps to see the intrinsically problematic character of the intentional and direct killing of human lives, and that stimulates people to find ways toward a more natural dying, is most valuable.

## REFERENCES

- Battin, Margaret Pabst  
 1981 “Manipulated Suicide.” In *Suicide: The Philosophical Issues*, edited by Margaret Pabst Battin and David J. Mayo, 169–82. London: Peter Owen.
- Biggar, Nigel  
 2004 *Aiming to Kill: The Ethics of Suicide and Euthanasia*. London: Darton, Longman, and Todd Ltd.
- Boer, Theo A.  
 2003 “After the Slippery Slope: Dutch Experiences on Regulating Active Euthanasia.” *Journal of the Society of Christian Ethics* 23.2: 225–42.
- Dyck, Arthur  
 2002 *Life's Worth: The Case against Assisted Suicide*. Grand Rapids, Mich.: Wm. Eerdmans.
- George, R.  
 1990 “Euthanasia: The AIDS Dimension.” In *Death Without Dignity*,



- edited by N.M. de S. Cameron, 176–95. Edinburgh: Rutherford House Books.
- GKN/NHK (Gereformeerde Kerken in Nederland, and Nederlandse Hervormde Kerk)
- 1988 *Euthanasie en Pastoraat*. Den Haag: Boekencentrum.
- Gorsuch, Neil M.
- 2006 *The Future of Assisted Suicide and Euthanasia*. Princeton, N.J. and Oxford: Princeton University Press.
- Gustafson, James M.
- 1973 “Mongolism, Parental Desires, and the Right to Life.” In *Death, Dying and Euthanasia*, edited by Dennis J. Horan and David Mall, 250–78. Washington, D.C.: University Publications, University of America.
- 1984 *Ethics from a Theocentric Perspective*. Vol. 2, *Ethics and Theology*. Chicago: University of Chicago Press.
- Harris, John
- 2003 “Consent and End of Life Decisions.” *Journal of Medical Ethics* 29: 10–15.
- Hof, Rob
- 2003 *Regie over eigen leven en sterven*, Part 1: *Een gewenste dood*, Hilversum: NCRV (Documentary Film).
- House of Lords
- 1994 *Select Committee on Medical Ethics Report*. 3 vols. London: The Stationery Office.
- 2004 *Assisted Dying for the Terminally Ill Bill*. Accessed 31 January 2007, at <http://www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.pdf>.
- 2005 *Assisted Dying for the Terminally Ill Bill*. 3 vols. London: The Stationery Office. Can also be downloaded at <http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldselect/ldasdy/86/86i.pdf>.
- Keown, John
- 2002 *Euthanasia, Ethics, and Public Policy: An Argument against Legalisation*. Cambridge: Cambridge University Press.
- KNMG (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst)
- 1997 *Commissie Aanvaardbaarheid Levensbeëindigend Handelen. Medisch handelen rond het levenseinde bij wilsonbekwame patiënten*. Houten/ Diegem: Bohn Stafleu Van Loghem.
- 2004 *Op zoek naar normen voor het handelen van artsen bij vragen om hulp bij levensbeëindiging in geval van lijden aan het leven. Verslag van de werkzaamheden van een commissie onder voorzitterschap van prof.dr. J.H. Dijkhuis*. (“Searching for guidelines for physicians in the case of euthanasia requests based on suffering from life: Report from a committee under the presidency of Professor J.H. Dijkhuis.”) Also known as Dijkhuis Report. Utrecht: KNMG.

Kuitert, Harry

- 1981 *Een gewenste dood. Euthanasie en zelfbeschikking als moreel en godsdienstig probleem.* Baarn: Ten Have.

Leenen, H.J.J.

- 2000 *Handboek Gezondheidsrecht. Deel I: rechten van mensen in de gezondheidszorg.* Houten: Bohn Stafleu Van Loghem.

Legemate, J.

- 2005 *De zorgverlening rond het levenseinde: een literatuurstudie naar begripsomschrijvingen en zorgvuldigheidseisen.* Utrecht: KNMG (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst).

Ministerie van VWS (Volksgezondheid, Welzijn en Sport)

- 2005 *Levensbeëindiging bij pasgeborenen. Brief aan de Tweede Kamer der Staten Generaal, 29 november 2005.* KST92518 0506tkkst30300XVI-90. Den Haag: Sdu Uitgevers.

NHK (Nederlandse Hervormde kerk)

- 1972 *Euthanasie: zin en begrenzing van het medisch handelen. Pastorale handreiking vanuit de synode van de Nederlandse Hervormde Kerk.* Den Haag: Boekencentrum.

NVK (Nederlandse Vereniging voor Kindergeneeskunde)

- 1992 *Doen of Laten? Grenzen van het medisch handelen in de neonatologie.* Utrecht: NVK.
- 2000 *Richtlijnen ten behoeve van beslissingen rond het levenseinde in de neonatologie.* Utrecht: NVK.
- 2005 *Groningen Protocol: Guidelines for Euthanasia for Children.* Utrecht: NVK. Not yet published.

Peters, Marleen

- 2005 "Lijden aan het leven is voor artsen en politici geen issue." *Relevant* 31.4: 8–9.

PKN (Protestantse Kerk in Nederland, a Union of Gereformeerde Kerken in Nederland and Nederlandse Hervormde Kerk)

- 2003 *Levensmoe: Pastoraat aan mensen op hoge leeftijd die levensmoe zijn en wachten op een natuurlijk levenseinde.* Utrecht: Samen op Weg Kerken.

Rurup, Mette

- 2005 *Setting the Stage for Death: New Themes in the Euthanasia Debate.* Amsterdam: Vrije Universiteit. Can be found at <http://dare.ubvu.vu.nl/bitstream/1871/10190/1/proefschrift-f.pdf>. Accessed 28 January 2007.

Sheldon, Tony

- 2007 "Suicide Counsellor Acquitted by Dutch Court." *BMJ* 334, 7587: 228–29.

Twycross, Robert G.

- 1995 "Where There Is Hope, There Is Life: A View from the Hospice." In *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, edited by John Keown, 141–68. Cambridge: Cambridge University Press.

- Van Der Wal, G., A. van der Heide, B.D. Onwuteaka-Philipsen, and P.J. van der Maas  
2003 *Medische besluitvorming aan het einde van het leven. De praktijk en de toetsingsprocedure euthanasie*. Utrecht: De Tijdstroom.
- Van Der Wal, G., A. van der Heide, B.D. Onwuteaka-Philipsen, et al.  
2007a *Evaluatie van de Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding: praktijk, melding en toetsing*. Utrecht: De Tijdstroom.  
2007b "End-of-Life Practices in the Netherlands under the Euthanasia Act." *NEJM* 356: 1957–65.
- Verhagen, A.A.E. and P.J.J. Sauer  
2005 "End-of-Life Decisions in Newborns: An Approach from the Netherlands." *Pediatrics* 116.3: 736–39.