

Copyright (c) 2001 Nat'l Legal Center for Medically
Dependent & Disabled, Inc.
Issues in Law & Medicine

Fall, 2001

17 Issues L. & Med. 167

LENGTH: 4877 words

ARTICLE: "Culture of Death" in the Netherlands: Dutch Perspectives

Raphael Cohen-Almagor, D.Phil.*

* Senior Lecturer, University of Haifa; Visiting Professor and the Fulbright-Yitzhak Rabin scholar for 1999-2000, UCLA School of Law; Director, Think-tank on Medical Ethics, The Van Leer Jerusalem Institute (1995-98); B.A., magna cum laude, M.Pol.Sci., magna cum laude, Tel Aviv University, 1986 and 1987 respectively; D.Phil., Oxford University, 1992; Author, *The Right To Die With Dignity: An Argument In Ethics, Medicine, and Law* (Rutgers University Press, 2001) and *Euthanasia in The Netherlands* (forthcoming); and Editor, *Medical Ethics at the Dawn of the 21st Century* (New York Academy of Sciences, 2000). The author is most grateful to the referees of *Issues in Law & Medicine* for their comments; to Evert van Leeuwen and Martine Bouman for facilitating the research, and to the interviewees for their kind cooperation.

SUMMARY:

... During one of my conversations with Daniel Callahan, he voiced his concern about the situation in the Netherlands, saying that a "culture of death" exists in the country that results in premature death of many patients. ... Before arriving in the Netherlands, I wrote to some distinguished experts in their respective fields: medicine, psychiatry, philosophy, law, social sciences and ethics, asking to meet with them in order to discuss the Dutch policy and practice of euthanasia. ... This is done in my forthcoming book *Euthanasia in the Netherlands*. ... The question was posed as follows: Daniel Callahan argues that there is a 'culture of death' in the Netherlands. ... Leenen is certain that the Netherlands does not have more euthanasia cases than other countries. ... Egbert Schroten, Director of the Center for Bioethics and Health Law at Utrecht University, thought that the notion of a culture of death is an exaggeration, claiming that it is much more difficult to control passive euthanasia. ... Doctors might cease treatment, but they will not perform euthanasia under these circumstances. ... The media invited him to debate on euthanasia issues only because they needed to depict "the other side," not because they were really interested in exploring the anti-euthanasia arguments. ... Furthermore, it was strange for me to discuss the issue of euthanasia in the Netherlands. Views that are extremely unpopular in other countries regarding euthanasia's place in society rule supreme in the Netherlands. ...

HIGHLIGHT: ABSTRACT: During the summer of 1999, extensive interviews with some of the leading authorities on euthanasia policy were conducted in the Netherlands. They were asked: Daniel Callahan argues that there is a 'culture of death' in the Netherlands. What do you think?

The majority of interviewees disagreed with the statement. They said that the Netherlands is not fundamentally different than other countries. If at all, the Dutch culture is open and tolerant, welcomes debates and plurality of views, and physicians are decent people who wish to help their patients, not to kill them. A small minority acknowledged that there is some truth in Callahan's observations, arguing that the Dutch actually do not welcome critique and are quite conservative in their liberal attitude toward euthanasia.

TEXT:

[*167] In March 1999 I visited the Hastings Center in New York. During one of my conversations with Daniel Callahan, he voiced his concern about the situation in the Netherlands, saying that a "culture of death" exists in the country that results in premature death of many patients. Having investigated the Dutch experience for a number of years, in the summer of 1999 I went to the Netherlands to visit the major centers of medical ethics as well as some research hospitals, and to speak with some of the leading figures in euthanasia policy and practice. I wanted to see [*168] what people who participate in the public debate think of the situation in the Netherlands, whether they evaluate the situation positively or negatively. For this purpose I raised the issue whether a "culture of death" exists in the Netherlands, to see what their reactions would be. This study reports their answers to this troublesome question. On purpose I refrained from explaining what I mean by a "culture of death." I wanted to know whether the interviewees have different ideas on what would constitute such a culture.

This question came late in the interviews. I admit that I did not ask it during all of the interviews for fear that the interviewee might walk away. Some of them did not appreciate this line of questioning, and I did not want to end the interview prematurely. Indeed, the question did upset some of the remaining interviewees.

Methodology

Before arriving in the Netherlands, I wrote to some distinguished experts in their respective fields: medicine, psychiatry, philosophy, law, social sciences and ethics, asking to meet with them in order to discuss the Dutch policy and practice of euthanasia. Only one--Dr. Chabot--explicitly declined my request for an interview. n1

The interviews took place during July-August 1999, in the Netherlands. They lasted between one to three hours each. Most interviews went on for more than two hours during which I asked more or less the same series of questions. n2 During the interviews I took extensive notes that together comprise some 200 dense pages. Later the interviews were typed and analyzed.

The interviews were conducted in English, usually in the interviewees' offices. Four interviews were conducted at the interviewees' private homes, and four interviews in "neutral" locations: coffee shops and restaurants. Two interviews were conducted at the office kindly made available to me at the Department of Medical Ethics, Free University of Amsterdam.

The interviews were semi-structured. I began with a list of fifteen questions but did not insist on all of them when I saw that the interviewee preferred to speak about subjects that were not included in the original questionnaire. With a few interviewees I spoke only about their direct involvement in the practice of euthanasia. [*169] This article reports the answers to only one of the questions concerning the Dutch socio-medical culture. For limitations of space I cannot possibly report the extensive answers to my fifteen questions. This is done in my forthcoming book *Euthanasia in the Netherlands*.

The Question and Interviewees' Responses

The question was posed as follows: Daniel Callahan argues that there is a 'culture of death' in the Netherlands. What do you think?

The majority of interviewees rejected Callahan's statement tout court. A small minority that objects to the euthanasia policy and practice agreed with the statement. Henk Leenen, one of the forefathers of the euthanasia campaign, was surprised by my question and looked somewhat offended. n3 He said: "We do not have a 'culture of death.' We strive to prevent the slippery slope. In the 1960s, the same criticism was voiced in regard to the legalization of abortion. Presently, the Netherlands, with its liberal policy on abortion, has the lowest rate of abortion in the world, in proportion to its size. There was no slippery slope as a result of the liberal abortion law." Leenen is certain that the Netherlands does not have more euthanasia cases than other countries. The problem is that there is no way to prove this because little data is available in regard to what is taking place in other parts of the world. n4 Leenen concluded his answer by saying that Callahan is speculating, "imagining fiction" without any hard data. On a personal level, it seems to Leenen that Callahan does not trust human intentions. After all, most people have respect for [*170] other people, and most physicians are not criminals. Physicians act in a bona fide manner to fulfill the wishes of their patients.

Rob Houtepen, an ethicist from Maastricht, argued that there is no general climate of death and that there are no shortcuts to performing euthanasia, as Callahan alleges. He acknowledges that there is a need to be on guard, but "there is no room for alarm." Yes, there is a need to improve the notification procedure, but if the Guidelines are followed, then there is no danger of abuse. At the present time, Houtepen admits, the Guidelines are insufficiently followed. Houtepen ended his defense by saying that the 1990 and 1995 reports do not indicate a slippery slope.

Interestingly, later in the interview, Houtepen suggested that hospital physicians thrive on action. In their quest to cure, they always seek something else to do, something to explore. This is their culture. Consequently, euthanasia is not a popular practice in hospitals, and there is no need to worry about physicians' conduct.

"Relatively speaking," Houtepen elucidated, "the weak point are the GPs." In hospitals and nursing homes, there are mechanisms of social control. The nursing staff works in teams, and there are usually people around, whereas GPs act more or less alone. It is worth noting that, as the data show, most of the euthanasia cases are performed by GPs. n5

Ron Berghmans, another ethicist from Maastricht, attempted in his answer to counterbalance the "culture of death" notion by pointing out that there are many cases in which euthanasia was requested but not performed. n6 In general, the spirit [*171] of medicine and health care is to help people and not to kill them. Berghmans explained that the Dutch climate is different from other countries insofar as patients feel that they have the right to request a quick death, to determine the moment of death, and to receive full compliance by their doctors. Consequently, patients can put a lot of pressure on doctors to comply with euthanasia requests. There is no insistence on continuing life by all means, and the emphasis is put on the meaning and quality of life. Furthermore, there are open discussions about what constitutes useful treatment. Euthanasia, physician-assisted suicide (PAS) and painkillers are all considered as legitimate mechanisms to prevent unnecessary suffering.

Egbert Schrotten, Director of the Center for Bioethics and Health Law at Utrecht University, thought that the notion of a culture of death is an exaggeration, claiming that it is much more difficult to control passive euthanasia. Sometimes doctors switch machines sooner than required, "but this happens all over the world." Schrotten added that he is not convinced that the way in which "we treat euthanasia makes passive euthanasia a greater problem. Our open discussions sharpened the awareness on the subject. We are more alert." Thus, it is "ridiculous" to speak of a "culture of death."

Heleen Dupuis, an ethicist from Leiden who has written widely on euthanasia, was thoroughly puzzled and surprised by the question. Like Leenen, she looked offended and like Schrotten dismissed the question as "ridiculous." Professor Dupuis said succinctly and conclusively: "We don't have a 'culture of death.' 'Angels of death' never happened in Holland. n7 They happen in countries that do not discuss euthanasia in the open, like Austria, but not here where everything is in the open, widely discussed and under scrutiny." Dupuis maintained that people normally want to live. Elderly people that are suffering are the ones who usually make requests for euthanasia. She asserted that she is much more afraid of a society that denies the euthanasia option, and emphasized that doctors do not perform euthanasia on patients if they are presently unable to express their will, even if the request for euthanasia was previously made in a living will. Doctors might cease treatment, but they will not perform euthanasia under these circumstances. The patient needs to be competent in order to exercise euthanasia as an option.

[*172] A. van Dantzig also dismissed the question, but during the interview he told me two stories. One was about a friend of his who put his one-week Down Syndrome child to death and did not report it. Van Dantzig saw nothing wrong with this behavior. The second story involved a request to cease treatment of a patient who was facing two options: to be confined to a wheelchair with no legs, or termination of treatment and death. The request to terminate treatment was initiated

by the patient's children, who were convinced that their mother was better off dead. Van Dantzig gave the order to cease treatment, saying that this is what he would have liked for himself were he in a similar situation. n8

By contrast, the three dominant critical voices in the interviews, Koerselman, Jochemsen and Rutenfrans, complained about the atmosphere surrounding the policy and practice of euthanasia, and voiced their dissent against the institutional mechanisms that are used to de-legitimize them and undermine their position. Koerselman said that advocates of euthanasia dismissed him as a Catholic fundamentalist. In fact, he is not a Catholic at all. He was brought up without any religious background, but his critics find it difficult to believe that a secular person would object to euthanasia with so much passion as Koerselman does. He also testified that he often felt treated like a clown. The media invited him to debate on euthanasia issues only because they needed to depict "the other side," not because they were really interested in exploring the anti-euthanasia arguments. Koerselman declared that he was fed up with this treatment and with the dismissive attitude that he received from scholars and colleagues.

Koerselman is worried about the general atmosphere in the Netherlands. He agrees with Callahan that a "culture of death" has developed, with life, autonomy and the prevention of suffering as the prime concerns. He feels that the Netherlands is becoming a narcissistic society, a place only for happy and healthy people. And if one is not happy and healthy, one has a right to die and to have a nice funeral, with the doctor being obliged to help. Koerselman does not know where this approach will lead. The debate, he argues, started with the assumption that it is possible to shorten life when the patient is suffering and life expectancy is very short. Hence, euthanasia would only shorten life by a few hours or days. The next stage broadened the framework so that the time one is expected to live is not important; only the suffering is important. Then the discussion evolved to speaking not only of physical suffering, but also of mental suffering. Koerselman asks rhetorically: What constitutes suffering? Living with a serious handicap entails suffering. Does it mean that all handicapped patients should be put to death? Parents [*173] with children who suffer from Down syndrome are asked: Why did you allow this to happen? How can you see your child living like this?

According to Koerselman, living wills for euthanasia that are signed by competent patients who become demented are now legally accepted. n9 The next stage might be killing these patients without satisfying the requirement of a written document. A guardian would be appointed for such patients, who would say that "this is a case of unbearable loss of dignity" and that "euthanasia is the answer." The principle of avoiding suffering thus overrides the principle of autonomy. The climate assumes that these patients are suffering and would probably opt to die if they were able to express their will.

One important factor in generating this culture, in Koerselman's opinion, is the Society for Voluntary Euthanasia. n10 He thinks that this is a very strong and successful movement, making euthanasia an integral part of the Dutch medical establishment. The Society places considerable emphasis on the concept of "dignity," suggesting to people that they prepare a document stating that if their dignity were to be

lost, they would prefer not to be treated. Then Koerselman added the following chilling statement: "If I'll be involved in a car accident and will be brought to hospital, I am not sure that all will be done to save my life. The climate is in this direction."

The concept that justifies physicians' decisions in such cases is quality of life. James Kennedy explains that there is a "collective consensus" about what constitutes quality of life. When the quality of a given life deteriorates, it is unclear whether treatment will be adequately provided until death. Treatment might be stopped prematurely at an early stage, when the patient is conceived to be leading a "pointless life" or when he "suffers a great deal." In such cases, passive euthanasia and double effect are the mechanisms used for ceasing treatment. n11

Chris Rutenfrans, who used to teach at the Catholic University of Nijmegen and later in his life became a journalist, expressed concern that the Netherlands allows doctors to be above the law in killing other people. This is very dangerous, especially when the necessary control mechanisms are lacking. He testified that he is not opposed to euthanasia in principle, but rather to the simple generalization and legitimization of euthanasia resulting from acknowledging its necessity in a few cases.

[*174] Rutenfrans said that 95% of all newspapers and magazines in the Netherlands are in favor of euthanasia; only some very small religious papers are against it. Nationwide, seven newspapers and many regional papers support the euthanasia campaign. Together, thirty to forty papers express a positive stance on the issue. Most newspapers reported the positive points covered in the 1990 and 1995 reports. The problem is that they hide the negative points, and the court cases are reported with a bias towards physicians who practice euthanasia. There is no sincere attempt to tackle the issue fairly, showing both sides of the debate. Rutenfrans maintained that it is bad for one's reputation to be against euthanasia because it gives the appearance of being conservative, and it is not good to be a conservative in the Netherlands. This is why Rutenfrans wants to disassociate himself from the subject and is inclined to write on other issues. In his view, the country is not very liberal, but rather is conformist in its liberalism. Its people do not want to hear ideas that clash with their liberal values.

Rutenfrans recounted that in 1986 he had co-authored a booklet against euthanasia, entitled *May the Doctor Kill*, with Caterina I. Dessaur, a novelist known under the pen name Andreas Burnier. This was a highly polemic, very controversial book. Rutenfrans maintained that Dessaur had been quite a famous novelist before publishing this book. After publication, Dessaur's consecutive novels were more harshly criticized than before, depicting her as a conservative reactionary. In effect, she was ostracized by the country's literary circles. n12

Govert den Hartogh does not agree with Rutenfrans on many issues, including this one. In his comments, he wrote that Dessaur's literary star had fallen in popularity simply because her later books were not as good as her early ones; her position on euthanasia had nothing to do with it. This is confirmed by the excessive popularity of the author Willem Jan Otten, who is as fervently opposed to euthanasia as Dessaur

ever was. Otten joined Koerselman and others in writing a pamphlet on the Chabot case, which was widely reported, discussed and also acclaimed in the Dutch press. n13

Henk Jochemsen indicated that during the past twenty years, the general atmosphere has been in favor of euthanasia. n14 The mentality now is to stop treatment at an early stage when the patient is suffering. Quality of life has become the major principle at the expense of respect for life. Jochemsen claimed that physicians had told him about the difficulties they would face in finding a job in some institutions if they declared themselves to be opposed to euthanasia. The establishment view is [*175] pro-euthanasia, and one's career opportunities might be harmed if one takes a contrary view.

I asked Evert van Leeuwen, Chairperson of the Department of Medical Philosophy and Medical Ethics at the Free University of Amsterdam, if he thinks it would be possible to elect an anti-euthanasia professor to the Chair in medical ethics in major universities. His candid answer was "probably not" because the Chair serves as a consultant in euthanasia cases referred to him by hospitals affiliated with the respective universities. If it is known that the professor objects to euthanasia, then there would be no point in consulting with him on this issue at a time when euthanasia does take place in hospitals. Hence, it is necessary to fill important posts with like-minded people who will maintain the positive climate towards euthanasia.

In his comments on the first draft of this study, Van Leeuwen noted that Henk ten Have, who opposes the practice of euthanasia, chairs the department on Ethics Philosophy and History of Medicine in the Catholic University of Nijmegen. n15 In this university, it would indeed be highly surprising to appoint a supporter of euthanasia for that position. n16

Conclusions

The majority of interviewees disagreed with Callahan's statement. They said that the Netherlands is not fundamentally different than other countries. If at all, the Dutch culture is open and tolerant, welcomes debates and plurality of views, and physicians are decent people who wish to help their patients, not to kill them. A small minority acknowledged that there is some truth in Callahan's observations, arguing that the Dutch actually do not welcome critique and are quite conservative in their liberal attitude to euthanasia. My own view is that the Dutch culture does not welcome a critical plurality of opinions regarding the legitimacy of euthanasia. Critics are regarded quite unfavorably. n17

[*176] Furthermore, it was strange for me to discuss the issue of euthanasia in the Netherlands. Views that are extremely unpopular in other countries regarding euthanasia's place in society rule supreme in the Netherlands. The discussions I had with the Dutch experts were almost a mirror image of discussions I had had in Israel, the United States, Britain, Canada and Australia. What was striking in my discussions was the prevailing acceptance of the euthanasia procedure. There were only a few dissenters who were willing to oppose the system. My first fourteen interviewees were, on the whole, in favor of the policy, and I felt a growing unease in encountering such unanimity of

opinion. This conformity worried me. Plurality and diversity of opinion are good for society, leading to a more comprehensive understanding of the issues, as well as a higher level of truth, as John Stuart Mill used to say. n18

I found it troublesome that scholars and decisionmakers would support a system that suffers from serious flaws while the stakes are very high; after all, we are dealing with life and death. n19 There were variants of opinion regarding specific questions and issues, but only a minority questioned the system as such. Many of the experts depicted a society in which it is the role of doctors to help patients. They did not question the doctors' motives and saw no reason why doctors would perform euthanasia without compelling reasons. They argued that, of course, criminals exist in every society, in every sphere of life, but policy is not built around this small number of criminals. They believed that there is a need to install control mechanisms against the possibility of abuse, but that the system's rationale is good--to help people in their time of need. They emphasized that the two major reports of 1990 and 1995 do not demonstrate a slippery slope, yet ignored the fact that there is already too much abuse. Even issues that are acknowledged as problems are not conceived to be serious enough to press. The Dutch tend to accept highly trouble-some contentions and to consider and allow euthanasia in cases where even the Guidelines are not satisfied. The surrounding culture around euthanasia makes the practice accessible within the confines of what is permissible. This culture, however, has a chilling effect upon open, critical debate. n20 In other parts of the world, [*177] under similar circumstances and in light of the justified critique expressed, inter alia, by Gomez n21 and Hendin, n22 euthanasia would not be considered an option. n23

Appendix

Interviews in the Netherlands (summer 1999)

Professor John Griffiths, Department of Legal Theory, Faculty of Law, University of Groningen (Groningen, July 16, 1999).

Professor J.K. Gevers, Professor of Health Law, University of Amsterdam (Amsterdam, July 19, 1999).

Professor Evert van Leeuwen, Department of Metamedicine, Free University of Amsterdam (Amsterdam, July 19, 1999; Haarlem, July 28, 1999).

Dr. Dick Willems, Institute for Research in Extramural Medicine, Department of Social Medicine, Free University of Amsterdam (Amsterdam, July 20, 1999).

Professor Bert Thijs, Medical Intensive Care Unit, VU Hospital, Amsterdam (Amsterdam, July 20, 1999).

Professor A. van Dantzig, retired expert in psychiatry (Amsterdam, July 20, 1999).

Professor H.J.J. Leenen, formerly professor of social medicine and health law, Medical Faculty and Faculty of Law, University of Amsterdam (Amsterdam, July 21, 1999).

Professor Gerrit van der Wal, Institute for Research in Extramural Medicine, Department of Social Medicine, Free University of Amsterdam (Amsterdam, July 21, 1999).

Dr. Jaap J.F. Visser, Ministry of Health, Department of Medical Ethics, The Hague (Amsterdam, July 21, 1999).

[*178] Professor Heleen Dupuis, Department of Metamedicine, University of Leiden (Leiden, July 22, 1999).

Dr. Margo Trappenburg, Department of Political Science, University of Leiden (Leiden, July 22, 1999).

Dr. Henri Wijsbek, Department of Medical Ethics, Erasmus University of Rotterdam (Rotterdam, July 23, 1999).

Dr. Arie J.G. van der Arend, Health Ethics and Philosophy, Maastricht University (Maastricht, July 26, 1999).

Dr. George Beusmans, Maastricht Hospital (Maastricht, July 26, 1999).

Professor G.F. Koerselman, Sint Lucas Andreas Hospital, Amsterdam (Amsterdam, July 27, 1999).

Professor Henk Jochemsen, Professor Lindeboom Institute (Ede Wageningen, July 27, 1999).

Dr. Gerrit K. Kimsma, Department of Metamedicine, Free University of Amsterdam (Koog aan de Zaan, July 28, 1999).

Dr. James Kennedy, Department of History, Hope College, Michigan. Visiting Research Fellow at the Institute for Social Research, Amsterdam (Amsterdam, July 29, 1999).

Professor Paul van der Maas, Department of Public Health, Faculty of Medicine, Erasmus University, Rotterdam (Amsterdam, July 29, 1999).

Dr. Chris Rutenfrans, Trouw (Amsterdam, July 30, 1999).

Dr. Arko Oderwald, Department of Metamedicine, Free University of Amsterdam (Amsterdam, July 30, 1999; August 8, 1999).

Ms. Barbara de Boer and her three children (Amsterdam, August 2, 1999).

Professor Egbert Schrotten, Director, Center for Bioethics and Health Law, Utrecht University (Utrecht, August 5, 1999).

Professor Govert den Hartogh, Faculty of Philosophy, University of Amsterdam (Amsterdam, August 10, 1999).

[*179] Dr. Johannes J.M. van Delden, Senior Researcher, Center for Bioethics and Health Law, Utrecht University (Utrecht, August 10, 1999).

Dr. Rob Houtepen, Health Ethics and Philosophy, Maastricht University (Maastricht, August 11, 1999).

Dr. Ron Berghmans, Institute for Bioethics, Maastricht University (Maastricht, August 11, 1999).

Professor Ruud ter Meulen, Director, Institute for Bioethics and Professor at the University of Maastricht (Maastricht, August 11, 1999).

FOOTNOTES:

n1 In his letter dated June 5, 1999, Dr. Chabot wrote: "After four years waiting for the final court judgment (1991-1995) and discussing the case with many people from abroad, I hope you will understand that I prefer to remain in the background now and not to make an appointment with you". Letter from Dr. Chabot to author (June 5, 1999) (on file with author). He, however, agreed to answer via e-mail some specific questions relating to his conduct that brought about the charges against him.

n2 My questionnaire consisted of fifteen questions. The Dutch comprehensive study of 1995 consisted of 120 pages and the interviews lasted for an average of two and a half hours. The pace of questioning was, apparently, frantic. See generally Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 *NEW ENG. J. MED.* 1700 (1996).

n3 My impression might be wrong. In his comments Leenen wrote: "I was not the least offended. Why do you think so?" Letter from Henk Leenen to author (July 25, 2000) (on file with author).

n4 An estimated 37,000 euthanasia deaths occur each year in Australia as a result of doctors intentionally accelerating a patient's death, according to a confidential new survey of 3,000 Australian doctors. Helga Kuhse et al., *End-of-life Decisions in Australian Medical Practice*, 166 *MED. J. AUSTRAL.* 191 (1997). The survey defined euthanasia as any death "intentionally accelerated by a doctor." *Id.* at 191. It included deaths caused by a doctor withholding or withdrawing treatment. This is quite a broad definition; well beyond the contemporary Dutch narrow definition of euthanasia. The survey suggests that almost a third of deaths occur after doctors intentionally hasten their patients' deaths. It found that the rate of doctor-assisted death in Australia was double that of the Netherlands, and that Australian doctors were far less likely to discuss their decision to hasten a patient's death with the target patients or even seek their consent. Incidents of non-voluntary euthanasia were five times higher in Australia than in the Netherlands. *Id.* at 191-96. Another study which compared attitudes and practices concerning end-of-life decisions between physicians in Oregon and in the Netherlands showed that American physicians found euthanasia less often acceptable than the

Dutch and have been involved in these practices less often than the Dutch. See generally Dick L. Willems et al., *Attitudes and Practices Concerning the End of Life: A Comparison Between Physicians From the United States and From the Netherlands*, 160 ARCHIVES INTERNAL MED. 63 (2000). A third study showed that a substantial proportion of physicians in the United States in the specialties surveyed reported that they received requests for physician-assisted suicide and euthanasia, and about six percent have complied with such requests at least once. See generally Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193 (1998). In Belgium, surveys conducted in 1985, 1987 and 1988 showed that 34%, 40% and 52% of physicians in the respective studies admitted practicing euthanasia. PROCEEDINGS OF EUTHANASIA AND ASSISTED SUICIDE IN THE NETHERLANDS AND IN EUROPE 23-24 (Maastricht, June 10-11, 1994, Luxembourg Office for Official Publications of the European Communities 1996). A recent study showed that end-of-life decisions (ELDs) are prominent in medical practice in Flanders. The frequency of deaths preceded by an ELD is similar to that in the Netherlands, but lower than that in Australia. However, in Flanders the rate of administration of lethal drugs to patients without their explicit request is similar to Australia, and significantly higher than that in the Netherlands. See generally Luc Deliens et al., *End-of life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey*, 356 LANCET 1806 (2000). In Denmark, a 1996 study among physicians showed that 30% of respondents said that they had received a request for euthanasia and that 5 percent had participated in the practice. In Norway, a 1997 study among physicians showed that six percent of respondents indicated that they had performed actions intended to hasten a patient's death. Martien T. Muller et al., *Euthanasia and Assisted Suicide: Facts, Figures and Fancies with Special Regard to Old Age*, DRUGS & AGING, Sept. 1998, at 188, 188.

n5 P.J. VAN DER MAAS ET AL., *EUTHANASIA AND OTHER MEDICAL DECISIONS CONCERNING THE END OF LIFE*, HEALTH POLICY MONOGRAPHS 40 (Amsterdam, Elsevier (1992)); Van der Maas et al., *supra* note 2, at 1701-02.

n6 About 37% of all serious and persistent requests will lead to euthanasia and PAS. Nearly half of the requests are refused because alternatives are still available, the request is not well considered, the patient does not have a proper understanding of the disease, or the physician has objections. See generally Paul van der Maas & Linda L. Emanuel, *Factual Findings*, in REGULATING HOW WE DIE 158 (L.L. Emanuel, ed., 1998). Note that Van der Maas and Emanuel label those requests "serious," apparently not aware of the inherent contradiction between that term and the reasons those requests are not honored.

n7 In *A Case Against Dutch Euthanasia*, THE HASTINGS CENTER REP., Jan./Feb. 1989, Special Supp., at 24, 24-25, Fenigsen argued that in 1987, a series of killings of comatose patients was taking place at the Department of Neurosurgery at the Free University Hospital in Amsterdam. Four nurses were responsible for these serial killings. Furthermore, a doctor was apprehended in The Hague under suspicion of having killed twenty inhabitants of De Terp old people's home without their consent or knowledge. He pled guilty to five, was accused of

four, and convicted of three killings. Witnesses testified that some of the victims were not ill but only senile and querulous, and that the doctor was impatient with elderly people, reluctant to treat them, frequently absent, and left many decisions to the male head nurse. Hendin writes on "angels of death," a team of traveling physicians that provided euthanasia to patients when family doctors were unwilling to do so. See HERBERT HENDIN, *SEDUCED BY DEATH* 110-13 (1997).

n8 In his comments on the first draft, Van Dantzig contended: "I find this misrepresentation of my views on the Mongoloid baby a serious matter! In the matter of the patient who had to have her legs amputated, she was a very old woman in a diabetic coma at the time of the decision, for whom life with no legs would have been hell. That should be added." Written comments from Professor A. van Dantzig, retired expert in psychiatry (Amsterdam) to author (July 6, 2000) (on file with author).

n9 Euthanasiewens Demente Geldig, *DE VOLKSKRANT*, July 16, 1999, at 1, 1, 7. For further deliberation on dementia, see Ron Berghmans, *Advance Directives and Dementia*, in *MEDICAL ETHICS AT THE DAWN OF THE 21ST CENTURY* 105-10 (Raphael Cohen-Almagor, ed., 2000).

n10 The society has more than 100,000 members. See <http://www.nvve.nl/new/>.

n11 For further deliberation, see generally R. Cohen-Almagor, *Language and Reality at the End of Life*, 28 *J.L. MED. & ETHICS* 267 (2000); R. Cohen-Almagor & Merav Shmueli, *Can Life Be Evaluated? The Jewish Halachic Approach vs. the Quality of Life Approach in Medical Ethics: A Critical Review*, 21 *THEORETICAL MED. & BIOETHICS* 117 (2000).

n12 For further deliberation, see HENDIN *supra* note 7, at 105-7.

n13 Written comments from Professor Govert den Hartog, Faculty of Philosophy, University of Amsterdam (Aug. 27, 2000) (on file with author). For further discussion, see R. Cohen-Almagor, *The Chabot Case: Analysis and Account of Dutch Perspectives*, in *MEDICAL LAW INTERNATIONAL* (forthcoming 2001).

n14 A poll in 1996 showed that 84% of the population is in favor of euthanasia if a fellow human being is in an "unacceptable and futureless situation." See <http://www.ves.org.uk/library/smook.htm>.

n15 Written comments from Professor Evert van Leeuwen, Department of Metamedicine, Free University of Amsterdam to author (Aug. 30, 2000) (on file with author).

n16 In his counter arguments to the text, Govert den Hartogh made the same observation, doubting whether a euthanasia supporter would be welcome in Nijmegen. The Free University in Amsterdam is a religious institute, so it traditionally imposes certain requirements with respect to opinions held by prospective staff members. But the medical director of the academic hospital of the University of Amsterdam is a member of an orthodox Protestant church, and never made a secret of his opposition to euthanasia under any conditions. See written comments of Govert den Hartog to author (Aug. 27, 2000) (on file with author).

n17 In his comments on the first draft of this study, Van Dantzig wrote that this assertion is fundamentally incorrect: "The whole of Dutch society is based on the cohabitation of people who fundamentally disagree on everything. The sometimes very creative solutions (soft drugs may not be bought by coffee shops, but their sale is not punished within certain limits) have given rise to the word "poldermodel," which expressly means living by compromise, or as I have once put it, the fair division of discontent. I write to you because such a fundamental misunderstanding may harm the quality of your paper." Written comments from Professor A. van Dantzig, retired expert in psychiatry (Amsterdam) to author (July 14, 2000) (on file with author).

n18 J.S. MILL, UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT (London, J.M. Dent 1948) (Everyman's Edition).

n19 In his comments on the first draft of this essay, Griffiths reacted to this statement by writing: "Nowhere do you suggest that anywhere else there is a better system. The Dutch know about the system's defects and are working to improve it. Can you tell me about another country where that is true? In short, I think you need to think again, and a lot more carefully, about what you are writing about, before you can expect to be taken seriously." Written comments from Professor John Griffiths, Department of Legal Theory, Faculty of Law, University of Groningen to author (July 10, 2000) (on file with author). Griffiths, it seems, finds a lot of comfort in comparative studies to the point of blurring his own careful thinking about the current situation in his country.

n20 Hendin reached a similar conclusion. HENDIN, *supra* note 7, at 100.

n21 See generally CARLOS F. GOMEZ, REGULATING DEATH (1991).

n22 Herbert Hendin, Euthanasia Consultants or Facilitators? 170 MED. J. AUSTRAL. 351, 351-52 (1999); Herbert Hendin, The Slippery Slope: The Dutch Example, 35 DUQ. L. REV. 427, 429-30 (1996); Herbert Hendin, Seduced by Death: Doctors, Patients and the Dutch Cure, 10 ISSUES IN LAW & MED. 123, 137 (1994); see generally Herbert Hendin et al., Physician-Assisted Suicide and Euthanasia in the Netherlands, 277 JAMA 1721 (1997).

n23 For further deliberation, see generally Raphael Cohen-Almagor, *An Outsider's View on the Dutch Euthanasia Policy and Practice*, 17 *ISSUES IN LAW & MED.* 35 (2001); and RAPHAEL COHEN-ALMAGOR, *THE RIGHT TO DIE WITH DIGNITY: AN ARGUMENT IN ETHICS, MEDICINE AND LAW* (Rutgers University Press, 2001).