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From the Editor

CHRISTIANS, AWAKE!

As *Ethics and Medicine* looks forward to its ninth year of publication much has changed. In Britain the debates around the Warnock Report, which for a time succeeded in focussing public debate on the fateful question of deleterious research on human subjects, have given place to legislation which takes that awesome departure from the humane medical tradition as a given. And in that same Human Fertilisation and Embryology Act of 1990 the best chance for a generation of rolling back the effects of the Abortion Act of 1967—if only by a few inches—was seized, lost, and, finally, made the humiliating occasion of yet further liberalisation of the law. In Germany, the only major western country where public policy has proved to have healthy instincts in matters of bioethics, the shadowside of reunification has been the undermining of the Federal Republic's relatively conservative abortion law (though Chancellor Kohl's courageous appeal to the constitutional court may yet save the day). In Holland, the world's euthanasia experiment, after hesitant beginnings, is running amok with the values of medicine and liberal democracy and the lives of thousands of Dutch women and men every year. The main item in this issue is a substantial study of Dutch euthanasia by Dr. John Keown of the University of Cambridge: it will repay careful study, and offers a mine of information for those engaged in public debate and professional consideration of euthanasia in the many countries where this journal is read.

In the United States, like Britain, long standing hope of curtailing liberal abortion provision has so far been disappointed. And the rapid rise of interest in euthanasia proves increasingly alarming. Dr. Kevorkian's spine-chilling 'suicide machines', Derek Humphry's *Final Exit*, widespread fear of overtreatment at the end of life and consequent enthusiasm (backed by legislative encouragement) for 'living wills', and anxiety over spiralling medical costs are fanning a public opinion which—using the procedure for legislation by ballot (binding state referenda)—could lead the Americans to beat the Dutch in creating the first euthanasia jurisdiction in the modern world, the Third Reich excepted.

Reference to the former DDR reminds us that public policy debate on issues of bioethics is no longer the prerogative of the 'west'. Your editor recently read a paper on 'Bioethics and the Future' at a conference in Novosibirsk, in Siberia. Elsewhere in this issue is a further announcement of the conference being arranged jointly by the Centre for Bioethics and Public Policy, London (with which *Ethics and Medicine* is associated) and the Centre for Christian Bioethics in Hungary to take place in Budapest in mid-June, 1993. We invite the assistance of our readers in publicising this important meeting. The Centre for Bioethics and Public Policy is actively seeking trust and other support to sponsor and co-sponsor a series of conferences in central and eastern Europe (one in Moscow is presently under discussion).

So much has happened in these eight years. Yet one factor has remained constant: the indifference of so many

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Christians—of every stripe—to the significance of what is happening. There are now dozens of journals in this field. How many have been initiated out of the Christian-Hippocratic tradition? How many Christian educational institutions (and in some countries there are many) have taken the initiative and established centres and programmes in bioethics—like so many secular universities? And how hard has it been to secure funding for such ventures? Is there no Christian foundation, or wealthy individual, who could endow a project on the scale of the Hastings Center, and thereby provide an international focus for the conscience of Christian Hippocratic medicine? It is hard to believe that any need could be quite so pressing, in the fast-moving and increasingly threatening world of human values.

Let there be no misunderstanding. These are no peripheral debates: the values of life and death which they treat are the fundamental values of our societies. The arguments over medical ethics, which the broader term 'bioethics' has helpfully brought out of the merely professional and clinical context, are finally arguments over power. In liberal abortion we have the resolution of one such argument: in the delicate balance between the child's human dignity, that of the mother, and the right of others—'society'—we have now come to one general conclusion, that the child loses every time. The role of the abortionist, after as before legalisation, is only in an extended sense that of a physician (which is one reason why so many doctors and nurses, to the credit of their faded Hippocratic instincts, have a deep distaste for abortion even if they have a role to play in its execution). So also in euthanasia, which is not merely something new in our medical tradition but its obverse; a short-circuiting of the pattern of healing and caring in which power is exercised for life or death and medicine gives place to an anti-medicine, well illustrated by the Dutch situation, where in so many cases 'informed consent' is ridden over rough-shod, and without a word of protest from the voluntary-euthanasia-only advocates many patients are already being killed without having been asked. Medicine has been reduced to manipulation and the final abuse of power.

So, Christians, awake!

John Keown, Faculty of Law, University of Cambridge

THE LAW AND PRACTICE OF EUTHANASIA IN THE NETHERLANDS

INTRODUCTION

Voluntary euthanasia has, since the early 1970s, become an established part of medical practice in the Netherlands. But to what extent does Dutch law permit euthanasia? And how far does the current practice of euthanasia conform to the law? There has been little precise investigation of these questions. Drawing on empirical research which I carried out in the Netherlands in 1989/1991,[1] I here give them a substantiated answer.

Part I deals with the offence of taking a person's life at his request, contained in article 293 of the Penal Code, and the extent to which the courts have allowed doctors a defence to this charge. Part II considers the guidelines for voluntary euthanasia which have been set out by the Royal Dutch Medical Association (K.N.M.G.). Part III examines the extent to which the Dutch experience confirms or confutes a major ethical argument against the legalisation of voluntary euthanasia, namely, the 'slippery slope' argument.

I. THE OFFENCE OF KILLING A PERSON AT HIS REQUEST AND THE DEFENCE OF NECESSITY

(a) The offence of killing a person at his request

Killing a person at his request is punished by article 293 of the Penal Code: a person who takes the life of another person at that other person's 'express and serious request' (*uitdrukkelijk en ernstig verlangen*) is punishable by imprisonment for a maximum of 12 years or by a fine.[2] I shall call this the offence of voluntary euthanasia. It is one of the 'Serious offences against human life'[3] in Title XIX of the Code.

Article 287 provides that a person who intentionally takes another's life without premeditation commits 'homicide' (*doodslag*) and is punishable by imprisonment for a maximum of 15 years.[4] But a person who intentionally and with premeditation takes the life of another is guilty of murder (*moord*) and is punishable by a maximum of life imprisonment: article 289.[5]

Article 294 punishes assisting suicide: a person who 'intentionally incites another to commit suicide, assists in the suicide of another, or procures the means to commit suicide' is punishable, where death ensues, by imprisonment for up to three years or by fine.[6] Suicide itself is not criminal; nor is aiding attempted suicide, evidently because the legislature feared that the imposition of criminal liability might encourage a further attempt.[7]

In short, voluntary euthanasia, or the intentional acceleration of a patient's death at his request as part of his medical care, is prohibited by article 293.

In short, voluntary euthanasia, or the intentional acceleration of a patient's death at his request as part of his medical care, is prohibited by article 293. The intentional killing of an incompetent person (non-voluntary euthanasia) or of a person against his wishes (involuntary euthanasia) would constitute either 'murder' (contrary to article 289) or 'homicide' (contrary to article 287).

(b) The defence of necessity

(i) *The Supreme Court decision of 1984*

Notwithstanding the apparently clear terms of article 293, the criminal courts have come to interpret the Code as providing a defence to a charge of voluntary euthanasia under that article and equally to a charge of assisting suicide under article 294. The line of relevant cases stretches from the decision of a District Court (*Arrondissementsrechtbank*) in 1973 to decisions of the Supreme Court (*Hoge Raad*) in 1984 and 1986.[8]

The Supreme Court decision of November 27, 1984, the *Alkmaar* case, involved the killing of an elderly woman, a 'Mrs. B,' at her request by her G.P. The doctor was acquitted by the Alkmaar District Court but, on an appeal by the prosecution, was convicted by the Court of Appeal at Amsterdam. He then appealed successfully to the Supreme Court[9] which held that the Court of Appeal had wrongly rejected the doctor's defence that he had acted out of necessity. The Supreme Court held that the Court of Appeal had not given sufficient reasons for its decision

and that, in particular, it should have investigated whether 'according to responsible medical opinion' measured by the 'prevailing standards of medical ethics' a situation of necessity existed.[10]

The Supreme Court held that the Court of Appeal had not given sufficient reasons for its decision and that, in particular, it should have investigated whether 'according to responsible medical opinion' measured by the 'prevailing standards of medical ethics' a situation of necessity existed.

The defence of necessity is contained in article 40 of the Penal Code, which provides that a person who commits an offence as a result of 'irresistible compulsion or necessity [*overmacht*] is not criminally liable,'[11] and takes two forms. The first is 'psychological compulsion.' The second is 'emergency' (*noodtoestand*) and applies when the defendant chooses to break the law in order to promote a higher good.[12] Commenting on the latter form of the defence as applied by the Supreme Court to euthanasia, Professor Mulder, an expert on criminal law, explains:

> '*Noodtoestand* refers to the situation of the patient's dire distress, wherein an ethical dilemma and conflict of interests arise, resulting in a decision by the physician to break the law in the interest of what is considered a higher good.'[13]

The Supreme Court observed in the *Alkmaar* case that whether a situation of necessity existed would depend on the circumstances of the case and that the Appeal Court could have taken into account, for example, the following matters:

> 'whether and to what extent according to professional medical judgment an increasing disfigurement of the patient's personality and/or further deterioration of her already unbearable suffering were to be expected;
> whether it could be expected that soon she would no longer be able to die with dignity under circumstances worthy of a human being;
> whether there were still opportunities to alleviate her suffering.'[14]

The case was referred to the Hague Court of Appeal with a direction that it investigate whether, on the facts, the performance of euthanasia by the doctor 'would, *from an objective medical perspective*, be regarded as an action justified in a situation of necessity.'[15] On September 11, 1986, the Court of Appeal acquitted the accused on the basis that the defence of necessity applied.[16] Having noted that the accused maintained that he had done nothing contrary to medical ethics, the court added that he had, on the basis of his expertise as a physician and his experience as Mrs. B.'s doctor, and after careful consideration of conflicting duties in the light of medical ethics, made a choice which had to be regarded as justified according to 'reasonable' medical opinion.[17]

Advocate-General Feber notes that in its judgment the Hague Court of Appeal raised for discussion, to a greater extent than had previous judicial pronouncements, the extent to which euthanasia could be justified by psychological as opposed to psychiatric suffering, by a normal as opposed to an abnormal psychological reaction to physical deterioration. Mrs. B. was, he observes, far from being a psychiatric patient: 'her longing for death was a normal reaction to her miserable physical condition.'[18] Feber also notes that the Court of Appeal replaced the Supreme Court's criterion of 'objective' medical opinion with that of 'reasonable' medical opinion.[19]

(ii) *The Supreme Court decision of 1986*

On October 21, 1986, one month after the decision of the Hague Court of Appeal, the Supreme Court delivered a second judgment on euthanasia.[20] This case[21] concerned the prosecution of a doctor who, after repeated requests, euthanatised a 73 year-old friend suffering from advanced multiple sclerosis. The doctor was convicted by the Groningen District Court and her conviction was upheld by the Court of Appeal at Leeuwarden. The Supreme Court, however, allowed her appeal, holding that the Court of Appeal had wrongly failed to consider two defences raised at trial. The first was that the accused acted because of her patient's 'dire distress'; the second that she acted out of 'psychological necessity' because she 'was confronted with the suffering of her patient and found *herself* under duress and could not arrive at any other decision than to grant the assistance requested.'[22] The Supreme Court remitted the case to the Court of Appeal at Arnhem for further investigation[23]; the doctor was convicted.[24]

(iii) *The criteria for lawful euthanasia: a summary*

The criteria laid down by the courts to determine whether the defence of necessity applies in a given case of euthanasia have been summarised by Mrs. Borst-Eilers, Vice-President of the Health Council (a body which provides scientific advice to the Government on health issues), as follows:

> '1 The request for euthanasia must come only from the patient and must be entirely free and voluntary.
> 2 The patient's request must be well considered, durable and persistent.
> 3 The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.
> 4 Euthanasia must be a last resort. Other alternatives to alleviate the patient's situation must have been considered and found wanting.
> 5 Euthanasia must be performed by a physician.
> 6 The physician must consult with an independent physician colleague who has experience in this field.'[25]

Whether consultation must be with an 'independent' physician is, however, doubtful; in the *Alkmaar* case the

defendant G.P. had merely consulted his assistant. Further, it has been pointed out by Eugene Sutorius, counsel to the Dutch Voluntary Euthanasia Society (D.V.E.S.), that the Supreme Court has stated that consultation is not always essential. He has explained that, although the Court did not elaborate on this point, in his view, as the purpose of consultation is to obtain a second opinion about the medical aspects of the case, consultation is not necessary when there is no doubt about these aspects and when witnesses are available to verify that the non-medical criteria have been satisfied.[26]

The judgment of the Hague Court of Appeal in the *Alkmaar* case gave striking weight to the views of a 'considerable number of medical doctors' against whom, it said, a judge could not 'make a choice in this matter'.

(iv) *Liability for falsifying the death certificate*

Necessity is not, however, a defence to a charge of falsely certifying the cause of death. In a case decided by the Court of the Hague (Penal Chamber) in 1987, the defendant doctor admitted that, having performed euthanasia, he had certified that death was due to natural causes.[27] The Court of Appeal upheld the trial court's decision that death by euthanasia was not death by natural causes and that the doctor could not rely on necessity as a defence to falsifying the death certificate. The Appeal Court declared that it was a matter of great public concern that non-natural deaths should be investigated by officials such as the coroner and prosecutor and that this was especially so in cases of euthanasia in view of the proven danger of abuse.[28]

II. MEDICAL GUIDELINES

The judgment of the Hague Court of Appeal in the *Alkmaar* case gave striking weight to the views of a 'considerable number of medical doctors' against whom, it said, a judge could not 'make a choice in this matter'.[29] In fact, the medical profession, or at least its main representative body the Royal Dutch Medical Association (K.N.M.G.), to which some 60 per cent of Dutch doctors belong, has played a significant role in the relaxation of the law and practice of euthanasia.

(a) The K.N.M.G. criteria

In 1973 the K.N.M.G. issued a provisional statement which said that euthanasia should remain a crime but that if a doctor shortened the life of a patient who was incurably ill and in the process of dying, a court would have to judge whether there was not a conflict of duties which justified the doctor's action.[30] In August 1984, three months before the decision of the Supreme Court in the *Alkmaar* case, the central committee of the K.N.M.G. produced a report setting out the criteria which the K.N.M.G. felt should be satisfied in cases of euthanasia.[31] As Borst-Eilers has pointed out, there is a close correspondence between these criteria and those laid down by the courts.[32] Subsequently, the K.N.M.G. formulated[33] certain 'Guidelines for Euthanasia.'[34]

The Report lists five criteria: 'voluntariness'; 'a well-considered request'; 'a durable death-wish'; 'unacceptable suffering,' and 'consultation between colleagues.'[35] These are reproduced in the Guidelines.[36]

(i) *Voluntariness*

The Report stresses that the request must be made of the patient's free will and must not be the result of pressure by others.[37] Conceding that it will not always be possible to be completely sure that the request is not influenced by others, the Report says that the doctor should talk privately with the patient and that, after a 'number of conversations,' he must be able to get a 'fairly reliable impression' of the voluntariness of the request.[38] The Guidelines, by contrast, state that there need only be 'a' conversation with the patient to verify voluntariness.[39]

(ii) *a well-considered request*

To ensure that the request is well-considered the Report urges that the doctor should give the patient a 'clear picture of his medical situation and the appropriate prognosis' and, because a request for euthanasia is 'not uncommonly found to be an expression of fear—such as fear of pain, deterioration, loneliness' the doctor should also examine the extent to which these fears influence the request, and should dispel them as far as possible.[40]

Similarly, the Guidelines state that a doctor must guard against granting a request which arises essentially from 'other problems than the will to terminate life' such as the feeling of being superfluous or a nuisance to the family. A request made on such grounds should first of all be an occasion for a consultation with the patient about alternative solutions; in no case should euthanasia be granted because of problems which could be resolved in another way.[41]

The Report lists five criteria: 'voluntariness'; 'a well-considered request'; 'a durable death-wish'; 'unacceptable suffering,' and 'consultation between colleagues.'

(iii) *A durable death wish*

The Report declares that requests arising out of 'impulse or a temporary depression' should not be granted but

adds that it is not possible to indicate what time span should have elapsed before a request becomes 'durable.'[42] The physician is advised to 'steer mostly by his own compass' but that 'durable,' in the opinion of the committee, does not simply mean more than once.[43]

(iv) *Unacceptable suffering*

The Guidelines state that the patient must experience his suffering as 'persistent, unbearable, and hopeless' and they add that the relevant case-law indicates that an important consideration is whether the patient will be able to die 'in a dignified manner.'[44]

The Report however, states that the committee, while aware that the courts indicated that the suffering must be persistent, unbearable and hopeless, declined to support this definition of the criterion because it felt that these concepts overlapped and were unverifiable.[45] It continues that although the degree of suffering is an important criterion, there are only limited possibilities for verification since the unbearable and hopeless character of a person's situation is so dependent on individual standards and values that an objective assessment is difficult.[46]

Suffering, says the Report, can have any of three causes: first, pain; secondly, a physical condition or physical disintegration without pain, and thirdly, suffering without any physical complaint which could be caused either by 'social factors and the like' in a healthy person or by a 'medical-psychiatric syndrome.'[47] Pain, the Report continues, can be controlled to such an extent that, in general, it is not a primary cause of unbearable suffering. And as to suffering caused by social factors, a doctor usually cannot assess the unbearability of the patient's situation or the prospects of its alleviation.[48]

The Report adds that, although the K.N.M.G.'s 1973 statement had raised the question whether euthanasia was justifiable if the patient were incurably ill and in the process of dying,[49] the committee felt that, quite apart from the fact that the 'dying phase' could not be clearly defined, it was not reasonable to deny a patient who was suffering unbearably the 'right to euthanasia' solely because he was not dying. Consequently, it could no longer support the 'dying phase' as a criterion.[50]

(v) *Consultation and reporting*

The committee considered consultation with a colleague with experience in this field to be 'indispensable' to promote well-balanced decision-making[51] and the Report recommends that the doctor consult first a colleague with whom he is professionally involved and later an independent doctor.[52]

Finally, having noted that it was 'not unusual' for euthanasia to be reported as natural death in order to protect the relatives and/or the doctor from police investigation, the Report urges that this 'improper' prctice be discontinued and stresses the committee's advocacy of due openness in the reporting of death.[53]

(b) Current medical and legal procedures

Procedures followed by doctors who have performed euthanasia vary throughout the country. At one of the leading centres for euthanasia, the Reinier de Graaf Hospital in Delft, the procedure is that the doctor does not certify a natural death but informs the police.[54] The municipal medical examiner (*gemeentelijk lijkschouwer*) comes to inspect the body and a policeman to interview the doctor. Both officials then file reports with the prosecutor who, if satisfied that the legal criteria have been met, gives permission for the corpse to be handed over to the relatives.[55] As Borst-Eilers comments: 'This whole procedure after death need only take a few hours. Only if the public prosecutor suspects that all the criteria have not been met with, he orders further interviews with nurses, members of the family *etc.*'[56] In November 1990, however, the Minister of Justice and the K.N.M.G. agreed that the doctor need only report to the medical examiner, and the Minister of Justice directed prosecutors that on receiving the medical examiner's report they should ask the police to investigate only if there are grounds for suspecting that the appropriate criteria have not been met.[57]

The final decision whether to prosecute is taken at a meeting of the country's five Chief Prosecutors (*Procureurs-Generaal*). The Chief Prosecutors, each of whom is attached to one of the five regional Courts of Appeal, meet every three weeks together with a representative from the Ministry of Justice, to discuss prosecution policy in relation to crimes in general and to decide, according to the criteria laid down by the courts,[58] whether to prosecute in each notified case of euthanasia. In practice, they simply approve the decision of the local prosecutor.[59]

Are the criteria for voluntary euthanasia laid down by the Dutch courts and endorsed by the K.N.M.G. adequate to prevent instances of euthanasia which do not satisfy the criteria, especially the requirement of a free and well-considered request?

III. SLIDING DOWN A SLIPPERY SLOPE?

The legal and medical criteria for voluntary euthanasia having been set out in Parts I and II, Part III examines the extent to which the experience of euthanasia in the Netherlands confirms or confutes the 'slippery slope' argument, an argument which has been deployed in major reports opposing the legalisation of voluntary euthanasia, such as those of the Working Party of the Church of England's Board for Social Responsibility, (1975),[60] the Canadian Law Reform Commission (1983),[61] and the Working Party of the British Medical Association (1988).[62] On this argument, even if euthanasia in certain circumstances (in particular that of a free and well-

considered request by the patient) is not intrinsically unethical, its legalisation will result in a slide down a 'slippery slope' to non-voluntary and possibly even involuntary euthanasia. It will do so, the argument runs, either because any safeguards which might prevent such a slide could not in practice be made effective or, more fundamentally, because the ethical reasoning underlying the case for voluntary euthanasia also supports euthanasia without request.

(a) The 'practical slope'

Are the criteria for voluntary euthanasia laid down by the Dutch courts and endorsed by the K.N.M.G. adequate to prevent instances of euthanasia which do not satisfy the criteria, especially the requirement of a free and well-considered request? It has been stressed by defenders of the Dutch criteria, such as Henk Rigter, Executive Director of the Health Council, that the guidelines for lawful euthanasia are both 'precisely defined' and 'strict.'[63] Are they?

(i) *Identifying the criteria*

Before deciding whether the criteria are precise and strict it is necessary accurately to identify them. The Supreme Court decided that necessity could operate as a defence to a charge under article but omitted to state with any exactitude the criteria to be satisfied for the defence to apply. Even taking into account the decisions of lower courts, the criteria are not easy to determine. For example, Professor Leenen, a leading medical lawyer, has written that each court decision has its own set of criteria, which creates 'much uncertainty.'[64]

(ii) *'Strict' and 'precise'?*

Even if, say, Borst-Eilers's list of criteria were definitive there would still remain the question of the precision and strictness of those criteria. As for their supposed precision, Dutch jurists, such as Leenen, have remarked upon their vagueness. He defines euthanasia as a 'deliberate life-shortening act—including an omission to act—by a person other than the person concerned, at the request of the latter.'[65] He observes that other elements such as 'unbearable pain' are sometimes included but objects that they cannot form part of the definition—first because they introduce judgments on which people disagree, and secondly because 'these elements cannot be delineated precisely.'[66] He continues that to include 'unbearable pain,' whether physical or psychological, is to render the definition of euthanasia 'vague and useless' by stretching it to cover a broad range of human suffering.[67] Moreover, far from clarifying these inherent ambiguities the Supreme Court in the *Alkmaar* case appears to have compounded the problem by introducing such opaque concepts as 'dying with dignity.'[68]

As for Rigter's claim that the criteria are 'strict,' this too is difficult to sustain, not only because of their imprecision but also because of the absence of any satisfactory procedure, such as an effective independent check on the doctor's decision-making, to ensure that they are met.

Take, for example, the first criterion, that the request must come only from the patient and be 'entirely free and voluntary.'[69] What this means is not explained. Does it, for example, preclude the doctor from mentioning euthanasia as an option? Although the K.N.M.G Guidelines state that the request must not be the result of pressure by others, they do not prevent the doctor or nurse from either mentioning euthanasia to the patient as an option or even strongly recommending it.

Moreover, although the Guidelines declare that a request for euthanasia on the ground of being a nuisance to family should be an occasion to discuss alternative solutions, and that euthanasia is not to be administered because of problems which can be resolved in another way, they by no means rule out euthanasia in such a case.[70] Herbert Cohen, a G.P., is one of Holland's leading practitioners of euthanasia. He has said that he would be put in a very difficult position if a patient told him that he really felt a nuisance to his relatives because they wanted to enjoy his estate. Asked whether he would rule out euthanasia in such a case, Dr. Cohen replied:

> 'I . . . think in the end I wouldn't, because that kind of influence—these children wanting the money now—is the same kind of power from the past that . . . shaped us all. The same thing goes for religion . . . education . . . the kind of family he was raised in, all kinds of influences from the past that we can't put aside.'[71]

Even if the meaning of 'entirely free and voluntary' were clear, do doctors possess the expertise to determine whether a request fulfils this requirement? If they do, can the recommended procedure for ascertaining whether a request is free—the Guidelines merely recommend 'a' conversation,[72] of unspecified length and content—ensure that any such expertise is effectively deployed? Leenen, observing that a doctor can never know that a request is free and not the result of pressure from relatives, has commented: 'He does not know about emotional influence from the family. . . . He never knows about the annoyance which patients can be to the nursing staff sometimes. All these factors can . . . be true.'[73]

Turning to the second criterion, that the request be 'well-considered, durable and persistent,' the question again arises how all this is to be determined. How is the doctor to decide whether the request is the result of rational reflection or the influence of pain or drugs? As Kamisar has observed:

> 'Undoubtedly, some euthanasia candidates will have their lucid moments. How they are to be distinguished from fellow-sufferers who do not, or how these instances are to be distinguished from others when the patient is exercising an irrational judgment, is not an easy matter,'

particularly when no psychiatrically-trained personnel assist in the assessment of the request.[74] He continues by asking whether, even if the mind of the 'pain-racked' patient is clear, it is not likely to be 'uncertain and variable?'[75]

The Guidelines merely state that one request is insufficient;[76] presumably two requests. even if made during the same consultation, would suffice. It is difficult to maintain that this is sufficient to meet Kamisar's point. Moreover, in assessing the practitioner's ability to ensure that a request is free, well-considered and durable, it is relevant to note that, on average, each G.P. in the

Netherlands sees 30 patients per day in consultations lasting only seven to ten minutes.[77]

Doubts about whether the Guidelines ensure that a request is well-considered and enduring have not been dispelled by a recent survey of G.P.s about euthanasia. The survey was carried out in 1990 by medical examiner van der Wal and others. It concluded that the interval between the first request for euthanasia and its performance was no more than a day in 13 per cent of cases; no more than a week in another 35 per cent, and no more than a fortnight in a further 17 per cent; and that the interval between the last request for euthanasia and its performance was, in three out of five cases, no more than a day. The survey also found that in 22 per cent of cases there was only a single request and that in a further 30 per cent of cases the interval between the first and last requests was between an hour and a week. Finally, in almost two-thirds of cases the request was purely oral.[78]

Moving to the third criterion, 'intolerable suffering,' the K.N.M.G.'s Report declared that the concept is imprecise, not susceptible to objective verification, and can be caused by non-medical factors.

Further, Kamisar asks whether, even if the patient's request could be said to be clear and incontrovertible, other difficulties would not remain.

> 'Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them . . .?'[79]

Moving to the third criterion, 'intolerable suffering,' the K.N.M.G.'s Report declared that the concept is imprecise, not susceptible to objective verification, and can be caused by non-medical factors.[80] Moreover, van der Wal's survey found that although in 56 per cent of official notifications 'intolerable suffering' was certified by doctors as the most important reason for euthanasia, only 42 per cent of the patients had mentioned it as a reason and only 18 per cent as their most important reason. 29 per cent of patients gave 'senseless' suffering as their most important reason, and 24 per cent 'fear/anticipation of mental deterioration.'[81]

One argument against entrusting the euthanasia decision to the patient's doctor is that the doctor is fallible and that he may make errors in diagnosis or prognosis which could lead him to conclude, mistakenly, either that the patient's suffering is unbearable or that there is no means of palliation.[82] Here one may mention a report of the Health Council, published in 1987, on palliative care in the Netherlands. It concluded that 54 per cent of cancer patients who were in pain suffered unnecessarily because doctors and nurses had insufficient understanding of the nature of the pain and the possibilities for its alleviation.[83] There is, moreover, the related argument that the doctor's objectivity can be swayed by emotional pressures; as Kamisar has commented: 'no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient.'[84]

Is the danger of fallibility, whether due to medical ignorance or emotional stresses, countered by the sixth criterion: consultation? It is questionable whether this criterion provides an effective safeguard against mis-interpretation and mis-application of the other criteria.

First, if consultation is a legal requirement at all, it may well only be required when there is doubt about the *medical* aspects of the case.[85] Now in a large proportion, if not the vast majority, of cases the doctor may well believe that there is no such doubt. Moreover, if consultation is not required when the diagnosis is clear, this suggests that when consultation is required, the requirement is satisfied if the second opinion is sought solely on the medical aspects of the case. Secondly, the consultation procedure recommended by the K.N.M.G. committee in 1984 has not been implemented. Nor has any court set out the form which consultation should take.[86] Thirdly, there is no requirement that the second doctor concur with the first doctor's interpretation of the criteria on which the second doctor is consulted or with their application to the patient in question. Further, the second doctor could adopt an interpretation of the criteria at least as relaxed as the first.

Finally, in September 1991, a government committee on euthanasia, chaired by Attorney-General Remmelink, reported that its own survey indicated that in 1990 there were 2,300 cases of euthanasia and 400 cases of assisted-suicide; 1,000 cases of life termination without an explicit request, and 15,975 cases in which it was the doctor's 'explicit' or 'secondary' intention to shorten life either by administering painkilling drugs (8,100 cases) or by withdrawing or withholding treatment (7,875 cases).

Even were consultation a universal practice it would,

therefore. be of limited value as a check on the judgment or integrity of the first doctor. It is, moreover, far from universal. Van der Wal reports: 'One quarter of the general practitioners said they had not had *consultation* prior to euthanasia/assisted suicide. . . . More serious is the finding that 12 per cent . . . manifestly had no form of *discussion* with any other caregivers either.'[87] When consultation did occur the second opinion was in most cases a colleague rather than an independent doctor. Further, the second doctor already knew the patient in about 60 per cent of cases and only put his opinion in writing in about a quarter of cases. Finally, fewer than half of the G.P.s consulted the patient's district nurse about his request for euthanasia.[88]

(iii) Empirical evidence

Another of Rigter's claims is that if a doctor were to press euthanasia on a patient 'this would surely be discovered, and the doctor would have to face charges of murder or manslaughter.'[89] Empirical evidence does not substantiate this claim.

Estimates of the number of cases of medical euthanasia in the Netherlands, which has a population of some 15 million, and some 130,000 deaths per year, put the figure at at least 2,000.[90] The survey by van der Wal estimates the annual number of cases of euthanasia and assisted suicide by G.P.s at 2,000. However, the survey excludes cases in hospital, mainly on 'the assumption that the incidence of euthanasia and assisted suicide is greatest in the home situation'; it also excludes cases of the 'discontinuation of or failure to institute a treatment' at the patient's request.[91] Finally, in September 1991, a government committee on euthanasia, chaired by Attorney-General Remmelink, reported that its own survey indicated that in 1990 there were 2,300 cases of euthanasia and 400 cases of assisted-suicide; 1,000 cases of life termination without an explict request, and 15,975 cases in which it was the doctor's 'explict' or 'secondary' intention to shorten life either by administering pain-killing drugs (8,100 cases) or by withdrawing or withholding treatment (7,875 cases).[92]

It is difficult to determine how many cases of euthanasia satisfy the legal criteria, not least because it appears that the overwhelming majority of cases are falsely certified as death by natural causes and are never reported and investigated.

(iv) *The prevalence of false certification*

It is difficult to determine how many cases of euthanasia satisfy the legal criteria, not least because it appears that the overwhelming majority of cases are falsely certified as death by natural causes and are never reported and investigated. Reported cases for the years 1987–1990 numbered only 122; 181; 336 and 454 respectively, and only one case was prosecuted to trial. In November 1990 the Minister of Justice reached an understanding with the K.N.M.G. that no doctor who followed the appropriate criteria for euthanasia would be prosecuted but, even after this indication from the Minister, only 600 cases were reported in the first 10 months of 1991.[93] Therefore, on even the lowest estimate of 2,000 euthanasia cases per year, over 90 per cent went unreported in 1988; over 80 per cent in 1989 and over 70 per cent in 1990. These statistics place a large question mark against Rigter's claim (in 1989) that if the situation in the Netherlands is at all unique, 'it is perhaps in the wish of physicians to subject their actions to public scrutiny.'[94]

Borst-Eilers has stated that in unnotified cases there is no guarantee of propriety and that it is impossible to evaluate what the doctors have done.[95] Similarly, Mrs. Tromp-Meesters, a spokesman for the D.V.E.S., has observed that under the present law 'there is no control,' that the purpose of notification is merely statistical and that it is not an adequate safeguard against abuse.[96]

In short, notwithstanding the permissive character of the Dutch criteria for permissible euthanasia, there would appear to be no hard evidence that these criteria are being widely observed; on the contrary, the fact that, as just noted, the vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths itself casts doubt on the lawfulness of much of the euthanasia which is being carried out. Moreover, it does not follow that the doctor who notifies the authorities has complied with the criteria; a doctor who has acted in breach of the law is no more likely to admit having done so in his report than a tax evader is likely to reveal his dishonesty on his tax return.

Moreover, whatever prospect there was of detecting abuse in a reported case has been reduced by the Minister of Justice's directive to prosecutors that they should order a police investigation only if the medical examiner's report reveals suspicious circumstances. One prosecutor regarded the directive (which, he revealed, had been introduced against the advice of the Chief Prosecutors) with dismay. He explained that the medical examiner does not have the necessary investigative expertise and conducts an inquiry which is 'just a chat between doctors and no inquiry at all.' The prosecutor added that the examiner's perfunctory certificate stating the cause of death was hardly of assistance in deciding whether the police should be asked to investigate. Under the previous system, he said, the prosecutor insisted on 'some hard facts' before deciding not to order an investigation. He continued that the directive has been welcomed by the medical profession because they saw it as an indication of the Minister's agreement with them that decisions about euthanasia should be made by doctors rather than by lawyers. 'So it can be,' I asked, 'a little chat between the medical examiner and the doctor and that's how they would like it?' 'Yes, yes,' he replied, adding that in the countryside there were some towns with only two or three doctors: 'What's the use,' he said, 'of asking one of those two or three to judge the handling of a euthanasia case by the other one? How objective can that be? I don't see it.' He concluded that the new directive required

prosecutors to lower their professional standards to what he regarded as below even the 'absolute minimum.'[97]

The statistical evidence does nothing to refute allegations of non-voluntary and involuntary euthanasia which have been made by several Dutch experts. For example, Dr. Fenigsen, a cardiologist at the Willem-Alexander Hospital, 's-Hertogenbosch, maintains that there is widespread public and professional support for euthanasia without request, as well as ample evidence of the practice.[98] Drawing on his own observations he declares:

> 'Doctors whose actions I observed repeatedly tried to justify euthanasia by making reference to false data—citing a nonexistent lung cancer, or a presumed, but never made, family request. . . .'[99]

He refers also to the work of experts such as Drs. Hilhorst and van der Sluis. Dr. Hilhorst, a sociologist who conducted empirical research in Dutch hospitals, reported that doctors and nurses told him that requests for euthanasia came more frequently from the family than the patient and he concluded that both the family and the doctors and nurses often pressured the patient to request euthanasia.[100] Dr. van der Sluis, a dermatologist involved with the treatment of AIDS patients, states that non-voluntary and involuntary euthanasia are common and openly defended in medical journals.[101]

Moreover, in a survey by medical lawyer Professor van Wijmen, 123 doctors, or 41 per cent of the respondents, admitted that they had performed euthanasia without the patient's request. Eighty-eight had done so in one to 15 cases and seven in more than 15 cases.[102] Further, the Remmelink Committee reported that in 1,000 cases death was intentionally accelerated without a specific request from the patient (although in about half there had been some discussion with the patient or he had previously expressed a desire that death should be hastened). In about a quarter of the 1,000 cases, moreover, the patient had some capacity to express himself.[103]

Other evidence of euthanasia without consent is provided by a number of criminal prosecutions. Professor Sluyters, a medical lawyer, mentions one case in 1985 involving a doctor who was convicted of killing several patients in a nursing home in The Hague and who was sentenced to one year's imprisonment; his conviction was quashed because the police had improperly seized incriminating documents and he was awarded 300,000 guilders (approximately £85,000) compensation for the six months he had already spent in prison. Sluyters also refers to cases in which nurses were convicted of killing handicapped children. Although expressing his support for 'the Dutch solution of restrained liberalisation' of the law relating to uthanasia, he concedes: 'In The Netherlands we have seen some cases in the courts in recent years which could perhaps be illustrating the adverse consequences of the liberalisation of euthanasia.'[104] Again, Borst-Eilers has commented that, although she did not believe that voluntary euthanasia led logically to involuntary euthanasia, 'if I am honest I must admit that I cannot judge whether the fact that euthanasia is openly talked about does not bring about a kind of feeling that it's something that you are allowed to do' and that this might have influenced the doctor and nurses in the above cases to perform euthanasia without request.[105]

In sum, the legal and medical criteria for euthanasia would not appear to constitute an effective safeguard against the practice of non-voluntary and involuntary euthanasia. Moreover, the evidence of critics of the Dutch euthanasia experience, such as Fenigsen and van der Sluis, suggests that what the criteria are sufficiently loose to permit is indeed taking place. There is, moreover, a dearth of evidence to support contrary claims that the criteria are being generally observed; as the K.N.M.G. indicated in its report, the failure of doctors to notify would mean the legality and propriety of what was happening in practice would be 'absolutely unverifiable.'[106]

(b) The 'logical slope'

Even if doubts about the criteria for lawful euthanasia were dispelled, there would remain the question whether these criteria state necessary as opposed to merely sufficient conditions for lawful euthanasia. Is the legal reasoning of the Supreme Court and the ethical reasoning of the Dutch proponents of euthanasia based upon a principle which entails that some or even all of the existing criteria are superfluous?

(i) *The legal slope*

In the *Alkmaar* case, the Supreme Court did not lay down a list of necessary criteria for lawful euthanasia, its judgment was framed in more general terms. It held that necessity was available as a defence to euthanasia and that in determining the availability of the defence in a given case, a crucial question was whether there was a situation of necessity according to 'responsible medical opinion,' tested by 'prevailing standards of medical ethics.'[107]

This suggests that the existence of necessity in a given case is to be determined primarily by criteria fashioned by the medical profession rather than by the courts. Commenting on the case Sutorius observes that according to the Supreme Court 'the primary judgment should remain with the medical discipline, the second judgment is a legal one and should rest with society' and he adds that in his opinion the court 'wishes to have euthanasia problems solved where they arise, notably in the medical discipline.'[108]

However, even if doctors were unanimous about the appropriate criteria, there would still be several weighty objections to the Supreme Court's reasoning.

However, it is doubtful whether there is a consensus within the profession about the conditions justifying euthanasia, and in the absence of an agreed set of criteria there will only be disparate bodies of medical opinion. Medical opinion is often divided over purely technical matters such as diagnosis and treatment, a fact recognised by the common law's test for medical negligence which

refuses to hold a doctor negligent merely because he acted in accordance with one responsible body of medical opinion rather than another.[109]

Medical opinion is likely to be at least as split over an ethical issue such as euthanasia. Presumably, a doctor performing euthanasia will not incur criminal liability if he acts in accordance with a body of medical opinion. But, does this not render the current criteria essentially provisional? Moreover, how is a court in determining what amounts to 'responsible medical opinion' to select expert witnesses and how is it to proceed if they disagree?

The centrality attached by the Supreme Court to medical opinion has attracted the criticism of a number of Dutch jurists. Feber concludes that the court's decision to cede so much influence to medical opinion leaves insufficient room for the judge to arrive at an independent decision.[110] Leenen has observed:

> 'By referring to medical ethics the Supreme Court left the problem of the criteria for the acceptability of euthanasia on request in essence unsolved. Moreover the reference is useless because of the . . . disagreement within the medical profession upon ethics.'[111]

However, even if doctors were unanimous about the appropriate criteria, there would still be several weighty objections to the Supreme Court's reasoning. First, if the court is effectively entrusting the determination of the lawfulness of euthanasia to the medical profession, does this not amount to an abdication of judicial responsibility? Mulder argues that the legal boundaries of euthanasia should be set by the judiciary as representatives of society and not by the medical profession.[112]

Secondly, are doctors, whose training is in medicine, not ethics or law, competent to determine when, if ever, euthanasia is justifiable?

Thirdly, are the existing criteria, which are presumably in line with 'responsible' medical opinion, consistent with the principles informing Dutch criminal law, particularly that, instantiated in article 293, which requires the protection of human life? Mulder states that whereas it has always been regarded as lawful medical practice, and as part of the dying process, for a doctor, in the course of lessening the pain of a dying patient, to administer analgesics even if they accelerate the patient's death, to accelerate death when the patient is not dying is not good medical practice but killing.[113]

Fourthly, the decisions of the court contain no adequate analysis of the doctor's duty to the patient nor reason why the alleviation of suffering should override the clear terms of article 293. The decisions are all the more remarkable when it is recalled that the very terms of the article emphasise that the victim's earnest request, let alone consent, is no defence to a charge of homicide. Sluyters has written that article 293 was enacted primarily 'to leave no doubt that the killing of a person is unlawful even if that person desires death.'[114] Moreover, the Explanatory Memorandum to article 293 states that, although one who takes the life of another at his request should be punished 'considerably less severely than those guilty of plain murder,' the victim's consent 'cannot abolish the criminality of taking someone's life.' It continues:

> 'the law so to speak no longer punishes the assault on the life of a particular person, but rather the violation of the respect due to human life in general—irrespective of the offender's motive. The criminal offence against life remains, the assault against the person expires.'[115]

Again, Mulder, having noted that life has value to the community as well as to the individual, observes that it is 'certain that the Lawgiver considered life worth protecting, even when it no longer has any value to the individual.'[116]

Neither the letter nor the spirit of the Code, then, appears to give any support to the Supreme Court's decision that a defence to a charge under article 293 is implicit in article 40.

Indeed, had the legislature intended to provide a defence to article 293 it could have done so expressly. There seems no evidence or reason to doubt that the legislature decided that the protection of life took priority over the autonomy of the individual or the alleviation of suffering. By holding that a doctor may choose to kill in order to relieve suffering, the court inverted (without any show of juridically sufficient reason) the legislature's ordering of values.

But perhaps the legislature did not foresee the acute suffering which can be imposed on patients by, or as a side effect of, modern medical technology? Perhaps the prohibition in article 293 is out-dated and could not have been intended to apply in contemporary Holland? But, in 1891 as today, the legislature must have been well aware that people typically seek euthanasia precisely to avoid suffering. There is no reason to think that the legislature was willing to allow the alleviation of even 'unbearable' suffering to take priority over the protection of life, or that the suffering experienced today is greater than when article 293 was enacted. As Driesse observes:

> 'Despite the fact that people were deeply persuaded that life could bring much and serious suffering, and despite the fact that in those days there were also people who requested death, the lawgiver in Article 293 . . . did not abrogate punishment.'[117]

Moreover, it would be reasonable to conclude that, with modern palliative care, the suffering which leads people to request euthanasia is substantially less today than it was when article 293 was enacted. Driesse concludes:

> 'To change this article . . . by declaring killing on request, or alternatively rendering assistance in self-killing, to be non-punishable in certain instances, is not the adaptation of an obsolete regulation which is required by changed circumstances. It is the concretization of fundamental change of attitude in regard to the inviolability of the human individual and of respect for human life.'[118]

To all this one must add that the legal position thus reached in 1984 would be all the more far-reaching if the Supreme Court were clearly to hold that the defence of necessity in euthanasia cases could extend to 'mental duress' *suffered by the defendant health care professional*. Mulder has commented that the courts should not be too eager to allow this type of defence as it paves the way to 'euthanasia-like' acts by other experts, especially nursing personnel.[119] But one must go further: to allow this defence of mental duress is already, in principle, to

have accepted *in*voluntary euthanasia, since the request or the consent of the person killed is quite irrelevant within the framework of such a defence.

(ii) *The ethical slope*

The main argument advanced in the Netherlands for legalising voluntary euthanasia has been that it respects the individual's right to self-determination. Leenen, for example, argues that interference with that right can only be justified if it is to protect essential social values, which is not the case where patients suffering unbearably at the end of their lives request euthanasia when no alternatives exist. He adds: 'Not allowing people euthanasia would come down to forcing them to suffer against their will, which would be cruel and a negation of their human rights and dignity.'[120] Echoing other proponents of legalisation,[121] he observes that modern medicine has contributed to the prolongation of suffering and the 'disfigurement of dying'[122] and he advances arguments in favour of the statutory legalisation of euthanasia such as the need to protect self-determination by ensuring that euthanasia is only carried out at the free, explicit and serious request of the patient, and the need to guarantee that doctors, who may be influenced by emotion, exercise great care in making the decision. He points to the legislative proposals of the State Commission on Euthanasia which reported in 1985 and which recommended that article 293 be amended to provide that it would not be unlawful to terminate the life of another at his express and serious request when he was in an 'untenable situation without any prospects' and when the termination was carried out by a doctor 'within the framework of careful medical practice.'[123]

There is some evidence that many of the Dutch proponents of euthanasia in fact regard the existing criteria for legal euthanasia as sufficient but by no means morally necessary conditions.

Dutch advocates of legalisation take pains to stress that they support *voluntary* but oppose *in*voluntary euthanasia. Their position on *non*-voluntary euthanasia is often obscure, largely because of a tendency to confine discussion to the voluntary type. This is often effected by adopting Leenen's definition of euthanasia as *voluntary* euthanasia[124] and declining to regard as euthanasia the termination of life without the patient's request.

Notwithstanding the difficulty of ascertaining their complete ethical position, there is some evidence that many of the Dutch proponents of euthanasia in fact regard the existing criteria for legal euthanasia as sufficient but by no means morally necessary conditions. occasionally expressed support for non-voluntary euthanasia. Asked whether he saw any moral distinction between removing artificial feeding from a comatose patient and actively killing him, Dr. Admiraal, an anaesthesiologist and leading practitioner of euthanasia, replied:

> 'No, I should kill the patient as well. . . . In a coma there is no . . . suffering . . . and there is no consciousness so there is no . . . reason to stop life immediately but I should do [so] and not wait for the starving of that patient for the next weeks. Oh no, I should say if I made the decision to stop tube-feeding, I should give active euthanasia. . . .'

He added that it was the same situation with a neonate: 'You can't speak about voluntary euthanasia, it's only the parents asking for . . . the judgment of the doctors and you are just killing that baby.' Asked whether there was anything wrong with that, he replied that he did not think so.[132]

The above considerations suggest that a substantial number of the most prominent Dutch advocates of voluntary euthanasia in fact support non-voluntary euthanasia. They may, moreover, be logically committed to this position, for the basis of their case for voluntary euthanasia, namely, respect for self-determination, may well be thought to provide little or no ground for judging wrongful the euthanatising of those who do not possess autonomy, whether because they are infants, or senile, or mentally handicapped, or comatose. The widespread condonation of euthanasia in the case of the comatose is particularly revealing, for it undermines the need for either a request or for suffering (whether unbearable or not) and suggests that the right to self-determination is, notwithstanding the emphasis commonly placed upon it, an incomplete explanation of the case for euthanasia which is advanced in the Netherlands. The case would appear fundamentally to rest on the principle that lives which fall below a certain 'quality' are not worth living. This principle has evidently been openly adopted by some of the leading Dutch exponents of euthanasia. For example, Professor van der Meer, former Head of Internal Medicine at the Free University of Amsterdam, has

Of course, if the Dutch case for voluntary euthanasia is, as it would appear to be, based on the principle that certain lives are not worth living, then it raises the questions whether this principle is defensible and whether it does not logically permit non-voluntary and even involuntary euthanasia.

For example, in relation to the criterion of 'unbearable suffering' Tromp-Meesters has stated that the D.V.E.S. would ideally like the law to allow anyone to ask their doctor for euthanasia even without such suffering: 'If you can convince your doctor that you have good reasons to want to die, the doctor should feel free to help you.'[125] She felt that ideally it would be like ancient Rome where (she says) once a year citizens could ask to be put to death.[126]

Again, there is widespread support for euthanasia even though the patient is incompetent. The State Commission, for example, recommended that

> 'the intentional termination of the life of a person unable to express his or her will should not be an offence provided this is performed by a physician in the context of careful medical procedure in respect of a patient who, according to the current state of medical knowledge, has irreversibly lost consciousness, and provided also that treatment has been suspended as pointless.'[127]

Further, the K.N.M.G. Report in 1984 did not condemn euthanasia without request but simply confined itself, for the time being, to euthanasia for those who were capable of expressing their will. Indeed, it did not even address the ethics of euthanasia but merely observed that euthanasia was practised and that in a pluralistic society views on the subject would always differ.[128] This approach could, of course, also be used to approve euthanasia without request. Indeed, in 1988 a K.N.M.G. working party condoned euthanasia for malformed infants,[129] concluding that in certain situations the doctor ought to terminate life.[130] In 1991, a K.N.M.G. committee considering 'Life-Ending Treatment of Incompetent Patients' condoned the killing of patients in persistent coma.[131]

Finally, leading proponents of euthanasia have written that it is obvious that the 'quality of life' of a person rendered permanently comatose has fallen 'below the minimum.'[133]

Of course, if the Dutch case for voluntary euthanasia is, as it would appear to be, based on the principle that certain lives are not worth living, then it raises the questions whether this principle is defensible and whether it does not logically permit non-voluntary and even involuntary euthanasia. One of the unfortunate consequences of the emphasis in the Dutch euthanasia debate on the right of self-determination has been that these important questions have not received the attention they deserve. They have, however, been addressed by opponents of legalisation, notably Kamisar. He concludes that there is a real danger of sliding down the 'slippery slope,' first because it has already taken place this century and started with the acceptance of the attitude that there is such a thing as a life not worth living,[134] and secondly because, as he demonstrates, many supporters of voluntary euthanasia have historically shared this attitude.[135] He argues, moreover, that reasons which have been advanced by proponents of voluntary euthanasia for not extending euthanasia to the senile and the defective are much more tentative and unpersuasive than the arguments they deploy for legalising euthanasia in the first place.[136]

CONCLUSION

The significance of the Dutch euthanasia experience for law, medicine and social policy in other countries is considerable, not least in respect of the support it lends to the 'slippery slope' argument. Some have argued that the danger of a slide into non-voluntary and involuntary euthanasia would be reduced if the criteria were statutory. It will be recalled that Leenen listed arguments in favour of legislation, such as the need to ensure that euthanasia was only performed at the patient's request.[137] He omits, however, to explain *how* legislation would provide more effective safeguards against abuse. Moreover, as medical lawyer Professor Gevers has observed:

> 'It is impossible to delineate precisely the situations in which euthanasia should be allowed; therefore, a new law cannot add very much to what has already been developed by the courts, and will only partially reduce legal uncertainty.'[138]

Further, the legislative proposals contained in the report of the State Commission on Euthanasia are, as Leenen himself has observed,[139] essentially the same as those developed by the courts. Indeed, it is arguable that the central criterion proposed by the Commission, an 'untenable situation' with no prospect of improvement,[141] is even looser than the existing criterion of unbearable suffering which cannot be alleviated.

It could, of course, be argued that although euthanasia without request may be practised in the Netherlands, it is also carried out in jurisdictions where euthanasia is unlawful, such as the United Kingdom, and that the legalisation of voluntary euthanasia helps prevent the carrying out of euthanasia without request. As a spokesman for the K.N.M.G. put it, there is a choice between on the one hand prohibiting euthanasia and not knowing how often it is carried out and, on the other hand, legalising it and knowing how most of it is carried out. The K.N.M.G., he explained, wanted it to be controlled, and if it were prohibited, it could not be controlled.[141] But it is clear from the evidence set out in Parts III(*a*) (iii) and

But it is clear from the evidence set out in Parts III(*a*) (iii) and (iv) above that all that is known with certainty in the Netherlands is that euthanasia is being practised on a scale vastly exceeding the 'known' (truthfully reported and recorded) cases.

(iv) above that all that is known with certainty in the Netherlands is that euthanasia is being practised on a scale vastly exceeding the 'known' (truthfully reported and recorded) cases. There is little sense in which it can be said, in any of its forms, to be under control. As Leenen has observed, there is an 'almost total lack of control on the administration of euthanasia'[142] and 'the present legal situation makes any adequate control of the practice of euthanasia virtually impossible.'[143]

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Unless the contrary is apparent, all translations are by Hub Zwart, to whom I owe a special debt of thanks. All references to 'interviews' refer to interviews I conducted between July 1989 and December 1991. Unless attributed to another, the views expressed in this paper are mine and I remain solely responsible for the accuracy of the paper.

2. Quotations from the Penal Code are taken from a translation of the Code by Louise Rayar.

3. *Ibid.*

4. B. Sluyters, 'Euthanasia in The Netherlands' (1989) 57(1) *Medico-Legal Journal* 34 at p. 35.

5. *Ibid.*

6. *Op. cit. supra*, n. 2.

7. Jurgen Woretshofer, 'Current Court Decisions and Legislation on Euthanasia in the Netherlands' (pp. 25–51 of an unpublished manuscript on euthanasia) at p. 26 (page references correspond to those in the manuscript). Article 293 and 294 were added to the Penal Code in 1891. H.J.J. Leenen, 'Euthanasia in the Netherlands' in Peter Byrne (ed.) *Medicine, Medical Ethics and the Value of Life* (1990) 10.

8. See generally H.J.J. Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands' (1987) 8 *Health Policy* 197 at pp. 200–202; *op. cit. supra*, n. 7 at pp. 4–6.

The pyramidal structure of the criminal court systems rises from the 62 Cantonal Courts, which deal with minor offences, through the 19 District Courts, each covering three or four cantons, to the five Courts of Appeal, each of which covers three or four districts. At the apex is the Supreme Court, which is concerned solely with questions of law. See Peter Zisser, 'Euthanasia and the Right to Die: Holland and the United States Face the Dilemma' (1988) 9 N.Y.L. Sch. J. Intl. & Comp. Law 361 at p. 365 n. 53.

9. *Nederlandse Jurisprudentie* (hereafter N.J.) (1985) No. 106.

10. J. K. M. Gevers, 'Legal Developments concerning Active Euthanasia on Request in the Netherlands' (1987) 1 *Bioethics* 156 at p. 159. The case report reads as follows:

> 'At the trial . . . counsel for the accused appealed to necessity [*overmacht*] in the sense that the accused found himself confronted by a 'conflict of duties, in which he came to a right choice in a well-considered manner.' This appeal to a conflict of duties, which should be distinguished from the accused's appeal to necessity in the sense of constraint of conscience [*gewetensdrang*], can hardly be interpreted otherwise than as an appeal to emergency [*noodtoestand*], which amounts to the accused carefully weighing the duties and interests which faced each other in this case, especially in accordance with the norms of medical ethics and with the expertise which he, as a physician, can be expected to possess; and making a decision which—considered objectively and in view of the special circumstances in this case—was justified' (N.J. (1985) No. 106, 451 at p. 452).

The report continues (at pp. 452–453) that the Court of Appeal had properly rejected the defence of 'constraint of conscience' but that its rejection of the defence of 'emergency' was unsound as it had failed to take into account the condition of Mrs. B and the fact that the accused in his 'competent judgment as a physician' felt that she experienced each day of life as 'a heavy burden under which she suffered unbearably.' In view of this, the Supreme Court continued (at p. 453):

> 'further clarification is needed as to why the Court of Appeal . . . still comes to the judgment that it 'has not become sufficiently plausible' that the suffering of B at the very moment the accused terminated her life . . . should be considered so unbearable that the accused in fairness had no other choice than to spare her suffering by means of euthanasia. . . . Rather it should have gone without saying that the Appeal Court, after having determined the facts and circumstances . . . [relating to B's condition], would have further investigated whether, according to well-considered medical judgment and in accordance with medico-ethical norms [*nader zou hebben onderzocht of naar verantwoord medisch inzicht, getoetst aan in de medische ethiek geldende normen*], it was a matter of emergency as claimed by the accused.'

11. *Op. cit. supra*, n. 2.

12. Woretshofer, *op. cit. supra*, n. 7 at p. 38.

13. 'The High Court of the Hague, Case No. 79065, 0ctober 21, 1986' (edited and translated by Barry A. Bostrom and Walter Lagerwey) (1988) 3 *Issues in Law & Medicine* 445 at p. 448 (emphasis in original). Bostrom and Lagerwey attribute this and other passages from the 'Note,' appended to the report of the case, to Att.-Gen. Remmelink. As the initials 'G.E.M.' at the end of the 'Note' indicate, it is in fact by Mulder.

14. N.J. (1985) No. 106, 451 at p. 453 (translated by Gevers, *op. cit. supra*, n. 10 at pp. 159–160).

15. Abstract (prepared from a translation and summary by Dr. Walter Lagerway) of H.R.G. Feber, *'De wederwaardigheden van artikel 293 vanhet Wetboek van Strafrecht vanaf 1981 tot heden'* ('The Vicissitudes of Article 293 of the Penal Code from 1981 to the Present') in G.A. van der Wal (ed.), *Euthanasie: Knelpunten in Een Discussie* (*'Euthanasia: Bottlenecks in a Dicussion'*) (1987), pp. 54–81 in (1988) *Issues in Law & Medicine* 455 at p. 458 (emphasis in original).

16. N.J. (1987) No. 608.

17. Faber. *op. cit. supra*, n. 15 at p. 462.

18. *Ibid.* at pp. 463–464.

19. *Ibid.* at p. 462.

20. N.J. (1987) No. 607.

21. See *op. cit. supra*, n. 13.

22. *Ibid.* at pp. 445–446 (emphasis in original). The court held: 'The Court of Appeal should have considered whether the accused, as she arrived at her decision and proceeded to execute it, acted in emergency [*noodtoestand*] or psychological compulsion [*psychische overmacht*]': N.J. (1987) No. 607 at p. 2124. In his 'Note' appended to the report of the case, Mulder explains: 'the Supreme Court considered it possible that, in view of the

determined facts, the accused acted through psychological compulsion [*psychische overmacht*], under the influence of a constraint she was not obliged to resist. This consideration is grounded in the conviction of the Court that the accused was in all sincerity convinced that she, being a physician, ought not to act otherwise than to let the patient, in the condition she was in, die, in view of the suffering and the urgent claim she made on the accused to let her die': N.J. (1987) No. 607 at p. 2129. He adds that two differences strike him between the Supreme Court decisions of 1984 and 1986. One is that in the 1984 case the accused was the patient's physician whereas in the 1986 case she was not. The other is that in the latter decision, the court 'provides an appeal to psychological compulsion [*psychische overmacht*] a chance of success': *ibid.*

23. *Op. cit. supra*, n. 13 at p. 446.
24. Because, says Leenen, she did not consult another doctor: *op. cit. supra*, n. 8 at p. 202. A further appeal to the Supreme Court was dismissed: N.J. (1989) No. 391. Att.-Gen. Remmelink informed me that, in the light of this case, psychological compulsion is only a 'theoretical' defence, especially for doctors, whom the courts expect to act in a professional manner (Interview, November 26, 1991).
25. E. Borst-Eilers, 'The Status of Physician-Administed Active Euthanasia in the Netherlands' (paper delivered at the Second International Conference on Health Law and Ethics, London. July 1989), p. 3 See also Leenen. *op. cit. supra*, n. 8 at p. 200; Sluyters. *op. cit. supra*, n. 4 at p. 41: Gevers, *op. cit. supra*, no. 10 at p. 158.
26. Interview, July 10, 1989. In the *Alkmaar* case the Appeal Court ruled that although the accused had consulted his assistant and Mrs. B.'s son, their opinions were insufficiently independent. The Supreme Court held that this did not prevent the euthanatising of Mrs. B. from being an act in 'emergency' according to 'objective medical judgment': N.J. (1985) No. 106 451 at p. 453. Again, A.N.A. Josephus Jitta, a public prosecutor, has written that the requirement of a second opinion was 'abandoned once by the Dutch Supreme Court in 1987' when it dismissed the case against a doctor who had been prosecuted solely because he had not consulted: 'The Right to Euthanasia in the Terminal Period' in *The Right to Self-Determination: Proceedings of the 8th World Conference of the International Federation of Right to Die Societies* (1990), 47 at p. 48.
27. 'Court of The Hague (Penal Chamber) April 2, 1987' (edited and translated by Barry A. Bostrom and Walter Lagerwey) (1988) 3 *Issues in Law & Medicine* 451.
28. *Ibid.* at p. 452. Affd. by Supreme Court, N.J. (1988) No. 811.
29. *Op. cit. supra*, n. 15 at p. 462. The prosecutor had sought the advice of the K.N.M.G. about the defence of necessity and, when the Association replied that euthanasia was permissible if the patient was suffering unbearably and made a free and well-considered request, had moved for the prosecution to be dismissed: *ibid.* at p. 461.
30. *Op. cit. supra*, n. 10 at p. 158.
31. '*Standpunt inzake euthanasie*' ('Standpoint on Euthanasia') (1984) 39 *Medisch Contant* 990. Quotations from the Report are taken from a translation by the K.N.M.G. entitled 'Vision on Euthanasia' (hereafter '*Vision*'). The translated version states that it has updated the Report on a few points to take account of developments in law, politics and within the K.N.M.G. until the end of 1986.
32. *Op. cit. supra*, n. 25 at p. 3.
33. In collaboration with the National Association of Nurses.
34. 'Guidelines for Euthanasia' (translated by Lagerwey) (1988) 3 *Issues in Law and Medicine* 429 (hereafter '*Guidelines*').
35. *Vision*, at pp. 8–11.
36. *Guidelines*, at pp. 431–433.
37. *Vision*, at p. 8.
38. *Ibid.*, at p. 9.
39. *Guidelines*, at p. 431.
40. *Vision*, at p. 9.
41. *Guidelines*, at p. 432.
42. *Vision*, at p. 9.
43. *Ibid.*, at p. 10.
44. *Guidelines*, at p. 432.
45. *Vision*, at p. 10.
46. *Ibid.*
47. *Ibid.*, at p. 11.
48. *Ibid.*
49. See text to n. 30, *supra*.
50. *Vision*, at p. 12.
51. *Ibid.*
52. *Ibid.*, at pp. 12–13.
53. *Ibid.*, at p. 14.
54. Borst-Eilers, *op. cit. supra*, n. 25 at p. 5.
55. *Ibid.*
56. *Ibid.*
57. Interview with public prosecutor, Alkmaar, December 7, 1990.
58. Leenen, *op. cit. supra*, n. 8 at p. 200.
59. Interview with public prosecutor, Rotterdam, July 31, 1989.
60. Working Party of the Church of England's Board for Social Responsibility, *On Dying Well: An Anglican Contribution to the Debate on Euthanasia* (1975), p. 62.
61. Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Report 20 (1983)), p. 18.
62. *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia* (1988) at pp. 4, 6, 31, 59.
63. Henk Rigter, 'Euthanasia in the Netherlands: Distinguishing Facts from Fiction' (1989) 19(1) *Hastings Center Report* 31.
64. H.J.J. Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands' (1989) 8 *Medicine and Law* 517 at p. 523. See also M.A.M. de Wachter, 'Active Euthanasia in the Netherlands' (1989) 262 *J.A.M.A.* 3316 at p. 3317.
65. H.J.J. Leenen, 'The Definitions of Euthanasia' (1984) 3 *Medicine and Law* 333 at p. 334.
66. *Ibid.*
67. *Ibid.*
68. See text to n. 14, *supra*.
69. See text to n. 25, *supra*.
70. *Guidelines*, at p. 432.
71. Interview, July 26, 1989. 'Not wanting to be a (continued) burden on family/surroundings' was mentioned by 22 per cent of patients in van der Wal's survey as a reason for requesting euthanasia: *op. cit. infra*, n. 78 at p. 214, table 5.
72. See text to n. 39, *supra*.
73. Interview, July 24, 1989.
74. Yale Kamisar, 'Some Non-Religious Views against Proposed "Mercy-killing" Legislation' (1958) 42 Minn. L. Rev. 969, in Dennis J. Horan and David Mall (eds.), *Death, Dying and Euthanasia* (1980) 406 at p. 425.
75. *Ibid.*
76. *Guidelines*, at p. 432.
77. Interview, Martens, July 24, 1989.
78. G. van der Wal *et al.*, '*Euthanasie en hulp bij zelfdoding*' ('Euthanasia and Assisted Suicide') (1991) 46(7) *Medisch Contact* 211 at pp. 212–214, tables, 2, 3, 4 & 7. This paper is the third of four published in the K.N.M.G. journal in February 1991 which contain the methodology and results of van der Wal's survey. The papers have been translated by the Hemlock Society. Quotations are taken from this unpublished translation: page references are to the journal.
79. *Op. cit. supra*, n. 74 at p. 427.
80. *Vision*, at pp. 10–11.
81. *Op. cit. supra*, n. 78 at p. 214, table 5.
82. See generally Kamisar, *op. cit. supra*, n. 74 at pp. 430–435.
83. Interview, Gunning, August 2, 1989. Dr P. Sluis, a founder

in 1987 of the Dutch Hospice Movement, has observed that palliative care is not very good in The Netherlands: 'The Dutch Hospice Movement' in *op. cit. supra*, n. 26, 97 at p. 103.

84. *Op. cit. supra*, n. 74 at p. 429.

85. See text to n. 26, *supra*.

86. This was stated by Sutorius in an interview on July 10, 1989. There is, indeed, no legal requirement that the second doctor should even see the patient and a public prosecutor told me that it has by no means been a universal practice for the second doctor to see the patient: Interview, Rotterdam, July 31, 1989.

87. G. van der Wal *et al.*, *'Toetsing in geval van euthanasie of hulp bij zelfdodtng'* ('Verification in Euthanasia or Assisted Suicide') (1991) 46(8) *Medisch Contact* 237 at p. 239 (emphasis in original).

88. *Ibid.*, at p. 240.

89. Henk Rigter *et al.*, 'Euthanasia across the North Sea' (1988) 297 B.M.J. 1593 at p. 1594.

90. *Op. cit. supra*, n. 64 at p. 3316. See also C.I. Dessaur and C.J.C. Rutenfrans, 'The Present Day Practice of Euthanasia' (1988) 3 *Issues in Law & Medicine* 399 at p. 400.

91. G. van der Wal *et al.*, *'Euthanasie en hulp bij zelfdoding door huisartsen'* ('Euthanasia and Assisted Suicide by General Practitioners') (1991) 46(6) *Medisch Contact* 171. See also *ibid.*, at pp. 174–176. The study's assumption seems questionable for, as Admiraal informed me, only 30 per cent of deaths occur at home. Interview, July 27, 1989.

92. See letter by K.F. Gunning (1991) 338 *Lancet* 1010: Paul J. van der Maas *et al.*, 'Euthanasia and Other Medical Decisions Concerning the End of Life,' *ibid.*, at p. 669. See generally *Rapport van de commissie onderzoek medische praktijk inzake Euthanasie* (SDU uitgeverij, Den Haag, 1991).

93. Personal communication from Ministry of Justice, November 29, 1991.

94. *Op. cit. supra*, n. 63 at p. 32. Almost half of the G.P.s in van der Wal's study had made no record of their last euthanasia case and, of those who had, fewer than half had done so in the form of a separate record: *op. cit. supra*, n. 87 at p. 240. His general conclusion is that 'a substantial proportion of general practitioners is not (yet) operating in accordance with current procedural precautionary requirements': *ibid.*, at p. 241.

95. Interview, August 1, 1989.

96. Interview, July 11, 1989.

97. Interview, Alkmaar, December 7, 1990.

98. 'A Case against Dutch Euthanasia' (1989) 19(1) *Hastings Center Report* 22 at p. 25.

99. *Ibid.*, at p. 30. See also (1990) 6 *Issues in Law & Medicine* 229.

100. Quoted in Barry A. Bostrom, 'Euthanasia in the Netherlands: A Model for the United States?' (1989) 4 *Issues in Law & Medicine* 467 at p. 477.

101. I. van der Sluis, 'The Practice of Euthanasia in the Netherlands' (1989) 4 *Issues in Law & Medicine* 455 at p. 463.

102. F.C.B. van Wijmen, *Artsen en het Zelfgekozen Levenseinde'* (*'Doctors and the Self-Chosen Termination of Life'*) (1989) 24, table 18. Van Wijmen observes that as cases of 'pseudo-euthanasia' (such as the withdrawal of futile treatment) were expressly excluded in the question, the answers are 'amazing': *ibid.* See also *op. cit. supra*, n. 90 at pp. 401–402.

103. Personal communication, Jochemsen, September 12, 1991. See also van der Maas *et al.*, *op. cit. supra*, n. 92 at p. 671.

104. Sluyters, *op. cit. supra*, n. 4 at p. 42. See also Ph. Schepens, 'Euthanasia: Our Own Future?' (1988) 3 *Issues in Law & Medicine* 371 at pp. 376–377: Fenigsen, *op. cit. supra*, n. 98 at p. 25.

105. Interview, August 1, 1989.

106. *Vision*, at p. 14.

107. See text to n. 10, *supra*.

108. Eugene Ph. R. Sutorius, *A Mild Death for Paragraph 239 of the Netherlands Criminal Code?* (1986), p. 7.

109. *Bolam v. Friern Hospital Management Committee* (1957) 1 W.L.R. 582.

110. *Op. cit. supra*, n. 15 at p. 458. See also *ibid.*, at p. 459.

111. *Op. cit. supra*, n. 8 at p. 201.

112. *Op. cit. supra*, n. 13 at p. 449.

113. *Ibid.*, at p. 446. A leading Dutch practitioner of euthanasia, Dr. Admiraal, has stated that he sees no moral difference between intentionally killing a patient and accelerating his death by administering analgesic drugs, even though the hastening of death is merely foreseen. He regards drawing any moral distinction as hypocritical and as a 'ridiculous way out of responsibility' (Interview, July 25, 1989). He thus elides a distinction which can be crucial for both legal and moral purses. For example, in English law, the doctor who intentionally kills his patient to alleviate pain commits the offence of murder: by contrast, if the doctor intends solely to alleviate pain and the acceleration of death is an undesired side-effect, even though it is foreseen as certain, he does not. See the Rt. Hon. Lord Goff of Chieveley, 'The Mental Element in the Crime of Murder' (1988) 104 L.Q.R. 30 at pp. 44–46. For a discussion of the ethical distinction which can exist see *The Principle of Respect for Human Life* (Linacre Centre Paper 1, 1978) and *Is There a Morally Significant Difference between Killing and Letting Die?* (Linacre Centre Paper 2, 1978). See generally John Finnis. 'Intention and Side-effects' in R.G. Frey and Christopher W. Morris (eds.), *Liability: New Essays in Legal Philosophy* (1991), p. 32.

114. *Op. cit. supra*, n. 4 at p. 35.

115. N.J. (1985) No. 106, 451 at p. 452.

116. *Op. cit. supra*, n. 13 at p. 449.

117. Marian H.N. Driesse *et al.*, 'Euthanasia and the Law in the Netherlands' (1988) 3 *Issues in Law & Medicine* 385 at pp. 386–387.

118. *Ibid.*, at p. 387.

119. N.J. (1987) No. 607 at p. 2131. In his 'Note' appended to the report of the *Alkmaar* case, Professor van Veen explains: 'there might be situations in which also the non-physician might appeal successfully to necessity. In his case, an appeal to psychological constraint [*psychische dwang*] would much rather apply than an appeal to emergency in the sense of ''conflict of duties'' '; N.J. (1985) No. 106, 451 at p. 467.

120. *Op. cit. supra*, n. 7 at p. 10.

121. See, *e.g.* Henriette D.C. Roscam Abbing, 'Dying with Dignity, and Euthanasia: A View from the Netherlands' (1988) 4 *Journal of Palliative Care* 70.

122. *Op. cit. supra*, n. 7 at p. 1.

123. *Ibid.*, at p. 7.

124. See text n. 65, supra. An example of this is to be found in a letter to the editors of the *Hastings Center Report* in reply to the article by Fenigsen, *op. cit. supra*, n. 98. Signed by many of the leading Dutch defenders of euthanasia it cites Leenen's definition and then states that 'euthanasia' is, therefore, necessarily voluntary, and adds that the killing of incompetent patients is not a part of the euthanasia problem: 'Letters,' *ibid.*

125. Interview, July 11, 1989.

126. *Ibid.*

127. 'Final Report of the Netherlands State Commission on Euthanasia: An English Summary.' (1987) 1 *Bioethics* 163 at p. 168.

128. *Vision*, at p. 3.

129. *Discussienota inzake levensbeeindigend handelen bij wilsonbekwame patienten, deel 1: zwaar-defecte pasgeborenen (Discussion paper on the termination of life of severely handicapped new-born infants)* (1988), cited by Sluyters, *op. cit. supra*, n. 4 at p. 35.

130. Interview, Gunning, August 2, 1989.

131. Personal communication from Gunning, April 27, 1991, about the second report (entitled 'Treatment of Patients in Prolonged Coma') of the K.N.M.G.'s Committee on the Acceptability of Life-ending Treatment.

132. Interview, July 27, 1989. Similarly, Professor Dupuis, an ethicist and ex-President of the D.V.E.S., has said that she accepts that in some cases a permanently comatose patient should be killed, as where the diagnosis was clear, stopping treatment merely increased the patient's suffering and there

was a consensus that the patient's life was senseless (Interview, July 28, 1989: See also 'The Right to a Gentle Death' in *op. cit. supra*, n. 26, 53 at pp. 55–56.) Again, Mrs Tromp-Meesters, asked whether the requirement of a request did not deprive those too young or too old to make a request of a right to be relieved of suffering replied: 'Yes, I think so, and that could never be, in my view, the decision of one doctor: that should be a team of two or three people.' She added that her Society had not ruled out non-voluntary euthanasia and was still considering the matter (Interview, July 11, 1989).
133. C. van der Meer, 'Euthanasia: A Definition and Ethical Conditions' (1988) 4 *Journal of Palliative Care* 103 at p. 104.
134. *Op. cit. supra*, n. 74 at pp. 468–469.
135. *Ibid.*, at pp. 451–467.
136. *Ibid.*, at p. 467.
137. See text to pp. 122–123, *supra*.
138. *Op. cit. supra*, n. 10 at p. 162.
139. *Op. cit. supra*, n. 7 at pp. 7–8.
140. See text to n. 123, *supra*.
141. Interview, Martens, July 11, 1989.
142. 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients' (paper delivered at the Conference on euthanasia, Instituut voor Gezondheidsethiek, Maastricht, December 2–4, 1990), p. 6. Similarly, Dr. Gomez concludes: 'on the core issues of the controversy—how to control the practice, how to keep it from being used on those who do not want it, how to provide for public accountability—the Dutch response has been, to date, inadequate': Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (1991) at p. 133. My review of this book appears in a special supplement of the *Hastings Center Report* (March 1992) on Dutch euthanasia.
143. *Ibid.*, at p. 11.

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