

# Summary <sup>1</sup>

## INTRODUCTION

The process of legal change with regard to euthanasia in the Netherlands began with public debates on the issue in the 1970s, and ended – at least for the time being – when the Law on Termination of Life on Request and Assisting Suicide was approved by the Dutch Parliament in 2001. I will summarise the book by describing the process of legal change in terms of the interplay of the various social actors who contributed to the making of the ‘requirements of careful practice’ – the judiciary, the medical profession, pressure groups, legal scholars and Parliament. Dealing in this summary way with each of their contributions in turn allows me to call attention to two secondary themes. The first highlights the unusual role played by the Royal Dutch Medical Association (KNMG) in the process. Its strategy may be explained by examining features of the Dutch elite and the Association’s recent history. The second disposes of a popular misconception regarding the so-called ‘policy of forbearance’ in the Netherlands.

Three articles of the Dutch Criminal Code are of particular importance in connection with euthanasia and assisting suicide: articles 40, 293 and 294.<sup>2</sup>

Article 40 states: A person who commits an offence as a result of a force he could not be expected to resist [*overmacht*] is not criminally liable.

Article 293: A person who takes the life of another person at that other person’s express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.

Article 294: A person who intentionally incites another to commit suicide, assists in the suicide of another, or procures for that other person the means to commit suicide, is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues.<sup>3</sup>

At the time the process of legal change began, a number of doctrinal approaches were in theory available to legitimate behaviour that at face value violates articles 293 and 294 of the Criminal Code. A first defence against a charge under articles 293 and 294 is the ‘medical exception’, which holds that, like other offences against the person, the two articles are implicitly not applicable to doctors. A second defence could be based on the doctrine of ‘absence of substantial violation of the law’: the idea that behaviour that violates the letter but not the purpose of the law does not constitute an offence. A third possible defence is offered by article 40 of the Criminal Code. This defence has two variants in Dutch law: the excuse of duress and the justification of necessity. The courts have held that the excuse of duress is not available to doctors in the case of euthanasia, since doctors are expected to be able to resist the pressures brought to bear by their patients. The justification of necessity applies to someone who, in a situation of conflict of duties, chooses to favour the value that from an objective standpoint is more important, even if this means doing something that in itself is forbidden. This defence was in the end the basis for the legalisation of euthanasia.

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<sup>1</sup> Published in slightly different form in Klijn e.a. 2001.

<sup>2</sup> The legal background is described in chapter 1.

<sup>3</sup> See for this translation Rayar and Wadsworth 1997: 73, 200.

In the 1960s and 1970s<sup>4</sup> the term 'euthanasia' was used to describe a large and varied range of behaviour that leads to the earlier death of the patient. This included refraining from treatment because of medical futility or because of the patient's refusal, death as a side effect of pain relief, and actively ending a patient's life (with or without his request). In 1977, a Dutch specialist in health law formulated a definition of euthanasia that in 1985 was largely adopted by the State Commission on Euthanasia. Since then, in the Netherlands, euthanasia has officially been defined as 'intentionally terminating another person's life at that person's request'.<sup>5</sup> This definition coincides with the act specifically prohibited by article 293 of the Criminal Code. (When a distinction is made between the offences covered by the articles 293 and 294, the term 'euthanasia' is reserved for killing on request - article 293 - as opposed to assisting suicide, but generally the two are treated together. In this summary I will follow this practice and use the term 'euthanasia' to cover both.)

Before 1970 there was a general lack of interest in euthanasia and very little had been written on the issue in Dutch. This did not change much even when, in 1952, a doctor stood trial for killing his brother at the latter's request. However, at the beginning of the 1970s this situation radically changed and euthanasia became very much a topic for public debate. Several developments lead to this change.

The 1960s were a crucial watershed for Dutch society. From a conservative, tradition-bound country the Netherlands changed into a hotbed of social and cultural experimentation. The Netherlands took a prominent place in the sexual revolution, the legalisation of abortion, the democratisation of social institutions, the questioning of religious authority, and so forth. Societal relationships also changed in this period, becoming more 'democratic', with a narrowing of the social distance between ordinary people and those in positions of authority. The Dutch came to expect to have their views listened to on issues that affect them. Similarly, the 1960s brought changes in views concerning the doctor-patient relationship, including a general acceptance of the idea of patient autonomy reflected in the doctrine of 'informed consent'.

Another circumstance associated with the growing interest in euthanasia was the development of medical technology. Such developments are assumed to have led to questions of a medical and ethical nature fundamentally different from any that had been asked before. In effect, doctors now had the ability to postpone death even when recovery was impossible. But prolonging life does not always go hand in hand with making it more bearable. Doubts concerning an unconditional 'duty to preserve life' became more and more insistent. If the answer to the duty question is 'no', and a doctor may decide not to engage in treatment that would prolong the patient's life, either because the patient does not want this or because it is not in his interest to do so, then the question soon arises whether there is a major difference between acting and refraining from action. In 1967, widespread public attention was attracted by a dramatic case to the question of whether it is permissible to end the life of a patient in a long and irreversible coma. A final stimulus to public debate was a book on medical ethics by a well-known Dutch doctor. His argument, formulated in an unusually provocative way, was that medical ethics must adjust to changes in medical technology, and that the motto of a new ethical code should be: "[I]t is the doctor's duty to pre-

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<sup>4</sup> The process of legal change with regard to euthanasia in the 1960s and 1970s until 1978 is described in chapter 2 and 3.

<sup>5</sup> The State Commission notes that a broad consensus exists that not beginning or stopping a medical treatment because it is seen as futile or is refused by the patient, and pain relief that leads to earlier death, fall under 'normal medical practice'. In effect, this means they are covered by the 'medical exception'.

serve, spare, and prolong human life whenever doing so makes sense".<sup>6</sup> He reasoned that a doctor may passively or actively shorten life that is no longer 'meaningful'.

#### THE FIRST CONTRIBUTORS TO THE 'REQUIREMENTS OF CAREFUL PRACTICE': COURTS, PRESSURE GROUPS AND LEGAL SCHOLARS<sup>7</sup>

In the 1970s formulations of what came to be called the 'requirements of careful practice' for legal euthanasia can be found in three sources: reports of medical organisations and pressure groups, individual opinions, and court decisions.

##### DISTRICT COURT LEEUWARDEN

In 1973, a doctor stood trial for killing her mother at the latter's request. At the trial, the medical inspector testified that the average doctor in the Netherlands no longer considered it necessary to prolong a patient's life endlessly. In his opinion, pain relief that runs the risk of the patient dying sooner had, under certain conditions, become widely acceptable in medical circles. The conditions mentioned by the inspector were:

- that the patient is incurably ill;
- that the patient finds his suffering mentally or physically unbearable;
- that the patient has expressed the wish to die;
- that medically speaking the patient is in the terminal phase of illness; and
- that it is a doctor who accedes to the request, preferably the doctor responsible for treatment.

The District Court largely agreed with the inspector's opinion although it did reject the requirement of the terminal phase. The Court convicted the defendant of having administered the morphine "too quickly".<sup>8</sup> Despite the apparent confusion between pain relief and euthanasia, the verdict of the District Court was the first authoritative formulation of the conditions for the legal shortening of life.

##### THE CONTRIBUTION OF PRESSURE GROUPS AND OPINION LEADERS

The conditions under which euthanasia is legal can be divided into substantive and procedural requirements. The substantive requirements refer to the request, the situation of the patient, and the doctor-patient relationship. Wide endorsement has from the beginning of the process of legal change in the Netherlands been found for the requirement that the patient himself must clearly express a wish to have his life ended.

There has also from the beginning been general agreement that the patient's illness should be incurable. Substantial agreement has also always existed as to the requirement of suffering. The Dutch Association for Voluntary Euthanasia (NVVE) proposed that a necessary feature of suffering should be that it is "unbearable and hopeless",<sup>9</sup> and a working group of the Dutch Medical Association (KNMG) proposed that it should not be possible to relieve it by any other means.

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<sup>6</sup> Van den Berg 1969: 47.

<sup>7</sup> Covered in chapter 3 and 4.

<sup>8</sup> *Nederlandse Jurisprudentie* 1973, no. 183.

<sup>9</sup> NVVE 1978: 26.

Participants in the public debate disagreed whether it is necessary that the patient be in the 'terminal phase'. Lawyers supported the Leeuwarden Court's view that 'terminal phase' should not be a prerequisite for legal euthanasia. Until the 1990s there were others, including at one point the Minister of Justice, who took the position that euthanasia is only warranted in the terminal phase.

The condition that it must be a doctor who accedes to the patient's request was early on emphasised by the Medical Association and has from the beginning been supported by nearly everyone. Whether the doctor must be the doctor responsible for the patient's treatment became a subject for discussion in the 1990s.

Although neither the inspector nor the Leeuwarden Court mentioned consultation as a requirement, the working group of the Medical Association argued in 1975 that a doctor considering euthanasia ought to discuss the matter with a colleague. A lawyer specialised in health law agreed this should be a prerequisite. He argued also for careful documentation.

#### DISTRICT COURT ROTTERDAM

The next formulation of the requirements for legal euthanasia by a court took place in 1981, when a woman, this time not a doctor, stood trial for having assisted the suicide of a friend. The District Court of Rotterdam commented that suicide is not necessarily unacceptable in all situations and that the assistance of others can sometimes be indispensable. However, in the light of the prohibition in article 294 of the Criminal Code, such assistance can only be justifiable if certain requirements are met.

The verdict of the District Court emphasises that the request for help must be voluntary, well-considered, lasting, and taken after being fully informed of the situation. Again the 'terminal phase' is rejected as a necessary condition. Other conditions mentioned are: physical or mental suffering, prolonged and unbearable suffering, no alternative to improve the situation, and the help is given by a doctor. A new procedural requirement was added: care should be taken to avoid unnecessary suffering by relatives. The District Court held that the defendant had not met these requirements and found her guilty of assisting suicide.

Following this verdict, the Committee of Procurators-General, the highest national authority in the prosecution system, decided that every case of death on request (article 293) or assisting suicide (article 294) that came to the attention of a prosecutor should be referred to the Committee for a decision on whether to prosecute. The object was to achieve national uniformity in prosecution policy. The conditions as formulated in the two cases described above were to serve as guidelines for the decisions of the Committee. Although there had been cases before 1982 in which doctors had not been prosecuted after carrying out euthanasia, we can only speak of a prosecution policy with regard to euthanasia after this decision of the Committee of Procurators-General. In a later section I will return to the role the prosecution authorities played in the process of legal change.

#### THE CONTRIBUTION OF THE MEDICAL PROFESSION

We can learn what conditions doctors themselves thought important both by looking at the official position taken by the Medical Association in 1984 and from the behaviour of doctors themselves as reported by their writings and reflected in the information they gave in cases that came to court.

## INDIVIDUAL DOCTORS<sup>10</sup>

In almost all cases the doctor claimed the patient had made a clear request for euthanasia. The way the request was expressed differed: sometimes it was written, sometimes not. In all cases the patient indicated that the suffering was unbearable and the doctor could agree that this was the case. Besides the level of suffering, doctors gave other reasons for their decisions, including their inability to relieve the suffering in any other way and their concern that the patient should die with dignity. Most doctors did not consider the terminal phase a prerequisite for carrying out euthanasia.

Few doctors consulted an independent colleague. Sometimes doctors discussed the case with other professionals such as pastors and nursing personnel. Members of the patient's family were nearly always involved in the decision-making. Sometimes relatives were not consulted, only informed, about the impending euthanasia, but often their approval was sought or they were asked to confirm the patient's request.

Doctors often filed certificates of natural death, thereby in effect concealing what they had done from the prosecution authorities. However, this did not necessarily mean that they had been secretive with others about the euthanasia. For example, two doctors later prosecuted for improperly filing certificates of natural death had talked about their intentions to other professionals involved with the patient such as a head nurse, and with the relatives.

## THE POSITION OF THE BOARD OF THE MEDICAL ASSOCIATION IN 1984

A new stage in the development of the 'requirements of careful practice' was reached in August 1984, when the Executive Board of the Medical Association published a new policy on euthanasia. The Board stressed that only doctors should be allowed to engage in actions that terminate life. Euthanasia was seen by the Board as an issue to be dealt with within the doctor-patient relationship.

The Board considered euthanasia performed by a doctor acceptable when the doctor has taken adequate steps to conform to the 'requirements of careful practice'. In the first place the request must be voluntary, well considered and lasting. In the second place the suffering of the patient must be 'unacceptable'. With this term the Board meant that the suffering must be lasting, unbearable and hopeless. Consulting a colleague was deemed indispensable, and the practice of filing a certificate of natural death was found unacceptable. In 1992, a full written documentation of the case was added to the list of requirements.

The Board did not mention the importance of discussing the case with the patient's relatives, a requirement that doctors themselves considered to be important. The main difference between the actual behaviour of individual doctors and the position of the Board relates to procedural conditions – the requirements of consulting another doctor and not filing a false certificate. These were requirements doctors often failed to comply with.

## THE ROLE AND STRATEGY OF THE DUTCH MEDICAL ASSOCIATION

Let me digress somewhat at this point to examine the role and strategy of the Medical Association. To date the Dutch Medical Association is the only national professional medical

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<sup>10</sup> Covered mainly in chapter 4 and 5. Chapter 5 deals with the period 1982-1984.

association in the world that has taken an affirmative view on the legalisation of euthanasia. Others, such as the American Medical Association and the Belgian Medical Association, have vigorously opposed legalisation of euthanasia or assisted suicide. Let me here mention some possible explanations for the unusual position of the Dutch Medical Association.

By taking a leading position in the public debate the Dutch Medical Association exhibited a well-recognised feature of the Dutch elite, who in the 1960s, according to James Kennedy,<sup>11</sup> tended to interpret social problems and crises as signs of unavoidable social change. Attempting to forestall change did not seem to them a feasible policy. In Kennedy's view the Dutch elite, after some hesitation, tended to support new ideas and be spokesmen for them.

In the debates on abortion in the 1960s, the Medical Association had acted rather differently and by doing so had got itself into difficulty. The social acceptance of abortion increased during that period and the idea that abortion, carried out by a doctor, fell within the bounds of an implicit 'medical exception' was widely shared. After 1969 a sort of legal vacuum had arisen in which abortion, though still illegal, was in reality available on demand. To satisfy the demand for abortion, special abortion clinics were set up. This development meant that for practical purposes enforcement of the ban on abortion was no longer feasible.

Throughout the period of change in the 1960s, the Medical Association had expressed opposition to abortion, and it was only in 1971, when the struggle was essentially over, that the Medical Association changed position. The Executive Board explained the change by referring to social and political developments that in its view could not be stopped. Its new position was that "the doctor's duty to give medical assistance can entail the decision to perform an abortion when he is asked to assist in an unwanted pregnancy".

The new position of the Association led to vehement debate and a number of doctors took the position that the Executive Board of the Association could not speak for all doctors and that terminating a life violates a doctor's fundamental duty. In 1972 some of these doctors founded the Dutch Association of Physicians, a 'pro-life' organisation.

In the 1980s a number of doctors feared that the Medical Association would follow a similar course in the case of euthanasia. They did not like the idea of once again being by-passed by social and political developments. In 1982 a working group was installed to formulate a policy on euthanasia. The working group drew the lesson from the recent abortion history that it was better to join the public debate in an early phase. There was no longer any reason to fear a split in the organisation since adamantly pro-life doctors had already founded their own association.

The working group artfully avoided the ultimate ethical and legal polemics by stating that it was not its intention to address the question of the permissibility of euthanasia. Euthanasia is a fact of life and the only question is how medical practice can be improved and regulated. The association's Executive Board adopted the working group's formulation of policy in June 1984. During discussions at the general membership meeting on the new policy, the chairman stated that the Board did not want to take a position for or against euthanasia. The purpose of the guidelines was to assist those doctors who were considering performing euthanasia. The debate closed with the assertion that the new policy was that of the Executive Board, and not necessarily that of all Dutch doctors. In taking this strategy the Medical Association avoided openly offending opponents of euthanasia while at the same time it gave a clear signal to the outer world. The Advocate-General of the Supreme

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<sup>11</sup> Kennedy 1995.

Court – who had argued against legalisation in the first case to reach the Court - speculated in his farewell lecture in 1992 that the Association's change of position had functioned as an *amicus curiae* brief in support of the Court's decision later the same year in the first euthanasia case to reach the Court.

## THE CONTRIBUTION OF THE SUPREME COURT

The first time the Supreme Court ruled on a case of euthanasia was on 27 November 1984.<sup>12</sup> The Court held in the *Schoonheim* case that the Court of Appeals had not properly considered the appeal to 'conflict of duty' (article 40).

... one would have expected the Court of Appeals to have considered ... whether, according to responsible medical opinion, subject to the applicable norms of medical ethics, this was, as claimed by the defendant, a situation of necessity.<sup>13</sup>

The Supreme Court considered specifically relevant the patient's "unbearable suffering" (including the prospect of increasing "loss of personal dignity") the risk that it might become impossible for the patient to "die in a dignified manner", and the existence of alternative ways to relieve her suffering. Not having consulted an independent doctor was not in itself a sufficient reason for rejecting the defence of necessity, according to the Supreme Court.

In the second case to reach the Supreme Court<sup>14</sup>, the idea that the 'medical exception' covers euthanasia was explicitly rejected. The Court held that the prohibition of euthanasia in article 293 did not appear to have been intended as subject to an exception for doctors. Furthermore there was no settled social consensus that euthanasia is a form of 'normal medical practice' that could be considered to fall within the 'medical exception'. The Supreme Court did not, however, agree with the Court of Appeals' rejection of the defence of necessity. The Court had not properly considered whether "according to responsible scientific opinion and according to norms applied in medical ethics, there had been a situation of necessity".<sup>15</sup>

In another case, the Supreme Court clarified the question of the death certificate. The Court upheld a decision that a doctor cannot invoke the justification of necessity to a charge of filing a (false) certificate of natural death in a case of euthanasia. Doing so, the Court of Appeals observed, undermines the system of legal control over the termination of life. The defendant's reliance on his oath of secrecy was rejected: this oath gives a doctor the right to remain silent, but not to give false information.

Although from the very beginning, as we have seen, the courts had held that the terminal phase was not a necessary condition, the Minister of Justice in the early 1990s was adamant that it should be, and maintained that the case law was not unambiguous on the point. In 1993, he ordered a number of doctors to be prosecuted on the ground they had not met

<sup>12</sup> The ruling of the Supreme Court in the *Schoonheim* case is one of the subjects of chapter 6.

<sup>13</sup> *Nederlandse Jurisprudentie* 1985, no. 106: 459.

<sup>14</sup> I describe the second and third rulings of the Supreme Court in chapter 7 that deals with the period 1986-1989.

<sup>15</sup> *Nederlandse Jurisprudentie* 1987, no. 607: 2124.

this requirement. In its next decision, in the *Chabot* case, the Court rejected the Minister's position.<sup>16</sup>

The *Chabot* case involved assistance with suicide by a psychiatrist to a woman suffering unbearably from a number of tragedies in her personal life. The Court rejected the argument of the prosecution that the justification of necessity is not available in the case of a patient whose suffering is non-somatic and who is not in the terminal phase.

The Supreme Court's decisions settled the question of the doctrinal basis for legal euthanasia and greatly clarified the conditions with which doctors – the only ones who can legally perform it – must comply. The Court emphasised the importance of the patient's request. The request must, in the terms of article 293, be 'express and earnest'. It must be explicitly made by the person concerned; it must be voluntary and well-considered. The patient's suffering must be 'unbearable' and 'hopeless'. However, the suffering need not be physical nor is a somatic basis required. Non-physical suffering can include such things as the prospect of physical deterioration and not being able to die in a 'dignified' way. Possibilities for treating the suffering must have been exhausted (or, in cases of a somatic illness, rejected by the patient).

In addition to these substantive conditions, the doctor who performs euthanasia must meet a number of procedural requirements. He must take adequate steps to satisfy himself with respect to the substantive requirements; he must consult at least one other doctor who should in principle be independent; if the patient's suffering is of non-somatic origin, the consultant must himself examine the patient. The doctor must not report euthanasia as a natural death.

The substantive requirements for legally justified euthanasia are enforced through the criminal law. It was for some time unclear to what extent conformity with the procedural requirements was necessary for a successful defence to a criminal charge. It seems to be settled now that deviation from these requirements does not necessarily stand in the way of an appeal to the justification of necessity. Thus failure to comply with the oft-stated requirements, such as discussing the case with relatives and other personnel involved with the treatment of the patient, record keeping and carrying out the euthanasia in a professionally responsible way, have in most cases been dealt with by means of a warning from medical disciplinary authorities. The law enacted in 2001 treats only consultation, reporting and professional carrying-out as conditions of legal euthanasia.

## THE FORBEARANCE THESIS REFUTED

It is relevant here to look at the question of whether, and since when, judicial and prosecutorial policy in relation to euthanasia could (before the recent law was enacted) properly be called one of 'forbearance'. Forbearance (*gedogen*) is an accepted legal practice in the Netherlands. Forbearance is one of several possible reactions to a violation of the law and it consists of refraining, on policy grounds, from initiating prosecution. Dutch drug policy, for example, is based on the doctrine. The policy formulated in 1982 by the Committee of Procurators-General can be seen as one of forbearance.

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<sup>16</sup> The policy of the Minister of Justice and the *Chabot* case are subjects of chapter 8. Chapter 8 covers the period 1989-1994.

In 1984, as we have seen, developments in the case law led to a situation in which a doctor who complied with the 'requirements of careful practice' could invoke the defence of necessity based on a conflict of duties. In effect, the decision of the Supreme Court in the *Schoonheim* case made euthanasia in conformity with the requirements legal.

In 1985, the Medical Association tried to get the Minister of Justice to clarify the policy of the prosecution authorities in light of the Supreme Court's decision in the *Schoonheim* case. When asked about this in the Second Chamber of Parliament, the Minister answered: "Broadly speaking, the public prosecutors will not prosecute a doctor, who in carrying out euthanasia complied with the requirements of careful practice developed in the case law and formulated by the Dutch Medical Association".<sup>17</sup>

The conclusion that a doctor who complies with the 'requirements of careful practice' could be assured of not being prosecuted for euthanasia was supported by a decision of the Supreme Court in 1987. In this case a doctor who had carried out euthanasia requested the Court of Appeals to quash the indictment when criminal charges were brought. The Court of Appeals held that the undisputed facts required the conclusion that prosecution of the doctor for euthanasia could not succeed, since if the case went to trial it would soon become evident that the defendant had acted in a situation of necessity. The Supreme Court rejected the prosecution's appeal on the ground that the arguments given by the Court of Appeals formed a sufficient basis for its conclusions. The Supreme Court in this way definitively settled the matter: a doctor could indeed count on not being prosecuted as long as he has met the 'requirements of careful practice'.

These developments fundamentally changed the position of the public prosecutors. The Minister's statement made prosecution unlikely, but the verdict of the Supreme Court gave prosecution no prospect of success. Since the prosecution authorities were no longer confronted with a violation of the law, decisions not to prosecute were henceforth based on legal rather than policy considerations, and it became impossible to describe the non-prosecution of doctors after 1984 as due to a policy of forbearance.

In short, Dutch euthanasia policy was only for a short period a policy of forbearance. Since 1984/1985, euthanasia, when carried out by a doctor who has complied with the 'requirements of careful practice', has simply no longer been unlawful.

A second remark about Dutch forbearance policy is in order. Forbearance is often painted in negative terms. It is widely associated with turning a deaf ear or a blind eye to something, and thus doing nothing. Characterising the policy of the public prosecutors in the case of euthanasia in such a way does no justice to the facts. For example, in the first prosecution after the new prosecution policy in 1982, the local prosecutor was of the opinion that the doctor in question had complied with the 'requirements of careful practice'. Nevertheless, the Committee of Procurators-General made the decision to prosecute. The Committee doubted whether the doctor's assistant could be deemed an independent consultant and sought to clarify exactly what consultation entails. In other words, the policy of forbearance went hand in hand with active efforts to promote further development of the 'requirements of careful practice'.

The efforts of individual prosecutors to get doctors to report cases of euthanasia are another example of the active involvement of the prosecution authorities in policy development. The best known example is the local prosecutor in the judicial district of

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<sup>17</sup> *Second Chamber of Parliament 1985-1986, Appendix, no. 359.*

Alkmaar. In the early 1980s, reporting a 'non-natural death' (euthanasia) was highly unattractive to doctors: it involved an investigation by the police with substantial emotional and practical consequences not only for the doctor but also for the relatives of the patient. The prosecutor in Alkmaar designed a procedure by which doctors could report euthanasia without having to undergo such unpleasantness. He promised the doctors in his district that they would not be troubled by the police if, in cases of euthanasia, they alerted the coroner and submitted a full written report. Evidence that the policy bore fruit is to be found in the rapidly increasing rate of reporting in the district of Alkmaar.

Another example of the active attitude of the prosecution authorities is the involvement of individual prosecutors in the formulation of protocols and guidelines for euthanasia by institutions such as hospitals and nursing homes. In the period 1989-1994 the number of Dutch hospitals and nursing homes to have an internal euthanasia policy rose considerably. Most of these policies reflect the emerging legal norms and in many cases local prosecutors were actively involved in stimulating and assisting the institutions concerned.

#### THE CONTRIBUTION OF PARLIAMENT AND THE FINDINGS OF EMPIRICAL RESEARCH

Until 1980, the role of political actors was very small in the process of legal change concerning euthanasia. However, from 1980 onwards political parties started to publish their points of view and in 1984 the first bill reached Parliament. The author of the bill thought that both the person who requested euthanasia and the doctor who agreed to carry it out were exposed to an unacceptable degree of legal insecurity. Regulation of euthanasia, in her view, was the responsibility of the legislature. Her bill was the first of a series of parliamentary efforts to deal with the problem of euthanasia.<sup>18</sup>

In 1985, the State Commission on Euthanasia brought out a divided advice in which a strong majority pleaded for legalisation. The government – a coalition of Christian Democrats (CDA) and a right-of-centre liberal party (VVD) – in its reaction to the report, was inclined to the view that the time was not yet ripe for such a change. In case Parliament should be of a different view the government submitted a so-called 'Discussion Draft of a Bill'. A year later this 'Discussion Draft' was dropped in favour of a proposal to standardise 'the requirements of careful practice' in the Law on Medical Practice, but to leave the Criminal Code unchanged. However, before Parliament could deal with the proposal, the cabinet fell.<sup>19</sup>

The following Government – a coalition of Christian Democrats and the Labour Party (PvdA) – proposed that before changing the law, there should be a national study of the practice of euthanasia. Such research could only take place with the co-operation of the medical profession. To ensure their co-operation one of the Medical Association's long-held wishes was met: a procedure was adopted for reporting euthanasia including guidelines for the police and prosecutorial reaction, so that matters relating to euthanasia could be handled as discretely as possible.<sup>20</sup>

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<sup>18</sup> The introduction of this first bill and the advice of the State Commission on Euthanasia are two of the major events of the crucial period 1984-1986, described in chapter 6.

<sup>19</sup> In chapter 7 I discuss the proposal to add the 'requirements of careful practice' to the Law on Medical Practice.

<sup>20</sup> I describe the study and the political discussion surrounding it in chapter 8.

The study showed that in 1990 almost 50,000 deaths (38% of all deaths) were preceded by a decision of a doctor to do something likely to lead to the earlier death of the patient. The vast majority of these decisions were decisions to abstain from treatment (22,500 deaths = 17.5% of all deaths) and to relieve pain with the risk of hastening death (22,500 deaths = 17.5% of all deaths). In 2700 cases (2.1% of all deaths) the death was due to euthanasia (2300) and assistance with suicide (400). The researchers estimated that doctors did not fulfil 4000 concrete requests. In 1000 cases (0.8%) the doctor had terminated the life of the patient although the patient had not explicitly requested this.

By 1990 all doctors were aware of the substantive conditions and procedural safeguards applicable to euthanasia. As might be expected, the requirements that doctors themselves considered important were most often complied with. Euthanasia requires by definition an explicit request from the patient and doctors considered this request in almost all cases to come 'entirely from the patient himself'. The extent to which life was shortened was a month or less in 90% of the cases. At the time the decision to carry out euthanasia was made, in almost 90% of cases the current treatment was only palliative and in the remaining 10% it was aimed at prolonging life, not at cure. In about 80% of the cases there were no longer any treatment alternatives, and in almost all the remaining cases the patient did not want further treatment.

In 1993 Parliament gave legal status to the reporting procedure as that had been adopted in 1990. In 1994 a new government was formed in which, for the first time in modern Dutch political history, none of the confessional parties was represented. This government initiated a replication of the national research.<sup>21</sup> In 1995 almost 60,000 deaths (42% of all deaths) resulted from a decision of a doctor that he knew would probably shorten the patient's life: 3200 cases of euthanasia (2.4%); 400 cases of assistance suicide (0.3%); 900 cases of termination of life without a request (0.7%); in 25,100 cases (18.5%) the doctor gave pain relief accepting the risk the patient would die; in 27,100 cases (20%) the patient died after a decision to abstain from treatment.

In 1995 there were 9400 concrete requests, of which about one in three actually resulted in euthanasia. The number of written requests increased from 35% in 1990 to 59% in 1995. In 92% of the cases of euthanasia the doctor had discussed the case with a colleague (84% in 1990) and in 79% the consultation was formal. The consulted doctor was seldom entirely independent. According to the findings, doctors discussed the situation with the family in 93% of all cases. It seems remarkable that a condition that has never attracted much attention from the KNMG, the courts, or other enforcing agencies has nevertheless remained so prominent in medical practice. Discussion with nursing staff took place in about a third of all cases of euthanasia and virtually across the board the frequency of discussion with nursing staff declined between 1990 and 1995.

From the 1995 research it became clear that the rate of reporting, while much improved from 18% in 1990, was still rather low (41%). To raise this figure it was decided to place a buffer between the doctors and the prosecution authorities. This took the form of Regional Assessment Committees, responsible for judging whether a case of euthanasia complies with the 'requirements for careful practice'. If this is the case, the Committees advised the prosecution authorities not to prosecute.

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<sup>21</sup> The second national study and the political reactions and actions form the largest part of chapter 9. Chapter 9 deals with the period 1994-2002.

In 1998, some members of Parliament again introduced a legalisation bill. The Cabinet - still without confessional parties - adopted the bill in somewhat revised form. In 2001 Parliament finally succeeded in enacting a euthanasia law. Under the new law a doctor who, after carrying out euthanasia, notifies the coroner of this fact will have his actions judged by a Regional Assessment Committee. If the Assessment Committee determines that the doctor complied with the 'requirements of careful practice' the case ends there.

Doctors are not criminally liable if they fulfil two conditions. First, they must adhere to the 'requirements of careful practice' as stipulated in the law; and second, they must report the termination of life to the coroner. According to the 'requirements of careful practice' provided in the law, the doctor must be convinced that the patient has made a voluntary and well considered request; he must be convinced that the patient's suffering is hopelessly and unbearable; he must have informed the patient about his situation and together they must be convinced that there is no reasonable alternative solution to the situation; he must have consulted at least one other independent doctor; and the ending of life must be carried out with due medical care.

The Law on Termination of Life on Request and Assisting Suicide adds essentially nothing to the 'requirements of careful practice' that emerged during the course of legal development. Formally speaking one might say that the requirements of consultation and reporting receive greater weight. These have now been included in the law, while heretofore the courts did not see shortcomings in these two areas as an obstacle to a successful defence of justification. However, during the parliamentary proceedings the Minister of Justice repeatedly stated that there would be no change in prosecution policy.

Considering that the legislature believed that the only effect of the legislation was to sanction the legal change already accomplished by the courts, one might ask why enacting the law took so long. One reason is to be found in the general features of 'social regulatory issues' such as abortion and euthanasia. Moral controversies tend to rage for a long time because of the intensity of ideological dispute. Judicial decisions in such cases do not necessarily bring the matter to a close. Awaiting social developments – for example a consolidation of public opinion – is an attractive option for a legislature bent on minimising political risk.<sup>22</sup>

This explanation is consistent with the characteristic Dutch politics of conflict avoidance. Avoidance has traditionally been accomplished by postponement of decision-making or by 'de-politicising' an issue as much as possible. Difficult political decisions are often side-stepped, at least for a time, by leaving immediate problems to the courts and by appointing advisory commissions. In the case of euthanasia, a state commission was appointed in 1982 and all legislation was put on parliamentary hold until its report in 1985. Postponement and de-politicisation can also be accomplished by referring an issue to 'research'. Once again euthanasia is an example, the national studies of 1990 and 1995 serving as excuses for the further postponement of legislative action.

Perhaps most importantly, the Christian Democratic Party, opponents of legislative legalisation of euthanasia, figured in all the different governments until 1994. The verdict of the Supreme Court in 1984 resulted in a political deadlock. A government bill to overrule the Supreme Court's decision would have been unacceptable to the coalition partners of the Christian Democrats – until 1989 the right-of-centre liberal party and between 1989 and

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<sup>22</sup> Tatalovich and Daynes 1984: 219.

1994 the Labour Party – but formally ratifying the verdict in legislation was equally unacceptable to the Christian Democrats.<sup>23</sup>

But even the two Governments after 1994, in which the confessional parties had no representation, did not put much energy into securing legislation. The guiding principle seemed to be not offending the Christian Democrats (and those members of their own parties who had reservations) and continuing the search for common ground. The government's hand was ultimately forced by a private member's bill that quickly attracted a parliamentary majority. At that point the government decided to retain control over the situation by introducing the bill that finally became law.

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<sup>23</sup> Van Hees and Steunenbergh 2000: 305-324.

