

# ***The Dutch way of death***

***Doctors and nurses in the Netherlands can practise euthanasia if they stick to certain guidelines. Yet many patients receive lethal injections without giving their consent***

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When a patient requests euthanasia, Jans Borleffs feels 'honoured' to oblige. 'It's very personal,' he says, 'not a kick, not a feeling of power.' But like most doctors who enter the moral maze of euthanasia, Borleffs is also awed by his responsibilities. 'How is it possible that I am the one who can decide about life and death, when to terminate a life?' Borleffs has helped two people to die and has promised to help others. All are terminally ill with AIDS. All want their suffering to end before the illness finally claims their lives.

Although technically illegal in the Netherlands, over the past decade euthanasia has become an accepted part of Dutch health policy. While elsewhere doctors and philosophers remain locked in debate over the ethics of helping the dying to die, Dutch doctors have grasped the nettle. Each year they respond to requests for euthanasia from some 2700 terminally ill patients. Most ask their doctors to inject them with a fatal dose of drugs; some ask to be given drugs so that they can take their own lives. A further 22 500 Dutch patients per year receive 'passive' euthanasia, where a doctor shortens a life either by withdrawing treatment or deciding not to start it.

In some hospitals, doctors routinely approach patients who are terminally ill, offering to inject them with lethal doses of barbiturates and curare when and if their suffering becomes too great. As long as physicians follow a set of guidelines on euthanasia, issued in 1987 by the Royal Dutch Medical Association, they will not be prosecuted.

Borleffs, who works at the Teaching Hospital in Utrecht, represents the acceptable face of this experiment with euthanasia: a humane doctor, striving to alleviate suffering while giving his patients the autonomy to determine the time and place of their own deaths. But Dutch euthanasia has its sinister side, too. A government survey published last September - dubbed the Remmelink report in honour of the attorney-general of the Dutch Supreme Court who chaired the commission - reveals that involuntary euthanasia of sick and elderly people is commonplace in the Netherlands, and that when patients do opt for euthanasia, it is frequently out of fear of being a nuisance rather than to avoid unnecessary physical suffering.

The details are alarming. At least a third of the 5000 or so Dutch patients who each year receive lethal doses of drugs from their doctors do not give their unequivocal consent. About 400 of these patients never even raise the issue of euthanasia with their doctors. Moreover, of those who willingly opt for euthanasia, only about 5 per cent do so solely because of unbearable pain. A much higher proportion, about a third, do so partly for fear of becoming dependent on others. Additionally, Dutch doctors kill about 1300 terminally ill patients each year by upping their dose of painkillers. In these cases, says the Rummelink report, the doctors acknowledge that their intention is to shorten the lives of the patients, not to alleviate pain.

These revelations strike a blow at the two central canons of the worldwide euthanasia lobby: that euthanasia should be used only as a means to end pointless physical suffering, and that the patient alone should make the decision. Now, some medical ethicists are saying that the Rummelink report proves that euthanasia is impossible to regulate, and that voluntary euthanasia should never be permitted because once sanctioned it leads inexorably to involuntary euthanasia.

## **UNNATURAL CAUSES**

The Dutch parliament will be grappling with these issues later this year when it votes on whether to legalise euthanasia and strengthen the existing guidelines. These currently stipulate that: the patient must explicitly and repeatedly request euthanasia; the patient must be subject to unbearable and intractable suffering; the physician must get a second opinion from another doctor before resorting to euthanasia; that the death be reported as due to euthanasia and not natural causes.

However, neither these nor any of the other charges contained in the Rummelink report have succeeded in galvanising world medical opinion against euthanasia.' The abuses do not weaken the argument for voluntary euthanasia,' says William Collins, a psychologist based at Cornell University in New York who studies euthanasia in the US. 'Instead, they argue for closer supervision of physicians, and penalties for those who step outside the boundaries.'

Legalisation, together with educational programmes on euthanasia for patients and physicians would help to stamp out its abuse in the Netherlands, argues Jacob Kohnstamm, a Dutch MP. At present, he says, patients and physicians are reluctant to discuss euthanasia because, although increasingly practised, it still carries the stigma of a crime. And that makes it difficult to obtain unequivocal consent.

The Rummelink investigation bears this out. In more than half of the 1000 or so cases of unrequested euthanasia, the physicians said that the patients had at least alluded to euthanasia. Even though the criterion of repeated requests had not been met, the physicians believed they had acted according to their patients' wishes.

A SLIPPERY SLOPE?

Opponents of euthanasia remain unconvinced. Daniel Callahan, director of the Hastings Center, a medical ethics think-tank in Briarcliff Manor, New York, believes that because euthanasia is an essentially private transaction between doctor and patient, it is impossible to regulate and should simply be prohibited. 'The slippery-slope argument against euthanasia has always been that once you start on voluntary euthanasia, you are likely to gravitate towards involuntary euthanasia,' he says. 'In Holland, this is no longer theoretical. It is actually happening.'

Callahan blames the drift towards involuntary euthanasia on the fact that doctors become inured to death. 'Euthanasia starts in the hands of a few very cautious, responsible people,' he says, 'but when it becomes a mass phenomenon, don't count on the same high standards.' In the Netherlands, standards may have fallen already.

Few of those involved in the debate doubt that the Rummelink report provides an accurate account of the overall incidence of euthanasia and euthanasia malpractice in the Netherlands. Where it has failed, say its detractors, is in depicting the gravity of the abuse. Carlos Gomez, a doctor at the University of Virginia Hospital in Charlottesville, Virginia, believes this can only be achieved by examining individual case histories of euthanasia. His doctoral thesis, researched in the Netherlands, details 26 such cases. While the majority of the patients appeared to meet the criteria for euthanasia, says Gomez, in at least four cases they did not.

In one case, a doctor injected a lethal dose of potassium chloride into someone who had been severely injured in a car accident and looked unlikely to recover. The doctor wanted to spare the family the emotional suffering, says Gomez. The same fate awaited a person who had suffered a stroke and looked unlikely to make a swift recovery. The third case involved a 78-year-old woman in a nursing home who had suffered several bouts of pneumonia. 'It was unclear what her wishes were, but clear what the doctors wanted,' says Gomez. But the most flagrant abuse of euthanasia was the killing of a two-day-old child with Down's syndrome - a child who would probably have lived for 40 to 50 years.

Such blatant disregard for the regulations is not limited to one incident. A Dutch physician told me of a similar abuse. One night the doctor discovered that his five-month-old son had stopped breathing. He was suffering from sleep apnoea, a condition thought to be responsible for many cot deaths. The doctor was able to revive his son, but not before the child had suffered severe brain damage. He subsequently arranged for a colleague to kill his son.

In the Netherlands, the central argument used to support euthanasia is the right of patients to determine when and how they die. Nonetheless, many Dutch physicians concede (often with an unnerving air of indifference) that involuntary euthanasia occurs. 'In Holland, you feel that something else is going on behind the argument for patient's autonomy,' says Gomez. 'Some physicians think that certain patients are better off dead than alive and they are willing to make that decision.'

## MORAL KILLING

Some Dutch physicians readily acknowledge that this is the case. One such person is Cor Spreeuwenberg, a general practitioner, committed Christian and veteran of nine

cases of euthanasia. If a patient is suffering unbearably but unable to consent to euthanasia, he says, a physician will have to decide whether it is better to allow the fruitless suffering to continue, or to end that person's life. 'Sometimes killing the person will be the morally correct thing to do,' he argues.

Kohnstamm weighs in with the example of a patient dying of throat cancer. '(Physicians) say it is one of the most horrible deaths you can imagine. At a certain point you can't breathe. It takes four to eight hours to die, fighting for every breath. The doctor can do two things: put the patient in an isolated room where nobody can hear or see his (or her) suffering and come back in 10 hours when the patient is dead; or decide to kill the patient.'

The battle lines are thus drawn. Those in Kohnstamm's camp argue that voluntary euthanasia for a patient who is dying in agony - perhaps even involuntary euthanasia if he or she is too delirious to make a request - can be justified on grounds of compassion. Others, such as Callahan, categorically reject euthanasia either with or without consent. The need for compassion, they argue, does not outweigh the risk of people feeling coerced into opting for euthanasia.

That risk is likely to be all the greater when people die at home, as most do in the Netherlands, surrounded by the relatives who are 'burdened' with looking after them. The problem of coercion looms larger still in the US, where patients without health insurance must pay for their own health care or rely on relatives to do so. For an American family, euthanasia for grandad may mean the difference between whether or not a younger member of the family can go to college, or whether the old station wagon can be traded in for a new one.

Of course, it is impossible to predict what effect, if any, the Netherlands' experiment with euthanasia will ultimately have on policy makers. The abuse exposed by the Rummelink report may scare some. But equally its message may eventually be lost amid the growing cries for patient autonomy and the burgeoning costs of caring for ageing populations. Perhaps the only certainty is that, legal or not, euthanasia is here to stay. As one Dutch doctor puts it: 'Everywhere doctors are terminating lives. The only difference in Holland is that here we talk about it.'

Rachel Nowak writes for the Journal of NIH Research in Washington, DC, and has travelled in the Netherlands.

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1: The means to the end

Drugs given for euthanasia should induce a deep, irreversible coma within 30 minutes and kill within hours. They should not induce hallucinations or convulsions, and any risk of vomiting should be countered by giving the patient additional drugs.

This is the advice contained in a document on euthanasia written for doctors by the Royal Dutch Association for Advancement of Pharmacy.

Twenty years ago, before euthanasia became an accepted part of Dutch health care policy, a patient who requested euthanasia risked a less dignified demise. Then, physicians desperate to put patients out of their suffering, but with little knowledge of the best drugs for the job, resorted to inducing hypoglycaemic comas with overdoses of insulin, injecting heart-stimulating drugs in an attempt to induce fatal heart attacks, or even suffocating their patients with pillows.

Now, the method of choice is an intravenous injection of a barbiturate to induce coma, followed by the injection of a muscle relaxant to paralyse the respiratory system.

Very occasionally Dutch doctors use suppositories containing barbiturates. The RDAAP document, however, points to a potential drawback: as death approaches, the body cools, and this slows release of the drugs from the suppository. If, after administering 15 suppositories (at the rate of three per hour), the patient is still alive, the physician must be prepared to terminate life with a muscle relaxant, says the document.

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## 2: The debate gathers pace in Australia

Doctors and nurses in the Australian state of Victoria have admitted in separate surveys that they have hastened the death of terminally ill patients. This is contrary to state law in Victoria which allows passive euthanasia - the withdrawal of medical treatment such as a life-support system - but not active euthanasia.

A majority of both doctors and nurses in Victoria favour a change in the law along the lines of the Dutch guidelines. But, according to a survey of nurses published earlier this year, nurses are more strongly in favour of changing the law in this way than doctors - 75 per cent of nurses surveyed, compared with 60 per cent for doctors. The doctors' survey was published in 1988.

According to Peter Singer and Helga Kushe, the researchers from Monash University who conducted both surveys, this suggests that nurses have a closer relationship than doctors with the terminally ill, and a better understanding of their plight.

A minority of nurses are prepared to take treatment into their own hands. Sixteen nurses, or 5 per cent of the respondents, said that they had complied with a patient's request to directly end his or her life without consulting a doctor. Another 37 nurses admitted performing passive euthanasia without the knowledge of a doctor. Rodney Syme, of the Voluntary Euthanasia Society, said these nurses were risking prosecution. The survey of nurses has caused controversy in Australia. Ann Monkivitch, a registered nurse, claimed in a letter to *The Age*, Victoria's main daily newspaper, that the questionnaire made no allowances for responses that would indicate opposition to euthanasia.

'The phrasing of the questions made the desired result inevitable,' she said.

Both Singer and Kushe, from the Centre for Human Bioethics at Monash, have publicly supported euthanasia, but they vehemently deny any bias in the survey. Nurses were able to voice their opposition by ticking 'no' in relevant boxes, they say.

Calls to change, or at least clarify, the law have been made since publication of the nurses survey. Active euthanasia is practised secretly in Australia, according to Singer. 'In Australia we have a de facto practice of completely uncontrolled euthanasia,' he says. Doctors and nurses widely believe that in theory they could be charged with murder.

Belinda Morleson from the Australian Nursing Federation said that health professionals were put in an untenable position because of the discrepancy between law and accepted practice. David Lanham, a law professor at the University of Melbourne, has urged a public inquiry into the law.

According to his interpretation of the law, it is possible for doctors, with a patient's consent, to administer drugs that will relieve pain but also shorten life. Singer says that if this view is correct, it is not widely appreciated by doctors.

But some doctors believe that the law should be kept well away from medical practice. 'Legislation has nothing to offer the intimacy of the doctor-patient relationship which is potentially a very powerful mechanism for resolution of suffering,' one doctor wrote in the survey.

Another doctor wrote: 'I am opposed to the Dutch measures and similar laws here because this is an area best left to the doctor to act as he thinks best - outside of legal constraints - as occurs right now.'

The nurses and doctors were asked almost identical questions. The survey of 869 doctors revealed that 107 doctors, or 29 per cent of doctors asked by a patient to hasten death, had complied with the request. Of those who did not comply, 65 per cent said that illegality was the reason. Two-thirds of nurses thought it was proper to assist a doctor based on the practice in the Netherlands.

The doctors were divided on the question of whether or not they would practice active voluntary euthanasia if it were legal: 41 per cent said no, 40 per cent said yes, and the rest did not answer.

## **Killing Babies, Compassionately**

*The Netherlands follows in Germany's footsteps.*

by Wesley J. Smith

03/27/2006

AT LAST A HIGH GOVERNMENT OFFICIAL in Europe got up the nerve to chastise the Dutch government for preparing to legalize infant euthanasia. Italy's Parliamentary Affairs minister, Carlo Giovanardi, said during a radio debate: "Nazi legislation and Hitler's ideas are reemerging in Europe via Dutch euthanasia laws and the debate on how to kill ill children."

Unsurprisingly, the Dutch, ever prickly about international criticism of their peculiar institution, were outraged. Giovanardi's critique cut so deeply that even Dutch Prime Minister Jan Peter Balkenende felt the need to respond, sniffing, "This [Giovanardi's assertion] is scandalous and unacceptable. This is not the way to get along in Europe."

As is often the case in the New Europe, what is *said* matters more than what is done. Thus, the prime minister of the Netherlands thinks that killing babies because they are born with terminal or seriously disabling conditions is not a scandal, but daring to point out accurately that German doctors did the same during World War II, is.

That being noted, one wishes Giovanardi had thought twice before raising the Nazi specter. Partly, this is because nothing we are talking about today matches the scope or magnitude of Nazi crimes. As a result, accusing people of Nazi-like behavior allows those amply deserving of moral condemnation to deflect reproaches. Thus, Giovanardi says that killing disabled babies is what the Nazis did, and the Dutch merely retort (correctly) that they are not Nazis.

Still, the "Nazi" analogy is worth exploring, precisely because it is unequivocally true that

German doctors *did* kill thousands of disabled babies, for which a few such physicians were hanged at Nuremberg. Dutch apologists know this, of course. But they claim that the Netherlands' infant euthanasia program is substantially different: Dutch doctors are motivated by *compassion* whereas the Germans' were motivated by the bigotry of racial hygiene. Of course it is the *act* of killing disabled and dying babies that is wrong, not the motivation. But even leaving that aside, the Dutch defense is not as persuasive as Prime Minister Balkenende would like to believe.

#### **German Euthanasia 1938-1945**