

The Contested Lessons of Euthanasia in the Netherlands

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It is frequently stated that the Netherlands moved to a permissive regime with respect to assisted suicide and voluntary euthanasia and then slid down the slope to involuntary euthanasia.¹ For example, Karl Gunning gave the following testimony before the Canadian Senate Committee on Euthanasia and Assisted Suicide:

[t]he lesson we can pass on to the world is that when you start to admit that killing is a solution to one problem, you will have many more problems tomorrow for which killing may also be a solution. Once you take away the dike that protects us, and if you have only one hole in the dike—and we have some experience with dikes in Holland —there will be a big flood, the dike will break, and the land will be flooded. That is exactly what is happening now in Holland.

We talk about the slippery slope. Holland is no longer on the slippery slope; it has turned into Niagara Falls, which we will go down quickly.²

If Canada decriminalized assisted suicide and voluntary euthanasia, it is argued, Canada too would slide to the objectionable bottom of the slippery slope.

In this paper, while I will conclude that the Dutch experience should give us some concern about a slippery slope, I will, more importantly, also conclude that it should not give us the level of concern suggested by some commentators. I will argue that it does not provide a basis on which to conclude that assisted suicide and voluntary active euthanasia should not be decriminalized in Canada. Rather, it provides a basis for proceeding with caution and developing a permissive regime that places barriers on the slope and contains mechanisms by which slippage down the slope can be detected (and, thereafter, rectified).

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¹See e.g. H. Hendin, "Seduced by death: doctors, patients and the Dutch cure" (1994) 10 *Issues in Law and Medicine* 123-168; H. Hendin, *Seduced by Death. Doctors, Patients and the Dutch Cure* (New York: W.W. Norton, 1997); H. Hendin, C. Rutenfrans & Z. Zylicz, "Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch" (1997) 277 *J.A.M.A.* 1720-1722; R. Fenigsen, "A Case Against Dutch Euthanasia" (1989) 19 *Hastings Center Rep.* 22-30; C.F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York: The Free Press, 1991); and E. Pellegrino, "The False Promise of Beneficent Killing" in L.L. Emanuel, ed., *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide* (Cambridge: Harvard University Press, 1998) at 87.

²Dr. K. Gunning, *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 17 (29 September 1994) at 88.

In my effort to accurately assess the force of the slippery slope argument grounded in the Dutch experience, I will first provide an overview of the legal status of euthanasia and assisted suicide. I will then address a number of the most common and/or egregious misinterpretations and misrepresentations found in the literature. I will then suggest a number of responses that might be made to the Netherlands-based slippery slope argument.

A. An Overview of the Legal Status of Euthanasia and Assisted Suicide in the Netherlands

Euthanasia and assisted suicide are illegal in the Netherlands; they are prohibited under Articles 293³ and 294⁴ of the *Criminal Code* respectively. However, Dutch courts have held that Article 40 of the *Criminal Code* can provide a defence (excuse or justification) to a charge under Article 293: "Article 40: A person who commits an offense as a result of a force he could not be expected to resist [*overmacht*] is not criminally liable."⁵ Through the concept of *overmacht* found in Article 40, defendants may argue that their actions were excused by duress or justified by necessity. Through a series of cases, the Dutch courts have explored the role of, and limits on, the application of *overmacht* in cases of euthanasia.⁶

1. Eindhoven, 1952⁷ – first euthanasia case

The first case of euthanasia to come before the courts⁸ involved a physician who, on request, killed his brother who was suffering from advanced tuberculosis. The physician claimed "it was impossible for him and he could not be expected, to ignore the claims of his conscience, which compelled him to comply with the explicit wish of his brother."⁹ The District Court convicted the physician but only sentenced him to one year probation.

³Article 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." See J. Griffiths, A. Bood & H. Weyers, *Euthanasia and the Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998) at 308.

⁴Article 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, assists in the 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." *Ibid.*

⁵*Ibid.* at 307.

⁶I will not review **all** of the cases involving euthanasia in the Netherlands. Rather, a select group will be reviewed with the goals of illustrating the evolution of the courts' responses to euthanasia and clarifying the current legal status of euthanasia in the Netherlands as delineated by the courts.

⁷*Nederlandse Jurisprudentie* 1952, no.275.

⁸The court said "because, as far as the Court is aware, this is the first time that a case of euthanasia has been subject to the ruling of a Dutch judge." Griffiths, *et al. supra* note 3 at 44.

⁹*Ibid.*

2. Postma, 1973¹⁰ – life-shortening palliative treatment guidelines

Guidelines with respect to assisted death began to emerge in the case law when a physician, on request, gave her mother a lethal injection of morphine and was prosecuted for doing so. In this case, the District Court quoted the Medical Inspector's testimony:

According to the expert witness, a doctor and medical inspector of national health, the average physician in the Netherlands no longer considers it right that the life of a patient be stretched to the bitter end when the following conditions are present:

A. [When] it concerns a patient who is incurable because of illness or accident – which may or may not be coupled with shorter or longer periods of improvement or decline – or who must be regarded as incurably ill from a medical standpoint.

B. Subjectively, his physical or spiritual suffering is unbearable and serious to the patient.

C. The patient has indicated in writing, it could even be beforehand, that he desires to terminate his life, in any case that he wants to be delivered from his suffering.

D. According to medical opinion, the dying phase has begun for the patient or is indicated.

E. Action is taken by the doctor, that is, the attending physician or medical specialist, or in consultation with that physician.

[When all of the above conditions are present] it is widely accepted in medical circles in our country and also by the expert witness, that in order to relieve the suffering of the patient completely, or as much as possible, ever larger doses of medicine are administered... and that the administering physician then is fully aware and accepts that the good intended, namely the alleviation of suffering, brings with it the shortening of the patient's life.¹¹

The Court accepted all but D (dying phase) of the conditions set out by the Medical Inspector. The Court then found that the physician had not met the conditions of accepted medical practice because she had given her mother an immediately lethal injection of morphine aimed at killing her rather than ever-escalating levels of morphine aimed at alleviating her suffering (the distinction mapping onto the

¹⁰*Nederlandse Jurisprudentie* 1973, no.183.

¹¹C.F. Gomez, *supra* note 1 at 30.

difference between euthanasia and the provision of potentially life-shortening palliative treatment that is strictly reflected in Canadian law. Ms. Postma was convicted but, because of “the perfect purity of [the defendant’s] motives beyond doubt,”¹² she was only given a suspended sentence of one week in prison.

3. Wertheim, 1981¹³ – assisted suicide guidelines

In this case, Ms. Wertheim (an assisted death activist) assisted a 67-year-old woman to commit suicide. The woman, suffering from a number of mental and physical conditions, sought assistance with suicide from her physician who refused and referred her to Ms. Wertheim who did help her to commit suicide. Ms. Wertheim failed to meet the requirements for justifiable assisted suicide set out by the Court in this case and was convicted. However, she was given a very light sentence.¹⁴

This case is particularly significant because, in it, the District Court set out the following conditions with respect to the person requesting assistance for justifiable violations of Article 294:

- the physical or mental suffering of the person was such that he experienced it as unbearable;
- this suffering as well as the desire to die were enduring;
- the decision to die was made voluntarily;
- the person was well informed about his situation and the available alternatives, was capable of weighing the relevant considerations, and had actually done so;
- there were no alternative means to improve the situation;
- the person’s death did not cause others any unnecessary suffering.¹⁵

The Court also set out the following conditions with respect to the person providing the assistance:

- the decision to give assistance may not be made by one person alone;

¹²*Ibid.* at 31.

¹³*Nederlandse Jurisprudentie* 1982, no.63.

¹⁴“A conditional sentence of six months subject to one year probation. As a special restriction, the court ordered that she be put under house arrest for the first two weeks of her probation.” Griffiths, *et al. supra* note 3 at 59.

¹⁵*Ibid.*

- a doctor must be involved in the decision to give assistance and must determine the method to be used;
- the decision to give assistance and the assistance itself must exhibit the utmost care which includes: discussing the matter with other doctors if the patient's condition is in the terminal phase, or, if the patient has not yet reached this phase, consulting other experts such as a psychiatrist, psychologist or social worker.¹⁶

Following this case, the Committee of Procurators-General decided that decisions on whether to prosecute cases of euthanasia and assisted suicide should be made by the Committee and that the Committee would use the guidelines set out in *Postma* and *Wertheim* to determine whether or not to proceed with a prosecution.¹⁷ Test cases would then be taken when the guidelines were insufficient for the determination of whether the euthanasia or assisted suicide fell within the boundaries of acceptability.

4. Schoonheim, 1984¹⁸ – euthanasia at the Supreme Court of the Netherlands

This was the first case of euthanasia to come before the Supreme Court of the Netherlands. The following facts were set out by the Court of Appeals:

From the beginning, she repeatedly made clear to the defendant and others that she was suffering seriously from the deterioration of her physical condition. She also repeatedly asked defendant to perform euthanasia.

Her wish to have her life terminated was especially manifest on two occasions. The first was in April of 1980, when Ms. B, at age 93, signed her living will. In this document she stated her wish that euthanasia be performed upon her in case her situation should develop into one in which no recovery to a tolerable and dignified condition of life was to be expected. The second occasion was after she had broken her hip on 16 September 1981, and surgery was being considered.

Ms. B suffered terribly from the steady decline of her health, which manifested itself in deterioration of her hearing, eyesight and power of speech, although the last showed temporary improvements. She had dizzy spells, she was permanently handicapped and bedridden due to the above-mentioned hip fracture, and there was no prospect of any substantial improvement of her condition.

¹⁶*Ibid.*

¹⁷*Ibid.* at 60.

¹⁸*Nederlandse Jurisprudentie* 1985, no.106.

In the weekend of the week preceding her death on Friday 16 July 1982, Ms. B was afflicted by a major deterioration in her condition. She was no longer able to eat or drink and lost consciousness. On Monday 12 July her condition had improved a little; she had regained the power of speech and was in full possession of her faculties. However, she had suffered severely under the collapse, mentally as well as physically, and she made clear that she did not want to have to go through something like this again. Once again she urgently requested the defendant to perform euthanasia upon her.

The defendant discussed the situation several times in depth with his assistant-physician, who had also spoken with Ms. B a number of times, and to whom she had also expressed her desire for euthanasia. After having spoken with Ms. B's son more than once as well, the defendant finally decided on Friday 16 July, with the approval of both his assistant and Ms. B's son, to comply with her request. In defendant's opinion, Ms. B experienced every day that she was still alive as a heavy burden under which she suffered unbearably. That same day, the defendant ended Ms. B's life, applying a medically accepted method.

A few hours later, the defendant reported the euthanasia to the local police.¹⁹

The case worked its way up to the Supreme Court of the Netherlands and this Court reviewed a number of possible defences to a charge under Article 293 and fixed upon *overmacht*, specifically the justification of medical necessity ("in accordance with norms of medical ethics, and with the expertise which as a professional he must be assumed to possess—balanced the duties and interests which, in the case at hand, were in conflict, and made a choice that—objectively considered, and taking into account the specific circumstances of this case—was justifiable"²⁰). The Supreme Court held that the Court of Appeals did not provide adequate justification for rejecting this defence in this case and referred the case back to another Court of Appeals. This second Court of Appeals reviewed the case and accepted Dr. Schoonheim's defence of necessity.

This case is of particular importance because it established, at the level of the highest court, that euthanasia can be justifiable and that cases must be viewed through the lens of *overmacht*.

¹⁹Griffiths, *et al. supra* note 3 at 323-324.

²⁰*Ibid.* at 327.

5. Admiraal, 1985²¹ – requirements of careful practice

Anaesthetist Dr. Peter Admiraal provided euthanasia to a woman suffering from multiple sclerosis at her repeated request. The woman felt that her life was no longer worth living as she was confined to a nursing home, in need of constant nursing care, and completely dependent on others. The Court acquitted Dr. Admiraal and thereby confirmed that physicians who follow the “Requirements of Careful Practice”²² set out by the Medical Association would not be convicted. The consequence of this decision was that the Minister of Justice subsequently informed the Medical Association that physicians who follow the “Requirements of Careful Practice” will not be prosecuted.²³

6. Chabot, 1994²⁴ – psychological suffering

Ms. B was a 50-year-old woman suffering from “an adjustment disorder consisting of a depressed mood, without psychotic signs, in the context of a complicated bereavement process.”²⁵ She had had two sons, Patrick and Rodney. In 1986, Patrick committed suicide. In late 1998, Ms. B’s father died and she left her husband. In 1990, she was divorced. In November 1990, Rodney was in a traffic accident and, in the course of treating him for his injuries, cancer was diagnosed. He died in May 1991 and Ms. B tried to commit suicide unsuccessfully. Later, through the Dutch Association of Voluntary Euthanasia, she was put in contact with Dr. Chabot, a psychiatrist. He met with her repeatedly, met with her family, and consulted with seven professionals (“four psychiatrists, a clinical psychologist, a GP and a well-known professor of ethics (of Protestant persuasion)”²⁶). Dr. Chabot concluded that Ms. B:

was experiencing intense, long-term psychic suffering that, for her, was unbearable and without prospect of improvement. Her request for assistance was well-considered: in letters and discussions with him she presented the reasons for her decision clearly and consistently and showed that she understood her situation and the consequences of her

²¹*Nederlandse Jurisprudentie* 1985, no.709.

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1. The request for euthanasia must be voluntary;
2. The request must be well-considered;
3. The patient’s desire to die must be a lasting one;
4. The patient must experience his suffering as unacceptable for him (The Board emphasized that there are only limited possibilities for verifying whether suffering is unbearable and without prospect of improvement. The Board considered it in any case the doctor’s task to investigate whether there are medical or social alternatives that can make the patient’s suffering bearable.);
5. The doctor concerned must consult a colleague.

Griffiths, *et al. supra* note 3 at 66.

²³*Ibid.* at 67.

²⁴*Nederlandse Jurisprudentie* 1994, no.656.

²⁵Griffiths, *et al. supra* note 3 at 332.

²⁶*Ibid.* at 331.

decision. In his judgment, her rejection of therapy was also well-considered.²⁷

The case worked its way up to the Supreme Court of the Netherlands. The Supreme Court drew several important conclusions with respect to possible limits on justifiable euthanasia: 1) suffering need not be physical; 2) a patient need not be terminally ill; and 3) a patient may be a psychiatric patient. However, the Court also held that, in the case of non-somatic suffering, consultation with another colleague is not sufficient – examination by an independent colleague is required.

Dr. Chabot had consulted widely but had not arranged for an examination. Therefore, he was convicted. However, taking into account the circumstances of the case, the Supreme Court imposed no penalty.

7. Prins and Kadijk, 1996²⁸ – nonvoluntary euthanasia

In 1996, the Dutch courts were confronted with two cases involving nonvoluntary euthanasia – two severely defective newborn babies were euthanized with the consent of their parents.

In *Prins*, a baby was born with severe anomalies. The decision was made to withhold and withdraw all treatment except comfort care. The baby was suffering unbearable pain and, at the request of the parents, Dr. Prins performed euthanasia. The District Court accepted the defence of necessity because:

- a. the baby's suffering had been unbearable and hopeless, and there had not been another medically responsible way to alleviate it;
- b. both the decision-making leading to the termination of life and the way in which it was carried out had satisfied the "requirements of careful practice";
- c. the doctor's behaviour had been consistent with scientifically sound medical judgment and the norms of medical ethics;
- d. termination of life had taken place at the express and repeated request of the parents as legal representatives of the newborn baby.²⁹

In *Kadijk*, a baby was born with trisomy-13 (a serious chromosomal anomaly incompatible with survival). Her parents were told about her condition and prognosis and the decision was made not to resuscitate or treat beyond the provision of comfort care. She then developed very painful complications and her condition

²⁷*Ibid.* at 332.

²⁸*Prins: Nederlandse Jurisprudentie* 1995, no.602 and, on appeal, *Nederlandse Jurisprudentie* 1996, no.113. *Kadijk: Tijdschrift voor Gezondheidsrecht* 1996, no.35.

²⁹Griffiths, *et al. Supra* note 3 at 83.

deteriorated further and her parents requested euthanasia. The physician consulted with colleagues and ultimately performed euthanasia.

In both cases, the District Court accepted the defence of necessity. In *Kadijk*, the Court issued the following judgment:

The Court concludes that the defendant's choice to bring about the girl's death in violation of article 289 of the Criminal Code, in the circumstances of this case, in which the girl—whose death was inevitable and who had been taken home so she could die there—was visibly in great pain and for whom an inhumane death, in a fashion strongly contrary to her parent's feelings, was imminent, was justified.

Important for the Court's assessment of the decision-making and carrying out of the decision is

- the fact that there was no doubt at all about the diagnosis and the prognosis based on it, and that the parents as well as the defendant were familiar with these;
- the fact that there was no doubt at all as to the well-considered consent of the parents to the termination of life;
- the fact that the defendant secured the advice of an independent, experienced doctor (GP) and consulted one of the responsible pediatricians;
- the fact that he brought about the baby's death in a conscientious and careful manner, after having satisfied himself of the correctness of the chosen method;
- the fact that he has carefully given account of his conduct in this matter.

The Court comes to the conclusion that the situation in which the defendant found himself can, according to scientifically responsible medical opinion and the norms of medical ethics, be considered a situation of necessity in which the choice made by the defendant is to be considered justified, so that he must be acquitted.³⁰

Conclusion

It is clear, following a review of the relevant legislation and case law, that euthanasia remains illegal in the Netherlands. However, if certain conditions are met, a defence of necessity will be available. In other words, if a physician

³⁰*Ibid.* at 350-351.

performs euthanasia having followed the "requirements of careful practice" he or she will not be prosecuted. If prosecuted, if a physician is found to have performed euthanasia in a situation which, according to scientifically responsible medical opinion and the norms of medical ethics, is a situation of necessity in which the choice made by the physician is considered justified, he or she will be acquitted. Ultimately, then, the basic boundaries with respect to justifiable euthanasia are drawn by the "Requirements of Careful Practice," and where those requirements do not provide adequate guidance with respect to the boundaries, the courts will provide additional guidance on a case-by-case basis with reference to scientifically responsible medical opinion and the norms of medical ethics.

B. Misinterpretations and Misrepresentations

1. Euthanasia is widespread

Some proponents of the slippery slope argument claim that euthanasia is widespread in the Netherlands. Richard Fenigsen, for example, claims that:

The findings published in the [Rommelink] report indicate that annually 25,306 cases of euthanasia (as defined by Fletcher) occur in the Netherlands.... The 25,306 cases of euthanasia constitute 19.4% of the 130,000 deaths that occur in the Netherlands each year.³¹

There are at least two cautions to be made about such claims about the incidence of euthanasia in the Netherlands. First, there is a great deal of confusion and equivocation around the term "euthanasia." The authors of the report referred to by Fenigsen include only voluntary active euthanasia in the term "euthanasia" while Fenigsen and many other opponents of a permissive regime with respect to assisted death include the withholding and withdrawal of potentially life-sustaining treatment and the provision of potentially life-shortening palliative treatment in the term. Thus, on the basis of the same data, the researchers themselves conclude that there are 2,300 cases per year of euthanasia and Fenigsen *et al* conclude that there are 25,306. On the broad definition, euthanasia is obviously far more widespread than on the former. However, on the latter, euthanasia is also far less morally controversial than on the former.

Second, the claim that euthanasia (defined narrowly) is widespread is simply not supported by the data. As was shown in the 1995 government-sponsored study, 2.4% of deaths resulted from voluntary euthanasia and .8% resulted from LAWER.³²

³¹R. Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia" (1991) 339 *Issues in L. & Med.* 339 at 340.

³²Life-terminating acts without explicit request of patient (LAWER). P.J. van der Maas *et al.*, "Euthanasia, Physician-Assisted Suicide, and other Medical Practices Involving the End of Life in the Netherlands, 1990-1995" (1996) 335 *New Engl. J. Med.* 1699-1705.

2. Euthanasia is available on demand

There are at least two ways in which it is claimed that euthanasia is available on demand; first, that all requests for euthanasia are granted and second, that euthanasia will be performed almost immediately upon request. However, neither of these statements are true. Consider each in turn.

The 1995 study revealed that there are approximately 10,000 concrete requests for euthanasia and assisted suicide each year and that approximately 6,000 are not carried out (because the physician refuses in approximately 3000 cases and the patient dies before the request can be honoured in most of the other cases).³³ Thus, only about one third of requests for euthanasia or assisted suicide actually result in a death by euthanasia or assisted suicide. The data thus clearly do not reflect a society in which euthanasia is available “on demand”.

With respect to the immediacy of availability, the Canadian Senate Committee on Euthanasia and Assisted Suicide was told that 59 per cent of patients undergoing euthanasia died on the same day that they requested euthanasia and that in 11 per cent of cases, patients died in the same hour.³⁴ Dr. Van der Wal, the author of the paper cited as authority for these statistics, was shown the numbers and, in turn, he explained what they actually represented:

Yes, [the patients] did die on the same day that they requested euthanasia for the last time. Do you understand the difference? The patients had discussed the subject and had explicitly requested euthanasia many times before, but the day on which they died was the last time that they requested it.

The next sentence says that in 11 per cent of cases, patients died in the same hour that the first request was made. It was not the first request; it was the last request.... The facts are completely distorted.³⁵

Sometimes and for a variety of reasons, there is relatively little time between first and last requests. However, quite clearly, the data do not support the claim that euthanasia is available “on demand”.

3. Palliative care is absent

A number of commentators on the Dutch situation claim that there is no (or grossly inadequate) palliative care in the Netherlands and, as a result, people seek

³³Griffiths *et al.*, *supra* note 3 at 211.

³⁴This claim was made in witness statements sent to the Dutch witnesses in advance of a video conference with the Special Senate Committee on Euthanasia and Assisted Suicide. See *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 21 (25 October 1994) at 62.

³⁵*Ibid.*

euthanasia. If there were (better) palliative care, it is argued, the incidence of euthanasia requests would decrease.³⁶

However, the claim of the absence or gross inadequacy of palliative care is grounded in a misunderstanding of the Dutch health care system. The Dutch, in general, do not have hospices or dedicated palliative care facilities. Rather, they integrate palliative care into the delivery mechanisms for health care. The following explanation was offered to the Canadian Senate Committee on Euthanasia and Assisted Suicide during a day long video conference with two panels of Dutch experts.

Dr. Van Delden: We do not have separate palliative care facilities in general. There are some facilities, but that is not the major way in which we deal with this. Palliative care is integrated into other existing forms of health care. Hence, it is integrated into the hospital. A central part is played by our nursing homes. Also, the general physician plays a central role in palliative care.

You must understand that we do not have a separate facility where we bring in people who need palliative care. Instead, we bring the care to where the needy are located.

Dr. Heintz: In the Netherlands, we also have a system of Comprehensive Cancer Centres, an administrative body that covers a certain area of the country. The whole country is covered by those centres. Within those comprehensive cancer centres, all the health care organizations, hospitals, GPs, and nursing homes can obtain advice or consultation from all the cancer specialists, including the palliative care specialists.

Dr. Dillmann: In order to get a good picture of palliative care in the Netherlands you must understand some important elements of the situation in the Netherlands. Palliative care is in operation in the general hospitals. In many hospitals, pain teams are in operation. If it is discovered that more treatment is impossible or patients want to go home, then they will usually be transferred to their home situation, provided substantial care is present there. The nursing home system could also play a role there in offering day care, which is important for demented patients.

If patients are too sick to be in their homes, they can go to a nursing home.

I will take this opportunity to give you more details about the nursing home system in the Netherlands. Many of your concerns about palliative

³⁶See e.g. K. Gunning *supra* note 2 at 91; Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide* (June 1995) at A-120; and J. Keown, "Euthanasia in the Netherlands" in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 1995) at 280.

care could be removed by taking a closer look at that particular system. In the Netherlands, there are approximately 50,000 hospital beds and 45,000 nursing home beds. It is approximately a 1:1 ratio.

A nursing home physician is a distinct medical specialty with its own curriculum and licensing authorities. Each nursing home has a staff of trained nursing home physicians. Moreover, nursing home medicine is covered by the state. It is a state expenditure based on social insurance. Nursing home patients do not pay for the treatment out of their own pockets. Generally, this is the case for health care facilities in the Netherlands, since 99.4 per cent of the population has proper health care insurance. Even if they do not have insurance, the state will cover their nursing home expenses.

When you take into account facilities such as nursing homes, the GP system – which is strongly developed in the Netherlands as has and [sic] a strong curriculum – hospitals, and cancer centres, you will understand why the label “palliative care” cannot easily be distinguished in the Netherlands. We feel that that is the case because many facilities are taken in by existing facilities.³⁷

The Dutch will admit that there is room for improvement (especially moving beyond pain control). However, palliative care is widely available in the Netherlands and claims to the contrary are not supported by the data.³⁸

4. Nonvoluntary euthanasia is widespread

Prior to the publication of the Rummelink Report, contested claims were made that nonvoluntary euthanasia was widespread in the Netherlands.³⁹ Following the publication of the Report, these claims were reiterated with what was taken to be proof found in the Report; the Report is frequently cited as revealing that there are 1000 cases of nonvoluntary euthanasia every year in the Netherlands.

However, the oft-cited 1000 figure must be carefully analyzed before drawing conclusions about the slippery slope. The figure of 1000 comes from a study that concluded that .8% of deaths resulted from LAWER.⁴⁰ The authors of the study that generated the 1000 figure offered the following explanation of their statistics in an article published in response to the concerns expressed about their findings:

³⁷*Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 21 (25 October 1994) at 28-29.

³⁸Griffiths *et al. supra* note 3 refer to the following as an authoritative literature study of palliative care in the Netherlands: A.L. Franke, *et al.*, *Palliative zorg in Nederland. Een inventarisatiestudie naar palliatieve zorg, deskundigheidsbevordering en zorg voor zorgenden* [Palliative Care in the Netherlands. A Survey of Studies of Palliative Care, Promotion of Expertise, and Support for those Giving Care] Utrecht: *Nederlands Instituut voor Onderzoek van de Gezondheidszorg*.

³⁹Fenigsen, *supra* note 1 at 25.

⁴⁰L. Pijnenborg *et al.*, “Life-terminating acts without explicit request of patient” (1993) 341 *The Lancet* 1196 at 1197.

In 59% of all LAWER [life-terminating acts without explicit request of patient] the physician had information about the patient's wishes (discussion with the patient and/or a previously expressed wish) short of an explicit request.⁴¹

Thus, in 600 of the 1000 cases, something about the patients' wishes was known although explicit consent according to the guidelines had not been given. In only 400 cases were the wishes not known at all. Quite clearly, the data on the incidence of LAWER in the Netherlands do not support a claim of widespread nonvoluntary euthanasia. They do support a claim of some nonvoluntary euthanasia but arguably considerably less than the projected 1000 cases per year.

5. Nonvoluntary euthanasia is increasingly accepted

Richard Fenigsen and John Keown have both claimed "growing condonation" and "growing support for" nonvoluntary euthanasia in the Netherlands.⁴² However, there is no empirical data to support the claim that nonvoluntary euthanasia is increasingly accepted. The incidence did not increase between 1990 and 1995.⁴³ Furthermore, and more significantly, the incidence of nonvoluntary euthanasia uncovered by the 1990 study was a source of concern and action on the part of the Dutch authorities as well as many proponents of the Dutch approach to euthanasia.⁴⁴

6. Involuntary euthanasia is being performed

Richard Fenigsen, Herbert Hendin, and others have claimed that involuntary euthanasia is being performed in the Netherlands.

Thus in Holland, "voluntary" and involuntary euthanasia are advocated by the same people and the same institutions, supported by the same public, practiced alongside each other and closely linked in the public mind. Both are manifestations of the same basic attitude, that is, the now widely shared conviction that people's lives may be cut short whenever there are good reasons for doing so. Those who contend that it is possible to accept and practice "voluntary" euthanasia and not allow involuntary totally disregard the Dutch reality.⁴⁵

⁴¹*Ibid.*

⁴²Fenigsen, *supra* note 1 at 25; J. Keown, *supra* note 36 at 285.

⁴³Griffiths, *et al.* *supra* note 3 at 210.

⁴⁴During the day long videoconference with the Special Senate Committee on Euthanasia and Assisted Suicide, several of the Dutch experts reported concern about the 1990 LAWER figures. *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 21 (25 October 1994) at 26-27; See also *supra* note 40.

⁴⁵R. Fenigsen, *supra* note 1 at 26.

The figures published in the [Rommelink] report indicate that 14,691 cases of involuntary euthanasia occur annually in the Netherlands. This is 11.3% of the total number of deaths in the country.⁴⁶

However, contrary to these claims, there were **no** cases of involuntary euthanasia in either the 1990 or 1995 studies. What Fenigsen calls involuntary euthanasia is at worst nonvoluntary euthanasia and cessation of treatment.

7. Involuntary euthanasia is increasingly accepted

Implicit in the claims made by Fenigsen and Hendin, is the claim that involuntary euthanasia is increasingly accepted in the Netherlands. However, there is no reputable evidence that involuntary euthanasia is happening let alone increasingly accepted.

8. Abuses are widespread

Many authors refer to specific cases which they feel indicate that abuses are widespread in the Netherlands. However, there is reason to be suspicious of these references. With respect to the cases described by Richard Fenigsen in his oft-cited *Hastings Center Report* article, John Griffiths reports that:

When these specific charges were investigated by the Medical Inspectorate at the request of the Dutch prosecutorial authorities (who were alerted by the NVVE to the fact that a number of cases of murder or manslaughter seemed to be involved), it appeared that the 6 cases Fenigsen referred to as based on his own personal knowledge had taken place a decade earlier. One had taken place in Denmark. Of the remaining 5, 4 involved abstinence and one termination of life without an explicit request (apparently a case of “help in dying”). There seems in several of the cases to have been some carelessness on the part of the doctors involved. Fenigsen himself agreed with these conclusions of the Inspectorate.⁴⁷

With respect to the cases described by Herbert Hendin in his article “Seduced by Death: Doctors, Patients, and the Dutch Cure,” Ronald Dworkin reports that:

Five doctors, four of whom Hendin describes as “major sources” of his research, wrote a joint letter to the journal that published his initial article, which had the same title as the later book. The letter read, in part, “The following persons interviewed by dr. (sic) Herbert Hendin... wish to declare that the texts of the interviews... do not contain a truthful

⁴⁶*Supra* note 31 at 341.

⁴⁷Griffiths, *et al. supra* note 3 at 23.

description of the interviews. The text contains several errors and flawed interpretations.” They asked that their letter be published with the article. It was not, and though Hendin made some changes in the article before publication, these changes, according to the Groningen scholars and three of the doctors, with whom I spoke on the telephone, did not correct the misinterpretations, which, in their opinion, are perpetuated in Hendin’s later writings.⁴⁸

With respect to the cases described by Carlos Gomez in his book *Regulating Death: Euthanasia and the Case of the Netherlands*, John Griffiths offers the following critique:

Gomez’ description of the interaction between doctor and patient is based on information concerning 24 cases, collected long after the fact by a person (himself) whose grasp of the context was limited and who apparently did not speak Dutch, by means of interviews with a highly unrepresentative group of doctors who themselves were operating on the basis of memory and trying to describe subtle and complex interactions that had taken place as long as 5 years earlier, and whose English probably was not muscular enough for the task. That Gomez draws firm conclusions about the influence of the doctor on the patient’s decision on the basis of this sort of information can only be described as scientifically irresponsible. The American reader who is inclined to dismiss such criticism of Gomez’ research methods as exaggerated would do well to ask himself how much confidence he would have in the conclusions of – say – a Japanese doctor who studied some controversial medical procedure in the United States by interviewing a handful of American doctors with whom he happened to come in contact about a small number [of] cases these doctors had been involved in several years earlier (and covering only cases in which the doctors had carried out a particular procedure, not the far larger group of cases in which they had not done so). Not speaking any English, our hypothetical Japanese researcher conducted the interviews through an interpreter. Based on the interviews (and without being able to read the American literature on the subject) the Japanese researcher felt able to make vigorous assertions not only about what American doctors generally do in such cases but also about what influence this has on the patients involved (none of whom, of course, he had talked to). And from these “findings” he came to the conclusion that American policy in the area concerned was dangerously defective. To lend his account authenticity, he larded it with local color such as the information that the “Bibel Beld” runs across the United States from New York to San Francisco.

⁴⁸R. Dworkin, “Assisted Suicide: What the Court Really Said” *The New York Review* (24 September 1997) 40 at 43.

Despite his ignorance of English, he informed his Japanese readers about the etymology of the word “autonomy”: when Americans speak of the autonomy of the patient, they refer to the patient’s continued ability to drive a car (“auto”). See Gomez 1991: 91 [*Ranstaad, sic*]; 155 n.96 [*ontluisteren*] for examples of the same sort of amusing errors.⁴⁹

I do not offer these critiques as proof that abuses do not occur. Rather, I reproduce them here to cast doubt on the “evidence” of abuse that has been produced to date and to suggest that narratives about these abuses should be read with a healthy degree of skepticism. The possibility that there is abuse should not be discounted but neither should it be regarded as proven to be more than a possibility.

C. Responses to the Netherlands-based Slippery Slope Argument

It should first be noted that there is good reason to be concerned about the situation in the Netherlands. As we have already seen, nonvoluntary euthanasia and nonvoluntary withholding and withdrawal of potentially life-sustaining treatment are all occurring. Procedural guidelines are not always being followed. For example, appropriate consultation and reporting do not always occur. The safeguards intended to protect the vulnerable do not appear, at least as currently implemented, to be sufficient.

However, reasons to be concerned about the situation in the Netherlands are not necessarily reasons not to decriminalize assisted suicide and euthanasia in Canada. At least the following responses to the Netherlands-based slippery slope argument can be made.

1. The temporal slippery slope

A critical step in the slippery slope argument is that legalization caused the slide down the slippery slope; if that is not true, then the Netherlands-based slippery slope argument against decriminalization loses its force. However, there is no evidence that the shift in policy and practice with respect to the state’s response to euthanasia and assisted suicide in the Netherlands caused any slide down a slippery slope.

As Van Delden *et al.* note in “Dances with Data”, “[t]o demonstrate a slippery slope one would need to show that something changed after introducing a certain practice and for this at least two investigations would be required.”⁵⁰ When that

⁴⁹Griffiths, *et al. supra* note 3 at 25.

⁵⁰J.M. van Delden, L. Pijnenborg & J. van der Maas, “Dances with Data” (1993) 7 *Bioethics* 323 at 327.

article was published in 1993, there had been only one investigation (the 1990 study). Therefore, no slide attributable to change could be demonstrated. Subsequent to the “Dances with Data” article, the 1995 study was conducted and it revealed no increase in the number of instances of LAWER.

2. The comparative international slippery slope

The slippery slope argument is also grounded in the assumption that the incidence of nonvoluntary euthanasia is higher in the Netherlands (where it is permitted in some circumstances) than in those countries where it is illegal. The truth of this assumption has not been empirically demonstrated and indeed there is now data to suggest that the assumption is false. The authors of a recent Australian study summarized their results as follows:

The proportion of all Australian deaths that involved a medical end-of-life decision were: euthanasia, 1.8% (including physician-assisted suicide, 0.1%); **ending of patient’s life without patient’s concurrent explicit request, 3.5%**; withholding or withdrawing of potentially life-prolonging treatment, 28.6%; alleviation of pain with opioids in doses large enough that there was a probable life-shortening effect, 30.9%. In 30% of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient’s life, of which 4% were in response to a direct request from the patient. **Overall, Australia had a higher rate of intentional ending of life without the patient’s request than the Netherlands.**⁵¹

The authors concluded that “Australian law has not prevented doctors from practising euthanasia or making medical end-of-life decisions explicitly intended to hasten the patient’s death without the patient’s request.”⁵²

These facts cast even more doubt on the use of the Netherlands in the slippery slope argument against decriminalization of assisted death.⁵³

⁵¹H. Kuhse *et al.*, “End-of-life decisions in Australian Medical Practice” (1997) 166 *Med. J. Australia* 191 at 191 [emphasis added].

⁵²*Ibid.*

⁵³Griffiths *et al.*, *supra* note 3 at 127, also provide the following as support for their dismissal of the comparative international slippery slope argument:

Recent research in the United States gives rates of assistance with suicide roughly comparable to the Dutch figure for euthanasia (see the sources cited in Dworkin *et al.* 1997). ‘Physician-negotiated death’ is estimated at about 70% of all deaths in the United States (see Kass 1993: 34; cf. Quill 1996: 199). Recent Australian research using the methods of earlier Dutch studies shows rates of euthanasia and assistance with suicide very similar to the Dutch rates (Kuhse *et al.* 1997)

....

Much of the ‘physician-negotiated death’ [referred to in note 23] must involve patients who are not competent or not conscious. Studies such as Anspach (1993) and Zussman

It should also be noted, from a comparative international perspective, that there is evidence of societies other than the Netherlands decriminalizing assisted suicide and/or voluntary euthanasia and **not** sliding down the slippery slope to involuntary euthanasia. Indeed, examples point in the opposite direction. Infanticide has been practiced in numerous cultures around the world without any of these cultures sliding to involuntary euthanasia.⁵⁴ Senicide was practiced by Inuit cultures again without any slide to involuntary euthanasia.⁵⁵ Oregon decriminalized assisted suicide in 1997 and has not witnessed any precipitous slide down the slippery slope.⁵⁶ The comparative international empirical data is thus, for the proponents of the slippery slope argument, at best neutral and, at worst, counter to their argument.

3. The current Canadian location on the slope

The slippery slope argument often implicitly assumes that we are currently at the very top of a slippery slope and must resist any reform that will put us onto the slope and take us inexorably down to the bottom of the slope. However, this assumption is incorrect for we are already on the slope.

Assisted suicide and euthanasia are already occurring in North America. At the very least, we know about the cases that come to the attention of the authorities. We have, to date, had at least nine deaths that have resulted in eight murder charges but these charges have resulted in six convictions on lesser charges (e.g., administration of a noxious substance), and only one prison sentence.⁵⁷

For obvious reasons, it is difficult to gain accurate and complete data on the incidence of assisted suicide and euthanasia; they are illegal acts and health care

(1992), and Quill's (1996) autobiographical account of end-of-life medical practice seem to confirm this inference. See Kuhse 1997 for Australian evidence to this effect.

⁵⁴E. Westermarck, *The Origin and Development of Moral Ideas*, vol. 1 (London: Macmillan, 1924) at 394-413.

⁵⁵*Ibid.* at 387 and 392.

⁵⁶A.E. Chin *et al.*, "Legalized Physician-Assisted Suicide in Oregon – The First Year's Experience" (1999) 340 *New Engl. J. Med.* 577. It is obviously early in this social experiment but the preliminary results run counter to the slippery slope argument. It should be noted that the methodology of those gathering data on the Oregon experience (including Chin *et al.*) has been challenged. See e.g. K. Foley & H. Hendin, "The Oregon Report: Don't Ask, Don't Tell" (1999) 29 *Hastings Center Rep.* 37. However, while their critique may diminish confidence in the data, it does not provide any evidence of any slide down a slippery slope.

⁵⁷Dr. Nachum Gal case described in E. Keyserlingk, "Nontreatment in the best interests of the child" (1989) 32 *McGill L.J.* at 416-417; case described by Dr. James Cairns, Deputy Chief Coroner, Province of Ontario, in his testimony to the Senate Committee on Euthanasia and Assisted Suicide, Senate of Canada, *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 20 (17 October 1994) at 7 and 13; *R v. Mataya* (24 August 1992), (Ont. H.C.J.), (Wren J. without a jury) [unreported]; case described by Special Senate Committee on Euthanasia and Assisted Suicide, *supra* note 36 at A-29; *R. v. de la Rocha* (2 April 1993), Timmins (Ont. Ct. (Gen. Div.)); *R. v. Latimer*, [1998] S.J. No. 731 (Sask. C.A.), online: (QL) (SJ); *R. v. Myers* (23 December 1994), Halifax, (N.S.S.C.); The Robert Cashin case described in B. Sneiderman, J. Irvine & P. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses, and other Health Care Professionals*, 2nd ed. (Toronto: Carswell, 1995) at 548; *R. v. Morrison*, [1998] N.S.J. No. 75 (Prov. Ct.), online: QL (NSJ); *R. v. Morrison*, [1998] N.S.J. 441 (S.C.), online: QL (NSJ).

providers are likely to under-report criminal activity. Nonetheless, recent studies provide some indication of the incidence of assisted suicide and euthanasia. Russel Ogden, a criminologist, testified before the Senate Committee:

I discovered that here in British Columbia, euthanasia in the AIDS population occurs both with and without the assistance of physicians. Between 1980 and 1993, I learned of 34 cases of assisted suicide and euthanasia amongst the AIDS population. I also learned of other deaths outside of the AIDS population, but did not include those in my data. I have learned of many more deaths amongst patients with ALS, cancer and AIDS since the publication of these findings.⁵⁸

In a study of Manitoba physicians released in 1995, 72% of those who responded to the survey said that they believe that euthanasia is performed by some physicians. 15% said that they had participated in an assisted suicide or euthanasia.⁵⁹

Studies have also been conducted in the United States with similar results. "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States" was published in the *New England Journal of Medicine* in April 1998. The authors concluded that "a substantial proportion of physicians in the United States in the specialties surveyed report that they receive requests for physician-assisted suicide and euthanasia, and about 6 percent have complied with such requests at least once."⁶⁰

It is perfectly clear that assisted suicide and euthanasia are occurring in North America. We are already on the slope, precisely where we do not know, but we surely know we are part way down it.

D. Conclusion

Much has been written and said about the situation in the Netherlands. Unfortunately, much that has been written has either misinterpreted or misrepresented the Dutch situation. John Griffiths *et al.* are blunt in their assessment of much of what has been written: "Imprecision, exaggeration, suggestion and innuendo, misinterpretation and misrepresentation, ideological *ipse dixitism*, and downright lying and slander (not to speak of bad manners) have taken the place of careful analysis of the problem and consideration of the Dutch

⁵⁸Special Senate Committee on Euthanasia and Assisted Suicide, *supra* note 36 at 54.

⁵⁹N. Searles, "Silence Doesn't Obliterate the Truth: A Manitoba Survey on Physician Assisted Suicide and Euthanasia" (1996) 4 Health L. Rev. 9.

⁶⁰D.E. Meier *et al.*, "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States" (1998) 338 New Engl. J. Med. 1193-1201. This article also includes references to and some discussion of prior surveys conducted on this issue in the United States.

evidence.”⁶¹ Much that has been written and said about the Netherlands is disrespectful of the Dutch and contributes much heat and little light to the debate about Canadian public policy with respect to assisted death.

More careful reflection on the Dutch experience provides information that can be used in the design of a permissive Canadian regime as we attempt to put in place a regime with the greatest possible safeguards against a descent down the slippery slope. However, it does not provide convincing evidence in support of the claim that if Canada decriminalizes assisted suicide and voluntary euthanasia, Canada **will in fact** slide to the objectionable bottom of a slippery slope.

Epilogue

On November 28, 2000, the Lower House of the Dutch Parliament passed a bill decriminalizing euthanasia and assisted suicide in certain clearly defined circumstances.⁶² This bill will become law if it is also passed by the Upper House. The bill sets out “requirements of due care” similar to the conditions spelled out in the earlier discussion of the case law and sets out the responsibilities and powers of the five Regional Review Committees for termination of life on request and assisted suicide – the bodies tasked with the statutory notification and review procedure.

⁶¹Griffiths *et al.* *supra* note 3 at 28.

⁶²Review procedures of termination of life on request and assisted suicide and amendment to the *Penal Code (Wetboek van Strafrecht)* and the *Burial and Cremation Act (Wet op de lijkbezorging)* *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*. The text of this bill is available from the Dutch Ministry of Justice website, online: <www.minjust.nl> (date accessed 20 January 2001).