

Editorial

Dutch higher court places further limitations on physician-assisted death

Recently a Dutch higher court judged that physicians should not be allowed to end the lives of patients for non-medical reasons. In the case before the court a general practitioner had ended the life of an elderly patient—a former member of the Dutch Senate—at the latter's urgent and repeated requests. Although he had not been seriously ill and a consultant psychiatrist had not found any indications of psychiatric illness, the patient did not wish to go on living any longer.

At the heart of the general practitioner's main argument in defence of the way he had dealt with his patient's request was his conviction that his patient had suffered unbearably under the need to continue living life without hope and in continuous mental despair.

Since 1984 different courts in the Netherlands—including the higher court in question have formulated standards for justifiable physician-assisted death, including the presence of an explicit, well-considered and repeated request except in the case of very young children; suffering without hope or a realistic alternative that might reduce suffering; consultation with another physician; and a medically justifiable way of terminating life. The definition of suffering is not restricted to the terminal stages of life or to suffering through physical causes. Chronic, severe and untreatable psychiatric illnesses also constitute justifiable reasons for physician-assisted death. Physicians who are involved in such deaths are not allowed to sign the relevant death certificate. Recently a law was passed by the Dutch parliament legalising the standards mentioned.

The law regulates euthanasia, physician-assisted suicide and other cases of justifiable assisted death. *Euthanasia* is defined as the actual and intended termination of someone's life by another person at the former's explicit request. *Assisted suicide* is defined as helping somebody to terminate his or her life at his or her explicit request. *Physician-assisted death* covers all actions by a doctor which result in intended early death, and, therefore, includes not only euthanasia and physician-assisted suicide but also actions such as ending the life of children with multiple serious defects and patients in a persistent vegetative state.

In 1991, the Dutch government started an information campaign to improve the quality of physician-assisted death and to provide instruments for public and social

control. The government hoped to reach full coverage of all cases and to make all procedures transparent [1]. The new law enables the setting up of committees, each composed of a lawyer, an ethicist and a physician, which will consider cases submitted to them.

The higher court has judged that the assessment of suffering that may justify physician-assisted death shall be limited to the domain that is compatible with a physician's training and qualifications in the area of medicine. This does not imply that the court limits the domain of the physician's intervention to terminal illness or to suffering due to physical causes. Physicians who terminate the lives of patients in the final stages of amyotrophic lateral sclerosis (ALS) or with chronic, untreatable depression, and who meet the standards set by former court hearings will not be prosecuted. However, the court has stated that physicians lack the appropriate qualifications to judge the full domain of human life. Situations in which a patient has reached old age, has some age-related handicaps and is convinced that further life is useless, do constitute a legal argument in favour of meeting a patient's wish. The court acknowledges that it is not always possible to distinguish suffering from its causes, and observes that, as a result of its judgement, some human beings will not be able to receive assistance from their physician if they wish their lives to be terminated. However, in the type of cases mentioned the court regards the active involvement of a physician as unacceptable.

Some see the judgement as an intolerable restriction on the autonomy of human beings. Apart from the argument that suffering cannot be divided into a medical and a non-medical domain they would argue that in our society physicians are the only persons to have access to lethal drugs as well as the knowledge to apply such drugs appropriately. General practitioners, the group of professionals who are most often involved in physician assisted death, have expressed the objection that more and more patients will come to assume that physicians are obliged to respond to the patient's request for termination, even in cases in which suffering is judged by the GP to be minor and realistic alternatives are available, or patients do not actually suffer but anticipate possible future suffering.

In the case heard by the higher court I was one of the expert witnesses and the court accepted the

arguments I put forward. Although I belonged to the small group of physicians who had, already in the 1970s, defended publicly the thesis that physicians must be given the opportunity to be involved in physician assisted death if there is no realistic alternative to relieve patient suffering, during the time of the court hearing I had come to be regarded as someone with very conservative opinions.

My involvement in the public debate on euthanasia followed my PhD study in 1981, in which I reported a number of interviews with GPs about their attitudes towards, and their experience with palliative care in the terminal stage of life [2]. At that time euthanasia was practised in secret. I divided the attitudes of GPs towards palliative care into 'paternalistic', 'mechanistic' and 'anticipatory'. The GPs who worked according to the paternalistic model told me they had had no experiences with euthanasia. Their patients had not asked for it. However, if a patient was suffering badly they increased the amounts of morphine even up to a lethal dose without discussing this with the patients or their families. The patients working according to the mechanistic model stated that they had a good deal of experience with euthanasia; more than ten cases being no exception. The GPs reported that they had acted in accordance with their patients' express wishes and saw no reason to discuss the pros and cons in depth. The most interesting group were the GPs who practised in accordance with the anticipatory model. They found it difficult to become involved in euthanasia but said that they would not refuse euthanasia if the patient requested it explicitly and they saw no reasonable alternative. They also stated that they would only practise euthanasia if they understood why the patient asked for it and if they were in agreement with the patient's wish. GPs working within the anticipatory model communicated much more frequently with their patients than other GPs.

Almost all GPs who had had experience of euthanasia stated that they never consulted colleagues or other professionals. There existed a lack of knowledge about the technical aspects of euthanasia but the GPs in question did not dare to ask pharmacists, anaesthetists or other GPs for advice, while textbooks and medical journals offered no information of any kind. One GP confessed to having suffocated a patient with a pillow. Many doctors had emotional problems after committing euthanasia, including mental stress and sleeping disorders. All were without anybody in their professional environment with whom they could share their experiences and problems.

The shocking results of my study motivated me to join, in 1984, a committee of the Board of the Royal Dutch Medical Association (RMDA) for the formulation of

guidelines on euthanasia. The committee did not defend the right of euthanasia but felt that the RMDA could not deny the fact that many doctors were involved in hidden euthanasia. It found that the RMDA had the obligation to support those doctors and to ensure that physicians should be able to decide and act in professionally sound ways. Subsequently the RMDA paid a great deal of attention to improving palliative care as well as the communication, consultation and assessment processes involved in physician-assisted death. After 1984 the RMDA was given a pivotal role in the debate about euthanasia in the Netherlands. By skilful negotiation the RMDA succeeded in introducing a notification procedure in 1991 by which the quality of physician-assisted death could be made subject to public and social control without the need to prosecute any doctors involved in physician-assisted death.

The key question in the euthanasia debate is what type of argument or condition could justify physician-assisted death. Some ethicists argue that the justification for a physician's acts should be assessed by establishing a number of criteria, including whether the physician respects the will of the patient (principle of autonomy), his or her treatment harms the patient (principle of no maltreatment) or benefits the patient (principle of beneficence) and whether all patients are treated equally (principle of justice). Nowadays most defenders of euthanasia in the Netherlands mention respect for the patient's autonomy as the strongest argument in favour of euthanasia and other life-terminating acts. However, I fear that this might lead to situations in which it would be hard to resist patients' wishes while reasonable alternatives were available, or suffering could not be regarded as unbearable. The presence of repeatedly iterated requests is insufficient, and in cases of multiple defects in young children even unnecessary. I regard physician-assisted death as an evil, but an evil that can be justified if continued living is an even greater evil. In other words, there are situations in which the evil of euthanasia may, relatively speaking, be preferable to the evil of prolonged suffering. Some say that it is the absolute duty of a doctor to regard the preservation of human life as sacrosanct and that the active termination of life is never compatible with this duty. I certainly respect this high moral principle but I am also of the opinion that there are certain duties which are determined by situations in which there is an equally moral duty to apply the standards of euthanasia mentioned earlier.

Some suggest that the 'double effect' argument offers a reasonable way out. This allows physicians to increase the amount of morphine, even if they know that the result is the patient's premature death. The disadvantage of this type of practice is that the doctors

involved neither discuss their real motives nor the expected results with either the patient or their families; thus acting without consent of any kind. This type of argument leaves room for morally ambivalent situations in which notification remains outside public control.

Thomas McLean has formulated the duty of a doctor as follows: “To assist us to come safely into the world and comfortably out of it and during life to protect the well and to care for the sick and disabled” [3]. I emphasise that he restricts the domain of a doctor to those who are sick and disabled. His way of looking at the problem also stresses the fact that people who have to face the end of their lives need palliative care. I would wish to add to this that, in my experience, we cannot avoid situations in which terminating life is the only way that makes it possible for people to leave this world comfortably, or in any case without unbearable suffering. This implies that the justification for physician-assisted death lies in the principle of beneficence rather than in the duty to respect patient autonomy.

I conclude with the observation that in some cases physicians are confronted with situations in which the arguments against assisted death weigh less than the arguments for. If a patient requests euthanasia at an early stage of illness, a doctor cannot but deny such

a request. In such a situation a patient will always appreciate and respect a doctor's promise never to leave the patient alone [4]. I would also wish to make a plea here for assisted death to be restricted to situations in which doctors are already involved in palliative care. Euthanasia and physician-assisted suicide must be compatible with, and be part of appropriate palliative care [5].

In all this it is important to keep in mind that society has a legitimate and genuine interest in the transparency of doctors' actions in death and dying. This means that physicians must have the courage to defend their actions in public debates and in the courts.

As stated earlier, I agree with the judgement of the higher court, while I see no merit in the argument that a doctor should be qualified to give professional judgements about situations in which patients suffer for reasons external to the domain of medicine.

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