Euthanasia:
a Christian appraisal of the Dutch situation.

H. Jochemsen, PhD [1]

1. Introduction

On June 1, 1994 a new legal regulation of euthanasia, assisted suicide and life-terminating actions without a request became effective in the Netherlands. This regulation can be seen as an experiment: will it be possible to tolerate and regulate euthanasia while at the same time keeping it under control and within specific boundaries? This paper presents an evaluation of this experiment so far. Against the background of this experience an overview will be given of the main arguments for and against (legalisation of) euthanasia. This will be done from a Christian point of view.

2. The situation

2.1 Definitions and distinctions

In the Netherlands euthanasia is nowadays defined as: *the active killing of a patient, at his or her request, by a physician*. Thus, the request of the patient has become part of the definition of euthanasia. In the international literature one usually distinguishes between voluntary euthanasia, which fully corresponds with the above definition of euthanasia, nonvoluntary euthanasia, which is the killing of a patient without an explicit request, and involuntary euthanasia which is the killing of the patient against his or her will. In the Netherlands nonvoluntary euthanasia is called a life-terminating action.
For clarity in the discussion and evaluation it is important to distinguish euthanasia from other actions of physicians that may appear to be euthanasia but are not. It has been agreed in the Netherlands that the following three categories of actions should not be considered as euthanasia.[1]
a) Stopping or not beginning a treatment at the request of the patient,
b) Witholding a treatment that is medically useless,
c) Pain and symptom treatment with the possible side-effect of shortening life.
We will briefly discuss these courses of action.

Ad a) No patient may be treated without his informed consent, and the patient is entitled to refuse treatment or to withdraw consent. As a rule the physician should respect such a wish, granted that the patient is competent. The physician has a moral duty to try to convince a patient to undergo medically useful treatment and the physician should not stop such treatment straight away, just because the patient asks for it. Yet, when the physician respects the wish of a fully competent patient and the patient dies soon after the withdrawal of life-supporting treatment refused by the patient, this cannot be classified as euthanasia. (I leave aside possibly difficult and ambiguous situations).

Ad b) Treatment that is medically useless should not be provided and can or should be withdrawn when it is provided. This, of course, raises the question what is medically useful treatment. Such treatment fulfills the following criteria:
- the treatment is effective and proportional, which means that the expected benefits of the treatment outweigh its expected or possible risks and burdens for the patient,
- the evaluation of benefits, risks and burdens for the patient should only take into consideration

[1] Director Prof. dr. G.A. Lindeboom Instituut (www.lindeboominsgtituut.nl). This is the text of a lecture given at the conference on `The Christian stake in dignity and dying' organized by the Center for Bioethics and Human Dignity, Bannockburn, Illinois, USA, July 13-15, 1995.

medical criteria and should not be an evaluation of the value of life of the patient.
It must be granted that the medical judgement of proportionality is not a value-free evaluation. To a certain extent such an evaluation is personal and subjective. This is why medicine is a moral enterprise in the first place and why medical practice cannot do without medical ethics.
Stopping medical treatment that has become medically futile, after which the patient dies, has sometimes been called passive euthanasia. I think this is confusing. Stopping disproportional medical treatment has always been good medical practice. The fact that in practice it is often not easy to determine whether a treatment becomes disproportional does not rule out this principle. It is important to note that the withdrawal of futile medical treatment does not intend the death of the patient. Neither can the death of the patient in a moral sense be considered the result of such a withdrawal. In other words, there is morally a fundamental difference between `killing' and `letting die'.[2] Only when medical treatment that should be considered proportional is withdrawn, with the intention to bring about the death of the patient, `letting die' morally equals killing.

Ad c) Pain treatment aims at the alleviation of the patient's suffering. It may, and in certain cases almost certainly will shorten the life of the patient. However, actions must be defined according to their aims and not according to their side-effects. So, the shortening of life as a side-effect of proportional pain and symptom treatment is a morally correct action and should not be classified as euthanasia. I think in these cases the principle of double-effect applies.[3]
It is obvious that in practice pain treatment can shift to the killing of the patient by gradually and intentionally increasing the medication, beyond doses needed to treat the pain and symptoms effectively.

2.2 Data

With these definitions and clarifications in mind, we will take a look at the main quantitative data on the practice of euthanasia in the Netherlands.[4]
Annually (the data are for 1990) in the Netherlands there are 9,000 requests for euthanasia (termination of life on request) 2,300 of which succeed (1.8% of total deaths [129,000]. There are 400 cases of assisted suicide and 1,000 cases of life-terminating actions without a specific request. The survey also found that in 7,100 cases physicians intensified pain and symptom treatment partly with the intention or with the explicit intention to shorten life, and, with the same intention, in 7,875 cases treatment was not started, or was terminated.[5] In 20% to 60% of these two groups of patients, the physician had not obtained an explicit consent.

These data raise a few questions.[6] The 1,000 cases of life-terminating actions without a specific request caused some uneasiness in political and medical circles, because it was contrary to the established requirements. People liked to believe that these requirements were generally well-observed (see further). It should be noticed that
- physicians distinguished these actions from the intensification of pain treatment with the explicit purpose of shortening life;
- about a quarter of these patients were competent to a certain extent, but their lives were terminated by the physician without an explicit request.

Intensification of pain and symptom treatment and forgoing medical treatment can be good medical practice, even when this may involve a shortening of life. This, however, should be a side-effect and not the intended result. Yet, in quite a number of cases physicians reported that they intensified pain and symptom treatment, or stopped treatment (including tube-feeding) partly with the purpose or with the explicit purpose of shortening life. In my opinion the intention to shorten life should not be part of the professional ethics of physicians. On the other hand, the intention itself to shorten life, does not make the action euthanasia. Euthanasia is defined as the *factual intentional shortening of life*, not just on the basis of the intention. Since the survey did not ask the physicians what they really did and how far they considered their treatment proportional, it is unclear to what extent the actions aiming at the

shortening of life were really cases of euthanasia.[7] This means that in fact we do not have a clear picture of the real euthanasia practice. It is clear that this will hamper effective control.

2.3 New regulation

The genesis of the new regulation was the Supreme Court's ruling (1984) that the physician who commits euthanasia can, in cases of an objectively established `conflict of duties' appeal to a defense of `necessity' (Penal Code art. 40). This conflict concerns, on the one hand, the duty to obey the law prohibiting euthanasia and assisted suicide (Penal Code art. 293, 294), and on the other hand, the duty to alleviate suffering.

The court ruled that the conditions establishing such a `conflict of duties' are essentially: a free, well-considered request, unacceptable suffering, consultation of a colleague by the physician.

The government approved the Supreme Court's decision, thereby accepting euthanasia under certain circumstances. At the same time, however, the government sought to maintain its responsibility for the effective protection of human life by maintaining the prohibition of euthanasia and assisted suicide in the Penal Code. They tried to reconcile these two aims by giving a statutory basis to the procedure by which physicians report death in cases of euthanasia, assisted suicide and life-terminating actions without an explicit request, by amending the law on the Disposal of the Dead. So the new law is in fact not so much a regulation of euthanasia, as a regulation of a reporting procedure of euthanasia. In terms of this procedure, a doctor who has terminated a patient's life informs the local medical examiner who inspects the body externally and takes from the attending physician a statement which contains the relevant data (the patient's history, request, possible alternatives, the consultation of a second physician, intervention etc.). This report, together with an evaluation by the local medical examiner, is checked by the Public Prosecutor, who considers whether the termination is contrary to the Penal Code as interpreted by the courts or not.

The fact that life-terminating actions without a specific request must be reported following to the same procedure as euthanasia has been debated fiercely. Critics say that this puts both kinds of actions morally on the same level, which they consider incorrect. The government's intention is that the courts should consider the acceptability or otherwise of the actions in every such case. To make this possible those actions should be reported in the first place.

2.4 Criticism of practice and regulation

a) In addition to the 2,300 cases of euthanasia there is a large grey area between good medical practice and the intentional shortening of life, with or without a request. It remains unclear from the survey what the physicians actually did in these cases but the intention to shorten life makes these actions ethically suspect. As these actions are not reported, control on what is happening is impossible.

b) The majority of euthanasia cases were *not reported*[8]; of the 1,000 cases of the termination of life without a request virtually none was reported, making it impossible for the legal authorities to evaluate and judge what had happened.

c) The *reported* cases represent a selection of all cases in which the requirements are met. Furthermore, when physicians report a case of euthanasia, they choose formulations which are known to satisfy the legal authorities, but which may conceal what has really happened.[9] Apparently the reporting procedure does not guarantee the effective control of life-terminating actions by the legal authorities. It is doubtful whether the new law will change this situation.

d) The new procedure also raises questions on the position of the medical examiner. He is supposed to sign a form stating that he has checked the notification of the physician who performed euthanasia and has found that the procedure has or has *not* been followed according to the rules. However, in most villages the medical examiner is working as a family doctor most of his time and is a colleague of the other family doctors in the village, with whom he has to collaborate regularly (performance of weekend duties etc.). In such situations the medical examiner will experience strong social pressure to give his approval of euthanasia cases even when he has doubts about the fulfilment of the requirements. Furthermore, it is impossible for the medical examiner to check the most fundamental criteria, viz. whether the patient was suffering intolerably and whether the request was completely voluntary and

well-considered, because the person whom it concerns has died.

2.5 Assisted suicide

The legislation did not stop the developments nor the discussions.
A landmark in jurisdiction was the decision of the Supreme Court on June 21, 1994.[10] This concerned a case of a psychiatrist, called Chabot, who assisted a woman in committing suicide. She was depressed because of very sad, personal experiences, including the death of her two sons - one had committed suicide. The psychiatrist had reported his `life-terminating action' and had been acquitted by two lower courts before the Supreme Court investigation. The Supreme Court decided that, in principle, a physician can also appeal successfully to `necessity' after performing euthanasia or assisted suicide on patients not in a terminal stage and with psychic, rather than somatic, suffering. To ascertain the free request of the patient a second psychiatrist must have seen the patient and confirmed that there are no other possibilities to alleviate the suffering, in which case assisted suicide is not permitted. Chabot had not asked a colleague to investigate the patient and for this reason was found guilty but not punished.
Chabot was also brought before the Medical Disciplinary Court in Amsterdam in February 1995.[11] This court rebuked Chabot for having assisted in suicide, but not on the ground that it is in contrast to professional ethics, but because he had not tried hard enough to treat the patient for her depression. In fact the Disciplinary Court applied the decision of the Supreme Court that a physician can only assist in suicide when there are no medical possibilities to relieve suffering. Furthermore, the court was of the opinion that because of her depression this patient could not be considered fully competent and therefore Chabot should not have fulfilled her request without having treated that depression. The Disciplinary Court also rebuked Chabot for not having observed sufficient professional distance to the patient.

The present Cabinet has adopted the Supreme Court decision and did not change this after the decision of the Medical Disciplinary Court.[12] In fact the ministers of Justice and of Public Health also apply the rule that no euthanasia/assisted suicide is permitted when there are medical possibilities to alleviate the suffering, to somatically suffering patients. Consequently, the Public Prosecutor has dropped the prosecution of physicians who euthanized somatically suffering patient not (yet) in a terminal stage.
It can be concluded that under strict conditions euthanasia and assisted suicide have also been accepted in cases of non-terminal somatically or psychically suffering patients.

2.6 Severely handicapped babies

The most recent significant development concerns two cases of severely handicapped babies who were killed by their physicians at the request of the parents. The first case was brought before a District Court in May this year, while the second case is still under investigation. In the first case the baby had spina bifida, hydrocephalus, a spinal cord lesion and brain damage. The specialists decided not to operate on the spina bifida, because of the bad prognosis. The baby appeared to be suffering severe pains that were hard to treat. The parents did not want the baby to suffer and asked for the termination of her life. Three days after the baby was born, she was killed. She died in the arms of her mother. The physician appealed to the defense of necessity and the Court accepted this appeal. In its judgment the court has formulated requirements the physician should fulfil in order to appeal successfully to the defense of necessity in similar cases. These requirements are:[13]
- the patient/baby suffers intolerably with no prospect of improvement; the suffering is incurable and can not be alleviated, at least not in a medically useful way,
- both the procedure leading to the decision to terminate the patient's life and the life-terminating action itself, should meet the requirements of carefulness and precision,
- the physician's actions should comply with scientifically responsible medical opinion and with prevailing standards of medical ethics,
- life-terminating actions shall only be performed at the explicit, repeated, and consistent wish of the parent(s) as the legal representative(s) of the baby.

With the phrase `suffering that could not be alleviated in a medically useful way' the Court hints at a situation in which the only way to take away the suffering is to bring the patient (almost) to a situation of coma. From the available data this is difficult to judge. In personal discussions other pediatricians have raised questions on this point: it seems unlikely that this was the case with this baby, but the available data are insufficient to get a full picture of the situation.

Basically, the killing of babies in certain cases is defended by two lines of reasoning. These are:
a) Stopping or not initiating a treatment and accepting that the patient will die, is construed as a decision for death. So, morally this decision equals a decision to kill the baby. Under certain circumstances one ought to do this, in order to prevent the baby from more suffering.
b) Closely related to this reasoning is the rejection of the principle of double effect. Accepting that pain and symptom treatment will shorten life, so the line of reasoning goes, is not fundamentally different from intentionally shortening life by medication to the extent of practically killing the patient.

Both arguments have been rejected above (paragr. 2.1). In fact, advocates of euthanasia and life-terminating actions are very ambivalent, if not contradicting themselves, in putting forward these arguments. For when they interpret the findings of Van der Maas et al. they do distinguish between euthanasia on the one hand and stopping or not starting a treatment or intensifying pain treatment with the (explicit) intention to shorten life on the other (see paragr. 2.1, 2.2). If they did not make this distinction the number of cases of euthanasia would be unpleasantly high. But why then denying the distinction between forgoing disproportional treatment and proportional pain treatment, taking for granted an unavoidable shortening of life on the one hand, and the intentional killing on the other? Is it because in this context blurring the distinctions is necessary to give the unrequested euthanasia an appearance of ethical correctness?

Though higher courts will still decide on this case, this judgment may well be a first step towards the formal acceptance of nonvoluntary euthanasia, the practice of which has already been demonstrated.

3. The debate

3.1 Arguments in favor of euthanasia.

3.1.1 Autonomy

A major argument of those who approve of euthanasia is the principle of autonomy or human self--determination.
More and more the right to self-determination is extended to the moment and the way one is going to die.[14, 15] Death should not be awaited with fear and trembling while one's physical and mental condition is deteriorating, but death should be brought about willfully by a 'free decision' of an autonomous person who has chosen to 'step out of this life'. Illustrating the rise of this mentality in the Netherlands is the wide support for a proposal from an elderly, well-respected man of law who suggested that from a certain age people should be able to obtain a 'euthanasia-pill' from their GP at their request. This would allow the elderly to terminate their life at a self-chosen moment.
Yet, internationally this use of the autonomy principle is certainly not generally accepted.[16]

3.1.2 Health and death

In modern society health is understood more and more as an ideal of vitality, wholeness, even beauty and of a sense of well-being, as the ability to function and to enjoy things. Health care and medicine are expected to maintain or restore health as much as possible.
Many people find it increasingly difficult to cope with incurable diseases and handicaps. When a certain health condition is prerequisite for a meaningful life, then life loses its meaning when that condition has become unattainable. So, when a certain situation of illness, discomfort, and dependency has been reached and the burdens of life outweigh its benefits, the death of the sufferer is considered

an advantage for everybody involved. Then why not bring about death?

3.1.3 Control and mercy

In modern medicine there is a tendency to gain control over life.[17, 18] The intention is to maintain life and health as much as possible. However, the enormous technological facilities also make it possible to prolong the life of patients into a situation which turns out to be `unbearable' for the patient. Such terrible suffering and agony toward the end of life is seen as a dehumanization. This should not be tolerated: man has a right to die with dignity, it is stated. Then the aspiration for control may lead to a choice for death. Killing the patient is then considered an act of *mercy* of the physician and of *beneficence* towards the patient.

3.2 Arguments against euthanasia.

3.2.1 Autonomy concept inadequate

The concept of autonomy, so fundamental for the advocates of euthanasia, is based on a certain view of man. It considers man basically as an individual, who by his reasoning can decide about his norms and values and can make decisions for his own life independently. What makes a human being really human is, in this view, his reasoning. This anthropology fails to recognize the importance of the spiritual, historical and social dimensions of mankind. It reasons in terms of rights and duties and not in terms of care and responsibility. In a Christian view all of these should have a place.

The autonomy concept is also unrealistic, particularly in health care. Can a very ill person really make an independent and free request to be killed? A Dutch neurologist has argued that the very fact of being in a terminal state, as well as the medication that is often given in those situations, make a clear and normal functioning of the brain almost impossible.[19, 20] Furthermore, the patient is completely dependent on others, who through their attitude, gestures, tone of voice, etc. can suggest the patient to ask for euthanasia. This is especially true for the physician and can even happen unconsciously if in the doctor's opinion euthanasia is considered to be a good `solution' in some cases. Even if a truly voluntary request existed theoretically, in practice it would be difficult to make sure if a request was voluntary indeed.[21]

Furthermore, the autonomy of the patient cannot be the main reason for accepting euthanasia, simply because the physician is performing it. Thus, at least euthanasia also requires the autonomous consent of the physician. This means that when performing euthanasia, the physician freely and intentionally kills the patient. But the free and intentional killing of another person, even with good intentions, will influence the attitude of the physician towards all his patients, both competent and incompetent. Therefore, euthanasia affects other patients and cannot be considered as an affair of the individual patient and his or her physician.

A last, and for Christians most decisive objection against the autonomy principle is the biblical teaching about God's sovereignty. God is the Creator and therefore the Lord of life. Man is not allowed to terminate a man's life (Genesis 1:27; 4:9,10; 9:5,6). The best-known formulation we find in the sixth commandment: 'You shall not murder' (Exodus 20:13).[22] In the New Testament this is one of the commandments Jesus explicitly radicalizes (Matthew 5:21-23). This commandment concerns all human beings. In the Christian view of life, the question whether life is valuable is not determined by the functions or capacities that can objectively be verified. The value and the dignity of man reside in being created by God and in being called to live in a relationship of love with God, one's fellowmen, and creation. In these relations the physical existence is fully involved. As long as there is a living human being, manhood implies personhood (total brain death being accepted as death of the person), because this is rooted in the relation with God, which cannot be measured medically.

3.2.2 Inadequate care

A request for euthanasia is very often a sign of insufficient or inadequate care or attention. The patient feels uncomfortable, has pain, is afraid of what still may happen, worried about relatives or relationships. Such a request should be taken as an appeal to our responsibility to provide the care that

is needed. This is precisely what hospice care intends to do. Good care and attention by physicians and nurses, attention by relatives, adequate pain treatment (nowadays almost always possible) in most cases make a request for euthanasia disappear.[23, 24] Exceptions to that rule may exist, but exceptions should not determine morality nor legislation. Fortunately, the alternative of better care is getting more and more attention, also in the Netherlands. `Quality of life' should not be a criterion in considering whether life can be terminated, but should be understood as a social duty, not least by Christians.

3.2.3 Slippery slope

Voluntary euthanasia will provoke nonvoluntary euthanasia. From the data of Dutch euthanasia practice, it can be concluded that not so much the request, but rather the condition of the patient is the fundamental reason for physicians to terminate a patient's life (cf. paragr. 2.2).
Yet, in cases where the condition of the patient gives reason to perform euthanasia on request, the patient will often no longer be able to make a free request. However, since the condition functions as the fundamental ground for euthanasia, the fact that there is no request could then be considered insufficient reason *not* to perform euthanasia. In this way the ideological background of voluntary euthanasia also provides a justification for nonvoluntary euthanasia (cf. paragr. 2.6).

3.2.4 Doctor/patient relationship

The acceptance of euthanasia will seriously change the doctor/patient relationship for the worse.[25] "There is an inherent conflict of interest between the beneficent healing and comforting role in which life and wholeness is sought, and one in which death is caused intentionally".[26]
The acceptance of euthanasia as a part of `good medical practice' will definitely change the attitude of health care workers to terminally ill patients, both competent and incompetent. Fenigsen has given several examples of that new mentality that is becoming manifest in the Netherlands (giving up patients unnecessarily, or withholding medically indicated treatment since the patient is "just living by himself", or is already 70 yrs. of age etc.).[27]

It may be granted that when the life of a patient is intentionally terminated, death itself is not the good that is sought for, but the elimination of suffering. However, medicine should fight suffering because of the person and should not turn against the person because of his suffering.
In extreme situations it is understandable that the patient, in the experience of those involved, almost completely coincides with his suffering. Even then, a conceptual identification is incorrect, and withholding or withdrawing disproportional life-sustaining treatment does not (necessarily) intend the death of the patient. Yet this obviously is the case when euthanatics are administered, because then the patient is killed to finish the suffering. Medicine becomes subservient to an undue aspiration for control. For when the quality of *life* cannot be maintained at the desired level, the *situation* can be brought back under control by killing the patient.
Behind this way of proceeding I suspect an understanding of medicine in which medicine is made responsible for the relief or the alleviation of all suffering. All suffering is considered wrong and its relief is considered the highest value. More and more this seems to include the suffering caused to the parents by the birth of a child with severe handicaps, even apart from the possible suffering of the child itself. This is a misunderstanding of the character and an overestimation of the task of medicine which entail the danger of overtreatment on the one hand and of considering killing a task of medicine on the other.[28] Both involve a dehumanization of medicine.

It is very important that physicians are able and willing to recognize the limitations of medicine in fighting death, and to accept that at a certain stage a soon death becomes inevitable (cf. paragr. 2.1). It then becomes very important not only to care for the patient, but also to help him or her, as well as the family, to accept that death is imminent.[29, 30]

3.2.5 Cultural suicide

Accepting (nonvoluntary) euthanasia will implicate that some people will decide about the lives of

others. This implies the acceptance of the concept of `human life that is better off not living', with the conclusion that such life may be terminated.
L. Kolakowski, a Polish philosopher has argued that the unique and irreplaceable character of each human being has been a fundamental value in European culture. Accepting that it would be right to kill certain people would be a denial of this value and would mean `cultural suicide', the consequences of which are incalculable, but which would certainly put at risk the lives of certain groups of people. Kolakowski acknowledges that this conviction about the sanctity of human life cannot be proven.[31] It rests on certain basic beliefs, just like every ethical position is eventually based on certain basic beliefs. In the Christian view of life the respect for human life, irrespective of its conditions, is ultimately based on the belief in a personal God Who created the human being in His image (Gen.1:26).

4. In conclusion

I think the Dutch experiment of trying to regulate euthanasia while at the same time keeping it under control has failed. The experiment has demonstrated that once euthanasia is officially approved and practiced, the practice develops a dynamic of its own that resists effective control and that tends to expand. The experiment has failed, but I am afraid that its consequences will be irreversible, at least for quite some time.
It is astonishing that so many people in the Netherlands do not seem to realize how much the present situation corrodes the basis of our constitutional state. Fortunately, the number of initiatives in hospice care, which may provide an alternative to euthanasia, is also increasing, not least by Christians.
The Word of God is not just for the private lives of those who believe in God. His commandments apply to all people (Eccl. 12:13) because they make life flourish. And when life presents us with situations so hard that there seems no good solution, the desire to follow God's indications will help us to find the way to go.

References

1. H J J Leenen, `Dying with Dignity: developments in the field of euthanasia in The Netherlands'. *Medicine and Law* 8 (1989), pp. 520-526.
2. Cf. D Callahan, `Can we return death to disease?', *Hastings Center report* 19 (1989) no.1, special supplement, pp.4-6.
3. See W Reich (ed.),`Acting and refraining', in: *Encyclopedia of Bioethics*, (New York: Free Press, 1978), pp.33-35; also T L Beauchamp, J F Childress, *`Principles of biomedical ethics'*, (New York: Oxford University Press, 1983, 2nd ed.), pp.113-115.
4. P J van der Maas, J J M van Delden, L Pijnenborg, `Euthanasia and other medical decisions concerning the end of life', *Health Policy* 22 (1992) nr.1/2), pp.1-262; also published in hardback by Elsevier Science Publishers, Amsterdam 1992.
5. The latter two numbers are not given in the report of Van der Maas et al., but are calculated form their data.
6. For a more detailed discussion of the data and of the new regulation see: H. Jochemsen, `Euthanasia in Holland: an ethical critique of the new law', *J Med Ethics* 20 (1994), pp.212-217.
7. The fact that in about 75% of these cases the physicians estimated that life was shortened by by more than one day by their action makes most of them look like euthanasia even more. Even so, to a certain extent, those actions may in their effect not have been different from adequate pain treatment. The question that should also have been asked is: What medication would you have given, had the shortening of life not been your intention?
8. In 1989, 336 cases were reported, in 1990, 454, in 1991, 590, in 1992, 1318, in 1993, 1303 and in 1994, 1417 cases. *Source: Year Report Public Prosecutor 1994*. It is not clear, however, whether the total number of cases of euthanasia has not also increased since 1990.
9. G van der Wal et al., *Medisch Contact* 47 (1992) nr.2, pp. 43-47; *Medisch Contact* 47 (1992) nr. 31/32, pp. 905-909; *Medisch Contact* 47 (1992) nr.36, pp.1023-1028.
10. This decision has been published in: *Ned Juristenblad* 69 (1994) afl.26, pp. 895 ff; for an extensive personal

presentation of this case, see: H Hendin, `Seduced by death: doctors, patients and the Durch cure', *Issues in Law & Medicine* 10 (1994) nr.2, pp.123-168.

11. `Psychiater berispt voor hulp bij zelfdoding', (*psychiatrist rebuked for assisted suicide)*, *Medisch Contact* 50 (1995) nr.21, pp.668-674.
12. Letter of the Minister of Justice and the Minister of Public Health, Welfare and Sports, d.d. 16 September 1994, to the Second Chamber, concerning the cosequences of the desicion of the Supreme Court of 21 June 1994, for the prosecution of euthanasia.
13. Decision District Court Alkmaar d.d. 26 april 1995 (parketnr. 14.010021.95) regarding mr. H. Prins, pediatrician.
14. Leenen, see note 1.
15. J H P H Willems, `Euthanasie en noodtoestand', *Ned. Juristenblad* 22 (1987), pp.694-698.
16. Cf. `The Appleton International Conference: developing guidelines for decisions to forgo life-prolonging medical treatment', *Journal of Medical Ethics* 18 (1992, supplement), pp. 3-5.
17. K Jaspers, `The physician in the technological age', *Theoretical Medicine* 10 (1989), p. 262.
18. Editorial, `A new ethic for medicine and society', *California Medicine* 113 (1970) nr.3, pp. 67, 68.
19. B P M Schulte, `Over euthanasie en in het bijzonder over de relatie tussen hersenfunctie en vrijwilligheid bij euthanasie', *Vita Humana* XV (1988) nr.1, pp. 9-12.
20. M Hunt, `Sick Thinking', *New York Times* March 1, 1988, who quotes dr. E. Cassell, clinical professor of public health: "Sickness changes people's ability to make decision. They become dependent on the doctor and others to take care of them and focus on themselves rather than the ouside world. ..... they no longer reason like well people".
21. D Callahan, `When self-determination runs amok', *Hastings Center Report* 22 (1992) nr.2, pp. 52-55.
22. For an instructive discussion of the meaning of the 6th commandment for the euthanasia issue, see: P Saunders, `Thou shalt not kill', *Journal of the CMF* 38.3 (July 1992), pp.3-11.
23. H L van Aller, et al., *`Stervensbegeleiding'* (Utrecht: Bunge, 1990), Chapter 6. (This is a publication on care for the dying, prepared by a working committee of two Dutch associations of physicians).
24. J M M Michels, `De symptomatische behandeling van terminale patiënten' (the symptomatic treatment of terminal patients), *Vita Humana* XIV (1992) nr.1, pp.5,6.
25. P A Singer, M Siegler, `Euthanasia - a critique', *New Engl J Med* 32 (1990) nr.26, pp. 1881-1883.
26. W Reiche, A Dijck, `Euthanasia: a contemporary moral quandary', *The Lancet* ii (1989), pp.1321-1323; quote p.1322.
27. R Fenigsen, `A case against Dutch Euthanasia', *Hastings Center Report* 19 (1989) nr.1, special supplement, pp. 22-30.
28. For a further elaboration of this point see: H Jochemsen, J Hoogland, S Strijbos, `The medical profession in modern society - the importance of defining limits', In: J F Kilner, Nigel M de S Cameron, D L Schiedermacher (eds). *Bioethics and the future of medicine: a christian appraisal* (Grand Rapids MI: Eerdmans, 1995), pp.14-29.
29. National Association of Health Authorities, `*Care of the dying'*, Birmingham 1987.
30. R G Twycross, *`The dying patient'* (London: CMF Publications, 1986).
31. L Kolakowski, `Het doden van gehandicapte kinderen als het fundamentele probleem van de filosofie' (the killing of handicapped children as the fundamental problem of philosophy), *Rekenschap* 19 (1972), pp.35-49.