

EUTHANASIA IN THE NETHERLANDS

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In early February of 1993, a large majority in the Lower House of the Dutch Parliament passed a bill on euthanasia. This event was followed by a stream of extremely critical commentaries in the international press. It was predicted in the Netherlands, however, that the Upper House would pass the bill. On November 30, 1993, it did so, with a slim 37-34 majority, and only after weeks of heated debate, political lobbying, and the threat of a more liberal proposal. On June 1, 1994, the new law came into force. This article, on the background of the euthanasia debate in the Netherlands, argues that the anxieties of some of the opponents of the bill certainly were justified.

The vote of the Upper House has made the Netherlands the first country to pass explicit legislation on this topic. It should be emphasized, however, that the new law does not legalize euthanasia. The law takes as its starting points that (1) euthanasia is to be defined as an active medical intervention to terminate life intentionally at the explicit request of the patient, and withholding or withdrawing treatment that is medically futile or refused by the patient (improperly characterized as passive "euthanasia") generally is accepted and legally sanctioned (since a 1973 court case); and (2) euthanasia must remain open to legal audit (which is possible only if it remains a criminal offense).

Consequently, the criminal code has not been changed and the practice of euthanasia remains illegal. The new law emphasizes that a case in which death has resulted from medical actions that accelerate death may not be reported by the attending physician as a "natural

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death." The attending physician should report the case to the local coroner, who will inform the prosecutor. The latter will then decide on a case-by-case basis whether prosecution should follow.²⁰

The legal foundation for this reporting procedure should enable the public prosecutor to assess each case of euthanasia. The physician involved in a case of euthanasia must submit a written report to the coroner that includes the following information:

1. The patient's medical history;
2. The request to end life and to whom this request was voiced; in this case, two situations could occur
 - There was an expressed, voluntary, and carefully considered request of the patient;
 - There was no expressed request of the patient; in this case, the physician must explain the reason for the absent request;
3. The consultation of a colleague;
4. The means used to end life.

On the basis of this report, the public prosecutor will decide whether or not to prosecute. The final format of the report has been laid down in a General Administrative Order.

HISTORICAL BACKGROUND

In 1969, the Leiden professor of psychiatry, J.H. van den Berg, published a booklet titled *Medical Power and Medical Ethics*.¹ Immediately, this early critique of the increasing power of modern medicine became a bestseller, with 25 editions and translations in many languages. In it, van den Berg argues that new technologic capabilities of medicine had been counterproductive in many cases because they were guided by the traditional medical-ethical prescript to maintain, restore, and protect life. The book contains photographs, for example, of children with phocomelia and hydrocephalus and of a patient whose entire body below the lungs and stomach had been removed. These photographs conveyed the message that modern medicine was applying every technique and intervention possible, without considering how the patients were benefiting from applications of medical technology. Van den Berg argued that modern medicine should reorient itself, from preserving biologic human life to sustaining meaningful personal life.

Van den Berg's book soon was followed by other critiques, such as Ivan Illich's *Medical Nemesis*,¹⁰ illustrating with a wealth of empirical data that the medical establishment itself has become a major threat to health. Illich shows how death has become a clinically supervised event with people losing their right to preside over their act of dying.

Although less of an attack of the medical establishment, the contemporary work of Elisabeth Kübler-Ross¹³ also called for more emotional support and counseling in the final phases of human life rather than technical interventions. The dying person should be allowed to die his

or her own death, but the ethos of medical interventionism precludes the patience and tolerance required by the respect for the process of dying one's own death.¹³

A review of the literature in the 1960s and 1970s on medicine's understanding of and approach towards death elucidates the euthanasia movement as it has arisen in the Netherlands during the last two decades. This movement started as a protest against medicine's growing tendency to alienate individuals from their own death and dying. It therefore emphasized respect for the patient's right to self-determination as the ultimate moral principle in matters of life and death. Provided it is the expression of the autonomous wish of the patient, the attending physician should respect the patient's decision to discontinue medical treatment. Similarly, if a patient's request for euthanasia is autonomous, physicians should comply with such a request. In sum, the moral principle of respect for individual autonomy was the cornerstone of the original ideologic theory justifying the medical practice of euthanasia.

Since the first court case in 1973, public debate on euthanasia in the Netherlands has become more intense.²⁴ The past decade, however, has shown a shift in the euthanasia debate from the level of critical medical-ethical arguments, justifying or opposing euthanasia within the physician-patient relationship, to the socio-ethical and political problems of whether and how to regulate the actual practice of euthanasia given newly accumulated empirical data. Medical-ethical viewpoints regarding euthanasia in clinical practice have been moved to the background.

THE MEDICAL PRACTICE OF EUTHANASIA

Although active euthanasia always has been a criminal offense, in the past two decades medical specialists and general practitioners have been quite open about their euthanasia practice, publishing case reports in influential Dutch medical journals.¹⁷ This professional candor has coincided with (and probably was fostered by) a considerable judicial lenience towards physicians practicing euthanasia under strict conditions. Among these conditions, three have been scrutinized most frequently in court decisions and bills: (1) the patient's voluntary and persistent request; (2) the hopeless situation of the patient; and (3) consultation of a colleague.²⁷

In spite of all this professional openness and legal lenience, many physicians who perform euthanasia have not been prepared to face the risk of the legal consequences of their practice, and have completed death certificates incorrectly. Consequently, the overall incidence of active euthanasia in medical practice remained unknown for a long time; estimates varied from 2000 to 20,000 per year. In January 1990, the "Rommelink Committee," comprising three lawyers and three physicians, was appointed by the Minister of Justice and the Secretary for Public Health, to obtain an empiric understanding of the frequency and nature of euthanasia in medical practice. A random population of some

400 physicians was interviewed retrospectively about their own experience with end-of-life decisions. These physicians were asked to provide prospectively (anonymously) the true cause of death of each of their dying patients in the next 6 months. Finally, an attempt also was made to verify the cause of death of a random sample of some 8500 recent deaths. In September 1991, the Committee issued its report.² The results of the empirical part of the Rummelink Report have been published elsewhere in the English language (both the complete report and summary articles).^{15, 16}

According to the Rummelink Report, physicians make decisions about their patients' deaths for some 49,000 of 130,000 patients who die each year. These decisions include whether to discontinue life support, provide increasing doses of pain medication, withhold treatment, assist in suicide, or commit euthanasia. Assisting in suicide was found to occur in only about 400 cases a year. Euthanasia, or "intentionally ending life," is practiced some 2300 times, or in 5% of those 49,000 cases.

Van der Wal and colleagues²⁵ undertook a similar exploratory, descriptive, retrospective study of morbidity, age, and sex of patients whose family practitioner helped them to die. Van der Wal found that in euthanasia or assisted suicide cases, 85% of the patients suffered from malignant neoplasm (that is, euthanasia mortality rates among patients with cancer were twice the normal cancer mortality rate). Euthanasia, or assisted suicide, also was relatively frequent among patients with AIDS or multiple sclerosis (more than 10 times the normal AIDS mortality rate). In approximately 20%, a secondary, usually chronic disease had been diagnosed. Van der Wal also sent questionnaires to a random sample of family practitioners asking them to rate 24 aspects of the suffering of the last patient they had euthanized and to assess the patient's life expectancy. According to the respondents, 90% of these patients showed severe physical suffering and 71% showed severe emotional suffering. "General weakness or tiredness," "dependence or being in need of help," "loss of dignity," and "pain" were the most frequently identified aspects of suffering. In 63% of the cases, life expectancy at the moment of execution of the request was estimated as less than 2 weeks; in 39% it was less than 1 week; in 3% less than a day; in 10% it was more than 3 months.²⁵

THE AMBIVALENCE OF MORAL JUSTIFICATION

Mass media was quick to conclude that euthanasia apparently was not as frequent as assumed by both protagonists and antagonists.³ As argued elsewhere, this conclusion fails to take into account that many physicians do not interpret and classify their actions as euthanasia cases, even when those actions strictly fall under the range of the definition employed in the Netherlands; that is, an active medical intervention to terminate life intentionally at the explicit request of the patient.⁶⁻⁸ For example, the empirical data from the Rummelink Study reveal that

hastening death was the explicit intention of the administration of high doses of "pain" medication in 6% of the total number of 22,500 cases in which such analgesics with a possible lethal effect were administered. And in an additional 30%, death was at least one of the purposes. There is no longer a case for indirect effect, because death is the intended, direct effect.

Van Delden and colleagues⁴ have argued that the formulation of the intention (i.e., hastening death) may be the same in the previously mentioned cases as they are in euthanasia proper, but "the 'sameness' of the intentions can be questioned." They claim that intentions ultimately are private, and therefore, beyond public evaluation.⁴ The authors agree that in many cases it will be very difficult to *prove* the intentions of the physician who hastens death, but this is primarily a lawyer's problem. Moreover, the intention of the actor has been made an essential element in the official definition of euthanasia and even in the legal definition, in spite of the foreseeable difficulties of proving the physician's intentions.

Even more troublesome is that the Remmelink Report has shown that annually, there are about 1000 patients whose death is caused or hastened by physicians without an explicit patient request. This number pertains to patients who no longer were competent to make decisions, yet apparently suffered severely. Not included are cases in which medically futile treatments were withheld or withdrawn, because such treatments always have to be withdrawn. Although it is not clear how many of these cases are involuntary (i.e., the patients would have expressed the wish *not* to be euthanatized, had they been able to speak about it), the absence of an expressed request precludes qualifying these cases as euthanasia proper. Nonetheless, the committee felt that these 1000 cases of nonvoluntary termination of life should not be of concern. Instead, they should be thought of as "providing assistance to the dying." Nonvoluntary termination of life was justified because the suffering of those patients had become "unbearable" and standard medical practice considered their life "given up." Death would have occurred quickly anyway (usually within a week), if the physician would not have acted.² The committee adds that actively ending life when "the vital functions have started failing" is "indisputably normal medical practice."²

Although about a quarter of these 1000 patients previously had expressed the wish to die, interestingly this was not always the leading argument for the physicians euthanizing them. Only 17% of the physicians involved in these 1000 cases mentioned "previously uttered request of the patient" as their reason to terminate their patient's life. The researchers explained this discrepancy by arguing that physicians more often are guided by their own "empathy" with the patient's unspoken but probable wishes, than by explicit oral or written patient requests.^{2, 15} One may, of course, wonder whether such "impressions" are always correct. More importantly, this explanation indicates a significant shift in moral justification. As argued earlier, respect for autonomy always had been the prime argument in favor of active euthanasia, publicly

defended by the physicians, lawyers, and courts. But now that quite a number of cases (between 1000 and 8000)⁶⁻⁸ have occurred without an explicit patient request, other arguments are brought forward to defend this practice.

A paradox, therefore, emerges between this line of reasoning, which is used to justify euthanasia without explicit request, and the very opposite reasoning by the original advocates of voluntary euthanasia, who argued that suffering is a purely subjective phenomenon. Only the patient can decide whether his or her suffering has become unbearable. Termination of life is only justifiable when the patient requests it.⁴ It seems that some advocates of euthanasia use the latter strategy when defending the right of the competent patient to ask for euthanasia autonomously, and the former strategy when defending the practice of euthanasia on the mentally incompetent patient.

A similar ambiguity is demonstrated in Van der Wal's study.²⁵ His conclusion that the majority of euthanized patients *have* severe physical and emotional suffering does not follow. It merely can be concluded that the physicians, in retrospect, *think* this about their patients.

The strategies used by the Remmelink Report and Van der Wal seem intended to justify physicians making judgments about their patient's suffering and deciding that it is better for the patient to be dead. Although such arguments are not without internal merits, their function in the euthanasia debate is rather dubious given the fact that euthanasia always had been justified in terms of the patient's right to self-determination as opposed to physician paternalism.

The medical practice of euthanasia in the Netherlands reveals that the ethical justification has been shifting from *respect for autonomy* to *relief of suffering*. But these two arguments are mutually exclusive; it only makes sense to talk about respect for autonomy if a physician *refrains* from making judgments about the patient's benefits. It simply is logically impossible to base a euthanasia decision on *both* autonomy and beneficence, as Van Delden and colleagues⁵ have suggested. Moreover, the primacy of the bioethic principle of respect for patient autonomy always has been grounded in the presumed inability—or virtual inability—of physicians (or any other third person) to make reliable judgments on the patient's well-being or suffering. If, on the other hand, physicians now are considered to be very well able to make such judgments, the decisive factor is no longer the patient's own explicit request for euthanasia, but the physician's concurring with the patient's assessment of the suffering being unbearable. The physician only will comply with the "autonomous" request of the patient if he or she agrees that the patient's suffering is, indeed, unbearable, or that the quality of the patient's life is so low that the patient is better off dead. In fact, the patient's request will be regarded as an *autonomous* request only if it is rational from a *medical* point of view. In this line of reasoning, nothing changes when the same medical rationality indicates that euthanasia is appropriate, but the patient is no longer able to express an autonomous wish. When

the patient is incompetent or his or her views are unavailable, the physician still is capable of making the assessment.

Both empiric research and political debate reveal that in daily practice, two moral considerations compete with each other: respect for autonomy and relief from suffering. From the physician's point of view, the latter consideration appears to be the most important; it is the prime motive to perform euthanasia in cases of incompetent patients who, in the judgment of the physicians, suffer unbearably. It is also a strong motive in cases of competent patients because less than a third of all requests are fulfilled.^{2, 15} This implies that the outcome of the euthanasia debate is paradoxical; physicians now seem to have ultimate control over the moral justification of active euthanasia. The moral sensibility and judgment of the medical profession is apparently the only safeguard against abuses. It is unclear why and how medical professionals are competent to make judgments about their patients' suffering, and whether they have the right to do so—a question Van der Wal raises but leaves unanswered.²⁶ Intervention-driven medical technology has led to the euthanasia movement in the first place, yet there is no sign that this characteristic of medicine has changed significantly. The initial cause of the problem is now considered the prime solution to it.

THE CULTURE OF DEATH

Amazingly, the Remmelink Committee's revelation of approximately 1000 cases annually of unrequested termination of life has caused little outcry in the Netherlands. In fact, the number of advocates of nonvoluntary termination of the life of an incompetent patient only seems to have increased. Recently, professional committees (of the Royal Dutch Medical Association, the Dutch Society of Pediatricians, and the Dutch Society of Psychiatry) have argued that actively terminating the life of certain comatose patients and disabled newborns can be morally justifiable. In regard to patients suffering from psychiatric illnesses, it is argued that their disorder does not reduce their voluntary decision-making competency; hence, the acceptability of euthanasia cannot be ruled out a priori.^{12, 18, 19}

These developments reveal a growing tendency to regard active euthanasia as normal medical practice; it is the rational response in hopeless cases. In early 1994, a court dismissed the case of a psychiatrist who had assisted in the suicide of a woman who was stricken by grief, but not psychiatrically diseased.²³ About the same time, a Minister of the Dutch Government stated in an interview in a women's magazine that he would like to have a suicide pill at hand when he was growing old.²² Lastly, the Dutch Society for Voluntary Euthanasia advocated that everyone who fears to be admitted to a nursing home should have a declaration ready requesting euthanasia in case of lasting admittance to a nursing home.¹¹

One reasonably may assume that incompetent patients, had they

been competent, would have requested euthanasia. If physicians are unwilling to comply with such reasonable requests, maybe they should be pressured to comply anyway. Indeed, in early March of 1993, the Society for Voluntary Euthanasia brought a case to the newspapers of a 65-year-old woman with multiorgan cancer. Her family practitioner did not want to comply with her request for euthanasia. She consulted the Society, which concluded that euthanasia was justified clearly and consequently publicized the case to elicit public pressure.²¹

Such events, furthermore, indicate a significant change in attitude, not only toward death and dying, but toward suffering, growing old, and being dependent on long-term care. Nursing home physicians, rightly, reacted against the Society's proposals, arguing that they only enhance popular prejudices against nursing homes without taking into account the positive effects that treatment and care can accomplish.⁹

Social developments toward nonvoluntary termination of life, despite the ideologic framework emphasizing patient autonomy, are undeniable. One of the underlying reasons for this development is the ambivalence of ethical justifications, discussed previously. A second reason is the blurred distinction between active and passive euthanasia. Authoritative Dutch ethicists, such as Kuitert, have argued that the distinction between active and passive euthanasia is no longer relevant; the physician is thought to bear responsibility for the patient's death, not only when actively terminating the patient's life, but also when withdrawing lifesaving treatment.¹⁴

Ignoring the moral significance of the intentions of the physician has far-reaching consequences. Not only does it nullify the moral distinctions between withholding or withdrawing medical treatment (resulting in the patient's death) and active termination of life (causing the patient's death); it also implies that if a physician has withdrawn life-sustaining treatment, and the patient does not die, the physician must be prepared to end the patient's life. Moral consistency would require this second step, which is what Kuitert defends.¹⁴

This line of argument (besides being fallacious) clearly misrepresents actual medical practice. Undeniably, the Rummelink Report has shown that cases do occur in which treatment is discontinued primarily to hasten the patient's death. But there is no doubt that death is not always the intended outcome of a physician's discontinuing treatment. Treatment, in many cases, is withdrawn because it is deemed medically futile, and therefore, no longer beneficial to the patient. Conversely, if available medical remedies were not judged medically futile, treatment would have been continued and the patient would not have died.

Simply because *some* cases of letting patients die are justified, it does not follow that all such cases are justified. Some cases of letting a patient die clearly are unjustified, for example, when a patient is left to die when beneficial treatment is available. Here the treatment is not given because someone simply wants the patient to die. In such cases, there is, indeed, no morally relevant difference between killing and letting die.

There is yet another reason to uphold the moral significance of the distinction between discontinuing medically futile treatment and withdrawing beneficial treatment in an attempt to hasten death. Categorizing all forms of withholding and withdrawing medical treatment as euthanasia is possible only on the assumption that such withdrawals are acts of ending human life. That assumption, however, is mistaken. When medically futile treatment is discontinued, the life of a patient ends; but the agent ending the patient's life is not the physician. It is the disease, the underlying pathology, or the patient's general condition that is the cause of death. In such instances, the physician is not morally responsible for the patient's subsequent death. Any other interpretation leads to hypertrophy of physicians' responsibilities; they would be morally responsible for the entire course of regretful events, even if they are unable to give that course of events a positive turn. This hypertrophy is counterproductive because it fails to recognize that medicine has its limits; some conditions are not able to be manipulated by medical interventions. When a patient is suffering and is no longer benefiting from medical care, *treatment* should be terminated, not the patient's life. Because of its aggressive interventionism and its inability to acquiesce, medicine could be instrumental in creating conditions that lead patients to request active euthanasia.

THE (IM)POSSIBILITY OF PUBLIC CONTROL

Rejecting euthanasia as normal medical practice implies that particular acts of euthanasia are in need of additional ethical justification. But how is review and evaluation of the euthanizing physician's justification to be carried out? Although it is too early to evaluate the effect of the new law, which only came into effect on June 1, 1994, the odds clearly are against a significant change of the current practice of euthanasia.

First, society's possibilities for controlling the practice of euthanasia are entirely dependent on the cooperation of those who are involved in this illegal practice. Since November 1990, new state regulations have required physicians to report cases of euthanasia to the local coroner and the public prosecutor. In almost none of these cases has prosecution followed. The number of reports rose from 454 cases in 1990, to 591 in 1991, 1323 in 1992, and 1318 in 1993. This is a considerable increase, but the number is merely half of the 2300 cases of euthanasia detected by the Rummelink Committee; more than half of the cases apparently remain unreported.

Second, the new law itself is unusual. Maintaining that euthanasia is illegal under the Penal Code, it is paradoxical to amend another law requiring the trespassers to disclose their illegal deed. Normally, criminals cannot be required to assist in their own conviction; actually, they have all kinds of rights hindering their conviction. This problem is even more pressing in cases of nonvoluntary termination of life. The government has stated that it would be extremely undesirable if the

practice of nonvoluntary termination of life were to escape legal scrutiny. It is mandated, therefore, for physicians to disclose their actions in the same way that they are supposed to do in cases of voluntary euthanasia. At the same time, the Minister of Justice announced that, unlike voluntary euthanasia, in cases of nonvoluntary termination of life the public prosecutor will, in principle, start proceedings. Again, it is quite paradoxical to require physicians to assist in their own arrests by disclosing their actions, even more so when those actions legally constitute one of the most serious crimes (i.e., murder). Obviously, as soon as the intention to prosecute all cases of nonvoluntary termination is carried out, it is quite unlikely that physicians involved in such cases will continue to report.

Third, the law is also very unusual in that it prescribes how to commit a serious crime—it even provides physicians with official documents to be used when disclosing this crime. This paradox aptly illustrates the ambiguous stance of the government (and society at large) towards euthanasia. On the one hand, it considers killing human beings, though seriously ill and on the verge of death, an extremely problematic practice requiring legal restrictions and judicial review. On the other hand, the government seems unwilling to scrutinize the medical profession rigorously. It sides with the profession's view that deviations from normal medical practice by individual physicians within the intimate relationship with their patient are to be considered indications of respect for personal wishes and conscientious decisions. Obviously, with this mutual trust and respect between physician and patient, the privacy of their relationship cannot be open to public scrutiny. If euthanasia is the prerogative of physicians, their conscientiousness cannot be doubted at the same time. Remarkably, this line of argument is accepted widely. Despite two decades of sharp criticism of the power of the medical profession, when it comes to decisions about life and death, Dutch physicians seem only to have gained in the unconditional trust of society.

SUMMARY

The present situation in the Netherlands leads to the following three conclusions: (1) in daily health care practices, the crucial distinction between voluntary and nonvoluntary termination of life is losing meaning; (2) contrary to previous decades, society tends to accept cases of nonvoluntary termination of life more easily. The Remmelink Committee does not consider these cases morally troublesome. Indeed, the new legislative proposals simply include nonvoluntary termination of life in the same disclosure regulation that governs voluntary termination of life; and (3) although the Dutch debate on euthanasia began as a protest against contemporary medicine's power over death and dying, the general acceptance of euthanasia and the recent legislation may *increase* medical power by shifting the balance further in the direction of physi-

cians. Euthanasia is, after all, the ultimate step in medical interventionism; suffering is to be relieved by any means, even if it entails the elimination of the sufferer.

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