The Legalisation of Euthanasia in the Netherlands: Lessons to be Learnt

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The euthanasia debate has been re-ignited by the decision of the Dutch Parliament to legalise the practice. This will make the Netherlands the first nation in the world to legalise euthanasia. This paper explains the key aspects of the legislation and considers whether it provides a viable model for reform.

INTRODUCTION

The Netherlands has recently become the first nation in the world to legalise euthanasia. *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (the Act) makes euthanasia (and assisted suicide) legal under certain conditions. The Act was passed on 28 November 2000 by the Dutch Parliament's Lower House, by a vote of 104-40, and by the Dutch Senate on 10 April 2001 by a vote of 48 to 26.

Few moral issues have evoked as much passion as the euthanasia debate. Given what is at stake, this is not surprising. The purpose of this paper is not to make a moral evaluation of the practice of euthanasia or the desirability of legalising it - this has been done elsewhere.[1] The focus of this paper is on examining the quality of the safeguards in the Netherlands legislation with a view to determining if it serves as a viable model for possible reform.

The Significance of the Act

As is discussed below, the practical importance of the Dutch Act has been overstated. Effectively the legislation merely legalises a non-prosecution policy that has been in place in the Netherlands for nearly three decades and which has seen euthanasia widely practiced during this period. Most Dutch hospitals, nursing homes and health service institutions have guidelines, procedures, protocols and directives for practising euthanasia.[2] Moreover, medical practitioners in the Netherlands have ready access to materials on how to provide active euthanasia.[3] There has been a tradition of openness towards voluntary euthanasia in the Dutch medical profession and a greater willingness to risk a prosecution than is evident in some Western countries. The prospect of token

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1 For example, see K Amarasekara, 'Paternalism and Discrimination: The Darker Side of Euthanasia' in *Legal Visions of the Twenty First Century: Essays in Honour of Judge Christopher Weeramantry* (Kluwer Law International) 261; M Bagaric, Euthanasia: `The Right to Autonomy Versus the Public Good' (1999) 18 *University of Tasmania Law Review* 146; K Amarasekara and M Bagaric, `The Vacuousness of Rights in the Euthanasia Debate' (2001, forthcoming) *International Journal of Human Rights;* D Mendelson, 'Medico-Legal Aspects of the Right to Die Legislation in Australia' (1993) 19 *Melbourne University Law Review* 112, 117; K Amarasekara, 'Euthanasia and the Quality of Legislative Safeguards' (1997) 23 *Monash Law Review* 1-42

2 M de Wachter `Active Euthanasia in the Netherlands' (1989) 262 *Journal American Medical Association* 3316, 3317; M G van Berkestijn, `The Royal Dutch Medical Association and the Practice of Euthanasia and Assisted Suicide' in RDMA, *Euthanasia in the Netherlands* (1991) 9.

3 P Admiraal, *Justifiable Euthanasia* (1980).

sentences with no system of minimum penalties under the Dutch Penal Code may partly explain this intrepidity.[4]

The most important aspect of the new Act is its symbolism. The Act formally makes euthanasia lawful in certain circumstances. The fact that it originates from, what in our view is correctly regarded as, a compassionate and progressive nation makes it likely that it will provide the catalyst for similar change in other jurisdictions. With 380 churches or denominations in a population of over 16 million, the country's religious and cultural diversity is significant.[5] In the Netherlands many patients die at home and not, as in many Western countries, in hospitals.[6] This is partly accountable to the close personal relationship between the Dutch doctor and the patient. The former is usually a general practitioner and a family friend of long standing who makes frequent house calls and is familiar with personal circumstances that may induce a request for euthanasia.[7] The Netherlands law is likely to be far more influential than was the case with the *Rights of the Terminally Ill Act (Northern Territory)* 1995, which saw the Northern Territory become for a short period the first jurisdiction to legalise euthanasia.[8] The decision by the Dutch to legalise euthanasia, in fact already seems to be having an influence:

> Euthanasia proponents are using the bill's passage to promote legalization internationally. In Canada, long-time euthanasia supporter MP Svend Robinson announced he would introduce a new bill early next year requiring that the House of Commons study Dutch euthanasia practice and make recommendations for changes in Canadian law. In South Australia, MP Sandra Kanck indicated that she too would introduce a euthanasia bill in that state's parliament early next year. Immediately after the Dutch bill passed the Lower House, Australia's Dr. Death, Philip Nitschke, told a New South Wales parliamentary forum that voluntary euthanasia should be included in a NSW bill of rights. In England, Voluntary Euthanasia Society head Malcolm Hurwitt told reporters that the Dutch vote "removes many of the arguments against euthanasia here (references omitted).[9]

4 M Otlowski, *Voluntary Euthanasia and the Common Law* (1997) points to the technical defences taken on a charge of euthanasia in the UK, Australia, Canada and the USA. 450, 141-5.

5 H Terborgh-Dupuis, `The Netherlands: Tolerance and Teaching' (1984) 14 *Hastings Centre Report* 23

6 80% of deaths in the USA occurred in hospitals as found by a President's Commission in Deciding to *Forgo Life Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions* (1983) 17-18.

7 See H Dupuis, `The Right to a Gentle Death' in O Aycke and M Smook (eds) *The Right to Self-Determination* (1990) 53, 56; M Battin `Seven Caveats Concerning the Discussion of Euthanasia in Holland' (1990) 34 *Perspectives in Biology and Medicine* 73.

8 The Act was assented to on 16 June 1995 and proclaimed on 1 July 1996. The principal objective of the Act was to legalise euthanasia by providing legal immunity to doctors. It was overturned shortly after its commencement by the *Euthanasia Laws Act* 1997 (Cth). Only four people utilised the Act to receive assistance in dying before it was overturned. These were all cases of assisted suicide rather than euthanasia. However theoretically the scope of the Act was wide enough to permit euthanasia (see s3, definition of `assist').

9 International Anti-Euthanasia Task Force IAETF Update - 2000, Volume 14, Number 3http://www.iaetf.org/iua22.htm#8. The Council of Europe also expressed vehement opposition to the measure, stating that it violates Article 2 of the European Convention on Human Rights which mandates that no individual should be intentionally deprived of life unless that person has been convicted of a crime serious enough to impose the death penalty. Council spokesman Edeltraud Gatterer called on the Dutch Senate to defeat the bill when it comes up for the final vote. [Australian Broadcasting Corp, 11/30/00].

The next part of this paper explains the importance of the safeguard issue in the context of the euthanasia debate. The legal position in the Netherlands on euthanasia prior to the Act is then discussed. This is followed by an outline of the key parts of the Act. Finally we evaluate the legislation to see whether it offers a viable model for reform in terms of whether it guards against potential abuses and avoids possible adverse side effects.

THE IMPORTANCE OF SAFEGUARDS

One of the principal arguments employed by opponents of euthanasia is that the power to accelerate the termination of life will inevitably lead to significant abuses, and that any legislative attempt to legalise the termination of life will be incapable of providing adequate safeguards due to the inherent nature of the circumstances in which the decision to die is made. This is commonly referred to as the slippery slope argument. More fully, the slippery slope argument is the view that if euthanasia is permitted, as a matter of fact, non-voluntary euthanasia and other immoral activities are but a short inevitable step away: once patients are assisted to die, they will then be covertly encouraged to die, then pressured to die. The slippery slope process already appears to be well advanced in the case of active euthanasia. From the fact that suicide is not illegal it has been argued that assisted suicide is therefore permissible, hence so too should passive euthanasia, and given that this is widely practised we should likewise sanction active voluntary euthanasia, because if we are going to stand by as the person dies anyway, surely we should hasten this to make the process as painless as possible. The issue then becomes whether this progression can be halted at active euthanasia.

There are two forms of the slippery slope argument. The conceptual or logical one is inductive in method and maintains that the movement from voluntary to non-voluntary euthanasia is unavoidable if the former is legalised, because it becomes necessary to make euthanasia available to those who lack the legal and mental prerequisites which entitle competent patients alone to request euthanasia. Legalising voluntary euthanasia is to discriminate against the mentally impaired, the non-sentient and minors. To rectify that disparity it will be necessary to substitute the imposed judgment of a court for the voluntary choice of the competent patient. The killing of an incompetent patient in his or her best interests will be an inexorable retrogression from legitimising the competent patient's request to be killed. The logical version sees the doctors assumption that that some lives are not worth living as the motivation for voluntary and non-voluntary euthanasia. The doctor's judgment and not the patient's choice is the crucial test. An autonomous patient's request is not necessarily heeded, for instance if drugs were sought which the doctor deemed to be unnecessary and not in the patient's best interests.

The empirical version points to the Dutch, Australian and Belgian experience for evidence that doctors have administered physician assisted suicide, voluntary and non-voluntary euthanasia in contravention of the criminal law. This version maintains that the non-prosecution of instances of euthanasia, the leniency of judicial sanctions and the failure to administer conventional punishments all

contribute to the downward spiral, aided by the enhanced power over life and death given to doctors by decriminalising euthanasia. The empirical version also draws on the example of abortion. Decriminalisation began on therapeutic grounds but has now been extended to 'widespread abortion for social reasons'.[10]

The slippery slope argument has proved to be quite persuasive in the euthanasia debate. Six inquiries which have been conducted to inquire into the consequences of decriminalising euthanasia have all concluded that it should not be legalised due to unacceptable detrimental consequences which would ensue.[11] The sentiments expressed by the House of Lords Select Committee on Medical Ethics are typical of some of the dangers which were adverted to in the various reports. Concerned that vulnerable people may feel pressure to request an early death if euthanasia was legalised, it stated that:

> Issues of life and death do not lend themselves to clear definition, and without that it would be impossible to ensure that it would be possible to frame adequate safeguards against non-voluntary euthanasia were voluntary euthanasia to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that liberalisation of the law was not abused.[12]

The Paradox of Euthanasia

The capacity for a legislative regime which legalises euthanasia to install safeguards against potential abuses and to avoid adverse side effects is, we believe, a fundamental issue in the debate and is at the heart of a striking paradox concerning the morality and lawfulness of the practice. The paradox we refer to is this: most opinion polls indicate that there is widespread community support for euthanasia. Polls taken in Australia, the United Kingdom, Canada and the

[10] J Keown provides a detailed account of both the logical and empirical versions, drawing on his extensive research into euthanasia in the Netherlands in 'Euthanasia in the Netherlands: Sliding Down the Slippery Slope?' in *Euthanasia Examined* ed J Keown (1995) 261, 262; and in 'The Law and Practice of Euthanasia in the Netherlands' (1992) 108 *Law Quarterly Review* 51 - 7. See also the dangers of the slippery slope alluded to by J Finnis in 'Bland: Crossing the Rubicon?' (1993) 109 *Law Quarterly Review* 329; Y Kamisar, 'Some Non-Religious Views Against Proposed Mercy-Killing Legislation' (1958) 42 *Minnesota Law Review*. 969; M Otlowski *Voluntary Euthanasia and the Common Law* (1997), 212. 219-48; M Somerville 'The Song of Death: The Lyrics of Euthanasia' (1993) 9 J *Contemporary Health Law & Policy* 1; W van der Burg 'The Slippery Slope Argument' (1991) 102 *Ethics* 42, 43; J Sullivan, *The Morality of Mercy Killing* (1950).

[11] These inquires were: Law Reform Commission of Canada, *Euthanasia, Assisting Suicide and the Cessation of Treatment* (1982); Social Development Committee of the Parliament of Victoria, *Inquiry Into the Options for Dying With Dignity* (1987); House of Lords Select Committee on Medical Ethics (1994); New York Task Force on Life and the Law, *When Death is Sought* (1994); and Special Committee on Assisted Suicide and Euthanasia of the Senate of Canada, *Of Life and Death* (1995); Senate Legal and Constitutional Legislation Committee, *Euthanasia Laws Bill 1996* (1997). Only the Report by the Northern Territory Select Committee on Euthanasia failed to be decisively swayed by the dangers of legalising euthanasia.

[12] Report of the House of Lords Select Committee on Medical Ethics, 49.

United States consistently show that about three quarters of the population are in favour of euthanasia.[13] In addition to this, the weight of academic commentary is firmly in favour of legalisation.[14] Yet, none of the countries mentioned above (save for the brief foray in Australia's Northern Territory which was quickly overturned by the Federal Government) has gone down the path of legalising the practice. This is despite the strong democratic nature of the governments in each of the jurisdictions. The answer to this apparent anomaly, we believe, rests in the attention to detail and pressure of accountability. In abstract, the notion of individual autonomy and relief of pain (which are the main arguments used in support of euthanasia) are highly attractive ideals and it is not difficult to dress them up in a manner which will engender considerable emotive support. However, when it comes down to the detail of how these ideals can be pursued in the context of intentional killing other considerations come into play. Normal citizens and academics can easily remove themselves from pragmatic difficulties and possible negative side effects associated with allowing deliberate killing. Governments and people charged with the responsibility of advising them cannot. At some point they will be accountable and attention to detail is everything.

THE LEGAL POSITION IN THE NETHERLANDS

The Law Prior to the Amendments

Euthanasia Technically Illegal

Even prior to the enactment of the new Act the Dutch law provided an example of the impact of state sanctioned voluntary euthanasia on issues of social policy, health care, law, medicine and ethics.[15]

As defined in the Netherlands, euthanasia is the deliberate termination of the life of another at the latter's request.[16] This definition pointedly excludes passive euthanasia in the form of withholding medically futile treatment, using analgesics which may shorten life, and a patient's refusal of treatment.[17]

[13] An early poll in 1986 which revealed that 74 per cent of Victorians supported active euthanasia (Morgan Research Centre Poll, May 1986). A more recent poll, published in the Australian on 15 February 1995, showed that 81 per cent of people favoured euthanasia. This figure is in line with international trends. Recent polls in the United Kingdom, the United States and Canada show approval rates for euthanasia of 78 per cent, 68 per cent, and 78 per cent respectively (Report of the Northern Territory Select Committee on Euthanasia 50-1). The results of a comprehensive range of surveys on euthanasia are detailed in the Report of the Senate Legal and Constitutional Legislation Committee, Parliament of Australia, *Euthanasia Laws Bill 1996* (Canberra, 1997), 81-92. See also M Otlowski, *Voluntary Euthanasia and the Common Law* (1997) 257-267, for further poll results.

[14] Among the chief proponents of legalised euthanasia are G Williams, `Euthanasia' (1970) 63 *Proceedings of the Royal Society of Medicine* 663; 'What Should We Do About Omissions?' (1987) 7 *Legal Studies* 92; R Dworkin, *Life's Dominion: An Argument About Abortion and Euthanasia* (1993). M Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford, 1997) 188-211; J Harris, 'Euthanasia and the Value of Life' in J .Keown ed, *Euthanasia Examined: Ethical, Clinical & Legal Perspectives* (1995); R Magnusson, 'The Future of the Euthanasia Debate in Australia' (1996) 20 *Melbourne University Law Review* 1108.

[15] B Bostrom, `Euthanasia in the Netherlands: A Model for the United States?' (1989) 4 *Issues of Law and Medicine* 467, 470.

[16] State Commission on Euthanasia (The Hague, 1985).

[17] Royal Dutch Medical Association, *Vision on Euthanasia* (1986) 4 - 5.

While euthanasia and assisted suicide have been openly practiced in the Netherlands since 1973, both practices are technically criminal acts under the Dutch Penal Code. Article 293 of the Code provides that killing a person at his or her `express and serious request' is an offence, punishable by up to 12 years imprisonment or fine, as distinct from life imprisonment for murder under Article 289. Article 294 prohibits assisted suicide, by making it an offence for a person to intentionally incite, assist, or procure the means for another to commit suicide. This is punishable by a maximum of 3 years imprisonment or fine.

The Defence of Necessity

Despite the apparently clear terms of Articles 293 and 294 the courts in a series of cases stretching back to 1973 have determined that the defence of necessity applies to euthanasia and assisted suicide in certain circumstances. The defence of necessity or force majeure is contained in Article 40 of the Penal Code, which provides that a person who commits an offence as a result of `irresistible compulsion or necessity is not criminally liable'. The defence can take one of two forms: psychological compulsion or breaking the law to promote a higher good. The latter form has been applied to cases of euthanasia, on the basis that doctors faced by the distress of their patients are permitted to break the law to promote a higher good.[18]

The courts have laid down guidelines to determine whether the defence of necessity applies in a given case. These have been given more formal effect in the form of an agreement between the Royal Dutch Medical Association (RDMA) and the Ministry of Justice that doctors will not be prosecuted for euthanasia or assisted suicide if certain guidelines are followed. By providing this general defence of 'emergency' or 'noodtoestand' the bans in Articles 293 and 294 were undermined.

The new Act was foreshadowed in 1990 by a uniform Protocol introduced by the government of the Netherlands which provided for reporting and investigating cases of voluntary euthanasia and assisted suicide. The confidence that this would result in impunity led to an increase of reported cases after the Protocol was given statutory effect.[19] The efforts of prosecutors to comply with case law developments have been noted. [20]

The new legislation is an advance on Bill 22572 of 1 June 1994 which merely changed the method of reporting cases of euthanasia in order to make the process more transparent. That Act does not change the guidelines for practising euthanasia and physician assisted suicide.

18 J Keown, `Some Reflections on Euthanasia in the Netherlands' in L Gormally (ed) *Euthanasia, Clinical Practice and the Law* (The Linacre Center, London, 1994) 193, 195.

19 Otlowski, above n 4, 444-5.

20 H Leenen, `Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients' in Royal Dutch Medical Association, *Euthanasia in the Netherlands* (1991) 5-6.

The main due care requirements which must be followed to avoid prosecution for euthanasia or assisted suicide are as follows:

(i) the patient's request to die must be *voluntary;*
(ii) the request is *well-considered;*
(iii) the request is *durable and persistent;*
(iv) the patient's pain is *unbearable with no prospect of improvement;*
(v) a *second doctor* must be consulted; and
(vi) euthanasia or assisted suicide is performed with due medical care.

In addition to the due care requirements there is also a reporting requirement which prescribes that when a physician terminates a patient's life, the physician is required to notify the coroner and report the circumstances of the death to one of five regional review committees. The committee (comprised of at least one lawyer, one doctor and ethicist) must then submit a report to the Public Prosecution Service to determine if proceedings against the doctor should be instituted.

The Act

As is adverted to above, the Upper House of the Dutch Parliament passed the Act legalising euthanasia on 10 April 2001.[21] The plan to legalise both euthanasia and assisted suicide was part of a coalition agreement forged by Labor and Liberal parties prior to the formation of the present government. The legislation is underpinned by a desire to avoid treating doctors like criminals according to Mrs Els Borst, the Minister of Health.

The Act legalises euthanasia and assisted suicide in certain circumstances. The Netherlands Criminal Code is amended so that the termination of life on request and assistance with suicide will not be a criminal offence if carried out by a doctor and certain criteria have been satisfied.

Summary of the Act

The Act sets out the circumstances in which a physician who helps a patient to die will not be subject to punishment. Broadly, there are two conditions which the doctor must comply with: the due care requirements[22] and a reporting requirement.[23]

These changes are effected by the incorporation of an exemption from punishment in the Penal Code.[24] Where the assistance does not comply with these requirements euthanasia and assisted suicide will still be punishable.

[21] The Act is in keeping with the Coalition Agreement which was reached at the beginning of the present government term: see http://www.minjust.nl:8080/a_beleid/fact/suicide.htm.

[22] The doctor must practice due care as set forth in a separate law (*The Termination of Life on Request and Assisted Suicide (Review) Act*).

[23] The doctor must report the cause of death to the municipal coroner in accordance with the relevant provisions of the Burial and Cremation Act.

[24] Article 293, paragraph two, and in Article 294, paragraph two, sentence two.

Due Care Requirements

The due care requirements stipulate that the physician:

a. holds the conviction that the request by the patient was voluntary and well-considered,
b. holds the conviction that the patient's suffering was lasting and unbearable,
c. has informed the patient about the situation he was in and about his prospects,
d. and the patient holds the conviction that there was no other reasonable solution for the situation he was in,
e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in part a ,
f. has terminated a life or assisted in a suicide with due care.[25]

Reporting Requirement

The five regional review committees continue to exist under the new legislation but they will play a different role. Each committee continues to be composed of at least three members: a legal expert, a doctor and an expert in the field of ethics or philosophy.[26] The committee will continue to assess whether a case of termination of life on request or assisted suicide complies with the due care criteria. If the committee is of the opinion that the physician has practised due care, the case is over. There is no need to refer the matter to the Public Prosecutor - thus, effectively watering down the level of scrutiny of doctors. The committee brings the matter to the attention of the Public Prosecutor only where it is not satisfied that the relevant conditions are satisfied. The Public Prosecutor has the power to launch his own investigation if he suspects that a criminal act may have been committed.

Important Features of the Act

Due Care - Status Quo

Perhaps the most important aspect of the Act, as is discussed below, is that the circumstances in which euthanasia and assisted suicide may be practiced have not been tightened or restricted compared to existing practice. The due care guidelines which are to be enshrined in legislation *effectively* mirror those which are already in place. This is in keeping with the intention of the legislature: `the new legal regulations do not essentially change anything in the grounds permitting termination of life on request and assisted suicide. However, the due care requirements have been formulated somewhat more extensively'.[27]

Minors

In relation to minors, the legislation provides that children of 16 and 17 can make their own decisions regarding the ending of their life, however, the parents must be *involved* in the decision.[28] The reason for this is that it is `assumed that minors too have the discernment to arrive at a sound and well-considered request to end

25 Article 2(1) of the Act.
26 Article 3 of the Act.
27 Ministry of Justice Press Release, `Review of cases of termination of life on request and assistance with suicide 28 Nov 2000': http://www.minjust.nl:8080/c_actual.persber/pb0668.htm
28 Article 2(2) and (3) of the Act.

their life.'[29] For children aged 12 to 16, the approval of parents or guardian is required.[30]

Declaration of will

The legislation recognises the validity of a written declaration of will regarding euthanasia (the so-called euthanasia declaration). A written declaration of will means that the doctor can regard such a declaration as being in accordance with the patient's will. In effect, the declaration has the same status as a concrete request for euthanasia. Both an oral and a written request authorise the physician to accede to the request. The advance directive gives the doctor a right to use his discretion whether to perform euthanasia where the patient is incapacitated. A committee which includes a physician, a lawyer and a medical ethicist must ensure that the criteria are satisfied.

Merits of the Act

Although the Act essentially gives formal legal effect to existing practice, arguably it has more to commend it than the earlier guidelines set out for the exercise of the prosecutiorial discretion. There is greater visibility and public awareness of the statutory limitations under which voluntary euthanasia can be carried out. Moreover, the sanctions set out for breaches of the Act are clearly delineated without the vagueness which characterised the consequences of not complying with the guidelines. Further, it is likely that the psychological incentive to follow statutory directions and to be mindful of penal sanctions is greater than the less publicised and less compelling format of administrative formulae.

All participants in the transaction which culminates in a person's voluntary euthanasia have access to the procedures that must be followed. This was not the case with the amorphous guidelines for a prosecution under the discretionary regime.

If the advancement of individual autonomy is the guiding principle of the Act there is greater progress than with the prosecution guidelines. The latter made provision only for terminally ill patients (although as is discussed below court decisions permitted euthanasia of non-terminally patients) unlike the legislation which legalises voluntary euthanasia for some minors as well as for some persons not suffering from a terminal illness.

The new Act should lead to a greater incidence of reporting of euthanasia and assisted suicide (which as is discussed below were often unreported). Part of the confusion in the pre-existing law was the inconsistency between the ban on active voluntary euthanasia under Article 293 of the Penal Code and Bill 22572 which condoned the practice by showing how a doctor could commit the act without being found guilty.[31] As long as the act was a crime there were some doctors who would not report their own conduct despite apparent compliance with the guidelines.

[29] Ministry of Justice Press Release, `Review of cases of termination of life on request and assistance with suicide 28 Nov 2000': http://www.minjust.nl:8080/c_actual.persber/pb0668.htm.

[30] Article 2(4) of the Act.

[31] J Legemaate, `Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands 1973-1994' (1995) *Cambridge Quaterly Healthcare Ethics* 112, 118.

Another problem with the previous guidelines lay in treating active voluntary euthanasia in the same way as non-voluntary euthanasia where life was terminated without the patient's request.[32] It was unlikely that such cases would be reported, given the greater risk of prosecution. Such an equation, with its implied suggestion that the patient's request may be dispensed with, was likely to contravene Article 2 of the European Convention of Human Rights which protects the Right to Life. Moreover, a requirement that a doctor should report a criminal act committed by him or her would violate the privilege against self-incrimination.

CRITIQUE OF THE ACT

Slippery Slope danger

Typically, there is a large amount of speculation involved in assessing the adequacy of pending or new legislation. The operation of any legislative scheme cannot be confidently predicted at the outset due to a variety of reasons. These include matters such as the manner in which the legislation will be interpreted and the cultural values of the community in which the statute is to operate. Fortunately, this type of speculation is largely removed in the case of the Dutch euthanasia law. As we have seen, the law essentially rubber stamps existing practice. Thus, in assessing whether the law has something to offer for other jurisdictions, the ultimate test is how the practice which the law codifies has operated to date. To this end, there have been two extensive surveys regarding euthanasia in the Netherlands.

Surveys Regarding Operation of Guidelines

In 1991, a government committee, headed by P J van der Mass,[33] reported that in 1990 there were 2300 cases of voluntary euthanasia; 400 cases of assisted suicide; and 1000 cases of non-voluntary euthanasia. Additionally there was a further 23, 350 cases in which doctors, by act or omission, intended to shorten life,[34] and according to the definitions adopted earlier 6858 of these cases constituted euthanasia.[35] Thus the total number of cases where the doctor's primary intention was to shorten life was 10, 558.[36] Notably in 5,450 of these

32 See J van Delden et al, `The Remmelink Study: Two Years Later' (1993) 23 *Hastings Centre Report* 24.

33 P J van der Mass et al, *Euthanasia and other Medical Decisions Concerning the End of Life* (1992) (`the van der Mass survey'). For a summary of these findings see J Keown, `Some Reflections on Euthanasia in The Netherlands' and `Further reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and The van der Mass Survey', (ed) L Gormally, *Euthanasia, Clinical Practice and The Law* (1994), 193, 219.

34 These are comprised as follows: 16, 850 cases where the doctor's explicit or partial purpose was to shorten life by either administering palliative drugs (8,100 - explicit 1350; partial 6750) or by withholding or withdrawing treatment without request (8,750 - explicit 4,000; partial 4750); and 5,800 cases of withholding treatment on request with the partial or explicit purpose of shortening life (explicit 1508; partial; 4292).

35 1350 plus 4,000 plus 1508.

36 6858 plus 2300 (voluntary euthanasia as defined in the survey) plus 1000 (non-voluntary euthanasia). Considering that the total number of deaths in that year in Holland was about 130,000 this represents about 8% of the total deaths.

cases (or 52%) the patient had not expressly requested a termination of life.[37]

Perhaps the most telling finding of the survey is the 1,000 cases of non-voluntary euthanasia. This translated to 27% of doctors admitting to terminating lives without request,[38] and clearly shows that voluntary euthanasia has led to widespread non-voluntary euthanasia. It has been suggested that these findings are somewhat ameliorated by the fact that `in more half of [the 1,000 instances of non-voluntary euthanasia], this *possibility* had already been *discussed* with the patient, or the patient had expressed, in a *previous phase* of the disease a wish for *active voluntary euthanasia*, if his or her suffering became unbearable (emphasis added)'.[39] However, this is little cause for comfort. Merely canvassing a certain option with another party, does not approach anything even resembling consent to that course of conduct.

Thus, the above study shows substantial non-compliance with the prosecution guidelines that when ending a life a physician must be convinced that the patient's request was voluntary, well considered and lasting. There is also other evidence that the requirement of considered reflection was not observed. A survey of physician administered euthanasia in nursing homes, showed that in 7% of cases death was administered in less than 24 hours after the first discussion with the patient. In 35% of these cases its administration was less than a week after the first request.[40]

The new law offers no basis for confidence that the conditions precedent to lawful killing will be observed. A conspicuous defect in the legislation is that no express provision is made for ascertaining whether the statutory conditions are being observed, as distinct from ex post facto reportage. In a matter involving life and death it is vital that there should be a contemporaneous verification that the statutory procedures are followed.

Overall, the survey supports the contention that the practice of euthanasia has not resulted in greater patient autonomy, but in doctors `acquiring even more power over the life and death of their patients',[41] and that within a relatively short period of time the Dutch have proceeded down the slippery slope from voluntary to non-voluntary euthanasia. It has been suggested, that `this is partly because the underlying justification for euthanasia is not ... self-determination, but rather acceptance of the principle that certain lives are not worth living and that it is right to terminate them'.[42]

A follow up study in Holland in 1995, revealed similar results to those some four years earlier. There was a slight increase in the percentage of overall deaths stemming from active euthanasia (2.4%, compared to 1.7% in 1991), but a slight

37 J Keown, `Further reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and The Van Der Mass Survey', (ed) L Gormally, *Euthanasia, Clinical Practice and The Law* (1994) 219, 232.

38 J Keown, `The Law and Practice of Euthanasia in the Netherlands' (1992) 108 *Law Quarterly Review* 51.

39 Otlowski, above n 4, 430-1.

40 M J Muller et al, `Voluntary Active Euthanasia and Physician Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?' (1994) 42 *Journal of the American Geriatrics Society* 624, 626, Table 2.

41 A M J Henk & V M Velie, `Euthanasia: Normal Medical Practice?' (1992) 22(2) *Hastings Centre Report* 34, 38.

42 J Keown, `Further reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and The van der Mass Survey', (ed) L Gormally, *Euthanasia, Clinical Practice and The Law* (1994) 219, 239.

decrease in the number of cases of non-voluntary euthanasia: from 1000 to 900 in 1995.[43] These results are somewhat equivocal in terms of establishing a general trend.[44] Given the small drop in the number of cases of non-voluntary euthanasia it could be argued that this throws doubt on the slippery slope argument.[45] This can be countered on the basis that the decrease in the incidence of non-voluntary euthanasia (10 per cent) over the four year period is not statistically significant and that the period of time between the surveys was insufficient for the cultural and attitudinal changes which it is feared will result in the advent of the slippery slope dangers to develop. Given the relatively small period of time between the two studies and the close correlation of the relevant data, perhaps the most telling result from the 1995 study is that it confirms the accuracy of the previous survey.

The Relevance of the Surveys

The significance of the 1991 Dutch survey has been questioned. The valid point has been made that in order to obtain meaningful information regarding the slippery slope dangers it is necessary to compare the level of abuse before and after voluntary euthanasia was introduced.[46] For this reason it can be argued that a final verdict has not been reached. But this should not prevent one forming a prima facie view. The evidence, the *only* cogent evidence, shows that in a climate where voluntary euthanasia is openly practiced, there are also a large number of cases of non-voluntary euthanasia. It may be that the rate of non-voluntary euthanasia in Holland was not increased by the decision to give the green light to voluntary euthanasia. But given that we know that one state of affairs (ie where euthanasia is practiced with impunity) *definitely* leads to undesirable consequences and are unsure about the situation in the alternative state of affairs (where euthanasia is prohibited and this prohibition is enforced), logically we ought to opt for the later - speculative or possible dangers being accorded far less weight than certain ones.

Abuse in Australia

Some rely on surveys to argue that the rate of non-voluntary euthanasia is much higher in Australia and Belgium where euthanasia is prohibited than in the Netherlands. This data is said to cast serious doubts on assertions about the slippery slope and to suggest that abuses are more likely where euthanasia is banned than in the Netherlands where it is regulated and open. The data is invoked to question the effectiveness of a policy of prohibition.[47]

For example, a postal survey in 1997 (the Kuhse-Singer survey) of some Australian medical practitioners was designed to compare end of life decisions by Dutch doctors.[48] The survey claimed that a significantly higher rate of Australian

43 The results of the 1995 study are summarised in the Report of the Senate Legal and Constitutional Legislation Committee, The Parliament of Australia, *Euthanasia Laws Bill 1996* (Canberra, 1997) 101-6.

44 Not surprisingly both sides of the debate have attempted to skew these results to their advantage: see Report of the Senate Legal and Constitutional Legislation Committee, Parliament of Australia, *Euthanasia Laws Bill 1996* (Canberra, 1997) 101-5.

45 For example, see M Angell, `Euthanasia in the Netherlands - Good or Bad?' 335 (22) *The New England Journal of Medicine* 1676.

46 For example, see Otlowski, above n 4, 439.

47 Comment by anonymous referee.

48 H Kuhse et al, 'End of Life Decisions in Australian Medical Practice' (1997) 166 *Medical Journal of Australia* 191-6

doctors (22.5% in 1995) intentionally ended life without patient consent than Dutch doctors (5.3% in 1991).[49] The Kuhse-Singer survey observed that '30% of all Australian deaths were preceded by a medical decision explicitly intended to hasten the patient's death' either by physician assisted suicide or by refusing or discontinuing life prolonging treatment. In only 4% of these cases was the decision taken in response to an explicit request by the patient.[50] The Kuhse-Singer survey is similar to one conducted in the Netherlands in 1993.[51]

These surveys are open to criticism. The Kuhse-Singer survey focused on the intention of the doctors but did not validate the complex and variable responses of the practitioners by examining clinical data and prescription records.[52] There was also a misjoinder of distinct issues into one category by the framing of questions in the Kuhse-Singer survey. A medical decision which intends to relieve pain but does not intend to cause death differs from one which means to accelerate death. The essence of the former is the foresight of death without an intention to kill, known as the principle of double effect. In not eliciting the true intent of the doctor and in not clarifying this distinction the findings constitute 'a serious obfuscation'.[53]

Arguably, legalising euthanasia may result in guidelines and audits to secure compliance.[54] However, the surveys merely demonstrate that legislation is futile. If non-voluntary euthanasia is greater where it is illegal as in Australia than where it is practised openly as in the Netherlands, then the effectiveness of all legislation has to be questioned. Australian law which prohibits the intentional termination of life by an act or omission `has not prevented the practice of euthanasia or the intentional ending of life without the patient's consent.'[55] It is equally certain that decriminalising legislation which imposes conditions under which voluntary euthanasia may be administered will not be complied with.[56]

The prevalence of non-voluntary euthanasia is attributable not to the ban on voluntary euthanasia but to the faulty exercise of a discretion not to prosecute violations of the ban. Seven doctors who administered voluntary euthanasia illegally have not been prosecuted in Victoria despite their written admissions to having done so and the attendant publicity.[57]

Overall then, the most surprising and disappointing aspect of the Dutch euthanasia law is that it entails that the government is prepared to accept such widespread abuses. The euthanasia Act, drafted in almost identical form to existing practice, appears tacitly to condone such outcomes. In light of the evidence of large scale abuse the most curious aspect of the Act is that there was not some attempt to limit the circumstances in which termination of life could

49 Ibid, 195; for a similar comparison with Belgium see L Deliens et al., 'End-of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey' (2000) 356 *Lancet* 1806.

50 Ibid, 196.

51 L Pijeneneborg, PJ van der Maas, et al, 'Life Terminating Acts Without Explicit Request of Patient' (1993) 341 *Lancet* 1196-9.

52 M Ashby, 'The Fallacies of Death Causation in Palliative Care' (1997) 166 *Medical Journal of Australia* 176, 177.

53 Dr J Fleming cited by A McGarry in The Autralian, 25 February 1997

54 M B Van Der Weyden, 'Deaths, Dying and the Euthanasia Debate in Australia' (1997) 166 *Medical Journal of Australia* 173, 174.

55 The Kuhse-Singer Survey, above n 48 above, 196.

56 K Amarasekara 'Euthanasia and the Quality of Legislative Safeguards' in (1997) 23 *Monash University Law Review* 1, 15-16.

57 Ibid, 25.

occur. In fact, as is mentioned above, the Act weakens the level of scrutiny over doctors. A known problem with the existing guidelines is that the majority of Dutch doctors do not even report acts which are aimed to shorten life. A study published in 1996 found that 59% of doctors do not report voluntary euthanasia and assisted suicide deaths and that cases of non-voluntary euthanasia (killing without the patient's consent or knowledge), are (not surprisingly) rarely if ever reported.[58] It seems remarkable that despite this finding the scrutiny requirements have been further watered down.

In our view the above empirical evidence provides sound reasons for not going down the path of the Dutch. There are however, some other aspects of the legislation which are worthy of consideration if only for the fact that they raise almost intractable difficulties associated with any attempt to legalise the termination of life.

Non terminally Ill

An interesting aspect of the Netherlands law is that it is not necessary for the patient to be terminally ill. The two main arguments traditionally used by proponents of euthanasia, are that it eliminates unnecessary suffering and advances patient autonomy. Followed to their logical conclusion, this means that euthanasia ought to be available to the non-terminally ill. Thus, the Netherlands law is in keeping with the rationales commonly advanced for euthanasia. However, the result (allowing the non-terminally ill to be killed) highlights the dangers of following any virtue in an absolutist manner, without regard to other principles that are trumped in the process.

Once euthanasia is not confined to the terminally ill (and even more to the point, once killing in any context is permitted), there is the inherent risk that it may result in a diminution of the importance accorded to the right to life across the board and therefore lead to killing in other circumstances, or at least to a reduction in the endeavours taken to protect and save life.

As a counter to this, James Rachels argues that once life in one circumstance is cheapened it does not necessarily follow that the currency tends to drop all round. In support he cites the examples of the Eskimos, who used to sacrifice infants and the feeble as a measure to ward off starvation, and the acceptance of killing in self defence, neither of which it is claimed have led to a reduction in respect for life.[59]

However these examples are not in point. The Eskimo and self-defence cases both involve a conflict of the right to life. Due to the extreme circumstances in which such clashes arise, a choice *must* be made between one life and that of another or others. Unlike with euthanasia, the reason for killing in these cases is due to the absolute *necessity* to preserve the lives of others. This does not lead to a devaluation in respect for life because the killing is in fact motivated by the desire to save life. The Eskimos kill as a last resort to save what they deem as more important lives. We kill in self-defence out of desperation, recognising that

58 Van der Wal et al, 'Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands' (1996) *New England Journal of Medicine* 1706.

59 Rachels, *The End of Life: Euthanasia and Morality* (1986), 1974. He also cites the example of the ancient Greeks who used to kill defective infants. However, he does not state why they used to engage in this practice, and hence we are unable to comment on the strength of this particular analogy.

when one life must be lost it should be that of the person who has wrongly created the desperate situation. There is no inherent devaluing of the life to be lost, merely an illustration of the fact that at times monumental choices are unfortunately cast upon us. Not so with euthanasia. There is no necessity to offset one life against the other. With euthanasia the choice is far more calculating. It requires one to arrive at the *considered* conclusion, which albeit may not be the decisive motivation for the act, that a particular human life is not worth continuing or can be sacrificed to satisfy some other interest. Not because it means that another life will be lost, but rather to pursue some other interest than the right to life itself. And this would constitute an immense shift in the regard paid to the importance of life; suddenly it would be subservient to other goals.

Thus history provides no comfort for the view that if we allow killing in the context of euthanasia that this will not lead to a devaluation of life generally and a lessening in the aversion to killing in other contexts. While it is difficult to obtain empirical evidence supporting the fact that it does,[60] given what is possibly at stake if the right to life is depreciated, surely the onus is on those advocating a change to produce cogent evidence or reasons disproving the likely advent of slippery slope dangers. In fact, the (albeit slight) evidence from the Netherlands, if anything, supports the view that condoning killing in any context cheapens life generally.

Killing not Confined to Incurable Physical Pain

Intentional killing is no longer confined to dealing with incurable physical pain and is used as a means to deal with problems stemming from psychological and social reasons. In June 1994, the Dutch Supreme Court in the *Chabot* case[61] was confronted with the situation of a 50 year old woman, Hilly Boscher, who was suffering purely psychological pain. She had a violent marriage and her two sons had died and she had a history of suffering depression. Following the death of the second son she decided to commit suicide and was referred to Dr Chabot who diagnosed her as suffering from severe and intractable mental suffering. He believed that she satisfied the guidelines to be euthanised. He consulted a number of colleagues but none of them examined her. In 1991 Dr. Chabot assisted Mrs. Boscher to commit suicide by prescribing a lethal dose of drugs.

Dr. Chabot was found guilty under Article 294 of the Dutch Penal Code. His plea of necessity failed, but not because the facts could not support such a plea. The court held that there was no reason in principle why the defence of necessity could not apply where a patient's suffering is purely psychological. However, in order for the defence to apply the patient must be examined by an independent medical expert. Despite finding him guilty the Supreme Court declined to impose a penalty. However, he did receive a *reprimand* from a Medical Disciplinary Tribunal.

The decision of the Supreme Court in *Chabot* to legitimise the practice of assisted suicide and active voluntary euthanasia for non-terminally ill patients led to the non-prosecution of several cases that had been instituted after a statement

[60] The immense civilian atrocities that have occurred during and immediately following wars provide some evidence of this, but given the large number of variables involved during such climactic periods it is impossible positively to isolate the cause for such disasters.

[61] A summary of the case (in English) is provided at: www.msu.edu/course/phl/344/phl344/fall2000/brody_4/chabot_case.htm.

by the then Minister of Justice that euthanasia was permissible only if the patient was terminally ill. The anxiety of the Dutch medical profession about the uncertain state of the law has been well documented.[62]

The *Chabot* case was unprecedented. Never before had a physician reported helping a depressed but otherwise healthy patient to commit suicide. Of an estimated 2300 cases of euthanasia and 400 cases of assisted suicide in Holland each year, virtually all involved patients suffering from a terminal illness or unbearable physical pain. The Supreme Court decision recognised the right of a patient with severe psychic pain to be assisted to commit suicide. Intolerable psychological suffering was seen as indistinguishable from intolerable physical suffering.

A request to be killed because of fear that an eating disorder would recur was regarded as a ground for not prosecuting a doctor who carried out the request. The *Chabot* case illustrates that psychological trauma justifies a request for and performance of euthanasia. Similarly, a fear that HIV infection may turn into full blown AIDS ought to suffice under this head.

The court has now moved from condoning killing for depression to killing those who are merely tired of life. A Dutch court ruled late in 2000 that Dr Sutorius was justified when he helped an 86 year old man who was not suffering pain and was not physically ill to commit suicide. The patient merely reported that he was 'tired of life' and his aging 'hopeless condition'. This decision is under appeal but the lenient attitude of the prosecution is seen in their application for only a three month suspended sentence.

The Act will accommodate the *Chabot* case by making voluntary euthanasia available for psychological suffering or grief and by differentiating between suffering and its cause. The Supreme Court's decision that a psychiatric disorder does not make the patient's request for euthanasia an involuntary one is reinforced by the legislation. It will extend to the *Sutorius* case by legitimising voluntary euthanasia for one who no longer wishes to live.

Logically, a claim of autonomy need not be contained by preconditions of `intractable suffering', `tiredness of life', or `hopelessness'. Mental anguish may arise from a variety of sources including poverty, destitution, financial loss or family bereavement. Greater scrutiny is necessary where suffering is not somatic because its gravity and prospects of improvement are not immediately evident. An agreement between two doctors that such a mental state does exist in the claimant is not a sufficient ground for allowing life to be terminated. It is but a natural progression from relieving such mental states to legitimising euthanasia on demand.

Informing Patient and no Reasonable Alternative

One of the guidelines (which is now also contained in the new law) requires that the physician must have informed the patient about their situation and prospects;

62 RDMA, `Vision on Euthanasia', in RDMA, *Euthanasia in the Netherlands* (4th ed, 1995) 41.For a similar assessment of the diffidence of Australian doctors, see H Kuhse et al., 'End-of-Life Decisions in Australian Medical Practice' (1997) 166 *Medical Journal of Australia* 196; D Lanham's discussion on whether instigation of suicide amounts to murder highlights a concern of the medical profession in England and Australia: `Murder by Instigating Suicide' [1980] *Criminal Law Review* 215, 220.

another one stipulates that the physician must have reached a firm conclusion with the patient that there was no other reasonable alternative solution. The evidence seems to support the view that these are observed in the breach. Most doctors who administer euthanasia in The Netherlands are general practitioners, not specialists. They often lack the expertise to know the treatment alternatives. The paucity of Dutch hospices means that many dignified methods of alleviating suffering may not be discussed with patients who request euthanasia.

The killing by Henk Prins, a Dutch doctor of a 3 day old infant born with spina bifidia and limb anomalies shows how easy it is to disregard the guidelines[63] The doctor rushed to kill the patient without attempting to close the opening in the spine or first attempting proper medical treatment. Euthanasia was instant and permanent pain relief for which the trial judge praised Dr Prins.

Minors

On its face the Netherlands law may appear to be doctrinally consistent with the arguments used in support of euthanasia - minors too can suffer pain and sometimes know what they want. However, total autonomy is not available under the Act and some arbitrariness is evident. While the legislature intended to provide a finite amount of freedom to request euthanasia, the basis of containment is unclear. On what ground is voluntary euthanasia made available to some minors and not to others? The grounds for selecting a limited sub-class of minors and patients while excluding other minors and patients are obscure.

Even more problematic is the decision to allow any minors to obtain assistance in dying. The law prohibits people who are not deemed sufficiently mature from making `important' decisions such as who they should vote for or whether they ought to consume alcohol; but the new law deems them to be competent to choose to die.

Under the general law some prohibitions placed on minors are absolute. The incapacity to vote and to drive are examples. Some disqualifications are subject to approval by a guardian or parent, as with litigation and signing contracts. One objectionable feature of the new Dutch law is that no absolute ban is placed on a matter as vital as the choice to be put to death, although the bans on voting and driving are retained under the general law. This inconsistency is compounded by the absence of guidelines for parental approval or involvement regardless of the specific age when the minor's request for death is carried out.

It is paradoxical that the voluntariness of an adult's request must be ascertained with due care when the minor's request and the propriety and voluntariness of the approval given by guardian or parent have no special guidelines.

Broad Discretion

The discretion not to prosecute remains whether the governing regime consists of prosecution guidelines or statutory conditions for administering euthanasia. When some acts of euthanasia, both voluntary and non-voluntary were not

63 Case cited in W J Smith, `We Ignore the Dutch Legalization of Euthanasia at Our Own Peril': www.euthanasia.com.nethcases. See also, 'Dutch Court Convicts Doctor of Murder' (1995) 310 *British Medical Journal* 1028; 'Dutch Doctor Convicted but not Punished for Euthanasia of Infant.' (1995) 14 (3) *Monash Bioethics Review* 5. A request to be killed because of fear that an eating disorder would recur was regarded as a ground for not prosecuting a doctor who carried out the request. See W J Smith, above.

prosecuted it follows that some breaches of statutory conditions may not be prosecuted. When legislative approval has been given to a long accepted practice carried out both covertly and overtly, the conditions sought to be imposed are peripheral to the practice. Just as doctors are likely to feel less inhibited about administering euthanasia once legislation is in place, prosecutors who refrained from instituting proceedings for murder are even more likely to exercise a discretion not to prosecute cases where the statutory conditions have been breached. The new law should have regulated the discretion not to prosecute. Under the previous regime the discretion was not exercised consistently and verged on an uncontrolled acceptance of the practice of administering euthanasia. It is submitted that there is no real discretion if a practice is exercised only in one way. It then becomes a rule.

CONCLUSION

Euthanasia has been a controversial moral issue for many decades. It has been claimed that the arguments for and against euthanasia have not changed in the last 120 years.[64] Proponents of euthanasia have failed to sway legislatures primarily because of the fear that legalising the practice will invariably lead to large scale abuses. The Dutch precedent offers no reason to dispel this fear.

Even prior to the passage of the Act the progression of euthanasia in the Netherlands has been from requiring a terminal illness to no physical illness at all, from physical suffering to depression only, from conscious to unconscious patients, from those who can consent to those who cannot and from being a measure of last resort to one of early intervention. Patient autonomy has been transformed by the courts to include a doctor's right to decide a patient's fate. The development of euthanasia has taken place in contravention of statute law. Community approval, a discretion not to prosecute and court decisions have helped to foster that development.

The new law removes the last obstacle in the path of doctors to killing patients, namely the illegal status of the act. The Act is the culmination of an inveterate practice. First there was killing on the request of terminally ill patients, then of chronically ill patients, disabled ones and depressed ones; and now, on the request of minors over the age of 16 years even without parental consent. Intermingled with these has been the killing of babies who could not ask for it (non-voluntary euthanasia).

An enhancement of a doctor's power over a patient's life and death [65] and a heightened perception that it is right for a doctor to terminate lives that are not worth living,[66] resulting in large scale abuses of patients at the lowest ebb of their lives is the inevitable consequence of the Dutch legislation.

64 E J Emmanuel, 'The History of Euthanasia Debates in the United States and Britain' (1994) 121 *Annals of Internal Medicine* 793.

65 A M J Henk and V M Welie, `Euthanasia: Normal Medical Practice?' (1992) 22 (2) *Hastings Centre Report* 34, 38.

66 J Keown, `Euthanasia in the Netherlands: Sliding Down the Slippery Slope?' in J Keown (ed) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995) 273. The sanctity of life ethic is discussed in R Magnusson, 'The Future of the Euthanasia Debate in Australia' (1996) 20 *Melbourne University Law Review* 1108,1115-20.