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The Dutch in denial?

The increasing body of evidence which has emerged from the Netherlands over the past fifteen or so years, not least the wealth of data produced by the two surveys, shows that the guidelines have been extensively breached and that there has been a marked lack of control by the authorities. Yet the disturbing reality of inadequate control still seems lost on many. As we saw in the Introduction to this book, even one of the Justices of the US Supreme Court who was referred to the leading exposés of Dutch practice nevertheless thought that the picture from the Netherlands was still unclear and that further evidence was needed.[1] Why such hesitation given the mass of disturbing evidence already in the public domain?

One reason is that the Dutch (and non-Dutch) supporters of VAE have often, not surprisingly, placed a misleadingly benign interpretation on the evidence. They have persistently sought to portray the Dutch experience in the best possible light, denying or at least downplaying its negative aspects. This is predictable but not productive and has inevitably served to muddy the waters. In particular, anyone who had uncritically read the benign interpretation of the data either by Professor Van der Maas or by the Remmelink Commission could be forgiven for thinking that VAE was under effective control.

Van der Maas and Remmelink

As we have seen, Van der Maas concluded that his surveys showed that decision-making by Dutch doctors was of high quality and that they were prepared to account for their conduct. His lack of criticism of the widespread breaches of the guidelines was remarkable and contrasts with his readiness to criticise those who identified a higher incidence of

[1] See p. 4.

intentional life-shortening disclosed by his surveys.[2] It will also be recalled that the Remmelink Commission placed a no less benign gloss on the data, not least on the 1,000 cases of NVAE, despite the fact that these cases drove a coach and horses through a fundamental guideline and that their revelation had initially come as a 'terrible shock' to the Commission's members.[3]

Dutch diplomacy

In view of the fact that the Remmelink Commission was a government-appointed body, it is not surprising that its report should have reflected the complacent views of the Dutch political establishment. Another channel for those views and another source of information which may well have led many to adopt a misguidedly favourable view of Dutch euthanasia is the Dutch diplomatic corps, which seems primed to counter any criticism of their country's slide down the slippery slope. This was certainly the impression given by the reaction of the Dutch Ambassador in London to English criticism of a Dutch television programme sympathetic to the Dutch experience – *Death on Request.*

Death on Request

Death on Request was screened by the BBC on 15 March 1995.[4] This programme, produced by a Dutch company, told the moving story of a patient with motor neurone disease, Cees van Wendel de Joode, who asked for and was given VAE by his GP, Dr Van Oijen. The programme implied that this case, in which the guidelines were apparently followed, was typical of practice generally. That the broadcast was intended to represent that practice in the best light is suggested by the fact that the protagonists were recommended to the programme makers by the Dutch Society for Voluntary Euthanasia.[5] Psychiatrist Herbert Hendin, a leading expert on suicidology and on the Dutch experience, has produced a disturbing analysis of the broadcast. For example, Hendin questions whether the patient was given a real choice. The doctor says he had to offer VAE because 'what else can I offer the man? I can give him wonderful equipment so he can make himself

[2] See pp. 99–101. [3] See p. 116, n. 8. [4] *Modern Times*, BBC2, 15 March 1995.
[5] Hendin, 127.

understood. I can give him the finest wheelchair there is, but in the end it is only a stopgap. He's going to die and he knows it'.[6]

But, as Hendin points out, Professor Stephen Hawking is alive twenty-five years after he was diagnosed with the same illness and, while far more incapacitated than Cees, has managed to live a brilliantly productive life, with meaningful relationships. Hendin concludes: 'Hawking, however, has been surrounded by people who have wanted him to live, and who have not considered mechanical aids worthless because he was destined to die eventually.'[7]

Moreover, Cees seems to have been given a misleadingly bleak prognosis. A second doctor, as required by the guidelines, was consulted by the first, and the programme contains a scene in which the second doctor talks with Cees and his wife. The doctor tells Cees that to qualify for VAE he must be experiencing 'hopeless suffering with no chance of a cure' and that he satisfied this criterion. The doctor adds: 'You have an incurable disease which will soon end in death. And unless something is done you will suffer terribly. You will probably suffocate.'

Commenting on the case in an ensuing studio discussion, Dr Nigel Sykes, a consultant in palliative medicine at St Christopher's Hospice, London, said that one of the things that struck him most about this film was the lack of real choice that Cees had: he was essentially presented with the choice of terrible suffering or death. Dr Sykes said:

> What I would want to do for this man is to give him a further choice. To acknowledge the suffering that he is going through, his pain, his breathlessness, and tell him what could be done for that. At St Christopher's we've now looked after at least 300 patients with motor neurone disease over more than a quarter of a century, and 120 of those we studied especially carefully. We were able to improve their pain in absolutely every case.[8]

The BBC sustained heavy criticism for screening *Death on Request*. A powerful letter to *The Times* criticised the programme as misleading in that it failed to show 'the wider implications of a legally permissive attitude towards euthanasia'.[9] Its signatories included Lord Walton, who chaired the House of Lords Select Committee on Medical Ethics, Lord Habgood, one of its members, and Dame Cicely Saunders, foundress of

[6] Ibid., 132. [7] Ibid., 133. [8] *The Late Show*, BBC2, 15 March 1995.
[9] *The Times*, 16 March 1995, Letters.

the hospice movement. The letter stated: 'Having embraced the practice of euthanasia, the Dutch now find themselves on a slippery slope which not only involves euthanasia for those who are not dying but also euthanasia without request.' It concluded that 'facts from the Netherlands show clearly why euthanasia should not be legally sanctioned in this country'.

The programme also prompted an Early Day Motion in the House of Commons. Tabled by Mrs Marion Roe, Chairwoman of the House of Commons Select Committee on Health, and signed by 117 Members of the House, the Motion called on the BBC to report 'the real situation in the Netherlands where in a substantial number of cases euthanasia is carried out without a request from the patients, where the hospice and specialist palliative care movement is very much less developed than in the United Kingdom with the result that patients may request euthanasia in the absence of effective specialist palliative care'. It urged the BBC 'to give a complete and balanced picture of the situation'.[10]

Given the misleading impression which such programmes inevitably convey to viewers unfamiliar with the reality of the Dutch experience, the MPs' call for balance was welcome.

The Dutch Ambassador

The Motion provoked a response from the Dutch Ambassador. He wrote that he 'felt obliged to dispel some serious misconceptions of the Netherlands euthanasia policy'.[11] The Ambassador's response was, however, even more misleading than the programme he sought to defend.

[10] 'Euthanasia in the Netherlands', EDM 740 of Session 1994–5, tabled on 7 March 1995. As an interesting postscript to the programme, it was reported in March 2001 that the doctor who starred in it, Dr Van Oijen, had been convicted of murdering a comatose and dying 84-year-old patient by injecting her with 50 mg of the drug alloferine. Expert witnesses testified that this could not be considered palliative treatment. The patient had made no request for VAE and had in fact said she did not want to die. There had, moreover, been no second opinion and Dr Van Oijen had reported that death had been due to natural causes. For misreporting the death, he was given a suspended fine of 5,000 guilders, but he was not punished for the murder. The court said he had made an 'error of judgment' and had acted 'honourably and according to his conscience'. The KNMG defended his actions as having 'complete integrity' (Tony Sheldon, 'Dutch GP Found Guilty of Murder Faces no Penalty' (2001) 322 *BMJ* 509).

[11] Letter from the Dutch Ambassador, Mr J. H. R. D. van Roijen, dated 24 April 1995. I am grateful to one of the recipients of the letter, Professor Luke Gormally of the Linacre Centre for Healthcare Ethics, for sending me a copy.

The Ambassador asserted that VAE in his country was 'rare'.[12] But 3,600 cases in 1995 indicate the contrary. He added: 'In the Netherlands *all* cases of euthanasia . . . *must* be notified to the Public Prosecutor.'[13] He omitted to mention that a clear majority were *not* in fact so notified. He went on to say that a doctor would in general be prosecuted for performing either VAE or NVAE.[14] The reality was and is, however, precisely the reverse: it is prosecution, not VAE, which is a rarity. As Griffiths has pointed out, prosecutors 'practically always' decide not to prosecute reported cases. Fewer than five per year are prosecuted, of which half are 'test' cases brought to clarify the law. From 1981 to 1998 there were only twenty final judgments. In nine the doctor was convicted, but no punishment was imposed in six and only a suspended sentence was imposed in the other three. Such a control regime, Griffiths aptly comments, seems on its face to be 'all bark and no bite'.[15]

Turning to NVAE, the Ambassador wrote that it was common knowledge that doctors all over the world sometimes decide to stop further medical treatment, or to increase the doses of drugs which will have the effect of shortening the life of a terminally ill patient. According to the Remmelink Report, he claimed, there were 1,000 cases in which doctors had so acted. But the 1,000 cases were *not* cases of stopping treatment or increasing doses of sedatives to alleviate pain but cases of doctors taking active steps to terminate patients' lives (without their explicit request).

His Excellency continued that patients in Dutch hospitals were provided with 'excellent palliative or terminal care' and that 'In medical student training, much attention is focussed on sedatives and palliative care'.[16] The Ambassador cited no evidence to support either of these assertions. They sit uneasily with Dutch research indicating that the pain of a high proportion of cancer patients is inadequately treated,[17] with the recognition by the Remmelink Commission that Dutch doctors lacked expertise in palliative care,[18] and with the views of the leading Dutch hospice doctor, Dr Zylic.

Dr Zylic recently wrote that 'Palliative care is virtually unknown in Holland'.[19] He added: 'Almost seventy percent of physicians in the

[12] Ibid. [13] Ibid. (original emphasis). [14] Ibid. [15] Griffiths, 268. [16] Ibid.
[17] See p. 111. [18] See p. 112 n. 61.
[19] Zbigniew Zylic, 'Palliative Care: Dutch Hospices and Euthanasia' in David C. Thomasma et al. (eds.), *Asking to Die* (1998) 187 at 196.

Netherlands have been involved in euthanasia of some sort. Yet there is virtually no training in treating dying patients and coping with the impending death. None of the medical schools offer any thorough training for their young students. It is unbelievable how we deny the importance of such training.'[20] He continued: 'we see poor symptom control among physicians',[21] and 'we see cases frequently enough of ignorance about palliative care that are causes of profound concern'.[22] 'Euthanasia', he argued, 'should never be seen as an alternative to good care. It was never meant to be this in Holland. It originated at the end of such care, when all else failed. But today it is growing to be seen as an alternative to the more difficult task of caring for the dying.'[23]

Finally, commenting on the *Chabot* case, the Ambassador asserted: 'Although the Supreme Court has opened the possibility of a discussion on euthanasia for [the] mentally ill, it has at the same time formulated such strict conditions that it will be extremely difficult at all times to perform euthanasia for [the] mentally ill.'[24]

This is a questionable interpretation of the *Chabot* case. The reality is that the Supreme Court held that the defence of necessity can apply in cases of mental illness, with the proviso that the second doctor must examine the patient and agree that the request is voluntary and that there is no other way to alleviate suffering. These conditions may not be so easy to satisfy if strictly applied. Nevertheless, the case did open the door to PAS for purely mental suffering, and although hitherto psychiatrists appear to have been hesitant to assist suicide on this ground there is no logical reason why the guidelines in relation to mental suffering should prove any more 'precise' or 'strict' than those in relation to physical suffering.

Whatever the explanation for the Ambassador's confusion, his misleading response to the House of Commons Motion seems not atypical of the reaction which the Dutch political establishment tends to exhibit in the face of any criticism, however cogent, of its inadequate control of VAE. Such reaction, which could not unreasonably be described as political propaganda, can only sow confusion, and helps to explain why so many in the Netherlands and abroad labour under an unduly favourable impression of the Dutch experience.

[20] Ibid., 198–9. [21] Ibid., 195. [22] Ibid., 200.

[23] Ibid., 199. See also Rien J. P. A. Janssens et al., 'Hospice and Euthanasia in the Netherlands: An Ethical Point of View' (1999) 25 *J Med Ethics* 408.

[24] Letter from the Dutch Ambassador, 24 April 1995.

Dutch reluctance to engage with criticism from abroad has been fairly acknowledged by Professor Griffiths, who has written:

> To a large extent, the Dutch tend simply to ignore foreign criticism. The more or less 'official' Dutch reaction, when there is one, amounts essentially to denial. Denial in the first place that there has been major legal change in the Netherlands: euthanasia, it is insisted, remains 'illegal'. This position is essentially disingenuous: it relies on the fact that the articles of the Criminal Code prohibiting euthanasia and assistance with suicide have not been amended and ignores the fact that another article of the Code has been interpreted to afford a defence of justification, so that if the relevant conditions are met, the behavior concerned is effectively *not* illegal.[25]

He continued:

> Denial, in the second place, that 'non-voluntary euthanasia' is taking place . . . Denial, most importantly, that there are problems of control. It is insisted that 'carefully and precisely drafted rules' make abuse impossible. But even a passing acquaintance with the applicable rules . . . shows that they can hardly be described as watertight, and in any case a precise rule is quite a different matter from an effectively enforced one. It is well known in the Netherlands, and since the early 1990s this has become a subject of increasing concern, that the existing control system, depending as it does on self-reporting, cannot be regarded as adequate.[26]

Dr Van Delden

To be sure, the Dutch approach has many *non*-Dutch defenders such as the American philosopher Professor Margaret Battin. Professor Battin, who has written widely on the subject of Dutch euthanasia, has gone so far as to claim that the Netherlands is 'virtually abuse-free'.[27] Conversely, though rarely, a Dutch defender of VAE may concede the lack of control. Professor Leenen, Emeritus Professor of Health Law at the University of

[25] Griffiths, 28–9 (footnotes omitted; original emphasis). [26] Ibid., 29.

[27] Margaret Battin, 'Should We Copy the Dutch?' in Robert Misbin (ed.), *Euthanasia: The Good of the Patient, the Good of Society* (1992) 95, 102. See also Battin, 'Voluntary Euthanasia and the Risk of Abuse: Can We Learn Anything from the Netherlands?' (1992) 20 *L Med & Health Care* 133; Ludovic Kennedy, *Euthanasia: The Good Death* (1990) 32–54. Otlowski asserts that there is 'no evidence of large scale abuses or extensions of the practice' (*Voluntary Euthanasia and the Common Law* (1997) 451). Cf. the review of her book in (1998) 57(1) *Camb L J* 209.

Amsterdam and a very influential figure in Dutch health law and policy, bravely admitted in 1990 that there was an '*almost total lack of control* on the administration of euthanasia' in his country.[28] Similarly, as we have just noted, Professor Griffiths has acknowledged the ineffectiveness of the Dutch regulatory regime.[29] Commenting on the two Van der Maas surveys, he observed that it seems fair to describe the results of that research 'as far as the effectiveness of control is concerned, as pretty devastating'.[30] More recently, Dr Van Delden, a member of the Van der Maas research team, replied in the *Journal of Medical Ethics* to some of the criticisms which have been made in this chapter.[31] Interestingly, he nowhere sought to question the central criticism that the guidelines have been widely breached and have failed to ensure effective control.

Van Delden rightly identified three of the major concerns which support that contention: first, the practice of NVAE; secondly, the use of VAE when palliative care could have provided an alternative; and, thirdly, underreporting.

As for the first concern, he agreed that NVAE was 'a very serious problem'.[32] As for the second, he did not dispute the frequent performance of VAE in cases where palliative care could have alleviated the suffering. He stated that there had been a 'shift' (his word) towards using VAE even when palliative care would have provided an alternative.[33] Thirdly, he nowhere sought to controvert the argument, based on the fact that the majority of cases of VAE were not reported by doctors, that the

[28] 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients' (paper delivered at a conference on euthanasia held at the Institute for Bioethics, Maastricht, 2–4 December 1990) 6 (emphasis added). The Ministry of Justice civil servant who wrote the Remmelink Report agreed that there was no control over cases which had not been reported and that even in relation to the reported cases the prosecutor did not know whether the doctor was telling the truth. He maintained that VAE occurred even if the law prohibited it, as was the case outside the Netherlands, and that it was preferable to try to control it (interview by author with Mr Kors, 29 November 1991).

[29] See p. 142 n. 26. See also Griffiths at 298: 'the current system of criminal enforcement of the legal requirements governing euthanasia and termination of life is ineffective'.

[30] Ibid., 268.

[31] J. J. M. van Delden, 'Slippery Slopes in Flat Countries – a Response' (1999) 25 *J Med Ethics* 22.

[32] Ibid., 24.

[33] Ibid., 23. His view was that this 'shift' was due to an increasing emphasis on patient autonomy. Even if his explanation were accurate, it would in no way detract from the force of the criticism that, whereas the guidelines require VAE to be applied only as a 'last resort' in cases of 'unbearable suffering', in a considerable number of cases in which palliative care could have made the situation bearable, VAE has nevertheless been carried out.

reporting procedure has failed to ensure effective control. The recent research by Cuperus-Bosma,[34] revealing inconsistent decision-making by prosecutors in VAE cases even in cases where important guidelines have been obviously breached, has served only to heighten doubts about the efficacy of the Dutch regulatory system. Van Delden noted the introduction of the modified reporting procedure, whereby the report is sent to an interdisciplinary committee rather than to the prosecutor, and commented that the effect of this change was not yet clear. There seems little reason to believe, however, that this modification, which renders the procedure even less strict, will ensure any greater control *even if* it turns out in time to encourage more reporting. Indeed, the change may lead to *less* control: under the revised procedure, although the medical examiner informs the prosecutor about the case, the report of the doctor who administered VAE is no longer sent to the prosecutor but to the committee.

In May 2000 the first annual report of the interdisciplinary appraisal committees was published.[35] Echoing Dr Van Delden, the national chairwoman of the committees concluded that it was too early to say whether the revised procedure will encourage doctors to report cases. In 1999, 2,216 cases were reported. This is a clear increase on the 1,466 reported in 1995. If there were the same number of cases of VAE and PAS as in 1995 (3,600), then 60% were reported in 1999 compared to 41% in 1995. It has been questioned, however, whether any increase was attributable to the revision of the procedure in view of the fact that 2,241 cases were reported in the first ten months of 1998, *before* the procedure was revised.[36] Moreover, slightly fewer cases were reported in 2000 (2,123) than in 1999 (2,216).[37]

The first annual report goes on to claim that the doctors' reports showed that the guidelines had been followed in nearly all cases. This is, of course, unsurprising: doctors are hardly likely to expose their own wrongdoing. Moreover, the report revealed that the information provided by the

[34] M. Cuperus-Bosma et al., 'Assessment of Physician-Assisted Death by Members of the Public Prosecution in the Netherlands' (1999) 25 *J Med Ethics* 8.

[35] *Regionale Toetsingscommissies Euthanasie, Javerslaag 1998–1999* (2000).

[36] Tony Sheldon, 'New Reporting Procedure for Euthanasia Shows Doctors Follow the Rules' (2000) 320 *BMJ* 1362.

[37] Agence France-Presse, 30 May 2001, reporting a statement made the previous day by a spokesman for the Dutch Ministry of Health. The spokesman added that three cases had been referred by the committees to the prosecutorial authorities, who had decided not to prosecute.

physicians about the criterion of 'unbearable suffering' was often quite brief; that the second opinion was almost always from a colleague in the same field (for example, general practitioners usually consulted other general practitioners); and that information about the second doctor's opinion was often very brief.[38]

To return to Dr Van Delden, he continued that 'there is no rule that cannot (and will not) be broken' and that this is true of the prohibition on drunken driving.[39] But it is precisely because of the high value the law has traditionally attached to innocent human life that killing, even by drunk-driving, is a serious crime. The mere fact that the prohibition is broken is hardly an argument for *relaxing* that prohibition. Moreover, decriminalising VAE in certain circumstances *compounds* the difficulties of enforcing the prohibition on killing. It is vain to cite the fact of breach in support of a change which would make breaches not only more likely but also more difficult to detect and prosecute.

Finally, Van Delden asserted that the interpretation of the data 'remains largely dependent upon our moral views'.[40] Moral views (whether for or against) can indeed (though they need not) influence interpretation of the facts. There appears, however, to be a growing acceptance, even among those in favour of VAE in principle, that it is inadequately controlled in the Netherlands. Van Delden's response could be said to reflect this acceptance. It is also reflected by the views of the former editor of the *Journal of Medical Ethics*, Raanan Gillon. Professor Gillon used to favour the legalisation of VAE but changed his mind because of the difficulties of effective regulation. He agrees that the evidence shows that the Dutch guidelines are being 'extensively ignored' and that it is surely justifiable to conclude that Dutch euthanasia is 'in poor control'.[41] And that is the central contention of Part III of this book.

[38] *Regionale Toetsingscommissies Euthanasie* 10–14.

[39] 'Slippery Slopes in Flat Countries' 24. [40] Ibid.

[41] R. Gillon, 'Euthanasia in the Netherlands – Down the Slippery Slope?' (1999) 25 *J Med Ethics* 3, 4. The pro-euthanasia editor of the *N Engl J Med*, commenting on the second Survey, opined that the similarity between the findings in respect of 1990 and 1995 showed that the Dutch were apparently *not* descending a slippery slope (M. Angell, 'Euthanasia in the Netherlands – Good News or Bad?' (1996) 335 *N Engl J Med* 1677). Such sympathetic interpretations are, however, unpersuasive. A more plausible interpretation of the evidence is that the descent had already occurred by 1990 and that the second Survey, far from showing that there had been no *de*scent from 1984 to 1995, merely showed that there has been no significant *a*scent from 1990 to 1995. In any event, that the data from both surveys showed widespread breach of the guidelines is unarguable.

Professor Gillon echoed the point often made by defenders of the Dutch that in view of the absence of statistics before 1984 there is no way of proving statistically that there is a higher incidence of NVAE now than then.[42] This is true. However, there is good reason to think that NVAE has indeed increased since 1984. Breach of the guideline requiring a request is more likely to occur in a situation in which some VAE is allowed than when none is allowed, if only because of the greater problems in policing a practice allowed according to professional guidelines than a practice which is legally prohibited. Moreover, the *official endorsement* of NVAE by, for example, the Remmelink Commission can only have served to lessen doctors' inhibitions against it. Despite the absence of prior statistics it is, therefore, more plausible to conclude that NVAE has increased since 1984 rather than remained static.

That slippage has occurred in the guideline requiring 'unbearable suffering' is even harder to deny. This guideline has not only been breached in practice by the performance of VAE as an alternative to palliative care (and it is relevant to recall Van Delden's acknowledgment that there has been a 'shift' in practice towards relaxation of this guideline), but the guideline has arguably, as the *Chabot* and *Sutorius* cases illustrate, been interpreted beyond breaking-point. In short, the only hard evidence we have is that since VAE was permitted NVAE has been commonly practised, and that the requirement of 'unbearable suffering' has been, in practice and in theory, substantially relaxed. In any event, the absence of statistics before 1984 is no answer to the *logical* slippery slope argument, the argument which, as we noted in chapter 11, was endorsed by Van der Maas and Van Delden themselves.[43] As that chapter showed, there is no shortage of evidence from the Netherlands, independent of statistics, which indicates *official condonation* of NVAE.

Conclusion

Part III has subjected the Dutch experience to close scrutiny. Having questioned the Dutch claim that their guidelines are sufficiently 'precise' or 'strict' to ensure effective control, it has reviewed the empirical evidence. That evidence, which comprises mainly the two valuable Van der Maas surveys (but also the research of Gomez,[44] Hendin[45] and the author[46]), amply

[42] Gillon, 'Euthanasia in the Netherlands' 3. [43] See p. 123 n. 38. [44] Gomez. [45] Hendin.
[46] See, e.g., Keown, chapter 16. See also the colloquy in (1992) 22(2) *Hastings Cent Rep.*

demonstrates that the guidelines have conspicuously failed. Despite Dutch representations to the contrary, whether in the form of sympathetic documentaries or diplomatic reassurances, the reality is that guidelines have been widely breached, and with effective impunity.

More particularly, the evidence points to the following three conclusions. First, VAE is far from a rarity[47] and is increasingly performed. Rather than being truly a 'last resort', it has quickly become an established part of mainstream Dutch medical practice to which doctors have resorted even when palliative care could have offered an alternative. As Professor Griffiths, a defender of Dutch euthanasia, has written: '[E]uthanasia and assistance with suicide have become essentially normal procedures in Dutch medicine. Dutch doctors receive some 34,500 requests "in general terms" per year, and 96% of them have at some time discussed euthanasia or assistance with suicide with a patient.'[48] He added: 'They receive about 9700 concrete requests per year, and 77% of them have at some time had such a request. About a third of all requests are refused (in about an equal number of cases the patient dies before the euthanasia request can be carried out).'[49]

Secondly, despite the insistent claims by proponents of VAE, inside and outside the Netherlands, that allowing it subject to 'safeguards' brings it from the shadows and 'into the open' where it can be controlled, the evidence indicates that such claims merit scepticism. The reality is that most cases of VAE, until recently a substantial majority, have gone unreported and unchecked. In view of the intractable fact that in a clear majority of cases there has not even been an *opportunity* for official scrutiny, Dutch reassurances of effective regulation ring hollow. The fact, which surely can only be disputed by those 'in denial', is that since its inception VAE in the Netherlands has been and remains, in Professor Gillon's words, 'in poor control'. More people would undoubtedly appreciate this fact were it not for the tendency of some defenders of the Dutch to paint a picture so persuasively misleading as to be worthy of a Dutch master. The reassuring picture of the euthanasia landscape portrayed by the Dutch is surreal. As Dan Callahan, a leading American bioethicist, has pointed out, the reality

[47] In 1977 as VAE was beginning to gain acceptance in the Netherlands, a leading physician there wrote: 'One can be sure that [VAE]... occurs extremely seldom. I presume that the majority of family physicians has never applied euthanasia' (J. C. van Es, 'Huisarts en de preventie van euthanasie' [The family physician and the prevention of euthanasia] in P. Muntendam (ed.), *Euthanasie* (1977) 159).

[48] Griffiths, 253. [49] Ibid.

is quite different: 'The Dutch situation is a regulatory Potemkin village, a great facade hiding non-enforcement.'[50]

Thirdly, the guidelines have not only been ignored in practice, but they have been diluted in theory. The *Chabot* and *Sutorius* cases illustrated the expansive interpretation placed by the courts on 'unbearable suffering' and, as the court decisions condoning the killing of disabled babies show, the requirement of a request in all cases has now been jettisoned.

The undeniable want of effective control lends strong support to the empirical slippery slope argument. That the Dutch experience supports the empirical argument should come as little surprise given that the slide was predicted almost thirty years ago, it will be remembered, by Lord Habgood.[51] Habgood later became a member of the Select Committee of the House of Lords which was set up in 1993 to consider the euthanasia question. A fact-finding delegation from the Committee visited the Netherlands in October that year.[52] Having witnessed the Dutch experience at first hand, the Committee went on to recommend[53] that the UK should not follow suit. An important reason was that 'it would not be possible to frame adequate safeguards against non-voluntary euthanasia'.[54] To its credit, the Committee obviously saw through the Dutch rhetoric to the Dutch reality.

In the debate on the Report in the House of Lords, the Committee's Chairman, Lord Walton, observed that those members of the Committee who had visited the Netherlands had returned 'feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia . . . was commonly performed'.[55] He added that they were 'particularly uncomfortable'[56] about the *Chabot* case.[57] Another member of the

[50] *The Troubled Dream of Life* (1993) 115.

[51] Rt. Revd J. S. Habgood, 'Euthanasia – A Christian View' (1974) 3 *J R Soc Health* 124, 126.

[52] A Dutch Ministry of Justice spokesman assured the delegation that 'the government held strongly to the position that euthanasia was not possible for incompetent patients' (Lords' Report, Appendix 3, 68). Remarkably, this statement was made eight months after the change in the law to provide a mechanism for the reporting of NVAE had been approved by the lower house of the Dutch Parliament and one month before its approval by the upper house. If euthanasia was 'not possible' for incompetent patients, why was the government making provision for its reporting? Or was the spokesman simply using the Dutch definition of 'euthanasia' which, perhaps unbeknown to the Lords' delegation, makes euthanasia *definitionally* impossible for incompetent patients?

[53] See chapter 16. [54] Lords' Report, para. 238.

[55] (1993–4) 554 Parl. Deb., HL, col. 1345 at 1346. [56] Ibid.

[57] See p. 109. His Lordship could, of course, have gone much further but expressed the view that it would not be proper for him to criticise the decisions of the 'medical and legal authorities in another sovereign state' ((1993–4) 554 Parl. Deb., HL, col. 1346).

Committee to comment unfavourably on the Dutch experience was Lord Meston. He said:

> it did not seem possible to find any other place beyond the existing law for a firm foothold on an otherwise slippery slope. The evidence of the Dutch experience was not encouraging: in the Netherlands, which apparently lacks much in the way of a hospice movement, there seems to be a gap between the theory and practice of voluntary euthanasia. One cannot escape the fear that the same could happen here, with pressures on the vulnerable sick and elderly, who may perceive themselves to have become a burden on others, and pressures on the doctors and nurses from relatives and from those who are concerned with resources.[58]

Of course, the reality of the slippery slope may not have been lost on at least some Dutch advocates of VAE, who may have thought it desirable to maintain a discreet silence about it for tactical reasons. Indeed, Professor Alexander Capron, a leading American health lawyer, has related how this was in fact conceded at a conference in the Netherlands by a leading Dutch figure who had been influential in gaining acceptance for VAE. This person revealed that the Dutch proponents of euthanasia began with a narrow definition of euthanasia 'as a strategy for winning acceptance of the general practice, which would then turn to . . . relief of suffering as its justification in cases in which patients are unable to request euthanasia'.[59] Capron observes: 'It was an instance, or so it seemed to me, when the candour of our hosts was a little chilling.'[60]

In short, the failure of the Dutch effectively to control VAE lends weighty support to the empirical slippery slope argument, and their growing approval of NVAE illustrates the force of the logical slippery slope argument.

[58] Ibid., col. 1398. In *Rodriguez* v. *Attorney-General* (1994) 107 DLR (4th) 342, which rejected an alleged right to PAS, Mr Justice Sopinka, delivering the majority judgment of the Canadian Supreme Court, noted (at 403) the 'worrisome trend' in the Netherlands towards NVAE, which supported the view that 'a relaxation of the absolute prohibition takes us down the "slippery slope" '.

[59] Alexander Morgan Capron, 'Euthanasia and Assisted Suicide' (1992) 22(2) *Hastings Cent Rep* 30, 31.

[60] Ibid.