

entitled, "Should Physicians Hasten the Death Angel When She Pauses in her Flight?" in which he argued that the medical-ethical and biblical traditions, the normative centers of our moral system, absolutely condemn "the intention to cause death."<sup>6</sup> In his inimitable way he criticized both the active euthanasic modes of "strychnine, gun, and morphine" and the passive modes of withdrawing nutrition and hydration. For Ramsey the will is decisive; paraphrasing papal teaching, he concluded that "any act or omission that by design and in reality brings on death is wrong morally."

While I wholeheartedly agree with the general tenor of Ramsey's view, I suggest that he has not fully understood how we have already "designed" the death-defying and death-prolonging situation. We have created the conditions for suspension of mortality so that it becomes morally incumbent upon us willfully to offer at some point a fissure of release in our own barricade. Having barred the door to Death, are we not then obliged at some point to open it?

Resisting death is indeed noble; we must do it. But we must finally yield. As Teilhard said:

We must struggle against death with all our force, for it is our fundamental duty as living creatures. But when by virtue of a state of things, death takes us, we must experience that paroxysm of faith in life that causes us to abandon ourselves to death as to a falling into a greater life.<sup>7</sup>

We must beware of allowing a case like Debbie's to create a general medical precedent. But neither should our fearful antipathy toward what happened to her make us inhumanely force individuals to outlive themselves. Just as physicians must not be accomplices to the modern euthanasic ritual we euphemistically call cost cutting, they must never open themselves to the currently widespread criticism that they cruelly prolong patients' dying. Our irresistible technology, joined to an insatiable need to help and an incoherent fear of death, could do this to us. Alternatively a new courage, grace, and reciprocity may mark our future, if we choose.

## References

- <sup>1</sup> Full discussion of the Debbie case can be found in the *Journal of the American Medical Association*, 259:2 (1988), 292; 259:14 (1988), 2094-98, 2139-43; 260:6 (1988), 787-89.
- <sup>2</sup> Easter hymn.
- <sup>3</sup> Paul Carrick, *Medical Ethics in Antiquity* (Boston: D. Reidel Publishing Company, 1985), 158.
- <sup>4</sup> Hippocrates, *The Art*, II, p. 193.

- <sup>5</sup> Andrew H. Malcolm, "To Suffer a Prolonged Illness or Elect to Die," *New York Times*, 16 December 1984, 1, 18.
- <sup>6</sup> To appear in *Covenants of Life: Contemporary Medical Ethics in Light of the Thought of Paul Ramsey—Essays and Response*, ed. Kenneth Vaux (Urbana, IL: University of Illinois Press) (forthcoming).
- <sup>7</sup> Pierre Teilhard de Chardin, *On Suffering* (New York: Harper and Row, 1974), 58.

## A Case Against Dutch Euthanasia by Richard Fenigsen

Dutch general practitioners perform voluntary active euthanasia on an estimated 5,000 patients a year; the larger figure cited of 6,000 to 10,000 patients probably also includes hospital patients. However, figures as high as 18,000 or 20,000 cases a year have been mentioned. The population of The Netherlands being 14½ million, the lowest Dutch figure published would correspond to about 80,000 cases of active euthanasia a year in the United States; the highest published Dutch estimate (20,000) would be tantamount to over 300,000 cases annually for the U.S. 81 percent of Dutch general practitioners have performed active euthanasia at some time during their professional careers; 28 percent perform active euthanasia on two patients yearly, and 14 percent on three to five patients every year. In Holland, the causes of death of people suffering from AIDS are different from those of patients with AIDS in other countries as 11.2 percent of Dutch AIDS patients die by active euthanasia.

Many people in The Netherlands carry a will requiring active euthana-

sia to be performed on them "in case of bodily injury or mental disturbance of which no recovery to reasonable and dignified existence is to be expected." Recently, the paper wills have begun to be replaced by small, handy plastic cards nicknamed "credit cards for easy death" by the Dutch press. In 1981 the number of people carrying such cards was reported to be 30,000, but is supposedly much higher now.

The law that would legalize euthanasia is a major issue in Dutch politics. Of the eleven political parties in Holland, ten have included the issue of euthanasia in their electoral platforms. Government coalitions rise and fall because of agreement, or disagreement, concerning euthanasia. Some representative headlines: "Majority of the Lower House [of Parliament] for Euthanasia"; "Coalition Splits on the Plan for Euthanasia"; "No Waiting Till the Elections: Christian Democratic Alliance and VVD [the Liberals] Want the Law on Euthanasia"; "The Parliamentary Fraction Sticks to the Euthanasia Bill of D-66: Conflict Looms Within the Liberal Party"; and, "Political Consensus on Euthanasia."

Acceptance of "voluntary" active euthanasia by the Dutch people is growing. According to two consecu-

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tive polls, 70 percent of the Dutch people accepted active euthanasia in 1985, and 76 percent in 1986. This is interpreted by the media as a vote for human freedom (including the freedom of the individual to decide upon his or her life or death), but the reality is more complex. An analysis of public opinion reveals other, and quite different attitudes, in particular, views that oppose the individual's freedom of choice and support society's right to cut short a person's life. Thus, there is considerable public acceptance of the view that life-saving treatment should be denied to the severely handicapped, the elderly, and perhaps to persons without families. Further, opinion polls show that a majority of the same public that proclaims support for voluntary euthanasia, freedom of choice, and the right to die, also accepts involuntary active euthanasia—that is, denial of free choice and of the right to live.

In Holland, the most prominent persons on the medical scene are at the same time leading figures in the movement to legalize euthanasia. The late Prof. Dr. P. Muntendam held both the chairmanship of the State Committee on Legal Reform of the Medical Profession and the presidency of the Dutch Society for Voluntary Euthanasia. The long-time president of the latter society, Dr. Helen Terborgh-Dupuis, has been offered the chair in medical ethics at Leiden University. Her inaugural lecture was entitled, "*Dood wordt te negatief gewaardeerd*" (death is being judged in too negative a way). Holland's leading specialist in pediatric oncology, Prof. P.A. Voute, recently revealed that since the early 1980s it has been his practice, at times without the parents' consent, to provide some of his patients with doses of poison, enabling them to commit suicide when they feel so inclined. An opinion poll showed that 70 percent of the public approved of Prof. Voute's actions.

In June 1984, the Board of the Royal Dutch Society of Medicine (KNMG, the main Dutch physicians' organization, with a membership of 30,000) approved a "Position on Euthanasia" supporting the legalization of voluntary active euthanasia.

In another official statement this same Board declared support for involuntary active euthanasia. It also indirectly supported involuntary active euthanasia in the affair of the "*De Terp*" killings in The Hague. The Royal Dutch Society of Pharmacology (KNMP) has compiled and printed the official list of drugs to be employed in performing active euthanasia. The Health Council (*Gezondheidsraad*, the official medical body advising the Dutch government) has issued numerous detailed guidelines concerning indications for, and the performance of active euthanasia. One of these, published in March 1987, states that requests for euthanasia submitted by minors and children should be honored, and euthanasia performed, not only when the child's parents consent, but also when the parents protest.

#### Euthanasia in the Courts

Of the 5,000 to 20,000 cases of active euthanasia occurring every year, an average of eleven prompt inquiries to be made by the offices of public prosecutors. The prosecutors act under a regulation issued by the Ministry of Justice which states that an inquiry should be launched only when it is suspected that the doctor performing euthanasia did not act in a careful manner. The legal authorities encourage doctors performing euthanasia to state active euthanasia as the cause of death to avoid their making false statements. In some cases, the doctors inform the public prosecutor beforehand that euthanasia is to be performed. The sentence passed by the court in Leeuwarden in 1972 (one week of suspended arrest for a doctor who killed her mother) initiated the judicial trend now followed by all the courts, higher appellate courts, the Supreme Court, public prosecutors, and the Ministry of Justice. In the few cases of "voluntary" euthanasia brought to trial, the court declares the doctor guilty but does not impose punishment, whereupon the higher court overturns the "guilty" verdict on the grounds that the doctor acted out of higher necessity. The latter ruling is now being applied in every such case.

When a perpetrator of involuntary euthanasia is brought to trial, as in the case of the doctor who secretly committed the killings in *De Terp* nursing home in The Hague, punishment is imposed but abolished on a technicality by a higher court.

#### Why Holland?

The causes and origins of Dutch euthanasia seem to be complex, rooted both in the past history and the present development of Dutch society. The subject deserves extensive study. Until such study is done, however, one can only offer views that are incomplete and partly conjectural.

An important current of Dutch medical, legal, and theological thought was influenced by such German thinkers as Haeckel, Jost, Binding, and Hoche, who introduced the concept of lives unworthy of being lived, and advocated the extermination of useless individuals to relieve society of that burden. Appearing on the scene half a century after their German predecessors, after the experience of Nazi euthanasia on psychiatric patients and the handicapped, after Europe's historical experience of genocide, and at a much further advanced stage in the development of the Western concept of human rights, the champions of euthanasia in The Netherlands had to present a modified and highly refined program. They emphasized the right to die, and stressed death as a relief from suffering and as being in the best interest of those who were ill and unhappy—a program designed to appeal to those who believe in human rights. The other theme, that of the right to kill in the interest of the society, has been downplayed but never actually eliminated, so as not to discourage those who believe that the human race should be improved by the extermination of weaklings. Thus, the prerequisite for the success of the pro-euthanasia movement in Holland has been its extremely well-constructed program.

This program, promoted by talented writers such as van den Berg, kept gaining support until an avalanche effect occurred. Editors and

publishers soon became reluctant to print or broadcast anything that went against the current. The media have been virtually monopolized by the euthanasia proponents, and a whole generation of Dutch people has been raised without ever hearing any serious opposition to it.

Several features of Dutch public life seem to have enhanced the rapid expansion of the pro-euthanasia movement. First, Holland is a very democratic, liberated, and permissive society that highly values unlimited freedom of thought and expression, and encourages the rejecting of dogmas and the overthrowing of taboos. This has facilitated open discussion of euthanasia and the questioning of the "taboo" upholding the sacredness of human life. One peculiar feature (or side-effect) of the advanced democratization and liberalism of Dutch society is popular antimedical feeling, which runs much higher here than in other European countries. There is great resentment against doctors who wield so much power without being elected, and who are seen as selfish, much too self-assured, devoid of common sense, and ignorant of people's needs. There is a strong link between this antimedical public mood, nurtured by propaganda in the Dutch media, and the rush to euthanasia. Some people would rather die soon than be left to the mercy of doctors "and their machines."

In The Netherlands, where Catholicism and Protestantism coexist, issues easily acquire religious connotations. As a result, the principle of the sacredness of human life has been unduly identified with, and confined to, the religious commandment. This has weakened the cause of opponents of euthanasia, as it is clear to all that the country belongs to believers and nonbelievers alike and no purely religious concept should be imposed as a general rule or made the law of the land. Secular reasons—moral, rational, and medical—for rejecting euthanasia are still unknown to the Dutch people.

Also, peoples speaking languages of the Germanic group have historically proved able to build particularly strong social structures. To maintain them requires the far-reaching sub-

ordination of the interests of the individual to those of the society. Important business, including the destinies of individuals, may and should be decided upon by public assembly, by consensus, or according to the tribe's laws and rules. It can be argued that these attitudes have determined the acceptance of involuntary aspects of euthanasia by the Dutch public.

Finally, while guilt about the Nazi past until recently precluded any serious pro-euthanasia movement in Germany, the Dutch, who never committed such crimes and, on the contrary, have built at an enormous cost to the national economy an exemplary system of care for the sick, the handicapped, and the elderly, have not been inhibited by such guilt.

#### **"Voluntary" Euthanasia**

It is the concept of "voluntary" euthanasia, evoking the themes of the right to self-determination and freedom of choice, that is being used to influence the public, the medical profession, and legislators to open the way to the legalization of euthanasia. However, there are, and always have been, compelling reasons for which "voluntary" euthanasia was rejected by Western civilization in the past, and should be rejected now and in the future.

"Voluntary" euthanasia should be rejected *because its voluntariness is often counterfeit and always questionable*. In Holland, doctors have tried to coerce patients, and wives have coerced husbands and husbands wives to undergo "voluntary" euthanasia. But it is not these flagrant incidents that matter, it is all the others. For twenty years the population of Holland has been subjected to all-intrusive propaganda in favor of death. The highest terms of praise have been applied to the request to die: this act is "brave," "wise," and "progressive." All efforts are made to convince people that this is what they ought to do, what society expects of them, what is best for themselves and their families. The result is, as Attorney General T.M. Schalken stated in 1984, that "elderly people begin to consider themselves a burden to the society, and feel under an obligation to start conver-

sations on euthanasia, or even to request it." Recently, the Dutch Patients' Association warned Parliament of reports showing how strongly a sick person's decision to request euthanasia is influenced by pressure from the family and the physician. It is striking that doctors who practice euthanasia have killed so many patients "at the latter's own request" (one doctor gives a figure of seventeen), while other, more traditional practitioners have yet to hear such a request from a patient. When evaluating the thousands of "voluntary" requests for euthanasia submitted every year in Holland, one should take into account the influence of propaganda and of the physician-provocateur.

#### **"Taigetian" Medicine and Crypethanasia**

"Voluntary" euthanasia must also be rejected because, contrary to the beliefs of some of its supporters, *it is inseparable from, and inherently linked to overtly involuntary forms of euthanasia*. The Dutch phenomenon of mass "voluntary" euthanasia can only be understood when it is considered in the broader context of a changed attitude toward human life, together with other important manifestations of this new mentality: "Taigetian" medicine and the practice of crypethanasia. There is a very widespread practice of intentionally allowing certain groups of people to die out. This aim is achieved by denying these people life-saving treatment. I call such practices "Taigetian" because of the Taigetos mountain chain near Sparta, where newborn babies not found strong enough by the Ephors of the State were left to die. Doctors allow at least 300 handicapped newborn Dutch babies to die every year; prevent surgery for congenital heart disease in Down syndrome children by refusing to give anesthesia; and refuse to implant pacemakers for heart block in patients older than seventy-five or to treat acute pulmonary edema in the elderly and in single people without close family. Some doctors justify these practices by arguing that it is in those patients' own best interest to die as soon as possible, but often the explanation is

that society should not be burdened with keeping such persons alive. The decisions are taken without the knowledge of the patients and against their will. Doctors who deny some of their patients available life-saving help violate thereby Rules 1, 6, and 7 of the Code of Medical Conduct adopted by the KNMG, the Medical Code of Ethics of the World Medical Association, the Declaration of Tokyo of 1975, the European Treaty in Defense of Man and the Basic Freedoms, Dutch civil law, and Article 450 of the Dutch Criminal Code. However, these Taigetian practices are strongly supported by the public, theologians, and the medical institutions of high authority.

There is now ample evidence that "voluntary" euthanasia is accompanied by the practice of cryphtanasia (active euthanasia on sick people without their knowledge). Gunning was the first to report attempts to kill off elderly patients instead of admitting them to the hospital. In 1983, extensive information on cryphtanasia became available with the publication of H.W.A. Hilhorst's well-researched book, *Euthanasia in the Hospital* (in Dutch), based on the results of a study conducted in eight hospitals. In this publication (sponsored by the Royal Dutch Academy of Science and the University of Utrecht) the author analyzed the practice of involuntary euthanasia and described cases of involuntary active euthanasia on adults and children. There followed, in 1985, reports on mass secret killings in the *De Terp* senior citizens' home in The Hague; my report about practices of cryphtanasia at the internal department of a hospital in Rotterdam; estimates by Dessaur, Gunning, Dessaur and Rutenfrans, and van der Sluis that more people die in this country by involuntary than by voluntary euthanasia; and, in 1987, the discovery of serial killings of comatose patients by four nurses in the department of neurosurgery at the Free University Hospital in Amsterdam. Whenever cases of cryphtanasia are revealed, attempts are made to dismiss them as abuses that have nothing in common with the regular practice of voluntary euthanasia—as exceptional, sporadic, and

criminally liable acts. However, the problem cannot be discarded in this way. It cannot be asserted that cryphtanasia occurs only sporadically.

Neither can it be claimed that the covert medical killings are perpetrated by some criminal outcasts whose actions are contrary to public mood and condemned by public opinion. The reverse is true. Two consecutive polls conducted by NIPO Institute showed that while 76 percent of the Dutch public approve "voluntary" euthanasia, 77 percent support involuntary euthanasia. Thirty-three percent of the respondents showed "considerable understanding" and another 44 percent "some understanding" for those who, out of mercy, kill their own father or mother without his or her consent. Forty-three percent approved of involuntary active euthanasia for unconscious persons "with little chance of recovery," while 10 percent were certain and an additional 17 percent deemed it probable that they would request involuntary active euthanasia for a demented relative. Ninety percent of the undergraduate economics students polled supported compulsory euthanasia on unspecified groups of people to streamline the economy. The perpetrators of cryphtanasia enjoy broad public and institutional support, and total judicial leniency. The doctor apprehended in The Hague under suspicion of having killed twenty inhabitants of the *De Terp* old people's home without their consent or knowledge pleaded guilty to five, was accused of four, and convicted of three killings. Witnesses testified that some of the victims were not ill but only senile and querulous, and that the doctor was impatient with elderly people, reluctant to treat them, frequently absent, and left many decisions to the male head nurse. The latter carried out the killings (using untraceable intravenous injections of insulin) and threatened other *De Terp* inhabitants with euthanasia. A Citizens' Committee of support for the accused doctor was formed in The Hague, and he received public declarations of support from, among others, the president of the Dutch Society for Voluntary Euthanasia, the vice-president of the KNMG, and a former Attorney General at the

Supreme Court, and others. In an official statement, the Board of the KNMG declared itself alarmed, not by the killings, but by the conviction of the doctor, which could cause feelings of insecurity among physicians who help their patients to die and discourage these doctors from doing so openly and from stating active euthanasia as the cause of death. Finally, a higher court dismissed the accused doctor's guilty plea, and found him innocent of the killings, while a civil court awarded him 300,000 guilders (\$150,000 U.S.) in damages.

Similarly, four nurses at the neurosurgery department of the Free University Hospital in Amsterdam, who admitted to having secretly killed several unconscious patients, received support from the hospital's Employees' Council (*Ondernemingsraad*), which demanded their immediate release and reinstatement. The Council raised the question of the responsibility of the doctors working in the hospital, suggesting that by unduly delaying euthanasia these doctors may have forced the nurses to act. When releasing the nurses from custody, the Amsterdam court held that their actions had been prompted by humane considerations. The victims' parents, who only after the arrests of the nurses learned how their sons and daughters had died, thanked the nurses at an emotionally charged, televised ceremony. Thus cryphtanasia is not an "abuse" of the practice of voluntary euthanasia; it is widely accepted, openly supported, and praised as a charitable deed.

The country's highest authorities show leniency toward doctors who practice cryphtanasia: Prof. Ch.J. Enschede, advisor to the Dutch government on the juridical aspects of euthanasia, informed me that "the government and the Council of State decided to keep just these cases out of the reach of the criminal code." Institutions that proclaim the voluntariness of euthanasia in their official platforms make use of every opportunity to promote involuntary euthanasia as well. A member of the Board of the Dutch Society for Voluntary Euthanasia pleaded for involuntary active euthanasia for the demented elderly, unconscious victims of road

accidents, and (conscious) Thalidomide-impaired children, while the president of the same society publicly defended the perpetrator of the *De Terp* killings. The society's quarterly publication printed without comment the exhortation to kill all handicapped newborn children to breed a strong race. The Board of the KNMG has ordered a special committee to work out guidelines for involuntary euthanasia of such newborns. Thus in Holland, "voluntary" and involuntary euthanasia are advocated by the same people and the same institutions, supported by the same public, practiced alongside each other and closely linked in the public mind. Both are manifestations of the same basic attitude, that is, the now widely shared conviction that people's lives may be cut short whenever there are good reasons for doing so. Those who contend that it is possible to accept and practice "voluntary" euthanasia and not allow involuntary totally disregard the Dutch reality.

### Social Implications

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"Voluntary" euthanasia should also be rejected *because of the ominous change it brings about in the society*. Instead of the message a humane society sends to its members—"Everybody has the right to be around, we want to keep you with us, every one of you"—the society that embraces euthanasia, even the "mildest" and most "voluntary" forms of it, tells people: "We wouldn't mind getting rid of you." This message reaches not only the elderly and the sick, but all the weak and dependent. Attorney General T.M. Schalken found that Dutch society has already undergone this transformation. As a consequence, some groups live in fear and uncertainty. The Dutch Patients' Association stated in 1985 that "in recent months the fear of euthanasia among people has considerably increased." A group of severely handicapped adults from Amersfoort stated in their letter to the Parliamentary Committees for Health Care and Justice:

We feel our lives threatened... We realize that we cost the community a lot... Many

people think we are useless... often we notice that we are being talked into desiring death... We will find it extremely dangerous and frightening if the new medical legislation includes euthanasia.

In their fears, people do not distinguish "voluntary" from involuntary euthanasia.

A study conducted among hospital patients showed that many fear their own families because these are people who could decide upon euthanasia or pressure them to request death. Out of fear of euthanasia some elderly people refuse to be placed in old-age or nursing homes, refuse to be hospitalized or to see doctors or take medicines. A study of the attitudes of the elderly showed that 47 percent of those living in their own homes, and 93 percent of those living in homes for senior citizens reject any active euthanasia "because later on, when they won't be in command of the situation any more, their lives, against their will, will be put to an end by others." Pathetic attempts are made to escape imposed medical death. The "Sanctuary Association" (*Schuilplaats*) printed "declarations of the will to live." This card "which anyone can carry on his person, states that the signer does not wish euthanasia performed on him." Thus, for the protection of their lives people no more rely on the rule of the law. The impunity of cryphtanasia, established as the practice of the courts and the policy of the government and the Council of State, indicates that articles of the Statutes for Batavian People and of the Dutch Constitution protecting life and person have been de facto suspended.

More change must be expected if the pro-euthanasia movement, having attained the legalization of "voluntary" euthanasia, is to achieve the rest of its proclaimed goals. Proposals calling for euthanasia of handicapped newborns mean that doctors acting, as they do everywhere, under state supervision, will issue some newborn citizens permits to live and destroy others. To exist, a human being will have to be approved by the government—a reversal of the democratic principle that governments, to exist, have to be approved by people. Such parts of the program as com-

pulsory euthanasia for the demented elderly and limiting the lifespan of people by denying medical help to those above a certain age, as, in general, any measures to eliminate from society large numbers of citizens, voters, life-long taxpayers, living people, are incompatible with our present system of government. This does not mean that these programs will not be put into effect, but it does mean that the implementation of euthanasia programs will involve an essential change in the system of government now prevailing in Western nations.

### False Promise

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"Voluntary" euthanasia should further be rejected *because its promise is false*. Euthanasia is supposed to spare the sick person the agony that precedes death or the sufferings of a prolonged illness. But this is not the case. When Wibo van den Linden filmed one patient's preparations for "voluntary" euthanasia, about a million Dutch television viewers watched the unfortunate lady's anguish and despair as the fixed day of execution approached. Millions die a human death, in uncertainty, fear, and hope, as cherished members of their family, of the human community, surrounded by those who won't let them go. But euthanasia causes extreme psychological suffering—the excommunication, the exclusion of a person from the community of the living while he is still alive.

Hilhorst's interviews with doctors who practice euthanasia reveal that they have recourse to cryphtanasia when they have neither the courage nor the cruelty to talk openly to the patient and offer him death. Because of the cruelty of the procedure, the most prominent champions of euthanasia—Foster-Kennedy in America, Lenz in Germany, and van den Berg in Holland—did not even consider "voluntary" euthanasia and advocated only the covert, involuntary variety.

### Fallibility and Irreversibility

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Voluntary euthanasia must also be rejected because of the *fundamental*

*discrepancy between the uncertainty of human (and medical) judgments, which are fallible, and the deadly certainty of the act.*

Clinicians have traditionally rejected euthanasia because they realized that we all make mistakes, that diagnoses are uncertain and prognoses notoriously unreliable. Erroneous diagnosis of fatal disease remains a very real possibility.

In their efforts to improve a patient's condition or save his life, doctors often have to rely on a diagnosis that is only probable. This course of action is unavoidable and justifiable intellectually. Yet, to perform euthanasia on the grounds of a diagnosis that might prove incorrect is as evil as it is mindless. We don't know how often this happens in The Netherlands because those who advocate euthanasia and the doctors who practice it never agreed to F.L. Meijler's demand that reasons for euthanasia be verified in every case by a post-mortem examination.

Moreover, plain mistakes occur in medicine as they do in every other human activity. A doctor's mistake is always deplorable but forgivable if he made it while doing his best to improve the patient's health. The damage can sometimes be repaired. The mistake of a doctor practicing euthanasia (and they do make mistakes, and even more than other doctors) is unforgivable and also irreparable: the patient is dead. It was not only a crime but an unforgivable professional mistake when an internist at a Rotterdam hospital decided to perform active involuntary euthanasia because the patient was semi-conscious, overlooking the fact that this condition was caused by the tranquilizer he himself had prescribed. At the intensive respiratory care unit of the University Hospital in Leiden, a female patient in fair condition after chest surgery died of respiratory arrest because the nurse told the physician on duty that there was an agreement not to reanimate. Later it turned out that the "agreement" did not apply to this patient but to another lady.

"The patient's own request" is not necessarily the firm grounds for "voluntary" euthanasia it is purported to be. Anybody may in a moment of

distress express wishes that he disavows the next day. The only patient ever to ask me for euthanasia recovered from his nearly lethal illness (severe heart failure due to multiple pulmonary embolism) and during six years' follow-up never again mentioned the request he had made in a moment of despair. It is also generally known that, in reality, a request to die very often signifies something else, and can be a cry for help, for understanding, an attempt to dramatize the situation. Even when someone requests death emphatically and repeatedly, in writing or in the presence of witnesses, this does not preclude in the least that he is actually asking for help and attention.

#### **Euthanasia Is Never "Necessary"**

"Voluntary" euthanasia is to be rejected *because it is totally unnecessary*. In my many years of work as a hospital doctor, I attended thousands of patients and, much to my regret, many hundreds of them died. They needed support, relief from pain, breathlessness, or nausea. Until their last conscious moments they needed to belong, to share with all of us our common destiny, fears, uncertainties, and hopes. None of them needed euthanasia, and with a single exception in thirty-six years, none asked for it.

It is a most demanding task of the doctor to assist his patient to the very end, one that is very different from what vocal supporters of euthanasia expect and demand. Suffering should be alleviated as effectively as possible. The drugs used to relieve pain, or the anticonvulsants used on patients who have suffered cardiac arrest, may shorten a person's life by suppressing respiration, but this is a risk we take; it should never be our intention. No treatment should be inflicted upon a patient that by itself is more harmful than the disease. When in doubt, I follow Dr. Loeb's First Rule of Therapeutics: Don't do to the patient what you wouldn't allow to be done to yourself. I stop treatment when everything has failed. I also stop or withhold treatment when the patient so requests, but this point requires some elaboration. First, there are situations when the patient's refusal of treatment is ill-informed and there

is no way of explaining this to him. The two examples I know from personal experience are: a patient who lost consciousness due to massive bleeding from a duodenal ulcer, having first refused to be operated on; and a relapse of ventricular fibrillation in a still conscious patient who had already been defibrillated and refused to undergo the electric shock again. In such situations I act against the will of the patient and assume the responsibility; I would rather be sued by a living person than take a patient at his word and allow his unnecessary death.

The situation is different when there is no emergency and the patient's refusal of further treatment seems a well-considered decision. Even then, however, we should not just accept the refusal, but try to encourage and persuade him. If nothing else is accomplished, we have still made the patient feel that his doctor has not abandoned him.

Turning off the respirator is an act often discussed. However, many patients on respirators recover and are disconnected from the machine. Others die, of pneumonia, cardiac arrhythmias, or kidney failure; often their death is due to our failure to regulate the body's functions, the acid-base balance, the liquids, and the electrolytes, in a way equal to that of natural regulatory mechanisms. The very, very few patients who require indefinite respirator support should receive it. The urge "to decide," "to do something" is misplaced. A society that can afford 20,000 respirators can also afford using respirators in 100 hopeless cases. What a society cannot afford is a legal and moral warrant to kill.

#### **Fallacious Reasoning**

"Voluntary" euthanasia should also be rejected *because of the flaws in its philosophy*. Euthanasia advocates base their positions on the following line of reasoning: Seriously ill people who in the end will die neither wish to nor are able to endure their meaningless suffering. This has become an important social problem in connection with an aging population and the proliferation of old-age homes and homes for the chronically ill whose

residents, cut off from their families and isolated from the rest of society, lose faith in the meaning of their lives. Moreover, as a result of medical and technical progress the lives—and the sufferings—of the seriously ill are extended and become unbearable. Like every important social problem, this one must be solved by society. The taboo on cutting short a person's life is at odds with a truly human attitude. A doctor who cuts short the life of a person experiencing terrible suffering acts out of higher necessity: he cannot act otherwise. People who want to die have a right to euthanasia. The individual's absolute right to self-determination must be acknowledged as fundamental.

However, rigorously applying the principle of voluntariness deprives infants, the mentally ill, paralytics who can neither speak nor write, and the comatose of the chance for a painless death. When a patient is inarticulate, but it can be assumed that if he were able to express his wish he would choose to die, euthanasia should be granted. In the case of the demented who "are beyond making their own decisions...someone else [should be given] the mandate to take over" and decide on euthanasia. As for the comatose, they are kept alive at great effort and expense to the despair of their families. Currently, no one dares to make a decision and cut short the lives of such people. But to keep a comatose person alive is also a decision that needs justification.

Anyone who intends to change the status quo must prove he is right; when the proposed change entails irreversible consequences, the arguments must be convincing beyond doubt and the proofs irrefutable. The philosophy of euthanasia does not meet these requirements.

Of course, the essential flaw lies in the attempt to justify both "voluntary" and involuntary euthanasia. "Voluntary" euthanasia is to be justified by the individual's right to self-determination. So absolute and inalienable is this right that we must overcome the obstacles of law and tradition, our habits of thinking and instincts, and kill people who request death. However, involuntary euthanasia also requires justification and then it turns out that the right

to self-determination is not so absolute after all: some people—the newborn, the demented, the comatose—do not have this right, and will undergo euthanasia though some of them (the demented) obviously wish to live and the others never expressed a wish to die.

The primary assumption that the human tragedy of confronting death and dying is a solvable problem is obviously erroneous. This problem is unsolvable and the "solution" offered is a sham (no problem is solved by destroying the thing involved). The assertion that technical progress in medicine has created the need for euthanasia is contrary to fact. This argument was used by proponents of euthanasia in 1875 and in 1899 when medicine's ability to prolong lives by technical means was almost nonexistent.

Neither can present-day euthanasia be explained by the suffering of people whose lives are artificially prolonged by machines: in Holland, most acts of euthanasia are performed by general practitioners at patients' homes, on patients treated without any special techniques. The assertion that the growing need for euthanasia is due to the proliferation of homes for the elderly, where the isolation and the meaninglessness of existence prompt people to request death is false. The homes for the elderly are not natural disasters to which, with all their consequences, we must resign ourselves. These institutions are the result of our own conscious action. They were created as places where the elderly can *live*. Had our efforts produced only the opposite results, led only to people asking for death, then the logical conclusion would be to close the residences, not kill the inhabitants.

When used to justify involuntary euthanasia, the concept of killing a person in his own best interest is obviously illicit. People who feel quite happy in their lives are put to death "in their own interest" by doctors who know better. What a person feels, desires, and values are by definition that person's subjective attitudes; no one but he can pass judgment on them and certainly no one can know these better than he. Doctors who practice cryphtanasia, or deny some patients life-saving help, assume a

right to judge and decide on behalf of another person that it is "in his own interest" to die, but this is a right that cannot exist either morally or logically.

Moreover, the practice of euthanasia is often in an obvious way directed against the involved person's interest. Doctors who refused to treat acute pulmonary edema or insert pacemakers because of the patient's age, or to administer renal dialysis because the patient was unmarried, condemned these people to a particularly painful death: rattling in mortal fear and suffocating from pulmonary edema, hitting the floor with their heads in Adams-Stokes seizures, or vomiting, bleeding, and gasping for breath in progressive kidney failure. These doctors cannot assert that dying in such a horrible manner is in the best interest of a person, even if that person is elderly, handicapped, or alone in the world.

Those who use the concept of killing a person in his own best interest to justify "voluntary" euthanasia disregard the fact that euthanasia destroys the very values in the name of which it is carried out: a dead man is deprived of all interests (and freedoms) once and for all.

The concept of "quality of life," frequently used in the philosophy of euthanasia, implies an objective, impartial assessment, but its very point of departure is biased. The use of this concept assumes in advance that life as such, life independent of its "quality," has no intrinsic value. Then, the concept of "quality of life" is in turn used to justify the assertion that some lives are not worth living, which is an inadmissible error of logic (*circulus vitiosus*). Such terms as "unbearable" or "senseless" suffering are value judgments that are inappropriate in logical argumentation. More important, reasoning that resorts to "unbearable" and "senseless suffering" is used to undermine the endurance, courage, and will to live of the severely handicapped or chronically ill. Such arguments are also used *instead* of adequate (and, indeed, attainable) alleviation of the sufferings of the gravely ill, thereby producing the very afflictions they decry.

### "Higher Necessity"

The concept of euthanasia performed out of higher necessity was devised by the supporters of euthanasia among the judiciary and is now routinely used to justify medical killing. This is, however, an error of judgment. Higher necessity is not an independent and separate concept but depends on the actions considered admissible in a certain situation; actually it is an offshoot of those actions. Someone who has robbed a bank will find it fruitless to appeal to higher necessity (his family's poverty, impending bankruptcy of his business), fruitless because his act is considered inadmissible under any circumstances whatsoever. A doctor who kills a patient can appeal to higher necessity because his action is considered a priori as possibly admissible. It is the a priori acceptance of euthanasia that creates the "higher necessity."

The assertion that keeping a person alive is a decision that must be justified is based on the same logical fallacy. Only those who assume a priori that a choice exists, that one can kill or not kill, can define leaving a person alive as a decision. Assertions that every person has the right to decide about his own life and death ("the right of self-determination"), or that nobody has this absolute right, are value judgments that cannot be proved or disproved by logical argumentation.

Traditional social practice, as well as legislation, considered human life the value worthy of the highest protection (at least in peacetime); all other values, including freedom, must be subordinate to the defense of life. It is important to notice that laws protecting a person's life, even against that person's will (for example, forcible hospitalization of the mentally ill who are in danger of committing suicide), are consistent with the deep belief we all share and which is a natural reaction: everyone rushes to help at the sight of a clothed person preparing to jump from a bridge into a river. Thus it cannot be argued that the right to self-determination is based on a general consensus among people. When confronted with attempted suicide, the great majority

of people act in accordance with the belief that the community of people has the right and duty to intervene to save human life. Thus the individual's right to self-determination is not a self-evident one. It is a controversial concept proclaimed by many but rejected by all when ultimately tested.

This concept is, moreover, improperly used in the philosophy of euthanasia. The advocates of euthanasia assert that the right to self-determination is the basis and justification of voluntary euthanasia. Those who recognize the right to self-determination supposedly recognize *eo ipso* the right to voluntary euthanasia. The latter assertion is, however, untrue. People who recognize the right to self-determination recognize the right of each individual to decide what will happen to his own body, his own life. But "voluntary" euthanasia includes more than that. Other people take part in the performance of euthanasia: a doctor, often nurses, and, as a rule, those who express their consent—the patient's relatives, guardians, members of the clergy, and sometimes the judiciary. The right to voluntary euthanasia (were we to recognize such a right) would thus include not only the right to exert control over one's own person but over other persons as well, over their acts and their consciences. The person requesting his own death would also have the right to make killers of other people and accomplices to killing of those who expressed their consent. He would have the right to compel society to renounce the principle of the inviolability of human life, that is, to destroy the barriers protecting the life of each person.

The philosophy of euthanasia, to which many brilliant writers have contributed, is ultimately a miscarried piece of work. It makes incorrect assumptions and uses obviously flawed or at best controversial concepts. Its aim is nonsensical: to convince humans that they have better options than life. As for its reasoning, the very idea of using logical argumentation to justify euthanasia, or, for that matter, any basic human choice, is erroneous. The view that one may kill a person, or that

one may not, are value judgments whose validity cannot be demonstrated by logical argument. They are rooted in our value system, which exists beyond logic, and are based on our traditions and, in the end, on our instincts. Nevertheless, the pro-euthanasia movement has taken on an impossible task and attempts to demonstrate logically that its choice is the right one. This inevitably results in arguments based on logical error, the vicious circle.

### The Danger to Medicine

"Voluntary" euthanasia should also be feared and rejected *because of the irreparable damage it causes to medicine*. It has become obvious that the practice of euthanasia interferes with doctors' performance as observers of nature and as helpers. The high occurrence of factual errors and oversights committed by doctors in the rush to euthanasia seems to be due to the excitement accompanying the socially and officially approved legalized killing. It has also been pointed out that it is the strong motivation of curative medicine that enables a doctor to grasp and memorize a great number of facts relevant to the case, while euthanasia dispenses the doctor from this necessity.

Desisting from potentially effective therapy because of the idea of euthanasia is a well-known phenomenon that is increasingly disabling the profession. Euthanasia does not just change medicine or extend its range; euthanasia *replaces* medicine.

Trends in medical thought and research also reflect this ominous change. The Dutch medical profession that gave the world Boerhave's clinical teachings, Jacobus Bontius's discovery of the dietary causes of beriberi, Donders's physiology of the eye and scientific correction of errors of refraction, Einthoven's electrocardiography, and Wenckebach's analysis and treatment of cardiac arrhythmias, now exerts itself in finding more and more reasons, opportunities, and ways to put sick people, and sick children, to death, or to let them die.

Euthanasia brings about the decline of medicine also by undermining the doctor-patient relationship. The old confidence of the public

in the medical profession, the old certainty that a doctor would do everything in his power to help the patient, that he would abandon nothing that could be of help, that he would never consciously do anything injurious—this certainty has vanished. Patients realize, too, that some of those doctors prepared to put patients to death at their own request will also be capable of doing it without a patient's knowledge. In the era of euthanasia, patients' attitudes toward doctors are increasingly marked by distrust, suspicion, and fear.

Doctors are plain people doing quite unique work. They may be irritable, exhausted after sleepless nights, frustrated by the failure of their efforts, or troubled due to difficulties at home. They may be, and some of them definitely are, emotionally unstable persons. Their actions, or, for that matter, the rate at which a potassium drip is administered, are often difficult to check or trace. And yet patients used to be safe in our hands; certainly safe from any intentionally inflicted harm. This derived from the particular and one-sided education and shaping of physicians. It has been imbued in us to identify ourselves, our ambitions, with the success of treatment, with improvement of the patient's health, with keeping him alive. For us, the clinical adage *primum non nocere* preserved its literal and absolute meaning.

At present, however, a generation of doctors is being raised who learn that a doctor may treat a patient or, sometimes, kill him. The thought of what's happening to the most humane profession is terrifying. Every society has learned to coexist with several dozen criminal killers. But no society knows how to live with an army of benevolent or casual killers, thousands strong.

### Charitable Euthanasia?

Euthanasia is depicted as an act of charity governed by truth and wisdom. Alas, the reality of euthanasia does not confirm these claims; rather, the reverse proves true. Doctors whose actions I observed, repeatedly tried to justify euthanasia by making reference to false data—citing a

nonexistent lung cancer, or a presumed, but never made, family request; or presenting a patient with a large and loving family as "a person completely alone in the world." A neurologist recommended euthanasia after a none-too-careful examination of the patient for he mistook a woman for a man. An internist ordered active euthanasia because the patient was semi-conscious but this condition was caused by valium the same doctor had prescribed. The same physician did not, as a rule, deem it necessary personally to examine candidates for involuntary euthanasia and relied instead on the opinion of the head nurse. Another internist intentionally allowed a sixteen-year-old physically active boy, and talented student, to die of cardiac arrhythmia because he had a congenital heart disease for which at that time surgery was not feasible. When at a departmental conference in a Rotterdam hospital an internist was asked why he attempted (involuntary active) euthanasia without knowing the diagnosis, on a patient who was not seriously ill, he explained that it is the calling of the doctor to perform euthanasia when the opportunity presents itself, regardless of the diagnosis, to spare people the illnesses and sufferings inherent to life. Life-saving medical help has been denied to Down syndrome children, the elderly, and single people without close family, on the grounds that society should not be burdened with keeping such people alive, and that it is in their own best interest to die as soon as possible. So much for my own observations; some of the cases published in the Dutch medical and popular press are equally distressing. A wife who no longer wished to care for her sick husband offered him a choice between euthanasia and admission to a home for the chronically ill; the man, afraid of being in unfamiliar surroundings and in the hands of strangers, chose to be killed. An elderly man coerced his healthy seventy-three-year-old wife to submit to euthanasia, promising to make recourse to it himself in three days, only to go off to Austria. In both cases the doctors were aware of the coercion; nevertheless, they put these people to death. A general practi-

tioner called to a patient's home, and seeing her for the first time, immediately asked her to choose between hospitalization and euthanasia. When the stunned patient could not reply, he gave her one hour to think it over. A chest physician told an interviewer about a chronically ill patient "who was quite young and clung to life," and how he treated the man for several years but finally killed him out of impatience, in an outburst of anger. According to testimony given in court during the *De Terp* trial, the male head nurse used to silence frightened inmates with the words, "When I and the doctor decide on euthanasia, euthanasia it will be, and you better shut up. I don't want to hear a single word from you, or else..." In the hospital where Father P. Verspieren is chaplain, it is the doctors' habit to order (involuntary) euthanasia by warning the nurse, "When I come back from the weekend I don't want to find this man here any more."

It is the attitude toward the evil and the absurdity of euthanasia that most clearly characterizes the two sides in the debate. To some, so unique is human life that even the possibility of error is sufficient reason to reject euthanasia once and for all. To others, so overwhelmingly important is euthanasia that it must go on regardless of all the nonsense, falsehood, reckless acts, and evil doings involved.

### Editors' Note

As Dr. Fenigsen's extensive references are largely in Dutch, with Dr. Fenigsen's consent, we elected not to publish them with the article. A copy of the original manuscript with citations is available from the *Report* upon request.

Dr. Fenigsen has discussed the Dutch experience in greater detail in his book, *Euthanasia: A Good Death?* (in Dutch) (Deventer: Van Loghum Slaterus, 1987).

