Chapter Two

Euthanasia and Assisted Suicide in the Netherlands and the USA: Comparing Practices, Justifications and Key Concepts in Bioethics and Law

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Introduction

Euthanasia and physician assisted suicide remain controversial in the United States of America, in the Netherlands, and in other western countries. Debates involve highly abstract and technical problems, situated at the intersection of ethics, law, and medicine; nevertheless, they have a very public character. The issues are broadly discussed in the media and elsewhere. The key concepts and definitions of euthanasia and physician assisted suicide differ between countries and their legal and medical traditions, fueling confusion and misunderstanding. For example, American debates cite the practice of ending lives under medical care in the Netherlands both as an example to follow and as one to refrain from at all costs.\textsuperscript{1,2} Even though the Northern Territories of Australia technically was the first place in the world to legalize euthanasia and assisted suicide, the Dutch experience continues to draw more attention from Americans. The figures published in Dutch studies are used and abused by Dutch and non-Dutch authors alike. The experiences of physicians and patients are cited to support a climate of death with dignity or to paint a picture of fear of physicians, lack of adequate care and legal permissiveness, resulting in the inability to hold the line between voluntary and involuntary euthanasia.\textsuperscript{3,4,5}

The majority of the Dutch population, including the medical profession, support the possibility of choosing one's death in the face of futile suffering. The latest polls show that 56% of the Dutch agree with the statement that a physician should give a lethal injection if asked by the patient to relieve suffering. Sixty-nine percent support active ending of life in cases of severe suffering without further medical perspective when the
patient is not able to express his or her opinion. Seventy-eight percent support active ending of life in cases of a very low quality of life.\textsuperscript{6} Dutch law, however upholds euthanasia and assisted suicide as crimes, indemnifying physicians from prosecution only if certain conditions are met. The legal procedures require physicians to report any "unnatural death," both with and without request and to let prosecutors judge whether these conditions have been fulfilled. Questionable cases are debated in a central meeting and then the decision is made to prosecute or not. Empirical research into the decisions of physicians in ending lives was instigated by the government in 1990 and 1995, the results confirming the conviction of the Dutch that the present medical practice works without a sign of "slippery slopes."\textsuperscript{7,8}

These reports of empirical research contain figures, definitions and statements without any international comparison or consensus. The Dutch effort stands by itself: no other country has undertaken comparable research on such a scale. One might say, with Buchanan, that "one great benefit of the current experiment with active euthanasia in the Netherlands is that at least it provides a concrete focus for debate" in other countries, like the USA.\textsuperscript{9} The size of the Netherlands is roughly that of Rhode Island, the smallest U.S. State. The Dutch population consists of 15 million people, and these figures as social-geographical parameters may explain why nationwide research into the medical decisions of ending lives has been possible in the Netherlands but does not take place in countries like the USA, with a much more diverse population of 268 million. Yet, even in small European countries no efforts to follow the Dutch experiment seem under way, even though the problems in clinical practice are perhaps identical.

Comparison of empirical findings and their interpretation within cultures with slightly different value-systems and legal traditions can take place only when conceptual differences in addition to the differences in cultural and legal context are well understood. If we assume that clinical practices do not significantly differ in technological or scientific aspects, it becomes probable that differences in systems of moral values and beliefs as well as differences in legal definitions and legal structures can account for the differences of opinion with respect to Dutch euthanasia and