

serious shortages of medical personnel. By the late 1970s, quick fixes had resulted in impressive quantities of physicians and hospital beds, but had also led to inferior quality of health services and increases in mortality and morbidity.

Whereas politics and recent history have had obvious effects on Soviet health policies, essays by M.A.M. deWachter and Baruch A. Brody reveal how consumers' expectations have had a heavy hand in agenda-setting in The Netherlands and the United States. Describing present debates in The Netherlands, deWachter notes that ethicists are calling for more realistic expectations about what the welfare state should provide. He entertains the sanguine view that externally imposed cost containment could become obsolete once "we have all become sufficiently cost conscious." Brody likewise pays tribute to protection of consumer freedoms. He recommends for the United States a

market approach whereby citizens receive vouchers that enable them to "ration themselves"—that is, choose between health care and other goods and between various health priorities.

In contrast to the Dutch and American emphasis on consumer choice, a relatively greater commitment to equality and cost containment is reflected in the German Statutory Health Care System (SHC). J-Mathias Graf von der Schulenburg explains how equality is achieved by enrolling roughly 90 percent of the population in the SHC; this effectively eliminates the American problem of large uninsured and underinsured populations. Of course, the flip side of this commitment to equality is a compromise in consumer freedoms: membership in SHC is mandatory for most citizens.

Reading these informative and provocative essays, one wonders whether Soviet or German health policies could ever gain favor in

America or The Netherlands. The pervasive feeling one gets from these authors is that they could not. Public policy and ethics debates appear inextricably linked to culture. Bettina Schöne-Seifert brings home this point by her observation that whereas in Germany the ethical debate focuses on defining a "decent maximum," in America the focal question seems to be whether there is any right to health care, and if there is, what constitutes a "decent minimum."

As medical ethics increasingly strives to be international, sensitivity to cultural diversity will be a central determinant of its success. Scientists of different nations are likely to succeed in transcending cultural barriers and forging common projects only if they first appreciate their profound differences and learn mutual respect. Both *Medicine and Culture* and *Health Care Systems* mark important steps forward in advancing these goals.

Mercy, Murder, and Morality

The General Assembly of the Dutch Society of Health Law unanimously adopted the following motion at its meeting on April 14, 1989.

The General Assembly of the Dutch Society of Health Law has taken notice of the contents of an article written by Mr. Richard Fenigsen in the January/February 1989 *Hastings Center Report* 19:1. In his article, "A Case Against Dutch Euthanasia," Mr. Fenigsen gives his personal views on the practice of euthanasia, the legal procedures, and the role of the courts. He also suggests that in The Netherlands doctors who terminate the lives of patients without their request remain unpunished. The General Assembly is unanimously of the opinion that this description of the situation in The Netherlands is incorrect and misleading. The General Assembly holds the editors of the *Hastings Center Report* responsible for publishing this particular article without verification of the facts by competent experts, and therefore requests the governing board of the Society to take appropriate action demanding publication of this motion in the *Hastings Center Report*.

C.J. van der Berge
Secretary
Dutch Society of Health Law

LETTERS

In a recent *Hastings Center Report* devoted to euthanasia, two articles emanated from The Netherlands. The first was written by Mr. Richard Fenigsen, a cardiologist, and the second, by Mr. Henk Rigger, the executive director of the Health Council of The Netherlands. The articles give widely different views on the discussion and factual situation regarding euthanasia in The Netherlands. According to the laws of logic, at least one of the two articles must be based on incorrect facts or draw incorrect conclusions.

We deplore that the reader has been confronted with these opposing articles without any further explanation, and seemingly without the editors of the *Hastings Center Report* having checked the facts of either article. This response therefore is not inspired by worry about a difference of opinion but about a difference in acknowledging the facts.

We hereby state explicitly that Mr. Rigger's article gives the correct assessment of the situation regarding euthanasia in The Netherlands. In our opinion, Mr. Fenigsen's article is completely misplaced. Apart from its insinuating negative tone, it is simply offensive in as much as it is filled with innuendos and contains errors as to the facts.

Mr. Fenigsen paints a nightmare situation in which voluntary euthanasia does not exist, euthanasia is unconditionally legalized, doctors are playing a stimulating role in performing euthanasia on a wide scale (whether voluntary or involuntary), and politicians are conspiring to influence the general public to vote in favor of euthanasia. We need to distinguish, as Mr. Rigger suggested in his straightforward way, between fact and fiction.

The fact is that in The Netherlands, a widespread consensus reigns about the following definition of euthanasia: "Euthanasia is a deliberate life-ending action by another person than the concerned person at the enduring request of the latter." "Euthanasia," therefore, is, by necessity, *voluntary*.

The fact is that euthanasia so defined remains a criminal offense in The Netherlands. Legislation in preparation will *not* alter this fact, but aims to shed light on what is to be regarded as

euthanasia and more importantly what is not. "Euthanasia" is explicitly distinguished from (1) requested nontreatment, (2) giving assistance to ease dying that unintentionally shortens life, and (3) discontinuing or omitting medically senseless treatment.

Furthermore, the proposed legislation outlines strict procedures and guarantees with respect to careful performance of euthanasia. Legislators thus aim to ensure a very careful (and caring) procedure. However, we want to stress that the doctor who practices euthanasia is and will be committing a criminal offence (Article 293 Criminal Code), even if he has adhered to the rules of procedure. In the case of prosecution, the doctor can always refer to justifying, excusing, or mitigating circumstances. Indeed, from much of the case law, including rulings by the Supreme Court of The Netherlands, we can deduce that a doctor can be acquitted based on circumstances that create a conflict of duties for the physician and together constitute a higher necessity. Any such case, however, would have to be judged by a court of law on its own merits.

The fact is that in The Netherlands, problems concerning the termination of life of incompetent patients, either comatose or newborn, are *not* a part of the euthanasia problem. Mr. Fenigsen's remark that "there is considerable public acceptance of the view that life-saving treatment should be denied to the severely handicapped, the elderly..." (p. 23) is completely unfounded, as is his assertion that the Royal Dutch Medical Association has stated, in an official declaration, its support of *involuntary* euthanasia.

The fact is that case law has played a significant, if not decisive, role in discussions on euthanasia and present-day medical practice in The Netherlands. The drafts of legislation have incorporated and refined this jurisprudence.

The fact is that Mr. Fenigsen's account of two cases that were dealt with by penal courts, the "de Terp" nursing home and nurses in a university hospital in Amsterdam, is both inexact and incomplete. Neither was accepted by the courts as instances of euthanasia (according to the definition above) as Mr. Fenigsen implies they were. In the "de Terp" case, the doctor was not convicted due to technical problems of evidence. There was no ruling as to guilt, and therefore it is incorrect for Mr. Fenigsen to say that he was found to be not guilty. This doctor has been held in preliminary detention for months. Nor does Mr. Fenigsen mention that the doctor was consequently disciplined by the medical court of justice. In the case of the Amsterdam nurses, Mr. Fenigsen did not mention that they were found guilty by the penal court and sentenced to a jail term that was suspended.

We totally dissociate ourselves from the

article written by Mr. Fenigsen. We deplore the decision by the *Hastings Center Report* to publish such an article. We cannot but conclude that this is attributable to insufficient editorial verification.

J.G.M. Aartsen, Secretary, National Ethics Committee on Medical Experimentation; **P.V. Admiraal**, Anesthesiologist, Hospital Reinier de Graef Gasthuis, Delft; **I.D. de Beaufort**, Lecturer in Health Ethics, Erasmus University, Rotterdam; **Th.M.G. van Berkestijn**, Dep. Secretary-General, Royal Dutch Medical Association; **J.B. van Borssum Waalkes**, Psychiatrist; **E. Borst-Eilers**, Vice-President, Health Council of The Netherlands; **W.H. Cense**, President, Royal Dutch Medical Association; **H.S. Cohen**, General Physician; **H.M. Dupuis**, Professor of Bioethics, University of Lyden; **W. Everaerd**, Professor and Chair, Department of Clinical Psychology, University of Amsterdam; **J.K.M. Gevers**, Professor of Health Law, University of Amsterdam; **H.W.A. Hilhorst**, Professor of Sociology of Religion, Catholic Theological University, Utrecht; **W.R. Kastelein**, Secretary, Royal Dutch Medical Association; **H.H. van der Kloot Meijburg**, Directorate National Hospital Association of The Netherlands; **H.M. Kuitert**, Professor of Ethics, Free University, Amsterdam; **H.J.J. Leenen**, Vice-President of the State Commission on Euthanasia; **C. van der Meer**, Em. Professor of Internal Medicine, Free University, Amsterdam; **J.C. Molenaar**, Professor of Pediatric Surgery, University Hospital, Rotterdam; **H.D.C. Roscam Abbing**, Professor of Health Law, University of Maastricht; **H. Roelink**, General Physician; **E. Schroten**, Director, University Center for Bioethics and Health Law, University of Utrecht; **C.P. Sporken**, Em. Professor of Health Ethics, University of Maastricht; **E.Ph.R. Sutorius**, Dep. Judge, Court of Appeal, Amsterdam; **J. Tromp Meesters**, Dutch Society of Voluntary Euthanasia, Boardmember, World Federation of Right-to-die Societies; **M.A.M. de Wachter**, Director, Institute for Bioethics, Maastricht

Richard Fenigsen does not provide the readers of the *Hastings Center Report* with a fair description of the developments with regard to euthanasia in The Netherlands. I consider his opinion representative of the views of a comparatively small group of people in this country, who resort to making statements about the problem based upon personal beliefs and specific experiences in the past. This approach has often resulted in the hardening of positions and sometimes strange allegations. To read that

with regard to euthanasia some Dutch are depicted as the epigones of Nazi-thinkers is offensive and quite off-balance with reality. When people start to argue on the basis of their fears and emotions rather than from arguments and insights, one can be sure that the outcome of the debate will please no one.

I would like to take a closer look at some of the outcomes of our debate of nearly twenty years on euthanasia, one of which is a widespread consensus on the meaning of "euthanasia." Both fervent supporters of life-ending treatment under certain conditions and strong opponents have agreed with the 1985 definition of the State Commission on Euthanasia that euthanasia refers to all actions aimed at deliberately terminating a person's life at his or her explicit and voluntary request. Consequently, it is impossible for people who do not want euthanasia to be maneuvered or forced into it. The requirement of voluntariness means no one need fear that his or her life is in danger because of age or ill health, and that those who cannot express their will, such as psycho-geriatric patients or the mentally handicapped, shall never be in danger as long as they live.

A second outcome is a general understanding that people have become aware that they need not consider themselves mere victims of suffering and death, but that they can have an opinion about and relate to pain and mortality in a personal way. Different opinions about the way individuals experience life and death have become generally accepted. This does not mean that in this pluralistic society people would not search for what they have in common.

There have also transpired important changes in the relation of patient and (home-) physician. No longer can the doctor dominate the reasoning of the patient. Consulting the (home-) physician has become a matter of finding a way in which the professional expertise offered can meet the specific needs and requests of the individual patient. Mutual understanding and respect are now prominent features, which are important in a request for euthanasia. The relationship has become more intimate and, for the (home-) physician, more demanding. Of course, should opinions between the (home-) physician and his patient differ widely on a request for euthanasia, it would be unwise to continue the relationship because no doctor can be forced to perform euthanasia against his will.

Since euthanasia is a criminal offense under Article 293 of the Penal Code, physicians are for obvious reasons reluctant to report a case of euthanasia to the public prosecutor. Presently, efforts are aimed at finding ways to have specific actions open to public scrutiny. An important development in this respect is a consensus among public prosecutors and physicians, including the Royal Dutch

Medical Association, about guidelines that will reduce court procedures in a case of euthanasia to a fair minimum. First, there should be an explicit and repeated request by the patient himself, leaving no doubt about his desire to die, or that he fails to understand the nature and consequences of his request. Second, the patient's mental and physical suffering must be very severe, with no prospect of relief. All other options must have been exhausted or refused by the patient. The primary physician must consult another physician and document these proceedings. In the event of euthanasia, the physician should make an honest statement on the patient's death certificate, indicating that the patient died an "unnatural death."

A new emphasis on the care of the terminally ill is another outcome of the debate. This is reflected in terminal care for the patient who prefers to die at home in familiar surroundings, in the emergence of the hospice movement in The Netherlands, and in the examination by nursing homes of the concepts that underlie their care for the chronically and terminally ill. It is often argued that once people are given the proper kind of care requests for euthanasia will disappear.

More critical questions are also being asked about the development and use of new medical technology. Medicine, in combination with modern technology can now have a more important effect on life and death than personal choice or even God. In The Netherlands, the question is not only whether there is a limit to introducing and applying every available new technology, but also whether we can cope with these developments in a human way.

In time, people in The Netherlands will know if they have gone to the heart of the matter with regard to euthanasia. But given the developments of modern society, I suspect this problem exists in other countries as well. If so, we should debate the various aspects of this complicated issue together. A fair exchange of thoughts, opinions, and personal experiences could be a first step. I hope to have made a small contribution to this dialogue.

Herman H. van der Kloot Meijburg
Nationale Ziekenhuisraad

Richard Fenigsen, a Dutch cardiologist, misrepresents the facts as well as the general atmosphere surrounding euthanasia in The Netherlands. Since our association, the Dutch Society for Voluntary Euthanasia (Nederlandse Vereniging voor Vrijwillige Euthanasie—NVVE), its (former) officers, and our newsletter are repeatedly named in (and out of) this context, we would like to respond to Dr. Fenigsen's diatribe.

Euthanasia in The Netherlands is by definition voluntary. "Involuntary euthanasia" is murder, and will be prosecuted and sentenced as such. In accordance with Article 160 of the Dutch criminal code, those who have knowledge of a crime against life such as manslaughter or murder are compelled by law to report such an act to the public prosecutor's office so that an indictment can be prepared. For someone with the foreknowledge of another person's intent to commit a crime, it is a criminal offense not to notify the authorities. Since Dr. Fenigsen claims such knowledge (in his article), he was asked by Peiter V. Admiraal, president of the NVVE, on April 20, 1989 which authorities he notified about these crimes. Dr. Fenigsen's reply did not make clear whether he had reported these cases, but he supported further inquiries with the authorities in Rotterdam and 's Hertogenbosch. He wrote that Dr. Admiraal can count on his active cooperation in the public discussion about the "evil" aspects of euthanasia. Since the NVVE is incriminated repeatedly in Dr. Fenigsen's article, on August 17, 1989 we filed a complaint with the public prosecutor in Rotterdam and 's Hertogenbosch for discovery and indictment of these alleged crimes.

In "From Voluntary to Involuntary Euthanasia" (*Trouw*, 20 September 1986), C.T.C. Rutenfrans, a criminologist and one of the authors repeatedly cited by Dr. Fenigsen, wrote, among other things, that "involuntary euthanasia, i.e. murder and manslaughter, provided that it is committed on....the elderly, the physically or mentally handicapped....becomes more and more acceptable and in wider circles than just the NVVE." The article cited the alleged statements of past presidents of the NVVE, Prof. Dr. P. Muntendam and Mr. J. Ekelmans, and the opinion polls as well as the periodicals of the NVVE (also alluded to but not quoted by Dr. Fenigsen), claiming that the NVVE did not object to involuntary euthanasia.

On October 10, 1986 the NVVE sued Rutenfrans for these statements requesting that he rectify his article. A court settlement was reached and Rutenfrans published a rectification of his original article on October 12, 1986 in *Trouw* acknowledging that "he no longer doubted the good faith of the NVVE with respect to the strict prerequisite of the voluntary nature of euthanasia." This was widely publicized in all the major newspapers, and broadcast on all television and radio stations. Is it plausible that Dr. Fenigsen was unaware of the motive of Dr. Rutenfrans's rectification?

We must offer some further observations in the interest of accuracy. In The Netherlands a well-orchestrated, radical, pro-life movement exists with professional and lay branches, each with their own periodicals. Dr. Fenigsen cites mainly these periodicals and articles from

one regional newspaper, often without the name of the author. In many other references, Dr. Fenigsen cites himself. His criticism should be heard, but the reader should be allowed the benefit of education, including the knowledge of the nature of his sources, not only of propaganda.

The pro-life movement has spread stories about the threat of involuntary euthanasia in their press, on television and on the radio for years, creating anxiety particularly among the less well-informed. The anxiety thus generated is then "found" in methodologically highly suspect "research" to demonstrate the existence of such fears. Thus the circle is complete.

While some may characterize the Dutch "Living Will" as "a credit card for easy death" (22) this is an unjust, and incorrect portrayal; whoever in The Netherlands desires euthanasia will have to "fight" urgently and persistently for it. Not everybody will have their last wish fulfilled.

Physicians, who may eventually agree to euthanasia in some cases, spend much of their time and energy in agonizing reflection. There is no "rush to euthanasia" as Dr. Fenigsen suggests, nor any foundation for the assertion that "euthanasia replaces medicine" in The Netherlands (29). As one physician puts it: proper terminal care precedes proper euthanasia.

The NVVE is in complete agreement with Dr. Fenigsen when he writes "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" (28). Some people desire euthanasia, also, after extensive information and long discussions. We in the NVVE respect that and seek the desired help for those so determined.

Dr. Fenigsen also writes that "traditional practitioners...have yet to hear such a request [for euthanasia] from a patient" (24). We might offer an instructive comparison: Some parents have never heard their children ask where babies come from. Why? They did not know how to answer the question, so they didn't hear it. Their children quickly learned that the subject was off limits and stopped asking.

On a final note, it is commonplace for the "pro-life" movement to speak of euthanasia as "killing a patient." Indeed, after euthanasia the patient is dead, but the motivation and decision process by which he or she obtains death is quite different from murder or killing. As an analogy, one may note that rape and making love involve the same act. Does anyone need an explanation as to the difference?

**The Board of the Dutch Society
for Voluntary Euthanasia**

From my perspective as an American as well as a Dutch physician-anesthesiologist who worked in tertiary care medical centers in The Netherlands and currently works in the U.S., Dr. Fenigsen liberally mixes fact with fiction. He uses hearsay, half truths, and distortions to permit comparisons of the Dutch debate on the living will and euthanasia with racist theories, atrocities of the Nazi era, "Taigetian" medicine, and the practice of "cryphanasia" with the right to kill in the interest of society.

Extreme presentations such as Fenigsen's detract from a dearly needed, constructive debate on the real issues. Those opposed to an erudite debate may use improper or unclear terminology and data to their advantage to obstruct the process of society's evolution. I think this article is a case in point.

For example, Dr. Fenigsen's numbers on the incidence of euthanasia are unfounded and dramatized to effect a horrifying picture of the legalized killing of up to 20,000 persons—one-sixth of all annual deaths (about 120,000) in The Netherlands. His citation of 5,000 to 20,000 euthanasia cases annually did not come from authoritative sources, but from *The Village Voice* (source of the highest of these figures), *The Herald Tribune*, *Brabants Dagblad* (Dr. Fenigsen's hometown newspaper), *The British Medical Journal*, and from a fellow opponent of euthanasia. Yes, there are flaws in the reporting of euthanasia in The Netherlands that can rightly be criticized, but does that warrant such extreme representations?

In a letter to the editor of the journal of the Dutch Society for Voluntary Euthanasia, Mr. Klaij, a fifty-three-year-old myelomeningocele patient, bitterly expresses his life experiences, apparently in response to a Medical Ethics Committee Report that advised *not* including newborns in a possible "euthanasia" bill (euthanasia in 1976 terms). Mr. Klaij wonders whether his bitter experiences could have been avoided if he had not lived, if he had not been treated at the time of his birth, had been allowed to die, or had received a (presumably lethal) injection. He expresses resentment of the medical profession's vested interest in maintaining life at all cost; he regrets that no one has asked him or his kind (*so he writes*) about euthanasia legislation for the handicapped newborn. This "authoritative" reference is cited five times by Dr. Fenigsen as "evidence" of prevailing attitudes in The Netherlands favoring euthanasia as a means of improving the human race (pp. 23, 26), of the "all intrusive propaganda in favor of death" to which the Dutch population is subjected (24), and of the effective usurpation of rights to self-determination and even existence itself for impaired newborns, the demented, and the comatose by the state acting through its licensed physicians (26, 28).

Dr. Fenigsen similarly misrepresents—in some thirty-two citations—the outcome of the "de Terp" case, in which three nursing home residents were killed. Because of illegally gathered evidence, a mistrial was declared (a difficulty not unknown in U.S. criminal prosecution). The indicted physician subsequently recovered damages for his "unlawful" suspension and jailing. None of the actions by the Dutch judiciary or the state, nor any writing of the Royal Dutch Medical Association (KNMG) implied any overt or covert support for the doctor's alleged role in the killings, contrary to what Fenigsen states.

Examining the sources of these disheartening "facts" and scenarios about The Netherlands—which we would like to guard against here in the U.S.—the reader discovers that 85.7 percent of the 155 references with which Dr. Fenigsen gives his report an air of credibility are written in Dutch. At most 33 percent of the references are available in the American library system, and at best 41 percent in Dutch libraries. Many references (71, or 46%) do not state the authors, titles, or page numbers (or even the publication), thus one is left to guess where in the publication the citation may have occurred. Thus even if one read Dutch *and* lived in The Netherlands, only a small part of the references would be retrievable.

When most of the author's sources cannot be verified, even by those who would wish to *and* who are in a position to do so, where does that leave the American reader? The latter may rely, as a "fail-safe," on an effective peer review process and the editorial scrutiny of a publication like the *Hastings Center Report*. But did this paper go through a credible review? Or was it considered opinion only? Or was it published as a counterpoint? Dr. Fenigsen's eight-and-one-half page article was indeed followed by a one-and-one-half page article by Dr. Henk Rigte, Secretary General of the Dutch Health Council, in which he explained legal and regulatory aspects of euthanasia in The Netherlands. However, Dr. Rigte had no knowledge of the actual text of the Fenigsen article (personal communication). Thus this co-publication cannot be considered a responsible point-counterpoint presentation. Neither can it be argued that the *Report* gave opposing views equal time.

In conclusion, "A Case against Dutch Euthanasia" reads more like a libelous harangue as part of a defamation campaign than as a responsible treatise. It behooves a journal concerned with ethics to take utmost care in its editorial process, recognizing the potential damage to the advancement of a meaningful, constructive debate, if elements of disinformation and propaganda are left unchecked.

Abraham van der Spek, MD
Associate Professor of Anesthesiology
University of Michigan

Dr. Richard Fenigsen replies:

I do not share Mr. van der Kloot Meijburg's view that voluntary euthanasia is the desirable solution for the human tragedy of suffering. Euthanasia, voluntary or otherwise, is a nonsensical act, and a danger to our civilization. My critics chose not to discuss this basic issue, focusing instead on the secondary subject of involuntary euthanasia. Twenty-five authors signed a letter denying that involuntary euthanasia exists in Holland. In all modesty, I am reminded of the book *One Hundred Authors Against Einstein*, and of the Professor's reply: "If I were wrong, then one would be enough."

The five letters' assertions are at odds with the reality:

1. It is not true that only voluntary euthanasia is practiced. There is unequivocal evidence that euthanasia without consent or knowledge of the patient (cryphanasia) occurs. In addition to numerous case reports, cryphanasia has been the subject of two substantial studies. In a 1983 study of eight hospitals supervised by the University of Utrecht, and sponsored by the Royal Dutch Academy of Science, Hillhorst found that not only voluntary but also involuntary euthanasia was practiced.¹ In 1989, van Wijnen revealed the results of a questionnaire of 299 doctors by the University of Limburg Medicolegal Group: 123 doctors (41.1%) admitted having performed "euthanasia without request of the patient"; seven doctors acknowledged participating in more than fifteen cases.² As Director of the Medicolegal Group, Mrs. Roscam Abbing must be aware of these findings. This did not prevent her from signing the letter denying the existence of involuntary euthanasia.

2. Mr. Aartsen *et al.* deny that the Royal Dutch Society of Medicine ever stated, in an official declaration, its support of involuntary euthanasia. May I remind them of the "Reply to the Questions of the State Committee on Euthanasia" in which the Board of the Royal Society suggests that in certain situations a right of decision-making may inevitably devolve on someone else when patients are unable to determine or express their will, i.e., the newborn, minors, the mentally retarded, and the demented elderly.³ As Deputy General Secretary of the Royal Society, Mr. van Berkestijn is certainly aware of this declaration. This did not prevent him from signing the letter denying the existence of an official statement.

3. It is not true that only voluntary euthanasia is tolerated by the courts. In releasing from custody the nurses who killed unconscious patients at the Free University Hospital, the Amsterdam court declared that the nurses' actions were prompted by humane considerations.⁴ The doctor who killed the inhabitants of "de Terp" nursing home without their consent or knowledge was released from

prosecution on a technicality,⁵ and awarded \$150,000 in damages.⁶ Contrary to Dr. van der Spek's assertion, I correctly rendered the reaction of the Royal Dutch Society of Medicine to the "de Terp" murders: The Board of this Society declared itself concerned, not by the killings, but by the prosecution of the perpetrator.⁷ In cases of crypethanasia publicly disclosed by Hilhorst, van Wijman, Gunning,⁸ and myself,⁹ an inquiry was not even initiated. In a written statement condemning crypethanasia, Mr. Enschede complained in 1987 that, against his advice, "the Government and the Council of State intended to keep these cases out of the reach of the criminal law."¹⁰ This did not prevent him from signing the letter denying any official or judicial leniency towards the perpetrators of crypethanasia. We now learn that the Board of the NVVE has filed a complaint with the public prosecutor, prompting him to launch an inquiry into cases of crypethanasia I had reported in my writings. One can only welcome this belated eagerness to let the law prevail.

4. It is not true that only voluntary euthanasia is approved by the public. When practices of involuntary euthanasia are revealed, perpetrators have received public declarations of support from prominent persons and institutions and citizens' committees have been founded in their defense.¹¹ Opinion polls show that 77 percent of the public support involuntary euthanasia.¹²

The denials and the self-contradictory statements of the advocates of euthanasia reflect a real conflict: between the irrepressible public support of involuntary euthanasia and the aims of respectability and legalization that can only be achieved by stressing the voluntariness of euthanasia.

Some claims of Dr. van der Spek's letter deserve separate attention. He questions the figures cited in my article, the rendition and interpretation of facts, the truthfulness of the quotations, the validity of the sources, and the way I depict the general atmosphere of Dutch euthanasia. Published estimates of annual cases of active euthanasia have ranged from 5,000, 6,000, 10,000, 18,000 to 20,000, and I cited all of these. Dr. van der Spek's assertion that these figures are unfounded, extreme, and dramatized, expresses his personal opinion, but lacks supporting data.

Contrary to Dr. van der Spek's rendition, what is relevant in Mr. Klaij's letter is not the author's personal infirmity but what he preaches, and whether he has a support and following. Mr. Klaij exhorts us to breed a strong race by killing all handicapped newborns.¹³

Dr. van der Spek is not satisfied with my sources. These include monographs, articles published in Dutch medical journals, official statements of the Royal

Society, and reports in Dutch newspapers. The excellent and reliable Dutch press is indeed one of the valuable sources of information on euthanasia. This whole nightmare—doctors supplying sick children with poison to enable them to commit suicide, official lists of drugs to be used to kill patients, official guidelines to perform "voluntary" euthanasia on children even when the parents protest, citizens' committees founded in defense of doctors who kill unsuspecting elderly, learned societies and public symposia debating over ways to justify euthanasia on "patients unable to express their will"—is reported in the Dutch press in an accurate and unbiased way. Anyone wishing to verify the reports I cited can check in a public library.

¹ H.W.A. Hilhorst, *Euthanasia in het ziekenhuis* (Euthanasia in the Hospital), (Lochem-Poperinge: De Tijdstroom Publishers, 1983), 174-75, 179-80.

² F.C.B. van Wijmen, *Artsen en zelfgehozen levenseinde* (Doctors and the Self-Chosen Ending of Life), (Maastricht: Vakgroep Gezondheidsrecht Rijksuniversiteit Limburg, 1989), 24.

³ KNMG, "Reactie op vragen Staatscommissie Euthanasie" (Royal Dutch Society of Medicine, Reply to the Questions of the State Committee on Euthanasia), *Medisch Contact* 31 (1984), 999-1002, item 2.7.

⁴ *Brabants Dagblad*, 30 January 1987.

⁵ *Brabants Dagblad*, 13 November 1985.

⁶ *Haagse Courant*, 5 June 1987.

⁷ *Brabants Dagblad*, 7 August 1985; 23 January 1987.

⁸ Interview with Dr. K.F. Gunning, *Panorama* (Haarlem) 41 (1972), 37.

⁹ Richard Fenigsen, *Euthanasie: een Weldaad?* (Charitable Euthanasia?), (Deventer: Van Loghum Slaterus Publishers, 1987).

¹⁰ Ch.J. Enschede, personal correspondence, 1 May 1987.

¹¹ *Amsterdam Stadsblad Zuid*, 14 August 1985.

¹² C.I. Dessaur and C.J.C. Rutenfrans, "Mag de dokter doden?" (Is the Doctor Allowed to Kill?) (Amsterdam: Querido, 1986), 31-32; *NRC Handelsblad*, 31 January 1986.

¹³ J. Klaij, Letter to the Editor, *Kwartaalblad van de Nederlandse Vereniging voor Vrijwillige Euthanasie* 2:4 (1976), 2.



I agree with Mr. Rigtter that the estimates sometimes published in the press on the extent of euthanasia in Holland are probably exaggerated ("Euthanasia in The Netherlands: Distinguishing Fact from Fiction" *Hastings Center Report*, January/February 1989, 31-32). But his contention that evidence for involuntary active euthanasia at family request, and secret involuntary active

euthanasia by both physicians and nurses "simply does not exist" is not true. It is not possible in this letter to corroborate part or all of the examples Dr. Fenigsen gives of euthanasia doctors who surreptitiously tried killing their patients, and sometimes succeeded. I shall limit myself to two very general remarks.

The Royal Dutch Society of Medicine published in the spring of 1988 the first part of a report on what was called "Terminating Life in Incompetent Patients" (*Medisch Contact*, 3 June 1988, 697-704). In this report it was stated that about 300 newborn babies have their lives ended every year, though only rarely by active killing.

Two categories were presented. The first consisted of babies who had no chance to survive—not treating these infants is of course sound medical practice and not controversial. The second group, however, consisted of children with more or less severe handicaps, who were allowed to die because their lives were not considered worth living, or because their parents did not accept them. For example, a child with Down syndrome and duodenal atresia was not operated on because its doctors and parents believed that such children ought not to live, even though their lives can very easily be saved. The Supreme Court recently reviewed this case and accepted the decision of a lower court that arguments of this kind are valid reasons for depriving a child of his life (*State of the Netherlands v. Molenaar and Sjouwkes*, April 28, 1989, No. 2238 & 2239).

Mr. Rigtter also comments that "euthanasia enthusiasts do not exist in The Netherlands any more than in other countries." Of course there are euthanasia enthusiasts in Holland, as in other countries. A Dr. Kenter claimed in a paper that he and some specialists cooperating with him had killed twenty patients in five years, out of a total of 111 people who had died in his practice during this period (*Medisch Contact*, 23 September 1983, 1179). When the patient didn't ask for it himself, Dr. Kenter's habit was to propose euthanasia to him.

Let's face the situation squarely: At least one percent of all doctors are heartless, at least one percent can be bribed by the family. Many more than one percent of young Dutch doctors think that very old people, the mentally retarded, and other sick people who are a social burden should not be allowed to live. These doctors do not really bother whether the patient agrees. For them euthanasia is a kind of panacea. They practice it on an extensive scale, and it is not always voluntary (see, for example, F.C.B. van Wijmen, "Doctors and Voluntary Death," a report of the University of Hamburg, 1989, 24-25, 31 [in Dutch]). Nor do they have to bother about the strict guidelines Mr. Rigtter describes. The overwhelming majority of Dutch doctors who practice

euthanasia simply sign death certificates saying the patient died from natural causes (see the remarks of H.Th.P. Cremers, chief medical officer of the Rotterdam police, *Medisch Contact*, 20 August 1987, 989-90).

The great danger of making voluntary euthanasia a respectable practice, as has been done in Holland, is that it will bring a small but by no means negligible part of the medical profession to practice involuntary euthanasia.

I. van der Sluis, M.D.

Henk Rigtter replies:

Dr. Richard Fenigsen offered a long list of unsubstantiated claims about euthanasia in The Netherlands, to which Dr. van der Sluis now adds. He writes that "it is not possible in this letter to corroborate...the examples Dr. Fenigsen gives of euthanasia doctors who surreptitiously tried killing their patients." Apparently, van der Sluis refers to involuntary "euthanasia." I would call that murder. Dr. van der Sluis chooses the easy way out by not providing any evidence. In doing so, he follows the example set by Fenigsen. This is not surprising, as they did the same when collaborating on a book on "euthanasia."¹

The failure of Fenigsen and van der Sluis to substantiate their claim that some doctors are murdering their patients (the unpublished list of references submitted to the *Report* offers no proof for their statements) is not only maddening, it is unethical, to say the least. In The Netherlands it is a criminal offense not to notify the authorities if one knows that someone has committed a crime.

Dr. van der Sluis refers to a publication by the family physician Dr. Kenter, asserting that it portrays Kenter as a euthanasia enthusiast who talks patients into accepting euthanasia. Rereading Kenter's paper, which presents data for the period 1977 through 1981, I failed to see that it supports this interpretation. Nine of the twenty cases of euthanasia cited by van der Sluis pertained, in fact, to discontinuation or omission of medically useless treatment. Dr. Kenter himself affirms that he was misquoted by van der Sluis (personal communication). Recently, Kenter published data for the period 1982 through 1986, demonstrating a decrease in cases of euthanasia in his practice, not quite in line with the theory of the slippery slope.²

I can be brief about Dr. van der Sluis's other comments. Of course, evil is among us and it will stay that way until the end of time. The incidence of murder and manslaughter is much lower in The Netherlands than, for instance, in the U.S., but the Dutch are no saints. Such general statements, however, are not helpful in elucidating the issue of euthanasia. The remarks by van der Sluis regarding newborns confuse the issue of euthanasia as they pertain to equally complex, but

These eight letters represent the range of opinion in the many letters we have received on Dr. Fenigsen's and Dr. Rigtter's articles. We regret that we cannot publish future correspondence on this subject.

—The Editors

quite different problems. This is not to say that van der Sluis handles these different issues with more care. He misrepresents the intention and the contents of the report by the Royal Dutch Society of Medicine and the well-publicized case of the baby with Down syndrome. His account of the Supreme Court verdict is similarly exasperating.

While people may object to (voluntary) euthanasia in general or to the way it is practised in The Netherlands (and many other countries), it is inexcusable to look at The Netherlands, with its relatively low incidence of major violence and its strong aversion to capital punishment, as the place of rebirth of fascism. It is also inexcusable to see the Dutch public, the Dutch press, and Dutch patients as ignorant and meek victims of medical fiction and suppression. The latest national opinion poll, in September 1989, again showed an increase in public support for euthanasia as defined by the Dutch (active, voluntary), 82 percent being in favor, despite publications by Fenigsen, van der Sluis and other members of the, in itself respectable, pro-life movement.

¹ R. Fenigsen, *Euthanasie: een weldaad?* (Deventer: Van Loghum Slaterus, 1987).

² E.G.H. Kenter, "Euthanasie in een huisartspraktijk. Vijf jaar later" ("Euthanasia in a General Practice. Five Years Later"), *Medisch Contact* 44 (1988), 907-910.

Courtney S. Campbell and Bette-Jane Crigger reply:

It is a serious moral matter for any society to go on record through its laws as unopposed to the taking of human life, even with a person's consent. We could not agree more, then, with those correspondents who endorse a public, and comprehensive discussion on the morality and legality of euthanasia. Our intention in devoting a special supplement, "Mercy, Murder, and Morality: Perspectives on Euthanasia," to these questions was to present the diverse professional, philosophical, political, legal, and theological perspectives that can and *should* contribute to an informed societal debate on euthanasia.

Dr. Richard Fenigsen holds a very committed and distinctive perspective on this issue. His is a voice which contends that, regardless of how rigorous the procedural safeguards of a policy of voluntary euthanasia, or how strictly adhered to, euthanasia should be ethically and legally prohibited, for it violates the moral core of our societal, and the medical profession's, ethos.

It is not an irrefutable voice, to be sure, but the questions it raises must be addressed if our public discussion is to be truly informed: Who, if anyone, can legitimately authorize the active taking of life in a medical context, and for what purposes? Have we exhausted all alternatives, short of taking life, in our care for the dying? What is the nature of our intentions? What outcomes can reasonably be expected to follow from a *practice* of euthanasia? And can such a practice be strictly limited without risking abuse?

The *empirical* claims of Fenigsen's article, that, in fact, abuse is already present in Dutch medical practice, raise an understandable question about whether our editorial review process sufficiently verified his controversial allegations. In our tenure as editors no manuscript has been subjected to more sustained scrutiny. It was reviewed by several individuals in the international bioethics community (as well as in Holland) with substantial knowledge of the practice of euthanasia in The Netherlands. Dr. Fenigsen was interviewed in person by a fellow of The Hastings Center; Center director Daniel Callahan also made a number of personal inquiries during a trip in The Netherlands. In addressing our own and reviewer's questions about the veracity of Dr. Fenigsen's citations, we were assisted in verifying the *data* in the references by individuals in The Netherlands. The interpretation, meaning, and significance given to that data are, of course, Dr. Fenigsen's. At the end of this review we were satisfied that however uncertain and arguable some of his claims, his concerns about a growing divergence among morality, policy, and practice were sufficiently credible to merit publication.

The exchange displayed in these letters reveals a pressing need to use our language and terminology carefully and to develop concepts and definitions that all parties can agree to. Clearly, Dr. Fenigsen and his critics are not of one mind on the meaning of "euthanasia." Conceptual consensus is necessary not only for constructive philosophical debate, but also for properly interpreting empirical data, such as studies of "public opinion" on euthanasia. At the same time, we must not assume that terminological consensus resolves substantive moral issues. We need also to recognize, as Dr. van der Kloot Meijburg and Dr. van der Spek acknowledge, that practice can differ from stated or accepted policy. Are "physicians reluctant to report" cases of euthanasia? Are there "flaws in the reporting of euthanasia" or discrepancies between cases of euthanasia and what is entered on death certificates? Such matters are just as relevant for the debate on euthanasia in the United States as in The Netherlands. We avoid these conceptual, procedural, and fundamentally moral questions at the peril of our common humanity.