

Ethical Issues of the Practice of ‘Medicide, Suicide and Laicide’ in the Netherlands after the Euthanasia Law of 2002

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Abstract

In June 2015 a proposed framework has been published on developments in the way people die in the Netherlands after both regulations (since 1997) and a ‘Euthanasia Law’ (since 2002) made it possible to help people die without repercussions for physicians. This framework with the central terms ‘medicide, suicide and laicide’ was intended as a descriptive model with a focus on the main actors (physicians, people themselves and non-medical/family persons) and actions in the area of end-of-life decision-making.

The following article elaborates on this descriptive model, described here in brief, with the aim to investigate ethical aspects of the current practice in the light of the past ethical arguments in favor or against physician-assisted dying (PAD) and reexamine their significance in the light of this practice and its empirical research over almost 20 years.

Keywords: Euthanasia; Physician-assisted suicide; Euthanasia law; Euthanasia practice; Euthanasia ethics

Introduction

So far the Netherlands, Belgium and Luxemburg are the only countries in the world with a law-based practice of euthanasia. In what follows the focus shall be on the Netherlands.

Unlike the UK, the USA and Germany, there has not been a history of public debate on euthanasia in this country. The Dutch medical profession first initiated an internal debate in 1973 and then came out in support for physician-assisted dying (PAD) in 1984. Dutch Courts have chosen to assess cases not from a criminal angle but rather from a medical perspective of helping suffering patients die at their request. The motive of the medical profession was to lift the taboo on the subject, come to terms with a reality of assisted dying and protect physicians from legal repercussions. The Courts, including the Hoge Raad or High Council, the highest legal authority, turned out to be supportive in describing the limits of and the conditions for acceptable euthanasia with a focus on medical practice and medical science. The result was a cooperation between ‘medicine and the law’, leading to regulations for PAD in 1997, followed by a ‘Euthanasia Law’ in 2002 [1,2]. In hindsight this cooperation has been more of a self-regulation by the profession, with massive popular and judicial support, while the political institutions trailed behind, not because of disinterest but because of a stalemate in parliamentary decision-making. The Euthanasia Law of 2002 proved to be a codification of the already existing and well-functioning practice. From a perspective of social change the realization of this practice must be seen as a ‘bottom up’ development of the primary stakeholders: the professions of medicine and the law. The Government takes its role of oversight serious and publishes since 1991 every five years national, broad and representative evaluations of the practice of PAD with the intention to detect and correct problems and improve where necessary and possible.

Preliminary remarks

Some preliminary remarks must be made. One has to understand that in the Netherlands euthanasia and assisted suicide are distinguished, as all over the world, but in this country’s practice are taken together. Both still are criminal acts, but at the same time allowed under the Euthanasia Law only if carried out with the help of a physician and dealt with under the regulations that apply to both. Euthanasia is since 1985 defined, by the ‘State Committee Euthanasia’, as ‘the intentional ending of life by someone else than the person involved after a request’ and with assisted suicide, a patient takes the deadly potion him or herself, again after a request [3]. In what follows, what is stated for euthanasia implies an inclusion of assisted suicide, because in the Netherlands from a medical ethical and legal perspective at present there is no relevant procedural difference.

For the Dutch it seems a remarkable fact that elsewhere assistance in dying is limited to physician-assisted suicide and recently some even see allowing assisted suicide as a safeguard to euthanasia, because of a supposed lower psychological threshold for assisted suicide in comparison to euthanasia [4]. Fact is also that in spite of the Dutch medical profession’s explicit advice to choose physician-assisted suicide over euthanasia if and whenever possible, since 1997, the start of the yearly collection of data, the majority of 90% of PAD occurs through intra-venous injections by physicians, without investigated concluding explanations. The ethical issue here is the presupposed presence of an inclination by patients and physicians alike towards euthanasia rather than assisted suicide, for different reasons. But to suggest allowing assisted suicide in order to prevent euthanasia is a social political position with from Dutch point of view questionable ethical implications: it may amount to limiting the freedom of choice of patients at the end of life and obstruct expression of self-determination or a joint decision between physician and patient, a not unproblematic position.

The second remark concerns the safeguards. From early on the intention to regulate the practice has been accompanied by decisions to build in safeguards, especially because the overall agreement was that physician-assisted dying (PAD) was 'not normal medicine' and these actions were not covered by the legal provision for 'medical exceptions' of invasive medical interventions on the body, thus in need of additional regulations to provide a legal basis and prevent mistakes or abuse.

These safeguards function at different levels prescribed first by regulations of the government and now by law. They concern the conditions: a request of a competent person, unbearable and hopeless suffering, without other medical including palliative options. There is also the condition to have an independent assessment prior to the intervention from a fellow-physician to check compliance with the law. And together with the duty to self-report plus a review afterwards of a Euthanasia Review Committee (ERC), established since 1997, this system of safeguards functions to general and official satisfaction [5].

There are five ERCs for the five legal regions of the country, with a multidisciplinary composition of judicial, medical and ethical expertise. The ERCs function outside out of the normal procedures that cover criminal actions. The reason for this procedure is based on the prudential idea that, given the irreversible nature of the act, there should be no room for mistakes in a correct assessment of the medical and legal requirements of allowable euthanasia and PAS. Pragmatic arguments lead to the multi-disciplinary composition of the committee. Medical knowledge is required to evaluate the medical conditions, but an important reason was the expectation that physicians would now self-report without fear for prosecution and hoped for in higher rates than before, as has proven to be a wise move, see table 1. The importance of the ERCs has increased over time, since they function as and also have a self-image as interpreters of the intentionally broadly defined conditions of the Euthanasia Law in need of further interpretation, incorporating trends in societal developments in the area of death and dying.

The Committees assess each reported case on the basis of individual merits. Their decisions have the actual position of jurisprudence, even though they formally are not part of the general legal system. So, in effect, the committees are a law-based multidisciplinary level of now 45 (5 X 3 X 3: with two subcommittees per region) persons' interpretation of the Euthanasia Law in the area of euthanasia and assisted-suicide without involvement of the courts, unless they deem a case 'not prudent', turn it over to the prosecution for legal assessment. So far no case of the few that were reported to the legal authorities has resulted in further legal investigations, so there is no 'real' jurisprudence.

The ERCs do not function without criticism, but to their defense it must be said that they only judge reported cases of PAD that physicians and consultants are convinced that these comply with the conditions of the Euthanasia Law. As such they do not merely function as 'rubber stamps', but create new decisions of 'acceptable euthanasia' that function as publicly reported 'jurisprudence' on the basis of individual physicians' ethical convictions, so far with the blessing of the Secretaries of Departments of Justice and Health Care, and even Parliament.

There is however a not insignificant development

From early on there was an agreement that the norms of medical ethics and practice were the basis of allowable euthanasia [6]. That basis would supposedly guarantee more or less uniformity in the final

decisions of the procedures. The recognition of this primary basis was affirmed when the Government requested from the RDMA a position paper on how to deal with cases of euthanasia when requesting patients had lost consciousness at the time of ending their lives after a prior independent collegial consultation, either because of the disease, through the effects of treatments or both causes. The core question was whether to continue the procedure because an agreement had been made to do so or to discontinue because of uncertainty about the suffering of an unconscious patient. The RDMA responded with a position paper, Euthanasia in case of a reduced consciousness, outlining its position as a guideline for assessment of consultants and the ERCs [7].

This basic orientation on the ethics of the profession now has changed: the ERCs have taken the lead in the interpretation of the limits of the Euthanasia Law, without taking into account the supposed priority of ethical consensus of the medical profession's body. The position of the Royal Dutch Medical Association (RDMA) on the interpretation of the Law now appears conservative, even though the profession published a new guideline in 2011, called 'The Role of the physician in the voluntary termination of life', including statements on the physicians' role in case of suicide through Stopping Eating and Drinking (SED) and/or taking an overdose of sleep medications (SLM) [8].

The role perception of the ERCs and its acceptance by the Dutch government has become a source of conflicts with the medical profession's organization. So from a dual point there is a reason for a critical look at the ERCs: they function both beyond and include the criteria of medical ethics and medical practice, but also define their norms without any basis in existing jurisprudence. Some hold the position that this development was intentionally chosen in defining the conditions in the Law in a undetermined, 'open' fashion, but many others feel that it is time for the highest legal authorities to step in and take a closer look. However, that procedure is only possible when the Government (Parliament or the Secretaries of Health and Justice) steps in or when a case ends up in the legal canals up to the Dutch Supreme Court. So far, neither has happened and it appears that the ERCs not only operate without pre-given limits but neither is there an outside check from the judicial establishment, a problematic situation from an ethical and a democratic perspective.

The legal condition for independent consultations by physicians has been institutionalized with the inauguration of a subdivision of the RDMA of SCEN-physicians, the acronym SCEN meaning: Support Consultation Euthanasia Netherlands. These consultants, all physicians and mostly functioning as regular caregivers, mainly family physicians, now more than 500 in number, function on a scheduled daily basis for immediate consultation. They are specially trained to perform their duties on a daily basis and are regionally organized. They have four times a year they have regional inter-collegial meetings for quality maintenance reasons, including attention for uniformity in their decisions. There are possibilities for filing complaints against SCEN-physicians by patients and involved others with an independent 'SCEN Committee for Complaints', located at the RDMA's headquarters.

The institution of SCEN can only function adequately on the basis of a fair, uniform procedure of assessment of the conditions of the Euthanasia Law, with limited differences in the results of the more than 6000 consultations yearly. Recent research however has uncovered a more than marginal difference in assessment [9]. This difference has been observed before but this particular survey showed quite fundamental differences in the assessments of 20 SCEN-physicians

who judged on the basis of three 'cases on paper'. It concerned a patient with 'a completed life', an Alzheimer's patient and a patient with a lower consciousness. Even given the fact that these were judgments based on 'paper patients' with fairly complex issues, the results were far from uniform. The cases were taken from one of the yearly reports of the ERCs and had been accepted previously as being with 'due care' and within the limits of the law. However, 45% of the consultants rejected the case of 'a completed life', 50% rejected the Alzheimer's case and 55% the 'lower consciousness' case. The authors conclude, not unexpectedly, that 'inequality under the law' should be prevented and that a more uniform assessment is needed. This is echoed by Esther Pans, who wrote a Ph.D dissertation on the normative aspects of the Euthanasia Law [10].

What is, however, more problematic is a possible conclusion that what is at stake here is the issue of consensus within the medical profession. The liberal approach of the ERCs with complex cases, such as with Alzheimer's and psychiatric patients and also patients with 'a completed life' has gone beyond the original professional consensus on patients with mainly severe suffering due to somatic diseases. At this moment the inescapable conclusion seems to be that there is no longer a clear professional consensus any more where it concerns the 'complex cases'.

Numbers and trends within the category 'medicide'

The term 'medicide' is used here for all medical decisions that potentially shorten life (MDELs): euthanasia (E), physician-assisted suicide (PAS), non-treatment decisions (NTDs), decisions to alleviate pain and suffering with the implicit possibility that they might be life-shortening (APSS), life-ending actions without an explicit request (LAWER) and palliative sedation. The focus shall be on the first two items: euthanasia and PAS, taken together as PAD. The numbers over the past twenty years are presented in table 1.

% of all deaths	1990	1995	2001	2005	2010
Euthanasia	1.7	2.4	2.6	1.7	2.8
PAS	0.2	0.2	0.2	0.1	0.1
LAWER	0.8	0.7	0.7	0.4	0.2
APS	19	19	21	25	36
NTD	18	20	20	16	18
Palliat. sedation			5.6	7.1	11.1
Reporting	18	41	54	80	77

PAS: physician-assisted suicide
 LAWER: Life-ending without explicit request
 APS: Alleviating pain and suffering
 NTD: Non-treatment decisions

Table 1: Percentage of medical decisions at the end-of-life (MDELs).

In general there is an increase in percentages of MDELs. In 1990 the total percentage is 39.7%, in 2010 this total without the category of palliative sedation is 57.1% and including sedation the percentage is 68.2%, suggesting that in almost 7 out of 10 deaths a decision and action or omission by a physician is involved. This difference in numbers is not explained by a difference in disease characteristics, as

far as is known. There are also few comparable data with other countries: only Belgium has similar research on this scale [11].

With a focus on cases of PAD, the main subject of this contribution, the following observations are relevant. It should be kept in mind that the discussion concerns less than three out of one hundred deaths. In between 1998 and 2010 the percentage of euthanasia cases varied slightly between 1.7% and 2.8% of all deaths in the country. After that year the yearly reports of the ERCs show an increase in numbers each year. The absolute numbers of PAD for 2009 are: 2636, for 2010: 3136 (+19%), for 2011: 3695 (+18%), for 2012: 4188 (+13%), for 2013: 4829 (+15%) and for 2014: 5306 (+10%) cases. One explanation is a growth in numbers of people asking for euthanasia with the 'classical indications', reflecting possibly and probably a growth in awareness of having a choice at the end of life and in itself this growth in numbers was and is a not foreseen effect on the populace.

What seems significant from an ethical perspective is a shifting trend in the medical diseases that qualify as 'befitting the limits' of the Euthanasia Law. The numbers show for example an increase in ending the lives of Alzheimer's patients. The figures for 2010 are: 25, for 2011: 49, for 2012: 43, for 2013: 97 and for 2014: 81. The ERCs report that in 'some cases' the Alzheimer's disease was in an 'advanced stage', implying that no communication was possible [12].

For chronic psychiatric patients there is also a trend that is reflected in the numbers. In 2010: 2 cases, in 2011: 13 cases, in 2012: 14 cases, in 2013: 42 and in 2014: 41. And the category 'combination of afflictions' shows an increase also: from 118 (2010) to 185 (2011) to 172 (2012) to 251 (2013) and 257 (2014), with a changed description since 2013 to 'multiple complaints of the elderly'. The relevance of this category is that it reflects a shifting trend in the assessment or appreciation of the condition of 'unbearable suffering', where it concerns the appreciation of individuals at the end of their life of the totality of the limitations of afflictions from degenerative diseases of the elderly and their quality of life. In 2005 researchers could conclude that even though 'being tired of life' played an important role in requesting euthanasia, irrespective whether the persons were suffering from cancer, another serious disease or no disease at all, they could conclude at that time that only the requests of the patients with cancer were granted, the others were refused [13]. Since roughly the last couple of years it cannot be denied that nowadays the option to be helped to die has been open to people with an accumulation of afflictions and/or diseases, none of them terminal in the short run, as witnessed in the ERCs yearly reports.

Over all these 17 reported years there is a certain consistency in the percentage of patients with cancer, roughly 80% of all cases. This consistency also is shown for patients with serious cardiac, pulmonary and nervous system diseases. However, from early on the idea has been also that patients not necessarily needed to be 'terminal', but unbearable suffering due their disease was a definite justification to allow helping them die. A medical and legal consensus in this area exists since 1974 with the (lower court) Leeuwarden trial, especially for patients with a chronic neurological disease without options for cure: multiple sclerosis, Lou Gehrig's disease and other chronic destructive diseases of the neuromuscular system without cure.

What appears as a significant trend concerns patients with Alzheimer's and chronic psychiatric diseases. Here new ethical issues arise, especially with respect to competence. In the course of the past twenty years consensus about the issue of competence has changed in a profound way, starting with agreements on general incompetence with respect to both diseases to a much nuanced description of several

varieties of competence, depending on the area in question. To ideas on 'global competence' a concept of 'task specific competence' has been added, focusing on the capacity to make specific decisions and being able to process information adequately related to a request to be assisted in dying [14].

With Alzheimer's patients the central ethical issue has become the question of competence at the moment of euthanasia.

There are two opposing positions. The first position is taken by the medical profession's Royal Dutch Medical Association (RDMA), insisting on being able to communicate with the patient, however rudimentary or symbolically, right before the moment of ending a life. The majority of life-endings with Alzheimer's patients are in this category of what has become to be called as the group of 'early Alzheimer's patients'.

The other position is defended by the lobby of the Dutch Voluntary Euthanasia Society (NVVE) and a not small portion of individuals, both inside and outside the medical profession. They also focus at 'advanced Alzheimer's patients' who have lost all capacities to communicate and/or to understand or make decisions. This position is in their opinion supported by an article of the Euthanasia Law (art. 2.2) stating that if and when a written request for euthanasia is present and the patient is not or not any more competent, a physician carrying out an end to life is legally protected, thus making it 'legal' to end life in these circumstances.

There is one not unproblematic aspect however. In general the axiom is that no one can ask for euthanasia for someone else, persons have to make their own request. And even when there is a written request, as the Law states, then someone other than the patient has to decide when that moment has arrived for life to be ended. The description of that moment usually reflects the intensity of compassion for the patients and often reads as: 'this is the state that my mother/father/family member/friend would not have wanted to live through'. This involvement is included in the assessments of the ERCs and so far has not resulted in conclusions of a 'not prudent procedure', with just a few exceptions. These exceptions have caused strong reactions in the media, reflecting on-going differences in opinions on the limits of the law. This ethical issue so far is unresolved. In one of these rare cases the argument to conclude to 'not prudent' focused on the fact that a request to assist in dying in a case of Huntington's disease was presented by the husband after communication with his wife was no longer possible. The main argument was that she had not repeated her request after putting it on paper during the period afterwards before the degeneration became complete. 'A request needs to be supported', meaning that it should have a function in the deliberations during the process of care before competence is lost [15]. This generally supported conviction is an indication that the mere presence of an advance directive, such as the Law makes possible as some perceive it, does not suffice in itself. It is not a legally binding contract, not for families, neither for a physician.

This conflict between the ERC's and the medical profession's organization has put a strain on the atmosphere of cooperation between the State and the medical professional body. But, as stated, it also underscores a lack of consensus within the medical profession as a group.

Numbers within the category suicide

The 'appearance' of a practice of 'personal and guided suicide' may be a reason to conclude that procuring death by personal choice maybe

a further extension of realizing the goal of self-determination at the end of life. Psychiatrist Chabot, whose assistance to die of a woman with mental suffering was accepted in a landmark case by the Dutch Supreme Court in 1994, who in 2007 was the first to 'uncover' in 2007 a so far fairly unknown practice of suicide through stopping with eating and drinking (SED) or by taking accumulated overdoses of anxiety reduction or sleep medications (SLM) [16,17]. There is no knowledge about the extent of this practice before 2007. And even though there is debate on the numbers it involves, about the same as the euthanasia and physician-assisted numbers in the national researches of 2010 or lower numbers, from an ethical perspective there are at least two important issues. In the first place, the fact that in six out of ten cases it concerns patients with a request to be helped to die who had been refused by their physicians and who took 'matters into their own hands'. But even more significant, four out of ten, made these decisions without involving a medical caregiver at all. Their motives varied largely, from being burdened with (potential) terminal cancer to psychiatric diseases, other somatic disease or deciding to have had a 'completed life' or being 'tired of life'.

It seems difficult to argue from an ethical point of view that these cases involve 'irrational suicides' that should have been addressed by psychiatric help services, even though it also concerns persons with a psychiatric disease. But not only that: others suffer from cancer, chronic diseases or sometimes no serious disease at all. Given the length of duration of these suicides and the necessary support of families and friends over a longer period, it is also difficult to argue that these are mere impulse suicides. Questions about authenticity can be raised, because it might concern patients with still possible psychiatric treatments, but in the end there seems to be just one conclusion: people decided to take matters into their own hands and went through with their plans to discontinue living, supported by others, over an extended period of time.

Another possibility for assisted suicide has been provided by a small group of advocates functioning under the name of 'De Einder', best translated as 'The Horizon'. Individuals of this group function as advisors to people with a request for assisted suicide by providing information on acquiring deadly quantities of pharmaceuticals from 'abroad', China or Mexico, through the mail. If and when the advices are limited to information, these actions do not lead to criminal charges, even though officially the mailing of substances is forbidden by law [18].

From an ethical and legal perspective there is at least one new area: are family members really assisting in suicide, a criminal act so far in the Netherlands, or are they supporting the choice to die for one of them within the limits of the law?

There is no recent legal case that provides an answer to that question. The Dutch medical profession has appreciated the existence of such a practice by adopting a policy that physicians should support these expressions of self-determination by helping with palliative measures to alleviate the real and not insignificant burdens of the choice to die through SED. This advice does not constitute a duty for physicians, it is an option. But they never are allowed to prescribe the medications to promote death through overdoses. However, it is a well-known fact that some physicians, even though they are aware of the intended use of sedatives and sleep medication, nevertheless prescribe.

Trends within the category laicide

With the term laicide is meant the involvement of non-physicians: laymen or lay persons, in realizing the death of an individual. Both the issues of unjustified refusals by physicians to help people die and the realization that family relations do matter in order to realize a death with dignity, at least how individuals perceive this, underscore a next step in 'allowable help in dying', as a further extension of the right to determine one's own death. The involvement of direct participants in realizing a 'good death' has appeared in several ways. In the area of organized and intended suicide a certain by-passing of physicians, whether a refusal was involved or not, leads to a practice without or with marginal support from physicians. This line of thinking has a (short) history in Dutch thinking about who should actually decide when to end life. Two positions should be mentioned here. The first one is a publication by retired member Huub Drion of the Dutch Hoge Raad, comparable to the Supreme Court, already in 1991! In his journal article [19] he argues for the availability of a 'pill' for elderly people in order to allow them to decide when and where to end their life in an acceptable way for them and their network, since then in the debates known as 'the pill of Drion'. Even though pharmaceutically this pill did not exist, the idea has been adopted by the pressure group of the Dutch Voluntary Euthanasia Society, currently with a membership of more than 160.000, the largest euthanasia society in the world. This society persists in attempting to realize what is being called 'the autonomous route'. This program aims to realize the option to choose the moment of dying, with available means, without necessary steps and conditions, especially with respect to the condition of unbearable suffering, an independent consultation and a physician who performs the intervention.

Movements to realize an end to life without the pivotal role of physicians have also been institutionalized in other ways, with public attempts to change or at least add other ways to assisted dying other than through the Euthanasia Law. In 2010 a committee of well-known Dutch civilians introduced a 'civil initiative' to the Dutch Parliament, with more than enough signatures collected in a few days, called 'Uit Vrije Wil', in translation: 'Based on Your Free Will'. In the trail of Drion's idea they proposed to allow elderly people over seventy years to choose to die after consultations with non-medical 'helpers for dying', without assessment of conditions for 'unbearable suffering', but with reporting and review afterwards by committees such as the ERC's, but with a 'helper for dying' instead of a physician. The Dutch Parliament duly organized a hearing on this proposal and decided not to act further on it.

Nevertheless, this development, to promote laicide, has received more public status since in 2008 a then 68-years old son helped his mother of 99 years to die by providing an overdose of sleep medication at her request, after a refused request by their family physician. He recorded his actions on video, it was shown on national TV and the public prosecution took four years to start proceedings, resulting in judgments that he was guilty but without punishment and then again on a higher court was found 'not guilty'. He appealed this last decision! And his appeal now is before the Dutch Supreme Court.

Other Developments since the Practice of PAD

While in most countries the ethical debates on euthanasia are still confrontational and resisting acceptance, the Dutch social development has been one of integration of accepted rules and regulations. The integration of euthanasia is seen as prime expression

of the current ideology of self-determination, accompanied by other anti-paternalistic practices in many walks of life: in schools and universities, in the workplace and in the churches. But the integration of euthanasia itself has produced additional unexpected and unforeseen effects. Effects not only for the practice itself with respect to the disease indications, where especially in the past five years, as stated above, the numbers of PAD in case of psychiatric diseases, of Alzheimer's patients and patients with multiple afflictions and diseases of the elderly have shown an increase. But there is also a growing effect on the public awareness to be able to shape one's end-of-life. Many people tend to view PAD as a right rather than an option. That tendency is visible in an increasing public demand for more self-determination at the end-of-life, not only reflected in the yearly numbers of euthanasia but also in growing public expressions of perceptions of a good death and the right to a self-determined death, nowadays with or without the help of physicians.

A new and serious ethical issue has come up in these past years with the subject of 'incorrectly refused cases'. The term implies that in certain cases the legal conditions to allow PAD were present, but individual physicians were of a different opinion. There are published case descriptions that reflect actual situations and attitudes of physicians with a far cry from a desired end of life [20]. From a legal point of view patients incorrectly were denied the option of PAD, even though according to other physicians these conditions were fulfilled and would have allowed PAD. It appears that there is not just a division within the medical profession between allowing and refusing PAD, in a sort of black and white division, but other personal and not professional normative elements play an important role in the process of PAD.

This subject of 'refused cases' has been on the agenda continuously since the Euthanasia Law. The sparsely available research in this area shows the problematic nature of a central condition of the legal process concerning the assessment of 'unbearable suffering'. Apparently physicians focus more on physical aspects of suffering rather than non-physical personal experiences, dealing with their position in life and their outlook on what is to follow in terms of deterioration and loss of dignity. Some felt that their suffering was severe enough to want to stop living, but not 'unbearable', reflecting a deep rift between patients' suffering and physicians' assessment of it [21]. That is a problem with ethical and legal dimensions, since incorrectly refused requests for patients mean a denial of an option that is legally possible, leading to unequal access to a death of their choice. This finding, based on only ten cases, has been investigated further by Van Tol c.s. [22] in a larger 'vignette study' with general practitioners, not only stressing the earlier conclusions but uncovering even more unpredictability for patients whose suffering consisted mainly in the perception of their suffering with functional losses and/or what the patients called 'existential' kinds of suffering. Now it may be very well that a vignette study is not the best or correct instrument to make an assessment of unbearable suffering, because it is based on 'paper patients' and not on meeting suffering persons in dialogue. But its conclusions show personal differences in the assessment of unbearable suffering within the medical profession that cannot be denied, and need to be addressed because these differences lead to inequalities and injustice for patients. That is an ethical problem that the profession needs to analyze and redress. But it has so far proven difficult to find adequate answers.

Not however for the euthanasia pressure group of the NVVE: A fairly recent step of the Euthanasia Society in 2012 has been the inauguration of a Life Ending Clinic, founded by the NVVE, now run

by an independent institution, consisting of more than forty ambulatory teams of a physician and a nurse who make home calls, visits in institutions for the elderly and hospices. Its aim is to realize euthanasia deaths for people whose requests have been incorrectly refused. The Clinic aims to operate within the broadly defined limits and procedures of the Euthanasia Law. One of its publicly stated goals is to make itself redundant, but so far the yearly 'load of requests' only shows an increase.

The Clinic's work is only possible because of an absence in the Euthanasia Law of a requirement that only physicians with a treatment relationship are in the position to help patients die. That, for much curious, absence has from early on been justified to accept and correct that some physicians refuse to participate based on their conscience. It has become customary that other physicians would step in and perform the final act, because from both medical and legal perspectives the conditions of the Law were fulfilled. The overriding concern was that suffering patients should not be left in the cold because their physician would not 'do euthanasia'. There are professional guidelines concerning a duty to refer a refused patient to another physician, who is more inclined to accept a request. From the point of view of the safeguards, the ERCs focus on the question whether these 'stand in physicians' could show to their satisfaction that they had familiarized themselves with both the cases and patients in a convincing manner, with frequent home visits and lengthy deliberations.

The Clinic's physicians also deal with 'more difficult cases' in the area of psychiatric patients, Alzheimer's patients and others that their regular physicians find difficult or refuse to do. This development will be described in more detail below, but is mentioned here because it reflects an entirely different concept of the physician-patient relationship described above. Many are convinced that the three or four longer visits of the Clinic's physicians/nurses with the patients cannot possibly be adequate in order to develop enough insight to be able to assess fulfilment of the conditions of the Law [23]. This conclusion is refuted by the Clinic's physicians [24] and so far the ERC's never have found a case of the Clinic lacking in this respect, but that bare fact does not really take away hesitations and reservations where it concerns the correct assessment of suffering of some chronic psychiatric patients: several commentators, even supporters of euthanasia in general, are convinced that a treatment relationship should be an essential part of the euthanasia process [25].

However, there are other aspects in the work of the Clinic that point to a fundamental change. Its only aim is to help people die. It is not at the end of a longer process of care, because caretaking is not the goal of the Clinic. What is observed here is a further 'functionalization' of euthanasia, a specialization as a next step. Here the request for an act of euthanasia is separated from and taken out of the context of 'care'. The emotional involvement of the Clinic's physicians is not part of a longer process of caretaking but structurally starts at the time of a request to be helped to die with that goal. The Clinic's physicians do not enter the process of euthanasia with hesitancy and emotional reserves, but they choose to confront a request head on, based on personal, rational and ideological conceptions that suffering patients need to deal with, wherever they are. A problematic aspect of the Clinic's functioning is a tendency to shop around for a 'granting' SCEN consultant after one or more 'negative' consultations, a reflection of the different conclusions SCEN physicians may reach. In itself a not unproblematic ethical issue.

Physician-patient relationship: changes through the practice of PAD?

In general, an increasingly higher significance is attributed to the condition of a voluntary well considered request, the first condition of the Euthanasia Law, together with a tendency to delegate a lower order of importance to what it means for physicians to assist in helping patients die. The third condition in the Euthanasia law stipulates that physician and patient together need to come to a conclusion that there are no more options available to alleviate the suffering of the patient. This relational foundation reflects respect for both physician and patient. It reflects also the risky position of physicians, full of conflicts on different levels. There are intrapersonal conflicts, going through psychological and emotional hurdles with uncertainties and anxieties, in addition to professional conflicts about the core of medicine to cure and to heal and not to end life. There is also the philosophical ethical conflict, with the realization that ending a life goes against a fundamental universal commandment not to take life, especially not 'innocent life' [26]. A number of studies testify to the intense involvement of physicians in the process of euthanasia, not just the final intervention [27-29]. These studies uncovered an intensified need for physicians to learn to know their patients as persons, not only in order to come to a clear understanding why they call their suffering 'unbearable', but also because ending life of a human being is painful experience that can be performed only when there is a deeper understanding and relationship. Clark and Kimsma proposed for this type of relationship the term 'medical friendship', a term describing the nature of euthanasia as a difficult, problematic deed in the interest of a patient that only 'friends' would ask from one another, based on classical Aristotelian descriptions [30,31]. This characterization was recognized by many physicians.

However, what ending life means for physicians may be recognized by physicians and some patients as an action fraught with emotions, others feel that the role of physicians in being able to refuse a request to be helped to die has a degree of importance they deem undesirable, even unacceptable. Illustrative of this position is a tendency in thinking of the NVVE, that 'an autonomous route' should be possible, where physicians merely function as carrying out the requests of individuals and do not seem to be taken seriously enough as moral agents with their own personal and professional moral rights and duties. That observation seems quite problematic from the angle of the ethics of physician-patient relationships with PAD.

The realization of a different emotional involvement of otherwise well-functioning physicians of the Life Ending Clinic is reason to rethink the issue of vulnerability for physicians who enter the process of euthanasia described above. Many of the Clinic's physicians are retired and see their work as a new satisfying role at the end of their careers to correct wrong situations and insufficient procedures with euthanasia in the Netherlands. They show a certain passion for this 'work'. And their choice is reason enough for a closer look at the issue of the emotional impact. The available data show that the 'negative' emotions of physicians described above apparently do not seem to have general validity. That conclusion could already have been made from the first overview by Haverkate c.s., from 2001, on 'the emotional impact on physicians of hastening the death of a patient'. It reports that 75% of the physicians experienced feelings of 'discomfort' with euthanasia, 58% following assisted suicide, 34% following ending life without an explicit request and 18% after ending life with high doses of opioids [32]. In the 2015 survey of the RDMA physicians still report

the emotional stress of euthanasia in 70%, even though in the end there may be feelings of satisfaction [33].

The publications of the years in between may after all not be representative since they focused on physicians who volunteered for the surveys (focus groups) and were not at random. All said, it seems an undeniable fact that there are physicians (30% of the surveyed) who perform PAD apparently without the same emotional resistance that others endure. Because this issue has not been researched there is no insight on how this not small group copes with the emotions of euthanasia. And there seems to be some reason for questions about the psychological experiences of physicians functioning within that part of the Dutch euthanasia practice.

Implications for 'Euthanasia Ethics'?

The ethical debates of confrontation over roughly the past 150 years fill libraries and appear as old as ancient medicine. The international public debates since the nineteenth century show a wide variety of arguments that over time are surprisingly consistent and similar, seemingly independent from advances of medical technology, with the exception of one: the discovery of anesthetic agents as chloroform, ether and morphine, even though the last one has been known and used for ages [34]. The application of these agents in medical practice prompted a powerful public debate and demand in the 1870-ies for their use to alleviate the suffering of incurably ill patients and lead to euthanasia debates, especially in the UK, the USA and Germany.

Attempts to 'organize' the arguments for or against euthanasia have been helpful with the distinctions offered by Finns and Bachetta (1995) [35]. They distinguish arguments of (1. Deontology, based on principles of good or evil of (2. Consequentialism, based on supposed consequences, including 'slippery slope' arguments; and (3. Clinical pragmatics, based on the effects on the doctor-patient relationship or health care as an institution. The following overview presents these arguments pro and contra euthanasia [36-39]. These arguments will then be re-examined, based on what is known so far about the practice of PAD.

Deontological arguments

Deontological arguments against euthanasia are for example the claim that life is sacred, God-given and has intrinsic value, without an option to end it. The end of life should be experienced because the end has lessons to be experienced and because suffering is God-given. Besides, there is a right to life that an individual cannot give up. A physician's duty is and has always been to protect and preserve that life, not to terminate it.

Proponents however claim that euthanasia is a human right, based on the principle of self-determination. There is no duty to undergo not relievable suffering. Also, active euthanasia should follow from the right to refuse further life-prolonging medical treatment without hope for cure. In addition: if suicide is morally defensible, than assisting in it is morally appropriate also.

Consequential arguments

Consequential arguments against euthanasia share a sense of distrust and fear. A central argument is fear for abuse of the practice and a 'slippery slope' with respect to the acceptable indications. Allowing physician-assisted dying (PAD) will send a message to society of the devaluation of human life. Moreover, allowing ending the

life of competent patients will be followed by accepting the ending of life of the non-terminally ill, the incompetent and in general all vulnerable patients. Psychological and economic arguments will play an increasing role: allowing PAD will cause suffering to others. And: assisted dying will be requested by patients feeling they are a burden desiring to take away the strain on their families or by family interests in ending life, not the least for economic reasons of cost, especially when there is no or adequate insurance. And physicians will give in to pressures of cost containment within an increasingly expensive health care system.

Consequential arguments supporting euthanasia are the following. Allowing PAD will increase self-control and individual self-esteem. It will also increase public awareness of the need to decide in time for a chosen manner to die, especially when incompetence might be a possibility at the end of life. It will also provide a wider moral basis for human rights in society. It will enhance a morality that secures the personal and individual character in making decisions on death and dying.

Clinical pragmatic arguments

Clinical pragmatic arguments against PAD are for example a claim that most deaths are not painful, nor that physicians are unwilling to stop treatments and use adequate pain medication to effectively alleviate suffering, in short: good medical/palliative care does not lead to a request for PAD. Besides that it is not always possible to predict with absolute certainty the inevitable outcome of death, resulting in ending the life of patients who could have continued a further full life.

Allowing or even legalizing PAD will be perceived as a threat by patients and lead to distrust of physicians and the system of health care. Besides that, it is nearly impossible to establish the voluntariness and thus the authenticity of a request, especially because family influences are difficult to assess. And requesting PAD hardly seems the act of a rational human being since incurably ill patients often suffer from depressions or have their minds clouded by the medications being used. The mere option of PAD may result in less willingness of families and physicians to care for their sick and old. Suggesting PAD itself may have the effect on patients that their suffering is futile and may erode their courage to fight against a disease.

Clinical pragmatic arguments in favor of PAD focus on limiting meaningless suffering. It is indicated only for terminal or chronic unbearable suffering patients, allowing PAD means less risk for in- or non-voluntary deaths. It means a greater sense of control for patients and less risk for suicide. A regulated practice with a focus on adequate palliative care, even for the poor or uninsured, would force institutions to provide adequate care before a request for PAD could be granted. The option of PAD increases the quality of dying, intensifies family relationships and effects lower grief reactions in the surviving families and friends. Instead of distrust it enhances trust in the medical profession, because patients realize the emotional distress of euthanasia for physicians.

What 'happened with these arguments' after a continuously reviewed practice developed over the past almost twenty years?

Does a practice of euthanasia of the past twenty years shed new light on the ethical arguments?

All of these ethical issues had validity as a claim, but until a practice existed there was no large scale empirical research to underpin

practically all claims, simply because a practice that legally is forbidden, 'officially' allows no large scale representative research on 'interventions that officially do not exist'. These 'classical' ethical issues, both on the opposing or supporting sides, had no empirical foundation, so it is important to take a look at their relevance within the context of an actual existing practice.

The focus in what follows shall not be on entirely new issues such as the relevance of euthanasia for organ donations [40] or side issues, like procedures to deal with euthanasia and artificial organs or pacemakers [41]. Neither is the focus on distinctions in theory and practice in the ethical importance of the differences between palliative sedation, terminal sedation and ('slow') euthanasia [42-43].

Looking again at the various types of arguments described above from the context of the present reality of an existing practice, the following observations are in order. The numbering of the different types of ethical arguments is followed throughout what follows.

Deontological arguments

With respect to the deontological arguments against euthanasia there has not been an observable change in position of opponents in these three areas; if PAD is not acceptable, then suicide without or with limited medical support or laicide, without involvement of the medical profession at all, can never be acceptable or part of the public agenda, even though its extent is not really known.

Proponents of euthanasia, stressing a right to self-determination, over these past years, now claim an extension of this right to suffering, from for them unacceptable diseases and functional limitations, formerly thought to be beyond the scope of regulation or dealing only with a few exceptional cases.

With respect to the medical profession a shift from a prudent liberal to a quite demanding liberal position can be observed. A 'Committee Acceptance Life-Ending Interventions for incompetent Patients' (CAL) of the Royal Dutch Medical Association (RDMA), active from 1985 through 1997(!), has from early on intensively discussed the options to have a dignified death for patients suffering from Alzheimer's and psychiatric patients, severely deformed neonates, patients in persistent vegetative state and patients without a clear request for euthanasia [44]. The conclusions of this committee did not lead to clear policy proposals at that time, but the expectation was that it concerned exceptional cases limited in numbers. However, in the past five years the options for Alzheimer's and chronic psychiatric patients have become more open, depending on more nuanced views on the level of competence or the weight for a perceived option for the Euthanasia Law in case of incompetence and the presence of a written request. This perception, stressing the consequences of a written request, underscores the weight of the right of self-determination, without recognizable attention of its meaning for physicians who are expected to carry out these interventions.

Consequential arguments

With respect to the consequential arguments against euthanasia there are interesting and important developments, as might be expected. The common line was a fear for a 'slippery slope' of morally flawed developments with extensions of ending life to the non-terminally ill, the incompetent patients and other vulnerable people. The extension to these groups has not really become a reality, because of the fundamental limitation or correction with upholding the legal

condition of the presence of a request. There is a widespread agreement in the Netherlands that there is no 'slippery slope' [45], but this conclusion is not necessarily shared by physicians in other countries. But without a request, whether oral or in writing, there cannot be physician-assisted dying (PAD).

A decisive reason why this so, is to be found in the context of Dutch euthanasia. That context is an obligatory universal health care insurance system for every individual, including 'state of the art' palliative care for terminal patients, without a risk of economic factors playing a role in decisions to help patients die.

Also the integration of physician-assisted dying (PAD) has not resulted in a devaluation of human life, on the contrary it might be argued. PAD has increased the awareness of a duty to provide a dignified death to requesting, seriously suffering patients, ensuring unavoidable deaths with dignity rather than devaluation of human life because of fulfilling a final request to prevent more suffering and loss this dignity.

This conclusion needs an addition with respect to PAD in case of severely malformed suffering neonates without hopes for a life at all. The debates on this topic resulted in the adoption by the Dutch Pediatrics Society of what since 2005 has become known as 'The Groningen Protocol', outlining the conditions and procedures for actively ending the lives of neonates [46]. The protocol caused much turmoil in the medical profession and the media. The gist of the protocol was to have a transparent procedure with all the relevant data on the case and on the physicians in charge, in agreement with the public prosecutor, to self-report every case, with the intention to prevent criminal procedures. The conviction of the authors of the Groningen Protocol is that an active end to life is more justified than terminal sedation because it is the lesser evil, 'because it is questionable whether keeping the infant sedated for many weeks to months, waiting for a certain death, is humane and qualifies s 'good practice' [47].

Today there is a special committee to assess these cases, parallel to the ERC's, that also deals with abortions on medical indications after 24 weeks gestation. This committee, called after its chairman 'Hubbeling Committee', so far received a few to no reports in the past year [48].

Consequential arguments supporting euthanasia focus on the rights and meaning of the option to end life for both individuals and society as a whole.

The claim for increased self-control and individual self-esteem seems to be realized and increasingly patients ask for euthanasia, witness not only the general increase of cases over the past few years, but even more in the increase of life-endings of Alzheimer's, psychiatric patients and elderly people with a combination of ailments of their age. Opponents of euthanasia may find this development an indication of a 'slippery slope' but it is difficult to argue that from an angle of self-determination this consequence is what the aim has been all along: the option to make decisions for the end of life is realized.

There is research supporting a claim that the mere possibility of euthanasia increases the quality of life during terminal stages of a disease. Francis Norwood, an American anthropologist, observed in a field study of terminal patients the importance of a 'euthanasia discourse' after a request to be helped to die. Irrespective of whether life ended with or without euthanasia, and most end without euthanasia, the emergence of this discourse helps patients, families and friends to cope more intensely, strengthens relationships and helps to

accept death with less anxieties because anticipation focuses on what a person wants with limited options [49,50]. There is also research on the effects of euthanasia for grieving family and other dependents. The authors conclude with: 'possible explanations for less grief symptoms among the bereaved family and friends of cancer patients who died by euthanasia are: (a) the opportunity to say goodbye while these patients were generally still fully aware, an interpretation that our results support;(b) the bereaved family and friends of these were probably more prepared for the way and day of the imminent death; and (c) when a terminally ill patient requests euthanasia, family member and the patient are often able to talk openly about death.' They finish their article with a cautionary note: 'our results should not be interpreted as a plea for euthanasia, but as a plea for the same level of care and openness in all patients who are terminally ill [51].

Clinical pragmatic arguments

Clinical pragmatic arguments against the option of assisted dying share a basic conviction that good medical care does not result in a need for requests for assisted dying, in other words: a request is actually redundant. There are no indications that good medical care will prevent all requests, what is to be seen is that in spite of good care, a good share of the patients nevertheless will want to orchestrate the end of their life in order to remain in charge of accepting the level of their suffering. Lack of palliative care is not a reason in the Netherlands; in general in countries allowing PAD, the level of palliative care is as good or better as elsewhere [52]. Furthermore, it has become clear that people with serious but not terminal diseases have different opinions on the relationship between their suffering and the timing of their deaths. This is reflected in what has been described above on the differences in perception of constitutes unbearable suffering between patients and physicians, and also in the increasing numbers of elderly people with an 'accumulation of diseases', who request an end-of-life.

What is more fundamental is the charge and fear that legalized PAD would be perceived as a threat by patients and reasons for distrust both physicians and the system of health care. This claim so far has not been investigated on a large scale. But a retrospective pilot study from 1994 with relatives showed a unanimous appreciation for the physicians who assisted in a chosen death after a terminal disease [53]. So what is known so far only supports an opposite position to distrust: statements from individuals reflect appreciation of physicians willing to enter the risky areas of assisted dying and nowhere so far has there been a sign based on experiences that a lessening of trust in the medical profession as a whole has been expressed. Norwood's research (Norwood, 2009) shows that the option of PAD does not serve as demotivation neither for care nor as a psychological 'caving in'. On the contrary, the option of being able to choose to die, the 'euthanasia discourse' serves as a strong force to focus at the end of life, stimulates the powers to stay alive for the patient, because there are options to decide how the end will be [54]. This statement is just as valid for patients who in the end 'received' euthanasia as for the majority who did not, when they died a 'natural death'.

So far there only have been foreign media claims, especially in the German press, without providing facts that elderly people would be in fear for safety at the end of their lives and moved to other countries, such as Germany.

Claims that it would be nearly impossible to correctly assess the voluntariness and the authenticity of a request are cornered in the processes leading up to an active life ending. It should be understood

that ending a life of a patient is a longer process, mainly in the course of a longer time after exhaustion of palliative medical interventions, mostly within the home care situation of patients, under the supervision of mainly family physicians, who perform these interventions in about 80% of the numbers over all these past twenty years. Overall this does not concern patients who cannot communicate any longer, on the contrary. Pressure from family members will be detected during the many home visits. A clearly opposite conclusion to unwanted pressures is drawn in the Norwood research, showing that in the successive stages leading to the final event, patients take the initiative to a next step instead of physicians. Any doubts about the voluntariness will appear in the long process of care leading up to an active end of life. And if or when doubts are not detected in time, then this factor will appear during the legally required consultation, often leading to an additional psychiatric consultation if competence or depression seems an issue.

With respect to attention to the issue of depression of opponents to PAD, the following observations are relevant. Positions on this subject vary from: the Hendin's conviction [55] that a request for euthanasia implies the presence of a psychiatric disorder such as suicide and should be treated, to: depression is a common experience at the end of life, but most of the time does not have the depth of a clinical depression nor does it compromise the competence of a patient [56]. One Dutch prospective cohort study and one study from Oregon show unambiguously that the majority of patients requesting euthanasia or physician-assisted suicide do not have depressive disorders [57,58]. Of the 130 patients in the Dutch study two patients had a major depressive disorder in need of treatment. In general there is a depression in cancer patients from 10 to 15%. Depressive symptoms in patients with a euthanasia request vary from 8 to 47%, but requests in these cases are more often refused than granted [59].

A core question is whether patients with a depressive disorder are competent or not. There is a consensus that more often than not competence is not compromised in these cases [60]. In case of treatment of depression in cancer patients methylfenidat may have the speediest palliative effect, especially since a short life expectation may make treatment with TCAs or SSRI/SNRI's impossible for their longterm effect to arrive, their side effects and interactions.

Another argument has been a claim that a mere presence of the option of PAD may have negative kinds of reactions of families to care and for patients to keep up courage to fight for their life, because of the psychological effect of the message of PAD. From early on in the Netherlands it has become clear that social networks have been involved in requests for euthanasia and all other phases. They were needed 'for good decision making with regard to euthanasia and for helping relatives to come to terms with the loss of a dear one' [61,62]. Here again the context of terminal patients in the Netherlands needs to be taken into account: mainly cared for at home by families and primary care physicians making frequent home calls, with extensive home-care and an obligatory health care system with high level palliative care support. There are no financial burdens on the families and there is no risk for diminishing of an inheritance. So in effect, the fears for a psychological retreat of both families and patients are unwarranted, on the contrary, as the work of Norwood shows.

There is however one issue of importance that needs to be addressed. That concerns the observation that some patients decide for life to be ended because they feel they have become a burden to the family. It is worthwhile to reflect on this particular issue further because its ethical impact can be explained in different, opposing ways.

This motive was reported for the first time in the National Investigations of 1996 with a frequency of 13%, in 2003 with a frequency of 17% [63,64]. Having the feeling of 'being a burden' and then choosing to die is often considered as a choice of a patient that indicates a compromised voluntariness and for that reason is considered as an argument against ending the life of a patient. In the Dutch researches it has appeared as one of the many reasons to ask for an end to life. It is important to realize that there are no financial reasons to decide to end the financial burdens of costly end-of-life care. When patients observe that their families and other dependents show signs of exhaustion due to the intense care needs, a request to be helped to die on a short notice may be motivated by compassion with the caregivers. In itself this motive may be laudable, it is relational and compassionate coming from the individual who is about to die. However, in the Dutch reality when a situation of overburdening arrives, physicians and family alike can apply for intensive home-care during day and night in order to allow family caretakers adequate rest to continue to perform their tasks at no extra personal costs.

Clinical pragmatic arguments in favor of PAD

Essentially the ideas of proponents of euthanasia have become a reality, sometimes even more than possibly could have been foreseen.

Patients are the central focus of care at the end of life. The professed motive of defenders of palliative care is the focus on autonomy of the patient as a person and the intention is to take care of all the patient's needs. But this focus shows a contradiction in the limit and exception to the one and final request: to be helped to die [65]. This option, to decide when suffering has become enough, has become a reality in the Netherlands (and Belgium and Luxemburg).

Allowing PAD has meant less risk for in- or non-voluntary deaths, even though the 'discovery' of the LAWER category, the acronym for Life Ending Actions without an Explicit Request, from its first description in 1991 has been met with an international 'wave' of accusations of non-voluntary euthanasia. The explanations [66] did not seem to quiet the storm of indignity. In the meantime the absolute numbers between 1991 and 2010 have been reduced from 1000 to 200 cases. Studies on end-of-life decision-making in six European countries [67] showed that for example in Belgium the LAWER figures were 2.5 times higher than in the Netherlands. With respect to incompetent patients with a short life expectancy of hours or days, prior discussions were highest in the Netherlands and Switzerland, and discussions with relatives were the highest in the Netherlands (85%) and Belgium (77%), with in more than 50% of the cases in Italy or Sweden the end-of life subject was discussed nor with patients neither with family members.

The aspect of a greater sense of control has been illustrated extensively in the observations above. What has appeared as a remarkable fact is that even though there is less need for suicide because of the option to be helped to die, there are a not insignificant number of people who decide to take their own life through overmedication or stopping with eating and drinking. They show a large variety of disease characteristics, some are not suffering from a terminal disease, and only a minority has been refused to be helped to die by their physician, not only in the home situation but also inside institutions for the elderly. The least one can say is that they were in control, and they were supported in their arduous tasks by others in realizing a death of their choice.

Other conclusions to be drawn from the available date are the following. A lack of available palliative care has not been an issue in the past twenty years. The legal conditions prescribe the affirmation that available care has to have been offered to patients before a final intervention can be accepted. In cases of psychic suffering of psychiatric patients there is a strong condition that a request in these cases can only be fulfilled when and after all available reasonable options for treatment have been followed.

The studies so far affirm that the option of PAD increases the quality of dying, intensifies family relationships and results in lower and less problematic grief reactions for the surviving relations.

Concluding Remarks

In this contribution the aim was to re-examine the validity of the main arguments against or in favor of physician-assisted dying, based on facts as they have emerged after a practice of PAD has been realized in the Netherlands.

It is clear that the principle of self-determination has become a guiding force, leading to expressions of requests to be helped to die. But, euthanasia is neither a right nor a duty for a physician. It is a claim right and an option that depends on the position of physicians: supporting or opposing.

What the Dutch reality shows is shifting trends in allowable euthanasia. First in the shifts in decisions of the ERCs in accepted medical indications with extensions to Alzheimer's patients and chronic psychiatric patients, all with transparent justifications, accessible on the internet. The same holds for elderly patients with an accumulation of in themselves not terminal diseases, but with symptoms that for them are 'unbearable' or unwanted and refused to undergo. These decisions of the ERCs or based on their own reflections have also resulted in an awareness that there somehow is a moral right to shape the end-of-life, irrespective of the presence of a serious disease. The NVVE has become the main voice of these options to be helped to die, as it has become visible in both the goal to realize, as described above, 'autonomous routes' and in its policy to inaugurate the Life Ending Clinic.

At the same time the position of physicians and their RDMA has changed. They had to come to terms with the shifting trends in indications, visible in the 'jurisprudence' of the ERC's and the result has been a loss of 'consensus', with personal choices and differences in willingness to provide euthanasia or to resist in these cases. Together with public awareness of the 'incorrectly refused cases' and the growth of ideas to choose an end to life without physicians' involvement, a certain anti-physician mood may be perceived. But even that statement should be made with nuances. In a recent meeting of the NVVE in November 2015, 37% of the respondent in a survey expressed a preference for 'the medical route' to death, where that figure in 2011 was 21%.

The position of the RDMA concerning refusal to accept the ending of life of 'late stage Alzheimers', in sharp dissent with the ERCs, affirms the opposition between the medical profession and the 'euthanasia establishment'. The core issue is the question who in the end decides where 'the limits of the Law' should be drawn and momentarily this question is unanswered. So far it is no longer only the medical profession, since the profession as arbiter of medical morals has been bypassed by the ERCs.

A more basic question regards the 'old' fear of 'a slippery slope'. Are these developments indications of a slippery slope or not. The answer is not a simple yes or no. The original 'slippery slope arguments' against euthanasia were based on fears. Namely, once allowed for the competent patients, it would only be a matter of time before euthanasia would be made possible for the vulnerable in general, the incompetents and last but not least, persons with low intelligence or anti-social behaviour. In the light of those fears, there is no indication whatsoever that a 'slippery slope' is a reality. The shifting trends in the indications for allowable euthanasia for vulnerable people has a fundamental limit in the law with respect to the presence of a 'competent' request, oral or in writing. The ERCs are the guards of these legal conditions. That does not mean however that there are no cases, judged as 'with prudence' by the ERCs, which do not raise fundamental questions and are difficult or impossible to defend. As has been noticed above, the fact that the ERCs have a continuing monopoly in establishing the limits of the law, so far without any case-connected oversight, seems difficult to defend.

Reservations are also in order for other issues. One is for example the fact that ending life is carried out in 90% of the cases by i.v. injections instead of assistance in suicide (PAS), even though it is advised strongly to employ PAS. Another is a certain lack of uniformity in the assessments of the consulting physicians where the 'complex issues' are concerned. The RDMA needs to improve that unacceptable fact, since it manages the SCEN organization. But what seems an even more important issue is the observation that such large differences exist inside the medical profession as a body with respect to at least some medical ethical conceptions and convictions, leading to the question whether there still is a consensus at all.

The development of the Life Ending Clinic still raises questions. The Euthanasia Law does not stipulate that with PAD there should be a prior treatment relationship, with the intention to respect conscientiously objecting physicians. This omission, with a positive reason, has been turned around to a 'legal' reading that the law does not forbid 'stand in physicians' and thus allows this option. As stated above, the reason for ideas of a Life Ending Clinic were partly the responsibility of the medical profession by not taking action on 'incorrectly refused requests', so in a way the profession is at least co-responsible for its realization. Even though the Life Ending Clinic claims to hope to become redundant, chances for that development are extremely small. Because they take on the more complex cases that many physicians do not address. So in the short run, the Life Ending Clinic will be needed to cater to a large number of people wishing to die, whose request was refused or who expect a request to be refused. The low number of cases of this Clinic's physicians deemed 'not careful' by the ERCs testifies to their adherence to the conditions of the Euthanasia Law.

Related to the Life Ending Clinic's existence is the issue of the vulnerability of physicians who participate in ending lives of patients. To earlier conclusions, based on individual and group testimony of reservations because of the emotional impact of PAD, must be added a conclusion that for some physicians these problematic emotional experiences apparently do not exist. That conclusion raises a number of questions that are still unanswered, but seem reason for concern.

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