POLICY REPORT

WALKING A KILOMETRE IN WOODEN SHOES

Understanding Euthanasia Policies in Cultural Context

By Dawn Oosterhoff

More than ten years ago, the Dutch parliament legislated a permissive regime of euthanasia for capable Dutch residents. Dutch legal precedent also allows physicians to take active measures in some circumstances to ensure an incapable person's death. The legislation does not herald anything new for the Dutch; it is, instead, a codification of a practice that has been tolerated for many years. Nonetheless, the process of passing the legislation caused the world to turn and focus attention on the Dutch practice of euthanasia.

Image Composite by Dawn Oosterhoff

Given the value-laden issue of euthanasia, it is no surprise that the Dutch approach to end-of-life care caused a flurry of commentary and controversy. For example, in a widely circulated medical manual, the Dutch approach to end-of-life decision making was characterized as akin to the extermination of Jews and Gypsies in Nazi Germany. In contrast, another author argued that Dutch laws amount to a legal normalization of medical practice in connection with death. The consistencies in this debate are the variety and volume of opinions, and the passion with which those opinions are expressed.

Dutch physicians have responded to the controversy by asking those who wish to state an opinion to, first, assay end-of-life decision making from a Dutch perspective. Yet many com-

mentaries, even those written by Dutch authors, fail to adequately discuss cultural context, thus implying that all Western industrialized cultures are similar. But they are not. Moreover, there are some aspects of Dutch culture, unique to the Dutch, that significantly affect how they conduct end-of-life decision making.

This report examines aspects of Dutch culture relevant to end-of-life decision making in the Netherlands. The intent is not to determine whether the Dutch practice is good; rather, the report considers whether Dutch end-of-life practice can be exported outside of its cultural context and adopted here in Canada.

Euthanasia in the Netherlands

The Dutch define *euthanasia* as an intentional act by one person to terminate the life of another person who is suffering "unbearably" and "hopelessly." Dutch law requires that the suffering person make the request. *Assisted suicide* differs from euthanasia only in respect of who administers the lethal agent. To be assisted suicide, the dying person must administer the lethal agent him- or herself.

Until 2001, the Dutch criminal code prohibited both euthanasia (Article 293) and assisted suicide (Article 294), identifying both acts as homicide. Nonetheless, the Dutch openly practised both for years, with many considering both practices to be acceptable.

There are, however, opponents to the regime. Some people carry what have been called "Do Not Kill Me Cards" out of fear that their lives may be arbitrarily ended should they be hospitalized and unable to vocalize their wishes. There may be more of these opponents than generally assumed. When parliament passed the euthanaisa legislation, the police and press were caught off guard by the number of protesters. Nonetheless, "the practice [of euthanaisa and assisted suicide] is supported by a majority of the Dutch populace (rising from 40 per cent in 1966 to 78 per cent in 1992) as well as a majority of Dutch physicians."

The rise of support is not a radical shift of opinion as much as it is an evolution of thought over years of consideration. The Dutch began openly discussing euthanasia in the 1970s with physicians playing an active role in that conversation from the start. A Delft anaesthesiologist wrote an article describing how, precisely, physicians could go about meeting a patient's need to die. A decade later, the criminal code provisions had been successfully challenged. In 1983, the courts had ruled that a physician could invoke a defence of necessity if:

(1) The physician was confronted by a conflict between the requirements of the criminal code and a duty to a patient whose suffering is "unbearable and hopeless," and

(2) The physician, in exercising the care required of a medical professional, made an "objectively justified" choice.

The decision in this case—*Schoonheim*—was the first in a subsequent series of judicial decisions in which the limitations and conditions of the defence were elucidated. Eventually, the legal precedent was embodied in prosecutorial policy that offered physicians a high degree of protection from prosecution for euthanasia provided the euthanasia was carried out within the proscribed limits set by the courts, known as the "requirements of careful practice."

The Dutch do not deny that euthanasia and physician-assisted suicide are killing; however, they consider such killing to be justified, in the same way that self-defence or killing in war might be justified. Codification of prosecutorial policy in legislation has not changed this perception. The Dutch criminal code simply makes it clear that physicians' actions are justified if euthanasia is carried out according to the now codified requirements of careful practice and the euthanasia is duly reported.

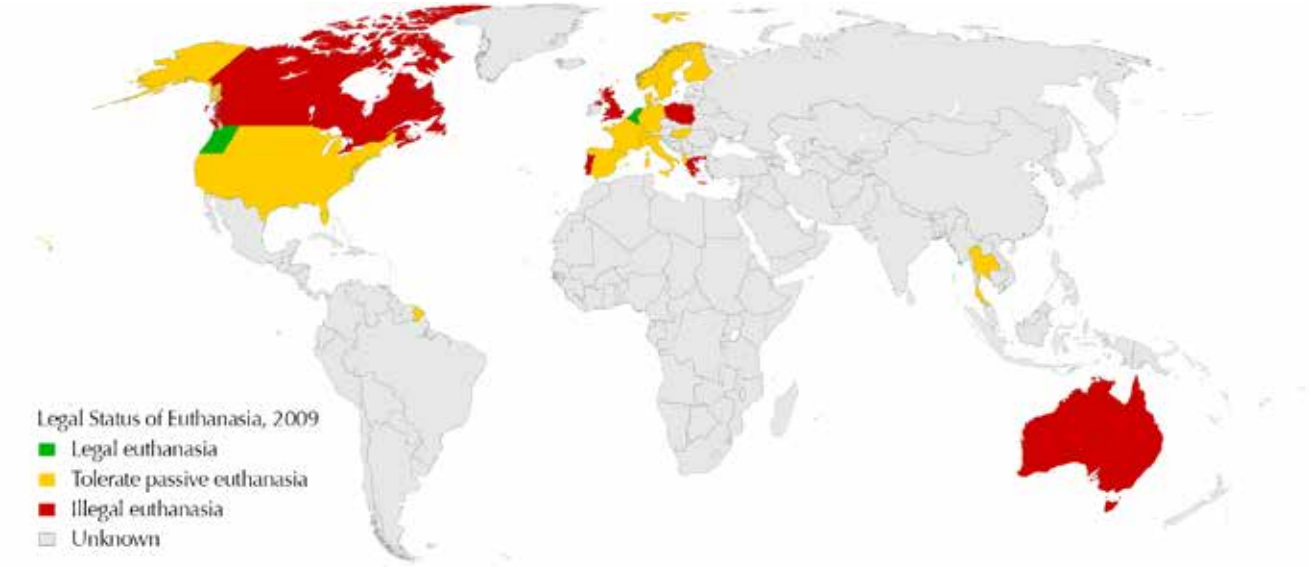
Going Dutch

Four aspects of Dutch society are relevant when considering what has led to open practice and justification of euthanasia in the Netherlands:

pragmatism, cooperation (the Dutch *polder-model*), socialized Calvinism, and autonomy.

Pragmatism

The Netherlands is one of the most densely populated countries in the world. The equivalent of half of Canada's population live in a country that is just a bit bigger than Nova Scotia or about half of the size of New Brunswick. Sixty percent of the population live on polders, pieces of land that have been reclaimed from the sea by completely surrounding an area of water with a dike and draining it with windmills. In other words, a very large part of the Netherlands exists solely as a result of Dutch diligence and tenacity in their fight against the ever-encroaching sea. The Dutch have an expression—"God made the Dutch and the Dutch made the Netherlands"—which summarizes Dutch pride in this feat against nature.



Map Source: Atelier Graphique, France

Examples of Dutch pragmatism abound. When a combination of heavy storms and a spring tide resulted in "The Disaster"—the flood of 1953 when nearly 2,000 people lost their lives and 500,000 were left homeless—the Dutch responded with the Delta Plan: a feat of engineering that controls the inlets of the North Sea and the outlets of three major rivers, and even adjusts ebb and flow to preserve salt beds for mussels. Another example is the Dutch creation of a new polder off the coast of Amsterdam in order to provide some relief to a housing shortage that has resulted in prices for a small apartment in Amsterdam reaching as much as half a million dollars Canadian.

This sense of control, or at least co-creation with nature, is evidenced in medical literature. In 1969, Dutch psychiatrist and neurologist Jan Hendrik van den Berg argued that medical ethics must adjust to changes in medical technology. Before technology, the physician's duty was to "preserve, spare, and prolong human life wherever and whenever he [could]." But with medico-technological power, van den Berg argued, the physician's duty was modified to preserve, spare, and prolong human life only whenever doing so has any sense. In his internationally popular book, *Medical Power and Medical Ethics*, van den Berg also declared that a physician can end a life actively or passively when that life is no longer meaningful.

In their report *Doen of laten?* [*To Do or Not to Do?*], the Dutch Association of Paediatricians turns the question of abstaining from life-prolonging treatment on its head. Instead of focusing

on shortening of life as artificial, the Association points out that what is artificial is prolonging a life that would otherwise end but for the medical intervention. Having engaged the technology and entered into a realm of co-creation, a physician is then obliged to take responsibility not only for ending the life-prolonging treatment when it becomes clear that the treatment was or is no longer justified, but also for assisting with dying when death is the anticipated outcome of ending the treatment.

This theme of controlling nature is not a statement of power but an acknowledgement of the practical interaction between man and nature. The Dutch are clear about their participation in causes and effects.

Cooperation

The importance of what is written in the medical reports should not be underestimated. Dutch society is known for its *poldermodel* of decision making, a cooperative process involving wide consultation and discussion. With a five-hundred year history of compromise between decentralized governments and cooperation in water management, and later, negotiation between multiple societies organized around societal pillars, the Dutch engage in cooperation, coalitions, and tolerance as a second nature. The resulting social and political approach to life has been dubbed the poldermodel, an acknowledgement of the type of close cooperation necessary to create and maintain a polder.

The model is not always successful. For example, coercion can sometimes replace cooperation, and dissent can be discouraged. Nonetheless, the poldermodel way of life continues as an ingrained part of business and political culture, buttressed by a financially egalitarian society. The Dutch like detailed agreements, thrive on organization and planning, and work hard with give and take to reach consensus.

The evolution of policy dealing with euthanasia is an example of the poldermodel in operation. Before the courts even made it clear that euthanasia could be justified with a defence of necessity, medical groups were writing reports that established euthanasia and physician-assisted suicide as reasonable medical practice in the correct circumstance, recognizing that some recommendations involved practices that were outside of the law. In other words, the reports were as much a call for legal reform as they were statements of practice guidelines.

Physicians then worked with legal prosecutors to bring certain test cases, such as the Schoonheim case, to court. The position statements of the medical associations were referenced in judgements, with the courts acknowledging the authority of physicians to collectively determine what constitutes appropriate medical behaviour. Eventually, prosecutors and physicians collaborated on a standards-of-care policy that met the legal precedents established by the courts. State commissions were then established to examine the matter. In a feat of ultimate cooperation between several government agencies, the Remmelink Commission gathered a mass of highly reliable data about euthanasia and physician-assisted suicide in the Netherlands.

In the end, it was interaction among many groups—the medical profession and their associations, interest groups, the government and parliament, state commissions (including the Remmelink Commission), researchers, academics, judiciary, prosecutorial authorities, medical disciplinary tribunals, several political parties, a variety of social and religious organizations, the media, and the public—who determined the norms that permit euthanasia despite proscribing legislation. Even still, cooperation between usually disparate groups continues. This usually involves physicians and prosecutors consulting and working together to resolve how guidelines are to be applied to cases that do not fall within the strict definition of euthanasia.

Socialized Calvinism

One may well wonder how a country that ignores its laws can survive in any peaceful or safe manner. Part of the explanation is what could

be called "socialized Calvinism." Calvinism, a Protestant tradition with direct ties to the Reformation, was embraced by many Dutch as Protestant theology swept through Europe in the 16th century. The Dutch, being a tolerant group, allowed individuals of other faiths to adhere to their own practices so long as the practices were carried out privately. Publicly, only the state church—the Reformed Church, the church that Calvin built—was tolerated. People did not have to be coerced into supporting their church; Dutch life until very recently revolved around their church and church-affiliated organizations.

The Calvinist ethic fosters self-restraint and demands care for the weakest members of society. This particular form of Christianity also advocates a type of individualism, expressed as responsibility for one's service to God and the community. Each individual is accountable for his or her own beliefs and actions. Calvinists are educated and are expected to know what is wrong and what is not. Moral dissonance is not tolerated: what you do, you ought to say that you do. Many Dutch are no longer practising members of the Reformed Church, but the Calvinist sense of rectitude and responsibility is now an ingrained part of the culture, an ethos into which Dutch society is woven.

This attitude explains, in part, why the courts would defer to medical authority on questions of moral practice. It also explains why the Dutch have been as public as they have in examining the euthanasia question. The Dutch believe that euthanasia is practised in many (if not most) countries behind a screen of euphemisms. For the Dutch, the danger lies more in the duplicitous nature of the behaviour than in the behaviour itself. Socialized Calvinism also explains the success of *gedogen*: permitting, living with, and tolerating acts that are officially illegal although arguably morally acceptable.

Autonomy

Socialized Calvinism may also be a contributing reason for the difference between Dutch and Canadian and American definitions of autonomy. The differing interpretations should come as no surprise: philosophers cannot agree on one single interpretation of autonomy, and even challenge the idea that there might be one single Western concept of autonomy.

In our country and the neighbouring United States, *autonomy* is defined as "the capacity to act intentionally, with understanding, and without controlling influences." The concept comes complete with rights language.

In the Netherlands and many other European countries, autonomy refers to an individual's capacity to make and impose moral judgements on oneself. In health care, the Dutch consider autonomy to be the right to participate fully in medical decision making, but not necessarily the right to control the decision. The wishes of patients and substitute decision makers are a central consideration, but may not necessarily dictate the outcome. Capable patients may always refuse treatment or intervention for themselves, but they do not expect the same kind of freedom as Canadians or American might have to make decisions about what treatment they *will* have. For the Dutch, the physician is very much a player in the decision-making process.

In the euthanasia regime, this plays out in three ways. First, while euthanasia is only to take place if the patient makes the request, the patient's request is only the condition precedent. The physician is responsible for a full assessment and for ultimately making the decision about whether euthanasia will take place. Second, when a patient makes a request for euthanasia, his or her request is reviewed not only by the patient's physician but also by a second physician. Granted, there is some concern (which is being addressed) that this second opinion may be perfunctory in that the first physician is likely to request a second opinion from a colleague of like mind. Nonetheless, to cast the Dutch system of euthanasia as a victory for autonomy as Canadians define it and for individual rights is to miss the fact that two physicians have final control over whether euthanasia will take place.

Finally, all deaths that are a result of euthanasia or physician-assisted suicide are to be reported to a committee that reviews the file and decides whether the physician complied with the guidelines or is to be prosecuted for homicide. While not an approving committee like the Canadian abortion committees were, the fact that these reviewing committees exist and most physicians honour their duty to the committees is an indication that the Dutch are comfortable with bureaucratic limits on their decision making. Patients do not complain about the fact that their files will be reviewed by a government mandated committee of professionals. Canadians and Americans would find such a review an invasion of privacy and an invasion of what we might consider a personal decision between a patient and physician.

Bringing It Home

Are Dutch and Canadian societies similar enough that the Dutch system of euthanasia could be successfully imported here? In both countries, individuals enjoy the advantages of an advanced welfare state, including a government funded, comprehensive health care scheme. Poverty or crippling medical costs are not likely to lead to an abuse of life-shortening practices. Adequate pain relief and supportive palliative care is, or ought to be, available to those who need it.

The differences arise with the Canadian confidence in professionals and public institutions. Here and in the United States, access to euthanasia is cast as an argument for the rights of patients. In contrast, the discussion in the Netherlands revolves around the discretion to be granted to physicians.

Physicians in this country often feel (and act) on the defensive, concerned about being labelled killers. Energies are spent drafting policies that guide physicians in avoiding legal confrontations. It is difficult to conceive of Canadians tolerating physician control over decision making about what we generally consider a "right to die," or physicians working with lawyers from the Attorney General's office to bring test cases before the courts and craft applicable guidelines.

Finally, an issue that is beginning to arise in the Netherlands merits consideration in the Canadian context: immigration and increasing heterogeneity. The euthanasia policy in the Netherlands was developed during a time when new immigrants could be folded into the culture. More recently, however, waves of immigration and an influx of foreign workers are challenging Dutch traditions of consensus and tolerance.

It is estimated that within the next two decades, fifty per cent of major cities in the Netherlands will be recent immigrants or their descendants. Many of the new immigrants are not Calvinists, and they are choosing to maintain their own culture in geographical pockets.

It is unclear what effect this will have on Dutch society, but out of fear that their tolerant society is being abused and their resources misused, some Dutch are becoming quite intolerant. As well, the increasing influence of North American style individualism (expressed as individual rights) is finding favour among the younger Dutch and newcomers to the Netherlands, resulting in a breakdown of the historical communitarian ethic.

What Canadians can draw from the Dutch experience is the breadth and depth of the discussion and self-examination undertaken over the thirty years that the Dutch euthanasia policy evolved. The Dutch, both supporters and dissenters of the euthanasia policy, are clear about their position on death, quality of life, and individual responsibility. Canadians are not as clear about what death and dying mean to us.

In an effort to be inclusive of all traditions and beliefs—an effort to be lauded—we have lost track of the values and beliefs that inform our Canadian understanding of death. Health care leaders and critics need to lead this discussion and examination; to be philosophical leaders, digging below the positions and position statements to find the values, traditions, and beliefs that make us who we are in our own cultural context.

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