Dying in dignity: The pros and cons of assisted suicide

RENÉ F. W. DIEKSTRA
University of Leiden, Leiden, The Netherlands

Abstract
This paper describes the historical background and the current situation regarding the practice of assisted suicide in The Netherlands. It outlines and discusses what is considered to be the 'golden standard' of conduct for doctors and other health professionals in this area, it describes experiences with the application of this standard and discusses some of the major pitfalls involved. It also describes the results of several empirical studies on the attitudes of the general public, and the nature and magnitude of the practice of assisted suicide in the country.

It is concluded that although perfect application of the 'Dutch Protocol' encourages and supports careful and responsible professional conduct regarding assisted suicide and provides satisfactory safeguards both for the patients involved, (potential) survivors and society as a whole, there are many cases where the desired perfection is far from feasible, hence assistance with suicide remains very hazardous. It is also concluded, however, that health care policy makers, as well as professionals, should confront the issue of assisted suicide, since, as the historical development in The Netherlands has shown, repression and denial implicates the worst of all possible scenarios, and does not contribute at all to the primordial goals of a humane health care system: the alleviation of suffering and the prevention of premature death.

Key words: death, ethics, euthanasia, suicide.

INTRODUCTION
In the morning of 28 September 1991, in her small hometown in one of the northern provinces of The Netherlands, a 50 year old woman put an end to her life with a number of capsules and the content of a small bottle. Both had been given to her just minutes before by her psychiatrist. At the time of her death, the woman was healthy physically but diagnosed as suffering from a depressive disorder in sensu strictu (DSM-III-R, code 296.23), related to severe traumatization after the loss of her two sons; one by suicide 5 years previous and one as a result of cancer about 5 months previous. Her death, as a consequence of assisted suicide, was reported as such to the legal authorities and the responsible psychiatrist was taken to court; first by a lower court, then by a higher court, and finally by the Supreme Court of The Netherlands in June 1994. The Supreme Court convicted but declined to punish the psychiatrist. In its ruling the court stated explicitly that assisted suicide might be justifiable in the case of unbearable psychic suffering, such as depressive disorders, even in the absence of a physical disorder or a terminal condition. The court also confirmed what had already been ruled in earlier cases, that assistance with suicide can go unpunished, despite the formal code of law that prohibits such assistance, only if carried out under a number of strict conditions. One of these being a second opinion examination of the patient requesting the assistance by another doctor/psychiatrist. Although this condition had not been met in this case, and although the existence of an emergency condition (a mitigating circumstance that was one of the grounds of the lower court's acquittal of the psychiatrist), according to the Supreme Court, was not supported by independent expert evidence, the court decided that no punishment should be applied because of 'the personality of the accused as well as the circumstances under which the assistance had been given'. In other words, the Supreme Court did not see any usefulness in putting the psychiatrist into custody because it saw him as a good person and it (the court) appreciated generally, despite certain omissions, the way he had handled the case.

However remarkable and peculiar this reasoning, the most important implication of the Supreme Court's verdict is, of course, that assistance given by health professionals to the suicide of patients suffering from psychiatric disorders, but who are not ill physically is acceptable and therefore can and should go unpunished, provided certain conditions are met.

Many both from within The Netherlands as well as from outside have fiercely, and often in extreme words, condemned both the psychiatrist's conduct as well as the Supreme and lower courts' verdicts. Ogilvie and Potts cynically asked the question whether one can see here 'the slippery slope in action'? Hendin wrote in an equally loathing way of the 'Dutch Cure' and even went as far as stating that 'if those advocating legalization of assisted suicide prevail, it will be a reflection that as a culture we are turning away from efforts to improve our care of persons who are mentally ill. We would be accepting the view of...
those who are engulfed in suicidal despair that death is the preferred solution to the problems of illness, age, and depression. Is this true? Has The Netherlands and its judicial system been taken over by a ‘pro death’ movement that now threatens to destroy the very first and fundamental values on which the health care and social security systems in democratic societies are and should be based? Have the Dutch gone too far?

The purpose of this paper is to approach those questions from a number of perspectives: historical, psychiatric, psychological and social. It will make clear that the issue at hand is an extremely complicated one that in no way lends itself to absolute and simple pro or con conclusions. It will also show that we are not dealing here with a Dutch issue or phenomenon. In the years to come, all developed, highly industrialized countries with a democratic parliamentary system will have to face, if they have not already, the issue of assisted suicide in more or less the same way as the Dutch are right now.

HISTORY

For those familiar with the history of the public and political debate and the jurisprudence on euthanasia and assisted suicide in The Netherlands, the Supreme Court’s ruling of June 1994 hardly came, if at all, as a surprise. In actual fact, it was more or less the logical climax of a process that was started at least one and a half decades before. Although, as shall be demonstrated later, this process from very early onwards appeared to be rooted firmly in large segments of the society, one man in particular played a major part in its development and direction in the early stages. The name of that man was Dr Nico Speijer, Professor Emeritus of Social Psychiatry at the University of Leiden, The Netherlands, an internationally renowned preventionist in the field of suicidology and an honorary member of The International Association for Suicide Prevention (IASP).

On 28 September 1981, to the day exactly 10 years before the (assisted) suicide mentioned previously, Speijer took his own life. He was 76 years old at the time and suffering from a severe and, on the short term, fatal form of cancer. As he explained in his suicide note to the author, for whom he had acted both as teacher and mentor in suicidology, he wanted to die in dignity, at a time and place and in a way chosen and implemented all by himself, instead of letting himself ‘degrade’ into a situation in which he could become totally dependent upon the mercy of others. Nico Speijer did not die alone, his wife decided to die with him. Although her health was not perfect, she did not suffer from any serious illness. Her motive for suicide was first and foremost an interpersonal one. She chose, as she put it, not to survive the man she had loved and lived with for the best part of their lives.

Being a man of nationwide reputation, Speijer’s suicide and the suicide of his wife made the headlines. In general, the reaction of the public and the media was one of understanding, of sympathy and respect. In the commentar-
and doctors. Speijer and I discussed and evaluated the case in two small conferences with other mental health experts, particularly with regard to possible treatment alternatives. We also had the patient visit two psychiatrist colleagues for diagnostic evaluation.

Eight months after I had seen him for the first time, he put an end to his life in what he in his suicide note described as 'the best possible of all ways'. After his death we decided to make our extensive file on the case available for the legal authorities, should they wish to access them, which they, for reasons that have remained obscure to this day, happened not to do.6

The main emphasis in Assisted Suicide, apart from a discussion of historical, ethical, legal and professional aspects, is on the formulation and implementation of a set of criteria and rules of conduct to be met/followed by health care professionals in cases of assistance with suicide. Immediately upon their publication, these criteria and rules of conduct became the subject of intense public, professional and legal debates. Some of the subsequent arguments introduced made the authors decide to reformulate some of these guidelines slightly, but certainly not on essential or principal aspects.

It was Speijer's outspoken wish, expressed by him a couple of weeks before his death, that these modified criteria/rules of conduct should be published in a handbook on suicide prepared by the present author. Three weeks after the death of Speijer the book was indeed published.7

In December of that same year the first lawsuit for a century for a case of assisted suicide took place. A female lay volunteer was brought before the Court of the District of Rotterdam because she had helped an elderly woman and former psychiatric patient to die by feeding her at her request chocolate custard in which barbiturates had been mixed. During the trial a number of expert witnesses were called, among them the author. The court convicted the volunteer and sentenced her to a suspended imprisonment.

Of crucial importance for future jurisdiction were the arguments on which the court based its sentence. In short, the court expressed as its opinion that the female volunteer had not provided the assistance with suicide in compliance with what could be considered professionally and socially (i.e. prejuridically) acceptable criteria and rules of conduct. In this respect the court followed the plea by the district state attorney who had referred explicitly to the criteria and rules of conduct published by the author, had taken 'the measure' of the female volunteer's proceedings using the yardstick of these criteria and concluded that she had not acted carefully and appropriately enough in this case. Of course, the volunteer as such could never have acted carefully and appropriately enough given these criteria, simply because one of the criteria is that assistance with suicide should only be provided by a certified health professional.

The clear-cut implication of the court's verdict was that if assistance with the suicide of a person who is not physically ill but suffers from (subjectively) unbearable mental agony is provided by a health professional in accordance with the published criteria and rules of conduct that professional might not be prosecuted, respectively the act might go unpunished. As a matter of fact the Supreme Court's verdict of June 1994 is hardly anything else but a reaffirmation of the ruling by the Rotterdam Court in December 1981, with one important difference: although the psychiatrist in the 1994 case did also not comply with all of the criteria and rules of conduct and therefore was 'guilty', he went unpunished.

Since 1981, jurisdiction throughout the country has complied with the ruling of the Rotterdam Court. No health care professional who has been reported to the authorities as having assisted with suicide, whether in case of physical or of psychiatric illness, and who carefully observed the rules of conduct, has been prosecuted or convicted; in spite of assistance with suicide being punishable by law in the formal sense. The Dutch code of law contains an article that threatens to punish assistance with suicide by imprisonment of a maximum 3 years. This makes it all the more pressing to answer the question of on what normative grounds the Rotterdam Court felt itself justified to set aside or how it could interpret the formal code of law in such a way as to make allowance for assisted suicide on certain conditions?

PREJURIDICAL DEVELOPMENT AND PUBLIC ATTITUDES TOWARDS SUICIDE

One of the chapters in Assisted Suicide describes a study on knowledge and attitudes towards suicide and assistance with suicide among the general public.8 The study comprises two general population surveys; one undertaken in 1975 and one in 1979. The conclusions from these surveys were that (1) over the period there had been a shift towards a greater acceptance of assisted suicide among the general public, (2) by 1979 the majority of the population was in favor of making assistance with suicide no longer punishable by law provided certain criteria are met and (3) the majority of the population rejected the establishment of special 'suicide assistance' teams or 'euthanasia' institutions and appeared to be in favor of having health professionals, and only health professionals, provide such assistance. Clearly then, the verdict of the Rotterdam Court did not come out of the blue but reflected the prejuridical development towards greater permissiveness in the population regarding assisted suicide.

The data from the 1975 and 1979 surveys also revealed another important fact. A large minority of the population tended to confuse assisted suicide with euthanasia (i.e. the killing of a person at his/her spoken request by a third party), or had difficulty in making an appropriate distinction between the two. Interestingly, this confusion was not dealt with adequately in the Rotterdam case and it may even have added to the confusion, since the feeding of barbiturates, very closely resembles common methods of euthanasia (injecting a lethal substance). In the arguments justifying its verdict, the Rotterdam court did not pay sufficient attention to this important issue, therefore implying that it
does not make much of a difference who ends the life of the patient once other criteria are met. This difference, however, can be psychologically as well as socially of enormous importance. It can even equal the difference between life and death.

What the court of Rotterdam had left unclarified or undecided, unfortunately, has also been left untangled and unclear in jurisprudence ever since. Consequently, it can still happen that patients are killed, be it at their own request, by doctors, while they (the patients) are able to kill themselves but are unwilling to do so and would possibly have stayed alive for a longer or shorter period, had the doctor not done what they themselves refused to do. If there is somewhere in The Netherlands a slippery slope in action, as Ogilvie and Potts put it, it is first and foremost here. \(^2\) Before going to discuss this and related aspects, and before describing in more detail the definition, the criteria and rules of conduct for assisted suicide as formulated in Assisted Suicide and On Suicide, as well as the principle where they are based upon, it is of importance to point to an other remarkable phenomenon that took place at the time. \(^6,7\)

The publication of Assisted Suicide, the attention paid to the suicide of the Speijers, as well as the verdict of the Rotterdam Court had another, unexpected consequence. Mental health care agencies and professionals all over the country as well as telephone emergency services and the telephone service of the Dutch Society for Voluntary Euthanasia, were suddenly contacted by persons, particularly males, who appeared to carry a very high risk for suicide. The reason many of them gave for seeking contact with those services was that they assumed that now finally assistance with suicide had become officially approved, and expected that health care professionals would indeed be prepared to provide them with the drugs they needed or wanted in order to kill themselves. Although the vast majority of them, with a few exceptions, inevitably had to become disappointed in this respect a favorable 'side' effect of this development was that quite a few of them entered treatment of one kind or another that in all probability has prevented their suicide. Therewith one of Nico Speijer's major of this development was that quite a few of them entered treatment of one kind or another that in all probability has prevented their suicide. Therewith one of Nico Speijer's

Of course, the influx of such helpseekers taxes heavily upon the competence and hardiness of health care workers because of the complexities involved in their treatment and the difficulties in redirecting their focus from waiting to die and towards the 'reuptake' of life.

Nevertheless, the increased proportion of high risk suicidal persons among mental health care patients, a development that has been sustained until today, appears an important suicide prevention opportunity created by the opening of the avenue of assisted suicide, however paradoxical this may seem.

**DEFINITION, CRITERIA AND RULES OF CONDUCT**

In Assisted Suicide the authors make clear that allowing for assisted suicide within the health care system does not at all imply 'promotion' of suicide nor does it testify to a general failure to prevent suicidal deaths. Suicide, as they assert, is by itself not a euthanasia, a good death. On the contrary, in the light of the available empirical evidence, a large majority of suicides are to be considered sorrowful, deplorable or even 'evil' deaths. Most suicides appear to be preventable because there usually are means and methods available for improving the quality of life of the suicidal persons involved to such a degree that life might become worth living (again).

It cannot, however, be denied, both from an empirical as well as a subjective point of view (i.e. from the point of view of the subject's experience), that a certain percentage of suicides (estimates vary from 5 to 10% but have to be taken with great caution) \(^6\) should indeed be considered 'eu-thanatoi', good deaths. There will probably not be much disagreement within the health care system about this assertion when it concerns persons who suffer from a chronic, incurable physical illness or who are suffering from a terminal condition. But there is, and there will continue to be, much disagreement when it concerns persons who are not physically ill in sensu strictu and who are not suffering from terminal condition, but who suffer from a chronic or episodic psychic disorder. Even if that disorder, time and time again, tends to profoundly disrupt their subjective wellbeing and social and interpersonal functioning, and even if there are no empirically substantiated alternatives to suicide available that can eliminate or diminish the (repetitive) unbearable emotional/psychological suffering of those persons to a subjectively acceptable degree, there still, and understandably will be, great reluctance towards the acceptance of assistance with suicide.

Apart from ideological/religious convictions, two of the most common arguments by psychiatrists and psychologists against assisted suicide in such cases are (i) that the suicidal inclination might be a symptom or a manifestation of the psychic disorder itself and therefore the person requesting the assistance cannot be assumed to be in the possession of his/her full mental capacities or to be compos mentis at the time of the request and (ii) it is highly unlikely that all available treatment alternatives in the realm of psychopharmacotherapy or psychotherapy have been tried long enough and adequately enough.

These objections have to be taken very seriously, empirically as well as professionally, and the authors of Assisted Suicide did consider them both in their definition of and their criteria for assisted suicide.

**Definition**

In Assisted Suicide the following definition is given: 'Assisted suicide is when someone deliberately performs or refrains from actions towards another person at this latter person's request, in order to enable this person to implement his/her
decision, taken voluntarily and composit mentis before the request was made, to end his/her own life in a manner determined and desired by him/herself, and when the death occurs in the desired way indeed.'

This definition has a number of important implications. First, it makes no distinction between physical vs psychic illnesses or disorders (nor does it specify, as has already been stated above, that the person making the request for assistance does need to be suffering from a terminal condition). This is a very important point, because terminological and conceptual confusion with regard to euthanasia and assisted suicide abounds among the public, politicians, policy makers, and health professionals. The term euthanasia is most often used to mean either that (i) a physician ended the life of a person who suffered from an incurable physical illness and was in a terminal condition, or (ii) that a physician provided a person in such a state with the means to end this life by his own hand. The latter, however, despite the presence of physical illness and terminal condition is assisted suicide and should therefore also be recognized, labeled and registered as such. The difference between assisted suicide and euthanasia (if meant to refer to the ending of a person's life at the request of that person by another person) lies in the fact that in the former the person is capable and willing to end life his or herself, and that in the latter the person needs and/or wants others to do this ending for him or her.

The authors of Assisted Suicide put forward the opinion that euthanasia in this sense is only then justified, professionally and psychologically, and only called for if the person in question is actually unable to end his life himself. If the patient is capable of doing this but opts to ask someone else to do it, then it is judged to be unacceptable for the helper to comply with the request. What the authors had in mind when stressing this point was that a physician should never terminate the life of a patient at his or her request if the patient is capable of doing it but refuses to. The great danger they foresaw here is that doctors gradually would be put in the role of 'the great justifiers' and in many instances become the actual 'cause of death'. They feared a development in which both individual patients as well as society in general would 'medicalize' assisted suicide, turn it into euthanasia, and therefore avoid taking responsibility for what is, in essence, an individual and social and not so much a medical issue using the justification that 'if the doctor approves of it and also does it, we can rest assured that it is all right'.

Speijer and Diekstra also pointed out the possibility that the person who wants to end life, although physically capable, has emotional and moral barriers against perpetrating the life-ending act and therefore wants to pass on this responsibility to someone else. From the 'working through' of these emotional and moral barriers may emerge motives or insights that might make the person decide to stall or even discard the decision to end life, for the time being.

In addition, the authors pointed to numerous experiences showing that making euthanaticum available to patients to enable them to take their own life, when and in circumstances they choose, does foster feelings of selfcontrol and personal autonomy and may make the pain and suffering more tolerable so that death could sometimes be postponed or delayed, and consequently life prolonged. The following example clearly illustrates this. Mr L had an advanced stage of cancer. It was estimated that he had at the most 6 months to live, but probably considerably less. He was a 69 year old former civil servant and was described by one of the his children as being a rather authoritative and stubborn man who, since his retirement, had developed a somewhat defeatist attitude towards life. Even before his illness had been made known to him, he had expressed that he felt his life to be useless. His wife knew about the nature of his illness before he did and she was the one who told him about it. The nature of this conversation and of later talks was described as being open and useful. Shortly after being informed about the nature of his disease, he stated that he would rather end his own life by taking medicine. The reasons he gave for this were that he felt life had become useless, he found the impending degeneration of his body unbearable, he could not bear the thought of becoming dependent upon someone else (a physician) regarding the choice over his own life and death and he was apprehensive about burdening his wife with the responsibility of nursing him during his final stage, something which he had seen happen to others. Also he refused to use painkillers in high dosage, because he did not want to doze away most of the time.

One of his sons was a doctor, but wanted no part in his father's decision, although he had no problems with a premature end to his father's life. The general practitioner made it clear that he wanted to give 'passive assistance' at the most, for instance by not prescribing medication in the case of pneumonia. He was unwilling to provide medication that would enable the patient to commit suicide.

Other family members also had no strong objection to the father's decision, but his wife felt that the moment for him to die had not yet arrived. The reason she gave was that she felt their relationship was good and still rewarding. The same held true for the relationship between Mr L and his children. His wife also felt that despite her husband's condition there still were plenty of rewarding opportunities for him to participate in family life. However, the family members were afraid that the definitive refusal by all physicians approached to provide him with the means to put an end to his life, could result in Mr L using 'hard' or dangerous methods (such as killing himself by a car accident). But they also felt that forcing him to live out his illness to the very end, would mean an unbefitting death for him.

From this description, it may seem obvious that we are dealing with a clear-cut, individual problem (serious/lethal physical illness) that, taken on its own, could easily lead to the conclusion that there exists every reason for suicide. If we look at the situation from an interpersonal angle, we find that this man is still important to his family, that his death would mean a serious and still premature, loss to them. Seen in this light, suicide and possible assistance with it appear
more problematic. If we look at the case from a societal angle, the image shifts again. The death of Mr L would not constitute a severe loss to society in general, at least not economically; after all, he was retired and was hardly socially active in other positions. In addition, refusing to provide the desired assistance could result in negative effects, such as prolongation of his suffering, resorting to harder or more brutal suicide methods, which could also endanger or have emotional traumatic consequences for others, for example for those confronted with his body after an accident.

The question whether assistance with suicide is justified in this case therefore cannot be answered with an easy 'yes' or 'no'. This uncertainty has nothing to do with the question of whether assistance with suicide should be given to this man at all, but when this should be done. This was clearly shown. His wife, at our instigation, told him that she felt it too early for such a final step, and that according to her he was still in a good enough condition to carry on with life for a while, and that she could not miss him yet. He replied that he was glad she had told him so, he was glad that he was still needed, and that he was willing to postpone the decision to the moment when he truly could not go on any longer. But he also stated that he did consider it extremely important to receive the assurance that he would be given the desired medication when that moment arrived. When this assurance was given to him, he not only relaxed enormously but also proved to be able to perform a positive role in the family for another 2 months.

In effect the assistance given was twofold. First, psychologically, by acknowledging the acceptability of his request for assistance, mobilizing communication with significant others about this request, and giving the man the assurance that the desired suicide method, when needed, would indeed be provided. This made it possible for the agitation and the anxiety he suffered to diminish and enabled him with to participate in family life in a constructive way in the time he had left. Second, technically, by providing him with the suicide method when the time came. Clearly, assistance with suicide in this case not only prolonged but also increased the quality of life of the helpseeker and others, during that period of prolongation.

The justification for promising and giving the assistance in this case were the following. First, he had asked for this assistance directly and voluntarily, that is to say without outside pressure. Second, his desire to end his life in this way was an enduring one; not a whim, not something that would

### Criteria and rules of conduct

The criteria and rules of conduct for assisted suicide formulated in the definition and guiding principles described previously are shown in Table 1 and will be elaborated upon in the following.

The decision to assist with a suicide requires very careful consideration and examination of a number of characteristics of the suicidal person and his/her situation/condition.

1. The (suicide) help has to be asked for voluntarily and explicitly by the suicidal person. The request has to be personally (face-to-face) addressed to the potential helper, who should be a qualified/certified health care professional.

2. The helper has to establish (by a reliable method) that the person is compos mentis at the time of the request. This means that the helper should have asked for a second opinion (collegial examination of helpseeker as well as intercollegial consultation) with regard to the mental state of the suicidal person. It is of crucial importance here to note the following considerations. The desire to end one's life should never per se be taken as sufficient proof of mental illness. It might be a symptom of a florid mental disorder.

### Table 1. Assisted suicide criteria

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<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Request made voluntarily and directly by patient</td>
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<tr>
<td>2</td>
<td>Patient compos mentis at time of request</td>
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<tr>
<td>3</td>
<td>Wish to end life is longstanding</td>
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<tr>
<td>4</td>
<td>Presence of unbearable suffering (subjective)</td>
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<tr>
<td>5</td>
<td>No reasonable perspective of improvement (objective)</td>
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<tr>
<td>6</td>
<td>Remaining treatment alternatives uncertain/only palliative (offered but rejected)</td>
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<tr>
<td>7</td>
<td>Helper is acknowledged professional</td>
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<tr>
<td>8</td>
<td>Helper has used intercollegial consultation (about points 1–6) (patient has been seen/examined by colleague(s))</td>
</tr>
<tr>
<td>9</td>
<td>Avoidance of preventable harm/damage to others</td>
</tr>
<tr>
<td>10</td>
<td>Decision-making process and steps taken documented for professional and legal evaluation</td>
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and it might not. The fact that the person concerned has (had) a psychiatric diagnosis does not necessarily imply that the psychiatric diagnosis and the suicidal inclination are related causally. Finally, where the two are related, it might sometimes still be the case that the suicidal wish has a solid empirical base. An estimated 10 to 15% of all cases of severe depressive disorders are not amenable to available methods of treatment and patients suffering from such disorders might, after many years and modalities of treatment, come to a realistic assessment of their prognosis. If the only possible way to prevent death by suicide of someone who is not psychotic or mentally retarded is by 'psychiatric imprisonment', assisted suicide might be considered the 'least of all possible tragedies'.

(3) The wish to end life should be an enduring one. This criterion is of utmost importance. The very fact that a person expresses the wish to end life is in itself never a sufficient justification for assistance with their suicide. Many conditions/situations that evoke suicidal tendencies are transient and many suicidal tendencies are transient, even in stable (unfavorable) conditions. The helper should, therefore, ascertain that the suicidal inclination of the person concerned has been present for many months (at least 6) and its presence should have been continuous during that period. In addition the helper should make sure that the suicidal wish is not associated exclusively with a specific condition (such as a depressive episode) that in the past has been proven to be amenable to intervention.

(4) It is of paramount importance (4 and 5) that the helper 'has had established' that the suicidal person suffers unbearably (subjective statement) and that there is no reasonable chance for improvement (objective evidence). This implies that both the helper and informed others/colleagues (called in for consultation) have assembled evidence that (a) the person concerned experiences suffering as unbearable (repeated statements with such a content suffice) and (b) neither the helper nor at least one other health professional with expertise relevant to the suicidal person's condition have been able to identify accessible and acceptable methods/treatments for reducing his or her suffering to any significant degree (or have ascertained that significant reduction of the suffering leads to a significant and unacceptable loss of quality of life). It is acceptable, and even obligatory, as shall be seen later, for a helper to point out or offer to the suicidal person possible alternatives to suicide and even to confront the suicidal person with the statement that no assistance with suicide can be given unless these alternatives, if scientifically substantiated, accessible and practical, are tried adequately. Health professionals, however, should be aware of an important ethical dilemma involved when offering possible alternatives to suicide; might it not be ethically dubious and professionally questionable if a helper demands a suicidal person try all possible alternatives to suicide but still refuses any involvement in assistance with suicide even when all these alternatives are tried by the patient long enough and seriously enough but without tangible results? Speijer and Diekstra* answered this ques-

tion in the affirmative, but others do not. Recently, however, the Chief Inspector for Health of The Netherlands wrote a public letter 10 in which he supported the position expressed by Speijer and Diekstra stating that physicians not willing to provide assistance with suicide in any way to one of their patients requesting such assistance and meeting the criteria outlined in Table 1, are at least obliged to provide this patient with information about where they can find a physician that might be willing to provide the assistance requested. In case the physician would refuse also to provide such information disciplinary action (by their professional organization) should be taken against them.

(5) The helper must ascertain that, wherever possible, preventable harm or damage to others as a consequence of the suicide is prevented. This means, among other things, that those near and dear to the suicidal person are, as much as possible, adequately informed and prepared. The helper has an important role to play both in raising the awareness of the suicidal person regarding preventable emotional, social and practical consequences for survivors and in assisting both the suicidal person and survivors in dealing with and communicating about these issues.

(6) The helper has to keep a detailed record of the whole assistance process, and to make the record accessible for legal and professional evaluation afterwards.

THE PRACTICE OF ASSISTING SUICIDE

In order to assemble information and experience with the criteria outlined and to prevent mistakes, under the auspices of the Dutch Association for Voluntary Euthanasia and the Dutch Humanist Association a committee for assistance to health care workers who are confronted with a request for assistance with suicide was established in 1982. This committee consisted of a lawyer, a psychiatrist, a clinical psychologist (the author), a professor of ethics, a pain-treatment specialist and a 'normal' citizen. The committee existed for 6 years and in these years the committee was consulted by many health care professionals. The procedure of assistance was as follows. Whenever a health professional (such a medical doctor, a psychotherapist/clinical psychologist) wanted to consult the committee, a questionnaire was sent to the professional asking for detailed and well-documented information on all criteria/rules of conduct. On return of the questionnaire the committee arranged a meeting with the professional. At this first meeting the case was discussed in detail, including the emotional involvement of the professional with the helpseeker. Usually the committee identified a number of blank spots or 'unknowns' in the information that the professional had made available and requested additional data collection and second opinions. In a second meeting the committee formulated advice and outlined a procedure to be followed by the professional.

In the majority of cases, applying the criteria as outlined in Table 1, the committee's advice was not to assist with suicide but to explore and to offer alternatives to suicide. In all those cases it appeared that this advice was accepted by
both the professional and the patient (who was never seen by the committee).

Paradoxically, the opportunity to discuss openly and explore the pros and cons of assistance with suicide as a problem-solving device (both for the professional with the committee and for the helperseeker with the professional) can have a preventive effect. It is of importance to note that almost all cases involving persons with a severe mental disorder (about 30% of all cases presented) for which the committee was approached, fell within this category. The members of the committee often were left with the impression that had the professional not been given the opportunity to consult with others about potential assistance with suicide, he or she might have provided such assistance, not because no alternatives to suicide were available but because of a certain type of emotional involvement in or commitment to the patient. Sometimes it turned out that the professional had, so to speak, prematurely translated his or her own feelings of powerlessness or helplessness with regard to the patient's condition into the rationality or even the unavoidability of the patient's suicide.

There have, however, also been cases in which the committee concluded that providing assistance with suicide by the health professional was acceptable and in all likelihood the least of all possible tragedies according to the criteria used. In all those cases the assistance was provided. A few of those cases involved persons who suffered from a chronic mental disorder while no physical illness (in the usual sense of the term) was present. In follow-up discussions after the suicide, it became very clear that assistance with suicide taxes very heavily the emotional resources of the health care professional. It is not so much the technical aspects (making drugs available) but rather the process of accompanying the suicidal person (almost) until the moment of death, the preparation of survivors, the fear of making an irrevocable mistake despite consultations with and guidance by knowledgeable others, as well as the fear of being held liable and possibly prosecuted despite careful observation of the rules of conduct, which place a heavy emotional burden upon the professional. Most health care professionals that 'appeared before the committee' were ill-prepared and badly trained for coping with such tasks. In addition, afterwards, they themselves often manifested all the signs and symptoms that are usually observed among survivors of suicide.

**EPIDEMIOLOGY OF ASSISTED SUICIDE**

In the period 1982 to 1990, around the period during which the committee was active, the issue of whether formal law with regard to assisted suicide should be changed or not, remained at the forefront of public, professional and political debate in The Netherlands. One of the reasons for this was that the divergence between the attitudes of the large majority of the public and health professionals on the one hand and the formal code of law and the attitudes among the leaders of the ruling political party (Christian Democrats) on the other appeared to be widening steadily. More and more doctors and other health professionals confessed that they had helped patients to die. Many of them also admitted that they purposely had 'cheated' on the death certificate, often indicating that the patient died a natural death while in fact the death was a suicide with assistance or a death brought about by the doctor at the patient's request. Most associations of health care professionals in the country held the opinion that indeed formal law should be changed in this respect because health care professionals could never be completely assured that they would not be prosecuted or punished, even if they had carefully followed the rules of conduct mentioned above. This position was supported by the left wing and liberal political parties. But efforts to 'sail' a new law through parliament continued to fail.

A first step to resolve the legal and political impasse resulting from these opposite points of view was taken when the Cabinet of Ministers in 1989 decided to undertake a countrywide study of what can be phrased as the epidemiology of euthanasia (ending life by a third person at a patient's request) and assisted suicide. The results of this study on the nature and magnitude of these practices were published in 1991 and the ongoing debate on euthanasia and assisted suicide received a major impetus from it.11

The political, legal, social and professional implications of the conclusions from this study did not stop at national borders but had their effect in other countries as well. It is for that reason that the design and main results of the study will be summarized briefly.

**The study**

The Dutch government study on medical practice regarding euthanasia and assisted suicide used retrospective and prospective data provided confidentially by a national representative sample of 406 general physicians, medical specialists and nursing home physicians. The data were collected by personal interview, by assembling data on a sample of cases of death among the physician's patients in the months preceding the interview, and by collecting information on all cases of death that occurred among the physicians' patients in the period of 6 months following interview. Altogether information was obtained on 7400 deaths.

The three most salient conclusions to be drawn from the study were the following (Table 2). First, both euthanasia and assisted suicide were not practiced as frequently as has been supposed hitherto by many, in particular by those critical of the 'Dutch euthanasia culture'. An estimated 2300 cases or 1.8% of all deaths in the country in 1990 can be considered to be the consequence of active euthanasia carried out by or under the supervision of a doctor at the patient's request. In addition, approximately 400 deaths (0.3% of all deaths) are the result of physician assisted suicide. Second, although the majority of all doctors (54%) have carried out at least one euthanasia or have assisted with suicide, two out of every three requests were denied. Third, it seemed that in almost all cases of euthanasia and assisted suicide doctors do
Pros and cons of assisted suicide

Table 2. The epidemiology of euthanasia and assisted suicide in The Netherlands, 1990

<table>
<thead>
<tr>
<th></th>
<th>Total no. deaths</th>
<th>Percentage of all deaths</th>
<th>Percentage of doctors ever assisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euthanasia</td>
<td>2300</td>
<td>1.8</td>
<td>54</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>400</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Any medical decision re. life termination</td>
<td>40,000</td>
<td>38</td>
<td>Regional differences</td>
</tr>
</tbody>
</table>

comply with the rules of proper professional practice and conduct.

These findings led the Cabinet of Ministers, under the guidance of the Minister of Justice and the Secretary of Health, to conclude that the present situation in The Netherlands in this difficult and sensitive area can be judged to be 'not unacceptable'. They therefore opted for a policy that consolidated the present situation. On the one hand, their proposal is that the laws prohibiting euthanasia and assisted suicide should not be changed because the existence of such laws may have a deterrent effect on those who otherwise too hastily or, for improper reasons, might be inclined to practice direct or indirect measures to shorten the lives of their patients. On the other hand, they issued a ministerial decree containing a set of rules for the practice of euthanasia and assisted suicide that, if complied with, will protect physicians against prosecution by the state.

The reactions to this policy (which in essence is a party-political compromise) has been predominantly negative, although the arguments put forward vary and can roughly be placed into two opposing categories. There were those, such as the Royal Society of Medicine and the Dutch Association for Voluntary Euthanasia, who feared that as long as there exists a code of law formally forbidding euthanasia and assistance with suicide, ambiguity, uncertainty and fear will be the helper's and the helpseeker's lot notwithstanding the presence of a ministerial decree protecting the doctor under certain conditions against the threat of prosecution. For, they argue, a change of cabinet or a change of minister may be accompanied by a change in policy in this area and repeal of existing decrees. But, more importantly, they point out the absurdity of the situation that an act that is formally and principally judged inadmissible, in thousands of cases in actual fact is considered admissible because it is carried out in ways that are not judged as being morally or professionally wrong. Their conclusion is that either the laws should be changed in such a way as to make provision for 'legal' euthanasia and assisted suicide or removed completely from the law and that it be left to professional organizations to draw up a golden standard of conduct in this area.

Another important argument is that legal examination of a case of assisted suicide is always 'ex post facto', after the assistance has been given and the death has occurred. It would be much less threatening, and much more reassuring for helpers, if such an assessment be made beforehand, without excluding the possibility of a legal assessment afterwards. Such a prior assessment would have to be made, however, not by the judicial system, but by a professional body. Therefore, there have been recent calls for the institutionalization of standing committees like the one described previously in this paper.

However, there are those, such as a minority within the Royal Society of Medicine and several right to life organizations, who believe that (physical) life should be protected at all costs and that every move towards a more permissive stance in this area will be a step on the slippery slope that will in the long run end in creating a society where human life will be easily ended, for economic, political or interpersonal reasons, it will no longer be considered useful or desirable. Such a position, however, if forced upon all citizens and prohibiting assistance with suicide for everybody at all costs, exists and will be even more so in the near future, precisely because of the reasons and the experiences described in this paper, judged upon not only as inhumane and careless, but also as an unacceptable impediment to the right of self-determination and to living and dying in dignity.

CONCLUSION

The future of death and the death of the future

It seems the cultures of developed democracies around the world are in need of re-evaluation of suicide. The dark clouds of secrecy and evil which have surrounded this death for so long are slowly forced away by the insight that suicide cannot be pushed aside any longer. We are forced into this almost despite ourselves. The increased control gained over biological life because of the progress of medical science and technology makes a confrontation with the subject of suicide inescapable. After all, we are capable of prolonging biological life to beyond the point where life, in a psychological and social sense, may become experienced as meaningless. With the increase of the control over life, the questions as to the meaning of prolonging life will increase accordingly. Concomitantly, more and more often the question will be asked whether life or death is the most humane choice. However, as paradoxical as it may seem, the increase in human ability to control the length of life will make self-chosen death (suicide) one of the most important and most preferred ways of death of the future. This in turn will cause a fundamental change in our view of human life and our concepts of normality and morality and force upon us a fundamental change in attitudes towards suicide. The issue will no longer only be which suicides can and must be prevented, but also which suicides can and must be 'advented' (i.e. allowed for, permitted and cared for). In the latter sense, assistance with suicide will one day become a 'normal' form of care, within the health care system. There are, of course, considerable risks attached to this development. Maybe the most import-
The greatest danger involved in such a policy, and one that already is manifesting itself in countries that are rather 'progressive' in this area, such as The Netherlands, is that society will become more at ease with one human being, such as a physician, terminating the life of a fellow human being, rather than with empowering the latter when suffering unbearably and without prospect of improvement, to end life him or herself at a time, place and manner self-determined and judged as dying in dignity.

Faced with the choice between euthanasia, in the sense of the termination of somebody's life by another person, and assistance with suicide, the most humane, reasonable and respectable choice is for the latter. Not only in spite of but as a result of such a choice, chances will be highest that no life will be lost before its time. For, as the experience in The Netherlands shows, if a society acknowledges suicide as a viable solution or coping strategy with problems of life under certain conditions, then health care systems of that society make themselves more approachable and attractive for those who consider suicide; erroneously, the only way out of their plight. Therewith, we maximize our preventive potential indeed.

REFERENCES