

Euthanasia in the Netherlands: human rights, human lives

Introduction

There can be few subjects which touch the twin human rights issues of the rule of law and the right to life more deeply than euthanasia. And yet, in a leading European Union country which vaunts its own commitment to the principle of human rights, euthanasia is widely and openly practised, even though it is against the law.

The Dutch capital, the Hague, was the place where the first steps were made towards establishing a system of international criminal law. Now, the Dutch capital is once again in the vanguard, as it hosts the International Criminal Tribunal for the former Yugoslavia, the court which is expected to give rise, in time, to the International Criminal Court with universal jurisdiction.

Despite this, there are serious grounds for concern that the internationally famous Dutch toleration of euthanasia contradicts the very principles to which the Dutch have proclaimed themselves attached for a century. The Dutch parliament is currently considering a bill to bring the law into line with a quarter of a century of official toleration of euthanasia. However, even this regularisation of the legal situation leaves open the more fundamental issues of the right to life and its potential infringement.

A history of Dutch euthanasia

The Netherlands is one of the most self-consciously secular and progressive countries in the world. It is notorious for having pushed back the boundaries of accepted morality on matters like drugs and sex, and its largest city, Amsterdam, is famous the world over for its live sex theatres and for the open consumption of cannabis. The same attitude applies to euthanasia and to the related question of assisted suicide. The Dutch often argue that they are prepared to debate matters which are elsewhere taboo – even though euthanasia and assisted suicide are very often discussed in other countries, only with the result that most countries come to the opposite conclusion from the Dutch.

A landmark in the euthanasia debate came in 1969, with the publication of *“Medical Power and Medical Ethics”* by J. H. van den Berg. The author argued in favour of voluntary and involuntary euthanasia: he also said that society should shake off the shackles of the past and embrace new moral values. Van den Berg did not flinch from pushing his theories to the limit, such as when he called for the killing of elderly demented people. (Such theories were not advanced in the Netherlands alone: similar arguments were advanced in the article in *California Medicine* from 1970, reprinted below.)

The book sparked a lively debate which has continued ever since, with the proponents of euthanasia demanding, and obtaining, ever greater concessions. In 1973, a doctor put an end to her mother’s life and was given a one week suspended sentence: ever since then, the practice of euthanasia has been officially tolerated in the Netherlands, albeit within a legal grey area.

In 1982, a State Committee on euthanasia was created. Composed of medical and legal experts, it laid down guidelines for euthanasia and assisted suicide. The following year, the first attempt was made to remove the criminal provisions against euthanasia and assisted suicide from the Dutch legal code. Attempts were made again in 1986. Like previous attempts, it failed but the practice continued along the guidelines laid down by the State Committee. Tens of thousands of people have been given euthanasia in this period.

Now, for the first time in decades, the parliamentary majority contains no Christian Democrats. The government is therefore moving to pass legislation which would bring the legal position into line with the practice. It is therefore expected that, by this autumn, the Netherlands may be the first country in the world formally to legalise euthanasia.

The present legal position

The present legal position, like the present Dutch practices, is ambiguous. From the purely legal point of view, both euthanasia and assisted suicide are illegal. However, even the law recognises euthanasia and assisted suicide as lesser crimes than murder, which is not the case in most other countries or in international human rights law. The sentence which apply to euthanasia and assisted suicide in the Netherlands are markedly lower than those which apply to murder, for the simple reason that Dutch law does not consider these acts to be murder. Adherents of the argument that even partially permitting euthanasia leads down a "slippery slope" to uncontrollable abuses might well locate here, in the Dutch criminal code itself, the beginning of the that slippery slope.

Article 293 of the Dutch penal code states, "He who, on the explicit and serious desire of another person, deprives him of his life, will be punished with an imprisonment of up to 12 years or a fine in the 5th category (100,000 guilders)." Article 294 states, "He who deliberately incites another person to commit suicide, renders assistance in doing so or provides him with the means to do so, will, in case suicide follows, be punished with an imprisonment of up to 3 years or a fine in the 4th category (10,000 guilders)."

In spite of these formal provisions in the Dutch criminal code, jurisprudence in Dutch courts has allowed the actual legal position to stray very widely from any criminalization of either euthanasia or assisted suicide. Following the landmark case in 1973, and as a result of the formal establishment of state and regional committees on euthanasia in the 1980s, the actual practice is currently as follows. Doctors are allowed to administer euthanasia after certain criteria have been fulfilled. The patient must have made a voluntary, well-considered and lasting request; he must have been faced with a condition of unremitting and unbearable suffering; a second physician must have been consulted; and termination of life must be carried out in a medically appropriate fashion.

The doctor's actions are submitted to a regional review committee which ensures that due care was observed. The opinion of the committee is then submitted to the Public Prosecution Service, which usually defers to it and forebears to bring a prosecution. The committees are composed of doctors, ethical experts and lawyers.

Although prosecutions of doctors are rare, the possibility of prosecution always remains under the present law. Consequently, not all doctors report cases of euthanasia, since they consider the procedure cumbersome and dangerous for them. In 1990, only 18% of cases of euthanasia and assisted suicide were reported to the authorities in the required way. (These figures were obtained from a comprehensive survey conducted on condition of anonymity, of which more later.) Although the figure rose to 41% by 1995, this still means that 59% of cases go unreported and therefore unregulated under the present arrangements.ⁱ

The reasons for this non-reporting are noteworthy. In 1995, the anonymous inquest found that, in 55% of the cases in which euthanasia was not reported, doctors did so in order to spare the family the unpleasantness of a judicial investigation. In 36% of cases, the stated reason was fear of judicial procedure. And some 30% of cases went unreported because the doctor had not fulfilled the criteria. (These categories overlap.)ⁱⁱ One expert has even suggested that euthanasia goes unreported in six out of ten cases.ⁱⁱⁱ

The failure to report euthanasia gives grist to the mill of those who argue in favour of the new law, whose provisions are examined below. They claim that it is better to bring this morally highly sensitive and difficult matter under the control of the law, rather than allowing the present legal ambiguity to continue. Opponents, however, may legitimately ask why the new law will succeed in bringing the practice under control when a culture of illegality on this question has been tolerated in the Netherlands for so long.

The danger of continued abuses, even under the new law, is real. Campaigners for euthanasia, such as the Dutch Union for Voluntary Euthanasia, as well as those who campaign for assisted suicide, such as the voluntary organisation De Einder (The Horizon), both say that the new law is an unwelcome retrograde step. **De Einder's counsellors advise people who want to end their lives, and they sometimes take a fee for their**

services. The Director of The Horizon, Mrs. Adriana Brolsma, is unhappy with the new law. "In the past, assisted suicide was illegal but tolerated. The new law will set up a bureaucratic procedure which will just keep people waiting. Under the new law, the doctor will decide, not the individual. Only the patient can decide. We like to talk about 'self-determination.'" Mrs. Brolsma is opposed to the idea that the authorities can prevent people from committing suicide.

The Dutch Union for Voluntary Euthanasia **also** believes in the right of individual to decide when to end his own life and regards the intrusions of the new law as unwelcome, especially because it restricts the right to euthanasia to those who are in unbearable pain. De Einde, a voluntary organization run mainly by militant humanists, which helps people to commit suicide, similarly believes that it is wrong for the state and law to tell an individual when and how he may take his own life. These arguments are powerful (they are discussed again below) and they have powerful appeal within the Netherlands: will a new law be sufficient to counteract them in a country whose whole culture has for decades and centuries been built upon radical individualism?

Human Rights and the practice of euthanasia in the Netherlands

The extent to which the practices of euthanasia, assisted suicide and other forms of doctor-assisted death have flourished in the Netherlands are relatively well understood, thanks to two surveys conducted confidentially in 1990 and 1995 by the Dutch government. They came to the following findings:

	1990	1995
	% of all deaths/number of cases	% of deaths/number
Euthanasia	2.4% / 3,256 cases.	1.8% / 2,319 cases
Assisted suicide	0.3% / 386 cases	0.3% / 407 cases
Cases in which a patient's life was deliberately ended by a doctor without the patient's request:	0.8% / 1,031 cases	0.7% / 950 cases
Intensified pain treatment, partly intended to hasten death	3.89% / 4,895 cases	2.9% / 3,935 cases
Withdrawal of treatment or decision not to administer treatment, with the explicit intention of hastening death	8.7% / 11,208 cases	13.3% / 18,045 cases

In other words, some 26, 593 deaths in the Netherlands in 1995 were either directly caused or hastened by medical practice. This is 19.6% of all deaths in the country.

How should one assess these figures from a human rights perspective? The first general methodological point is that the very notion of human rights is ill-equipped to deal with the complexity of such matters. By definition, human rights are rights which the individual is said to enjoy autonomously – as separate from both state and the rest of society. It is therefore extremely difficult, within the framework of the ideology of human rights, to assess the wider social impact of euthanasia practices on people who neither request nor want euthanasia. Indeed it is simply not possible, within a legal framework - i.e. in a court of law - to give protection from fear to a weak and dying person who may be afraid of euthanasia. Such protection can only be afforded, if it is deemed necessary, by an overall political

approach to the question based not exclusively upon the individualistic approach inherent in the ideology of human rights, but more widely on an attempt to promote the common good.

Such considerations may sound technical but they are of the very first importance to doctors and to society generally. **The standard argument in favour of euthanasia goes like this, in the words of one life-long practitioner, Professor Anries van Dantzig: “Abortion and euthanasia are part of the process of making room for the conviction of those of us who no longer believe in the sanctity of human life,” he says. I do not think it is democratic that I should be forced to suffer on the basis of another person’s principles.”**^{iv} **Such an approach may have its merits but it is very individualistic.** In Britain and Canada, doctors who otherwise disagree on the rights and wrongs of euthanasia have reached very wide agreement that any moves towards legalising the practice would radically change the relationship between all patients and doctors in society. Meanwhile, the British House of Lords’ Select Committee on Ethics came to the conclusion that arguments based on individual autonomy were insufficient to deal with the complexity of the issues at stake:

“Ultimately we do not believe that the arguments are sufficient reason to weaken society’s prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that we all are equal. We do not want that protection to be diminished. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundations of a policy which would have such serious and widespread repercussions. Dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interests of the individual cannot be separated from the interests of society as a whole.”

This point is of the first importance because, as the analysis below will show, the arguments in favour of autonomy have, in any case, given rise to cases of euthanasia and doctor-induced death where no request has been made on behalf of the patient.

Indeed, as the figures show, one of the most basic human rights, the right to life, is systematically violated in the Netherlands thanks to its relaxed attitude towards euthanasia. Moreover, these violations are not prosecuted under the Netherlands’ own laws against murder. The lives of between 950 and 1,000 people are ended every year in the Netherlands without them having requested euthanasia. Many of these cases are severely handicapped new-born babies. Ending a new-born baby’s life is *de facto* considered lawful in the Netherlands if the baby has no chance of survival, or if the baby can never, or probably never, live without intensive medical care. In such cases, the baby’s case is deemed “hopeless”. In the case of adults who are either unconscious or suffering from dementia, they are considered to be incapable of deciding anyway and so the doctor decides for them.

The point is that, whatever the rights and wrong of euthanasia, Dutch practice does not conform to international human rights law. The arguments in favour of euthanasia, whether voluntary or involuntary, are intelligible arguments. They rely on notions such as the right to autonomy, or on the belief that some human lives are not worth living. To be sure, these underlying notions are themselves questionable. But what seems incontrovertibly true is that, in the Netherlands, the right to life, proclaimed in human rights documents, is violated. In other words, it is inconsistent for the Dutch government to proclaim its adherence to documents like the European Convention on Human Rights or the forthcoming EU Charter of Fundamental Rights, both of which documents stipulate in their respective Article 2 that everyone has the right to life. (In the case of the EU Charter, the rule is even stricter than in the European Convention, since the latter convention allows for an exception to be made in cases where the death penalty is provided for by law, and also where life is taken in self-defence, during lawful arrest or to prevent escape, or in ‘action taken for the purpose of quelling a riot of insurrection.’) There is no right to euthanasia, whether voluntary or involuntary, in any supranational human rights document and consequently Dutch law and practise are in contravention of the very principles – i.e. that such supranational documents have legal force - which the country claims to uphold.

Pro-euthanasia commentators may claim that in 15% of these cases, the patient expressed a wish for euthanasia at some previous point in his life (e.g. before dementia or unconsciousness set in) while in 14% of cases, a request was made by a next of kin. But such figures only underline the very flexible notion of “consent” or “autonomy” on which the practice of euthanasia in the Netherlands is based.^v

This is an important point for assessing the overall right of a patient to ask for euthanasia. The right autonomously to decide over one’s own life is the argument advanced most forcefully by those who campaign for euthanasia and it is also the one which is usually accepted most widely by the general public. It should be emphasised that the Dutch use of the word ‘euthanasia’ reflects this: in Dutch parlance, the word refers only to active measures taken by a doctor to end a patient’s life on his request. ‘Voluntary euthanasia’ is thus, strictly speaking, an oxymoron.

Comment is also called for on the question of non-treatment decisions with the intention of hastening death. The Dutch no longer consider such cases to be “euthanasia”. And yet the practice of withdrawing treatment for the explicit purpose of hastening death is, as the tables above show, common.

Philosophically, this is perhaps the most difficult area of the whole debate. Where is the dividing line between deciding not to prolong a dying person’s life artificially and ending it deliberately? The philosophical difficulties are, of course, exacerbated by the improvements in medical science which increase the ways in which life can be prolonged.

Despite these difficulties, some attempts at clarification seem in order. There are numerous categories of medical decision taken as death is approaching. The doctor can decide to do nothing; he can decide to administer certain palliative medicine, in the knowledge that a side-effect of this may be to accelerate the patient’s death; or he can take action with the explicit intention of hastening death. There may be further sub-categories but these three would seem, nonetheless, to exist.

As the table shows, Dutch doctors regularly take decisions in the third category. They accounted for 13.3% of all deaths in the Netherlands in 1995. Opponents of euthanasia in the Netherlands say that the withdrawal of medical treatment has now become established practice in the country, even to the extent of hastening a patient’s death. Furthermore, the patient’s consent is not always sought or obtained. In 80% of these cases in which life is shortened because treatment is either withheld or broken off, the doctor was convinced that the patient was fully conscious of the decision to administer euthanasia and that he agreed with it: in 20% of cases, in other words, the patient was not thus capable. In 15% of cases, doctors acted without consulting the patient or a relative of the patient; in 4% of cases, doctors act without even consulting a colleague.

In these cases, as in others, supporters of euthanasia in the Netherlands often claim that the time by which life is shortened in these cases is very low, often as little as 24 hours. If this is true, it is difficult to see what is the point of euthanasia, since its practice obviously has an overall effect on the relationship between the patient and the doctor. Apart from the difficulty of knowing exactly how long a dying person has yet to live (or for that matter of being sure that they are, in fact, dying) there are certainly also cases where life is shortened by a considerable period of time. One lifelong practitioner and theoretician of euthanasia has said that it should be considered for severely handicapped new-born babies “who have no hope of joining the human community” – i.e. for people who may otherwise live.

In other words, the Dutch practice of euthanasia, as they narrowly define it, has led to very considerable spill-over into other areas of medical practice. In particular, it has caused the withholding of medical treatment to be considered normal medical practice, and has also sanctioned euthanasia of people whose consent has been neither sought nor obtained and who, in the case of babies, could not give it under any circumstances. Figures are not available for the number of cases of narrowly-defined euthanasia (i.e. a doctor ending a patient’s life on his request) of people with mental illness. Although people with depression

can ask for an obtain euthanasia in the Netherlands, it is questionable to what extent one can properly speak of 'autonomy' when people are suffering from clinical depression or schizophrenia.

Comparison with Britain

In dealing with this exceedingly difficult area of medical ethics, it is illustrative to compare the difference in philosophical approach between Dutch doctors and their colleagues in other countries.

As a matter of moral principle, the British Medical Association makes a distinction between, on the one hand, breaking off or withholding treatment which is artificially prolonging the dying process or which is counter-productive, and, on the other, measures taken with the intention of ending a person's life. In other words, it draws a distinction between allowing death to occur and causing it. Its guidelines say that doctors should never withhold treatment with the intention of hastening death. The former is regarded as acceptable and natural; the latter as illegal and wrong. The BMA writes, "There is a difference between respecting the competent patients' autonomous refusal of treatment and intervention, even if it results in the patient's death, and acts or omissions with the intention of causing death."^{vi} Conversations on this subject with British geriatricians reveal the difference in philosophical approach: while they stress that death should be allowed to come "naturally" or "when the time comes", the Dutch seem obsessed with the notion of controlling the moment of death.

The notion of "nature" is key. Obviously it is not possible to say with certainty when death will occur. But there is a difference between withdrawing treatment which is artificially prolonging life, or embarking on palliative treatment which may have the result of accelerating death, and withdrawing treatment with the explicit intention of shortening life unnaturally. If Dutch doctors, like their British counterparts, took non-treatment decisions only because they were artificially prolonging life, they would not refer to these as having been taken "with the explicit intention of shortening life." When a doctor decides that a patient is dying, the explicit intention in Britain will generally be to make the patient as comfortable as possible and to allow death to come when the time is right. Even if palliative medicine is administered in the knowledge that it will accelerate death, this is not the explicit intention. (The Dutch survey has a separate category for this anyway, although more detailed breakdown of the figures show that, even in some of these cases, the decisions are taken "with the explicit purpose of shortening life".)

In other words, the concept of "nature" allows us to distinguish, in general terms at least, between different courses of medical action. It seems indubitable that the Dutch, having admitted in their law and medical practice the principle that death is sometimes the right medical solution for terminal illness, now act very regularly on the basis that medical decisions should be taken with the explicit aim of causing death. It is an indication of the extent to which lifting the absolute ban on mercy killing has corrupted the analytical faculties of pro-euthanasia commentators and practitioners that they cannot see the difference between these two approaches.

The proposed reform in the Netherlands

The proposed new law has been introduced into the lower house of the Dutch parliament by the Minister of Justice, Bank Korthals, and the Minister of Health, Dr. Els Borst. A provision is to be included in the Netherlands Criminal Code which would provide for the termination of life on request and assistance with suicide would not be punishable if certain criteria were fulfilled. The bill is a consequence of the coalition accord which led to the present coalition government, involving the Labour party and two Liberal parties.

The two conditions under which a physician will not be subject to prosecution are:

1. The physician must have fulfilled the requirements on due care, as laid down in a separate act, namely the Termination of Life and Request and Assistance with Suicide (Review) Act.
2. The physician must notify his or her actions to the municipal coroner in accordance with the relevant provisions of the Burial and Cremation Act.

Under circumstances other than these, euthanasia and assisted suicide would continue to be “illegal” under Dutch law, although the culture of illegality is now so great that it is difficult to know quite what deterrent effect this could have. Where assisted suicide is concerned, for instance, organisations exist openly in the Netherlands to help people to commit suicide. They are allowed to counsel people who want to end their lives and they distribute literature with step-by-step guides to how to kill yourself.^{vii} These actions are illegal under Dutch law - not least because the suicide counsellors are not doctors - and yet the police have never brought any prosecutions for them.

The new statutory rules will not make any substantial changes to the grounds on which life may be terminated on request or on which assisted suicide is permitted. Instead, the main change is to modify the role of the five regional review committees which examine whether a case of euthanasia has followed the criteria. Henceforth, if the committee considers that due care has been observed, the case will be closed. Only where this is not so will there be a referral to the Prosecution Service. The Prosecution Service retains the power, however, to instigate investigations of its own when it suspects that an act of euthanasia has not fulfilled the criteria.

In keeping with a recommendation of the Council of State, made in respect of a previous version of the bill, the new law will include a provision for the request by minors for termination of life and assistance with suicide. The provision in question is based on the existing rules for medical treatment for minors. This means that 16 and 17 year olds can decide independently over their own lives. In the case of children between 12 and 16, the consent of the parents is required. But in the event of a refusal by one or both parents, a minor’s request may nevertheless be met if the physician is convinced that this would prevent serious harm to the patient.

The main function of the law, in other words, is to effect an institutional change to the legal fabric of the Netherlands. The new law will formally take life and death decisions out of the hands of the law and to place it in the hands of “experts”, even though pro-euthanasia campaigners are right to say that it does formally de-criminalize euthanasia. This has significant implications for the rule of law in the Netherlands. It means that the medical profession will (in the words of one lifelong abortionist and euthanasia practitioner) “lift the sword of Damocles from above doctors’ heads”. Indeed it will, but by what right should some of the most important questions of society be hived off from the responsibility of the law and the prosecution authorities and given to a privileged group ?

As has been already stated, a culture of illegality has grown up in the Netherlands on these questions. It is not clear how the rights of people to whom euthanasia may have been administered by mistake, or against their explicit request, will be strengthened by this new law.

Deficiencies in palliative care in the Netherlands

It is often claimed, especially by opponents of euthanasia, that one of the reasons why euthanasia is practised so widely in the Netherlands is that palliative medicine is underdeveloped there. Palliative medicine is medical treatment whose purpose is to cure symptoms where there is no hope of curing the underlying illness. This was developed, especially in England, after the Second World War.

A leading opponent of euthanasia in the Netherlands is Dr. Karel Gunning. He presides a Dutch and an international organisation of anti-euthanasia doctors. He is highly critical of the present arrangements, and says, “The whole law is complete nonsense because

doctors know in advance that they cannot be punished. If they fill in the forms wrongly (explaining why they put an end to their patients' life) they will simply be asked to fill them in again."

He is also highly critical of the effect which the practice of euthanasia has had on medical practice in the country. "Giving overdoses of morphine or withdrawing essential food and liquid with the intention of killing patients are now considered normal medical practice in the Netherlands." He learned about the merits of palliative medicine by coming to London to study in a hospice. When he returned to Netherlands, he says, his colleagues simply did not believe that such things were possible. In particular, he insists that pain can be cured in 100% of cases, even if in a small minority of cases extreme measures have to be taken. There are no cases, he argues, where pain is so severe that death is the only solution. By contrast, the Dutch have started to create Hospices only about five years ago.

Dr. Gunning is convinced that the new law will provide no safeguards for those who do not want euthanasia. "Society is now being run by doctors," he says. "They decide who will live and die." Quite apart from the moral questions which this raises, Dr. Gunning thinks that doctors are not even professionally competent in this field. He tells the story of a young man who asked a doctor to kill his dying father because he was due to go on holiday and did not want to have to cancel his trip for the funeral. The doctor agreed and administered a large dose of morphine. But the attempt to kill the man failed because the doctor got the dosage wrong. He later found the old man in fine spirits, feeling better than he had for ages, because the amount of morphine had in fact been sufficient to kill his pain but not to kill him.

Appendix

"A new Ethic for Medicine and Society", Editorial in California Medicine, Volume 113, Number 3, September 1970

The traditional Western ethic has always placed great emphasis on the intrinsic worth and equal value of every human life, regardless of its age or condition. This ethic has had the blessing of the Judeo-Christian heritage and has been the basis for most of our laws and much of our social policy. The reverence for each and every human life has also been a keystone of Western medicine and is the ethic which has caused physicians to preserve, protect and repair, prolong and enhance every human life which comes under their surveillance. This traditional ethic is still clearly dominant but there is much to suggest that it is being eroded at its core and may eventually be abandoned. This of course will produce profound changes in Western medicine and in Western society.

There are certain new facts and social realities which are becoming recognised, are widely discussed in Western societies and seem certain to undermine and transform this traditional ethic. They have come into being and into focus as the by-products of unprecedented technological progress and achievement. Of particular importance are, first, the demographic data of human population expansion which tends to proceed, uncontrolled and at a geometric rate of progression; second, an ever growing ecological disparity between the numbers of people and the resources available to support these numbers in the manner to which they are or would like to become accustomed; and third, and perhaps most important, a quite new emphasis on something which is beginning to be called the quality of life, a something which becomes possible for the first time in human history because of scientific and technological achievement. These are now being seen by a growing segment of the public as realities which are within the power of humans to control and there is quite evidently an increasing determination to do this.

What is not yet so clearly perceived is that in order to bring this about, hard choices will have to be made with respect to what is to be preserved and strengthened and what is not, and this will of necessity violate and ultimately destroy the traditional Western ethic with all that this portends. It will become necessary and acceptable to place relative rather than absolute values on things such as human lives, the use of scarce resources and the various elements which make up the quality of life or of living which is to be sought. This is quite distinctly at variance with the Judeo-Christian ethic and carries serious philosophical, social, economic and political implications for Western society and perhaps for world society.

The process of eroding the old ethic and substituting the new has already begun. It may be seen most clearly in changing attitudes toward human abortion. In defiance of the long held Western ethic of intrinsic and equal value for every human life regardless of its stage, condition or status, abortion is becoming accepted by society as moral, right and even necessary. It is worth noting that this shift in public attitude has affected the churches, the laws and the public policy rather than the reverse. Since the old ethic has not yet been fully displaced it has been necessary to separate the idea of abortion from the idea of killing, which continues to be socially abhorrent. The result has been a curious avoidance of the scientific fact, which everybody knows, that human life begins at conception and is continuous whether intra- or extra-uterine until death. The very considerable semantic gymnastics which are required to rationalize abortion as anything but the taking of a human life would be ludicrous if they were not often put forth under socially impeccable auspices. It is suggested that this schizophrenic sort of subterfuge is necessary because while a new ethic is being accepted the old one has not yet been rejected.

It seems safe to predict that the new demographic, ecological and social realities and aspirations are so powerful that the new ethic of relative rather than absolute and equal values will ultimately prevail as man exercises over ever more certain control over his numbers and uses his always comparatively scarce resources to provide the housing, economic support, education and health care in such ways as to achieve his desired quality of life and living. The criteria upon which these relative values are to be based will depend considerably upon whatever concept of the quality of life or living is developed. This may be expected to reflect the extent that quality of life is considered to be a function of personal fulfilment; of individual responsibility for the common welfare, the preservation of the environment, the betterment of the species; and of whether or not, or to what extent, these responsibilities are to be exercised on a compulsory or voluntary basis.

The part which medicine will play as all this develops is not yet entirely clear. That it will be deeply involved is certain. Medicine's role with respect to changing attitudes toward abortion may well be a prototype of what is to occur. Another precedent may be found in the part physicians have played in evaluating who is and who is not to be given costly long-term renal dialysis. Certainly this has required placing relative values on human lives and the impact of the physician to this decision process has been considerable. One may anticipate further development of these roles as the problems of birth control and birth selection are extended inevitably to death selection and death control whether by the individual or society, and further public and professional determinations of when and when not to use scarce resources.

Since the problems which the new demographic, ecological and social realities pose are fundamentally biological and ecological in nature and pertain to the survival and well-being of human beings, the participation of physicians and of the medical profession will be essential in planning and decision-making at many levels. No other discipline has the knowledge of human nature, human behaviour, health and disease, and of what is involved in physical and mental well-being which will be needed. It is not too early for our profession to examine this new ethic, recognize it for what it is and will mean for human society, and prepare to apply it in a rational development for the fulfilment and betterment of mankind in what is almost certain to be a biologically oriented world society.

ⁱ Jean-Pierre Wils, *Sterben, Zur Ethik der Euthanasie*, Schöningh, Paderborn, 1999, p. 172. Professor Wils is one of those who thinks that it is better to have a law than to allow the present situation to go unregulated.

ⁱⁱ Wils, p. 173

ⁱⁱⁱ Interview with Professor van der Wal, author of the 1995 Dutch government enquiry into medical decisions at the end of life, reported in Newsletter 60 of the Voluntary Euthanasia Society, May 1997.

^{iv} **See article by John Laughland, The Mail on Sunday, 11th June 2000**

^v Wils, p. 171

^{vi} Extensive policy papers, guidelines and other reference material on the questions of euthanasia, assisted suicide and other life and death medical decisions can be found on the BMA's web page, www.bma.org.uk

^{vii} *Begeleiding van Mensen met een Doodswens*, ('Accompanying people with a death-wish') by Andri Brolsma, Marjolijn van Dierendonck and Jan Hilarius, published by *Stichting De Einder op Humanistische Grondslag*, Castricum, October 1999.