Submission to the
Senate Standing Committee on Legal and Constitutional Affairs Regarding its Inquiry into the Rights of the Terminally Ill (Euthanasia Law Repeal) Bill 2008

April 2008

In this submission we focus on several key aspects of euthanasia with regard to the Bill's intention to re-establish euthanasia in the Northern Territory. We consider that euthanasia itself, rather than Territory rights is the issue.

The matters we wish to focus on are the human rights perspective, the Dutch experience with euthanasia, and the particular risk to Australia's indigenous people.

Human Rights

This Bill will reinstate the legal permission for doctors in the Northern Territory to be able to kill their patients by administering a lethal injection. This is the reality behind often used euphemisms like "the administration of medical procedures to assist the death of patients who are hopelessly ill".

Relatives and loved ones are happy to assist a patient to die. We do that by the love and support we give, and by seeing to it that the terminally ill have the best palliative care a prosperous civilised society like ours has to offer.

But assisting a patient to die is **not** the same as killing a patient.

Moreover, euthanasia construes the whole question of doctors giving patients a lethal injection in terms of the "choice" of individuals, as if voluntary euthanasia had no impact on anyone else.

However, the legalisation of the intentional killing of one person by another, even at that person's own request, cannot reasonably be construed as a matter of personal choice affecting only the patient and the patient's doctor. It has serious implications for all members of our society.

In international law the right to life, like the right to liberty or freedom, is seen as an "inalienable" right, a right of which I cannot be deprived and of which I cannot even deprive myself. This universal understanding of the rights to life and to personal liberty as "inalienable" rights is based upon an understanding that the legal right to give up these inalienable rights threatens others who do not agree to have those rights taken from them.

Take the case of the right to freedom. The State will prevent me selling myself into slavery even if I competently wish to make that choice for very compassionate reasons. I may believe, at a time of high unemployment, that my family will financially benefit from the money derived from my enslavement. For this transaction to occur, however, it would be necessary for the State to legalise the slave trade for those who wish voluntarily to enter it. The State, however, cannot derogate from its obligations to protect the inalienable right to liberty because the State knows that others will be drawn into the slave trade non-voluntarily if the slave trade is allowed to exist. In other words, to allow some to sell themselves into slavery voluntarily puts at risk the right to liberty of others in the community, particularly the weak and the vulnerable.

It is the same with the inalienable right to life. The State's human rights obligations require it to protect the right to life of all citizens, particularly the weak and the vulnerable. The State cannot reasonably legalise voluntary euthanasia because it is impossible to quarantine voluntary euthanasia from non-voluntary euthanasia. The evidence for this is overwhelming.

The Netherlands allows the practise of voluntary euthanasia through certain case law judgments which set up the 'strict' conditions which must apply. The Dutch evidence set out in the Remmelink Report shows that, in 1990, there were 10,558 cases of medical decisions at the end of life which involved the 'explicit' intention to hasten the end of the life of the patient by act or omission. There were 2,300 cases classified as 'euthanasia; 400 cases classified as 'assisted suicide'; 1,000 cases of administering drugs 'with the explicit purpose of hastening the end of life' without explicit request; 1,350 cases of the administration of opioids 'with the explicit purpose of shortening life'; 4,000 cases of withholding or withdrawing treatment, without explicit request, 'with the explicit purpose of shortening life'; and 1,508 cases of withdrawing or withholding treatment, on explicit request, 'with the explicit purpose of shortening life'.

Of these 10,558 cases where there was an 'explicit' intention to hasten the end of life by act or by omission, 55% were non-voluntary. Put another way, in the practice of euthanasia in The Netherlands, more are killed without their knowledge and consent than with their knowledge and consent.

The authors of the Remmelink study have conceded that voluntary euthanasia inevitably leads to non-voluntary euthanasia. In an essay in the Hastings Center Report, the prestigious American bioethics journal, they said:

"But is it not true that once one accepts [voluntary] euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? *In our view the answer to this question must be affirmative*." (My emphasis)

In the State of South Australia, where voluntary euthanasia is illegal, scholars in the sociology discipline at Flinders University carried out a survey of doctors and nurses. The survey revealed that 19% of doctors and nurses had ever taken active steps to bring about the death of a patient. Of this group of euthanasia practising doctors, 49% of them had never received a request from a patient to take such active steps.

If a group of doctors (a minority) is prepared to break what civilised societies regard as a fundamental and central law, ie the law against homicide, it would be naive to imagine that they and others will not break a voluntary euthanasia law, if it were enacted, and begin to kill those they consider ought to have the benefit of euthanasia if only they were competent enough to ask for it.

The evidence in The Netherlands is that doctors do not comply with the law in deciding who will get the lethal injection. This, perhaps, explains why only 41% of cases of euthanasia or physician-assisted suicide were reported despite the fact that Dutch law requires all of them to be reported.

Some of our Parliamentarians believe that it is possible to regulate voluntary euthanasia by setting strict criteria such as those contained in the Northern Territory's now repealed *Rights of the Terminally Ill Act*. Such confidence is misplaced in light of a research article published by the prestigious medical journal *The Lancet* that showed that it was far from clear that the 4 euthanasia deaths in Darwin really did meet all the criteria set down in the Act.

The fact is that, given human nature, it is dangerous to put into the hands of very fallible human beings the ultimate power that one human being can have over another, to deliberately cause another's death. And it is also a fact that many proponents of voluntary euthanasia also propose the non-voluntary killings of other classes of human beings whom they 'believe' are not 'persons'. Those classes of individuals include newborn children with physical or intellectual disabilities, the mentally ill, and the demented elderly. Once a decision is taken to allow the killings of patients who ask for it on the grounds of 'compassion', other 'compassionate' killings of those who do not or cannot ask for it are bound to follow as is already the case in The Netherlands.

Our elected representatives in our Parliaments have a responsibility to protect the inalienable right to life. They must, as lawmakers, stand back from the unrefined data of opinion polls and enact laws for the common good of all our citizens. Since non-voluntary euthanasia follows voluntary euthanasia, as sure as the night follows the day, and no matter how clever and how strict the legislative provisions appear to be, parliamentarians must protect human rights by honouring our obligations in international law. Resistance to legalised voluntary euthanasia is a moral imperative for all our members of Parliament, no matter what their personal views on euthanasia may be.

Good public policy occurs when the law protects impartially the fundamental human rights of all. That means the ban on voluntary euthanasia must be maintained to protect the common good of all citizens.

Extracts from a paper by Dr Henk Jochemsen regarding the Dutch experience with euthanasia

Incompetent patients

It should be pointed out that both by the medical profession and by the courts life terminating actions with incompetent patients have been accepted. The clearest examples are two severely handicapped and ill babies whose lives were intentionally ended. The attending physicians reported the case and were prosecuted and brought before a District Court (Alkmaar[i] and Groningen[ii]) and later before a Court of Appeal (Amsterdam[iii] and Leeuwarden[iv], respectively). We will briefly present these cases.[v]

In the Alkmaar case the baby had spina bifida, hydrocephalus, a spinal cord lesion and brain damage. The specialists decided not to operate on the spina bifida, because of the bad prognosis. The baby appeared to be suffering severe pain which was difficult to treat. The parents did not want the baby to suffer and asked for the termination of her life. Three days after the baby was born, she was killed by the attending gynecologist, P., after consultation with other specialists who had examined the baby. She died in the arms of her mother.

The Groningen case concerned a newborn baby with trisomie-13, a syndrome that manifested itself in a number of disorders (deformities of skull, face and hands, heart and kidney malfunction and brain damage). The baby was diagnosed to be non-viable; death was to be expected at most within a year, and probably within six months. After the situation had stabilized to a certain point, the baby was taken home and looked after by the parents, who had learned to supervise the tube-feeding. After a week some tissue (meninges) came out through an opening in the skull. This appeared to be very sensitive and the baby appeared to be in pain. The family physician, K., gave pain treatment, but that did not appear to be fully effective. After a number of days, with the explicit consent of the parents (though whether it was at their request remains unclear), and after consulting the pediatrician who had seen the baby before, the life of the baby was ended by lethal injection.

Both doctors appealed to the defense of necessity. All four courts accepted this and released the physicians without punishment.[vi]

In the court decisions two lines of reasoning can be traced, not uncommon in discourses that defend euthanasia. First, in cases of short life expectancy, stopping or not starting treatment while accepting that the patient will die, is virtually morally equated with intentionally killing the patient. A decision not to treat is regarded as an intention to shorten the life of the patient. The second main reasoning of the courts is that proportional pain and symptom treatment with has as a side-effect a shortening of life is morally equated with intentional killing by the administration of lethal substances. So, the moral significance of the principle of 'double effect' is rejected.

The 1995 survey reports that over 1000 newborns die in the Netherlands before their first birthday and estimates that the lives of about 15 are actively and intentionally terminated by doctors.

I conclude that under specific circumstances the intentional shortening of life of incompetent patients is supported by the KNMG (Royal Dutch Medical Association), is practiced to a certain extent and is justified by the courts. Therefore, the practice of intentional shortening of life is not following the condition of a voluntary, well-considered, free request.

Unacceptable suffering without prospect

According to the physicians this clearly is the most important reason for patients to ask for euthanasia. It is, however an 'open' criterion, i.e. not clearly defined and in no way objectivized so far. It is the doctor who decides whether the suffering has become sufficiently unacceptable to give in to a request for euthanasia.[vii] With about two-thirds of the 9700 requests for euthanasia the physicians did not comply, probably because in their opinion the situation had not yet become intolerable.

On the other hand, according to the attending physicians there were medical alternatives to alleviate the suffering in about 17% of the cases of euthanasia and assisted suicide, but the patients rejected them and the doctors complied with the request. This is at odds with the requirement that there must be no (reasonable) alternative to alleviate the suffering. Euthanasia should only be used as a last resort. This condition (an application of the subsidiarity principle) was supported by the former Cabinet and by the KNMG.[viii] However, the present Cabinet appears to have reversed this position. The bill that is now before the Dutch parliament (see paragraph 4.2) establishes that the refusal by the patient of available treatment alternatives does not render euthanasia unlawful.[ix] Furthermore, the integral terminal palliative care is not very well developed in the Netherlands. Only in recent years the hospice movement is really gaining importance.[x]

I conclude that this requirement (a) is interpreted differently by different physicians, (b) is not always fulfilled in the sense that euthanasia is only used as a last resort. With respect to the latter two contradictory movements can be distinguished. On the one hand the acceptance that this condition can also be fulfilled when a patient refuses a reasonable medical alternative to alleviate the suffering and on the other hand the increasing possibilities and availability of integral palliative care that could take away a request for euthanasia. If both movements will gain force, euthanasia will become less and less a last resort and more and more a choice for a certain kind of death. This will confront society even more urgently with the question how to regulate this and avoid abuse, and will confront the medical profession with the question whether it want to be the executioner of such deaths.

Consultation

The guidelines for permissible euthanasia and assisted suicide require the doctor, before agreeing to either, to engage in a formal consultation (*consultatie*), and not merely an informal discussion (*overleg*), with a colleague.

In cases of euthanasia and assisted suicide 92% of doctors had, according to the survey, discussed the case with a colleague[xi] but in 13% of these cases the discussion did not amount to a formal consultation. Hence, consultation took place in 79% of cases. However, other figures of the survey indicates that consultation occurred in 99% of the reported cases but in only 18% of unreported cases.[xii] Since almost 60% of all cases of euthanasia and PAS were not reported (see next section) it can be calculated that consultation occurred in only around half of all cases. The discrepancy between this 50% and 79% is not exactly clear, but seems to be related to a certain bias in responses to some questions.[xiii]

In 97% of the cases of life-termination without explicit request there was no formal consultation, though in 43% the case was discussed with a colleague. Even when consultation did take place, it was usually with a physician living locally and the most important reasons given for consulting such a physician were his views on life-ending decisions and his living nearby: expertise in palliative care was hardly mentioned.

I conclude that even this relatively easy condition did not reach a truly high level of compliance.

Reporting

In 1995 41% of cases of euthanasia and assisted suicide were reported to the local medical examiner, as required by the reporting procedure (cf. paragraph 3). While this is an improvement on the figure of 18% reported in 1990, it means that a clear majority of cases, almost 60%, still go unreported. Furthermore, the increase in reporting from 18% (1990) to 41% should not lead to optimism, since the number of euthanasia cases increased between 1990 and 1995 (900 cases) with almost the same number as the reported cases (980 cases). Moreover, the survey confirms that the legal requirements are breached more frequently in unreported cases, in which there is less often a written request by the patient; a written record by the doctor; or consultation by the doctor.[xiv]

The most important reasons given by doctors for failing to report in 1995 were (as in 1990), the wish to save oneself and/or the patient's relatives the inconvenience of an investigation by the authorities, and to avoid the risk of prosecution (though, as the consistently tiny number of prosecutions indicates, this risk is very small indeed).

The purpose of the reporting procedure is to allow for scrutiny of the intentional termination of life by doctors and to promote observance of the legal and professional requirements for euthanasia. *The fact that a clear majority of cases still goes unreported confirms the failure of the procedure to fulfill its purpose and belies any claim of effective regulation, scrutiny and control.*

Developments after 1996 - a new procedure

In 1998 the Parliament accepted a new regulation of euthanasia reporting that became effective on November 1, 1998.[xv,xvi] This does not imply a change of the Penal Code prohibition of euthanasia, but a change of the procedure by which euthanasia should be reported. According to the new procedure, the report of every euthanasia case as well as the filled out form of the medical examiner, should no longer be sent directly to the public prosecutor, but should be sent to one of five regional euthanasia review committees. This committee, consisting of a physician, a lawyer and an ethicist, should evaluate the case in the light of the courts' decisions on life-terminating actions thus far. The committee's opinion on the case is sent to the public prosecutor, together with the reports of the attending physician and of the medical examiner. The prosecutor has the freedom and duty to form his own opinion on the case, but the opinion of the committee will be of major importance in the decision of the prosecutor to prosecute or not.

Since in this procedure the legal authorities find themselves at larger distance from the euthanising physician, the government hopes that a higher percentage of cases will be reported. However, the first year report of these review committees indicate that so far this new procedure has not resulted in a substantial increase of the number of reported cases.[xvii] Furthermore, this report indicates that in the reported cases the information of the attending physician on the existence of alternatives and on the quality of the consultation was not always sufficient. In some cases additional information was requested from the physician. Ultimately in all cases the euthanasia or assisted suicide was approved by the committee concerned.

A second change in the reporting procedure is that euthanasia (at the request of the patient) and life-termination without explicit request should be reported by different procedures. In this way the government wants to stress that the two kinds of acting should not be morally equated. This does not mean, however, that unrequested life-termination is ruled out altogether. Actions of this kind should be reported to a national committee, that will give its evaluation and then send the case to the public prosecutor who will decide whether the case should be brought before court. Also in these cases the opinion of the national committee as well as the court decisions on such cases (cf. paragraph 3.3.1) will significantly influence the decision of the prosecutor. But also in these cases there is no guarantee that they will be reported in the first place. So far this national committee has not yet been established.

Juridical evaluation

The empirical evidence on euthanasia practice in the Netherlands, not least that of the two major surveys, is far from reassuring. Advocates of voluntary euthanasia have long claimed that tolerating it subject to 'safeguards' would allow it to be 'brought into the open' and effectively controlled. The data discussed above prove this to be only partly true. The reality is that an increasing number of cases of euthanasia and assisted suicide is indeed reported. But it is not certain that all the reports contain complete and correct information on the case in question. And, more seriously, most cases of intentional life terminating actions - at least until very recently a clear majority - have gone unreported and unchecked. In view of the undisputed fact that in these cases there has not been even the opportunity for official scrutiny, claims of effective regulation are unwarranted. The way in which euthanasia has been brought into the open and been dealt with by political and legal authorities and leaders of the medical and ethical elite has in my opinion led to quite a permissive attitude towards intentional life-terminating actions in a situation of seriously inadequate control.

In the light of the assertion made in the introduction that any form of legal regulation of euthanasia is only acceptable if it would guarantee that the state would in principle be able to assess each case, this development constitutes a strong argument against legalization of euthanasia.[xviii]

ROTTI and the Indigenous Community

The impact of ROTTI on Aboriginal people was an important factor influencing support for the Andrews Bill among Federal Parliamentarians.

25% of the population of the Northern Territory is Aboriginal. Senator Bob Collins (Australian Labor Party, Northern Territory) released to his fellow Parliamentarians a copy of a Report from Green Ant P/L (dated 28 June 1996), a local NT company commissioned by the NT Government to carry out an education programme in Aboriginal communities on the euthanasia legislation. The company is described as “a highly experienced research and communication organisation”. The author of the Report is a supporter of voluntary euthanasia.

The Report found that “the level of fear and of hostility to the legislation is far more widespread than originally envisaged ... which makes one wonder about the public opinion polling that suggests high support among the NT public for the legislation. One imagines that phone polling doesn’t get to too many Aboriginal people.”[1] The Report identified the philosophical problem that “is related to the widespread Aboriginal beliefs about cause of death and that deaths are caused by external agencies such as sorcery, payback, transgression of the Law etc. In simple terms this means that those things non-Aboriginal people may identify as ‘causes’ such as cancer, HIV-AIDS, car accidents etc are not seen as such - even by long term Aboriginal Health Workers.”[2] Indeed, “the greatest fear and reluctance about the legislation would appear to be coming from Aboriginal Health Workers themselves. They are concerned that their position within their own communities has been or might be irreparably damaged by the existence of the legislation.”[3]

In evidence given to the Senate Legal and Constitutional Legislation Committee of the Australian Senate, the Reverend Djiniyini Gondarra stated:

> Our ancient Law/Maḏayin [the Maḏayin is a foundation law common to all Aboriginal people] *does not empower* our Traditional Närra/Parliaments, to create Law/Wäyuk, that give an individual the right to take the life of another. The same Law/Maḏayin states, as a principle of law, that death should be by natural causes only, except of course in the case of capital punishment.[4]

Although some people disputed that euthanasia was contrary to Aboriginal law, and questioned whether Aboriginal objections to euthanasia were based on traditional Aboriginal Law or on Christianity (in the 1991 census 66.6% of Aborigines in the Northern Territory identified as Christian), the consensus among Aborigines giving evidence to the Committee was that euthanasia was not “the Aboriginal way”. Moreover, Aboriginal opposition to ROTTI was authoritatively reported to be “near universal”[5], and that “the very fact of the legislation, at least anecdotally, is causing people to be reluctant to present, or to present not as soon as one might, to attend clinics or to go to hospital”[6].

Summary

We have sought to present a case for the rejection of measures that would provide legislative permission for euthanasia, in particular rejecting this Bill which would permit euthanasia in the Northern Territory. The crux of the matter is the State’s human rights obligations that require it to protect the right to life of all citizens, particularly the weak and the vulnerable. The State cannot reasonably legalise voluntary euthanasia because it is impossible to quarantine voluntary euthanasia from non-voluntary euthanasia. This is evidenced by the reality of the Dutch experience with euthanasia. We have also

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[1] *Report to Aboriginal Reference Group: Rights of the Terminally Ill Act Education Program 28 June 1996*, 1

[2] *Ibid.*, 3

[3] *Report to Aboriginal Reference Group: Rights of the Terminally Ill Act Education Program 23 July 1996*, 1

[4] Senate Legal and Constitutional Legislation Committee, *Euthanasia Laws Bill 1996*, March 1997, 47

[5] *Ibid.*, 43

[6] *Ibid*., 50

sought to highlight the impact of euthanasia upon Australia's indigenous community, who would be placed at great risk if euthanasia were legally reinstated.

We urge the committee to carefully consider the evidence from the Netherlands which shows the impact of legal euthanasia upon those at most risk, and who do not request it. The Dutch experience with euthanasia indicates that despite all the rhetoric about strict criteria, mandatory reporting and tight regulation, it is impossible to safely manage legalised euthanasia. As Herbert Hendin, head of the American Suicide Foundation and Professor of Psychiatry at New York Medical College, puts it "One hardly knows which is more chilling, the widespread flouting of the scant and effectively toothless legal regulation of euthanasia in Holland, or the sangfroid with which it is defended by the Dutch practitioners." Sangfroid is from the French, meaning literally, cold-blooded.

In addition, euthanasia will also rob people of the critical and valuable moments in their last days to 'make their peace' and honestly 'close the books'. Premature departures with a lethal injection make short shrift of that, and can leave others grieving over lost opportunities and things left unsaid.

In the end, it is cannot be assumed that where Holland has failed, we can make it work. For legalising euthanasia is by nature fatally flawed.

Yours Sincerely

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[i] Vonnis Arrondissementsrechtbank te Alkmaar d.d. 26 april 1995 in the case against P. *Tijdschrift voor Gezondheidsrecht* No.5 (1995) p.292-301.

[ii] Vonnis Rechtbank te Groningen d.d. 13 november 1995 in the case against K. *Pro Vita Humana* 3, no.1 (1996) p.29-32.

[iii] Arrest Gerechtshof te Amsterdam d.d. 7 november 1995 in the case against P. *Pro Vita Humana* 3, no.1 (1996) p.25-28.

[iv] Arrest Gerechtshof te Leeuwarden, d.d. 4 april 1996 in the case against K. *Tijdschrift voor Gezondheidsrecht* No.5 (1996) p.284-291.

[v] For a more extensive discussion of these cases, see: Jochemsen H. Dutch court decisions on non voluntary euthanasia critically reviewed. *Issues in Law & Medicine* 13, no.4 (1998) p.447-458.

[vi] The Leeuwarden court formulated the following conditions that at least must be fulfilled by the physician to be able to successfully appeal to the defence of necessity (see *op cit* n 15, section 12.10):
- no doubt must exist about diagnosis and prognosis,
- the doctor must consult colleagues,
- death must be brought about in a careful and correct way,
- the doctor must report the case.
- the parents must consent to the killing of the baby

[vii] In a recent publication dr. Dillmann, secretary of the KNMG medical ethical committee, argued that indeed the physician must make a judgement on the suffering of the patient and conclude that this is unbearable before he can perform euthanasia. The moral justification of euthanasia is not just the request of the patient but as much his suffering, according to Dillmann. Dillmann RJM. Euthanasie: de morele legitimatie van de arts [Euthanasia: the moral legitimation of the physician]. In: Legemaate J, Dillmann RJM (red.) *Levensbeëindigend handelen door een arts: tussen norm en praktijk [Life terminating acting by a physician: between norm and practice].* Houten: Bohn Stafleu Van Loghum 1998, p.11-25.

[viii] See: Sorgdrager W, Borst-Eilers E. Euthanasie. De stand van zaken. *Medisch Contact* 50, no.12 (1995) p.381-384) and Kastelein WR, 1995, op cit n 8, resp.

[ix] *Wet Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Legal assessment of life termination on request and assisted suicide*]. Tweede Kamer 1998-1999, 26691, nr. 3, 10.

[x] I speak of hospice *movement* since it is rather a kind of approach to terminal care than recognizable institutions or the availability of certain medical 'know how' as such. I do not deny that palliative care and palliative medicine is practiced in the Netherlands for many years. However, the application of the most modern pain and symptom control in the context of integral palliative care according to the hospice philosophy is not widespread and still depends very much on local initiatives. An inventory in 1997 demonstrated that there were 35 initiatives in palliative care, six of which are (mostly small) hospice institutions and the others concern intramural palliative care within other health care institutions like nursing homes. In addition to these 35 there were about 120 initiatives of activities that show some overlap with hospice care, like the functioning of a special pain team or specific caring facilities for terminal patients; see: Francke AL, et al.. *Palliatieve zorg in Nederland.* Utrecht: Nivel 1997. More recently the government and the medical profession are making considerable efforts to improve the situation (cf. www.palliatief.nl).

[xi] Survey, Table 10.1

[xii] *Ibid*, Table 10.2

[xiii] *Ibid*, p.113

[xiv] *Ibid*, Table 11.6.

[xv] These changes are announced and described in: Kabinetsstandpunt naar aanleiding van de evaluatie van de meldingsprocedure euthanasie. *Brief van Minister van Justitie en van de Minister van Volksgezondheid, Welzijn en Sport aan de Tweede Kamer, d.d. 21 januari 1997 (kenmerk 603400/97/6)*. [*Position of Cabinet with respect to evaluation of reporting procedure of euthanasia. Letter of Ministers of Justice and of Health, Welfare and Sports, d.d. January 21, 1997].*

[xvi] *Staatscourant 1998*, 101 and 103.

[xvii] Regionale toetsingscommissies euthanasie. *Jaarverslag 1999*. [Regional euthanasia review commitees. *Year report 1999*]. Den Haag 1999, p.8ff. This report indicates that in 1999 2216 cases of euthanasia or assisted suicide were reported, whereas in 1998 2241 cases were reported. (Jaarverslag Openbaar Ministerie 1998 inzake euthanasie en hulp bij zelfdoding. *ProVita Humana* 7, no 1 (2000), p.34).

[xviii] Cf. the conclusion of the British Select Committee of the House of Lords on the question whether euthanasia should be legalized: "Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. (...) 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 foundation of a policy which would have such serious and widespread repercussions". *Report of the Select Committee on Medical Ethics*. House of Lords, Session 1993-94. London: HSMO 1994, p.48. This report received remarkably little attention in the Netherlands.