



SELF-EUTHANASIA, THE DUTCH EXPERIENCE: IN SEARCH FOR THE MEANING OF A GOOD DEATH OR EU THANATOS

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ABSTRACT

My main purpose in this article is to establish the meaning of a 'good death' when death is self-chosen. I will take as my point of departure the new notion of 'self-euthanasia' and the corresponding practice that has evolved in the Netherlands in recent years. Both physician-euthanasia and self-euthanasia refer to an ideal process of a good death, the first being ultimately the physician's responsibility, while the second is definitely the responsibility of the individual choosing to die. However, if we also accept the existence of a fundamental moral difference between ending another person's life and ending your own life, and if we accept this moral difference to be also relevant to the normatively laden good death, then this difference represents a strong reason for preferring self-euthanasia to physician-euthanasia.

My main purpose in this article is to establish the meaning of a 'good death' *when death is self-chosen*. I will take as my point of departure the new notion of 'self-euthanasia' and the corresponding practice that has evolved in the Netherlands in recent years.¹ 'Euthanasia' in accordance with the so-called Dutch 'euthanasia law', the *Law on the Review of the Termination of life on request and assistance with Suicide* (LRTS), will be referred to as 'physician-euthanasia'.

As I will concentrate on self-euthanasia using lethal drugs, and will only incidentally refer to the process of Stopping Eating and Drinking (STED), the relationship of self-euthanasia to 'normal' or 'plain' suicide must be clarified.²

¹ Cf. Chabot, B. & Braam, S. 2010. (in Dutch) *Uitweg. Een waardig levenseinde in eigen hand. (A Way Out. A dignified and self-determined death)* Amsterdam; Nijgh & van Ditmar. See also www.dignifieddying.com; Vink, T. 2013. (in Dutch) *Zelfeuthanasie. Een zelfbezorgde goede dood onder eigen regie (Self-euthanasia. A self-performed and self-controlled good death)* Budel: Damon.

² As to the frequency of self-euthanasia, research differs widely. Cf. Chabot, B. 2007. (in Dutch) *Auto-Euthanasie. Verborgen stervenswegen in gesprek met naasten. (A humane self-chosen death. Hidden dying trajectories in conversation with proxies)* Amsterdam: B. Bakker; and: Van der Heide, A.(e.a.). 2010. (in Dutch) *Sterfgevallen onderzoek 2010*.

1. SOME DEFINITIONS

The constituent parts, defining a self-chosen 'good death' as I will understand it, in both physician-euthanasia and self-euthanasia, are given below at the beginning of Section 7 (and further discussed in that section).

In the Netherlands physician-euthanasia is understood as 'the deliberate termination of the life of a person on his request by another person, in accordance with the demands of the LRTS'.³ This is supposed to cover both procedures of termination either by drip and lethal injection, or by assistance with the patient's suicide.

Euthanasie en andere medische beslissingen rond het levenseinde. (Investigation into deaths 2010. Euthanasia and other medical decisions related to the end of life) Den Haag: ZonMw. Also: Van der Heide, A. (e.a.). 2012. (in Dutch) *Wet Toetsing Levensbeëindiging op verzoek en hulp bij zelfdoding. Tweede evaluatie. (Law on the Review of the Termination of life on request and assistance with Suicide. Second evaluation)* Den Haag: ZonMw. Self-euthanasia by STED occurs at least 600 times a year, by lethal drugs or medication at least 300 times a year in the Netherlands (Van der Heide 2010, p.84; 2012, p.111). This number of 300 is slowly climbing and is misrepresented in official suicide-rates (totaling approx. 1850; see: <http://statline.cbs.nl/Statweb/search/?Q=suicide&LA=EN>).

³ I deliberately use 'understood'. The definition of the Dutch State Commission on Euthanasia (1985; also adopted in the Belgian *Law on euthanasia*) actually ends after my comma. By way of definition this is quite disastrous, as it covers the neighbour teenage-girl deliberately ending the life of her friend on her request as being a case of 'euthanasia'.

In the same vein, I define self-euthanasia as ‘the deliberate termination of his or her own life by the person himself, under his own control, after clear and careful consideration, and carried out with due care.’ (This is not to define self-thanasia but self-*euthanasia*; I will expand below on what makes it *eu* or good.)

In physician-euthanasia as well as self-euthanasia death is ‘self-requested’. However, by way of vital distinction, only self-euthanasia is also ‘self-performed’ and ‘self-determined’. Self-requested refers to the individual himself wanting, requesting, an end to his life. Self-performed refers to the individual himself preparing and carrying out all of the act. Self-determined refers to the individual having the only autonomously deciding voice.

Finally, I will define ‘self-determination’ (or ‘autonomy’) in the context of self-euthanasia and physician-euthanasia as: ‘The attaining and keeping of control and authority over the process of preparing, deciding and bringing about the termination of one’s life with due care and concern.’

2. A CLARIFICATION: SUICIDE AND EUTHANASIA

If (1) you jump from a 20-storey building, step in front of a speeding train, put your Hemmingway rifle in your mouth and pull the trigger, or take some nasty poisonous substance, then, when you hit the pavement, get hit by the train, have the cartridge splash your brains out, or the have poison burn away your bowels, you will be very dead.

Further (2), depending on the circumstances, some of those who are well-acquainted with your dire situation might after your suicide even say that, irrespective of the way you committed your suicide, it is good, that is, something positive for you, that you’re dead.

But (3) did you die a good death? Obviously (1) results in what we know as ‘normal’ suicide, but for such a suicide to qualify as self-euthanasia, more is needed to be able to speak of a good death. Whether and how far (2) is relevant, will also be subject of debate.

For the moment we can say that every case of self-euthanasia is, by definition, a case of suicide, but the reverse is not true.

3. A CLARIFICATION: PHYSICIAN ASSISTED SUICIDE (PAS)

As to PAS, confusion reigns. If we take PAS-O (Oregon)⁴ we get closer to self-euthanasia as defined above (and to be further clarified below). However, PAS-N (Netherlands) is far removed from PAS-O. In the latter, the physician is allowed to hand over a prescription for lethal medication to his patient, the patient being terminally ill

⁴ Oregon here also represents Vermont, Montana, Washington and California.

and in approximately the last six months of his/her life. The patient thus having obtained his lethal medication returns home and has the liberty to end his life, if he so chooses, during these last months of his life.

In PAS-N this is out of the question. The physician is not allowed to put his patient in the possession of lethal medication to take home and use at his own discretion. On the contrary, in the case of PAS-N the physician is the person in whose possession the lethal medication will remain, until the very last moment. The physician is only allowed to hand over the lethal medication to the patient when the patient is going to ingest the medication *at that moment* and *in the presence of the physician*, this presence being obligatory (in the case of PAS-O a physician *may* be present at the patient’s request, as long as the physician does not administer the medication him/herself).⁵

And in the case of PAS-N the physician also prepares an infusion in order to be able to end the patient’s life by drip, if death does not come within an agreed timespan. (In 2015 this happened in 31 cases, there being 208 cases of PAS-N and 5277 cases of death-by-drip at the physician’s hand.)⁶ The Dutch physician is allowed to do this, as the requirements of due care in both cases are exactly the same. Needless to say, this is not allowed in PAS-O.

The Dutch Annual Reviews contain very instructive case histories, but these case histories only very exceptionally mention whether death resulted from drip or PAS-N. Why? Because the difference is not deemed relevant *in terms of the LRTS*.⁷

4. A FURTHER CLARIFICATION: ‘IT’S THE PHYSICIAN, STUPID’

It is of vital importance to realize that in the Netherlands under the LRTS the requirements of due care are requirements that have to be met *by the physician*, not by the patient.⁸ Although the patient must indeed make his

⁵ Cf. Royal Dutch Medical Association (KNMG) & Royal Dutch Pharmacists Association (KNMP). 2012. *KNMG/KNMP Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide*. Utrecht/Den Haag. Also in English. Available at: file:///C:/Users/Beheerder/Downloads/KNMG-KNMP_Euthanasie_Digi_ENG_DEF.pdf. See p. 13: ‘During the practice of euthanasia or physician-assisted suicide, the doctor must remain present. For the oral method (physician-assisted suicide), this can take several hours.’

⁶ www.euthanasiacommissie.nl: Jaarverslag 2015, April 2016, p. 17. The Annual Reviews are also (partly) translated.

⁷ California’s proposed legalization of *PAS* was announced in the Dutch press (9 December 2015) as the proposed legalization of *euthanasia*. Of course, euthanasia remains illegal in the US.

⁸ For the readers’ convenience, this is what the law requires the physician to do in art. 2.1 of the LRTS: ‘The physician: a. must be convinced that the patient’s request was voluntary and well-considered, b. must be convinced that the patient’s suffering was hopeless and unbearable, c. has informed the patient about his situation and his prospects, d. has come to agree with the patient that there was no other reasonable solution to

well-considered request, the decisive voice is the physician's, that is to say: the physician has to decide whether he or she is *in principle* prepared to put an end to a/the patient's life. If 'no', the request fails and the physician is expected (but not formally obliged) to refer the patient to a colleague. If 'yes', the physician has next to determine whether or not he (the physician) is able answer the requirements of due care. Again, if 'no', the request fails; if 'yes', the request succeeds.

The physician's autonomy is decisive. The patient's autonomy may be of importance in his *requesting* euthanasia, however: '...respect for personal autonomy is not the leading principle of the Dutch approach to euthanasia. (...) Compassion is the leading principle of the Dutch legal norms for euthanasia.'⁹

5. THE DUTCH LAW ON PHYSICIAN-EUTHANASIA

In the European countries of Belgium and Luxemburg, legislation comparable to the Dutch euthanasia-law is now also in effect. But is the Dutch euthanasia-law really about euthanasia or a 'good death'?

For a start, euthanasia isn't mentioned a single time in the entire law. It certainly pays off to look at what this law is literally called: *Law on the Review of the Termination of life on request and assistance with Suicide*.¹⁰ This type of termination of life had already been taking place for years. What the law does is introduce a statutory review procedure, such that while the termination of life remains punishable, a physician answering the requirements of due care as formulated in the Dutch LRTS, will not in fact be prosecuted.

The *reviewing* is the core business. This *reviewing* is done by a small number of committees that style themselves *Regional Review Committees on Euthanasia*. One might therefore think that these committees review whether the patient had died a *good death*. But no. What these committees (in whose formal name the word *euthanasia*, equally, doesn't appear¹¹) review, is whether the physician answered

the patient's situation, e. has consulted at least one other, independent physician who saw the patient and gave a written report on the requirements of due care, referred to above in a to d, and f. has performed the termination of life or given the assistance with suicide, with due medical care.'

⁹ Esther Pans. 2006. *The normative values underlying the Dutch euthanasia law*. Nijmegen, Wolf Legal Publishers, pp. 398/399 (dissertation).

¹⁰ The name of this law is almost always mistranslated by Dutch authors writing in English, ignoring the law's core business. This is the law: *Wet (Law) Toetsing (Reviewing) Levensbeëindiging op verzoek (Termination of life on request) en Hulp bij zelfdoding (and assistance with Suicide)*.

¹¹ They are formally called: Regional Review Committees for termination of life on request and assistance with suicide. From here on: RRC. Reported cases of physician-euthanasia now total some 5000 a year. In 2010: 3136; in 2011: 3695; in 2012: 4188; in 2013: 4829; in 2014: 5306; in 2015: 5516.

the requirements of due care in the LRTS. And you will look in vain for the requirement of the patient dying a 'good death'.

Over the years now some 50,000 cases have been reported to the RRCs. Virtually *all* cases (close to 99.9%) were judged to meet the requirements of due care and, although on a few exceptional occasions an RRC had some criticism or invited the physician for some further clarification and duly reported to the public prosecutor, so far not a single physician has ever been brought to court, let alone been convicted, due to the review of the RRCs.

But what about the patient? Did he or she die a *good death*? We may have little reason to doubt that an overwhelming majority of the 50,000 died a good death and it is more than likely that the requirements of due care contributed to this. But we don't really know; *the question isn't asked* by the RRCs and it seems to be taken for granted. However, what we *do* know, is that on occasion a patient dies a death that in no way can be called 'good'. And as Karl Popper would have it, this refutes the theory that all physician-euthanasia 'with due care' results in a good death for the patient.

A case in point is the death of a patient suffering from advanced dementia.¹² The physician acted on the well-kept advance directive of the patient who had left no doubt about her views and wishes over the years, but who was no longer mentally competent enough to verbally ask for the termination of her life. The physician acted in accordance with Section 2.2 of the LRTS. The RRCs judged that the physician met the requirements of due care. The patient however, was described in the Annual Review as 'in fear', 'in panic', 'desperate' and 'no longer mentally competent'. Some information reached the RRCs only *after* their judgement (though they might have been more critical *before*).

As it turned out later, the requirement of consulting 'at least one other, independent physician' was not really met, as this physician who reported positively was *before-hand* known to take a favourable stand.¹³ Also, the patient was no longer really aware of what was happening when death came,¹⁴ and previous to the official procedure, sleeping medication (*not* pre-medication as mentioned in the official formal procedure) was

¹² Jaarverslag (Annual Review) 2011, pp.21–24, Casus 7, www.euthanasiecommissie.nl.

¹³ There is no doubt about this, given the honest story as published by the surviving partner, in H. Smit & H. van Gelder. 2013. *Wils Verklaring. De alzheimerepidemie en het recht op zelfbeschikking (Wil's Advance Directive. The Alzheimer-epidemic and the right to self-determination)* Arnhem: aquaZZ. (See: www.wils-verklaring.nl.) A firstly consulted physician reported negatively.

¹⁴ As investigative journalist Antoinette Reerink uncovered in her report 'The woman who no longer knew she wanted to die' (NRC 2 February 2012).

administered secretly.¹⁵ Most conspicuously, the physician told the family that he would *not* proceed with the termination of life if any member of family insisted on being present.¹⁶ (The presence of a trained ex-nurse and friend of the family was allowed). The physician, who kept his promise to his patient in dire circumstances, was aware that members of family would not be looking at a pretty sight.

It is certainly debatable whether this patient died a good death.¹⁷ This is especially interesting, as this is a case in which it might be argued that it is good that the patient is dead.

6. AN EXAMPLE OF SELF-EUTHANASIA

Thomas, who was 83 when we met, was suffering from the onset of dementia. It was an illness he had seen progressing in both his parents for years. Already a long time ago he, therefore, had decided that, should he be diagnosed with the same disease, he would put an end to his life in time, on his own conditions before his dementia could get the better of his autonomy. This was his reason for deciding to consult a counsellor. Thomas had a partner who supported him, children who did the same (in fact the counsellor was at first called in by one of his children) and a number of grandchildren who were also aware of the state their grandfather was in, and of the plans he had made for himself. In this respect, despite his illness, Thomas was well off. Needless to say, the family was in pain about his impending final goodbye.

Thomas' physician, who felt he could not answer the requirements for physician-euthanasia, nevertheless continued to give his support to Thomas and his family. The physician contacted the counsellor because he wanted to assure himself of the reliability of the process, including the medication Thomas was going to use (anti-emetic; 1,2 grams of oxycodone; 120 milligrams of flunitrazepam).

The local pastor – obviously of a free-thinking kind – was also aware of what was going to happen and he offered his spiritual support to the family. So, the evening before Thomas was going to take his lethal dose of medication, the pastor held an intimate service at their home. Present were Thomas, his wife, their children and grandchildren, to celebrate Thomas' life.

Next morning, surrounded by his family, Thomas said his final good-bye. At the beginning of 2014 the family

¹⁵ See: Reerink note 14, and Smit & Van Gelder, *op. cit.* note 13, p. 148.

¹⁶ Smit & Van Gelder, *op. cit.* note 13, p. 134: 'Strange as it may sound, I would have loved to be present at my mother's death. But the physician wouldn't have it.' (Says one of the children)

¹⁷ The case became notorious and as such is one of the cases that caused the government to ask for a 'Code of Practice' by the RRCs: www.euthanasiecommissie.nl (April 2015).

published a small booklet telling the story of the self-euthanasia of their beloved Thomas.¹⁸ They openly told their story, including the contributions by the physician, the pastor and the counsellor, who were all mentioned by name.

7. A GOOD DEATH

Now, what about a 'good death'? Did Thomas die a *good* death? His death was self-requested (as it would have been as physician-euthanasia), but it was also self-performed and self-determined (distinguishing it as self-euthanasia).

But what would allow us to call his death an example of '*eu* thanatos', a '*good* death'? Thomas' obituary opened quoting Seneca: 'Dying well means escaping from the danger of living badly' (*Letters to Lucilius*, 70). This is certainly not to say that he liked to die, but there was a danger lurking: the mental darkness of his progressing dementia. And that, to him, meant a future of 'living badly'. To avoid this danger, he himself chose to die – the lesser of evils. And being able to make this choice, autonomously and independently, and thus avoiding the danger meant he died well.¹⁹

Seneca's saying (*Bene autem mori est effugere male vivendi periculum*) is therefore also aptly chosen as it does not say that it is good that Thomas is dead. It doesn't say 'Being dead means having escaped from a bad life' because being dead means having escaped from any life, good or bad. Seneca's 'dying well' refers to the quality of a deliberate choice in the face of an impending danger. A good death in self-euthanasia therefore refers to a *process* (autonomously led by the still living individual) rather than to a *result* (the individual being dead).

What are the constituent parts of such a 'good death', the qualities of this process? There certainly is an individual, indeed subjective, maybe even arbitrary element involved in such a choice, as we are dealing with the self-determination of individuals in situations that are specific to the individual as well. After all, it is *their* life (and death).

But nevertheless, I will propose, as such constituent parts of a 'good death', the following. A 'good death' means a death:

- (a) decidedly self-chosen after clear and careful consideration
- (b) in which the individual's role is as large as possible

¹⁸ Eykman, M. 2014. (in Dutch) *Liever Goed Sterven. Dit verhaal moet verteld worden (Better to Die Well. A story that must be told)* www.bestelmijnboek.nl/www.bol.com.

¹⁹ Thomas might have approached his physician, requesting physician-euthanasia. As a matter of fact he did (*Ibid.*: p. 11) but supportive as the physician was, this was 'a bridge too far'.

- (c) carried out with the utmost care and without adding pain or suffering
- (d) that is not executed in forced loneliness
- (e) if at all possible, prepared in contact with loved-ones
- (f) considered (given the circumstances) as dignified
- (g) and accepted by the individual in peace and quiet.

Two further constituent parts, vital in the case of self-euthanasia, are:

- (h) death is self-performed, and
- (i) death is self-determined.

This 'good death' is aimed at in *both* physician-euthanasia and self-euthanasia. But there are differences, as conditions (b), (h) and (i) will be met to a (sometimes very much) lesser degree in the case of physician-euthanasia, while death will still be a *good* death. This 'good death' is *an ideal* that you might strive for, *a value* you might strive to realize as completely as possible, in often trying circumstances.

Let's take a closer look at these constituent parts.

- (a) *Decidedly self-chosen after clear and careful consideration.* This is very similar to the first requirement of due care in the LRTS, where it is stated the physician must have convinced himself that his patient's request was voluntary and well-considered.

In the case of self-euthanasia this will refer to the individual being mentally competent. In the Netherlands adult individuals are taken to be mentally competent, *unless* lack of mental competence is evident (e.g. on psychiatric grounds or dementia already having progressed too far). The decision to end your life after clear and careful consideration is *not* taken to be a sign of a lack of mental competence.

There is no outside authority involved in the case of self-euthanasia. It is advised to leave behind, clearly visible, written or recorded documentation such as a 'living will' or 'advance directive' and a document stating that the self-euthanasia was: turned to after careful consideration; performed without punishable assistance of others; prepared by oneself, the preparation including the obtaining of the lethal medication; and performed using the following medication (names); attended to by loved-ones who were present only by way of moral support, without actively contributing to the process.

- (b) *In which the individual's role is as large as possible.* Here – and actually in (h) below – we have qualities that are cause for debate. It is only in less than 4% of the Dutch cases of physician-euthanasia that the patient has lethal medication handed over to him by the physician and ends his

life by drinking it, in the presence of and under the responsibility of, the physician.²⁰ Of course, the patient's condition may be such that it is impossible or irresponsible to have the patient (try to) drink lethal medication; in this situation drip and/or lethal injection will be not only inevitable but mandatory. However, it is highly questionable if this is the condition the patients where in, in all of the 96% of the cases where drip and/or injection was in fact resorted to. Why isn't the patient required to perform himself all the acts he *responsibly* can? The weight and importance of the occasion would surely justify this.

As to self-euthanasia, (b) – and even more (h) and (i) –, are constituent and distinctive parts; they must be, as it is *self*-euthanasia and also in order to prevent others from coming into conflict with the Dutch law against assistance with suicide.²¹ This does not mean that some form of help may, in exceptional cases, not be required and allowed.²²

- (c) *Carried out with the utmost care and without adding pain or suffering.* This corresponds to one of the requirements of the LRTS saying the physician-euthanasia must have been performed 'with due medical care and attention'. In the case of self-euthanasia it refers to death being brought on without causing harm to others, i.e. no sudden confrontation, no aggressive methods; and to ensuring that death will follow with the utmost certainty.

Very often, or almost always, there will be pain and suffering in the circumstances leading up to either physician-euthanasia or self-euthanasia. But (c) simply also requires no more pain or suffering being added.

In the case of physician-euthanasia this will seldom if ever cause any problems. In the case of self-

²⁰ See the Annual Review 2015, p. 17, www.euthanasiecommissie.nl, April 2016.

²¹ The legal situation regarding assistance with suicide may vary significantly in different countries. Due to several court-rulings (Mulder-Meiss 1995, Cornelisse 2003, Muns 2005, Vink 2007) a measure of non-punishable assistance with suicide is recognized in the Netherlands, usually summarized as 'having talks, supplying information and offering moral support'. The talks are important, not in the least because of their preventive effect (which is not their purpose). The information may be in the nature of advice, but it must not be an instruction. The moral support may include being present at the self-euthanasia, but with no active contribution.

²² I am referring to a case in point in the Netherlands, presented by a 99-year old woman who received help from her son who supplied her with (part of) the medication she needed for her self-euthanasia. This case was brought to court. The son was found guilty-without-punishment. Both prosecutor and defence appealed. In appeal the son was acquitted and the case will now be brought for the Dutch Supreme Court. The case might go as far as to the European Court of Human Rights. It is extremely interesting but there is no room to go into it here.

euthanasia the matter of obtaining the right means and/or support to end life may complicate matters.

Self-euthanasia by way of voluntary refusal of food and drink requires, by necessity, the collective support of physician, domiciliary care and, if available, family. Together they can ensure that no unnecessary pain or suffering is added. Further, Dutch authorities consider death caused by the voluntary refusal of food and drink a natural death. This is a very fortunate, although not very logical, circumstance, keeping the police at bay and allowing an atmosphere of peace, quiet and possibly serenity.²³

The situation changes when life is ended by the use of lethal drugs. It is vitally important that these drugs be reliable, answering to pharmaceutical standards. This means no fake medication or insufficiently effective drugs be used. Though it is surely (that is: empirically proven) possible to obtain reliable drugs without too much difficulty, this may easily constitute a criminal offence, as many of these drugs are prescription drugs. This is part of an ongoing debate: is an individual allowed to decide that the value of gaining and keeping control, for now or in the future, over the end of his or her own life, is of such importance that it allows the individual the put aside as (far) less important the value of obeying the law on pharmaceuticals?

- (d) *That is not executed in forced loneliness.* In (d) we meet with a demand that is easily answered in the case of physician-euthanasia, being covered by law. It is certainly possible that it is an event that causes hardship and grief to surviving relatives and they may be in need of comfort, support and spiritual aid. However, they will not be bothered by legal authorities.

This changes in the case of self-euthanasia. Being present at the self-euthanasia of your loved one is allowed in the Netherlands and there is no obligation to prevent the event occurring. Court-rulings have made this clear. But as death by self-euthanasia is (still) considered to be a non-natural death, your physician has to contact the coroner, the coroner has to contact the (assistant) public prosecutor, and the (assistant) public prosecutor will order police-officers to go down and check if nothing untoward has happened.

This means that surviving relatives who may be equally in need of comfort, support and spiritual

aid, will instead meet with (actually unnecessary) police interrogation and investigation. As a result, it sometimes happens that an individual deciding on self-euthanasia, in order to protect his loved ones from the emotional strain occasioned by having to confront police and legal authorities, may feel obliged to end his life in (forced) loneliness. This surely is regrettable and unnecessary. It would be wise if in the near future it was decided that physician and coroner together suffice, further action only being undertaken when they, together, deem this necessary on relevant grounds.

- (e) *If at all possible, prepared in contact with loved ones.* Closely connected with (d), the contact with loved ones again is something of a matter-of-course in the case of physician-euthanasia. But it is equally important, and perhaps even more so, in the case of self-euthanasia. The matter at hand is of deep significance and will continue to play an important role in the lives of the surviving relatives. This makes it important, if not imperative, to try to make a decision of this nature in contact with loved ones, so as to allow them to come to grips with what will eventually happen. It may help them to find peace with otherwise confronting events.

Just ask yourself what would disturb you most: hearing your loved one just died in a serious traffic accident, or hearing your loved one just ended his/her life by way of self-euthanasia? An accident is easier to cope with, because, well, because it was an accident. Self-euthanasia is never an accident, and that may make it a heavy load indeed.

- (f) *Considered (given the circumstances) as dignified.* Here we meet with a quality that has something of a slogan. There are organizations such as Dignity in Dying, and Oregon even has a Death With Dignity Act. The situation that causes people to want to put an end to their lives, often shows little 'dignity'.

But even though it may be difficult to pinpoint what this dignity exactly 'is', its absence due to illness breaking down the individual physically and mentally, will certainly be considered adverse to a 'good death'. So whatever may contribute to the dignity of the situation is certainly welcome.

- (g) *And accepted by the individual in peace and quiet.* This is a spiritual quality of a good death. In the process the individual will need to grow towards an acceptance of his approaching end, such that, in both physician-euthanasia and self-euthanasia, the end of life is sincerely self-requested.

If there is no such acceptance in peace and quiet, death may certainly be the cause of added pain, grief and sorrow; for the (hesitating)

²³ As Govert den Hartogh, former professor and former member of one of the RRCs argued, e.g. in his commentary (*Tijdschrift voor Gezondheidsrecht* 2014; 3: 193–201) on the recently published 'Caring for people who consciously choose not to eat and drink so as to hasten the end of life', by The Royal Dutch Medical Association (KNMG), January 2015.

individual at the moment of death itself and for relatives in times to come.

- (h) *Death is self-performed* and (i) *Death is self-determined*. These are features only fully present in self-euthanasia.

End-of-life decisions surely are among the most important decisions anyone can take. In the case of self-euthanasia, the weight of responsibility rests squarely on the shoulders of the individual choosing to end his or her life. To me, this seems both obvious and preferable. However, under the Dutch LRTS it is the physician who carries – and *has* to carry – the weight of responsibility, even though it is the patient who has to make a well-considered *request*.²⁴

I would hazard a guess that this is a main part of the explanation for the mere 4% of PAS-N, the physician saying ‘well, if I am to carry this responsibility, I want my control over the event also to be as full as possible, for which reason I will end my patient’s life by drip and injection.’ Conditions (h) and (i) will therefore only be (very) partially met in physician-euthanasia. And so Kouwenhoven’s (et al.) concluding ‘Paradoxically, the choice for PAS is predominantly a physician’s one’ is, as it concerns PAS-N, less paradoxical than it may seem.²⁵

These several constituent parts distinguish self-euthanasia (and physician-euthanasia, for that matter) from plain suicide (and killing on request). And what should also be clear by now is that the difference lies primarily in the *process* and its constituent parts, not in the result. Comparing Thomas’ self-euthanasia (Section 6) with the case of physician-euthanasia (the patient in Section 5) underlines this. Given the patient’s consistent wishes and views, it is tempting to say that it is good and a relief that she’s dead, but she certainly did not die a good death. Thomas’ relatives will never say that it is good and a relief that he is dead; but they are grateful that he died a good death.

Self-euthanasia is clearly normatively laden. As a result individual cases may come close to the ‘best practice’ (the case of Thomas) or may fail to do so. This makes the distinction with plain suicide fleeting.²⁶

²⁴ Such a request certainly does *not* imply a patient’s *right* nor a physician’s *obligation*.

²⁵ Kouwenhoven, P.S.C., Thiel, G.J.M.W. van, Raijmakers, N.J.H., Rietjens, J.A.C., Heide, A. van der, Delden, J.J.M. van. Euthanasia or physician-assisted suicide? A survey from the Netherlands. *Eur J Gen Pract* 2014; 20 (1), 25–31. See also note 5 for further corroboration on account of the time-laps in the case of PAS-N.

²⁶ As is also the case with physician-euthanasia and killing on request, the LRTS being founded on open norms or ethical principles: compassion (the leading principle), the value of human life, respect for autonomy and human dignity (cf. Pans, *op. cit.* note 9, p. 398 ff). The ‘Code of Practice’, published by the RRCs in April 2015 is surely a ‘Code of best Practice’.

8. A MORAL ISSUE AND ORDER OF PREFERENCE

Both physician-euthanasia and self-euthanasia refer to an ideal process of a *good* death, the first being ultimately the physician’s responsibility, while the second is definitely the responsibility of the individual choosing to die. They differ in the extent to which conditions (b), (h) and (i) are met, and this ultimately boils down to the difference between ending or terminating another person’s life, and ending or terminating your own life.

How important is this difference? Are we not to say that the only life that we are master of, even to this extreme extent of terminating it, is our own life? And not the life of another human being, excepting certain very special situations? (Even the *denying* this mastery over our own life is our own choice and ought to be limited to our own life.)

What, then, is the moral weight and justification of asking someone else (your physician) to end your life (physician-euthanasia under the Dutch LRTS), while you could do this yourself (self-euthanasia)? Isn’t this an unburdening of yourself of a responsibility that is actually inalienable, again excepting certain very special situations?

Both the Dutch and Belgian law on physician-euthanasia provide for an advance directive. In case of a sudden and speedy deterioration, loss of speech, loss of consciousness, coma, etc. this may supply the physician with valuable information on how to act in agreement with the patient’s views, provided the physician is able to answer the requirements of due care.

However, the advance directive is hotly debated when it comes to Alzheimer’s and other forms of slow but certain loss of mental capacities. Isn’t an advance directive here equally an unburdening of yourself, by you yourself writing down when someone else is supposed to terminate your life, in an adverse situation that you see coming ahead and before the arrival of which you could end your life yourself?

And given that the laws on physician-euthanasia specify the *necessary* conditions that have to be met, does this mean that therefore *sufficient* conditions to end another person’s life, are met at the same moment as well?

These questions all seem to point in the same direction, when dealing with a self-chosen death – again excepting and accepting the necessary special situations – that we ought on moral grounds to prefer, whenever possible, self-euthanasia to physician-euthanasia and in the case of physician-euthanasia, whenever possible, assistance with suicide to drip and injection.

Currently, the order of preference is that firstly physician-euthanasia by drip and/or lethal injection

ought to be used; secondly, but as it seems reluctantly, physician-assistance with the patient's suicide; and thirdly, but with a sense of disapprobation, self-euthanasia.

However, my arguments in this article lead to the opposite order of preference, the fundamental reasons being (1) the constituent parts of a good death as a process, discussed in section 7, supplemented by (2) the moral weight of the difference between ending or terminating another person's life, and ending or terminating your own life.

A self-chosen *good* death may result from both physician-euthanasia and self-euthanasia, both being normatively laden processes, representing an ideal to realize as fully as possible and as such to be distinguished from plain killing on request and plain suicide,

respectively. However, if we also accept the existence of a fundamental moral difference between ending another person's life and ending your own life, and if we accept this moral difference to be also relevant to the normatively laden *good* death, *then* this difference represents a strong reason for preferring self-euthanasia to physician-euthanasia.

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