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Trust and Cooperation in the Euthanasia Discussion in the Netherlands and United States

Religion, prostitution, marijuana, euthanasia— for centuries, the Netherlands has been known for its tolerant approach to a variety of controversial topics. From the country's history with religion to the current era with drugs, sex, and euthanasia, tolerance under the reasoning of openness has been a hallmark trait of Dutch culture and society. Meanwhile, a majority of the world (including developed countries such as the United States), retains a conservative approach in legislation regarding all three current topics. What factors influenced Dutch culture to allow an entire country to take such a socially liberal stance? This paper aims to examine the historical and cultural settings that gave rise to Dutch tolerance, with a specific focus on trust and cooperation in the Netherlands in the context of euthanasia, and will briefly contrast it with the United States.

An Overview of Dutch History and Culture: Cooperation

Perhaps one of the most striking aspects of Dutch culture to visiting foreigners is the unique blend of individualism and teamwork. While the United States is known for the Revolutionary War saying, "United we stand, divided we fall", the euthanasia debate (among other topics) has proven to be particularly divisive throughout the country. So how did this paradoxical yet effective combination for the Dutch come about?

Geographically, the Netherlands is where three large rivers— the Rhine, the Meuse/Maas, and the Scheldt— reach the ocean. The land on which the country is located is essentially a river delta. However, since the area is rich in peat, which is preferable for farming, early settlers developed a complex system of dikes, pumps, and channels to allow for the peat to be drained. As a result, since peat sinks when drained of water, most of the country lies below sea level, so the drainage system remains in place to this day to keep water out (Shorto 2013).

It is this constant threat that appears to set the Netherlands cooperation apart from the United States—for the Americans, the revolution has long been over. For the Dutch, the sea will always remain a concern. If defenses are overwhelmed, severe flooding would occur— the most recent instance being the North Sea flood of 1953. As a result, in spite of whatever differences individuals or groups may have in beliefs and opinions, the maintenance of the country's water

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system requires cooperation by all, especially since no single political party has ever claimed a majority of the Dutch Parliament (Trappenburg and Oversloot 2012). This “work together or drown” mentality, described as “high on cooperation and low on competition”, persists throughout Dutch society and politics, allowing for compromises to be reached for less dramatic topics—one example being the decades-long abortion debate ending with compromise in the formation of an abortion law in 1982 (Trappenburg 2012; Trappenburg and Oversloot 2012).

An Overview of Dutch History and Culture: Individualism

A combination of factors can be attributed to the sense of individualism in Dutch society. Some of these can be traced back to when the Netherlands were merely provinces of the Holy Roman Empire. Since Amsterdam had become an international religious site and trading hub, the region’s taxes supplied a sizable portion of the Empire’s income. In return, they received protection from and were, for the most part, left undisturbed by the Empire.

Unlike the majority of medieval Europe, the provinces of the Low Countries did not function under a manorial economic system, where serfs and peasants served nobility. And, since the land had been reclaimed from the sea or peat bogs, neither the Church nor nobility had any ownership claims. Instead, individuals from all societal levels had ownership of their plots of land. This allowed even peasants to rent, buy, or sell their properties as they pleased, rather than working on nobility-owned lands (Shorto 2013).

While Russell Shorto notes in his history that it is impossible to determine definitive causes-and-effects for the hallmark traits of Dutch society and culture, he comments that this combination of a wealthy international trade port (which increased residents’ exposure to a variety of beliefs and cultures), and individually owned plots of land likely contributed to citizens being “less inclined to adopt the posture of obedience that serfs and peasants elsewhere were forced into” (2013).

So, with this blend of community cooperation, self-reliance, and individualism, combined with the flat landscape allowing for easy diffusion of ideas and beliefs, Dutch administrators under the Holy Roman Empire were among the first to explicitly point out that tolerance would be a more practical approach to actions that would happen regardless of law. This attitude would

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later play a large role in the Low Countries during the Spanish Inquisition and subsequent Dutch revolt, and would persist through the centuries to modern times in euthanasia discussion (2013).

A Brief History of Euthanasia/PAS in the Netherlands

For many Western countries, the word “euthanasia” has a strong negative connotation associated with Hitler’s actions leading up to and during World War II. Prior to that, in the early 20th century, a few other countries—including the United States—had open discussions regarding the possible legalization of euthanasia. All of these discussions eventually ended without legalization (Kennedy 2012).

Such discussions arose in the Netherlands several decades later, in the 1960s. James C. Kennedy offers an explanation for the delay: the social and political aftermath of World War I neutrality and privacy of religion discouraged open discussion about such a topic. However, this later discussion eventually allowed for the Dutch to view euthanasia as a morally acceptable action. Three key factors were involved: unlike the United States, the euthanasia debate in the Netherlands only briefly offered social arguments in favor and instead approached the subject from an individual perspective. This in turn allowed for the argument to become dissociated from the term’s negative connection with World War II. Finally, anti-taboo cultural movements in the 1970s and 1980s allowed the Dutch to use the open discussion of death and dying as an opportunity to grow from their old “hypocritical and untruthful” moral system where euthanasia existed but only in secret (Kennedy 2012; Trappenburg 2012).

This discussion eventually led to the requirement for physicians to report euthanasia and physician-assisted suicide (PAS) in 1991. General practitioners (GP) sent reports to the medical examiner, who passed them on to the prosecution system. While euthanasia and PAS were not technically legal, there was little risk of prosecution of the physicians as long as they acted with due care. The requirements for due care are as follows: the request for euthanasia must be voluntary, lasting, and well-considered, the patient must be suffering unbearably and hopelessly, without any acceptable alternatives for treatment, and the GP must consult another physician and report the case (Weyers 2012).

The prosecution chain changed in 1998—euthanasia and PAS reports went to Euthanasia Review Committees (ERC), which read the cases and advised the prosecutors regarding due care

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practices. The prosecutors retained the power to decide whether or not to pursue a case. Finally, the most recent iteration of the law was passed in 2002. This law permits euthanasia and PAS under the condition that due care has been met. The ERC continues to review cases, but only passes them to prosecutors if they determine that the criteria for due care have not been met (Onwuteaka-Philipsen 2012).

Throughout all three versions of the law, it is clear that meeting due care criteria is a key point in euthanasia and PAS regulation. The criteria remain essentially unchanged while the reporting chain progressively increased the distance between physician and prosecution. Since a 1995 study had shown that the 27 physicians who chose not to report euthanasia and PAS mostly did so to avoid judicial inquiries, the reasoning behind the reporting changes was to encourage more physicians to report euthanasia and PAS. This seemed to be a step in the right direction—in addition to finding that the number of unreported cases was even lower than before, a 2001 study showed that reporting physicians indicated themselves that they would have been less likely to report under different circumstances (such as increased risk of prosecution, reporting to the prosecution office instead of ERC) (Onwuteaka-Philipsen 2012).

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These review committees are unique to the Dutch system. In the United States, Oregon and Washington have legalized PAS (but not euthanasia). Since there is no independent committee dedicated to reviewing PAS reports, cases are instead monitored by the states' respective health departments.

It is interesting to note that American critics of the PAS laws within the United States and abroad are primarily concerned with physician bias influencing patients' and consultants' decisions. In addition to bias, in the instance of Oregon, there are criticisms of limited data collection and a lack of transparency in data release. Their proposal to introduce an independent committee of expert, out-of-state reviewers stems from a desire to counteract perceived biases (Foley and Hendin 2002).

A difference in relationships can be seen here: while the Netherlands introduced ERCs with the primary goal to reduce the number of unreported cases (thus increasing transparency, as Griffiths (2012) notes) by increasing prosecution distance and decreasing its likelihood,

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