Attitudes of Dutch General Practitioners and Nursing Home Physicians to Active Voluntary Euthanasia and Physician-Assisted Suicide

The November 1995 report[1] on attitudes of Dutch general practitioners toward euthanasia was both thought-provoking and disturbing. Dr Onwuteaka-Philipsen et al make several inaccurate generalizations in the article. They state that "requests made to Dutch physicians far outnumber the actual administrations of EAS [euthanasia and physician-assisted suicide]." According to statistics reported by the government-appointed Committee to Investigate the Medical Practice Concerning Euthanasia, there are actually 25 306 cases of euthanasia annually in the Netherlands. This number far exceeds the 2300 cases of active voluntary euthanasia, which was the definition of euthanasia used by the committee. The figure of 2300 refers only to only voluntary and active cases, thereby excluding all cases of involuntary or indirect euthanasia. Taken as a whole, these figures far exceed the 6700 annual requests for euthanasia. The massive underreporting and underrecognition changes the setting within which physician attitudes are described.[2]

The rule that physicians in the Netherlands are required to report cases of euthanasia is often disregarded. In cases of voluntary euthanasia, 72% of physicians had concealed the fact that a patient had died by means of euthanasia and 19% of general practitioners had disregarded the rule for consultation. There were over 5900 cases of active involuntary euthanasia. This is clearly a violation, because the patient's request is supposed to be mandatory. The article by Dr Onwuteaka-Philipsen et al contributes to a superficial and very alarming appraisal of the situation of euthanasia in the Netherlands. The conclusions of their study of general practitioner attitudes becomes invalid given the reality of Dutch government statistics on euthanasia.[2]

Some Dutch physicians are now opposing further liberalization of the laws governing euthanasia, saying "euthanasia has already placed a heavy burden on doctors' shoulders, and that they should not accept [a] further burden."[3] Dutch physicians and others can no longer uncritically accept the Dutch experience with euthanasia.

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1. Onwuteaka-Philipsen BD, Muller MT, van der Wal G, van Eijk JTM, Ribbe MW. Attitudes of Dutch general practitioners and nursing home physicians to active voluntary euthanasia and physician-assisted suicide. *Arch Fam Med.* 1995;4:951-955.
2. Fenigsen R. The report of the Dutch Governmental Committee on Euthanasia. *Issues Law Med.* 1991;7:339-344.
3. Sheldon T. Dutch doctors oppose new euthanasia proposals. *BMJ.* 1996;312:465-466.

In reply

The reaction of Dr Hammer shows concern for the Dutch experience with EAS. However, his comment is based on some misconceptions. Reading the primary data source, it becomes clear that the Committee to Investigate the Medical Practice Concerning Euthanasia (the "Remmelink Study") did not report that there are 25 306 cases of euthanasia annually in the Netherlands.[1,2] *That figure is arrived at by reordering the data, adding up voluntary active euthanasia, physician-assisted suicide, life-terminating acts without explicit request of the patient, a large part of the decisions to alleviate pain and symptoms, and nontreatment decisions and defining it all as euthanasia. The problems and confusion that are a result of this reordering are well described by the researchers of the Remmelink study.*[3] *The Remmelink study did not report 5900 cases of involuntary euthanasia. They did report about 1000 cases of life-terminating acts without explicit patient request. Preferring this terminology over "involuntary euthanasia" is based on more than semantics, since 600 (59%) of these patients were involved in some way or other, although not in the sense of explicitly requesting the end of life to be hastened.*[2] *The other 400 patients did not voluntarily request euthanasia, but there was no indication that physicians ended their lives against their will (involuntary).*

We studied euthanasia and assisted suicide following the same definitions as the Remmelink study. Euthanasia is the intentional termination of life, by someone other than the patient, at the patient's request, and assisted suicide is intentionally helping a patient to terminate his or her life at his or her request. The responding physicians' attitudes only concern euthanasia and assisted suicide following those definitions. Therefore it is fair to say that the number of requests far outnumber the actual administrations of EAS.

Finally, the quote from the report by Sheldon (Dr Hammer's reference 3) is blown out of proportion, since it concerns criticism of the reporting procedure and not of the practice of euthanasia itself. Euthanasia, assisted suicide, and other decisions concerning the end of life are difficult subjects in which moral, emotional, judicial, and medical aspects come together. We think an open debate is necessary to make sure these decisions are made prudently, transparently, and in a controlled manner. It is desirable to use the same definitions to avoid confusion. Studying the attitudes of the people involved and the inci-

dence and characteristics of these decisions is important for such a debate. For participation in the debate it is also necessary to read the original data.

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1. van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. *Lancet*. 1991;338:669-674.
2. van der Maas PJ, van Delden JJM, Pijnenborg L. Euthanasia and other medical decisions concerning the end of life. *Health Policy*. 1992;22:1-262.
3. van Delden JJM, Pijnenborg L, van der Maas PJ. Dances with data. *Bioethics*. 1993;7:323-329.

The Emotional Impact of Mistakes on Family Physicians

Concerning the editorial, "Physicians' Mistakes,"[1] and also the article by Dr Newman, "The Emotional Impact of Mistakes on Family Physicians"[2]—yes, we all make mistakes, as we all know. The pity of it is not just the mistake itself, but that the atmosphere in which we practice militates against our learning from each others' mistakes.

About 2 or 3 years ago, there was a spate of items in various medical journals (mainly letters to the editor) about whether it was as much fun to practice medicine compared with 10 or 15 years before (*American Medical News*. August 23, 1993:30 and October 4, 1993:27f). The fact that we do not discuss our mistakes is part of the reason much of the "fun" is gone.

This whole topic of "mistakes" and the difference between now and then was brought forcefully home to me in, of all places, the Cardiology Institute in Mexico City, Mexico. A large delegation from the Maryland medical society scheduled 3 days of lectures at the institute. One of the most fascinating papers read was by the director of the institute, and consisted of an hour of discussion, complete with statistics, x-rays, cineaortography, and so forth of various clinical procedures and diagnostic studies that had gone "wrong." This paper elicited a lively discussion, as physicians in the audience began exchanging clinical information on things that had gone wrong for them.

Eventually, a member of the audience asked the inevitable question, "What do you do about malpractice?" The answer brought first a pause, and then even some cheers as some of the audience stood. The director said that in Mexico it was illegal to sue a doctor who had merely made a mistake.

'Nuff said.

This is the reason that we feel so constrained with one another about our mistakes, and the pity is we then have lost opportunities to learn from them and to help one another and, ultimately, our patients.

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1. Ely JW. Physicians' mistakes: will your colleagues offer support? *Arch Fam Med*. 1996;5:76-77.
2. Newman MC. The emotional impact of mistakes on family physicians. *Arch Fam Med*. 1996;5:71-75.

Editor's Note: Most malpractice insurance companies and risk management consultants recommend that physicians not discuss potential lawsuits, ie, mistakes, with anyone except their lawyer. That way, physicians cannot be forced in court to testify that they have already admitted "guilt." I think this forced silence makes the burden of malpractice suits even greater.

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In reply

I agree with Dr Guazzo that we have created an environment that constrains our capacity to learn from one another's mistakes. A number of factors are responsible for this lack of opportunity. A primary reason is our preoccupation with perfection. Our perfectionism is embedded in personal, social, and professional norms. One of the greatest challenges we face is accepting ourselves for who we are. By nature of our inherent human imperfection, we all are bound to miss the mark and make mistakes. But the high expectations we have of ourselves often do not allow us to be any less perfect in our personal lives than in our professional roles.

The physicians in my study condemned themselves not so much because they feared malpractice, but primarily because they were ashamed of their mistakes and afraid of what other people would think of them. A culture founded on compulsion, overachievement, and being in control makes vulnerability, fallibility, and imperfection taboo. Being less than perfect is shameful, and disclosing failure is humiliating.

Unfortunately, as Dr Guazzo points out, the looming threats and painful wounds of malpractice rob us of opportunities to learn from our mistakes and help each other. They compound our tendency to hold in negative feelings and turn them against ourselves instead of sharing them with others. These conditions should compel us even more to re-create an environment where we can feel safe, receive support, provide acceptance, and experience forgiveness. This requires us to take the risk of being vulnerable and opening up to one another. Doing so will hopefully enable us to overcome our perfectionism and accept ourselves for who we really are.

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