

COMMENTARY

Commentary on Rissfeldt: The Small Matter of the Doctor's Autonomy

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Introduction

In his article, Thomas Rissfeldt argues the compatibility of palliative care with euthanasia and assisted suicide.¹ By his account, many working within the field of palliative care feel that euthanasia and physician-assisted suicide are incompatible with palliative care. Wrongly, according to the author, since (1) the aims of palliative care and euthanasia/assisted suicide are not different, (2) euthanasia and assisted suicide are compatible with the fundamental role of the physician as healer, and (3) euthanasia and assisted suicide do not necessarily constitute patient abandonment.²

I assume that Rissfeldt's argument is addressed primarily to the opponents of euthanasia and physician-assisted suicide in general. But I also assume that it is directed at physicians practicing in countries where euthanasia and assisted suicide are legally possible, and that it is intended to persuade them to be less reticent when asked to perform euthanasia or to assist in suicide. According to the author, there is little reason for such reticence, as palliative care does not make euthanasia or assisted suicide redundant: Palliative care is not always available and effective, and palliative care is not always preferable to euthanasia or assisted suicide.³

In my commentary, I hope to explain why in at least one country in which euthanasia and physician-assisted suicide have been legalized—the Netherlands—physicians are not likely to be persuaded by Rissfeldt's line of reasoning.

Patient Abandonment

Rissfeldt acknowledges that a patient who requests palliative care but is offered euthanasia instead is abandoned by her physician.⁴ However, because palliative care and euthanasia (or assisted suicide) are alternative options at the end of life, the reverse is equally true, according to the author. The patient who requests euthanasia but is offered palliative care instead is also abandoned by her physician. Respecting a patient's autonomous decision is what constitutes companionship, so he adds, whether the decision is for palliative care or for euthanasia.⁵

This would also imply that the patient's autonomous decision for euthanasia (or assisted suicide) also constitutes a *moral right to euthanasia*. When palliative care and euthanasia are alternative options, a physician is *morally obliged* to perform euthanasia if her patient autonomously decides to have euthanasia performed. Now, a physician who has *promised* her autonomously deciding and terminally ill patient to perform euthanasia to relieve her suffering, and subsequently fails to deliver on that promise, is definitely guilty of abandoning the patient. Such a physician conducts herself in a morally reprehensible way. But this does not mean that, upon the autonomous request of her competent patient, the physician was ever morally obliged to make such a promise. Of course, promises need to be kept, but making such a promise is something different altogether. Even at the end of life, the autonomous decision

for euthanasia or assisted suicide of a competent and terminally ill patient cannot constitute a moral obligation on the part of the physician to perform euthanasia or assisted suicide in order to relieve suffering, at least not in the Netherlands.

The Professional Standard

Under Dutch law, termination of life on request (euthanasia) and assisting in suicide are criminal offenses.⁶ However, under certain circumstances, the person committing such an offense may be exempt from prosecution. That person needs to be a physician who has observed certain statutory due care requirements and has notified the municipal coroner of her actions.⁷ If, in the opinion of a review committee, these actions were indeed in accordance with the requirements, the public prosecutor will remain unaware of the facts.⁸

The due care requirements of the Dutch Euthanasia Act are well known. The physician must (1) be satisfied that the patient's request is voluntary and well-considered, (2) be satisfied that the patient's suffering is unbearable, with no prospect of improvement, (3) have informed the patient about their situation and prognosis, (4) have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation, (5) have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out above have been fulfilled, and (6) have exercised due medical care and attention in terminating the patient's life or assisting in the patient's suicide.⁹

If we compare all these with Rissfeldt's "paradigmatic" euthanasia, certain differences stand out. Of course, both cases involve physicians and their patients, with the physician ending the patient's life at the patient's request in order to remove her suffering. But the Dutch rules do not require patients to be terminally ill, nor do they grant patients a *right* to euthanasia. If all the statutory due care criteria have been complied with, and the physician has notified the coroner, she is no longer criminally liable; that is all. Of course, one might argue that the absence of a *legal* obligation to comply with a request for euthanasia is not incompatible with the existence of a *moral* obligation, but such an obligation does not exist either, as I will demonstrate.

In the Netherlands, medical treatment is governed by civil law. The relationship between healthcare providers and their counterparts (usually the patients themselves) is contractual. The Dutch Civil Code contains provisions pertaining to information, consent, confidentiality, quality of care, surrogate decision-making, and so on, aimed at safeguarding patients' rights.¹⁰ These rules are automatically part of every individual medical treatment agreement. But since criminal law applies, Dutch physicians tend to speak of euthanasia and assisted suicide as "non-standard medical practice".¹¹ For certain acts, special rules apply.

Under Dutch law, parties to a contract are bound by the limits imposed by law. Legal acts conflicting with duty-imposing statutory rules are invalid.¹² And since euthanasia and assistance in suicide are included in the Criminal Code as punishable acts, they cannot be part of a contract between a patient and her physician in the context of medical treatment. As a consequence, the patient who requests euthanasia cannot accuse her physician of malpractice if the latter is unwilling to grant it. Complying with such requests is not a requirement of the applicable legal rules, and neither is refusing to comply. But I suppose one could still argue the existence of a *moral* obligation, in spite of the rules of criminal law, and notwithstanding the rules of civil law applicable to "standard medical practice".

According to the Dutch Civil Code, the patient is contractually entitled to care in accordance with the healthcare provider's professional standard.¹³ The physician who does not achieve the standard of her profession is negligent by definition. In the Civil Code, "professional standard" is used as an open concept. Physicians are professionals; they are members of a professional group. Such groups are defined by the power to self-legislate.¹⁴ The professional standard is the law imposed by the group upon its members. The medical profession is autonomous in the truest sense. In law, the concept is meant to be "filled in" by the profession itself, primarily by rules (protocols, guidelines, rules of conduct, recommendations, etc.) developed by bodies representing the group. These professional rules must not be

confused with the standard itself. Adhering to a professional rule might result in negligence if the physician should have deviated from it in the interest of her individual patient. And of course, not acting in compliance with an applicable professional rule when it should be followed in the interest of an individual patient, also amounts to negligence. The professional standard is also referred to in other Dutch laws relating to healthcare.¹⁵ In different legal contexts, not acting in accordance with the professional standard will have different consequences. Under civil law, it can lead to an obligation to compensate for damages. In disciplinary law, acting contrary to the professional standard can result in the imposition of a disciplinary measure. And in criminal law, death or injury as a result of negligence can lead to imprisonment or a fine.

The professional standard is acknowledged in positive law. But it is not primarily made up of legal rules. Again, it is essentially supplemented by professional rules. They can be artisan rules, but they can also refer to other aspects of the profession (confidentiality, conduct, etc.). These rules can be documented or undocumented. They are known under different names (“protocol,” “guideline,” “directive,” etc.) and they may impact differently on members of the profession, depending on the level of scientific support, the authority of the issuing body, and their scope.

Professional rules can also be conditional and unconditional.¹⁶ Once a body representing the medical profession has decided that the appropriate therapy for patients with condition *X* is therapy *a*, an individual physician should, in principle, follow that rule and prescribe therapy *a* after having diagnosed *X*. In principle, because such an artisan rule usually addresses a patient population. A physician does not treat patient populations but individual patients. The individual physician is clinically autonomous in that the standard may require her to consider disregarding the rule if that could be in the interest of an individual patient. It is up to the individual physician to decide what is in that individual patient’s best interest. Nevertheless, that there is such a rule an individual medical professional must in principle abide by does not depend on her approval. Professional rules are part of the professional’s standard, whether she agrees with them or not. In this sense, the validity of professional rules is *unconditional*. But their validity is unconditional only when they refer to *standard medical practice*.

The Conditional Validity of the Professional Rules on Euthanasia

With the professional standard referred to in other laws, the statutory due care criteria of the Euthanasia Act share the need for specification. As global standards, the due care criteria have also been supplemented by representative bodies of the profession. For example, the sixth and final criterion, requiring the physician to exercise due medical care and attention in terminating the patient’s life or assisting in the patient’s suicide, is specified in detail in *Performing euthanasia and assisted suicide*, a guideline developed and issued by the Royal Dutch Medical Association (KNMG) in collaboration with the Royal Dutch Pharmacists Association (KNMP).¹⁷ A physician who performs euthanasia or assists in suicide incorrectly, that is, in violation of this guideline, runs the risk of not complying with the legal requirement. That physician is at risk of being reported to the public prosecutor by the competent euthanasia review committee.

Although the rules on euthanasia as laid down in the KNMG/KNMP guideline are professional rules, their validity is not unconditional. The rules only apply to those physicians who are willing to consent to patients’ requests for euthanasia or assisted suicide. In this sense, their validity is conditional. These rules are only part of the professional standard if the individual physician feels that they should be part of it. For professional rules applying to standard medical practice, the medical profession decides; for professional rules applying to nonstandard medical practice, such as those found in the KNMG/KNMP guideline *Performing euthanasia and assisted suicide*, the individual professional decides. Individual physicians are therefore free not to include these rules in their standard, also for reasons that have nothing to do with the profession. A physician who does not grant a request for euthanasia because she feels that performing euthanasia is not part of her profession is not negligent. And a doctor who never grants such requests due to religious beliefs is not a less competent physician because of it.

As regards the professional rules applying to standard medical practice the profession decides whether they are part of the professional standard; as regards the professional rules regarding euthanasia, the profession has ruled that such a decision is a strictly personal one. A patient diagnosed with condition *X* is entitled to therapy *a*, etc if according to a professional rule *a* needs to be prescribed to patients suffering from *X* (unless not following the rule is medically warranted for that particular patient). In standard medical practice, patients are entitled to being treated in accordance with the professional standard; physicians are obliged to treat their patients according to that standard. The rules regarding palliative care, including continuous deep palliative sedation, are part of the professional standard of Dutch physicians.¹⁸ According to the medical community in the Netherlands, these rules apply to standard medical practice. Medical professional morality entitles severely suffering patients to palliative care, continuous deep palliative sedation included.

The individual physician who is willing to consider euthanasia has no choice but to do it by the book. She has to follow the appropriate professional rules, but the requesting patient is never morally entitled to have it performed, nor is her physician ever morally obliged to perform it. Common morality dictates that promises are kept, when a physician who has promised her patient euthanasia or assistance in suicide delivers on that promise, but nothing in the morality particular to physicians and their patients obliges a physician to make such a promise.

The Dutch medical profession has acknowledged that the willingness or unwillingness of a physician to consider performing euthanasia or providing assistance in suicide rests on a deeply personal decision taken in a realm not governed by the rules of professional morality. Rissfeldt's claim that the offer of palliative care constitutes patient abandonment when euthanasia or assisted suicide is requested, will not even be endorsed by those well aware of the limitations of state-of-the-art palliative care.

Compassion, Not Respect for the Patient's Autonomy

The author says that "always expecting palliative care to relieve physical suffering - let alone non-physical suffering is unreasonable and is not 'failing' of palliative care in any important sense."¹⁹ Now, anyone with at least a basic understanding of modern palliative care will agree with that observation. But it is preceded by "Euthanasia is sometimes more successful at relieving suffering than palliative care."²⁰ And that is a peculiar statement.

Previously, Rissfeldt pointed out that "palliative care and euthanasia both ultimately aim at achieving an absence of suffering."²¹ According to the author, the difference between euthanasia and palliative care is merely a matter of immediacy, since palliative care combats the suffering directly, whereas euthanasia achieves "an absence of suffering indirectly by virtue of removing the potential for that suffering."²² Of course, when the difference between euthanasia and palliative care is explained in these terms, one could also say that as regards the ultimate aim euthanasia always succeeds whereas palliative care does not. In other words, euthanasia is *always* more successful at relieving suffering than palliative care. It is so by definition.

Therefore, on occasion when palliative care cannot be equal to euthanasia with respect to the relief from suffering, euthanasia should be performed if that is requested by the patient. And if palliative care could be equal to euthanasia in that respect, the latter should also be performed as per the patient's request. In other words, when euthanasia is asked for, it should be performed as long as the requesting patient is terminally ill, competent, and autonomously deciding. This is my understanding of the author's position. What matters is respect for the autonomy of the patient. But this is not the Dutch position. Respect for the patient's autonomy is not the underlying principle of Dutch euthanasia law.

Little importance should be given to the fact that the due care criterion pertaining to the patient's request is the first one mentioned in the Euthanasia Act. Although this requirement is a material one (unlike the fifth and sixth ones), it is a *condicio sine qua non* first and foremost. That it is on top of the list is due to the system of the law. The Euthanasia Act is in part an addition to two provisions of the Dutch

Criminal Code.²³ Termination of life on request and assistance in suicide happen to be serious crimes prohibited in separate penal provisions. Unlike the provisions that label murder and manslaughter criminal offenses, the element of request is essential. This element is specified in the first due care criterion. The statutory “voluntary and well-considered request” criterion should definitely not be seen as the expression of respect for the patient’s autonomy as the most fundamental value.

The due care criteria are the outcome of criminal case law, codified by the Euthanasia Act. Prior to the enactment of the law, and following the medical profession, criminal courts in the Netherlands ultimately accepted a conflict of duties as *force majeure*,²⁴ the duty to preserve human life on the one hand and the duty to relieve suffering on the other.²⁵ The physician who chooses to relieve her patient of that kind of suffering by ending this patient’s life (at her request), *out of compassion*, should not be punished.²⁶ Such a physician ought, therefore, not to be prosecuted. This was and is the view of the Dutch medical profession, a view endorsed by both the courts and the legislator.

Euthanasia is by definition more successful because it removes (to quote the author) “the potential for suffering”²⁷; by ending life. But life is not just “the potential” for suffering. It is “the potential” for a multitude of experiences. Admittedly, an individual may feel that her life consists of nothing but suffering. A physician could indeed remove that suffering by performing euthanasia or by providing assistance in suicide. An elderly patient recently diagnosed with Alzheimer’s may be fearful of the future “loss of self, due to personal disintegration” and may already suffer a consequence. And yes, her physician could end that suffering by removing “the potential for suffering” altogether. But whether she should or should not grant such requests is entirely the doctor’s choice. But an unwilling doctor, even one who sincerely believes that her patient’s life is still worth living while the patient herself fundamentally disagrees, *cannot be accused of paternalism*. Not by her peers,²⁸ not in the Netherlands.

Rational, but Unreasonable and Illiberal

Of course, respect for autonomy is one of the key principles of medical ethics. The autonomy of the patient should be respected by physicians and for this reason shared decision-making (SDM) must be practiced whenever possible and as long as this is the patient’s choice. However, despite SDM being the morally preferable decision-making model, it should not be forgotten that for patients there is nothing to claim or negotiate beyond the professional standard. Such is the nature of the relationship between patients and their physicians. There is little tolerance for consumerism.

In standard medical practice, patients are entitled to be treated according to the professional standard and within that standard they can agree to whatever they and their treating physicians deem appropriate. The tolerance for paternalism on the part of the physician is equally limited. In the Netherlands, known for its liberal stance on the matter, termination of life on request by physicians and physician-assisted suicide are referred to as nonstandard medical practice. The Dutch law on euthanasia does not express respect for the patient’s autonomy so much, rather the reverse. It reflects the morality of the Dutch medical profession and as such it expresses respect for the individual physician’s autonomy. Not the respect the physician is owed as professional (in that, a patient cannot ask for what is at odds with her professional standard), not the respect demanded by the physician as clinician (in that, a patient may expect her physician to act independently with that patient’s particular medical needs in mind, and not to blindly follow protocol or to disregard guidelines out of ignorance), *but the respect the physician is entitled to as human being*.²⁹

Although the author’s arguments are *rational*, his position is *unreasonable* from a Dutch point of view. The relationship between a physician and her patient should be understood properly, that is, in all its moral dimensions and in all its depth. The claim that offering palliative care to a fully competent patient requesting euthanasia constitutes patient abandonment would bewilder many within the Dutch medical profession. The argument that a terminally ill patient entitled to palliative care also has a right to euthanasia or physician-assisted suicide would be understood by many within that community as profoundly *illiberal*.

Notes

1. Rissfeldt T. Euthanasia and assisted suicide are compatible with palliative care, and are not rendered redundant by it. *Cambridge Quarterly of Healthcare Ethics* 32(2):254–62.
2. See note 1, Rissfeldt, at 254–62.
3. See note 1, Rissfeldt, 257–58.
4. See note 1, Rissfeldt, at 256.
5. See note 1, Rissfeldt, at 256.
6. Criminal Code, Sections 293 and 294.
7. Criminal Code, Sections 293 and 294 j° Euthanasia Act, Section 2, and Burial and Cremation Act, Section 7, paragraph 2.
8. Euthanasia Act, Section 9, paragraph 1, under a.
9. Euthanasia Act, Section 2, paragraph 1.
10. See also the website of the Dutch regional euthanasia review committees, available at <https://www.euthanasiecommissie.nl/uitspraken/vragen-en-antwoorden/welke-medische-handelingen-val-len-niet-onder-euthanasie> (last accessed 13 July 2021). Continuous palliative sedation (allowed if the patient is expected to die within 2 weeks), pain management with the side effect of hastening death, not initiating or not continuing with medical treatment if the patient does not consent, not initiating or cessation of medically futile treatment are standard medical practice.
11. Civil Code, Book 7, Sections 446–68.
12. Civil Code, Book 3, Section 40, paragraph 2.
13. Civil Code, Book 7, Section 453.
14. Reaffirmed for the medical profession by the World Medical Association (WMA) by the adoption of the *Declaration of Madrid on Professionally-Led Regulation*, available at <https://www.wma.net/policies-post/wma-declaration-of-madrid-on-professionally-led-regulation> (last accessed 13 July 2021).
15. For example, the *Wet op de individuele beroepen in de gezondheidszorg* [Individual Healthcare Professions Act], Section 47, and the *Wet kwaliteit, klachten en geschillen zorg* [Quality, Complaints and Disputes in Care Act], Section 2.
16. See Buijsen M, Göttgens W. And what about the pharmacist? On the position of the provider of lethal drugs in Dutch euthanasia practice. *Cambridge Quarterly of Healthcare Ethics* 2020;29(3): 378–80.
17. KNMG/KNMP. *Richtlijn Uitvoering euthanasie en hulp bij zelfdoding* [Guideline for performing euthanasia and assisted suicide]. Utrecht/The Hague: Royal Dutch Medical Association/Royal Dutch Pharmacists Association; 2021; available at <https://www.knmp.nl/praktijkvoering/richtlijnen/multi-disciplinaire-richtlijnen/richtlijn-uitvoering-euthanasie-en-hulp-bij-zelfdoding> (last accessed 13 July 2021).
18. KNMG. *Richtlijn palliatieve sedatie* [Guideline for palliative sedation]. Utrecht: Royal Dutch Medical Association; 2009; available at <https://www.knmg.nl/advies-richtlijnen/dossiers/palliatieve-zorg-en-palliatieve-sedatie.htm> (last accessed 13 July 2021).
19. See note 1, Rissfeldt, at 259.
20. See note 1, Rissfeldt, at 259.
21. See note 1, Rissfeldt, at 255.
22. See note 1, Rissfeldt, at 255.
23. Criminal Code, Section 293, paragraph 2, and Section 294, paragraph 2 (last sentence).
24. Criminal Code, Section 40.
25. In the famous *Schoonheim* case, see Hoge Raad [Dutch High Council] 27 November 1984, *NJ* 1985, 106. For an overview of relevant case law, see Pans E. *De normatieve grondslagen van het Nederlandse euthanasierecht* [The normative foundations of Dutch euthanasia law]. Nijmegen: Wolf Legal Publishers; 2006.
26. See note 25, Pans 2006, at 398–9.
27. See note 1, Rissfeldt, at 256.

28. Of course, Dutch patients requesting euthanasia or assisted suicide do accuse unwilling doctors of being paternalistic. But such is the nature of the relationship between doctors and their patients in this respect. In the Netherlands, a patient is free to ask for this way to have her suffering ended, and her physician may grant the request or not. If she chooses to grant it, the requirements must be met and the rules obeyed. If she does not, and if she never does out of principle, the requesting patient has no option but to ask another physician. Medical professional morality dictates that doctors (and hospitals) make their position known beforehand.
29. If it makes any sense to distinguish between public and private morality, and if medical professional morality belongs to the realm of the former, then both the unwillingness and the willingness to consider requests for euthanasia or physician-assisted suicide are based on decisions subject to the rules and principles of private morality.