

## **Episode 6 – Once you start killing you can't stop: Netherlands part II**

**[SUICIDE WARNING]**

**[PRAYER BELL CHIMES]**

**[Ethereal female voice]:** There is no death. There is only me, me, me who's dying.

**Mariska Koster:** I still see it. I can recall everything that happened as if it happened yesterday. I was standing in the corridor and I was shaking and sobbing, and the nurse took me away, gave me tea and sympathy and everything, and I was so grateful. That she supported me meant so very much.

**Andrew Denton:** This is Mariska Koster of the Netherlands, describing her memories of being involved in a euthanasia death six years ago. Mariska is not a family member recalling the passing of a loved one. She is the doctor who performed the euthanasia.

**Mariska Koster:** It goes beyond everything. You are treading into life and death, and you are trained to always stay on the side of life; death is a no-go area.

**Andrew Denton:** Doctors in the Netherlands have been treading in the no-go area of death and euthanasia for over a decade now. Most of the cases they deal with are people who are terminally ill. But a small number are not. Could it be that they have trodden too far?

**[OPENING TITLES]**

**Andrew Denton:** My name is Andrew Denton and you're listening to *Better Off Dead*.

**Theo Boer:** According to Dutch law, killing another person is a crime, but under certain conditions a doctor who kills a patient will not be prosecuted.

**Andrew Denton:** This is ethicist Theo Boer, speaking by video link to an anti-euthanasia conference in Adelaide. Theo knows Dutch euthanasia laws well. For nine years he sat on one of their Euthanasia Review Committees – each one made up of a doctor, a lawyer, and an ethicist. Their job is to review all euthanasia cases to see that they have complied with the law.

In 2014 Theo resigned, concerned, not just about the rising numbers of euthanasia cases, but also about their nature.

**Theo Boer:** Whereas in the first year, hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Many of these patients could have lived for months, years or even decades.

**Andrew Denton:** Theo's concerns didn't stop there.

**Theo Boer:** Euthanasia for a man with autism who fears retirement. Assisted dying for a mother of two suffering from tinnitus. In 2012 under the End of Life Clinic, a nationwide network of travelling euthanasia teams became active.

**Andrew Denton:** Mobile death units. Others had warned me about these. Just as I'd been warned that in the Netherlands there were people being euthanased without their consent, and that doctors had become desensitised to the idea of killing patients.

Put together, these warnings made a single allegation: that the Netherlands is a “slippery slope” whose euthanasia laws are now bent out of all recognition.

So I've come to see if the warnings hold true. To find out, if you're a doctor working here, how slippery the slope is. And if it really is a slope at all.

**Steven Pleiter:** My name is Steven Pleiter. I will be 60 this year, and I am the chief executive officer of the Levensindekliniek, which is quite a unique organisation in the Netherlands.

**Andrew Denton:** Can I refer to it as the Life-Ending Clinics? Is that a correct...

**Steven Pleiter:** Yes, that is right.

**Andrew Denton:** Steven Pleiter is a retired physician leading a team of 80 doctors and nurses. They specialise in the very cases Theo Boer is concerned about – where a person who may not be terminally ill is helped to die.

**Steven Pleiter:** Well, we're open now for over three years. We see at this moment about 1100 people a year, and there is a common red line in what we see. What we do and what we specialise in is investigating complex euthanasia requests.

**Andrew Denton:** Those who hold out the Netherlands as a textbook case of “slippery slope” point to a law originally designed to help the terminally ill that has now “slipped” to include, for example, those with dementia. But Dutch law wasn't written to deal only with certain diseases. Guided by doctors themselves, it was deliberately created for people whose suffering is “unbearable and untreatable”. And that can mean many things.

**Gerrit Kimsma:** Psychiatric cases, Alzheimer patients, elderly people with a number of serious, let's say, functional limitations as part of becoming older.

**Andrew Denton:** Gerrit Kimsma is a doctor of 40 years standing. He was a member of the Euthanasia Review Committees for 12 years.

**Gerrit Kimsma:** According to the review committees, these cases for the past years have been deemed acceptable. And now you see that concerning cancer patients, you can say it is a 90% medical professional consensus. With respect to Alzheimer patients, it may be 50-50, psychiatric cases, the same. So, the Life-Ending Clinics actually fill that gap, so to say, where physicians feel they are willing to help patients die with cancer feel they are not willing to help patients die with psychiatric diseases.

**Andrew Denton:** The Life-Ending Clinics came into existence because of the Dutch Right To Die Organisation, known locally as the NVVE – 160,000 members strong – bigger than any political party in the Netherlands – they are essentially the patient's advocates, advising them about their end of life choices and arguing for their rights under the law.

What the NVVE discovered was that, despite “unbearable and untreatable suffering” being the basis of the law, some patients were being refused their legal right to euthanasia. Some doctors refused on moral grounds. Others had a different reason. Stephen Pleiter.

**Stephen Pleiter:** The reason that these doctors hesitate to do the investigation themselves is that these cases are rare. So, a general practitioner cannot gain the experience in doing this investigation rapidly enough, and that is why he is hesitating.

**Andrew Denton:** So in 2012 the Life-Ending Clinic was established, working within the Dutch euthanasia law, to deal with rare and complex cases.

**Stephen Pleiter:** If it applies to the law, if we really understand from each person why this is the solution that this person is looking for, then we respect the choice of that person and are willing to help that person.

**Andrew Denton:** Just as patients are represented by the NVVE, doctors are represented by the Royal Dutch Medical Society. What do they think of the Life-Ending Clinic? Spokesman Eric Wijlick.

**Eric van Wijlick:** First is that we felt very hesitant about this initiative, because they started as a clinic, where they would help patients within a certain time to grant a request. What they are doing now is completely different. They have mobile teams because we also stated that most patients wanted to die at home, so if you want to take care of patients – they feel most comfortable in their own situations – then you have to be at the place where patients stay.

**Andrew Denton:** So these are the “mobile death units” I’d been warned about – established, as it turns out, because most people want to die at home. Nothing sinister here. Just a compassionate and practical response to a very human need.

Nonetheless, Eric explains to me that some Dutch doctors worry that, because the Life-Ending Clinic has only one purpose – to grant a patient euthanasia – they don’t establish a proper doctor-patient relationship. I put this to Stephen Pleiter.

**Andrew Denton:** I think the major criticism that I have come across is that this place is a one-stop shop, that all it sells is euthanasia. Do you understand that discomfort?

**Stephen Pleiter:** Yes, I understand, and I disagree, if you don't mind. Yes, we are a one-type-solution shop, if that is the situation. But it's like the dentist or the eye doctor or – there are many specialists in the world that are focused on one type of area or one type of solution. So what we do and what we specialise in is investigating complex euthanasia requests that are not being helped by other doctors.

We know we are being looked at as an organisation that works on the edges of the legislation in the Netherlands – by the way, we are not searching these edges, but the patients coming to the Levensindekliniek bring us at the edges – OK, that is a fact. So, we need to be careful.

**Andrew Denton:** Indeed they are being looked at. One of the hallmarks of the Dutch euthanasia laws is how carefully they are scrutinised and how openly they are discussed. Gerrit Kimsma, for example, also expresses concerns that the nature of the Life-Ending Clinic may mean that the basic doctor-patient relationship is missing.

**Gerrit Kimsma:** They start with a request to be helped to die of a patient they have never met before. I find it problematic. That is not the doctor-patient relationship that originally accompanied the whole institutionalisation of euthanasia in the Netherlands. So, it is, I would say, it is the next step that I see some validity for because there are incorrectly refused euthanasia cases. But it worries me also, because it misses a basic element that I believe should be there.

**Andrew Denton:** What is interesting about Kimsma's critique is that he is also a consultant to the Life-Ending Clinic. In airing his concerns, he underlines the strength of the system. Rather than being 'slippery', or devious, as some would imply, this kind of open conversation is exactly what you would hope for when dealing with such complex medical issues. In that same spirit, Stephen Pleiter responds.

**Stephen Pleiter:** We would say yes it would be better if the general practitioner would be doing this but since there are a number of general practitioners that are not willing to help a patient, we think the demand of the patient is that serious and that strong, then they should be helped. Instead of having a typical doctor-patient relation, we are having what I would call a trust relation. So if we come to a patient, we don't take our time to drink a cup of coffee or have a social talk. It goes on to the subject immediately. And a good relation, where trust is there, is established very rapidly. The contacts that our teams have are long-lasting; it is very common that we sit with the patient for one and a half to two hours – many times. It is a different type of relation. And I am absolutely confident that it is a good way of doing these investigations.

**Andrew Denton:** In 2014, the Life-Ending Clinic helped 231 people to die: Only a tiny proportion of the close to five thousand Dutch euthanasia deaths in that year, the total number of which is less than 4% of all the people who die in the Netherlands annually. Still, even seen through this prism, the point is the nature – not the number – of cases.

**Andrew Denton:** You are dealing with cases which, by their very nature, are difficult sometimes to clearly define. They are, if you like, at the edge of the knowledge of medical science. With psychiatric illnesses, how do you assess untreatable suffering?

**Stephen Pleiter:** Well, the investigation first of all, takes more time but then the psychiatric patients that end up, and that we are willing to perform euthanasia on, those patients have been in psychiatric clinics, etcetera for many, many, many, many years, most of the time, for decades. They've had treatments, a lot of them, and only after a long-lasting wish to die and many, many treatments, we are willing to say OK, there is no treatment that makes any sense anymore, even though in psychiatry, always, there is another treatment, but at a certain point you can say it does not make sense. Like someone [with] cancer, some of the time you cannot do anything anymore. That occurs to psychiatric patients also. So that is the situation that we help them.

**Andrew Denton:** Psychiatric euthanasias are a very complicated issue and we will return to them in detail in when we look at what's happening in Belgium. But what of the equally challenging question of patients with Alzheimer's or dementia? If the basis of your law is that only a mentally competent adult can request euthanasia, how does that apply to patients like these?

Here, there is a tension between what Dutch law allows – and how that law is carried out in practice. Eric Wijlick from the Royal Dutch Medical Society.

**Eric van Wijlick:** The bill was discussed in Parliament and it says it really clearly that although law article part 2 states that a written request replaces the oral request, history shows also that you have to discuss this with your physician as well, because otherwise a physician cannot be really convinced that the request was done by a competent patient. How can you know? So it is not directly put in the law, but we learnt from analysing again that you really have to have an oral request because if a request was done 10 years ago, how do you know that the patient really does want this situation still?  
That is what we think also from an ethical point of view. That is, most of our doctors say, “I cannot kill a patient if I never discussed all these kinds of topics”.

**Andrew Denton:** If the law says that it’s *possible* for a patient to be euthanased based on a written directive, how does the Life-Ending Clinic deal with that? Stephen Pleiter.  
A number of doctors we’ve spoken to are uncomfortable with the idea that Alzheimer's patients be euthanased. And their main concern is how is it possible to show due care, which is that key criteria, to people who may not be mentally competent or even capable of communicating at the time of their death? How do you address that problem?

**Stephen Pleiter:** So, let me be absolutely clear in that – the Levensindekliniek has not given any patient euthanasia that was not able to express their will. So, dementia, or Alzheimer, is a disease that takes quite some time before it is in the situation that you don't know where you are, you don't know who you are, you don't know your relatives anymore. So the people that really think about this and don't want to get into that situation need to come to us early and ask for help in an early stage. So these people are *compos mentis*, so they know what they are asking. It's like Cinderella – you need to leave the party before midnight.

**Andrew Denton:** If you have Alzheimer’s or dementia, how is it possible to know – to really know – that you are at 5 minutes to midnight?  
Meet Barbara Heetman, whose mother, Jeanne, did choose to “leave the party early”.

**Barbara Heetman:** My mother was an enjoying person, so if there was something – music or the grandchildren...

**Andrew Denton:** Jeanne Heetman had lived with Alzheimer’s for seven years. There was laughter and joy in her life still, but she told her three daughters she didn’t want to ever reach the point of not recognising her family.

**Barbara Heetman:** She knew with Alzheimer’s you will turn out to be a totally different person. But she said, “No. I don’t want to be another person. I had a good life”. I mean, she was 80, and she thought there will not be more new nice things or whatever, and it will only get worse.

**Andrew Denton:** Is it possible that your mother felt like she might be a burden to you and your sister?

**Barbara Heetman:** As a burden? No, no. I said, “You can live and sit and we will still come”.

**Andrew Denton:** So Jeanne Heetman went to see her local GP.

**Barbara Heetman:** She said, “Hello, I’m Jeanne Heetman. I have Alzheimer’s, and if it is getting worse, I would like to die”. And then the doctor said, “I cannot do that. I never did that and I do not want to do it. I don’t have experience with that”.

**Andrew Denton:** At her GP’s suggestion, Jeanne contacted the Life-Ending Clinic. Before they would meet with her, as Stephen Pleiter explains, she had to fill in a detailed application form.

**Stephen Pleiter:** It asks why the person wants to have help with euthanasia since that request is quite serious. So it is a long application form that they fill in. When we receive it the first thing that we do is that one of our doctors gives a call to the general practitioner of the patient in order to ask whether they know the request of the patient, what their own position with regards to the request is.

Also we ask the doctor for information from the medical files of the patient. That helps us to do a pre-investigation, which is a first step in helping us decide whether we need to send in a team or whether we need to have a psychiatrist at first to have an interview with the patient or whether we already can say, “This doesn't make sense, this will not apply for euthanasia, so we don't need to spend all the effort”.

**Andrew Denton:** With help from Barbara, Jeanne answered every question – but one.

**Barbara Heetman:** But then we come to the question: “Do you want to die now?” Then she said, “No”. I said, “OK, we stop”. So we put it aside. I said, “You call me if you want it”.

**Andrew Denton:** A few months later, Barbara received a call from the family GP. She said Jeanne had visited her again to talk about dying before she got lost in her disease.

**Barbara Heetman:** Then the doctor said, “Your mother is really going backwards and now she can still say it, and that is very important with Alzheimer’s, or with euthanasia or help with dying, because you have to be totally [Speaks Dutch]”

**Andrew Denton:** Competent.

**Barbara Heetman:** Competent. Competent.

**Andrew Denton:** So your GP, even though she certainly would not euthanise someone with Alzheimer’s and maybe did not even approve, she nonetheless saw the need in your mother and was prepared to help out.

**Barbara Heetman:** Yes, because my mother was asking.

**Andrew Denton:** Jeanne completed her application for the Life-Ending Clinic. For three months, while the Clinic investigated, the family heard nothing. Then a doctor’s visit was arranged.

**Barbara Heetman:** And he would just talk with my mother, just for seeing how is the situation. He said, “OK. I think this is a real question,” because he was asking my mother and

she had difficulty to find the words, but then she could... If you say, “What is dying?”, then she said, “No, I just want to die at peace” – you know, putting her hands under her face like going to sleep softly or something.

**Andrew Denton:** At that first meeting Jeanne spoke to the doctor for two hours.

**Barbara Heetman:** But we had a good feeling, and then he said, “There will be a test. Your GP has to find a psychiatrist. That person, who is not known by anybody else, will come to your house and ask you questions to know if you are depressed or not and if you are competent”. Because if you are depressed and you want to die, no. You really have to want it with your deepest will, yes?

**Andrew Denton:** Once Jeanne had passed the psychiatrist’s tests, the Life-Ending Clinic began examining her request more closely.

**Stephen Pleiter:** After that, a team will be formed, based on the case, and that team will do the investigation. And that investigation takes as many interviews as the team requires to find out whether they can feel with the patients, why this request for this patient makes sense, and whether all criteria are met – as many interviews as it takes. It is up to the decision of the team. And the team are highly trained professionals – doctors and nurses who know exactly what they’re they are doing.

**Andrew Denton:** So this process could take several months?

**Stephen Pleiter:** Absolutely. All decisions are about life and death.

**Andrew Denton:** A few weeks after the assessment by the psychiatrist a second meeting was arranged between Jeanne Heetman and a team from the clinic.

**Barbara Heetman:** We want to do everything in the whole family, so we were sitting there around. But that was not how they wanted it, because my mother was too much looking to us when she was searching for a thing: “How old am I? Hmm, 80 — eh, how old am I?” You know, so she was asking. They did not like that, so they said, “OK, we had this talk, but we will come again”. They said, “We will come next week, and then we want to talk to you alone”.

**Andrew Denton:** It makes sense they wanted to do that because they also needed to know that this was your mum not you or your sister...

**Barbara Heetman:** My mother had to say totally from her own brain, heart, whatever, “I want this”. There was the three conversations with that doctor and that nurse, and it was also recorded, by the way. That was for justice of course, for later. So that you hear my mother say what she wants.

**Andrew Denton:** For Barbara, the whole experience felt somehow...unreal.

**Barbara Heetman:** Because we were nervous for our mother that she would pass all the exams, but then on the other hand what were we waiting for? For our mother to die. And that feeling I never had in my life.

**Andrew Denton:** Having satisfied her GP, a psychiatrist, and the Life-Ending Clinic that she was mentally competent, Jeanne still had one more test to pass.

**Barbara Heetman:** But then you know that there also had to come a second opinion.

**Andrew Denton:** The SCEN doctors, yes?

**Barbara Heetman:** The SCEN doctors.

**Andrew Denton:** SCEN doctors are specially trained to make sure that the due care criteria of Dutch euthanasia law are upheld. Stephen Pleiter.

**Stephen Pleiter:** Absolutely. That's one of the criteria that needs to be met. So we don't find friendly SCEN doctors who we know and we know how they think; we just go through the front door and a SCEN doctor is being allocated to our case, and it is not the other way around.

**Andrew Denton:** And do SCEN doctors sometimes say that it is not appropriate to go ahead with euthanasia?

**Stephen Pleiter:** Yes they do or they hesitate. Sometimes, they say, 'Not at this moment, you need to do a little bit more or you need to do quite some more'.

**Andrew Denton:** For Jeanne Heetman, determined to die as herself, not as the ghost of the person she was, this last test meant everything.

**Barbara Heetman:** So then the SCEN doctor came, and she had to do it on her own. My sister came in and my mother was writing words: "*Ik wil dood*". She put it on paper, and she was practising, because she said, "I have to remember those words".

**Andrew Denton:** "*Ik wil dood*" is "I will die"?

**Barbara Heetman:** I want to die.

**Andrew Denton:** I want to die.

**Barbara Heetman:** So the persons came, and they said in the end, "I think you're clear. You made your point clear". So they were making it more and more realistic.

**Andrew Denton:** Shortly after, a call came. Jeanne had fulfilled all the due care criteria. A date was set for her to die. December 4 – only a few weeks away.

**Barbara Heetman:** So we hang up. "What's this all about?" my mother said. "Yeah, it's about when you can die". "Ah!" Then she said, "Bah, it has to be more than enough. It can happen" – you know? I mean – "I'm ready for it".

That was a relief, so she gave the answer. We were all in panic, because of course then it becomes so real when you have a date. No, but she said, "Hey, listen. I did enough saying goodbye". Because there was also in November a kind of party. So there were all her friends and people came.



**Andrew Denton:** So they knew your mum was going to die?

**Barbara Heetman:** Yeah, and still that was strange, because in the end it was all depending on my mother. Would she say yes or no?

And at 2 December we really had what you call the last supper. Then we were all drunk and we said toasts, and you see my mother all the time with the liquor and singing a song.

**Andrew Denton:** And your mum was happy?

**Barbara Heetman:** Ja. And the moment she knew that, one week before, she was the most relaxed. When she knew that the day would come she was most relaxed, and then I felt she was becoming almost an ambassador of the self-chosen end of life.

**Andrew Denton:** After seven years of living with Alzheimer's, Jeanne Heetman had decided to leave the party before midnight. Still, despite all the care taken, Barbara had the slightest thread of doubt.

**Barbara Heetman:** We were in the flow of my mother. She was the leader, and it was good that she could say that in the end. And, but, I also felt, "Does she really want it?".

**Andrew Denton:** But Barbara's slight doubt was dispelled the night before Jeanne was due to die, when she overheard her mother reply to a question from the clinic nurse; would Gene prefer to die by injection or by drinking the medication?

**Barbara Heetman:** And then ... my mother said, "Oh, no, I take the drink. I did everything myself in my life, so also I will do this". So good to hear, because then you can see, my mother she is really competent. She knows what she is doing.

**Andrew Denton:** Despite advancing Alzheimer's, Jeanne Heetman had been able to persistently express her clear wish to die. But are there others in Jeanne's position who the clinic refuses?

**Stephen Pleiter:** Absolutely. We have a general rule – the team needs to be 100% certain that they do the right thing. If they hesitate on that, whether they think it's 1% doubt in there, then they will not perform euthanasia.

**Andrew Denton:** It must be a hard thing to say no to patients, particularly after you've been through a long consultation process.

**Stephen Pleiter:** Yeah, that is difficult. We know that we are a kind of last resort for these persons applying for help of the Levensindekliniek, or the End of Life Clinic. But that doesn't mean that we should step over our edges and over our borders.

The most critical thing is that we are 100% sure that any euthanasia request has been investigated correctly, and that for this patient this is the only solution available.

**Andrew Denton:** This caution in assessing whether or not patients are eligible is borne out by the fact that two out of every three euthanasia requests in the Netherlands are declined.

It is clear, listening to Jeanne Heetman's story, that the criteria of "due care", designed by Dutch doctors and laid down in law, are taken seriously.

But Canadian anti-euthanasia campaigner Alex Schadenberg doesn't think this is necessarily true. He goes so far as to say that some Dutch – and Belgian – doctors are criminals – and that they're hiding their crimes.

Citing official figures of 1000 deaths recently in Belgium, and a similar number in the past by doctors in the Netherlands – deaths which, he says, occurred without the patient's consent – Alex makes a startling accusation.

**Andrew Denton:** Is it your assertion that those 1000 deaths, or the majority of them, were in effect a murder because they were not deaths that anyone had consented to?

**Alex Schadenberg:** murders, manslaughter – it depends on how you define it in the law. Yes, they are. They're deaths that occurred – that is, the doctors admitting that they intentionally hastened those deaths.

**Andrew Denton:** Not only, says Alex, are Dutch doctors killing people without their consent but they are hiding this fact because these deaths are not recorded as cases of euthanasia.

When he first told me this I thought, "If this is true, it surely throws into question the entire system". I wondered how it could be that doctors are killing patients without their consent – and then not reporting it? Gerrit Kimsma studied the same Netherlands data quoted by Alex. What can you tell me about the circumstances of those unrequested deaths?

**Gerrit Kimsma:** Yes, well the 1000 cases were from 1991, actually. In 2010 they have been lowered to less than 200.

**Andrew Denton:** So they do exist. But why?

**Gerrit Kimsma:** The majority of the cases, patients had said before that they did not want to suffer extensively. The medical situations of these cases were all very hopeless. And most interesting, I found – and I hope your Canadian knew that too – that even in Australia there were more cases of life-ending without explicit request.

**Andrew Denton:** Can you explain that? Why would that be happening in Australia?

**Gerrit Kimsma:** Well, those are the patients who are in a hopeless situation, no cure is possible, are suffering extensively, and what physicians often do is they raise the morphine level. They raise the morphine level even beyond the level of treating excruciating pain. So they hope that a quick raise of morphine will really end life by taking away the breath.

**Andrew Denton:** So this is something that takes place largely within palliative care?

**Gerrit Kimsma:** It takes place in palliative care. If you look at the level of morphine used, you see that morphine was used mainly, mostly in countries who are heavily opposed to euthanasia and assisted suicide.

**Andrew Denton:** This I do know about. It's how my dad was helped to die after falling into a coma – slowly, painfully, using morphine. These are the unrequested deaths Alex describes as murders. That they are not recorded as euthanasia cases is, according to Eric Wijlick, from the Royal Dutch Medical Society, absolutely appropriate.

**Eric van Wijlick:** We do not talk about euthanasia if there is not a request, so it is deliberately ending the patient without request. That's what it's about, and sometimes the areas are grey. In such situations, sometimes doctors hope that patients will die. They prescribe the medications – for instance, the medications for palliative sedations. They give you the medication. Do we give a lot of medication? Do you speed it up? Those are the questions we are talking about, and sometimes doctors think they killed their patients. They did not, if you look at the amounts and the speed of those. That is a grey area.

**Andrew Denton:** There is nothing hidden about any of this. The Dutch question and record doctors end-of-life actions more meticulously than any country on earth. That's how they know the practice sometimes still happens, though far less now that euthanasia laws have been introduced.

Dutch doctors have been tagged killers because they are describing in detail the decisions doctors the world over make when their patients are dying. The medication they prescribe, the doses even if they hope, in their hearts, their suffering patients might die more quickly.

They tick boxes on death certificates and fill in questionnaires that shine light on the dying hours – an honest effort to be transparent – but one open to a cynical twist.

**Andrew Denton:** Even though doctors helped write Dutch euthanasia laws, that doesn't mean they find them easy to carry out.

Mariska Koster, a pulmonary specialist, was profoundly affected by helping one of her patients to die.

**Mariska Koster:** I remember it as if it happened last week. Actually, it was – it is now over six years ago, but I remember it vividly.

**Andrew Denton:** Her first experience came when an elderly patient, hospitalised and dying, requested Mariska help her to die.

**Mariska Koster:** Her children adored her, her husband adored her, and she said to me, “What I am having now, this disease – which is wasting me; I feel my strength slipping away – it is so contrary to who I am, who I always have been, how I want to be remembered”.

For over a week every day after work hours I went to her. We sat together and we talked, and during that week – I saw her deteriorating, because she was severely ill. We came to know each other, in a way we became friends, and after a week I said, “Well, yes, now I see this. Giving you your death is the very last thing that I can do for you, and now I am willing to do this”.

**Andrew Denton:** Following the due care criteria, Mariska ended her patient's life. What happened next caught her by surprise.

**Mariska Koster:** I was standing in the corridor and I was shaking and sobbing, and the nurse took me away, gave me tea and sympathy and everything, and I was so grateful. That she supported me meant so much. And the whole procedure was so emotionally uprooting, that I was really very grateful for this support from the nurses.

For doctors it's very difficult to really accept that their patient is going to die.

**Andrew Denton:** When it came to the moment where you did what you were asked to do did your training take over or were you still very emotionally engaged?

**Mariska Koster:** Both. I really felt I am doing something that is huge, that is grand. I am going beyond what is normal medical care. That really cost me.

I still see it. I can recall everything that happened as if it happened yesterday.

**Andrew Denton:** And when you recall, what is the strong thing that remains for you?

**Mariska Koster:** The thing that I see in my mind is the moment when the family had left, and the nurse and I went back into her room to look at her for the last time. And it was an evening in the late summer. The light was golden, a beautiful sunset, and the light was on her face, and she was lying there so completely tranquil, so essentially at peace, so different from the days before, when she had actually been suffering.

**Andrew Denton:** For Mariska, suggestion that doctors in the Netherlands become desensitized to killing their patients couldn't be further from the truth.

**Mariska Koster:** You don't do this lightly. It is not something doctors like to do; they don't. If you can get around euthanasia as a doctor, you will do it, because it costs you.

**Andrew Denton:** For some people, cases where patients who don't have a terminal illness but who are helped to die will always be sensitive. Particularly if, like Theo Boer, you have a moral objection to euthanasia in the first place.

**Theo Boer:** Just like many of you, I consider the active termination of a human life to be intrinsically problematic.

**Andrew Denton:** But Theo's is a minority voice. According to polling conducted by *The Economist* magazine in 2015 public support for euthanasia in The Netherlands runs at over 80%. And, to date, no other member of the Euthanasia Review Committees has joined him in publicly expressing concerns.

The fact that Theo has, simply highlights one of the great strengths of the Dutch system – that it is transparent and open to debate.

What his concerns do not illuminate, however, is a slippery slope. Instead, it's opposite: a law, devised by doctors, to encompass the unbearably and untreatably ill. And a system where close scrutiny is not only demanded, but enforced.

When I asked Gerrit Kimsma about the slippery slope, he was emphatic in his response.

We have been talking about the more difficult areas of Alzheimer's and psychiatric illness. That is the slippery slope that some people choose to describe, is it not?

**Gerrit Kimsma:** No, I don't think so. Because the reviews on a case-by-case basis make it possible to control it. A slippery slope is something that even if you want to, you cannot control it.

We have the safeguards before and, what we are confronted with is within society different moral limits, different moral conceptions about a good death. The fact that Theo de Boer disagrees with it means only that he holds a different opinion about the rights of human beings, and he is a Christian. He believes that life is precious and is God's gift, and actually it's impossible to return the gift.

**Andrew Denton:** For Kimsma, and the overwhelming majority of his fellow citizens, it is about an entirely different view of the universe to Theo Boer: One where people have a right to determine what happens at the end of their lives.

**Gerrit Kimsma:** What we do see is that there is a shift towards autonomy, meaning that people get the deaths that they choose for, that they request. And in itself I cannot see that that is immoral unless it is a case that as a society we have failed to support an individual. But that is not the case.

We are being transparent and I think we have a good system. We should be proud of it.

**Andrew Denton:** Dutch people don't die more easily than anyone else. Death remains mysterious, grand. Dutch doctors weep and tremble when they help someone die. In Dutch homes families shake and blink at the unreality of it all – just like they do in ours.

But – unlike in ours – in the Netherlands, there are clear and comfortable conversations about the end, which, thanks to Dutch law, means that people don't need to die the lonely, fearful, agonising deaths they are dying in Australia.

And in those conversations is a word you don't often associate with dying: "beautiful". Grateful children describe the beautiful deaths of their parents – eaten up by cancer, eroded by Alzheimer's – who know that there is nothing left for them but suffering. Not people who don't value their lives, but people who can rationally see that, for them, their lives no longer have value.

Under Dutch law, they get the opportunity to choose their ending without shame or fear. Better – with joy and the chance to farewell the ones they love with nothing left unsaid.

And for those left behind, who have seen their loved ones die well, instead of the scars carved by that awful question: "Should we have done more?" There are just the gentle tears we all shed for the dead – and for ourselves.

As Jeanne Heetman's story shows, even on the fringes – those cases so beloved of the slippery slopers, where many Dutch doctors simply will not tread but where the Life-Ending Clinic willingly go – great caution is exercised. This is a mature and sober conversation. Even if doctors disagree – and some do, and they always will – on the limits of their law, they all understand the seriousness and due care that must, and does, lie at the heart of their system.

Yes, it is possible to cite the rising numbers of Alzheimer's and psychiatric cases as cause for alarm, but not if you keep it in perspective: These are still a tiny percentage of the roughly 5000 euthanasia deaths in the Netherlands last year – themselves less than 4% of all the people who die there annually.

But even if those numbers were to double, each one of them would still represent a human being with suffering so unbearable that they have asked for help to die. Think about that. How terrible must things be for any human to reach that point where living has become harder than dying?

I'll say it again: This is a mature conversation, built on years of openness, and a willingness to look, straight on, at the reality of all societies, including ours: that there is a small percentage of every population who will suffer horribly before they die and who medical science can't treat. Faced with the choice between turning away from this suffering, because their own morality instructed them to, or stepping forward with compassion and due care to help, the Dutch chose to step forward.

Is it possible that we might do the same?

**[SONG 'FORTY-EIGHT ANGELS' BY PAUL KELLY]**

**Andrew Denton:** If you'd like to know more, head to the episode page at: [wheelercentre.com/betteroffdead](http://wheelercentre.com/betteroffdead).

Next episode, I'm heading to Belgium, home of the most liberal euthanasia laws in the world. Home, also, of Tom Mortier, a man who claims his mother was wrongly killed because of them. Tom's story is being used around the world as a cautionary tale about the slippery slope of euthanasia. But is it a true reflection of a law, and a society, gone wrong?

**Andrew Denton:** Steven, you've explained things very clearly, thank you. I hope I'm never in this building again in my life. But don't take that personally.

**Steven Pleiter:** [Laughing] OK. You're welcome. And even if you change your mind, you are still welcome.

**Andrew Denton:** I'm not coming back, Steven. That's what I'm saying. [Laughing]

**[CLOSING CREDITS]**