

THE CHABOT CASE: ANALYSIS AND ACCOUNT OF DUTCH PERSPECTIVES

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ABSTRACT

The aims of this essay are twofold: to point out the main problems of the *Chabot* precedent and to report the findings of a fieldwork in the Netherlands during which some experts were asked to voice an opinion regarding the psychiatrist's conduct and the legal precedent. During the summer of 1999, twenty-eight interviews with some of the leading authorities on the euthanasia policy were conducted in the Netherlands. Multiple reasons were mentioned to either condone or condemn Chabot's practice.

INTRODUCTION

Euthanasia and physician-assisted suicide have been practiced in the Netherlands since the 1970s. Some of the problematic cases reached the courts. One of the most well known cases is *Chabot*, a case that attracted national and international attention. The *Modern Law Review* has addressed the court ruling in the past.² The *Chabot* precedent has generated debates and heated discussions because it concerns an issue that was rarely discussed up to that point: physician-assisted suicide and euthanasia in psychiatric practice.

Having investigated the Dutch experience for a number of years, in the summer of 1999 I went to the Netherlands to visit the major centers of medical ethics as well as some research hospitals, and to speak with leading figures in euthanasia policy and practice. I shall first provide the background for the *Chabot* debate, outlining the main facts and the troubling issues that evoked the controversy. Subsequently I report the main answers to my question: What do you think of the *Chabot* case?

Before starting the analysis, let me clarify the methodology. Prior to my visit to the Netherlands, I wrote to some distinguished experts in their respective fields: medicine, psychiatry, philosophy, law, social sciences and ethics, asking to meet with them in order to discuss the Dutch policy and practice of euthanasia. The list of interviewees included, *inter alia*, the authors of the major research projects of 1990 and 1995; the person who drafted the euthanasia law; chairpersons of medical ethics depart-

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who consented to be interviewed.)

The interviews took place during July–August 1999, in the Netherlands. They lasted between 1 to 3 hours each. Most interviews went on for more than two hours during which I asked more or less the same series of questions.⁴ During the interviews I took extensive notes that together comprise some 200 dense pages. Later the interviews were typed and analyzed.

The interviews were conducted in English, usually in the interviewees' offices. Four interviews were conducted at the interviewees' private homes, and four interviews in 'neutral' locations: coffee shops and restaurants. Two interviews were conducted at the office kindly made available to me at the Department of Medical Ethics, Free University of Amsterdam. To have a sample of different locations I traveled from Groningen in the north to Maastricht in the south, making extensive use of the Dutch efficient train system.

The interviews were semi-structured. I began with a list of 15 questions but did not insist on all of them when I saw that the interviewee preferred to speak about subjects that were not included in the original questionnaire. With a few interviewees I spoke only about their direct involvement in the practice of euthanasia. Because I was interested in the problematic aspects of the euthanasia practice, after some general questions I addressed the troublesome aspects reiterated in the Remmelink report. This line of questions disturbed some of the interviewees, who wanted to know my own opinion on the subject matter before continuing to answer my questions. Others seemed eager to bring the interview to a close.

This article reports the answers to one question concerning the *Chabot* precedent in my questionnaire. The entire extensive report is included in my forthcoming book *Euthanasia in the Netherlands*.

Chabot

Hilly Bosscher was a 50-year-old patient with no history of psychiatric disorder. She wanted to die because she felt that her life had lost its meaning after the death of her two sons: Peter from suicide at the age of 20, and Robbie five years later from cancer, also at the age of 20. In May 1991, on the day of Robbie's death, Mrs. Bosscher tried to commit suicide, unsuccessfully. After her personal family doctor, as well as some other people she knew, refused to help her commit suicide, she approached the Dutch Society of Voluntary Euthanasia for help, and they

referred her to a psychiatrist, Dr. Chabot.⁵ Dr. Chabot conducted a 'trial therapy' with Mrs. Bosscher, consisting of a series of thirty sessions of 55 minutes each over a two-month period. However, Mrs. Bosscher told Dr. Chabot that she was not prepared to undertake the commitment to work with him to change her bleak outlook on life. In her personal diary she wrote:

I have lost everything and will never get it back. I do not want to become another person than I was when I was a mother and happy. It is finished, it is all over. For me alone there is no purpose in life. I know who I am or what I am. To become so different that I will want to or have to live means to me that I have to lose again. I am not allowed to be who I am or was. That's not right.⁶

In a letter to Dr. Chabot in September 1991, after he told her that he would assist in her suicide, Mrs. Bosscher wrote:

I feel so 'happy' with the help in dying I'll receive. I got everything in my life with which I couldn't possibly live any further. Am I egoist to not want, nor not to be able, to live on? Not having the urge or power to endure, to fight? ... I am certainly making life difficult for you. You told me that was none of my business. You wanted to 'invest' in me (I don't know how to express this in a better way). You are a psychiatrist, and as such you tried everything to hold me. But I feel you tried as a human being as well. I must have been a heavy load to take on.⁷

I asked Dr. Chabot what Mrs. Bosscher meant by her use of the term 'invest'. In his personal letter, Chabot's response was that Mrs. Bosscher felt that he really wanted her to go through her vale of grief. He offered her intensive grief therapy, not just in an impersonal way but in a way that showed he cared about her as a human being. Mrs. Bosscher 'was not just an egocentric who could not perceive' Chabot's intentions; 'she had felt that, as a professional, I wanted "to invest" (time, energy, sharing her pain, etc.) in her'. This she could not nor would not accept.⁸

The short but intense acquaintance with Mrs. Bosscher (from 3 August to 7 September 1991) led Dr. Chabot to conclude that she was a mentally competent person whose freedom of choice was not constricted by mental illness. In his opinion, Mrs. Bosscher had been suffering from a complicated grief process for five years following the suicide of her son, Peter, in 1986. Chabot did not see any psychiatric illness, clinical depression, trace of psychosis, or personality disorder. He believed that for her, there was no future without her children. He accepted that suicide was the only option to end Mrs. Bosscher's misery and was convinced that she would kill herself in any event, with or without his help. Chabot tried to give her antidepressant medication but she refused, saying that 'the only sense life has got for me now is to find my way to Peter and Robbie through a dignified death'.⁹

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antidepressant medication, Chabot answered: 'This question I consider to be very tendentious given her grief. I hope that no pill will be discovered that will prevent or cure grief. Certainly, antidepressants don't cure grief'.¹¹ I asked Dr. Chabot about this puzzle, and his answer was that he did insist on antidepressants for the few symptoms of depression that he noticed. He felt that the patient should give them a serious try. But, Chabot explained, depression is not identical with grief. It was Mrs. Bosscher's grief that he considered to be by far the most important in her wish to die. Chabot testified that he has had quite a lot of experience in grief therapy and has been successful in that field, 'but never with pills'. Hence, urging Mrs. Bosscher to try antidepressants for what Chabot conceived as 'mild depression' seemed to him perfectly compatible with his hope that there would be no medicine discovered that *by itself* (Chabot's emphasis) will cure grief.¹²

Dr. Chabot had transcribed all the sessions with Mrs. Bosscher, which he sent to four psychiatrists and a clinical psychiatrist. He also consulted a family physician and a theologian-ethicist. He then held lengthy telephone conversations with the consultants, four of whom he met with in person. He asked one of the psychiatrists to meet with Mrs. Bosscher in person, but the colleague declined because Dr. Chabot's extensive documentation of the case had convinced him that it was not necessary. All save one reported that it was unlikely that anything could be done to make Mrs. Bosscher's life bearable and that they would support his decision to assist in her suicide. The psychiatrist who expressed a contrasting view thought that Mrs. Bosscher's condition was not hopeless and that Dr. Chabot should persist in treating her.¹³

In a personal communication, Dr. Chabot wrote that the account of the case, as described by Barney Sneiderman and Marja Verhoef, is accurate.¹⁴ The immediate questions that come to mind are: Why did the four experts, who read the detailed transcripts, take the time to meet with Dr. Chabot but saw no need to meet with Mrs. Bosscher? In other words, if the transcripts were so straightforward, to the extent of making a meeting with the patient redundant, why was there a need to meet with the doctor? Furthermore, was the lone dissenter asked to meet with Mrs. Bosscher? What was his reaction? Did he refuse as well? Maybe he could have saved her life.

Hendin argues that Chabot asked only Dr. Frank van Ree, one of the few Dutch psychiatrists publishing on assisted suicide, to see Mrs. Bosscher. Van Ree felt that this was unnecessary.¹⁵ If this information is correct, it is like inviting the 'right' answer rather than seeking professional evaluation of the patient's condition. Later, the court asked van Ree why he did not see the patient. Van Ree explained that he felt he knew

the case and that it would only cause the patient further pain to be seen again by someone else. Presumably, Hendin writes, it was less harmful to Mrs. Bosscher to help her commit suicide.¹⁶

Given the near unanimity of opinion, Dr. Chabot felt assured that he could in good conscience assist Mrs. Bosscher's suicide. Sneiderman and Verhoef wrote that still Chabot sought further counsel from Dr. V., a family physician whose clinical judgement he highly respected. After lengthy discussions on the case, Dr. V. agreed that Mrs. Bosscher's frame of mind precluded any change of heart. However, he was not asked to examine the patient.¹⁷

This is striking and strange. Why not? It seems that the purpose of the meeting was to calm the conscience of Dr. Chabot and to reassure his decision, rather than to seek an independent and free opinion. It seems that Dr. Chabot was seeking not just any opinion, but a certain opinion, namely, one that conformed to the decision that he apparently had already made to help Mrs. Bosscher end her life.

On 28 September 1991, Dr. Chabot assisted Hilly Bosscher to commit suicide and subsequently stood trial. This was a little over two months after their first meeting and about four months after the death of her younger son. The Assen District Court acquitted him in April 1993 after becoming convinced that Mrs. Bosscher was experiencing long-term psychic suffering that for her was unbearable and unremitting.

Four of the clinical experts consulted by Dr. Chabot appeared as witnesses for the defence. They all testified that the case was so well documented that it was 'highly unlikely' that any new information would have been gained by interviewing the patient. The Court then consulted three additional experts who provided written testimonials. None of the seven experts expressed disagreement with Dr. Chabot's role in Mrs. Bosscher's suicide,¹⁸ a fact which critics of the Dutch policy on euthanasia may take to be worrisome and disturbing.

The Appeal Court of Leeuwarden upheld Dr. Chabot's acquittal, but on 21 June 1994, the Supreme Court reversed the decision and convicted Dr. Chabot under Article 294 of the Penal Code.¹⁹ The Supreme Court accepted the contention of the public prosecutor that the defence of *overmacht* was not allowable because none of the experts consulted by Dr. Chabot had personally examined the patient. The Supreme Court held that in non-somatic cases (*i.e.*, cases which have to do with the psychological rather than the physiological condition of the patient), the absence of a face-to-face examination leads to the conclusion that, as a matter of law, the physician may not have truly acted in a state of necessity. Thus, personal contact between consultant and patient constituted a precondition to the acceptance of the *overmacht* defence in such a case.

Although Dr. Chabot was found guilty under Article 294 of the Penal Code, the Supreme Court exercised its prerogative under Article 9(a) of the Criminal Code not to impose any punishment or other measure in light

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...sanction of reprimand. The Disciplinary Court's ruling was based on three accounts: (1) Chabot was faulted for not insisting on therapy as an alternative to assisted suicide. The patient's refusal of treatment should have been a reason for Chabot to refuse the request; (2) Chabot failed to arrange for Mrs. Bosscher to be personally examined by another consultant, a failure which amounted to an ethical breach of duty; and (3) Chabot had not adequately preserved his professional distance, particularly in light of the frequency and length of his sessions with Mrs. Bosscher and the fact that these took place at his home.²¹ Dr. Chabot himself regrets his failure to arrange consultation in person with Mrs. Bosscher.²²

The next section details the Dutch perspectives on the *Chabot* case. Let me proceed, however, by providing an account of my communications with Dr. Chabot. As said before, he was the only person who explicitly declined my invitation for an interview.²³ Chabot first referred me to three writings on his court case,²⁴ saying that Hendin's account of his case was not authorized by him, and in fact gave a tendentious account of his discussion of the case with him.²⁵ Chabot ended his first personal communication by saying that neither before the Boomsma case in 1991 nor since the Supreme Court verdict in 1994 'have I ever assisted someone again in his/her suicide. Of course, many depressed patients have asked my help to commit suicide. But contrary to the impression some have given about my professional stance I know how to give adequate treatment for that request'.²⁶

After a careful reading of the suggested writings I wrote to Dr. Chabot again, asking him to consider seven queries pertinent to his case. Below are presented word for word the questions and the answers.²⁷

Q1. Is it a common practice within psychiatrists' circles to rely on transcripts as a substitute to meeting with patients?

A1. Yes, it definitely is. In fact it is very exceptional for a consultant psychiatrist to see a patient himself after reading transcripts of sessions. A reason for doing so might be that the transcripts don't make sense or that he/she has good reason for not trusting the content of the transcripts. In previous verdicts by the Dutch Supreme Court, no obligation for a consulted doctor to see the patient himself had ever been formulated before my case. I can certainly understand the requirement now and I wish one of the consulted physicians had asked me to see my patient. But there was no way to know any obligation existed to do so at the time, in 1991.

Q2. Had you asked the lone dissenter, who thought that you should persist in treating Mrs. Bosscher, to meet with her? If yes, what was his

reaction? Did they meet? If not, why didn't you ask the dissenter to meet with her?

A2. No. He was definite in his view and showed no interest in either testing or strengthening his view by seeing my patient.

Q3. At the stage when you met with Dr. V., had you already decided to comply with Mrs. Bosscher's request?

A3. Yes.

Q4. Why didn't you ask Dr. V. to examine Mrs. Bosscher?

A4. Dr. V. was not consulted by me to give his agreement with my decision. The suggestion in Dr. Sneiderman's paper that Dr. V. was consulted by me to test once more my views on Mrs. B. is not correct. Yes, I did discuss her wish to die with him but more as a good friend as well as experienced family doctor than in a formal professional way as I had done with the others. I decided to ask him to join me to be present as a professional observer who could possibly testify (if need be) later in court whether or not I behaved in a professional and responsible way. Don't forget that I had never dealt before with physician assisted suicide. What if, against all odds, she failed to die? I felt more comfortable to have a doctor-witness present apart from the witness-friend of Mrs. B.

Q5. Dr. V. attended Mrs. Bosscher's home on the day of her death. Was it the first time that he met her? Why then?

A5. Yes, it was the very first time. He knew me as a conscientious psychiatrist and he accepted my need for a doctor-witness. So he didn't feel any need to check on my decision. He was definitely not present in the role of a consulted doctor.

Q6. How many doctors, who met with Mrs. Bosscher, shared your view that her situation was hopeless?

A6. Only her own family doctor met her between May 1991 and her death. He opposed assisted suicide on principle (being of a Christian denomination). She knew this and therefore she did not seriously enter discussions with him about her motivation to die. This family doctor was later questioned about his views on her by the Medical Disciplinary Board. He expressed himself critical of her death wish saying that 'in his experience after heavy weather there always was bound to follow sunshine'. But the Board did not use his views in their judgment. I guess this was so because they felt his negative views on Mrs. B.'s death wish were more determined by his general world view than by professional considerations.

Q7. Was there the possibility for pressing the option of anti-depressant therapy more vigorously?

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because by mourning and by growing over my losses I will become a different person than I was when I was a mother and happy. I don't want to become that different person. It would feel for me like becoming disloyal to my two sons'. I (and so did others later) think this is a well-considered refusal: loyalty to her sons was the prime value of her life. By being treated and forgetting about them she felt she would become disloyal to her 'core-self'. I urged her to enter mourning therapy, preferably with antidepressants, arguing that after the war people came back from the German extermination camps with less than she had still now and that some of them had grown over their losses and meant a great deal to the next generation; so why couldn't she become a 'different person' and help others overcome their losses? She thought it over and then refused saying: 'that is them, I am a different person. My life is over. If you continue insisting on treatment it is better our ways part now and I will not bother you further with my request'. It was then that I stopped pressing for antidepressants.

Interviewees' Perspectives

As expected, the interviewees exhibited contradictory views on the *Chabot* case. Some supported what Dr. Chabot did and consequently objected to the Supreme Court decision.²⁸ Others had mixed views about the case.²⁹ The majority of interviewees thought that Dr. Chabot had acted unprofessionally and in haste and therefore considered the court decision to be proper and justified.³⁰

The two well-known psychiatrists, A. van Dantzig and Frank Koerselman, exhibited the two polar views. Their professional assessments of the case coincide with their general views on euthanasia. I will outline the different views on a scale from the whole-hearted support to the passionate opposition. The strongest supporter of Chabot among the interviewees was van Dantzig, who said that euthanasia prevents people from dying alone. This was the first time that he had been consulted about a euthanasia case. Van Dantzig was certain, as was his colleague Chabot, that Mrs. Bosscher would have committed suicide anyway. She was not going to accept any further treatment or therapy. Chabot had the choice of helping her to die with her relatives present or to let her commit suicide alone. Mrs. Bosscher refused to take antidepressants. Van Dantzig did not think she was depressed; it was a natural reaction to the death of her two sons. If van Dantzig had felt that pills could help, he would have ordered that Mrs. Bosscher be institutionalized and forced to take the pills. But this was not the case here. There was no cure for her. Suffering from

depression is not different from suffering caused by cancer. Suffering is suffering. Van Dantzig maintained that in the current environment, it is needed that another expert sees the patient. At that time, however, this was not the case.

In his comments on the first draft of this essay, van Dantzig added that he did not see the patient because he was asked by Chabot to examine the procedure and to assess if it was complete. That van Dantzig did find to be the case. Chabot had correctly diagnosed his patient as suffering unbearable pain from losing both her sons. His patient was firmly resolved to try to commit suicide again if euthanasia was denied (she had made a serious suicide attempt before, but failed, and now wanted to be sure of dying). For these reasons, van Dantzig could concur with Chabot's conclusion and still does. If Chabot had come to him now with this request, van Dantzig would want to see the patient. In that respect concluded van Dantzig, times have changed.³¹

Heleen Dupuis, a Leiden professor who is very active in the pro-euthanasia campaign, agreed with Chabot that Mrs. Bosscher was qualified for assisted suicide. She was not depressed in the psychiatric way that may be conducive to treatment. Dupuis reiterated that people should be allowed to choose the moment of dying, maintaining that if people wanted to die, 'what's wrong with providing them the pills?' Doctors are the only people who have access to those drugs. It is far more humane than to force patients to jump from bridges or buildings. If people feel that death is a good solution, why not help them? Dupuis acknowledged that most people, however, do not share her view. They feel that it is not morally acceptable to provide the pills. Doctors are reluctant to euthanize incompetent patients because they are unsure of the will of the patient in the present condition. They would be willing to withhold or withdraw treatment, but not to euthanize. Morally speaking, Dupuis thinks that end-of-life decisions are about tolerance. Dying is a private matter, and it should be kept as a private choice. Society should provide safeguard mechanisms, but should allow euthanasia and PAS as options. Dupuis seemed to have a very good experience with doctors, trusting them wholeheartedly without reservations.

Henri Wijsbek published a prize-winning essay in which he defended Chabot's decision to assist in the suicide of Mrs. Bosscher on the grounds that she had a right to protect the narrative unity or authenticity of her life. He called it unusual that the Supreme Court convicted Chabot and did not refer the case to a lower court. As for the facts of the case, Chabot complied with all existing rules. Mrs. Bosscher did try other forms of therapy when her first son committed suicide, but it did not help her. It is impossible to impose treatment against the patient's will. Her suffering was unbearable, and she could not go on living. Furthermore, Chabot asked one of his colleagues to see her, but he said that there was no point, having learned everything he wanted to know from Chabot's transcripts.

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On the one hand, Leenen thinks that psychiatric patients should be seen by a consultant. On the other hand, Leenen felt a lot of sympathy with Chabot insofar as the patient was suffering and could not be cured. Only one of the seven consultants indicated that there was potential therapy for her. As a result of this case, the Supreme Court introduced the new requirement that a psychiatrist needs to consult another expert, who must see the patient before euthanasia or assisted suicide is performed. However, this requirement did not exist at that time. Like Wijsbek he wondered: 'how could you blame someone for failing to do something that was not required at that time?'³² For this reason, Leenen thinks that the decision of the disciplinary court to reprimand Chabot was unfair. The court was too hard on him, and Leenen feels that it was not a fair trial. The court ignored that the majority of consultants sided with Chabot.

Govert den Hartogh, a philosopher who is a member in the newly instituted Amsterdam regional committee that reviews all reported euthanasia cases in the region, seemed to be influenced by Wijsbek's reasoning. He argued that Chabot acted in a very careful way. He did not act upon an impulse, but rather thought about what he was doing. Maybe he should have invested more time, but the disciplinary court wrongly condemned him. Mrs. Bosscher was competent to make her choice. There was no real available form of treatment. Chabot tried to find an alternative solution to help her and concluded that no treatment was available. At the same time, den Hartogh admitted that he was unsure about whether a doctor should have cooperated with Mrs. Bosscher to kill her, and that Chabot should have insisted on a consultant seeing her. This aspect is important in order to maintain control.

The response of Rob Houtepen, an ethicist from Maastricht, was also fascinating because it was incoherent. He seemed to condone what Chabot did although recognizing that his conduct was faulty. Houtepen said that there were two problems in the case: not securing adequate consultation and not exploring alternatives for treatment. At the same time, Houtepen said that there was 'no reason' to worry about the case. It might be defensible to assist in the suicide of patients in depression, who have a history of depression. Chabot's conduct was not defensible, but if the procedures are properly followed, then euthanasia should be considered as an option for depressed patients. Houtepen apparently assumes that after the *Chabot* case, all of the intricate questions concerning depressed people will be resolved and psychiatrists will be bound to follow the procedures.

John Griffiths, Sjef Gevers, Ron Berghmans and Arie van der Arend had mixed feelings about the case. Griffiths seemed the least concerned

...papers gave a very supportive view of Chabot, at first even depicting him as a hero. Later, when the Supreme Court found him guilty, Chabot ceased to be a hero, but the media still cast a positive eye on the crossing of another border—allowing the performance of euthanasia in psychiatric cases.

Henk Jochemsen of the Lindeboom Institute and the Free University contended that even if you accept the need for euthanasia on some occasions (which Jochemsen does not), Chabot did not try enough, did not explore all possible alternatives for treatment, and behaved unprofessionally by becoming too close to his patient. Jochemsen further noted that very few psychiatrists would present themselves to the Society for Voluntary Euthanasia as one who would be willing to consider euthanasia, as Chabot did. This was quite unusual.³⁵ After the case was published, Chabot became a hero in the pro-euthanasia circles.

Gerrit van der Wal, Jaap Visser, Dick Willems, Egbert Schroten, and Evert van Leeuwen did not side with Chabot for the same reasons that Houtepen mentioned. Unlike Houtepen, they seemed more worried about the case. They thought that a consultant should see the patient, and that in this case there were other treatment options for the patient, which Chabot should have insisted on exploring. Egbert Schroten, Director of the Center for Bioethics and Health Law at Utrecht University, said that he respected the autonomy of the patient, but how can we speak of autonomy in time of depression? Schroten said that Chabot should have refused the euthanasia request, and that if Mrs. Bosscher did not accept his decision, she was always free to go to another psychiatrist. Evert van Leeuwen, a professor of philosophy and medical ethics from Amsterdam, said that there are psychiatric reasons for euthanasia, but not in this case.

Two of the physicians, Gerrit Kimsma and Johannes van Delden, also objected to Chabot's conduct. Kimsma, who practices euthanasia, explained that all of his patients were terminal. He would not do what Chabot had done. Moreover, like van Leeuwen, Kimsma thought that Mrs. Bosscher was not a patient in the psychiatric sense. She was shopping around for someone to help her. She was a client, not a patient. Furthermore, there was the development of a friendship beyond the doctor-patient relationship and problems of transference (the patient's unconscious feelings and attitudes toward the therapist and vice versa) and counter-transference. Koerselman, below, elaborated on this issue. Similarly, van Delden who co-authored the 1990 Rummelink report concurred that he would not have acted in the way Chabot did. He criticized Chabot for relying too heavily on the autonomy factor, indicating that there must also be *unbearable* suffering. It is not the role of the doctor to assist in the suicide of his patients when life gets tough.

Ruud ter Meulen, university professor and Director of the Institute of Bioethics at Maastricht, noted that the *Chabot* case sheds further light on the difficulties involved in the understanding of the concept of suffering. While it was possible to reach an agreement on euthanasia for cancer patients, it is far more problematic to agree on euthanasia in relieving psychological suffering. Ter Meulen thought that Chabot was rightly condemned. Like Kimsma, he felt that Chabot was too involved in his relations with Mrs. Bosscher and failed to maintain sufficient distance.

Margo Trappenburg, a political scientist, said she was 'extremely shocked' by Chabot's conduct. Evidently, Mrs. Bosscher was unhappy. It was a pity that the Supreme Court ruled that she suffered from a psychiatric disorder. Chabot himself said that she was not a psychiatric patient. Doctors should not provide euthanasia to unhappy people. They should restrict their conduct to helping medical or psychiatric patients, not to solving unhappiness. For Trappenburg, this was a step taken too far. She testified that the Chabot case scared her. If euthanasia should be allowed for psychiatric patients, then the procedure should be extra careful and not be conducted in Chabot's way.

G.F. Koerselman, a well-known psychiatrist, expressed the most vehement opposition to Chabot's conduct. Evidently, he was deeply disturbed by the conduct of his colleague when he first heard about the case and became even more so after reading Chabot's book³⁶ about his patient. It appeared that Chabot was unable to diagnose Mrs. Bosscher. She suffered from depression, something that is quite normal in her condition. Koerselman's view was that Mrs. Bosscher also had a personality disorder. She focused totally on her sons. There were pathological relations between her and the older son, as evidenced by her involvement in his relationship with his girlfriend.

Like Kimsma, Koerselman concludes that there was a counter-transference problem.³⁷ Chabot had personal feelings for his patient, as reflected in his relations with Mrs. Bosscher. Yet, he did not realize his growing emotional involvement in the treatment. Koerselman added that many doctors try to relieve guilt feelings that stem from their personal past in their treatment of patients. The problem in this case was that Mrs. Bosscher made *everyone* feel guilty and was very aggressive. Many people, including Chabot, felt guilty for their inability to help her. Furthermore, the entire process took only two months. This is an extremely short time for therapy.

Koerselman regarded Chabot's conduct in the case as extremely unprofessional. He explained that psychiatrists should not talk for hours with a patient in one session so as not to become over-involved. Chabot asked Mrs. Bosscher to take a room in a hotel near his work place because he wanted to spend more time with her. Subsequently, Chabot even allowed her to sleep in his house.³⁸ In his book, he appeared to be even proud of it.³⁹ He lost all professional guidelines. Like Jochemsen and

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... aspect in Chabot's behavior: that he talked about the case in the open. Koerselman testified that he was unaware of what was accepted conduct in psychiatrist circles prior to that time. He said: 'I don't know what was the common practice. I, myself, would always want to see the patient. I was amazed that leading psychiatrists were willing to comment on the patient without seeing her in person'.⁴⁰

I asked Koerselman whether the Amsterdam medical tribunal's penalty of *berisping*, or reprimand, was serious. His answer was that receiving a reprimand is a rather serious punishment. It is more serious than a warning. Next on the scale is a payment penalty, and the most serious penalty is revoking of the doctor's license. The latter has been done only rarely, when, for instance, a doctor sleeps with his patient. In the Netherlands, Koerselman said cynically, 'you can kill your patient but you should not sleep with her'.⁴¹

CONCLUSIONS AND FURTHER REFLECTIONS

The aims of this essay were twofold: to point out the main problems of the *Chabot* case and to report the findings of a fieldwork in the Netherlands during which some leading experts were asked to voice an opinion regarding the psychiatrist's conduct and the legal precedent. Different views were expressed, the majority of which found Chabot's conduct in the case problematic. Some experts condoned what Chabot did and saw no room for concern.

Subsequent to the Supreme Court ruling, the Dutch Ministers of Health and Justice commissioned research to study the phenomenon. In March 1996, a one-page questionnaire was sent to a sample of 673 psychiatrists. Of the 552 respondents, 205 (37%) had at least once received an explicit and persistent request for physician-assisted suicide from a patient. Twelve (2%) had at least once assisted in suicide. An additional 345 respondents (64%) thought physician-assisted suicide for psychiatric patients could be acceptable; of those, 241 said they could conceive of a situation in which they would be willing to assist in suicide. Detailed information was obtained from 202 respondents about their most recent requests, with 43 of them (21%) reporting that they contemplated granting the patients' requests for PAS. Of those, 40 consulted one or more colleagues each.⁴² Nearly all respondents said that one or more psychiatrists should be consulted on such a matter. The main reasons for consultation were to assess whether the phenomena of transference and

counter-transference might have influenced the decision-making process (50%), whether the request was well considered (58%), and whether there were still remaining treatment options (58%). Of 537 respondents, 438 (82%) thought that the psychiatrist consultant should always examine the patient; 93 (17%) thought this was necessary in some but not all cases, and 6 (1%) thought it unnecessary.⁴³

Between 1981 and 1997, there were 20 prosecutions against physicians that ended with a judicial verdict. In nine of these cases, the doctor was found guilty. No punishment was awarded in three cases and in the other six the doctor was given a conditional sentence without imprisonment. In a few cases, a fine was imposed because the death had been incorrectly reported as natural.⁴⁴

In 1997, Ganzini and colleagues conducted a study among board-certified forensic psychiatrists in the United States. The study shows that many psychiatrists would support procedural and legal safeguards for patients choosing assisted suicide. For the majority of respondents, a patient requesting assisted suicide would be found competent after an evaluation by two independent examiners, followed by judicial or local administrative review, rendering a determination of competence at a clear and convincing level of proof. The recommended extensive evaluation would assure that only competent patients have access to assisted suicide. The presence of major depression would automatically result in a finding of incompetence.⁴⁵

NOTES

1. D. Phil. (Oxon., 1991); Senior Lecturer, University of Haifa; Visiting Professor and the Fulbright-Yitzhak Rabin scholar for 1999-2000, UCLA School of Law; Director, Think-tank on Medical Ethics, The Van Leer Jerusalem Institute (1995-1998); author, *The Right to Die with Dignity: An Argument in Ethics, Medicine, and Law* (NJ.: Rutgers University Press, 2001) and *Euthanasia in the Netherlands* (Philadelphia: University of Pennsylvania Press, 1992); editor, *Medical Ethics at the Dawn of the 21st Century* (New York: New York Academy of Sciences, 2000). The author is most grateful to Evert van Leeuwen and Martine Bouman for facilitating the research and to the interviewees for their kind cooperation.
2. John Griffiths, "Assisted Suicide in the Netherlands: The Chabot Case", *Modern L. Rev.*, Vol. 58 (March 1995): 239-248; *idem*, "Assisted Suicide in the Netherlands: Postscript to Chabot", *Modern L. Rev.*, Vol. 58 (November 1995), 896.
3. In his letter dated 5 June 1999, Dr. Chabot wrote: 'After four years waiting for the final court judgement (1991-1995) and discussing the case with many people from abroad, I hope you will understand that I prefer to remain in the background now and not to make an appointment with you'.
4. My questionnaire comprised of 15 questions. The Dutch comprehensive study of 1995 consisted of 120 pages (!) and the interviews lasted for an average of 2.5 hours. The pace of questioning was, apparently, frantic. Cf. Paul J. van der Maas, Gerrit van der Wal, Ilinka Haverkate *et al.* "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995", *New Eng. J. of Med.*, Vol. 335, No. 22 (28 November 1996), p. 1700.

- ... with gratitude for Dr. Chabot for sending me excerpts of Mrs. Bosscher's farewell letter (on 16 July 2000).
8. Chabot's letter dated 14 August 2000.
 9. "Arlene Judith Klotzko and Dr. Boudewijn Chabot Discuss Assisted Suicide in the Absence of Somatic Illness", *Cambridge Quarterly of Healthcare Ethics*, Vol. 4 (1995), pp. 241-242.
 10. *Ibid.*, p. 244.
 11. *Ibid.*, p. 246.
 12. Chabot's letter dated 14 August 2000.
 13. Barney Sneiderman and Marja Verhoef, "Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases", p. 402. According to Hendin, two of the experts did not recommend Dr. Chabot to assist in her suicide. See "Seduced by Death: Doctors, Patients and the Dutch Cure", p. 147. I asked Chabot about this discrepancy, and he explained that 'both Sneiderman and Hendin are right; they simply refer to different moments in the process'. Sneiderman refers to the period when Mrs. B. was still alive, whereas Hendin refers to the later phase, when the Medical Disciplinary Board invited another expert to give his opinion and he disagreed with Chabot. Strictly speaking, this later expert was not consulted by Chabot. Letter dated 14 August 2000.
 14. Personal communication by Dr. Chabot, dated 5 June 1999.
 15. Hendin, "Seduced by Death: Doctors, Patients and the Dutch Cure", p. 147. See also "Arlene Judith Klotzko and Dr. Boudewijn Chabot Discuss Assisted Suicide in the Absence of Somatic Illness", p. 245.
 16. Hendin, "Seduced by Death: Doctors, Patients and the Dutch Cure", p. 150.
 17. Barney Sneiderman and Marja Verhoef, "Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases", p. 402.
 18. *Ibid.*, p. 403. See also Gene Kaufmann, "State v. Chabot: A Euthanasia Case from the Netherlands", *Ohio Northern University Law Review*, Vol. 20 (1994): 815-820.
 19. Article 294 prohibits assisted suicide: 'Any person who intentionally incites another person to commit suicide, assists him in the act or provides him with the means to commit suicide shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fine of NLG 25,000'. Cf. Netherlands Ministry of Foreign Affairs—APPENDICES. For further reading, see H.J.J. Leenen, "Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands", *Health Policy*, Vol. 8 (1987): 197-206; J.K.M. Gevers, "Legal Developments Concerning Active Euthanasia on Request in the Netherlands", *Bioethics*, Vol. 1, No. 2 (1987): 156-162. http://www.bz.minbuza.nl/English/Policy/c_eutheng-app.html#
 20. *Nederlandse Jurisprudentie*, 1994, no. 656; John Griffiths, "Assisted Suicide in the Netherlands: The Chabot Case", *Modern L. Rev.*, Vol. 58 (March 1995), p. 239.
 21. John Griffiths, "Assisted Suicide in the Netherlands: Postscript to Chabot", p. 896. See also http://www.bz.minbuza.nl/English/Policy/c_eutheng-A.htm
 22. "Arlene Judith Klotzko and Dr. Boudewijn Chabot Discuss Assisted Suicide in the Absence of Somatic Illness", p. 246.
 23. Three people did not answer my letters and I don't know whether they did not wish to meet or simply failed to receive my letters.
 24. J. Griffiths, A. Bood and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998); Barney Sneiderman and Marja Verhoef, "Patient Autonomy and the Defence of Medical Necessity: Five Dutch

...ingen (Groningen, 10 July 1999).
Professor J.K. Gevers, Professor of Health Law, University of Amsterdam (Amsterdam, 19 July 1999).
Professor Evert van Leeuwen, Department of Metamedicine, Free University of Amsterdam (Amsterdam, 19 July 1999; Haarlem, 28 July 1999).
Dr. Dick Willems, Institute for Research in Extramural Medicine, Department of Social Medicine, Free University, Amsterdam (Amsterdam, 20 July 1999).
Professor Bert Thijs, Medical Intensive Care Unit, VU Hospital, Amsterdam (Amsterdam, 20 July 1999).
Professor A. van Dantzig, retired expert in psychiatry (Amsterdam, 20 July 1999).
Professor H.J.J. Leenen, formerly professor of social medicine and health law, Medical Faculty and Faculty of Law, University of Amsterdam (Amsterdam, 21 July 1999).
Professor Gerrit van der Wal, Institute for Research in Extramural Medicine, Department of Social Medicine, Free University of Amsterdam (Amsterdam, 21 July 1999).
Dr. Jaap J.F. Visser, Ministry of Health, Department of Medical Ethics, The Hague (Amsterdam, 21 July 1999).
Professor Heleen Dupuis, Department of Metamedicine, University of Leiden (Leiden, 22 July 1999).
Dr. Margo Trappenburg, Department of Political Science, University of Leiden (Leiden, 22 July 1999).
Dr. Henri Wijsbek, Department of Medical Ethics, Erasmus University of Rotterdam (Rotterdam, 23 July 1999).
Dr. Arie J.G. van der Arend, Health Ethics and Philosophy, Maastricht University (Maastricht, 26 July 1999).
Dr. George Beusmans, Maastricht Hospital (Maastricht 26 July 1999).
Professor G.F. Koerselman, Sint Lucas Andreas Hospital, Amsterdam (Amsterdam, 27 July 1999).
Professor Henk Jochemsen, Professor Lindeboom Institute (Ede Wageningen, 27 July 1999).
Dr. Gerrit K. Kimsma, Department of Metamedicine, Free University of Amsterdam (Koog 'aan de Zaan, 28 July 1999).
Dr. James Kennedy, Department of History, Hope College, Michigan. Visiting Research Fellow at the Institute for Social Research, Amsterdam (Amsterdam, 29 July 1999).
Professor Paul van der Maas, Department of Public Health, Faculty of Medicine, Erasmus University, Rotterdam (Amsterdam, 29 July 1999).
Dr. Chris Rutenfrans, *Trouw* (Amsterdam, 30 July 1999).
Dr. Arko Oderwald, Department of Metamedicine, Free University of Amsterdam (Amsterdam, 30 July 1999, 8 August 1999).
Ms. Barbara de Boer and her three children (Amsterdam, 2 August 1999).
Professor Egbert Schrotten, Director, Center for Bioethics and Health Law, Utrecht University (Utrecht, 5 August 1999).
Professor Govert den Hartogh, Faculty of Philosophy, University of Amsterdam (Amsterdam, 10 August 1999).
Dr. Johannes J.M. van Delden, Senior Researcher, Center for Bioethics and Health Law, Utrecht University (Utrecht, 10 August 1999).
Dr. Rob Houtepen, Health Ethics and Philosophy, Maastricht University (Maastricht, 11 August 1999).

Dr. Ron Berghmans, Institute for Bioethics, Maastricht University (Maastricht 11 August 1999).
Professor Ruud ter Meulen, Director, Institute for Bioethics and Professor at the University of Maastricht (Maastricht, 11 August 1999).

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