25. Nederlandse Patiënten Vereniging. *Reactie van de Nederlandse Patiënten Vereniging op het Kabinetsstandpunt euthanasie* [Reaction of the NPV on the Cabinet's viewpoint on euthanasia] 1991. Veenendaal: NPV.
26. Euthanasie uit het strafrecht [Remove euthanasia from the Penal Code]. *Euthanavisie* 1992, nr. 1: 10.
27. de Lange, F., and J. Jans, eds. 2000. *De dood in het geding. Euthanasiewetgeving en de kerken* [Death at issue: Law on euthanasia and the churches]. Kampen: Uitgeverij Kok.
28. Hagenouw, R. 1999. Wetsvoorstel Toetsing Levensbeeindiging op verzoek en hulp bij zelfdoding' [The Termination of Life on Request and Assisted Suicide (Review Procedures) Act]. *Medisch Contact* 54: 1452–1453.
29. Hildering, P. 2000. Bezwaarschrift NAV [Petition NAV]. *Pro Vita Humana* 7: 11–13.
30. Standpunt NVVE betreffende wetsvoorstel euthanasie. Amsterdam 16–11–1999 [Opinion of the NVVE on the euthanasia bill: Amsterdam, November 16, 1999]. 1999. http://www.nvve.nl/nvve2/dossierdetail.asp?pagkey=71802&dossier=72075.
31. Gill, K., and G. Schellekens 1999. Wetsvoorstel euthanasia en hulp bij zelfdoding [Bill on euthanasia and assisted suicide]. *SVL Nieuws*, no. 5: 1–3.
32. de Lange, F. 2000. Verschuivingen in het kerkelijk spreken – Verschuivingen in het debat over euthanasie [Shifts in clerical speaking – Shifts in the debate on euthanasia]. In 26. F. de Lange and J. Jans 2000, pp. 46–58.

6

The Dutch Social Fabric

Health Care, Trust, and Solidarity

Margo Trappenburg and Hans Oversloot

INTRODUCTION

In this chapter, we will discuss the social and political "fabric" of the Dutch euthanasia regime. The Dutch regime – described more extensively in other chapters – can be characterized as both liberal and moderate. It is liberal compared to many other countries where euthanasia is strictly forbidden. It is moderate because of the many safeguards involved: Dutch people are not entitled to euthanasia or physician-assisted suicide, and doctors cannot perform euthanasia as they see fit. Both patient and doctor must adhere to legal criteria and procedural norms.

Three strands that make up the social fabric of this regime come very clearly to the fore in the literature on euthanasia in the Netherlands. They have kept the regime liberal as well as moderate.

The first strand is the consensual character of the Dutch social and political culture. Dutch political elites – adherents of various ideologies, with different opinions on euthanasia – felt that they had to work out a regulatory regime that would suit most of them, rather than a regime that would accommodate liberal preferences while disregarding religious or conservative objections, or vice versa.

The second strand is the Dutch health-care system, in particular the system of general practitioners, who supposedly know their patients much better than most hospital doctors. General practitioners are entrusted with euthanasia decisions because of their knowledge of their patients.

The third strand is the trust that Dutch patients have in their doctors and their willing submission to rules and decisions made by the medical elite. Dutch patients trust their doctors with their lives and deaths, even more literally than patients in countries where euthanasia is forbidden. Dutch patients seem to be willing to accept medical decisions in other areas as well; they tend to accept that "you can't always get what you want" with regard to health care.

Recent social and political changes could begin to fray this tightly woven fabric, however. In the early years of the twenty-first century, new populist parties have challenged traditional political elites, altering the consensual character of Dutch politics. Similarly, as more and more women physicians enter general practice on a part-time basis, fewer general practitioners (GPs) fit the traditional model of the longtime, trusted advisor who knows the patient and family well and can be called at all hours. Finally, the introduction of a more market-based health-care system that – as is emphasized again and again in public and political debate – puts patients in the driver's seat as consumers is undermining patients' willing submission to the rules and decisions of the medical elite.

In what follows we will explore whether and how these changes may – in the long run – also change the Dutch euthanasia regime itself.

THE THREE STRANDS IN FOREIGN EYES

Several foreign commentators have expressed wonder about the reason that euthanasia was first legalized in the Netherlands. What made the country unique or unusual in this respect? Israeli researcher Raphael Cohen-Almagor noticed with alarm the wide consensus among what some have called the "euthanasia elite," the researchers, ethicists, lawyers, politicians, and policymakers involved in the euthanasia regulations:

> What was striking in my discussions was the prevailing acceptance of the euthanasia procedure. There were only a few dissenters who were willing to oppose the system. My first fourteen interviewees were, on the whole, in favor of the policy, and I felt a growing unease in encountering such unanimity of opinion.[1]

American medical anthropologist Frances Norwood points – with warmth and approval – to the unique relationship between Dutch patients and their general practitioners:

> What I first noticed conducting observations with *huisartsen* [general practitioners] was that their daily practice was quite different from what I had observed ... in the United States. Dutch *huisartsen* tend to work alone in offices situated within neighborhoods, homes converted into office space typically, and they continue to this day a long tradition of conducting home visits, or house calls.... Another important distinction between the Dutch and U.S. general practice is the power differential, the relationship between patients, families and *huisartsen*. In some ways the power differential in terms of physician authority is more equalized between Dutch patients and *huisartsen* than between their US counterparts.[2]

Dutch GPs take time to discuss their patients' personal life. Unlike the majority of contemporary American doctors, they do not restrict themselves to their patients' medical condition. A conversation between patient and *huisarts* tends to become a form of mutual consultation, a kind of conference. Patient and doctor try to reach consensus, although in this process patients generally follow the doctor's lead.

Whereas Norwood was impressed by the easy relationship between GPs and their patients, Herbert Hendin, professor of psychiatry at New York Medical College, was struck by what he perceived as the uncanny amount of trust in physicians that he found in the Netherlands. Apparently, possibly because of their personal acquaintance with their doctors, Dutch patients are willing to grant their physicians the right to end their suffering by putting them to death. Hendin observed:

> The Dutch accept the authority of physicians in ways that would seem foreign in the United States. Malpractice suits are rare in the Netherlands. Even when physicians end the lives of patients who have not requested it, the Dutch are inclined to be forgiving on the grounds that the physicians' intentions were benevolent.[3]

Hendin attributes this leniency to what he considers to be the ambivalent Dutch attitude toward authority. As traditional Protestants, the Dutch defied the authority of the pope and of the Roman Catholic Church, yet they appear to be willing to accept "authority that is less direct and obvious; doctors and judges fall into this category."[3]

These and other foreign observers point to three characteristics of Dutch (political) culture that also have relevance for explaining the way in which the legal framework and the actual practice of euthanasia came about – and have been maintained: 1) the culture of consensus, in which elites of all sorts seem to make complicated decisions together in some fuzzy way; 2) the familiarity between Dutch GPs and their patients; and 3) general willingness to submit to the medical elite. In fact, these observations by "outsiders" and "foreigners" do not differ much from (earlier) observations by "insiders" and "natives," and (the effects of) these findings continue to be discussed by Dutch social scientists, political theorists, and moral philosophers.

A CLOSER LOOK AT THE SOCIAL AND POLITICAL FABRIC OF THE EUTHANASIA REGIME

Dutch political culture has usually been described as pragmatic, consensual, and corporatist. The country's electoral system is based on proportional representation. Broadcasting time, mayoralties, and high-ranking positions in government bureaucracy are also distributed according to various proportionality principles. Coalition governments are a fact of life; no individual political party has ever managed to win a majority of seats in Parliament. Sensitive issues touching on religion or morality are carefully discussed in advisory councils and expert committees. Labor relations are discussed in advisory councils in which employer organizations and trade unions try to agree on cutbacks, wage raises, job security, and so on.[4] Political scientist Rudy Andeweg characterizes the political system as follows:

> "Cosy consensus" is the *Economist*'s pet phrase to describe Dutch politics. Indeed, whatever criterion is used, or whatever aspect of the political system is analysed, the

Netherlands always scores high on cooperation and low on competition. Together with Austria, Belgium and Switzerland, the Netherlands is regarded as one of the classic cases of consociational democracy, in which the destabilizing effects of deep social divisions are neutralized by cooperation among the leaders of the social segments. Neo-corporatism – a combination of non-competitive relations among interest associations with bargaining between interest associations and government – is also characteristic of the Dutch system.[5]

In such a system elites of all kinds learn that they must be moderate and that at one moment or another they will have to agree on important points, or at least do business together. Andeweg stresses that Dutch political elites tend to search for consensus and compromise. A large number of legislative government proposals are approved by both ruling coalition parties and parties in opposition.

Consensus and compromise seeking is also practiced in the arena of interest groups. Once a decision is taken and a compromise has been reached, protest tends to disappear in the Netherlands. The political debate about abortion ended in 1981 when a compromise bill was finally adopted. After that, both the pro-life and the pro-choice movements virtually disappeared, despite the fact that neither had accomplished its goals.[5] One might expect a similar course of events with regard to euthanasia after the introduction of the current law in 2002. Proponents of a more liberal regime as well as opponents of the present law would then accept the chosen compromise. They would not fight either for an extension of the present possibilities or for tighter rules and regulations.

To understand the way in which the practice of euthanasia in the Netherlands originated, and how this practice has been maintained, one must pay special attention to the relationship between patient and doctor, that is, the relationship between patient and GP.[6] Studies of euthanasia in practice have shown time and again that euthanasia is very much a matter between family doctor and patient, rather than a medical procedure confined to hospitals or nursing homes.[7,8,9] It involves a process that was intended to safeguard Dutch patients from unexamined or hasty decisions about ending their lives by compelling them to convince their family doctor that they really want to die. That process of persuasion requires more than a single conversation. The doctor, for his or her part, is legally obligated to seek consultation from another physician in assessing whether a decision to perform euthanasia is appropriate.

American media may portray Dutch citizens as free-spirited individuals preoccupied with drug abuse, abortion, and pornography right up to the time they end their lives prematurely by means of euthanasia, but citizens' willingness to submit to medical authority disproves that caricature. The Dutch acknowledge authority and do accept limits on ethical issues; in most cases, they are willing to forgo the treatments that physicians choose not to employ. For example, for a long time prenatal diagnosis was available only to pregnant women and aspiring parents who were categorized as having a medical "indication," such as maternal age, family history, or a previous child with a genetic

condition. One could not receive an amniocentesis without such an acknowledged medical indication, even if one were willing to pay for it. Similarly, the ideology of natural birth is very much alive among the medical elite (especially among midwives), and up till very recently Dutch women could not demand an epidural because of a preference for a less painful birth process than the one nature provides.

New medical technology, such as predictive genetic testing, is not simply thrown on the market following government approval; it is regulated through medical channels, and people have access to it if their doctor thinks that they have a proper medical reason. Former Health Minister Elizabeth Borst-Eilers, who is a member of D66 – generally considered the most liberal political party in the Netherlands with respect to (regulation of) ethical issues – announced in a white paper on new genetic technology:

> In my eyes [the health-care sector and the medical profession] should produce a protocol for predictive genetic diagnostic research. Consensus about indications must decide when and under what conditions the use of this kind of technology could be appropriate.... The fact that professionals will act in accordance with professional standards will guard us against unjustified demands for genetic diagnostic research from patients, and against requests that could lead to an excessive burden on the patient and no compensatory advantages in case of an unfavorable outcome.[10]

Medical professionals must write protocols and uphold professional standards. A mere request should not suffice to get a predictive test, nor should a mere request ever be enough to grant someone a mercy death.

One might say that these three characteristics – the culture of consensus, the special relationship patients have with their GP, and people's submissive attitude toward the medical elite – have made the Dutch euthanasia regime what it is today, a moderately liberal regime: moderately liberal in that it provides individual freedom of choice within a formal, legal framework that sets limits to individual self-determination; moderately liberal because two doctors must classify the patient's suffering as unbearable before they would consider going along with a wish to die.

Its liberal aspects make the regime unacceptable to citizens with strong traditional religious views, who feel that we should not intervene in God's way. But neither does it satisfy hard-core social liberals. For those who think that an individual's life is his or her own for the taking, who are convinced that people fully own their individual lives, and who believe that a request alone should be sufficient to get euthanasia, the present regime is not liberal enough, or perhaps not even liberal at all.

All three seemingly fixed characteristics have recently become more or less unhinged, however, and are perhaps now in a state of flux. In the remainder of this chapter, we discuss what is happening to Dutch political culture, the traditional GP system, and the general populace's acceptance of medical authority. We also explore the implications of these changes for the euthanasia

regime and whether it is likely to become more conservative or more liberal in direction, including even, perhaps, a change in the legal status of euthanasia.

FROM CONSENSUS POLITICS TO POPULISM OR POLARIZATION?

From 1918 to 1994, the Dutch were governed by a coalition of one or more Christian Democratic political parties, and most of the time by either a Social Democratic party or a Liberal party. During that time, the Netherlands had center-left coalitions (Christian Democrats plus Social Democrats) or center-right coalitions (Christian Democrats plus Liberals). For those citizens who were interested in changing the law on moral issues (such as abortion, euthanasia, equality between men and women etc.), this state of affairs was often disappointing. The Christian Democratic participation in each and every government was a clear impediment to "progress" – as the Social Democrats and Liberals of different persuasions were inclined to characterize the changes they desired.

The Social Democrats and the Liberals differed widely on socioeconomic issues, but with respect to moral questions they were expected to be able to come to an agreement fairly easily. After all, beginning in the 1970s, the Netherlands had become a highly secularized country, in which traditional, observant Christians (Protestants of different persuasions as well as [Roman] Catholics) had become a minority. Thus, a politically liberal regime with regard to moral issues was regarded as fitting and proper. However, Liberals and Social Democrats were never able to let their potential agreement on ethical issues prevail over their diverging socioeconomic convictions. They always preferred a like-minded Christian Democratic coalition partner on socioeconomic issues. For this reason, a "purple coalition" (of the red Social Democrats and the blue Liberals) was expected to remain merely a dream of the political leaders, member-activists, and voters of D66, a smaller party with strong liberal preferences on moral issues.

In 1994, however, D66 got a chance to realize its dream. The 1994 parliamentary elections had led to a stalemate. There was neither majority support for a coalition of center and right nor a feasible majority for a center-left coalition. Thus, the larger parties would have to cooperate with D66, which had won quite a number of seats. D66 made it clear that they were only willing to talk about their dream: a purple coalition of Liberals, Social Democrats, and, obviously, D66. Four months after the 1994 election, the so-called Purple Government was a fact; it would survive the next elections in 1998 and last until 2001.[a]

During its first years (1994–1998), the purple coalition was extremely popular, but its popularity faded the longer it was in office. The Social Democrats

[a] Factual information about Dutch coalitions at http://www.parlement.com.

signed a coalition agreement dominated by a significantly new perspective on state regulation of the public and private sector, calling for public services to be privatized and market incentives to be introduced into government. Social Democratic Prime Minister Wim Kok announced that his party would have to lose its "ideological feathers" and embrace modern times.[11]

The Liberal Party, traditionally known as tough on crime and more recently as tough on immigrants, was led by Vice Prime Minister Hans Dijkstal, who was generally considered to be soft on both these issues. The purple coalition thus led to substantial convergence between the two traditional opponents in Dutch politics. Political scientists drew attention to the effect that this convergence might have on the electorate in the long run. In effect, the purple coalition put an end to Dutch citizens' traditional expectations that elections would allow for a choice between center right and center left (even if politics meant that their preferred party would always have to give up some of its political preferences). Putting an end to this choice, political scientists pointed out, would make the country susceptible to populism.[12,13,14] If people cannot choose between competing political elites because they have good reason to think that these are all alike, they may decide to vote for someone who challenges the political elite as such and who presents him- or herself as the representative of a totally different *kind* of politics (nonpolitics).

Such was the situation when Pim Fortuyn, a columnist of a widely read weekly, decided to take part in the 2002 parliamentary elections. His platform was a mix of issues that had been neglected during the purple years: He took a tough stance on crime, he promised to be extremely tough on immigrants, and he had no sympathy for the privatization of public services, although he found the Dutch welfare state far too generous in many respects. Fortuyn was highly ideological, though he could hardly be praised for ideological consistency. His "ideology" was quite personal, in some respects idiosyncratic, but not, therefore, unpopular; on the contrary.[b] Opinion polls predicted a very successful election result.

On May 6, 2002, Fortuyn was murdered by an animal rights activist. His list of candidates participated, in Fortuyn's name, in the general election of May 15 and managed to win 26 (of 150) seats in Parliament. But the Pim Fortuyn parliamentary group was soon torn apart. They could not decide who should lead them; they seemed to disagree on many issues, both procedural as well as

[b] Pim Fortuyn, from a lower-middle-class Roman Catholic family, had studied sociology in Groningen, where he was appointed assistant professor when he was a Marxist. Later in life he had, in vain, applied for a leading position in the Christian Democratic Party. Openly homosexual, he perhaps would have fitted better within the Social Democratic Party, but although his career – as a consultant and interim manager – had been fostered by people prominent in that party, he would delight in pestering the Social Democrats in particular – which fitted well with the traditional position of the weekly *Elsevier* (a right-wing nonreligious periodical), for which he worked as a columnist.

substantive; there was a clash of personalities. None of them had any parliamentary experience, which turned out to be a major handicap when the party was asked to participate in the new coalition (Christian Democrats, the Liberal Party [SJY], and the Pim Fortuyn Party). Their May 2002 electoral result would never be equaled again, and the Pim Fortuyn Party formally ended its existence in 2007. In 2003, a traditional center-right cabinet took office, and in 2006, a center-left coalition succeeded it, suggesting that the normal routine in Dutch politics had been restored. However, Dutch politics did not really get back to business as usual.

The populist threat presented by the Pim Fortuyn Party was overtaken, first by the former immigration minister, Rita Verdonk, and then by Geert Wilders, a dissenting member of Parliament who left the Liberal Party in 2004 to start his own Partij voor de Vrijheid (Party for Freedom). This new populist party won 9 seats in Parliament in 2006 and 24 in 2010. The present coalition is a center-right minority Cabinet supported in Parliament by the Party for Freedom.

Compared to members of previous Parliaments, members at present feel much more insecure than their predecessors. When asked what they would do in case differences of opinion come to the fore between themselves and their voters, a high percentage of parliamentarians have indicated that they would follow their voters, rather than their own preferences. Before the Fortuyn upheaval, this percentage was much lower.[15]

The events of September 11, 2001, followed by the rise of populism, contributed to politicians' feeling of insecurity with respect to the Muslim minority in the Netherlands. There are about 850,000 Muslims in the Netherlands at present, out of a total population of 16 million.

The religion of Islam was imported into the Netherlands in the 1960s and 1970s by Turkish and Moroccan "guest workers," and subsequently by the spouses and family members who joined them. A large percentage of the first generation of Turkish and Moroccan immigrants speaks Dutch only poorly. This lack of fluency often persists in later generations. Many of the original immigrants' descendants prefer to marry in their parents' (or grandparents') native country and bring their spouses – few of whom have any Dutch and many of whom are not literate in their own language – to the Netherlands. The result is that their children do not learn Dutch at home, which creates difficulties when they enter the Dutch educational system.[16]

Many of these families live in highly segregated neighborhoods where they associate infrequently with native Dutch-speaking people; for many ethnic minority children, their teacher will be the first Dutch-speaking person they meet on a regular basis, and they do not meet a teacher until they are four years old. School segregation is prevalent in the Netherlands, and immigrant children often spend their school years in classrooms dominated by other nonnative speakers who are not fluent in Dutch, potentially leaving them at a permanent disadvantage with respect to the language. This may be one reason that ethnic minority citizens are more often unemployed than other members of Dutch society, and partly why minority children drop out of school more often than other students or become juvenile delinquents at a higher rate (a problem especially among Moroccan youth).

Other factors also play a role in politicians' insecurity, including the highly divergent views of the immigrant Muslim and Dutch-majority communities on moral issues, such as homosexuality and the status of women.[c] So does criticism by activist former Muslims – for example, Ayaan Hirsi Ali, who now resides in the United States – that (immigrant) Muslim children are being raised to be anti-Western and anti-Dutch. Anxiety only increased after the November 2004 murder of writer, master provocateur, and movie director Theo van Gogh by a Muslim fundamentalist. Van Gogh had made a short film based on a scenario by Hirsi Ali about the subjection of Muslim women.

Dutch politicians are permanently insecure about the right policy toward the country's Muslim citizens. Will kindness and understanding help minority citizens come to feel welcome and "at home" in their new country? Or is such a policy a misguided relic of the 1970s? Is it acceptable to be kind out of fear of terrorist attacks or riots like the ones that took place in the Parisian suburbs? (In October 2005 two North African juvenile delinquents were electrocuted when they tried to hide from the French police in an electricity plant. Thereupon riots broke out in the Parisian *banlieus*. Cars were set on fire and police officers were molested. French President Nicolas Sarkozy announced that he would clear the streets from scum). Or is it cowardice, which will only breed more resentment and contempt among the Muslim minority? Choosing a complicated compromise in the old Dutch way may lead to fierce criticism from the populist Party for Freedom.

What effect might this social and political turmoil have on the current euthanasia regime? Will the euthanasia regime become more conservative or more liberal in response to the Muslim minority or the uncertain Dutch policy toward that minority? To us, this does not seem likely. To be sure, the Muslim community is much more conservative on many morally charged issues than is the secular Dutch majority[17][d] and might be expected to support (political) action geared toward changing the Dutch "moral regime" and law. But

[c] More orthodox groups, especially among the (native) Christian population, are averse to the public manifestation and public recognition of homosexuality, too. Their aversion to homosexuality and homosexuals is a political issue as well, in that it has an effect, among other things, on hiring policies (orthodox Christians often do not want to hire employees with a homosexual lifestyle). But they do not vilify homosexuals in the public sphere, they do not shout abuse at them, and they do not behave violently toward homosexuals. And although the attribution of sex-specific roles to men and women by these orthodox Christian groups may lead others to denigrate their position as discriminatory toward women, their young males treat their own and other women with respect in the public sphere.

[d] Research among young people in Rotterdam has shown that Moroccan and Turkish youngsters are much more conservative with regard to abortion and euthanasia than native Dutch people. Among native Dutch respondents, about 75% thought that people should be able to get an abortion or euthanasia if they wanted to. Among Turkish youngsters, about one in three shared this opinion, among Moroccans less than one in five. The poll was taken in 1999. The results were published in 17. Phalet, van Lotringen, and Lotringen 2000.

euthanasia does not seem a viable starting point for promoting broad change in a conservative direction for either aspiring Muslim politicians (of whom there are now many at various levels of government) or for majority politicians who want to meet them halfway. A strategy with more promise would include efforts to seek special accommodation of Muslim religious beliefs in health-care institutions – perhaps, for example, *halal* hospitals that respect dietary rules, prohibit care by members of the opposite sex, and are also "euthanasia free." While such action wouldn't be popular among the Dutch majority, there is precedent in the country's tradition of consensus democracy[18] or, alternatively, in contemporary calls for "patient-centered" and "demand-oriented" health care.

It is imaginable too, however, that if the issue of euthanasia were to be taken up as a vehicle for changing the moral, and legal, climate of the Netherlands, the majority of secular Dutch might feel compelled to make a point of the native majority's positive, liberal, progressive stance toward euthanasia and strive for an even more liberal regime. But we do not think this is is a promising result either. There is a profound public debate going on about Dutch identity, provoked by the very question of what "we" should make immigrants and their descendents understand about the country in which they live. We make a point of enlightening immigrants about what are supposedly Dutch *traditions*:[19,20] male and female equality; tolerance toward homosexuals (albeit not a very ancient tradition); tolerance of recreational drugs, free euthanasia, and mercy killing by physicians. It does not make sense to argue that immigrants should embrace these traditions, or at least respect them, when one is planning to change them soon.

Dutch (political) culture is presented to "recent arrivals" as if it is more (or less) fixed; it is simplified, standardized, perhaps even canonized. It is not presented as something in flux. Today's positions on moral topics, whether euthanasia, homosexuality, or the substantive (as opposed to merely juridical) equality of men and women, are taken to be and are presented to others as "essentials" of Dutch culture and hallmarks of "Dutchness."

In our view, then, although major changes have indeed taken place in the Dutch culture of consensus, no changes are to be expected in the practice or legal framework of euthanasia – not because this cultural aspect appears to be unimportant after all but because of the specifics, the politics of this breakup of the culture of consensus: There is no majority to be found, no coalition of forces foreseeable, strong enough to tilt the regime in either a more conservative or a more liberal direction. Equally important, this has occurred, perhaps not accidentally, when the Dutch identity itself has become a focus of discussion and debate in which the present regime of euthanasia is being made to serve almost as an icon of Dutch culture and society.[21]

We now turn to the second aspect of the Dutch euthanasia regime: the Dutch GPs. What – if any – have been the consequences of changes in the role of GPs and their relationship with patients?

FAMILY PRACTICE IN MODERN TIMES

The classical image of the Dutch GP dates from the 1960s and 1970s: the dedicated male professional who takes an interest in his patients as human beings rather than as mere patients, who discusses and addresses their problems and needs, even if their complaints are, at heart, nonmedical – (e.g., because what they actually need is a steady job, a loving wife, or some appreciation from their boss); who makes house calls in order to treat and observe his patients in their natural habitat; and who works around the clock because he wants to be available for his patients whenever they need him. This is – was – the GP's rather rosy image. An image, of course, is different from an actual fact, but many GPs at least tried to live up to this ideal.[22,23]

This "modern classical" GP has become an endangered species. In the 1970s and 1980s, the practice began to change, although the GP's (self-)image was changing gradually even before that. In her 2008 review of all issues of the GPs' scientific journal in the Netherlands to trace changes in their professional ethics, Jolanda Dwarswaard observed that the image of total dedication had suffered its first blows as early as 1960, when a GP wrote:

> The group practice system allows every doctor a free afternoon in which he can practice a personal hobby.

In 1963, another GP expressed his opinion that

> [the family physician] will be less and less prepared to sacrifice his family life to his practice. For him too, the psychological well-being of his family has become more important. Hence he will strive to organize his practice in such a way as to give family life its due. One expression of this is the growing desire to have a vacation.

Another GP confessed in 1968:

> We are not that happy anymore with the role of the counselor available at all hours, even though some patients still expect us to fulfill that role.

About house calls, the GP journal wrote as early as 1968:

> One should investigate whether we could not save an enormous amount of time by reducing the number of house calls. No doubt this will entail lesser service, but this is what we see happening in all sorts of service activities, because of their labor-intensive character. We cannot ignore these economic considerations with regard to health care.

Moreover (again in 1968):

> We feel that the number of house calls should be strongly reduced in order to get a nicer life with rational working hours.[24]

[22] On the classical GP during the fifties, see F. J. A. Huygen, *Family Medicine: The Medical History of Families* (reprinted version of a book originally published in 1978), typically dedicated to "the families I had the privilege to serve so long as their personal doctor and whom I came to love" (22. Huygen 2006).

During the seventies and eighties, house calls were in fact reduced. In that same period, so-called group practices were introduced in which three, four, or more GPs together started to take care of a common clientele.[f][25] The group practice has become ever more popular in recent times. In 1993, 52% of the general practitioners worked in a solo practice and 17% in a group practice. Ten years later, in 2003, 39% of family doctors operated solo and 29% in a group practice. Of all GPs who graduated in 2002, 45% started work in a group practice and only 20% in a solo practice. The remaining 36% of GPs went to work in a two-physician practice.[26]

Ever more medical students (more than half) are female, and women in the Netherlands usually work only part time. Female medical doctors are no exception to this rule. In November 2002, 64% of all GPs in training were women.[26] Female doctors have an even stronger preference for group practices than do their male colleagues. In these group practices, doctors share their patients, and patients have to share their (increasingly frequently female) doctor's attention with the doctor's spouse, children, and children's after-school program, such as soccer and scouting activities.

Obviously, there is no need to assume that female doctors are not up to the professional task or that they tend to lack professional skills. One can be very good at what one does only three days a week. However, the continuous care and the intimate knowledge of the patient as a person, which has underpinned the euthanasia regime in the Netherlands, may suffer as a result of group practices and the more frequent occurrence of part-time GPs.

It was the more enduring, intimate relationship between patient and family doctor – the doctor's willingness to provide help and care to his or her (dying) patient on what at life's (approaching) end might be an almost daily basis for weeks at a stretch – that gave the GP, as the personal doctor, a very good reason to be granted a say in the joint decision of possible mercy killing, of euthanasia. Less frequent and more intermittent contact between doctor and patient may come to undermine the acceptance of euthanasia, which in fact was only recently established.

To put it differently, could this development of "collective care" by a group of part-time GPs for a "panel" of patients change the actual practice of euthanasia? Is it perhaps already changing this practice? It is possible that physicians who do not know their patients as well as the family doctors "of old" did will be more hesitant to perform euthanasia. Frances Norwood and other researchers, such as Robert Pool, Bert Keizer and Anne-Mei The, remind us that a euthanasia request must be made repeatedly and in a specific manner before it is acted upon.[27,28,29,30] The doctor has to be convinced that euthanasia is what the patient really wants. If the patient does not get as many chances to convince a GP as before, or if the patient has to convince two or three part-time GPs,

[f] The first GP group practice was registered in 1969.

he or she may not succeed in making a request that is up to this standard. If this logic prevails, patients, who under previously established standards would have been aided by their (personal) physician to shorten the span of their last days, would now be trying in vain to get "their" physician's ear.

Alternatively, one might hypothesize the following consequence: Taking a terminally ill patient's claim to a medically aided "soft death" to be essentially the patient's right, part-time GPs might be less meticulous about the standards for request and more inclined to go along with their patient's wish to die, without the proper reticence and without taking adequate precautions. They might be (dutifully) inclined to alleviate the patient's suffering by mercy killing without properly knowing him or her, because they have not been in a position to truly understand what the patient really wishes.

We may – indeed, we must – theorize about the possible consequences of major changes in the general practice of medicine and how GPs actually work. But theorizing cannot replace research into the effects of these changes on the actual practice of euthanasia. What does the research show so far?

At this point, the evidence we have does not yet point in the direction of any of these potential changes. So far the research shows that when patients get seriously or terminally ill, individual GPs often return to a practice that more closely resembles the personal, intimate doctor–patient relationship of old.[31] GPs find the provision of care for terminally ill patients a very important, rewarding part of their job.[32] They want to make house calls to their dying patients, and they feel a responsibility to be available outside office hours for these patients (an opinion that is shared by patients).[33] Seventy-five percent of GPs make themselves personally available to terminally ill patients at all times.[34] So when the situation arises that the patient might be willing to express his or her wishes as to a medically aided death, the GP in this respect can and does function again as the family doctor.

Researchers also point out that this may not last, however. Thus, for example, Sander Borgsteede and others studied the ideas of patients and GPs about what counts as "good care" with regard to terminally ill patients. Four values were identified: 1) the GP's availability for house calls and after-hours care, 2) medical competence and cooperation with other professionals, 3) personal attention to the individual patient, and 4) continuity of care.[35] The researchers observe that these values will be challenged by the ever-growing percentage of part-time doctors and the fact that after-hours care is increasingly transferred to large GP collectives that may or may not be able to call the dying patient's own GP, depending on how effectively the after-hours service is set up to coordinate care.

To conclude, it is feasible that the changing GP practice system will prompt change in the euthanasia regime, either in a more strict direction, because part-time doctors who do not know their patients as well as traditional family doctors do not dare to end their patients' lives, or in a more "consumerist" direction whereby doctors would go along with their patients' requests without further

ado. However, to date, researchers have not found any evidence of change in either direction. In the next section we continue to explore the move toward consumerism because this tendency is fostered by government policy, as well as well as popular culture.

INCONSISTENT CIVICS

The third element of the social fabric underpinning the euthanasia regime in the Netherlands has been patients' willingness to submit to medical rationales for decision making and for doctors' authority. What has changed in this respect in the recent past and what might change in the years to come? For a better understanding of how attitudes toward doctors and the medical profession may have changed recently or are likely to in the future, we focus first on reforms in the formal, institutional set-up of health care, especially the financing of care.

In 2006, the government changed the health insurance system. Before 2006, the Dutch health-care system was extremely complicated. It consisted of three tiers. Long-term institutional care (in a psychiatric hospital, a geriatric ward, or an institute for the mentally disabled) was financed by means of a social insurance system, which covered the whole population. Less expensive home care for chronically ill, elderly, or handicapped patients also belonged to this first tier.

Acute care, including "ordinary" hospital care, visits to general practitioners, and midwives, as well as several other provisions broadly classified as curative, were financed differently for different segments of the population. In this second tier of the Dutch health-care system, roughly two-thirds of the population was legally obliged to pay income-dependent premiums into the state sickness fund. These patients never saw a medical bill because their sickness fund paid hospitals and other care providers directly. The remaining one-third of the population (the majority of whom were citizens with a high income) could choose a private health insurer.

There were some elements of solidarity built into this private insurance part of the second tier as well. Private insurers had to offer a so-called standard package to less healthy, higher-risk clients whom they might have preferred to refuse. Although these high-risk clients had to pay high premiums for the standard package, those premiums did not cover their health-care costs entirely. The healthier, privately insured clients had to pay a "solidarity bonus" on top of their premiums to make up for the losses that private insurers suffered as a result of being obliged to take in chronically ill or otherwise extremely expensive clients.

The third tier in Dutch health care was quite small and covered mostly elective medical services (such as cosmetic surgery) that people could do without or might choose to pay for out of pocket.

This health insurance system had always been considered a messy compromise that no political party really liked or considered its own. Most left-wing political parties would have liked to do away with the private insurance part of the system. They would have preferred a tax-funded national health insurance scheme for all citizens. On the other side of the political spectrum, the right wing never liked the income-dependent insurance premiums of the sickness fund(s). The Christian Democrats in the middle of the political spectrum sided with the Left on the issue of general health insurance but were much more concerned about cost containment and thus were favorably inclined to out-of-pocket payments, copayments, and other private ways to cofinance the general scheme. Thus, there was general discontent with the old system among politicians, some parties unhappy with the social components of the system and others objecting to the free market components. During the 1980s and 1990s and into the first years of the twenty-first century, Dutch politicians discussed the health-care system numerous times. Several minor changes were introduced, but for a long time, a real overhaul of the system seemed impossible – until 2006, that is, when a new system was finally introduced by the then-ruling center-right coalition.

Under the new regime, health-care insurance is offered by private insurers. However, insurers cannot offer whatever provision they want, to anyone who is willing to pay the premium. In the new system, they are compelled by law to offer the so-called standard health-care package (roughly comparable to the old sickness fund package) to their clientele and to charge the same price to everybody. Health insurers are not allowed to show preferences or attract younger, healthier clients by offering them cheap insurance. If they want to offer cheap insurance, they have to give it to old and young, sick and healthy alike. Insurers may try to achieve lower prices than their competitors by striking bargains with hospitals and other care providers. Clients are entitled to change insurers once a year, and so insurers have to compete for their favors constantly. Low-income clients get a tax rebate or tax bonus that enables them to pay for their health insurance premiums.

Although this present system mixes social insurance with a market orientation, it was introduced by a liberal minister in a center-right coalition government, who emphasized the importance of the elements of both regulated competition and market incentives in the new scheme. Patients were addressed as "consumers of care," who had to "shop around to find the best insurance package for themselves," "tailor made to their individual situation." Clients were invited not to restrict themselves to finding merely a good insurer; they were advised, almost admonished, to look for the very best hospital and the ultimate GP. A fancy government Web site (http://www.kiesbeter.nl) features patients shopping around in the health-care system. The Web site offers a short video about a recently widowed woman who did not take the trouble to look for a good GP; she just happened to pick one near her home from the yellow

pages. The man turned out to be an inadequate doctor who did not diagnose her husband's skin cancer in time, and here she was now: a poor widow. Other patients are pictured as much more sensible. The video shows them interviewing one GP after another before finally choosing the one that fits their personal preferences. The government's rhetoric stresses individual choice and preferences and assertive consumer behavior, rather than the collective package, the tax refund, and the built-in elements of solidarity among individuals of all ages and health status.

This newly advocated consumerism sits uneasily with the traditional reticence toward ethically sensitive treatments. Remember: Dutch women could not get an epidural on request, nor could Dutch citizens simply ask for a genetic test or an MRI scan without medical approval. A similar regime held and still holds for euthanasia: Patients cannot obtain euthanasia unless their doctor and an independent colleague classify their suffering as unbearable. In practice, this means that many patients will not receive a euthanasia death if their suffering is mostly psychological or psychiatric or if they are tired of life because they have grown too old and lonely, because doctors do not classify these conditions as medical conditions or as unbearable.

One can see a potential tension here. If citizens are explicitly encouraged to be assertive consumers in health care, they may no longer be willing to practice restraint and accept the boundaries drawn by medical professionals. If in the future the patient as client is paramount, one can indeed imagine that patients will be inclined to behave less deferentially toward medical professionals. Is such a change of attitude, and a concomitant change in patients' behavior, likely to occur?

Successive governments have shown an ambivalent attitude toward (the importance and desirability of) individual choice in the health-care system. This ambivalence dates from even before 1987, when the government-commissioned Dekker Report laid out the contours of a new health-care system, a system that was basically very much like the one actually introduced in 2006. The Dekker Report introduced the concept of the health-care consumer who would bid on the market for health and happiness.[35] In 1991, however, another government-sponsored report advocated a "community-oriented" vision of health care, inspired by the works of the American communitarian philosopher Daniel Callahan. In the Dunning Report, people's health-care needs were to be determined by asking whether their illnesses prevented them from participating in the community, and if so, what treatment or provision would help restore their capacity to participate. Those treatments or provisions should then be financed collectively. Needs that did not undermine one's capacity to participate were classified as less important, as were treatments or provisions that would not restore one's capacities to participate in society. The Dunning committee recommended a government education program to teach citizens that they must not behave like spoiled consumers trying to get everything they want in the health-care mall. Citizens would have to be taught that "trees do not grow into heaven," as the Dutch saying goes – that is, that all good things (must) come to an end. They would have to learn to be frugal with health care.

Ever since the beginning of the 1990s, these two streams of government education have existed alongside each other, without much challenge and even without causing much wonder. On the one hand, the market rhetoric emphasizes individual choice and tailor-made care, and stresses the benefits of a demand-driven health-care system and consumer sovereignty. On the other hand, the community rhetoric stresses budget restraints, solidarity, equality before the doctor, equal treatment, and boundaries. "You can't always get what you want" indeed captures the essence of the community rhetoric. The acceptance of medical authority and the honoring of medical indications as limits to care clearly belong to the community rhetoric.[36]

Public opinion polls have consistently shown strong popular support for the community approach.[8,37] The Dutch have found it very desirable that doctors treat people according to medical need and not according to income or social class. They did not like the system of copayment. They did not favor the idea of changing the system in order to allow individuals to buy preferential treatment. They did not favor the liberalization and "marketization" of the public sector.[8,38] Whereas the community approach echoed shared understandings that exist in the Netherlands, the market rhetoric actually has been a form of government education, even of government propaganda, foisted on an unwilling populace.

At long last, however, the market propaganda (or "civic education," depending on one's political preferences) seems to be having an effect. Half of the respondents in a large-scale poll in 2007 indicated that they would find it acceptable if people could buy more luxurious forms of care in hospitals.[f] Almost half of the male respondents found it acceptable for people to be able to buy higher-quality care, a marked increase in percentage from a few years earlier; in female respondents no change was reported.[39] Another survey indicated that 50% of respondents agree with the idea that people should be allowed to buy extra care, for example, in order to get private facilities rather than a bed in a hospital ward. Yet the same recent poll still shows continuing support for the community value system: 92% of respondents find it unacceptable to allow people to buy a higher place on a waiting list, and 85% of all respondents agreed that social solidarity is "important" or "very important."[f]

[f] The opinion poll figures can be found at http://www.scp.nl.

[8] This goes for citizens in other Western countries as well. C. Pollitt and G. Bouckaert studied New Public Management measures in several European countries, Australia, and New Zealand. They concluded: "Certainly, there is no firm ground for the assertion that the public would like the welfare state to be 'rolled back' and replaced by private modes of provision" (see 38. Pollitt and Bouckaert 2004).

[f] The results of the poll were published in *NRC Handelsblad*, October 5, 2007, http://www.2minuten.nl.

[f] The results of the poll were published in *NRC Handelsblad*, October 5, 2007, http://www.2minuten.nl.

Perhaps the actual introduction of a new system (rather than endless debates about it, as in the 1990s) has changed people's attitudes after all. Citizens have constantly been addressed as *consumers* in health care by government education/government propaganda, and they are now actually being treated as consumers of health care in the "marketized" system. The growing emphasis in government policy on consumer sovereignty, individual choice, and tailor-made care could affect the traditional willingness to submit to medical authority. The Dutch association for midwives and gynecologists is currently considering a new guideline that would allow women to indicate their preference for an epidural without a clear medical indication. Hospitals in the Netherlands now give young, single, and/or career-oriented women the opportunity to freeze their eggs for later fertilization, a procedure that was riddled with ethical objections just a few years ago. In tune with the general development toward consumerism, the Dutch Association for Voluntary Euthanasia (NVVE) produced a new strategic statement in 2008, in which it is argued that patients should have a menu of choices regarding their death.[40] According to the NVVE, it should be possible to ask for physician-administered euthanasia as one option. One should also be able to choose palliative sedation, assisted suicide, or a do-it-yourself death by starvation, with a little help and information from your doctor.

In February 2010, a group of prominent citizens (former politicians, media personalities, and retired professors, among others) started a so-called citizens' initiative. They found that elderly people who are tired of life (though not terminally ill) should be able to end their lives without having to resort to gruesome means like hanging or jumping in front of a train. Their petition to Parliament was supported by more than 100,000 people. Parliament has to take a citizen's initiative into consideration although it is not obliged to go along with it.[41] In August 2010, the NVVE announced that it would like to investigate the feasibility of an end-of-life clinic, for people who are not eligible for physician-assisted euthanasia or suicide.[42]

CONCLUSION

We set out to study recent changes pertaining to three strands in the fabric of Dutch (political) culture that have (had) direct relevance for explaining how the legal framework and actual practice of euthanasia came about and have been maintained. To reiterate, these strands are the culture of consensus, the close relationship of Dutch GPs with their patients, and most people's willing submission to the medical elite. How much has changed in the social fabric, and what are the actual or likely effects of change on the euthanasia regime in the Netherlands? Let us try to summarize the competing pressures with which this regime is being confronted.

The corporatist, pragmatic, consensual political culture has changed to a considerable extent, mainly due to the settlement of a Muslim minority in the Netherlands and the wave of populist politics in reaction to it. However, we have concluded that it is unlikely that these changes will lead to a change in the euthanasia regime. Although the legal framework of euthanasia evolved in a specific party-political setting, we have argued that law and actual practice nevertheless can be expected to endure in even quite different circumstances.

The emerging system of group practice and part-time GPs is gradually changing the doctor–patient relationship. It is plausible for one to think that part-time GPs have less contact with their patients and are more reluctant to grant their wishes with respect to euthanasia. Research indicates that, so far, this has not been the case.

Lastly, we pointed out that the change in the health insurance system toward a more market-oriented system may diminish people's willingness to submit to medical authority and professional decision making. If the government rhetoric continues to emphasize the importance of individual choice, demand-driven and tailor-made care, and consumer sovereignty while neglecting the competing discourse of solidarity, community, and frugality, citizens may decide to take up the consumer role laid out for them and demand tailor-made, end-of-life care according to their own preferences and principles. This could provoke a change of the current regime in a more liberal direction.

References

1. Cohen-Almagor, Raphael. 2001. Culture of death in the Netherlands: Dutch perspectives. *Issues in Law & Medicine* 17: 167.
2. Norwood, Frances. 2006. A hero and a criminal: Dutch huisartsen and the making of good death through euthanasia talk in the Netherlands. *Medische Antropologie* 18: 329–346.
3. Hendin, Herbert. 2002. The Dutch Experience. *Issues in Law & Medicine* 17: 3.
4. Andeweg, Rudy B., and Galen A. Irwin. 1993. *Dutch Government and Politics*. Houndmills: Macmillan.
5. Andeweg, Rudy B. 2000. From Dutch disease to Dutch model? Consensus government in practice. *Parliamentary Affairs* 53: 697–709.
6. Weyers, Heleen. 2004. *Euthanasie. Het proces van rechtsverandering*. Amsterdam: Amsterdam University Press.
7. Onwuteaka-Philipsen, Bregje D., Agnes van der Heide, Dirk Koper, Ingeborg Keij-Deerenberg, Judith A.C. Rietjens, Mette Rurup, Astrid M. Vrakking, Jean Jacques Georges, Martien T. Muller, Gerrit van der Wal, and Paul van der Maas. 2003. Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001. *The Lancet* 362: 396–399.
8. Borgsteede, Sander D., Luc Deliens, Corrie Graafland-Riedstra, Anneke L. Francke, Gerrit van der Wal, and Dick L. Willems. 2007. Communication about euthanasia in general practice: Opinions and experiences of patients and their general practitioners. *Patient Education and Counseling* 66: 156–161.
9. Heide, Agnes van der, Bregje D. Onwuteaka-Philipsen, Mette Rurup, Hilde M. Buiting, Johannes J. M. van Delden, Johanna E. Hanssen-de Wolf, Anke G. J. M. Janssen, J. Rocline W. Pasman, Judith A. C. Rietjens, Cornelis J. M. Prins, Ingeborg

M. Deerenborg, Joseph K. M. Gevers, Paul J. van der Maas, and Gerrit van der Wal. 2007. End-of-life practices in the Netherlands under the Euthanasia Act. *New England Journal of Medicine* 356: 1957–1965.
10. Trappenburg, Margo. 2001. Paarse ethiek, In *Zeven jaar paars*, ed. F. Becker et al., 53–74. Amsterdam: De Arbeiderspers.
11. Oversloot, Hans. 2002. Van politiek naar economie, van staat naar markt en management. In *Democratie in verval?* ed. J. van Holsteyn and C.Mudde, 123–137. Amsterdam: Boom.
12. Andeweg, Rudy. 2001. Lijphart versus Lijphart: The cons of consensus democracy in homogeneous societies. *Acta Politica* 36: 117–128.
13. Katz, Richard, and Peter Mair. 1995. Changing models of party organization and party democracy: The emergence of the kartel party. *Party Politics* 1: 5–28.
14. Hakhverdian, Armen, and Christel Koop. 2007. Consensus democracy and support for populist parties in Western Europe. *Acta Politica* 42: 401–420.
15. Andeweg, Rudy, and Jacques Thomassen. 2007. *Binnenhof van binnenuit. Tweede Kamerleden over het functioneren van de Nederlandse democratie*, p. 16. http://www.rob.rfv.nl.
16. Dagevos, Jaco, and Merove Gijsberts. 2007. *Jaarrapport integratie 2007*. Den Haag: SCP. http://www.scp.nl.
17. Phalet, K., C. van Lotringen, and H. Entzinger. 2000. *Islam in de multiculturele samenleving. Opvattingen van jongeren in Rotterdam*. http://www.manavzw.be/_files/Islam%20in%20de%20multiculturele%20samenleving_%20Opvattingen%20van%20jongeren%20-%202000.pdf (accessed October 30, 2011).
18. Lijphart, Arend. 1968. *The Politics of Accommodation: Pluralism and Democracy in the Netherlands*. Berkeley: University of California Press.
19. Scheffer, Paul. 2000. Het multiculturele drama. *NRC Handelsblad*, January 29.
20. Scheffer, Paul. 2007. *Het land van aankomst*. Amsterdam: De Bezige Bij.
21. Mak, Geert. 2004. *In Europa: Reizen door de Twintigste Eeuw* Amsterdam: Atlas.
22. Huygen, F. J. A. 2006. *Family Medicine: The Medical History of Families*. Assen: Royal Van Gorcum.
23. Mol, A., and P. van Lieshout. 1989. *Ziek is het woord niet. Medicalisering, normalisering en de veranderende taal van huisartsgeneeskunde en geestelijke gezondheidszorg 1945–1985*. Nijmegen: Sun.
24. Dwarswaard, J. 2011. *De dokter en de tijdgeest. Een halve eeuw veranderingen in de beroepsethiek van huisartsen en chirurgen*. Amsterdam: Boom/Lemma.
25. Ree, J. W. van. 2005. *Eenmaal huisarts*. Farewell lecture, Maastricht University. http://www.google.nl/search?hl=en&source=hp&q=van+ree+eenmaal+huisarts&aq=f&aqi=&aql=&oq=&gs_rfai= (accessed August 23, 2010).
26. Kenens, R. J., and L. Hingstman. 2003. *Cijfers uit de registratie van huisartsen, Peiling*. Utrecht: NIVEL.
27. Pool, Robert. 1996. *Vragen om te sterven. Euthanasie in een Nederlands ziekenhuis*. Rotterdam: WYT.
28. Keizer, Bert. 1995. *Het refrein is Hein: dagen uit een verpleeghuis*. Nijmegen: Sun.
29. The, Anne-Mei. 1997. *Vanavond om 8 uur … Verpleegkundige dilemma's bij euthanasie en andere beslissingen rond het levenseinde*. Houten: Bohn Stafleu Van Loghum.

30. Tol, D. G. van, S. van de Vathorst, and Bert Keizer. 2008. Euthanasie voor beginners. *Medisch Contact* 4, January 25.
31. Schers, Henk, Hans Bor, Wil van den Bosch, and Richard Gol. 2006. GPs' attitudes to personal continuity: Findings from everyday practice differ from postal surveys. *British Journal for General Practice* 156: 536–538.
32. Groot, Marieke, Myrra Vernooij-Dassen, Ben J. P. Crul, and Richard Grol. 2005. General practitioners (GPs) and palliative care: Perceived tasks and barriers in daily practice. *Palliative Medicine* 19: 111–118.
33. Borgsteede, Sander, et al. 2008. Goede zorg in de laatste levensfase volgens patiënten en hun huisarts. *Huisarts en Wetenschap* 51: 120–124.
34. Giesen, P. H. J, E. Terpstra, and B. P. M. Schweitzer. 2008. Terminale zorg buiten kantoortijd. *Medisch Contact* 63, 6: 240–243.
35. Achterhuis, Hans. [1979] 1983. *De markt van welzijn en geluk: een kritiek van de andragogie*. Ambo: Baarn.
36. Trappenburg, Margo. 2008. *Genoeg is genoeg. Over gezondheidszorg en democratie*. Amsterdam: Amsterdam University Press.
37. Trappenburg, Margo. 2005. *Gezondheidszorg en democratie*, rede EUR. Inaugural lecture, Erasmus Medical Center, Rotterdam.
38. Pollitt, C., and G. Bouckaert. 2004. *Public Management Reform: A Comparative Analysis*. Oxford: Oxford University Press.
39. SCP/Netherlands Institute for Social Research. 2007. *De sociale staat van Nederland 2007*, p. 179. http://www.scp.nl/dsresource?objectid=19574&type=org (accessed August 23, 2010).
40. NVVE (Nederlandse Vereniging voor Vrijwillige Euthanasie). 2008. *Perspectieven op waardig sterven*. http://www.nvve.nl/assets/nvve/nieuws/Perspectievennota.pdf (accessed August 23, 2010).
41. Uit vrije wil, burgerinitiatief Voltooid leven. 2010. http://www.uitvrijewil.nu/index.php?id=10 (accessed August 23 and 27, 2010).
42. NVVE (Nederlandse Vereniging voor Vrijwillige Euthanasie). 2010. NVVE onderzoekt mogelijkheid levenseinde kliniek. http://www.nvve.nl/nvve2/pagina.asp?pagkey=143915&metkey=375 (accessed August 23, 2010).