Covid-19 and the Dutch context: Some ethical comments

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The Covid-19 pandemic has unknown political, economic, cultural, and ethical ramifications. Even with the hope for an effective vaccine soon being realized, countries will continue to experience the pandemic's impact for years to come. The most important ethical problems can be described in terms of finding a balance between opposite concerns: keeping the economy going versus protecting vulnerable people; individual freedom versus governmental regulations; protecting the elderly in nursing homes versus providing companionship; and privacy versus monitoring public health.

Many of these problems will be found in any country that is seriously affected by Covid-19. Without pretending to be exhaustive, this article looks at some ethical issues that are specific to the Netherlands. Although it seems to have weathered the pandemic reasonably well, there are at least four developments that are cause for concern in the Netherlands: (1) arguments for using age as a criterion in the event of insufficient availability of intensive care beds may undermine the sense of self-worth of the elderly; (2) such age-discrimination brought on by scarce Covid-19 care resources may be connected to initiatives to offer senior citizens assistance with suicide; (3) the temporary suspension of euthanasia in Covid-19 times may be indicative of the limited urgency of euthanasia; (4) financial support for Dutch businesses suffering from economic damage is in contrast with the position of the Netherlands regarding the European Union's attempts to be in solidarity with heavily stricken countries.

Key terms: euthanasia; MAiD; assisted dying; assisted suicide; Covid-19; coronavirus; pandemic; Netherlands; ethics; elderly people; age discrimination.

1. Introduction

In the spring of 2000, the Netherlands went into what nationally became known as an "intelligent lockdown," combining strict guidelines about hygiene and social distancing with a minimum of state-enforced rules. Although there was an appeal to behave responsibly and to stay at home, people did not need special permission to leave their homes or to travel. Public events and most air traffic were cancelled, train frequencies reduced, schools and public buildings closed. Thanks to a highly developed digital network – the Netherlands ranked number three worldwide in digitalization in 2018 (Kepinski 2018) – digital meetings and classrooms could be joined from almost any household in the country. The initial exponential increase of infections in March 2020 was followed by a decrease in the months to follow. After many of the public health measures were reversed in June, the country saw an increase in infection rates that culminated in a second wave in the fall of 2020, as can be seen in Figure 1. (Some of the high numbers in the fall of 2020 compared to those in the spring can be explained by the limited testing capacity in the early months, causing many Covid-19 cases to go unreported. See the ICU admissions in Figure 2.)

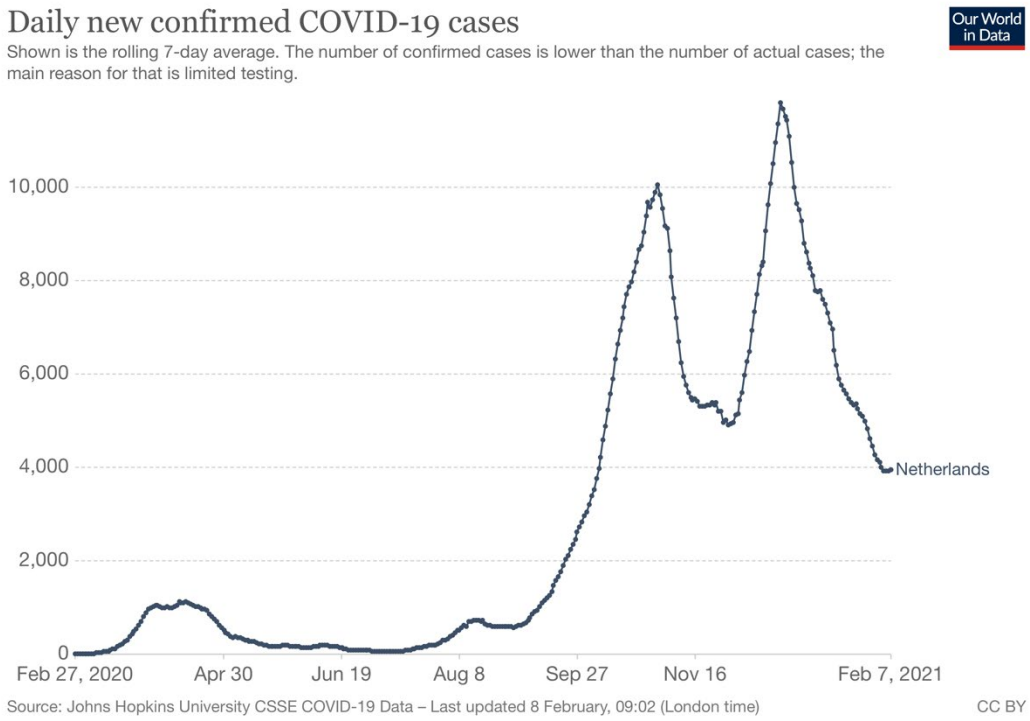

Figure 1. Number of new Covid-19 infections. ourworldindata.org.

2. Ethical aspects

Ethical dilemmas connected to the Covid-19 pandemic are likely to be found in other affected countries as well. They can be described in terms of finding a balance between:

- keeping the economy going and protecting vulnerable people;
- individual freedom and government regulations;
- protecting elderly people in nursing homes from becoming infected, and providing them companionship and care;
- privacy and monitoring public health.

During the pandemic's early months, the United States' federal government chose to emphasize the first part of the balance, reflecting a concern with individual rights: the economy, individual freedom, and privacy. Italy, Spain, France, and Belgium chose to highlight the second part of the balance, the more community-centred elements, whereas countries such as Sweden, and the Netherlands with its "intelligent lockdown," along with Germany, are somewhere in the middle. Making an ethical, cultural, and socioeconomic appraisal at the end of 2020 is premature; the vaccine remains a promise, we are still knee-deep in the pandemic, its long-term effects are unknown, nor is there empirical certainty about how all these factors are connected to ethics, anthropology, and politics.

This article has therefore an explorative character. I will limit myself to four ethical themes that have prompted discussion in the Netherlands: access of elderly patients to an intensive care unit (ICU), discussions about euthanasia for healthy persons aged seventy-five or older, suspension of the access to euthanasia, and international solidarity. Given how current the topic is, most of my sources are taken from media reports.

2.1. Access of elderly patients to the ICU

In March 2020, the number of hospitalized patients and patients admitted to intensive care units rose rapidly. The Netherlands has a relatively low number of IC beds *per capita*: whereas the average is 10 beds per 100,000 inhabitants in the European Union (EU) and 30 in Germany, the Netherlands has only 6 beds (1,500 beds for 17 million inhabitants). By the end of March, Dr. Gommers, chairman of the Dutch Association of Intensivists, predicted that the need could climb as high as 2,500 beds within a week, which was about 40% higher than the ICU's maximum capacity at the time (Nieuwsuur 2020a; NOS 2020a). Part of the reason for the exponential surge was not only the increase of Covid-19 patients, but also the fact that these patients were found to require a much longer stay. Efforts were made

to reach a level of 2,400 units, and neighbouring Germany admitted dozens of Dutch patients to their ICUs. The fear was that in the event of a continuing increase even all those measures would be nowhere nearly enough to accommodate need. Discussions began about the "black scenario" of having to turn patients away. In an op-ed in *De Volkskrant*, ethicists Marcel Verweij and Ronald Pierik defended the prioritization of younger patients (Verweij & Pierik 2020). Apart from a medical argument – younger and fitter patients have better chances of recovery than elderly people; prioritizing them is a more efficient use of scarce medical care resources – they invoked a "fair share" principle: "for [people in their twenties] dying is a much more serious loss than for people of fifty years and older: they have had fewer opportunities to live their lives."

The authors received much criticism on social media. Ethicists Fleur Jongepier and Karin Jongsma wrote a more thorough critique (Jongepier & Jongsma 2020). The prioritization of younger patients, they argued, can never be seen in terms of a *bona fide* moral argument. Triage is and remains a tragedy; prioritizing younger and fitter patients may at best be "the best of two indescribable moral evils." Verweij and Pierik's piece suggests that it is "acceptable" to sacrifice the elderly to save younger people. Seventy-five years after the end of World War II, triage was back on the national agenda.

In the months that followed, the worst-case scenario did not materialize. The increase of IC admissions levelled off and top-occupancy was reached on April 7, with 1,311 Covid-19 patients occupying most of the beds in the ICUs. Whereas this stabilization can no doubt be explained by the measures taken to contain the virus, two other factors may also have been relevant. First, following the discussions and fuelled by images from ICUs in Italy, there was increased public awareness of the miseries of an ICU stay and of the high mortality rate among elderly people and persons with comorbidity (Van de Wier 2020). In addition, there was an associated need for extensive, long term and expensive recovery. In a radio discussion, the 66-year-old retired intensivist Paul Lieverse indicated that he would decline admission to an ICU since he would likely come out "as a wreck" (NPO1 2020). Lieverse named another argument that came closer to Verweij and Pierik's article: "Do I want to take the place of a young person who has a much better chance of surviving and getting out of it?" Although he added that this was his personal preference, his line of reasoning and those of others may have led to people refraining from seeking admission to the ICU (Boer & Lieverse 2020).

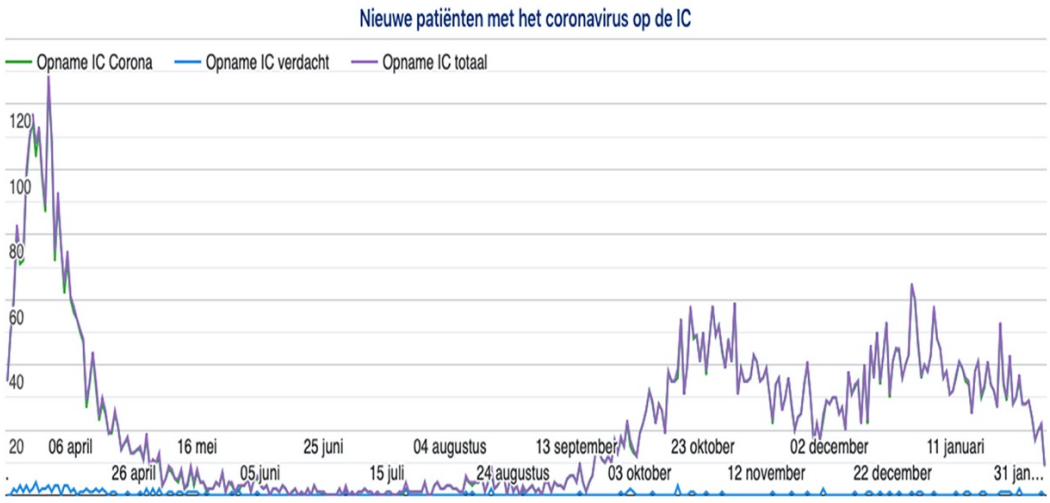

Figure 2. New patients infected with coronavirus in the ICU.
https://allecijfers.nl/nieuws/statistieken-over-het-corona-virus-en-covid19/

Although the number of ICU admissions continued to drop (see Figure 2), discussions about the plausibility of using age-related criteria continued, partly in anticipation of the expected second wave later in 2020. In a discussion broadcast on radio, journalist and influencer Jort Kelder was the first to be openly critical of attempts to save elderly people: "We are now rescuing people over eighty who are overweight and who are smokers. That sounds harsh, but statistically this is what is going on" (Mediacourant 2020). Two weeks later, columnist Marianne Zwagerman advocated a rationing of scarce health care resources based on age (Zwagerman 2020). Her argument was that Covid-19 is primarily an "old-age disease" and old people are, as a matter of course, supposed to die. Zwagerman used the term "dead wood" for elderly people and added, "Do you know what is worse? That people die as a juicy twig." She faced enormous criticism, while the hashtag #doodhout ('dead wood') trended for some time. Despite the public outcry, age continued to be debated as a decision criterion under conditions of extreme resource scarcity. In June 2020, the Royal Dutch Medical Association (KNMG) propagated it in a protocol for prioritization on ICUs in case of a second wave. The position is that in the event of resource scarcity, medical professionals and younger people should be prioritized (KNMG & Federatie Medisch Specialisten 2020). The Dutch minister of health Martin van Rijn responded that he could not support the passage about age prioritization (Van den Dool 2020), but on July 25, Dr. Gommers repeated his claim that age selection is what doctors will and should do: "In the ICU, we would really rather choose a 16- than a 70-year-old" (Nieuwsuur 2020b).

Notwithstanding new insights regarding how to effectively treat Covid-19 patients, the second wave in the fall of 2020 once again led to large numbers of hospital admissions and ICU admissions. Anything is possible: in the end, perhaps the dreaded black scenario will become a reality. I therefore choose to insert a normative-ethical remark here. As Jongepier and Jongsma argue, triage is never unproblematic, and one can only sympathize with doctors who insist that physicians in an ICU face dire circumstances and that ethicists and politicians should allow them some leeway to make their own decisions. Nevertheless, I would argue that age is unfit as a decision criterion, since it involves an element of "desert": people other than the patients make a normative assessment about who "deserves" a chance to live more than others. When it comes to less consequential choices, desert may have to play a role, but when it comes to life and death, the risk (or for that matter the appearance) of "playing God" is too close for comfort.

There are other criteria that can guide us; there, age plays a more modest role: the criterion of medical success will favour younger patients, since they will normally have the best chances of recovery. But this should suffice: a "fair share" criterion brings unwarranted value judgments into the discussion. Furthermore, such evaluative judgments are questionable for practical purposes: who is to decide that Mr. Smith at age 74 has had a fairer share of life than Mr. Jones at 37 years of age? What if Mr. Smith, after a life of bad luck, unemployment and grief, has recently found the love of his life? What if young Mr. Jones has always been the fortunate one, travelling around the world, lucky with women, but never counting his blessings?

In order to avoid any appearance of partiality, the medical chances of success should be at the centre. In the unlikely event of a choice between patients with identical medical prospects, rolling the dice will probably be the morally most modest alternative.

2.2. Discussions about euthanasia for any elderly person

Demeaning remarks heard in the Netherlands about elderly people stand in sharp contrast to practices found in Mediterranean countries, in which the oldest generations often form the heart of a family. Images from hospitals in Northern Italy contributed to the impression that in some countries anything will be done to rescue a Covid-19 patient, irrespective of age. It is noteworthy that in Italy a patient's right to refuse treatment was legalized as late as 2017 (Povoledo 2017). By contrast, a similar right has existed in the Netherlands for decades and can be overruled only if the patient is incompetent.

Non-treatment decisions have since long formed a key element in the fabric of Dutch thinking. It started in 1969 with the pamphlet *Medical power and medical ethics* by the Leiden psychiatrist Jan Hendrik van den Berg (Van den Berg 1969). With the help of photos of patients who were enduring heartbreaking suffering, Van den Berg argued that advances in medical technology have led to more and better treatment options but also to much suffering. His thinking was that doctors should not only practice restraint in treating patients with a poor prognosis, but they should also have the courage to actively end a patient's life. Van den Berg, a liberal Christian, published his book through an orthodox Christian publisher, and his view was not only adopted by the general public, but even by the Protestant Church in the Netherlands in 1972, little short of the nation's state church at the time (Boer & Groenewoud forthcoming). The book saw at least twenty reprints.

In the decades that followed, the view that physicians may have to end the lives of their patients, at their request, became one of the most well-known features in Dutch politics. It led from a Ministerial Agreement in 1985 to not prosecute euthanizing doctors if they had fulfilled a number of criteria via a makeshift law in 1994, to a fully-fledged euthanasia law in 2002. This Euthanasia Act, the first of its kind in the world, was followed by Belgium, Colombia, and Canada. Unlike in Canada, the Dutch Act does not contain the criterion that an unavoidable natural death must be reasonably foreseeable. The years after 2002 saw a tripling of the numbers and an expansion of the pathologies underlying a euthanasia request, so as to include early-stage dementia, advanced-stage dementia, psychiatric illnesses, and various disabilities (Boer 2020).

From the outset, one particular group of citizens felt ignored by the medical focus of the Euthanasia Act. In 1991, former vice-chairman of the Supreme Court Huib Drion published an opinion article in a leading newspaper, entitled, "The self-desired end of elderly people" (Drion 1991). Drion suggested that the availability of a suicide pill would be a relief for many elderly people filled with horror at the prospect of an endless old age. But the times were not ripe; not even traditional euthanasia had been legalized. Once that happened ten years later, the minister of health, Els Borst, put as a new point on the horizon the legalization of euthanasia for "tiredness of life," later referred to as "completed life" (Oostveen 2001). The increase of public support for the idea resulted in a "Completed life-petition" in 2010. It petitioned the Dutch parliament to legalize assisted dying on the basis of a life that is considered completed. A governmental committee advised in 2016 against such a law, arguing that it could carry unwanted side effects, such as a message sent to the elderly that society can do without them (Adviescommissie voltooid leven 2016). A separate law was deemed redundant: not only is the demand probably small, but also most of those who

consider their lives completed suffer from one or more medical conditions that would make them eligible for euthanasia under existing law. Governmental plans to proceed towards a Completed Life Act were put on hold after a government coalition change in 2017, in which two Christian-democratic and two liberal parties joined hands. Another research report, published in early 2020 and focusing more intensely on the precise demand for euthanasia in patients with a completed life, draws similar conclusions as the 2016 study (Commissie Van Wijngaarden 2020).

The liberal coalition partner D66 nevertheless announced that it would soon present an initiative bill. It was expected in March 2020 (NOS 2020b). With some months' delay due to Covid-19, D66 spokesperson Pia Dijkstra announced a draft-bill giving any Dutch citizen of 75 and older a state-facilitated and conditioned right to assistance in suicide (Bremmer 2020). Many reactions to the law's proposal were emotional and parallels were drawn to how elderly people are affected disproportionally by the Covid-19 pandemic. Publicist Tonnie van der Honnekreek sees continuity between what she considers the government's failure to protect elderly people in nursing homes from the virus, and the Completed Life Act: "Under the watchful eye of the Minister of Health, the virus was allowed to take its course among the frail elderly" (Van der Tonnekreek 2020). She calls the proposed law "yet another attack on the 70-plus generation."

Arguments for state-facilitated assisted suicide for any elderly person thus form a red thread in Dutch discussions over the past three decades. In my view, they have had an enormous impact, even without a law being passed.[1] The fact that in the past mainstream political parties such as Prime Minister Mark Rutte's liberal VVD, Dijkstra's D66, as well as the Social democrats and most of the members of the Green Party have supported the idea, may have impacted the self-understanding of many elderly people and undermined their self-esteem. In the Netherlands, a person reaches retirement at the age of 67 and can expect some eight years in relative health and prosperity. When a healthy person of, say, 70 years of age has a serious death wish, they are referred to the suicide prevention hotline "113" and are offered social and psychiatric help. Should the government, when that same person is five years older, offer to facilitate their suicide wish? Despite the compassion of the initiators of the law for the suffering of elderly people, I am afraid of considerable collateral damage. If the law is accepted in parliament, society in effect sends a message to anyone over 75 that

[1] Personally, I think the law's high-water mark occurred in 2016; since that year, voices from all sides – not only religious, but also including secular, Humanist, and liberal people – have unanimously criticized the idea. It is my impression that the odds that a Completed Life Act will be supported by a parliamentary majority in the Netherlands are low.

they are no longer worth fighting for and that it can be rational to kill yourself. From that age on forward, society can do without them.

The acceptance of the high Covid-19 mortality rate in nursing homes, together with the arguments to use age as a criterion to allocate scarce resources on ICUs, may have a link with the anthropology that lies behind plans to facilitate a suicide pill for persons 75 years of age and older. Both come dangerously close to contempt for the intrinsic value of elderly people.

2.3. Suspension of euthanasia

The following discussion of two other ethical issues connected to Covid-19 in the Netherlands will focus on the suspension of euthanasia services by some caregivers and the role of the Dutch in a European context.[2] Surprisingly, in the Netherlands the only dedicated clinic providing euthanasia and assisted suicide, the Euthanasia Expert-Centre (formerly known as the End of Life Clinic), suspended all euthanasia procedures in mid-March 2020. The Centre's website indicated that existing procedures had been put on hold and new patients were no longer being admitted. The Centre, which in 2019 alone provided euthanasia to 898 patients suffering from cancers, psychiatric problems, early-onset dementia, and accumulated age-related complaints, made an exception only for those expected to die soon and those who might soon lose their capacity for decision making, and for patients to whom euthanasia had already been promised (and only in the presence of a very limited group of family members). "Special circumstances force us to take these inevitable steps," an announcement on the Centre's website read. The Centre wanted to protect its workers, many of whom are retired physicians, from being infected (Expertisecentrum Euthanasie 2020a, 2020b). Its statement concluded: "However bitter, euthanasia care cannot be identified as a top priority in healthcare."[3] Although no numbers are available yet, there are signs that even euthanasia provided by regular physicians has decreased in frequency.

The assertion that euthanasia is not a priority health care issue is an unusual and, in my view, painful admission.[4] Euthanasia is generally believed to be

[2] The Expert Centre's suspension of euthanasia services in the Netherlands, as well as similar developments in Canada, are discussed in Boer and Yuill (Forthcoming).

[3] In Canada, health authorities said that MAiD (Medical Aid in Dying) is being cut back along with other "elective services." Two areas in Ontario suspended the provision of assisted dying for the same reasons. British Columbia and Nova Scotia temporarily amended some of their MAiD rules in a bid to expose fewer health-care professionals to the risk of becoming infected with the coronavirus (Grant 2020).

[4] In fact, it is so extraordinary that the Centre has deleted its earlier webpage: in a later version the reference to euthanasia not being a top priority is absent.

necessary as a last resort to prevent unbearable suffering. To suspend this because of the danger of infection means that those who perform euthanasia no longer believe their service is that necessary; otherwise, why not brave the risk and despatch suffering patients? Steven Pleiter, the director of the Centre, stated earlier that "if the situation is unbearable and there is no prospect of improvement, and euthanasia is an option, it would be almost unethical [for a doctor] not to help that person" (De Bellaigue 2019). In Canada, Medical Aid in Dying (MAiD) is even deemed a human right. This suspension thus is in stark contrast to other forms of essential health care. Cancer treatment, for example, continued to receive the highest possible priority and was not suspended. Furthermore, hospice services continued their vital service to the dying despite the higher risks of contagion for care personnel than those performing euthanasia. It is true that the use of palliative care declined: at the peak of the first Covid-19 wave, the use of palliative beds had dropped by about 12% (Eijrond 2020). But this is not due to a reduced supply of palliative beds, but rather because patients and their relatives preferred palliative care at home where there are fewer limitations to visiting them. There are no reports of hospice closures in the Netherlands.

It may be too early at this point to come to any solid conclusions, but responses to the Covid-19 pandemic suggest that the need for assisted dying may be abstract rather than practical, and ideological rather than medical. In early discussions on the topic, euthanasia started out as an ultimate solution to an unavoidable horrible death. In present times, with high level palliative care available in both the Netherlands and Canada, assisted dying is less about preventing a terrible death – most people die peaceful deaths through the assistance of palliative staff – than about preventing a dreaded life. People may fear a loss of control and find the prospect of others caring for them, or living with intense feelings of loneliness and alienation, terrifying. The Euthanasia Expert Centre's remark that "euthanasia-care is not a top priority in health care" suggests that there may be other solutions to unbearable suffering, rather than death.

Through the media, the Covid-19 pandemic brings the reality of death, the necessity of caring for others and being cared for by others into our living rooms, making the preciousness of all lives and the tragedy of all deaths real. We see the humanity of the elderly and frail; no longer are they burdens to be eliminated from this world but victims of a horrifying disease against which all of us are enlisted. This awareness may have formed the background for Dutch columnist Maxim Februari's criticism of the decision of the Supreme Court to acquit a physician who euthanized a patient with advanced dementia: "[N]ow I suddenly understand why I think it is an unwise decision: it expresses a pre-corona view of life" (Februari 2020).

2.4. International solidarity

Covid-19 has also played an important role in relations within the European Union. Prior to the pandemic, the Netherlands had a comfortable surplus concerning both the trade balance and the national budget. In 2019, the national debt as a percentage of the GDP was, for the first time since 2008, below 50% (whereas Italy had a percentage of 138%) and a further decrease was expected in 2020 (Business Insider 2020). At the beginning of the lockdown in March 2020, Minister of Finance Wopke Hoekstra announced a large-scale financial support program for businesses: "Our pockets are truly very deep and I am willing to empty them entirely" (De Witt Wijnen 2020). In 2020 alone, the Dutch government is poised to have subsidized the economy with close to 100 billion Euros without getting into dire straits.

Yet, the way the Netherlands is acting on the European stage reveals a completely different attitude from this national solidarity displayed at home. Several European countries that were hit hard by the first Covid-19 wave, notably Italy and Spain, were already experiencing considerable budgetary problems. At the July 2020 EU-summit in Brussels, under the presidency of Germany, the most important point on the agenda was the proposal of the European Commission to establish a 750-billion-euro fund, to be distributed among the countries and sectors most impacted by the pandemic and taking the form of grants and loans. Dutch prime minister Mark Rutte led the so called "frugal four," consisting of Austria, Denmark, the Netherlands, and Sweden, later joined by Finland. These countries expressed their objections to helping countries that in their eyes exercised insufficient budgetary discipline. Whereas in recent years Germany and the Netherlands were in close agreement about budgetary requirements, Germany now took a different path and advocated a more generous, "motherly" approach.[5] The marathon summit held over four days yielded a compromise in which the loans part was increased, while the grants part reduced. Moreover, individual countries were granted the right to veto Europe's payments if a receiving country failed to implement the conditions.

The approach of Rutte and his four colleagues can be understood for a number of reasons. Financial donations from countries that have a strict budgetary discipline (the Netherlands has raised the retirement age to 67 years and three months) are difficult to justify if the receiving countries fail to adhere to the same (France has a retirement age of 62-64, Italy of 66). Moreover, the United Kingdom, once a powerful ally against European federalism, was no longer there to support the case and Rutte may have felt committed to take over this role. Last

[5] In Germany, Chancellor Angela Merkel is often referred to as *Mutti* ('mother').

but not least, several heads of government, amongst whom Rutte himself, have to deal with increasingly influential anti-European critics (Engelbart 2020). The more willing the Dutch government is to support ailing European economies, the greater the damage in the upcoming 2021 elections may become.

Still, as a consequence of Covid-19 the Dutch reputation in Europe has suffered major damage. The country could have expressed more awareness of the fact that by being so massively dependent on trade it benefits more than many others from the European project. By playing hard ball it may have lost much of the goodwill it may need on other occasions, for example, when it comes to securing fishing rights. And last but not least, the European project is not only about rules, but also about solidarity. Finger pointing at countries that find themselves in unprecedented economic, political, and health troubles by a country that is doing relatively well may not be an expression of the European idea that is needed right now. Rutte may have saved his credibility nationally, but he has lost much of it internationally.

3. Conclusion

Up to now, the Netherlands seems to have done relatively well in fighting the novel coronavirus pandemic. During regular press conferences Prime Minister Mark Rutte, assisted by officials of the National Institute for Public Health and the Environment RIVM, and when needed in the presence of the ministers of health and justice, has demonstrated remarkably clear leadership from early March 2020 on and well into the fall. Governmental regulations and appeals to individual freedom and responsibility proved to be a workable combination. Although we do not know if and when a third wave will come, governmental and societal responses to the corona crisis are encouraging.

Despite all this, the article explored areas that I think the global public health crisis has shown to be problematic aspects of Dutch culture. At the end of the day, has the country treated its elderly citizens with proper respect? And has the Netherlands generated sufficient solidarity with countries that have less prosperous household budgets?

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La Covid-19 et le contexte néerlandais : quelques enjeux éthiques

La pandémie de Covid-19 entraîne des retombées dans les domaines politique, économique, culturel et éthique, qui demeurent inconnues pour l'instant. Même si l'espoir de trouver un vaccin efficace se concrétise, les pays continueront à éprouver à long terme les conséquences de la pandémie. Les problèmes éthiques les plus importants posés par la pandémie concernent souvent la recherche d'un équilibre entre deux pôles opposés : faire rouler l'économie tout en protégeant les personnes vulnérables, respecter la liberté de l'individu tout en imposant des mesures gouvernementales, protéger les personnes âgées, particulièrement dans les maisons de retraite, tout en reconnaissant l'importance du contact humain, et protéger la vie privée tout en surveillant de près la santé publique.

Tout pays qui est gravement touché par la Covid-19 doit faire face à ces problèmes. Sans vouloir être exhaustif, j'examinerai dans cette contribution quelques défis éthiques qui sont spécifiques aux Pays-Bas. Bien que le pays résiste relativement bien à la pandémie, au moins quatre développements sont préoccupants : (1) les plaidoyers pour le recours à l'âge comme un critère de sélection dans le cas d'un éventuel manque de lits aux soins intensifs risquent de miner l'estime de soi des personnes âgées, (2) une telle discrimination fondée sur l'âge en cas de pénurie des soins de santé liés à la Covid-19 pourrait se rapporter à des initiatives qui visent à offrir aux personnes âgées l'aide médicale à mourir ou le suicide assisté, (3) la suspension temporaire de l'euthanasie en ces temps de pandémie permettrait éventuellement de conclure que l'euthanasie n'est pas toujours urgente, (4) la solidarité nationale avec les entreprises qui souffrent à cause de la pandémie contraste grandement avec le rôle et la réputation des Pays-Bas au sein de l'Union européenne.

Covid-19 en de Nederlandse context: Enige ethische beschouwingen

De Covid-19-pandemie heeft onbekende politieke, economische, culturele en ethische gevolgen. Ook als er op korte termijn een effectief vaccin gevonden is, zullen veel landen de impact ervan nog lang ervaren. De belangrijkste ethische problemen die zich hier voordoen zijn het vinden van een evenwicht tussen het draaiende houden van de economie en het beschermen van kwetsbare mensen, tussen individuele vrijheid en overheidsvoorschriften, tussen het beschermen van ouderen en het hun gezelschap bieden, en tussen privacy en toezicht op de volksgezondheid.
Veel van deze problemen doen zich voor in elk land dat ernstig wordt getroffen door Covid-19. Zonder volledig te kunnen zijn, bekijken we in deze bijdrage enkele ethische vraagstukken die specifiek zijn voor Nederland. Hoewel het land de pandemie redelijk lijkt te doorstaan, geven ten minste vier ontwikkelingen reden tot bezorgdheid: (1) pleidooien om leeftijd als criterium te gebruiken bij een tekort aan intensive care bedden kunnen bij ouderen gevoelens van uitsluiting oproepen; (2) leeftijdsdiscriminatie bij schaarse Covid-19-zorg kan verband houden met initiatieven om ouderen hulp bij zelfdoding te bieden; (3) de tijdelijke opschorting van euthanasie in Covid-19-tijden kan een aanwijzing zijn dat euthanasie niet altijd even urgent is; (4) nationale solidariteit met bedrijven die economische schade lijden, contrasteert met de rol en de reputatie van Nederland in Europees verband.