English Summary

**Boundary disputes.**

A study of the classification of euthanasia and other medical behavior that shortens life

About one hundred forty thousand times a year someone dies in the Netherlands. It is estimated that in about sixty thousand of those cases the doctor concerned made a medical decision in which he took account of the probability that the life of the patient would be shortened. Some of these cases of ‘physician-negotiated death’ (MBSL) fall under a legal control regime that is supposed to ensure that the doctor's behavior satisfies a number of requirements of careful practice. For other MBSL such control is not required. Questions concerning how various kinds of MBSL should be distinguished, how legal categories of action should be defined and how concrete cases of medical behavior at the end of life should be classified, have been a source of debate, controversy and confusion for decades.

The problem of the boundaries of key classifying concepts has been a persistent theme of the Dutch efforts legally to regulate physician-negotiated death. That theme is followed and discussed in the first two parts of this dissertation (chapters 2-6). The third and last part (chapters 7 and 8) describes an empirical study of the way actors who are supposed to apply the rules concerning MBSL use and interpret the classifying terms with which those rules are constructed. The results of this research give insight into the way the current regulatory system works in practice. The theoretical theme illustrated in the three parts, can be described as the role classifications play in the social working of (legal) rules and the importance for the sociology of law of careful attention to (legal) classifications.

**The origins and course of the debate on classifications**

Debate concerning the classification of MBSL originated in the 1950s and 1960s. Chapter 2 describes how developments in medical science led to a revision of traditional medical ethics. By the end of the 1960s a growing body of opinion claimed that traditional medical ethics was no longer able to deal with the situations created by advanced medical technology. Medical-technological change had greatly increased the doctor's ability to postpone death, with the consequence that the medical imperatives 'do whatever is possible' and 'relieve suffering' no longer always went hand in hand. The growing ability to postpone death implied that death itself became more and more an event negotiated by medical practitioners. Medical decisions that were expected be followed by death came to be regular features of the dying-process, and the old interpretation of the basic ethical principle of 'absolute respect for life', was no longer apt to serve as a guideline for medical action. Doctors, lawyers and ethicists and other participants came to agree that a doctor should not preserve, spare and prolong life whenever possible. It should be the doctor's duty to preserve, spare and prolong human life, whenever doing so has any sense. Perhaps, some participants suggested, a doctor might even be allowed actively to bring about the end of life.

In the early 1970s legal, medical and ethical professionals began more systematically to discuss the permissibility of medical behavior at the end of life, and whether this was something the law should regulate. This resulted in various efforts to try to distinguish between different kinds of MBSL. This debate is described in chapter 3. Absence of consensus between participants in the debate manifested itself in a jumble of classifying terms and proposals for definitions. The key-term in the debate was ‘euthanasia’, which referred to many things: direct, indirect, voluntary, involuntary, active and passive forms of MBSL. The main objective of the debaters was to settle on which forms of MBSL were ethically and legally problematic and which were not.
During the debate various participants claimed that the definitions they proposed were ‘neutral’, value-free, and objective. I show, however, that proposals to demarcate the various (behavioral) categories of action, are time and again interlaced with the medical ethical points of view of their advocates as well as with the legal solution they have in mind for the regulatory problem. This is the case, for example, in the official definition of ‘euthanasia’, which was arrived at after 15 years of debate. In 1985 the State Commission on Euthanasia restricted the legal meaning of the word ‘euthanasia’ to: “intentionally terminating another person’s life at that person’s request”. The State Commission claimed this was nothing more than a neutral summary of the features of the concept. However, making the patient’s request the key element was inseparably connected with the idea that autonomy of the patient is the most important value at stake, an idea of which Leenen, professor of medical law and vice-president of the Commission, was one of the strongest and most influential protagonists. The success of his position resulted in the fact that ending the life of severely suffering incompetent patients was placed outside the euthanasia debate.

The State Commission’s definition also indicated where the answer to the question of the legality of euthanasia was to be found. The chosen definition meshed perfectly with article 293 of the Dutch Criminal Code, which since 1886 forbids ‘termination of life on request’. The Commission proposed that the prohibition of the behavior covered in article 293 should not apply to a doctor who meets certain requirements of careful practice.

In order to guarantee that euthanasia is only performed in a careful way, the Commission proposed that doctors should account for their behavior to an external control system. However, argued the State Commission, such external assessment was not necessary in the case of:

- a patient who refuses a life-saving or life-prolonging treatment;
- withdrawing or withholding a medical treatment that is regarded as ‘medically futile’;
- giving a medically-indicated dose of pain-relieving medication with possible life-shortening effect.

Although these kinds of behavior can have an anticipated life-shortening effect, they should not be classified as ‘termination of life’ but as ‘normal medical practice’.

Enschedé and other lawyers argued against the proposals of the State Commission. Enschedé claimed that the various kinds of medical behavior to which the Commission attached different legal consequences, were not easy to distinguish in practice. Enschedé’s argument is directly connected with his plea to regulate MBSL outside the criminal law. Enschedé was an advocate of the so-called ‘medical exception’, which would have left the regulation and control of all forms of MBSL, like that of other medical behavior, to the medical profession itself. His proposal, however, did not succeed. Leenen and the State Commission convinced most of the participants in the debate that a special regulatory regime should be established for specific kinds of MBSL, in particular euthanasia.

With the publication of the report of the State Commission, the focus of debate shifted to the question how euthanasia should be controlled. Chapter 4 describes how the solution for this problem was found in the Law on the Disposal of Corpses. This resulted in a new discussion about the meaning of the concepts ‘natural’ and ‘non-natural’ death, concepts that a doctor must use when filling out a death-certificate. This discussion illustrates once more that the way the boundaries of classifying concepts are drawn is closely connected to the (normative) purpose the category is supposed to serve.

*The reporting procedure*

The current control system was established in 2002, with the Act on Termination of Life on Request and Assisted Suicide. Earlier, in the 1980s, the Supreme Court had ruled that termination of life on request by a doctor can be justified on the basis of necessity in the sense of a conflict of duties (the duty to respect life versus the duty to relieve the suffering of the patient), provided the doctor has met what came to be called the ‘requirements of careful practice’. Apart from a well-considered request of the patient, the most important requirements are that the suffering of the
The patient has to be unbearable and hopeless and that the doctor is obliged to consult an independent colleague.

The reporting procedure was first formally set up in 1990, adapted several times during the 1990s, and finally given statutory form in the 2002 law. The reporting procedure works as follows. When a doctor performs a medical treatment that should be classified as 'euthanasia', 'assistance with suicide' or 'termination of life without a specific request', he may not file a certificate of natural death. In these cases the death of the patient should be classified as due to a 'non-natural' cause, and the doctor must notify the coroner. In cases of 'euthanasia' and 'assistance with suicide', the coroner sends a report to one of the five 'regional assessment committees', which assesses whether the doctor has met the requirements of careful practice. Unless it concludes that the doctor was 'not careful' the Committee’s assessment is final. In case of ‘termination of life without a specific request’ the doctor’s report is sent directly to the prosecutorial authorities. The decision whether or not to prosecute in these cases is always made in consultation with the Minister of Justice.

A crucial aspect in this procedure is that it relies on self-reporting by doctors. For the rules to work, doctors have to be able to classify their own behavior as ‘termination of life’ (euthanasia, assisted suicide or termination of life without a specific request) or ‘normal medical behavior’, and the death of the patient as ‘natural’ or ‘non-natural’.

**Nationwide surveys to estimate the scale of MBSL**

Toward the end of the 1980s politicians and others began to call for reliable information about the scale of the practice of physician-negotiated death in general and the number of cases of euthanasia in particular. This resulted in a series of quantitative empirical studies. The demand for quantitative information put the problem of classifying MBSL in a new light. Now the purpose of classification was not to distinguish problematic from unproblematic kinds of MBSL but to count how many times the various sorts of MBSL that were officially differentiated on paper, actually occur in medical practice.

The first estimates of the amount of euthanasia varied enormously: from several thousands to no less than twenty thousand cases of euthanasia per year. Chapter 5 discusses how these widely diverging estimates can be explained, partially with the help of the results of qualitative research carried out in the same period. Several studies suggested that medical practitioners were frequently using and interpreting the MBSL-categories of the State Commission in a different way from what was ‘officially’ intended. It seemed that it is not always easy to fit concrete medical behavior into one of the official categories. This frustrated the making of unambiguous and reliable estimates, for ‘you can’t count what you can’t distinguish’.

In 1990 the government installed the so-called Remmelink Commission. The Commission was supposed to put an end to speculations concerning the extent of euthanasia and to give recommendations for further policy concerning the practice of euthanasia and other MBSL. This led to the first of three nationwide quantitative studies by Van der Maas, later joined by Van der Wal (1991, 1996, 2003). At the onset of the first study, the Royal Dutch Medical Association (KNMG) agreed with the Minister of Justice to advise its members to cooperate in the research, on condition that a special reporting procedure be introduced. The KNMG expected this to give more legal certainty to doctors performing euthanasia.

The nationwide studies have supplied the debate on MBSL with a statistical basis for the last fifteen years and have therefore had great influence. Chapter 6 critically discusses the studies. Special attention is paid to the classification system that was constructed in order to make estimates of the frequencies of MBSL. The researchers acknowledged the above-mentioned confusion among doctors concerning the way the official categories should be used. In order to prevent this confusion from disturbing their estimates, the classification of behavior was not left to the doctors but was strictly directed by the researchers themselves. The classification system that was used in questionnaires and interviews depends largely on the intention a doctor attributes to his behavior.
The classification system constructed by the researchers categorizes medical behavior as ‘termination of life’ only if the doctor says he gave medication ‘with the explicit purpose of shortening life’.

I critically discuss the decisive role of intentions in the classification system used in the research. The approach, for example, does not correspond to the way Dutch criminal law handles intentions, nor to the way the State Commission drew the lines between various kinds of MBSL. Dutch criminal law and the State Commission do not rely on subjective intentions but objectify these by concentrating on the ‘knowledge of consequences’ a physician reasonably could have had. Furthermore, the psychological theory of ‘cognitive dissonance’ suggests that a doctor who performs one or another MBSL will probably – at least in his own experience - act with the intention to alleviate suffering of the patient. Subjective intentions therefore probably do not have much distinguishing power and seem not to be a useful criterion for classifying kinds of MBSL.

Based on these critical remarks I argue that the estimates made in the three national studies should be taken with some reservations. This is exactly what the researchers themselves advised, at least in their first research report (1991). The results are presented carefully and are repeatedly put into perspective. Especially the distinction between ‘termination of life’ on the one side, and pain-relief on the other, turned out to be hard to make. The researchers emphasized the so-called ‘gray area’ between the two that was estimated to be around the same size as the total estimated number of cases of euthanasia. The researchers therefore stated that one should be prudent in drawing conclusions based on the constructed estimates. The call for prudence, however, was almost instantly forgotten after the publication of the research report. Even the advisory report of the Remmelink Commission (1991), that accompanied the research report, did not mention the ‘gray area’. Instead, it described the estimates as a “factual description of reality”.

By stressing the factual and scientific nature of the research results, the Commission gave the estimates an almost infallible status. Attention was deflected from the important decisions the researchers had had to make in order to produce the estimates. In their later reports (1996, 2003), the researchers themselves seem to have forgotten their earlier reserves. All this contributed to a process I have called the ‘reification of medical behavior that shortens life’: the steadily growing conviction that the officially-defined categories of MBSL reflect ‘reality’ and correspond with clearly identifiable phenomena that can be classified and counted in an unambiguous manner. In the course of the 1990s this reification was rarely scrutinized critically by policymakers and other participants in the ongoing debate concerning physician-negotiated death.

The reporting rate

A consequence of the process of reification was that attention for the idea that concrete situations in medical practice are not always easy to fit into the officially constructed MBSL categories and that doctors may sometimes come to diverging or unforeseen classifying judgments, largely disappeared from the public and scientific discussion. The control-regime that took shape during the 1990s is based on the idea that the distinctions are not problematic: doctors are required to classify their own behavior by means of the official classificatory framework of the State Commission, and to report a death which is the result of termination of life (‘euthanasia’, ‘assisted suicide’ or ‘termination of life without an explicit request’) as ‘non-natural’.

In the most recent two studies (1996, 2003) the researchers were asked not only to make new estimates, but also to evaluate the reporting procedure. By dividing the number of actually reported cases of euthanasia by the total number of cases identified by their classification system they were able to calculate a figure that gives instant information about the functioning of the reporting procedure: the reporting rate.

Precisely because the reporting rate is based on the classification system constructed by the researchers, a paradoxical situation emerged. The classification system was necessary precisely to prevent the conceptual confusion among doctors from disturbing the reliability of the estimates. The researchers therefore did not leave the classification of MBSL to the doctors themselves. This
method, however, was now used in order to evaluate a control procedure that is based on the assumption that doctors are able to use the official classificatory framework the ‘right’ way, and thus ‘know’ which behavior should and which behavior does not have to be reported.

For the years 1995 and 2001 the researchers estimated that doctors had reported respectively 41 and 54 percent of the cases of euthanasia that emerged from the national studies. The main explanations the researchers give for not reporting were fear of the possible legal consequences and aversion to the bureaucratic rigmarole involved. The process of reification seems to have led them to overlook an alternative explanation for not reporting: it is possible that a doctor does not report a case of MBSL simply because he thinks that the case does fit into one of the categories involving a duty to report.

Shortly after the publication of the last national research report (2003), the ethicist Den Hartogh calculated an alternative reporting rate, based on a train of thought similar to that presented here. Den Hartogh assumes that cases of ‘euthanasia with morphine’ and so-called ‘terminal sedation’, that had been categorized as ‘euthanasia’ by the researchers, were probably not seen as such by the doctors involved. Den Hartogh filtered out these cases and came to an alternative reporting rate of somewhat more than 90 percent. He also argued that the way doctors classify is legally correct. This brought him to the conclusion that the reporting procedure is highly effective.

**Empirical research into classification by doctors and prosecutors**

Den Hartogh’s assumption that doctors classify MBSL in a different way from the researchers’ classification system is a matter of well-informed speculation. Whether it can be supported with empirical information is the question in the empirical research reported in chapters 7 and 8. This research departs from the central question in Griffiths’ approach to the social working of legal rules: what difference does a (legal) rule make in social practice? The initial focus of my research was on one condition that has to be met before a rule can make a difference. This condition is that the rule has to be known to the people whose behavior it regulates. If the rule is ‘known’, at least two questions follow. The first is how the actors interpret and apply the rule in practice. The second question is whether the various actors interpret and use the rules in the same way.

In the first chapter of this dissertation I show that classifications are a crucial element of a rule. This led me to see the question whether doctors know the legal rules governing MBSL, as a question about the way doctors interpret and use the classifying concepts with which the rules are constructed. One of the hypotheses underlying my research has been that there may be important differences between the way actors with a medical or with a legal background understand the classifying terms. This hypothesis is a further refinement of Griffiths’ argument that lawyers and doctors are members of different semiotic groups; the concepts used in legal rules may therefore well have a meaning among doctors that is significantly different from the meaning they have among lawyers.

In the empirical part of my research I focused on the different meanings the classificatory concepts have for various actors who are supposed to work with these concepts in actual practice. I therefore sent a questionnaire to actors from both medical and legal practice: general practitioners, coroners and public prosecutors. In the questionnaire I confronted the participants with seven cases of MBSL. Most of the cases were based on events that had actually happened in medical practice. With respect to each case respondents were asked to answer a number of questions. The central questions focused on the classification of the behavior of the doctor in the case (for instance as ‘euthanasia’, ‘abstention’, ‘palliative care’) and the classification of the death of the patient (as ‘natural’ or ‘non-natural’).

The survey concentrated on the way the actual users of the rules concerning MBSL classify situations of MBSL. The overall question of the survey was, whether actors representing the medical and legal perspectives classify cases of MBSL in similar ways. In this respect I have used the term *cognitive solidarity* (taken from Bruner & Amsterdam, 2000). There is cognitive solidarity between members of groups when they classify a phenomenon (behavior, thing, idea, animal,
etcetera) the same way, in other words when they agree that a phenomenon should be considered as belonging to a certain category.

In order to get more insight into the origins of the classification judgments revealed in the questionnaire, I carried out follow-up research. Several respondents who had participated in the survey were interviewed. During the interviews, three of the eight cases used were thoroughly discussed, and I asked the respondents to explain why they chose to classify the cases the way they did.

**Lack of cognitive solidarity between doctors and lawyers**

The main finding of the empirical research is the systematic difference in the way general practitioners, coroners and public prosecutors classify the various cases. A majority of the doctors classified most of the various situations as ‘normal medical practice’, in which the patient died of a ‘natural cause’. The public prosecutors see this quite differently. A majority of them classified the same situations as cases of ‘termination of life’, in which the patient died from a ‘non-natural’ cause. The coroners take a middle position, although their answers are closer to those of the doctors.

The conclusion can be drawn that there is little cognitive solidarity between general practitioners and public prosecutors. This implies that general practitioners will often not report cases of MBSL that public prosecutors think should be reported. This conclusion cannot be brushed aside with the argument that it only applies to rare sorts of cases. The general practitioners stated they found all the cases used realistic and familiar. In most of the cases more than one in three of the participating doctors said they had actually acted in a similar way. In short, the case descriptions used reflect everyday medical practice.

**A ‘prototypical’ view of the category ‘termination of life’ and ‘subjective’ vs. ‘objective’ intentions**

There is no formal legal definition of the behavior that should be considered ‘termination of life’. The interviews, however, show that many doctors have a prototypical view of this behavioral category. They only seem to speak of ‘termination of life’ (with or without a request), when the patient is given a lethal injection (not morphine), which immediately terminates life at a moment determined beforehand. Behavior that might otherwise be related to the death of the patient – for example, withdrawing life-sustaining treatment or administering opioids to relieve suffering - is usually not seen as terminating life. In those cases, death is usually considered to be due to natural causes (the underlying condition of the patient).

Public prosecutors do not share this prototypical view. They draw the boundaries of ‘termination of life’ (with or without a request) more widely and take the term to include all behavior that can be considered to have caused death intentionally. The ‘subjective’ intent (motive) a doctor claims to have acted with, is not relevant. Public prosecutors ‘objectify’ the intention in terms of whether the doctor could reasonably have foreseen that his behavior would shorten the life of the patient. If this can be assumed, public prosecutors classify the behavior as ‘termination of life’. For them, this does not imply the doctor did something that cannot be justified, but it means that his behavior needs to be assessed.

The way public prosecutors objectify the intentions of the doctor is customary in criminal law. Doctors handle intentions very differently. They often let intentions, in the subjective sense, play a role in the way they classify the doctor’s behavior and the patient’s death. A respondent doctor who thinks that the primary objective of the behavior of the doctor in a particular case was to alleviate the pain and suffering of the patient is inclined to put the behavior outside the life terminating categories and to classify the death as a natural one.

Considering the role of intentions in the reasoning of the various professional groups it can be concluded that the classification-system used in the nationwide studies is in line with the way doctors classify and differs from the reasoning of public prosecutors, which is rooted in criminal law.
Legal ignorance?

The results of the survey might be taken to reflect a lack of legal knowledge among doctors. The interview research showed, however, that such a conclusion would be incorrect. During the interviews it appeared that doctors often can support their classificatory judgments with legally relevant arguments. Doctors often lay emphasis on aspects of the case that were not explicitly given in the case description, but which can nevertheless be relevant for classifying the situation. An example of this is the importance of ‘medical futility’ in the case of withdrawing life-sustaining treatment. Based on the assumption that in the circumstances further treatment would have been ‘futile’, many doctors classified such a situation as ‘normal medical practice’/ ‘natural death’. In reasoning this way, they displayed a good command of Dutch medical law. Doctors also stressed aspects of the cases such as ‘was sedation medically indicated?’, and ‘did the use of morphine actually hasten the death of patient?’ Interesting, however, is the fact there was considerable disagreement on such questions among doctors. This was especially the case concerning the concept ‘medically futile’.

It was mostly doctors who referred to such aspects in explaining their classifications. Public prosecutors seem much less aware of the relevance of such basic questions. The way they classify is mainly driven by the central ideal around which the current control system is built: medical practice involving termination of life (with or without a request) must be made open and transparent, and doctors should therefore account for their actions in an external reporting procedure. Motivated by this ideal, public prosecutors tend to classify all situations that cannot unmistakably be considered to fall within the categories of ‘normal medical practice’ / ‘natural death’, as ‘terminating of life’ / ‘non-natural death’.

The lack of cognitive solidarity between doctors and lawyers can therefore not be explained by pointing to a lack of legal knowledge among doctors. They do have, however, a very different point of departure. When asked to classify the various situations, public prosecutors are, as we have seen, mainly focused on the issue whether or not the behavior at hand should be assessed. Whether or not the behavior was morally or legally justified, is for them, a question that can only be answered within the context of the system of control. General practitioners, by contrast, concentrate in making a classificatory judgment directly on the question whether or not the behavior can be justified. This different approach leads to different classificatory judgments based on different yet legally relevant considerations.

The finding that general practitioners are driven by the question whether or not the behavior of the doctor in the case-description can be justified, also clarifies another finding: when used by general practitioners, the classifying terms have a normative connotation which is usually absent when the terms are used by public prosecutors. Public prosecutors repeatedly emphasized that classifying something as ‘termination of life’ / ‘non-natural death’, did not mean the behavior could not be justified. Doctors did not do this. On the contrary, doctors who could not identify with the doctor in the described case – who stated that they would have acted differently - judged the behavior as not justified. This resulted in a collection of arguments pointing in the direction of the categories ‘termination of life’ / ‘non-natural death’. Doctors who, on the other hand, could identify with the doctor in the case – who could imagine acting similarly or who had actually done so in practice – considered the behavior of the doctor to be justified. This expressed itself in a collection of arguments on the basis of which the case could be classified as ‘normal medical practice’ / ‘natural death’.

It is all with all not very likely that any of the cases used in this research would ever be reported by the doctor concerned. The interviews with the coroners and public coroners confirm this. Although they do not doubt that similar cases happen in practice, they hardly ever run into them.
**Not reporting**

Public prosecutors and general practitioners classify cases of MBSL in systematically different ways. Remarkably, results both from the questionnaire as from the interviews show that both parties realize that this is the case. General practitioners know or suppose that lawyers would like to see a case reported, and nevertheless state that they would not report it. Two reasons seem to explain this. The first has already been given: general practitioners can give substantial arguments to explain why they classify the behavior of the doctor and the death of the patient as 'normal medical practice' / 'natural death'. In other words, they are convinced of their own judgment.

A second explanation for not reporting a case of which general practitioners suppose a public prosecutor would want it to be reported, is related to the mutual distrust between the two professions. A somewhat exaggerated picture of the relationship between general practitioners and public prosecutors is as follows. Doctors consider public prosecutors as distant black-and-white thinkers with only a marginal awareness of the emotional and sometimes hardly objectifiable considerations a doctor is confronted with in medical practice. Their main purpose is to put doctors on trial. Public prosecutors, on the other hand, have the idea that doctors do not want to account for what they do, especially not to non-physicians. During the interviews, both general practitioners and public prosecutors made statements reflecting such mutual stereotypes.

Given such stereotypes it is no wonder that physicians do not report every case of MBSL that they suppose a public prosecutor might want to see reported. Physicians do not always believe that behavior they themselves consider to be careful and justified, will be regarded as such by a public prosecutor. In short, doctors have a sense of legal uncertainty in regard to situations that lie somewhere on the fuzzy boundary between ‘termination of life’ and ‘normal medical practice’, situations such as those used in this research.

From the interviews it is apparent that this sense of legal uncertainty is much less present when it comes to cases doctors themselves classify as ‘euthanasia’, that is, ‘prototypical’ cases in which a doctor administers an injection with an immediately instantly lethal substance (not morphine) to a patient on his or her request at a moment agreed upon beforehand. From the interviews it is clear that doctors are well informed concerning the various requirements of careful practice and the procedural steps they should take into account in case of ‘euthanasia’. This knowledge seems to relieve them of much of their feelings of uncertainty concerning legal assessment afterwards. The interviews therefore did not give rise to doubts concerning Den Hartogh’s assumption that doctors report almost all cases they themselves classify as ‘euthanasia’.

**Closing remarks**

Using the classification system designed by Van der Maas leads to a reporting rate of 54 percent (2003). As Den Hartogh has suggested, that system most probably classifies cases of MBSL as ‘euthanasia’ that doctors themselves classify otherwise and therefore do not report. Den Hartogh argued that the doctor’s perspective is legally correct and calculated an alternative reporting rate. According to Den Hartogh doctors report almost everything they should report. However, based on the insights derived from the survey and the interviews, it is possible to follow a strategy similar to Den Hartogh’s and calculate an alternative reporting rate which is based on the way public prosecutors classify. From the prosecutor’s perspective the reporting rate would appear to be a bit more than 30 percent. In other words, there is not just one reporting rate, there are several. The reporting rate is highly dependent on the perspective from which situations of MBSL are classified.

The point of my research has not been to argue for the suitability of either one of these reporting rates, nor to argue which of the perspectives is legally correct. The aim of my research has been to investigate how the official legal classifications of MBSL are interpreted and used by the actors who are supposed to apply them in practice. The empirical information resulting from the research reveals that on the shop floor opinions about how cases of MBSL should be categorized diverge widely. Cognitive solidarity between the two professions directly involved is largely absent. Although the conceptional confusion bothering the public debate since the early 1970s has been
‘officially’ solved – that is, solved on paper - in practice it lingers on undiminished. This frustrates not only attempts to evaluate the control system with quantitative methods, it frustrates the working of the control system itself. This is because both the method of evaluation and the control system are based on the idea that situations of MBSL can be univocally and unambiguously classified. This assumption has been shown to be unfounded.