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# Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia

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# CROSSING THE RUBICON: THE NETHERLANDS' STEADY MARCH TOWARDS INVOLUNTARY EUTHANASIA

## I. INTRODUCTION

In December of 2004, administrators at a Dutch hospital announced a new policy that would allow pediatricians to kill severely handicapped newborn infants.[1] In early 2005, the Royal Dutch Medical Association revealed that it had asked the government to propose new rules to facilitate the killing of "disabled children, the severely mentally retarded and patients in irreversible comas."[2] To foreign observers who have not been following developments in the Netherlands, these news stories may have seemed shocking. Modern, liberal democracies are supposed to protect the mentally challenged and physically handicapped, not kill them. For those who have been paying attention, however, these latest news reports merely represent the next logical step[3] in the Netherlands' quixotic attempt to regulate euthanasia.[4]

The Netherlands became the first country in modern history to formally decriminalize euthanasia, the controversial practice in which a physician terminates the life of a patient upon the patient's request.[5] The

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1. Michael Horsnell, *Netherlands Hospital Started to Kill Terminally Ill and Severely Disabled Babies with the Consent of their Parents*, TIMES LONDON, Dec. 4, 2004, at 13. The administrators at Groningen Academic Hospital in the Netherlands have issued procedural guidelines to guide physicians as they provide euthanasia to infants. *Id.* The clinical guidelines are not yet available in English.

2. *The Dutch Ponder "Mercy Killing" Rules*, CNN.com, Dec. 1, 2004, http://www.cnn.com/2004/HEALTH/12/01/netherlands.mercykill/index.html.

3. Ian Traynor, *Secret Killings of Newborn Babies Traps Dutch Doctors in Moral Maze: Call for New Rules to End Dilemma for Medical and Legal Professions*, GUARDIAN, Dec. 21, 2004, at 3 ("From the point of view of the Netherlands, this debate about newborns is a logical development," says Professor Henk Jochemsen, a medical ethicist and Christian critic of euthanasia. "It's another step in the wrong direction.").

4. Euthanasia typically refers to an act of a physician that is primarily intended to cause, and in fact causes, the death of a patient. Euthanasia was archaically referred to as 'mercy killing,' however, that term is generally avoided due to its highly pejorative connotation. *See, e.g.*, Lara L. Manzione, *Is There A Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)*, 30 GA. J. INT'L & COMP. L. 443, 444–46 (2002).

5. The Dutch define euthanasia as "the termination of life by a doctor at the patient's request, with the aim of putting an end to unbearable suffering with no prospect of improvement." MINISTRY OF HEALTH, WELFARE AND SPORTS, INFORMATION AND COMMUNICATIONS DEPARTMENT, EUTHANASIA: THE NETHERLANDS' NEW RULES (2002), *available at* http://www.minvws.nl/en/folders/ibe/euthanasia_the_netherlands_new_rules.asp [hereinafter NETHERLANDS' NEW RULES]. The generic term "euthanasia" derives from ancient Greek for "good death," meaning a wholesome and honorable end of one's exis-

Termination of Life on Request and Assisted Suicide (Review Procedures) Act[6] encapsulates within a single regulatory system developments in Dutch medical practice and case law dating from 1984.[7] Although the Dutch criminal code continues to prohibit the intentional killing of another individual,[8] a physician who performs euthanasia may invoke the defense of *noodtoestand*[9] and escape criminal prosecution, provided the physician complies with specific statutory requirements.[10]

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tence. THE NEW LEXICON WEBSTER'S DICTIONARY OF THE ENGLISH LANGUAGE 327 (1989). In general, the Greeks' conception of euthanasia did not entail the benevolent killing of another. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 78 (1994) [hereinafter NEW YORK STATE TASK FORCE]. Conceptually, commentators frequently distinguish among different kinds of euthanasia, for example, between voluntary and involuntary euthanasia. A summary of the terminology used to describe various forms of euthanasia follows in Part II of this Note.

6. Termination of Life on Request and Assisted Suicide (Review Procedures) Act, chs. 4-A, 4-B (2002) (Neth.) [hereinafter Termination of Life Act or "the Act"], *available at* http://www.nvve.nl/assets/nvve/english/euthlawenglish.pdf. *See* Press Release, Ministry of Health, Welfare, and Sports, Bill for Testing Requests for Euthanasia and Help With Suicide Passed by the Upper House (Apr. 10, 2001), *available at* http://www.minvws.nl/en/press/ibe/bill_for_testing_requests_for_euthanasia.asp.

The Upper House of the Dutch Parliament passed the Termination of Life Act on April 10, 2001 with forty-six votes for the Act and twenty-eight votes against. The Lower House had approved the Act on November 28, 2000. *Id.* In September 2002, the Belgium parliament passed a bill that legalized active euthanasia by a vote of eighty-six to fifty-one, with ten abstentions. *Belgium Legalizes Euthanasia*, BBC NEWS, May 16, 2002, http://news.bbc.co.uk/1/hi/world/europe/1991995.stm. Oregon has legalized euthanasia, and two reported Japanese court decisions have stipulated the conditions under which active euthanasia could be permitted in Japan. Danuta Mendelson & Timothy Stoltzfus Jost, *A Comparative Study of the Law of Palliative Care and End-of-Life Treatment*, 31 J.L. MED. & ETHICS 130, 130 n.128 (2003).

7. NETHERLANDS' NEW RULES, *supra* note 5, at 5 ("The new Act on euthanasia does not change the legal status of termination of life on request or physician assisted suicide.").

8. Article 293 of the Dutch Penal Code states, "any person who terminates another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fifth-category fine." Termination of Life Act, ch. 4-A (2002) (Neth.). Article 294 states, "any person who intentionally incites another to commit suicide shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fourth-category fine." *Id.* ch. 4-B.

9. The Dutch term, "*noodtoestand*," refers to "circumstances in which, faced with a conflict between two interests, a person sacrifices the lesser interest to serve the greater interest." Julia Belian, Comment, *Deference to Doctors in Dutch Euthanasia Law*, 10 EMORY INT'L L. REV. 255, 260 n.36 (1996), *citing* L.H.C. Hulsman et al., *The Dutch Criminal Justice System From a Comparative Legal Perspective*, *in* INTRODUCTION TO DUTCH LAW FOR FOREIGN LAWYERS, 289, 303 (D.C. Fokkema et al. eds., 1978). In the Netherlands, Article 40 of the Dutch Penal Code provides a general waiver of criminal

The Dutch government asserts that its approach to euthanasia brings the debate about euthanasia out into the open, protects "physicians and other people" who are "concerned with the limits of human suffering," and promotes physician compliance with the law.[11] Some Dutch physicians and international observers, on the other hand, express concern and outright outrage.[12] Not only has the Netherlands rejected centuries of conventional Western morality, which counsels that the intentional killing of another individual is always morally wrong,[13] the new law potentially opens the door to non-consensual mercy killings and state-sanctioned murder.[14]

The Dutch attempt to regulate euthanasia is significant for three reasons. First, the decriminalization of euthanasia, initially by the courts and subsequently by Parliamentary sanction in 2002, offers researchers access to the most complete and detailed data ever assembled regarding the practice of euthanasia in a modern industrialized society.[15] Second, the

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liability for any individual who has committed a crime but was compelled to do so out of moral or psychological necessity. Jos V.M. Welie, *Why Physicians? Reflections on the Netherlands' New Euthanasia Law*, 32 HASTING CTR. RPT. 42, 44 (2002).

10. The statutory requirements of due care are discussed in Part II of this Note.

11. NETHERLANDS' NEW RULES, *supra* note 5, at 1 ("Thanks to the new Act, doctors and terminally ill patients know now exactly what their rights and obligations are."). Paradoxically, even some opponents of the Termination of Life Act admit that the new law finally provides clarity to a previously confusing mix of euthanasia statutes and cases. *See, e.g.*, Welie, *supra* note 9, at 44.

12. *See, e.g.*, Karel F. Gunning, *Why Not Euthanasia*, COMPASSIONATE HEALTHCARE NETWORK, Oct. 9, 2004, *available at* http://www.chninternational.com/why_not_euthanasia_by_karel_f.htm; Richard H. Nicholson, *Death is the Remedy? Old World News, European Laws on Assisted Suicide and Voluntary Euthanasia*, 23 HASTING CTR. RPT. 9, 9 (2002).

13. WESLEY J. SMITH, CULTURE OF DEATH: THE ASSAULT ON MEDICAL ETHICS IN AMERICA 10–19 (2000).

14. *See, e.g.*, Welie, *supra* note 9, at 44.

15. Paul van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End-of-Life in the Netherlands, 1990–1995*, 335 NEW ENG. J. MED. 1699 (1996) [hereinafter Van der Maas Report]. In response to the protests of pro-euthanasia citizen groups, political pressure from the Royal Dutch Medical Association (KNMG), and several controversial euthanasia court decisions, the government instituted a series of studies in order to quantify the frequency of euthanasia in the Netherlands and assess physician attitudes towards euthanasia. The first nationwide study, known as the Remmelink Report, was commissioned in 1990 and chaired by the former attorney general of the Supreme Court, Professor Jan Remmelink. Additional studies were produced in 1995 and 2001. Although the original studies are not available in English, summaries of the 1995 and 2001 reports have been published by the original authors in *The New England Journal of Medicine* and the British medical publication *The Lancet*, respectively. *See generally* Van der Maas Report, *supra*. *See also* Bregie D. Onwuteaka-Philipsen et al., *Euthanasia and other End-of-Life Decisions in the Netherlands in 1990,*

arguments raised in the Netherlands parallel the arguments currently being raised in other European nations and the United States.[16] Finally, the Termination of Life Act's post-euthanasia reporting procedure and general reliance on voluntary physician compliance provides a concise case study from which legislators and jurists may extract useful lessons of law and public policy.[17]

According to the Dutch government's own research, physicians intentionally kill patients without those patients' request or consent in approximately one thousand cases each year.[18] Other researchers, pointing to the narrow definition of euthanasia used in the Netherlands and the government's own admission that physicians significantly under-report the incidence of euthanasia, estimate that physicians intentionally end the life of their patients in as many as six thousand cases annually without consultation or consent.[19] The staggeringly high incidence of non-consensual euthanasia, as reported by the Dutch government's own experts, suggests a systemic flaw in the government's approach to euthanasia law.[20]

This Note will argue that the Dutch attempt to regulate euthanasia fails, both conceptually and practically, to prevent non-consensual killing of patients. Dutch physicians and jurists appear reluctant to face the empirical evidence of widespread non-consensual or "involuntary" euthanasia.[21] By relying on the principle of *noodtoestand* or necessity, the Dutch

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*1995, and 2001*, LANCET, June 17, 2003, *available at* http://image.thelancet.com/extras/03art3297web.pdf [hereinafter Onwuteaka-Philipsen Report].

16. CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 16 (1991).

17. For example, officials in the United Kingdom and the United States have referenced the Dutch approach during their domestic deliberations regarding PAS and euthanasia. *See, e.g.*, Oregon v. Ashcroft, 368 F.3d 1118, 1123 (9th Cir. 2003); R. v. Dir. of Public Prosecutions [2002] 63 B.M.L.R. 1 (U.K.); Manzione, *supra* note 4, at 452.

18. The one thousand cases of involuntary euthanasia each year represents between 0.7–0.8 percent of all deaths in the Netherlands. *See* Onwuteaka-Philipsen Report, *supra* note 15, at 2.

19. *E.g.*, Herbert Hendin, *The Dutch Experience*, 17 ISSUES L. & MED. 223, 230–32 (2002).

20. Because no other state has formally legalized active euthanasia, there is little data available with which to measure the Netherlands' rates of voluntary and involuntary euthanasia. One survey of physician attitudes regarding PAS and euthanasia suggests that 18.3 percent of American physicians have received a request for assistance with suicide and 6 percent of American physicians have complied with such requests at least once. Diane Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193 (1998).

21. For example, the authors of the 2001 report flatly state, in reference to the evidence of one thousand cases of termination of life without explicit request each year, that

shift the focus of the legal inquiry to the physician instead of the patient and thereby damage the foundational principle of patient autonomy. By disavowing the principle of patient-autonomy in favor of the principle of physician beneficence, the current approach to euthanasia regulation creates a system in which there appears to be no logical reason to prohibit the non-consensual killing of sick or marginalized patients.[22]

Part II of this Note will present a brief overview of the Netherlands' healthcare and legal systems and discuss early euthanasia case law. Part III will critique the Termination of Life Act and the efficacy of the Act's due care requirements. Part IV will review empirical data from the Netherlands and other scholars' research regarding the prevalence of euthanasia and other end-of-life medical decisions. Part V will critique the Netherlands' euthanasia regulatory scheme and explain how its conceptual approach permits and even encourages involuntary euthanasia.

## II. INTRODUCTION TO THE NETHERLANDS' LEGAL AND PUBLIC HEALTH SYSTEMS

### *A. Explanation of Terms and Phrases used in this Note*

Despite voluminous academic writings and legal discourse on the subject, there is no universally accepted definition of "euthanasia."[23] In common usage, the term typically refers to an act of a physician that is primarily intended to cause, and in fact causes, the death of a patient.[24] Significantly, the generic definition of euthanasia does not imply anything regarding the physician's motives, the patient's physical or emotional condition,[25] or the imminence of death.[26] Unless preceded by a descriptive modifier such as "voluntary" or "active," the appearance of the word "euthanasia" in this Note refers to the generic definition.

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"[a]pparently it is difficult to avoid this kind of action." Richard Fenigsen, *Dutch Euthanasia: The New Government Ordered Study*, 20 ISSUES L. & MED. 73, 75 n.18 (2004), *citing* Onwuteaka-Philipsen Report, *supra* note 15, at 4.

22. GOMEZ, *supra* note 16, at 135.

23. JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALIZATION 9 (2002) [hereinafter KEOWN, PUBLIC POLICY].

24. *E.g.*, NEW YORK STATE *supra*, note 5, at 63.

25. Physicians refer to the process of evaluation and subsequent classification of a patient's condition, symptoms, or disease as the patient's "diagnosis." The accurate assessment and classification of a patient's diagnosis allows physicians to "provide a logical basis for treatment." TABERS'S CYCLOPEDIC MEDICAL DICTIONARY 492–93 (C.K. Thomas ed., 16th ed. 1989).

26. The prediction of the progression of a patient's disease or condition, including the estimated chance of recovery or eventual likelihood of death, is referred to as the patient's "prognosis." *Id.* at 1492.

One conceptual dichotomy that has arisen is the distinction between "active" and "passive" euthanasia. "Active" euthanasia refers to situations in which a physician performs an affirmative act, such as injecting a lethal dosage of opiates into the patient, with the intent of causing the patient's death.[27] In contrast, "passive" euthanasia refers to the physician's inaction or omissions, such as withholding life-sustaining hydration and nutrients or refusing to initiate potentially life-sustaining therapies.[28]

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27. JOHN KEOWN, EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 99–100 (John Keown ed., 1995) [hereinafter KEOWN, PERSPECTIVES].

28. Many Western societies have implicitly accepted the legality of, or more accurately, have refused to recognize the illegality of, passive euthanasia, although legislators and physicians scrupulously avoid using the technical term. Only the Netherlands, Belgium, and the state of Oregon have legalized active euthanasia, although recent court rulings in Japan hint that active euthanasia could be permitted in certain circumstances. Mendelson & Jost, *supra* note 6, at 130 n.121.

On the other hand, passive euthanasia in the form of physicians withdrawing life-sustaining treatment from competent, adult patients is permitted in the United Kingdom, Australia, Canada, Poland, Germany, France, Japan, and the United States. The Supreme Court of the United States and the United Kingdom's House of Lords have expressly authorized physicians to withdraw life sustaining care for the purpose of hastening death. *Id.* at 133.

In *Cruzan v. Mo. Dep't of Health*, the United States Supreme Court upheld the constitutionality of a Missouri law that required "clear and convincing proof" of an incompetent patient's wishes regarding euthanasia before a court could authorize the removal of life-sustaining nutrition and hydration therapy. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 287 (1990). While upholding Missouri's "clear and convincing" standard of proof requirement, the Supreme Court appeared to uphold the earlier holding of the New Jersey Supreme Court in *In re Quinlan* that a court may authorize, in appropriate cases, the withdrawal of life-sustaining medical care. *Id.*; *In re* Quinlan, 355 A.2d 647 (N.J. 1976), *cert. denied*, Garger v. New Jersey, 429 U.S. 922 (1976). In *Washington v. Glucksberg*, the Court later affirmed that patients have a constitutionally protected right to refuse lifesaving hydration. Washington v. Glucksberg, 521 U.S. 702, 723 (1997). Currently, virtually every U.S. state and the District of Columbia recognize the right of patients to request withdrawal of life-sustaining treatment. S. Elizabeth Wilborn Malloy, *Beyond Misguided Paternalism: Resuscitating The Right To Refuse Medical Treatment*, 33 WAKE FOREST L. REV. 1035, 1052–53 (1998).

Similarly, in the British Tony Bland case, the parents of an accident victim who had lapsed into a persistent vegetative coma sought to have his medical and nutritional care stopped in order to facilitate his death. When a public magistrate sought to prevent the hospital from withdrawing life-sustaining medical treatment, a majority of the five Law Lords who heard the case refused to enjoin the hospital from following the parents' wishes. Although the House of Lords preferred not to characterize the proposed withdrawal of life-support as euthanasia, which they understood to be illegal in English common law, their decision implicitly recognized a moral and legal distinction between active and passive euthanasia. KEOWN, PUBLIC POLICY, *supra* note 23, at 12–15.

"Voluntary" euthanasia refers to euthanasia performed upon the explicit and affirmative request of a patient.[29] In contrast, "involuntary euthanasia" signifies an act of euthanasia performed without the request or consent of the patient.[30] The term involuntary euthanasia itself is subject to confusion. For some, involuntary euthanasia implies situations where the patient did not provide consent but possessed the capacity to do so.[31] As such, involuntary euthanasia is different from "non-voluntary" euthanasia, which involves patients who lack the legal or physical capacity to provide consent.[32] Under this approach, non-voluntary euthanasia is the correct term to describe euthanasia performed on adult patients who are mentally incapacitated or infants who therefore lack the legal capacity to either provide or withhold consent. Other commentators reject this approach and characterize any euthanasia performed without an explicit and affirmative request as involuntary euthanasia.[33] Because of the host of conceptual problems raised by the distinction between involuntary and non-voluntary euthanasia, this Note will avoid the term non-voluntary euthanasia.[34]

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When the House of Lords Select Committee on Medical Ethics, in a reply to the Tony Bland decision, issued their Report one year later, the Law Lord's reluctance to refer to the withdrawal of care as "passive euthanasia" was only partly remedied. The Report of the House of Lords Select Committee on Medical Ethics chaired by Lord Walton of Detchant, characterized the term "passive euthanasia" as "misleading" and adopted the phrase "treatment-limiting decision." KEOWN, PUBLIC POLICY, *supra* note 23, at 96–100.

29. KEOWN, PUBLIC POLICY, *supra* note 23, at 96–100.

30. *Id.* at 9–12.

31. *See, e.g.*, Jocelyn Downie, *The Contested Lessons of Euthanasia in the Netherlands*, 8 HEALTH L.J. 119, 133 (2000) (responding to a report that as many as 14,691 patients were terminated without request in 1990, the author noted, "what [a critic] calls involuntary euthanasia is at worst non-voluntary euthanasia and cessation of treatment.").

32. *Id.*

33. *E.g.*, JOHN LADD, ETHICAL ISSUES RELATING TO LIFE AND DEATH 8–9 (John Ladd ed., 1979).

34. For example, consider the case of an adult, healthy individual who records a written request to receive euthanasia should the individual ever enter into a "lengthy" coma. One year later, the individual suffers an accident and lapses into a coma. Complying with the patient's earlier written request, the physician provides euthanasia to the comatose patient. Has the physician provided involuntary or non-voluntary euthanasia? Would the answer change if the patient had only been in the coma for two hours? What if the patient had lain comatose for two years? While the precise characterization of this and comparable examples are certainly open to debate, that debate provides only limited insight into the broader discussion of legalized euthanasia. Consequently, this Note will classify all cases where the patient has not made an explicit, affirmative request for euthanasia as involuntary euthanasia.

Physicians, legislators and social commentators frequently distinguish between euthanasia and physician-assisted suicide (PAS).[35] In the case of active voluntary euthanasia, a physician performs the actual step of administering the lethal treatment.[36] Individuals who request PAS perform the actual, volitional act of suicide but require the assistance of a physician to prescribe a suitable pharmaceutical agent to bring about death and to be present during the actual suicide to ensure the correct and effective utilization of that agent.[37] Although many of the same moral and legal issues arise under both PAS and euthanasia,[38] this Note will not directly address PAS. Moreover, because the Termination of Life Act treats PAS and voluntary euthanasia similarly, the legal distinctions between active voluntary euthanasia, on the one hand, and passive euthanasia or PAS on the other, have been rendered moot.[39]

"Palliative care" is the technical term for the medical care given to relieve the pain and symptoms caused by severe illness, but not intended to cure the underlying disease or condition itself.[40] "Terminal sedation" refers to the administration of high doses of pain relieving medications for the primary purpose of alleviating a patient's suffering, but with reasonable awareness that death may result.[41]

Dutch physicians, as well as the Ministry of Health, Sports, and Welfare, which is responsible for monitoring compliance with the Termination of Life Act, do not distinguish among passive and active euthanasia.

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35. KEOWN, PUBLIC POLICY, *supra* note 23, at 12–15.

36. *Id.*

37. Even with a physician present, patients who attempt PAS frequently experience medical complications. An analysis of the 1990 Van der Maas Report and 1995 Onwuteaka-Philipsen Report indicates that, in 16 percent of PAS cases, patients faced complications with completion, including longer-than-expected time to death, failure to induce coma, and induction of coma followed by awakening of the patient. *See, e.g.*, Johanna Groenewoud et al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 NEW ENG. J. MED. 551 (2000).

38. For example, opponents of euthanasia sometimes assert that efforts to decriminalize PAS represent political palatable tactics to pave the way for decriminalized voluntary euthanasia. Wesley J. Smith, *Continent Death: Euthanasia in Europe*, LIFENEWS.COM, http://www.lifenews.com/oped24.html (last visited Feb. 16, 2006). Jeff McMahan, a bioethicist, asserts, "[s]uicide and euthanasia are concepts with blurred edges. It is often unclear whether a certain act counts as suicide or whether an act is an instance of euthanasia." JEFF MCMAHAN, THE ETHICS OF KILLING: PROBLEMS AT THE MARGINS OF LIFE 455–56 (2002).

39. *See* Termination of Life Act, chs. 4-A, 4-B. *See also* EUTHANASIA: THE NETHERLANDS' NEW RULES, *supra* note 5, at 5.

40. *See* NEW YORK STATE TASK FORCE, *supra* note 5, at 35.

41. In Japan, courts refer to terminal sedation as "indirect" euthanasia, a classification not adopted in this Note. Mendelson & Jost, *supra* note 6, at 130 n.23.

The Termination of Life Act defines euthanasia as the "termination of a life on request" and regulates both euthanasia and PAS.[42] Thus, the Dutch have eliminated the legal distinction between "active" and "passive" euthanasia.[43] The official stance of the Dutch government is that all cases of euthanasia are, by definition, active and voluntary.[44] The Dutch government prosaically refers to cases that foreign observers would characterize as involuntary euthanasia as "ending of life without explicit request."[45]

### *B. The Dutch Historical Experience*

The Netherlands' enthusiastic acceptance of euthanasia invariably prompts the question, of all of the liberal democracies of Western Europe and industrialized nations of the modern world, why has the Netherlands taken the bold step of decriminalizing voluntary euthanasia?[46] Many commentators explain Netherlands' acceptance of voluntary euthanasia as a natural outgrowth of the country's historical tradition of progressive politics and religious tolerance.[47]

The Netherlands is a constitutional monarchy with a population of over 16.3 million inhabitants.[48] The Dutch won their independence from the

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42. Termination of Life Act, pmbl.

43. GOMEZ, *supra* note 16, at 16.

44. *See* Termination of Life Act, pmbl.; *see also* EUTHANASIA: THE NETHERLANDS' NEW RULES, *supra* note 5, at 2 ("The voluntary nature of the patient's request is crucial: euthanasia may only take place at the explicit request of the patient.").

45. *E.g.*, Van der Maas Report, *supra* note 15.

46. As previously noted, in September 2002 Belgium became the second country to legalize voluntary active euthanasia. Mendelson & Jost, *supra* note 6, at 130.

47. Netherlands' religious composition may be relevant for a variety of reasons. The historical presence of distinct religious minorities, with sometimes markedly different social customs and religious attitudes, appears to have instilled in the Dutch a highly deferential attitude towards personal belief systems. HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE 135–36 (1997), *citing* T.H.C. BUELLER, *The Historical and Religious Framework for Euthanasia in the Netherlands*, THE GOOD OF THE PATIENT, THE GOOD OF SOCIETY (R.I. Misbin ed., 1992). Professor A. van Dantzig, a retired expert in psychiatry, has asserted that, "[t]he whole of Dutch society is based on the cohabitation of people who fundamentally disagree on everything. The sometimes very creative solutions . . . have given rise to the word '*poldermodel*,' which expressly means living compromise, or as I have once put it, the fair division of discontent." Raphael Cohen-Almagor, *"Culture of Death" in the Netherlands: Dutch Perspectives*, 17 ISSUES L. & MED. 167, 175 n.17 (2001). On the other hand, Dutch religious tolerance should not be overstated. One vocal critique of euthanasia, Dr. G.F. Koerselman, reports that he has often been dismissed as a "Catholic fundamentalist," even though he was born Protestant and raised as a devout secularist. *Id.* at 172.

48. CIA WORLD FACTBOOK: THE NETHERLANDS, http://www.odci.gov/cia/publications/factbook (last visited Feb. 22, 2006).

Hapsburg Kings of Spain in the seventeenth century and, in the subsequent years, proceeded to develop a robust system of mercantilism and broad civic equality.[49] The Netherlands was an early center of Calvinist activism and, in later centuries, was renowned for its religious tolerance of both Jews and Roman Catholics.[50] Occupied by the Germans during World War II[51] and a central member of the North Atlantic Treaty Or-

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49. R.R. COLTON & JOEL COLTON, A HISTORY OF THE MODERN WORLD, 126–31 (6th ed. 1984).

50. HENDIN, *supra* note 47, at 135–36.

51. Until relatively recently, the collective memory of the Nazi occupation shaped many civilian attitudes towards euthanasia. In October 1939, German Chancellor Adolph Hitler signed an executive order instituting the T4 Euthanasia Program, named after the program's administrative offices at Tiergarten Strasse 4. Unlike the modern conception of voluntary euthanasia, which envisions the termination of a sick and suffering patient upon the patient's affirmative request, the Nazi euthanasia program represents an extreme manifestation of involuntary euthanasia as official government policy.

Administered by the Reich Chancellery under the direction of Philip Bouhler and Dr. Karl Brandt, the program targeted German nationals suffering from mental incapacity, insanity, or severe congenital birth defects. Various estimates put the number of patients killed between 50,000 and 250,000 German civilians, representing both adults and children. Physicians performed the medical screenings and selections. Patients selected for euthanasia were transferred to one of several state-run hospitals located inside the borders of pre-war Germany. Patients were killed either by lethal injection or by suffocation by carbon monoxide gas, delivered in specially constructed gas chambers designed to look like communal showers. Typically, the victims' relatives were later informed that the patients had died of communicable diseases.

Although no foreign prisoners and only one thousand German Jews were killed by the Nazi euthanasia program, T4 was a crucial testing period in which Nazi physicians and bureaucrats developed the techniques later used in the extermination camps in Poland and Eastern Europe. For example, the T4 program perfected the use of gassings to kill large numbers of prisoners, while Franz Stabgl, commandant of the Sorbibor and Treblinka extermination camps, and Christian Wirth, commander of the Chemlno extermination camp, both received their operational training as T4 euthanasia technicians. The T4 program was discontinued in August 1941, shortly before Germany's invasion of Russia, largely due to massive public protests lead by Germany's Catholic and Protestant religious communities. In 1942, S.S. Reichsfurher Heimlich Himmler reassigned the entire former staff of the T4 program to Operation Reinhard, the Nazi campaign to exterminate Polish Jewry.

Germany invaded the Netherlands on May 10, 1940 and continued to occupy the Netherlands until 1945, by which point over 107,000 Dutch Jews had been deported. Approximately 102,000 died in the Auschwitz, Sorbibor, and Bergen-Belsen death camps. Many thousands of other Dutch civilians were also deported to concentration camps in Nazi-occupied Europe, however, aside from the Jewish population, Dutch deportees were not generally targeted for extermination. Although no Dutch nationals died in the T4 program, the Nazi occupation of the Netherlands continues to shape opinions regarding euthanasia, and in the minds of many elderly Dutch citizens, euthanasia remains synonymous with state-sanctioned murder. *See generally* SMITH, *supra* note 13, at

ganization,[52] Netherlands was later a founding member of the European Union.[53] More recently, the country has adopted progressive policies in its regulation of recreational drug use and prostitution, and remains at the forefront in developments of international human rights law.[54]

Like many other nations of the European Union, the Dutch are committed to the principle of universal access to health care and health insurance.[55] Health care is financed via a mixture of mandatory employment-related health insurance and population-wide coverage of long-term care.[56] Private health care providers deliver the bulk of health care services.[57] Unsurprisingly, advocates for legalized euthanasia point to the availability of universal health and long-term care as evidence that the financial pressure of continuing treatment has not improperly influenced patients who request euthanasia.[58] On the other hand, some physicians have noted that the Netherlands currently faces a shortage of nursing homes and nursing staff.[59]

The Dutch enjoy one of the highest life expectancies and lowest death rates of the industrialized world.[60] Between 120,000 and 140,000 people

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40–43; DANIEL JONAH GOLDHAGEN, HITLER'S WILLING EXECUTIONERS 119 (1997); MILTON MELTZER, NEVER TO FORGET: THE JEWS OF THE HOLOCAUST 131 (1976); RICHARD RHODES, MASTERS OF DEATH: THE SS-EINSATZGRUPPEN AND THE INVENTION OF THE HOLOCAUST 155–61 (2002); *The T4 Euthanasia Program*, JEWISH VIRTUAL LIBRARY, http://www.jewishvirtuallibrary.org/jsource/Holocaust/t4.html (last visited Feb. 22, 2006).

52. North Atlantic Treaty, *ratified* Aug. 24, 1949, 34 U.N.T.S. 243.

53. The Member States of the European Union: The Netherlands, http://europa.eu.int/abc/european_countries/eu_members/netherlands/index_en.htm (last visited Feb. 22, 2006).

54. *See* Belian, *supra* note 9, at 256 ("As harbingers of liberal social change, the Dutch hold an almost prophetic role as they work through the tangles of contemporary moral and legal debates.") .

55. NETHERLANDS INSTITUTE FOR HEALTH SERVICES RESEARCH, INTERNATIONAL PUBLICATION SERIES, HEALTH CARE, HEALTH POLICIES AND HEALTH CARE REFORMS IN THE NETHERLANDS 5 (2001), *available at* http://www.minvws.nl/images/Healthcare07_tcm11-45335.pdf.

56. *Id*.

57. *Id.* at 6.

58. *E.g.*, Leonard M. Fleck, *Just Caring: Assisted Suicide and Health Care Rationing*, 72 U. DET. MERCY L. REV. 873, 879 ("[T]he Dutch have in place a scheme of national health insurance. Therefore, there are no unsavory financial incentives motivating terminally ill Dutch individuals to opt for 'voluntary' euthanasia.").

59. Raphael Cohen-Almagor, *Non-voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives*, 18 ISSUES L. & MED. 239, 253 (2003).

60. The current average life expectancy is 76.68 years at birth, while the Dutch suffer 0.67 deaths per 1,000 inhabitants. In comparison, Americans suffer 8.34 deaths per 1,000 inhabitants and enjoy an average life expectancy of 77.43 years, while the United King-

died each year from 2000 to 2003, while 55,000 of those typically expired from non-acute disease.[61] According to official estimates, approximately 44 percent of all deaths involved end-of-life medical decisions[62] while less than 3 percent of all deaths involve active voluntary euthanasia.[63]

### *C. Overview of the Dutch Legal System*

The Netherlands' legal system is a relatively typical European civil code system.[64] Unlike the American adversarial system, the Dutch legal system is consensual, meaning that public prosecutors, judges, and litigators work together to arrive at decisions that meet the needs of the entire community.[65] Public prosecutors play a role in implementing public policy, and may waive prosecution of any criminal offense on the grounds that the criminal offense could be more effectively dealt with using non-prosecutorial measures, for example, resorting to community involvement.[66] Prosecutors are expressly required to refrain from prosecution if such prosecution does not serve the public interest, a subjective standard that the prosecutor alone has authority to determine.[67] Although active voluntary euthanasia remained technically illegal until the enactment of the Termination of Life Act in 2001, for almost two decades prosecutors declined to charge doctors who performed active euthanasia within the limits suggested by the Dutch Supreme Court in 1984.[68]

As a member state of the European Union, the Netherlands' national laws are subject to the European Convention on Human Rights and Fun-

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dom suffers 10.19 deaths per 1,000 inhabitants and has an average life expectancy of 78.27 years. *See* CIA WORLD FACTBOOK: THE NETHERLANDS, http://www.odci.gov/cia/publications/factbook (last visited Feb. 22, 2006).

61. The leading causes of death include cancer, chronic heart failure, and cerebrovascular disease. Sixty-five percent of Dutch cancer related deaths occur at home, while 25 percent occur in a hospital and less than 1 percent in a hospice. NETHERLANDS INSTITUTE FOR HEALTH SERVICES RESEARCH, INTERNATIONAL PUBLICATION SERIES HEALTH, WELFARE AND SPORT NO. 16, PALLIATIVE CARE FOR TERMINALLY ILL PATIENTS IN THE NETHERLANDS 4–5 (2003), *available at* http://www.minvws.nl/images/palliative_eng_tcm11-45291.pdf.

62. *Id.* at 29. End-of-life medical decisions include express requests for PAS and euthanasia as well as decisions to forego available medical treatment, such as additional invasive therapies or life-sustaining nutrition and hydration.

63. Onwuteaka-Philipsen Report, *supra* note 15, tbl. 1.

64. Mendelson & Jost, *supra* note 6, at 130.

65. Hendin, *supra* note 19, at 236.

66. JULIA FIONDA, PUBLIC PROSECUTORS AND DISCRETION: A COMPARATIVE STUDY 98–99 (1995).

67. Belian, *supra* note 9, at 258–59.

68. *See generally* Mendelson & Jost, *supra* note 6, at 130.

damental Freedoms.[69] As such, Dutch courts are bound by the decisions of the European Court of Human Rights.[70] Significantly, in the same month that the Termination of Life Act went into effect, the European Court of Human Rights held in *Pretty v. United Kingdom* that the Convention does not confer upon citizens an affirmative right to euthanasia, although apparently the Convention does not preclude the Dutch government from permitting voluntary euthanasia.[71]

Before the Termination of Life Act went into effect on April 1, 2002, Article 293 of the Dutch criminal code, the *het Wetboek van Strafecht*, prohibited any individual from killing another at the latter's request. An

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69. European Convention for the Protection of Human Rights and Fundamental Freedoms, *opened for signature* Apr. 11, 1950, 213 U.N.T.S. 221 (entered into force Sept. 3, 1953) [hereinafter Convention on Human Rights]; *see also* Mendelson & Jost, *supra* note 6, at 130.

70. Mendelson & Jost, *supra* note 6, at 130.

71. Diane Pretty, a British subject, suffered from motor neurone disease, a degenerative illness. As the disease progressed and she became paralyzed, Mrs. Pretty decided that she wanted to commit suicide but lacked the physical capacity to do so. *Id.* at 68. She petitioned the British Director of Public Prosecutions for an exception that would allow her husband to escape criminal sanction if he assisted her in committing suicide. *Id.* at 68–69. After the prosecutor refused her petition and the House of Lords denied her appeal, Mrs. Pretty sued the British government in the European Court of Human Rights, alleging that the British government's position amounted to violations of Articles 2, 3, 8, 9 and 14 of the Convention. *Id.* at 67.

Mrs. Pretty alleged that, because the United Kingdom had abolished the felony of suicide in 1961, the British law prohibiting a person from assisting in another's suicide constituted discrimination against individuals who, like Mrs. Pretty, were paralyzed and could not take their own lives. *Id.* at 88. Moreover, Article 2 of the Convention, which protects the "right to life" and narrowly regulates the permissible deprivation of life by state actors, also guaranteed a converse right to die. *Id.* at 75. Finally, Mrs. Pretty alleged that, by failing to provide assistance in her attempt to commit suicide, the United Kingdom was subjecting her to "inhuman or degrading treatment" in violation of the Article 3 prohibition against the use of torture. *Id.* at 77.

In a widely read and much anticipated decision, the European Court of Human Rights in a unanimous decision held against Mrs. Pretty on every count. The court rejected the contention that Article 2 contained a "negative aspect." *Id.* at 77. In other words, the Convention protects individuals' rights to life from violation by the government or individuals, but does not create a right to choose the manner of one's own death. *Id.* at 81. The court affirmed that Article 3 pertained to the intentional use of state power and imposed a obligation on states not to inflict serious harm on persons within their jurisdiction. Article 3 does not establish the countervailing responsibility to prevent all harm to such persons. *Id.* Finally, the court declined to recognize Mrs. Pretty's class of persons, namely those who are physically unable to commit suicide, as a class warranting protection under the Convention. *Id.* at 86. In short, the European Court on Human Rights held that the Convention did not confer a "right to die" and therefore upheld the authority of signatory states to proscribe active euthanasia. *See* In the case of Pretty v. United Kingdom, Eur. Ct. H.R. 423 (2002), *reprinted in* 18 ISSUES L. & MED. 67, 71 (2002).

individual found guilty of such an offense may have been sentenced to up to twelve years of imprisonment.[72] Article 294 of the code prohibited an individual from assisting or inciting another person to commit suicide,[73] with a possible sentence of three years of imprisonment.[74]

The Dutch criminal justice system recognizes the *noodtoestand* defense, variously translated as force majeure,[75] choice-of-evils,[76] or the defense of necessity.[77] The *noodtoestand* defense states that an individual, when faced with two conflicting duties, may violate one law in order to avoid violating another law or principle of greater moral significance.[78] Alternatively, the choice may be characterized as one in which the individual chooses the "least unacceptable" option available.[79] Thus, an innocent bystander, seeing a pedestrian about to be run over by a speeding car, may be excused for the crime of battery when the bystander pushes the pedestrian out of the way in order to prevent the pedestrian's death.[80] Article 40 of the Dutch Penal Code codifies the *noodtoestand* principle.[81] The Dutch concept of *noodtoestand* remains significant because Dutch courts have come to rely on it, as codified in Article

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72. *See* SR art. 293 (Neth.), *translated in* AMERICAN SERIES OF FOREIGN PENAL CODES, THE DUTCH PENAL CODE 200 (Louise Rayar trans., 1997) [hereinafter AMERICAN SERIES OF FOREIGN PENAL CODES].

73. *See* SR art. 294 (Neth.), *translated in* AMERICAN SERIES OF FOREIGN PENAL CODES, *supra* note 72, at 200. Indeed, the criminal prohibition of assistance with or incitement to suicide predated the adoption of the Dutch Penal Code in 1886. *See also* Mendelson & Jost, *supra* note 6, at 130.

74. *See* SR art. 294 (Neth.), *translated in* AMERICAN SERIES OF FOREIGN PENAL CODES, *supra* note 72, at 200.

75. *E.g.*, GOMEZ, *supra* note 16, at 37–38. "Force majeure" is French for "a superior force" and in Anglo-American jurisprudence refers to "[a]n event or effect that can be neither anticipated nor controlled." BLACK'S LAW DICTIONARY 657 (7th ed. 1999).

76. *See* GOMEZ, *supra* note 16, at 37–38.

77. Some commentators have asserted that the passage of the Termination of Life Act merely provided statutory basis for physicians' previously recognized de facto immunity from prosecution. *E.g.*, Nicholson, *supra* note 12, at 9.

78. *See* KEOWN, PUBLIC POLICY, *supra* note 23, at 84–85.

79. GOMEZ, *supra* note 16, at 37–38.

80. *See generally* Belian, *supra* note 9, at 261. Unlike English and American legal systems, the Dutch do not appear to distinguish among legal excuses, defenses, and excuses. *See generally* AMERICAN SERIES OF FOREIGN PENAL CODES, *supra* note 72, at 73–74 (listing statutory provisions which may either decrease or increase liability for otherwise criminal conduct).

81. *See* SR art. 40 (Neth.), *translated in* AMERICAN SERIES OF FOREIGN PENAL CODES, *supra* note 72, at 73.

40, as the doctrinal justification for the legality of both active voluntary and, as will be seen, active involuntary euthanasia.[82]

One last feature of the Dutch legal system concerns the Medical Assistance Act of 1994, which entered into force in 1995.[83] The Medical Assistance Act codifies the principle of informed consent, the common law doctrine that all legally competent adult patients must consent to treatment prior to undergoing medical care.[84] As a corollary, the doctrine of informed consent states that patients enjoy the right to refuse unwanted medical care, including potentially life-saving care.[85] Physicians have the duty to explain, in lay terms, the nature of a patient's condition, a description of any proposed treatment or therapy, the risks associated with the proposed treatment, and the availability of any alternative treatments.[86] Patient rights law in the Netherlands therefore mirrors the informed consent laws of most other developed nations.[87]

## III. THE DUTCH APPROACH TO REGULATING EUTHANASIA

### *A. Euthanasia Case Law*

Prior to 2002, active euthanasia remained technically illegal under Article 293 of the Dutch Penal Code.[88] Public prosecutors and the courts therefore turned to the principle of *noodtoestand* to justify euthanasia and excuse physicians from criminal penalties.[89] The first case that expressly decriminalized euthanasia occurred in the town of Alkmaar in 1984. In the *Alkmaar* case, the Dutch Supreme Court reversed the conviction of a

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82. *See* Welie, *supra* note 9, at 42–43; *see generally* Ubaldus de Vries, *A Dutch Perspective: The Limits of Lawful Euthanasia*, 13 ANN. HEALTH L. 365 (2004).

83. Nel Koster, *Patient Rights and Patient Education in the Netherlands*, UNIV. NOTTINGHAM STUDENT HUMAN RIGHTS LAW CENTRE, May 19, 1997, *available at* http://www.nottingham.ac.uk/law/hrlc/hrnews/may97/koster.htm.

84. *Id.*

85. *Id.*

86. T. PATRICK HILL & DAVID SHIRLEY, THE NATIONAL COUNCIL FOR THE RIGHT TO DIE, A GOOD DEATH: TAKING MORE CONTROL AT THE END OF YOUR LIFE 7–8 (Sharon Sharp ed., 1992).

87. All common law and most civil code systems presume the right of competent adults to consent or refuse medical intervention, including life-sustaining treatment, unless that presumption is rebutted. Mendelson & Jost, *supra* note 6, at 130.

88. *See* SR art. 293 (Neth.), *translated in* AMERICAN SERIES OF FOREIGN PENAL CODES, *supra* note 72, at 200.

89. The irony of using *noodtoestand* defense in euthanasia cases has not been lost on some foreign commentators. Article 293 was adopted to discourage suicide by imposing criminal sanctions on individuals who assist in suicide. In essence, reliance on *noodtoestand* allows Dutch courts to use a legal exception in order to nullify a law that was created to eliminate the exception. GOMEZ, *supra* note 16, at 25.

physician who had performed euthanasia on a ninety-five year old woman whose health was deteriorating.[90] The woman suffered from moderate but not "acute" pain and was not facing imminent death.[91] In pronouncing the defendant guilty but imposing no punishment, the district court rejected the physician's attempt to establish a *noodtoestand* defense. The defendant argued that he had attempted in good faith to resolve his conflicting duties, namely, to observe the Article 293 prohibition against killing another individual and his duty to respond to the patient's request to alleviate her unbearable suffering.[92] The defendant, with assistance from the Netherlands Society for Voluntary Euthanasia,[93] appealed to the Dutch Supreme Court, which overturned his conviction and ordered the district court to reconsider the *noodtoestand* defense.[94]

Interestingly, the Dutch Supreme Court rejected the defendant's initial theory of the case. The defendant had agued that the ethical conflict involved his duty to obey Article 293, on the one hand, and his professional responsibility to respect his patient's right to personal autonomy, on the other.[95] Disposing of the personal autonomy argument, the court noted that the district court had overlooked the physician's duty to alleviate his patient's suffering according to the prevailing standards of medical ethics.[96]

The Supreme Court's line of reasoning significantly influenced the conceptual development of euthanasia law. First, the court expressly denied the significance, as a determinative factor in euthanasia cases, of the patient's right to personal autonomy, manifest here as her right to determine the course of her own medical treatment.[97] Secondly, the *Alkmaar* case established the precedent in which Dutch courts would turn to the medical profession itself to develop the ethical standards through which the courts would legitimize physician conduct.[98] The court's adoption of

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90. This case is variously referred to as the "*Schoonheim* case," after the name of the physician defendant, or the "*Alkmaar* case," after the name of the town where the events occurred. *E.g.*, Belian, *supra* note 9, at 267–68.

91. *Id.*

92. Mendelson & Jost, *supra* note 6, at 130.

93. GOMEZ, *supra* note 16, at 36.

94. Belian, *supra* note 9, at 268–71.

95. GOMEZ, *supra* note 16, at 36.

96. KEOWN, PUBLIC POLICY, *supra* note 23, at 85. The Dutch Supreme Court appears to have relied on the beneficent approach to medical ethics, which holds that it is the physician's prerogative, as opposed to the patient's right, to decide the proper course of medical treatment.

97. *See* Downie, *supra* note 31, at 124.

98. Belian, *supra* note 9, at 270.

these two principles would later result in increased legal acceptance of involuntary euthanasia.

Soon after the *Alkmaar* case was decided, the Royal Dutch Medical Association (KNMG) published a set of "due care" guidelines that purported to define the circumstances in which Dutch physicians could ethically perform euthanasia.[99] The KNMG guidelines stated that, in order for a physician to respond to a euthanasia request with due care, the euthanasia request must be voluntary, persistent, and well-considered.[100] The patient must suffer from intolerable and incurable pain and a discernable, terminal illness.[101] Thereafter, Dutch courts adopted the KNMG guidelines as the legal prerequisites of due care in a series of cases between 1985 and 2001.[102]

Despite the integration of the KNMG's due care provisions, courts remained confused regarding what clinical circumstances satisfied the requirements of due care. In 1985, a court acquitted an anesthesiologist who provided euthanasia to a woman suffering from multiple sclerosis.[103] The court thereby eliminated the due care requirement that a patient must suffer from a terminal illness. By 1986, courts decided that a patient need not suffer from physical pain; mental anguish would also satisfy the "intolerable pain" due care requirement.[104] Similarly, all reported prosecutions of euthanasia prior to 1993 involved patients who suffered from either physical or mental pain.[105] Then, in the 1993 *Assen* case, a district court acquitted a physician who had performed active voluntary euthanasia on an otherwise healthy, forty-three year old woman.[106] The patient did not suffer from any diagnosable physical or mental condition, but had recently lost both of her sons and had divorced her husband.[107] With the *Assen* case, Dutch courts seemed to abandon the requirement that a pa-

99. KEOWN, PUBLIC POLICY, *supra* note 23, at 83.

100. *Id.*

101. *Id.*

102. HENDIN, *supra* note 47, at 47–48.

103. Downie, *supra* note 31, at 125. Multiple sclerosis is an inflammatory disease of the central nervous system. Although extremely painful and massively debilitating, multiple sclerosis is not typically terminal. *See* TABERS'S CYCLOPEDIC MEDICAL DICTIONARY 1156–57 (C.K. Thomas ed., 16th ed. 1989).

104. Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427, 428 (1996).

105. HENDIN, *supra* note 47, at 48.

106. The 1993 case against Dr. Chabot is frequently referred to as the "*Assen* case," after the city in which the trial was held. *Id.* at 47–48.

107. *Id.*

tient suffer from intolerable pain or, for that matter, from any discernable medical condition as a pre-condition for the *noodtoestand* defense.[108]

By 1999, Dutch euthanasia case law seemed to have weakened the "voluntary and well-considered request" requirement as well. Public prosecutors declined to bring charges against a physician who acquiesced to a request for PAS from a seventy-one year old male patient with vascular dementia.[109] Because the patient was suffering from a degenerative psycho-organic disorder, the patient's hospital organized a consultation by the hospital's chief psychiatrist, a committee of independent medical professionals, and an external psychiatric consultant.[110] After the review committee and other consultants concluded that the patient possessed the requisite mental competence to make a PAS request, the patient's doctor prescribed a high-dose barbiturate solution.[111] However, the patient did not actually drink the solution and commit suicide until four months after his psychiatric evaluation.[112] In those four months, there appears to have been no effort to continue to monitor the patient's mental capacity.

Through these series of decisions, Dutch courts diluted most of the due care requirements first articulated by the KNMG guidelines.[113] Indeed, foreign critics saw incontrovertible evidence that the Netherlands had descended the slippery slope towards completely unfettered euthanasia-on-demand.[114] Other detractors went further, arguing that the Dutch at-

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108. Since the *Assen* court acquitted Dr. Chabot in 1993, the court's holding that a patient need not suffer from a diagnosable medical condition is no longer valid under Dutch case law. In 2003, after the Termination of Life Act went into effect, the Dutch Supreme Court ruled in the *Sutorius* case that "being tired of life" was not a sufficient reason for assenting to a patient's request for active euthanasia. In that decision, the court upheld the conviction of Dr. Sutorius, who had performed euthanasia on former Dutch senator Edward Brongersma. An Amsterdam court had convicted Dr. Sutorius under Article 293 of the Dutch Penal Code but had imposed no penalty. Responding to his appeal, the Dutch Supreme Court held that a patient's suffering must be linked to a recognized physical or mental condition. Tony Sheldon, *Being Tired is Not Grounds for Euthanasia*, 326 BRIT. MED. J. 71 (2003).

109. Tony Sheldon, *Euthanasia Endorsed in Dutch Patient with Dementia*, 319 BRIT. MED. J. 75 (1999).

110. *Id.*

111. *Id.*

112. *Id.*

113. *See id.*

114. For example, one witness, testifying before the Canadian Senate Committee on Euthanasia and Assisted Suicide, asserted, "Netherlands is no longer on the slippery slope; it has turned into Niagara Falls. . . ." Downie, *supra* note 31, at 119 n.2; GOMEZ, *supra* note 16, at 38–39.

There are three different types of slippery slope arguments that critics of the Dutch euthanasia system rely upon. First, some critics argue that legalization increases the frequency and volume of cases of voluntary euthanasia. As Jocelyn Downie demon-

tempt to regulate euthanasia failed to prevent involuntary euthanasia as well.[115]

The Dutch appeared to have crossed the Rubicon when, in December 2004, the Groningen Academic Hospital announced new guidelines that would permit physicians to perform involuntary euthanasia on severely handicapped newborn infants.[116] Equally troubling, the hospital revealed that it had already performed four such killings in 2004[117] and had been performing similar procedures since at least 2000.[118] The revelation coincided with reports that the KNMG had asked the Ministry of Health, Sports, and Welfare to recommend new guidelines that would permit involuntary euthanasia for "children, the severely mentally retarded and patients in irreversible comas."[119] Predictably, this latest evidence of involuntary euthanasia has engendered a fresh wave of alarm among international observers.[120]

Netherlands' euthanasia case law suggests three primary findings. First, rather than addressing euthanasia as a question of patients' rights or self-determination, Dutch courts frame the euthanasia debate as a question of prevailing medical ethics.[121] Second, by defining the extent of a physician's duty in terms of "prevailing standards of medical ethics," and by adopting the KNMG's proposed practice guidelines as binding law, Dutch courts institutionalized a broad degree of deference to the opinions

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strates, the empirical data provided by three consecutive studies indicates that this argument is not valid; after an initial increase in the number of voluntary euthanasia cases between 1990 and 1995, the number of voluntary euthanasia cases appears to have stabilized from 1995 through 2001. Downie, *supra* note 31, at 135.

The second slippery slope argument, dubbed the comparative international argument, asserts that the Netherlands' euthanasia policy has resulted in a relative higher incidence of euthanasia in Netherlands compared to other nations. Although Ms. Downie asserts that data exists that suggests this argument is false with respect to Australia, there is simply insufficient reliable data regarding the incidence of euthanasia in most other countries to prove the veracity or falsehood of this argument. *Id.* at 136.

Finally, a third version of the slippery slope is the argument that, by decriminalizing voluntary active euthanasia, the Dutch approach has inoculated Dutch physicians, the courts, and society against the unacceptability of involuntary euthanasia. *E.g.*, KEOWN, PUBLIC POLICY, *supra* note 23, at 70.

115. HENDIN, *supra* note 47, at 23.

116. Horsnell, *supra* note 1, at 13.

117. *Id.*

118. Casey Research: What We Now Know, *Euthanasia: The Netherlands' Slippery Slope*, Dec. 14, 2004, http://www.howestreet.com/story.php?ArticleId=815 [hereinafter Casey Research].

119. *The Dutch Ponder "Mercy Killing" Rules*, CNN.COM (Dec. 1, 2004), http://www.cnn.com/2004/HEALTH/12/01/netherlands.mercykill/index.html.

120. *E.g.*, Casey Research, *supra* note 118.

121. GOMEZ, *supra* note 16, at 36–37.

and social judgments of the medical community.[122] Finally, the KNMG guidelines, originally intended to safeguard against physician abuse, have consistently failed to prevent Dutch physicians from performing euthanasia in a widening array of clinical circumstances.[123] These findings indicate that the courts have abrogated at least some of their responsibility to serve as an independent check on physician conduct.

### *B. The 2002 Termination of Life on Request and Assisted Suicide Act*

As previously noted, the Termination of Life Act codifies, with several minor but important modifications, substantially all of the due care requirements adopted by Dutch courts since 1984.[124] Technically, both active voluntary euthanasia and PAS remain criminal offenses under the Dutch Penal Code.[125] However, the Act grants a statutory exemption for a physician who performs active voluntary euthanasia when the physician satisfies the requirement of due care and subsequently notifies the municipal pathologist.[126] Significantly, the Act does not address involuntary euthanasia or terminal sedation. Presumably, both practices remain illegal, but as with active voluntary euthanasia prior to 1984, physicians who perform involuntary euthanasia or terminal sedation rarely face serious criminal penalties.[127]

The first requirement of due care states that the physician who seeks to perform euthanasia must "hold the conviction that the request by the patient was voluntary and well-considered."[128] The Act thus dispenses with the requirement, first suggested in the 1984 KNMG guidelines, that the

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122. *See generally* Belian, *supra* note 9.

123. As one vocal Dutch critic of the legalization of euthanasia has stated, "[i]f we today accept the intentional killing of a patient as a solution for one problem, then tomorrow we will find a hundred problems for which killing must be accepted as a solution." Gunning, *supra* note 12.

124. *See generally* Mendelson & Jost, *supra* note 6, at 130.

125. Termination of Life Act, chs. 4-A, 4-B.

126. *Id.*

127. For example, Dr. Wilfred van Oijen, an active euthanasia advocate who appeared in a 1994 television documentary on euthanasia, was convicted of murder in November of 2004. Dr. van Oijen had injected a lethal dose of alcuronium chloride into an eighty-four year old comatose patient. The patient had made no previous euthanasia request and was expected to die within 48 hours. The Dutch Supreme Court held that Dr. van Oijen's conduct failed to satisfy both the due care requirements of the Termination of Life Act and the prevailing standards of palliative care, and therefore was guilty of murder. After seven years of trials and appeals, Dr. van Oijen received a one week suspended sentence. Tony Sheldon, *Two Test Cases in Netherlands Clarify Law on Murder and Palliative Care*, 328 BRIT. MED. J. 1206 (2004).

128. Termination of Life Act, ch. 2, art. 2(1)(a).

patient's request was "durable" and "persistent."[129] More importantly, the earlier KNMG guidelines indicated that the patient's request must be free and voluntary, while the new Termination of Life Act only requires that the physician "hold the conviction" that the patient's request is free and voluntary.[130] The Act, therefore, appears to adopt a less rigorous standard than the KNMG guidelines.

Similarly, the second requirement of due care states that the physician must "hold the conviction that the patient's suffering was lasting and unbearable."[131] Like the "voluntary and well-considered" element, the emphasis on the "lasting and unbearable suffering" requirement is not on the patient's actual state of suffering, but rather the physician's subjective belief. Moreover, the Termination of Life Act does not define "suffering" as either physical or emotional pain, nor does the Act provide objective criteria or clinical indicators that would assist physicians or prosecutors in determining whether a patient's actual suffering fits the statutory standard.

The clinical due care requirement states that the patient must "hold the conviction that there was no other reasonable solution for the situation he was in."[132] Unlike the "voluntary and well-considered" and "lasting and unbearable suffering" requirements, the "no other solution" criteria places the emphasis on the patient's subjective beliefs. Ironically, the availability of other medical solutions represents the one due care requirement that physicians, by virtue of their professional training and clinical expertise, are better positioned than patients to decide. Once again, the Termination of Life Act appears to have misallocated the responsibilities between the physician and the patient.

Regarding the Act's procedural requirements, a physician must, as a preliminary step, have informed the patient about the "situation he was in and his prospects."[133] This procedural protection represents a reaffirmation of the doctrine of informed consent first codified in the Medical Assistance Act of 1994.[134] Finally, the Act also requires that the physician consult with a colleague prior to performing the requested euthanasia.[135]

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129. KEOWN, PUBLIC POLICY, *supra* note 23, at 85. The old standard of "durable and persistent" incorporated the important dimension of time, whereas the new standard presumably dispenses with the requirement that a patient's desire to undergo euthanasia be maintained for any discernable length of time.

130. Termination of Life Act, ch. 2, art. 2(1)(a).

131. *Id.* ch. 2, art. 2(1)(b).

132. *Id.* ch. 2, art. 2(1)(d).

133. *Id.* ch. 2, art. 2(1)(c).

134. Koster, *supra* note 83.

135. Termination of Life Act, ch. 2, art. 2(1)(e).

The Act stipulates that the physician consulted must actually see the patient and provide a written opinion as to whether the patient meets the statutory requirements of due care.[136] Once the requirements of due care are met and the euthanasia is performed, the physician must notify the municipal pathologist and document the patient's death as termination from non-natural causes.[137] The pathologist, in turn, is required to perform an autopsy to determine how the euthanasia was performed and to provide independent documentation of the event.[138] Finally, all cases of euthanasia must be reported to one of five regional euthanasia review committees who are charged with ensuring physician compliance with the due care requirements.[139]

The due care provisions are striking for what basic procedural protections appear to be missing. First, it remains unclear what specific information or technical details regarding euthanasia the physician must disclose to the patient.[140] Likewise, the physician is not obligated to obtain formal documentation of consent. There is no mandatory waiting period. Patients are not required to undergo a psychiatric screening or other mental competency evaluation. The Act does not specify what types of physicians are permitted to perform euthanasia.[141] Finally, the only procedural protections that involve non-physicians, namely, the post-mortem evaluation by the pathologist and documentary review by the regional review committees, occur after the patient has already died.[142] In other words, the Termination of Life Act relies solely on physician self-regulation and after-the-fact review to identify and prevent cases of involuntary euthanasia.

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136. *Id.*

137. NETHERLANDS' NEW RULES, *supra* note 5, at 7.

138. *Id.*

139. The review committees consist of, at a minimum, one lawyer, one bioethicist, and one physician. Members are paid for their services, may be removed at any time without cause, and serve as a clearinghouse for euthanasia data and liaison among the physician community, national government, and local public prosecutors. Termination of Life Act, ch. 3, arts. 3–19.

140. For example, Dutch physicians have noted that the euthanasia procedure itself sometimes results in clinical complications, including failure to induce coma, induction of coma followed by the patient's re-awakening, and longer-then-expected time until death. Johanna H. Groewoud et al., *Clinical Problems with the Performance of Euthanasia and PAS in the Netherlands*, 34 N.E. J. MED. 551 (2000).

141. Apparently, radiologists, dermatologists, and foot surgeons may perform euthanasia with equal competence as internists or anesthesiologists. The only limitation appears to be the general standard of due care which, as previously noted, represents a completely self-defining standard for the medical profession.

142. Termination of Life Act, ch. 3, art. 3.

## IV. ANALYSIS OF THE EMPIRICAL EVIDENCE REGARDING EUTHANASIA

### *A. Source of Data and Methodology*

The preceding sections traced the decriminalization of euthanasia by Dutch courts, the adoption and subsequent deterioration of the due care requirements recommended by the leading Dutch medical society,[143] and the expansion of the situations and circumstances in which euthanasia might be considered accepted medical practice.[144] Growing public support for euthanasia culminated in the passage of the Termination of Life Act in 2002.[145] When the Dutch Supreme Court first decriminalized euthanasia in 1984, however, physicians, patient advocates, and the Dutch government all lacked hard data concerning the frequency and nature of actual euthanasia practice.

In response to the public debate and growing body of case law, the Dutch government commissioned the first nationwide study of euthanasia and PAS in the Netherlands in 1990.[146] The resultant Remmelink Report constituted a comprehensive study of end-of-life medical decision.[147] The government commissioned similar studies in 1995 with the Van der Maas Report and again in 2001 with the Onwuteaka-Philipsen Report.[148] These reports provide unparalleled information regarding the frequency of euthanasia during the specific years studied and general trends regarding euthanasia and end-of-life treatment decisions in a modern industrialized society.[149]

For each study, the researchers conducted a series of interviews with approximately 400 general practitioners, specialists, and nursing home

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143. *Id.* ch. 2, art. 2.

144. *Id.*

145. *Id.* chs. 3, arts. 4-A, 4-B. It is perhaps significant that, although the Netherlands' euthanasia regime is the most far reaching and therefore classically liberal regulatory regime of all developed nations, the legalization of voluntary active euthanasia was ultimately achieved through the electoral political process. In the United States, developments in the law relating to end-of-life medical decisions have typically occurred through litigation. *Cf.* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 287 (1990) (passive voluntary euthanasia); Roe v. Wade, 410 U.S. 113 (1973) (abortion); Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Or. 2002) (PAS).

146. The commission was chaired by the attorney general of the Dutch Supreme Court, Professor Jan Remmelink. Van der Maas Report, *supra* note 15.

147. Cohen-Almagor, *supra* note 59, at 240–41.

148. *See* Van der Maas Report, *supra* note 15 at 1699; Onwuteaka-Philipsen Report, *supra* note 15, at 1. In addition, the original 272-page Dutch version of the Onwuteaka-Philipsen Report has been translated and analyzed by Dr. Richard Fenigsen for his own research. His findings were published in 2004. Fenigsen, *supra* note 20.

149. The 2001 report provides summary data comparing the results of the 1990, 1995, and 2001 studies. *See* Onwuteaka-Philipsen Report, *supra,* note 15, at 1–5.

physicians.[150] The researchers adopted strict procedural safeguards to ensure the anonymity of both the physician interview subjects and the deceased patients.[151] In addition to the interview component of each study, researchers analyzed large samples of death certificates provided by the Dutch government, representing over 40,000 deaths in each of the three studies and encompassing the entire universe of natural and non-natural deaths.[152]

Foreign observers note that the government-ordered studies reflect the distinct usages and phrases of the Dutch approach to euthanasia. For example, the studies eschew the term involuntary euthanasia in favor of the phrase, "ending of life without a patient's explicit request."[153] Likewise, the authors avoid the term "terminal sedation" in favor of "alleviation of symptoms with possible life-shortening effect."[154] "Euthanasia" in the official reports refers to active voluntary euthanasia, while cases which might otherwise be classified as passive voluntary euthanasia are generally described as "non-treatment decisions."[155] Consequently, foreign observers may interpret the empirical data differently than the studies' authors.

### *B. Voluntary Euthanasia and PAS*

In 2001, almost two out of every five deaths in the Netherlands were at least partly attributable to a medical decision to hasten the patient's death.[156] Patients made 9,700 explicit requests for euthanasia.[157] Dutch

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150. *Id.* at 1–2.

151. *Id.*

152. *See* Van der Maas Report, *supra* note 15, at 1700. The 40,000 cases studied in each report included a cross section of all Dutch deaths for the study period, including deaths from natural and non-natural causes.

153. Onwuteaka-Philipsen Report, *supra* note 15, tbl. 2.

154. *Id.*

155. *Id.*

156. *Id.* at 1 ("[A]bout 39% of all deaths seemed to be preceded by a medical decision that probably or certainly hastened death.").

157. Of the documented requests for euthanasia, less than one-third resulted in a physician actually performing euthanasia. It remains unclear, however, how many of the remaining two-thirds of patients died from natural causes before the treating physician could act on those requests. The fact that at least some patients die from natural causes prior to receiving euthanasia appears to rebut the principle argument in favor of active euthanasia, namely, that it is necessary to relieve patients' suffering. *See* Onwuteaka-Philipsen Report, *supra* note 15, tbl. 1.

Defenders of Dutch euthanasia practices argue that the consistently low proportion of euthanasia cases to euthanasia requests belies the charge that Dutch physicians are overeager to perform euthanasia, and reflects the seriousness and caution with which physicians undertake end-of-life treatment decisions. However, the 1995 Van der Maas

physicians actually performed euthanasia 3,500 times, representing 2.6 percent of all deaths.[158] Compared to previous years, the number of requests for euthanasia increased slightly, from 8,900 requests in 1990 to 9,700 requests in 1995.[159] Thereafter, the number of euthanasia requests stabilized.[160] Interestingly, PAS is generally unpopular in the Netherlands, accounting for only 0.2 percent of all deaths in 2001. Together, the official figures for voluntary euthanasia and PAS account for less than 3 percent of all deaths.

The Ministry of Health, Welfare and Sports reports that between 4 percent and 10 percent of all deaths occurred following terminal sedation in 2002.[161] These official figures probably understate the actual incidence of terminal sedation, which the authors refer to as "alleviation of symptoms with possible life-shortening effect,"[162] as the reports indicate that an additional 20 percent of all deaths involved alleviation of symptoms with the foreseeable potential side effect of shortening the patient's life.[163] Therefore, assuming that the relative percentage of deaths due to terminal sedation could not have changed dramatically between 2001 and 2002, the actual number of cases of terminal sedation may account for between 24 percent and 30 percent of all deaths each year.

While the official government report concludes that only 2.6 percent of all deaths involve active voluntary euthanasia, that figure probably understates the actual incidence of euthanasia in the Netherlands. The Dutch government has indicated that physician self-reporting of euthanasia and other end-of-life treatment decisions has consistently declined

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Report indicates that 59 percent of euthanasia cases resulted in the shortening of the patient's life by less than one week, and over 90 percent by less than one month. Although the Onwuteaka-Philipsen Report omitted similar data in the 2001, both the number of euthanasia requests and the number of euthanasia cases remained relatively constant between 1995 and 2001. *Id.* tbl. 4. Most likely, the vast majority of euthanasia cases in 2001 resulted in shortened life spans of less than one month.

158. End-of-life decisions include active euthanasia, PAS, termination of life without explicit request, possible cases of terminal sedation, and withholding or withdrawing life-sustaining treatment. Bregie D. Onwuteaka-Philipsen et al., *Euthanasia and other End-of-Life Decisions in the Netherlands in 1990, 1995, and 2001*, tbl. 1, LANCET, June 17, 2003, *available at* http://image.thelancet.com/extras/03art3297web.pdf.

159. Onwuteaka-Philipsen Report, *supra* note 15, at tbl. 1.

160. *Id.* tbls. 1–2.

161. Tony Sheldon, *'Terminal Sedation' Different from Euthanasia, Dutch Ministers Agree*, 327 BRIT. MED. J. 465 (2003), *available at* http://bmj.com/cgi/content/full/327/7413/465–a.

162. Onwuteaka-Philipsen Report, *supra* note 15, tbl. 4.

163. *Id.* tbl. 1.

between 1990 and 2001.[164] Currently, the Ministry of Health, Welfare, and Sports estimates that physician self-reporting reflects only half of the actual cases of euthanasia.[165] Consequently, the actual incidence of active voluntary euthanasia could be double the official estimates.

*C. Involuntary Euthanasia*

All three studies explicitly addressed the practice of involuntary euthanasia, obliquely referred to in the official reports as "ending the life of patients without explicit request."[166] Involuntary euthanasia occurred in approximately 900 cases each year from 1995 through 2001.[167] These cases represented 0.7 percent of all deaths in 1995 and 0.6 percent in 2001.[168] In general, the official estimates of involuntary euthanasia suggest that the practice is a relatively rare but stable component of Dutch medical practice.

The 1995 Van der Maas Report reported that in about half the involuntary euthanasia cases the patient had previously expressed a wish for euthanasia in the event that the patient's suffering became unbearable.[169] Likewise, in slightly less than half of all involuntary euthanasia cases, the patient had not discussed euthanasia with the physician nor expressed a wish to be relieved of suffering.[170] Significantly, in 79 percent of these cases, the patient was mentally incompetent.[171] The same figures also lead to the inescapable conclusion that, in approximately 210 cases each year, Dutch physicians intentionally terminated the lives of mentally competent patients without consultation or consent.

The Van der Maas Report further reported that, in about 95 percent of cases of termination without explicit consent, the physician discussed the decision to terminate the life of the patient with either a colleague or the patient's relatives.[172] Relatives were consulted 70 percent of the time,

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164. Tony Sheldon, *Only Half of Dutch Doctors Report Euthanasia, Report Says*, 326 BRIT. MED. J. 1164 (2003).

165. *Id.*

166. Onwuteaka-Philipsen Report, *supra* note 15, tbl. 3.

167. Sheldon, *supra* note 164.

168. Onwuteaka-Philipsen Report, *supra* note 15, at 1.

169. Van der Maas Report, *supra* note 15, at 1701. The 1995 report provides more detail regarding the circumstances and frequency of non-voluntary and involuntary euthanasia than either the 1990 or 2001 report. Because the relative frequency of involuntary euthanasia did not change significantly from 1995 to 2001, the 1995 data is probably still a valid estimate of current medical practice. *See* Onwuteaka-Philipsen Report, *supra* note 15, tbls.1–2.

170. Van der Maas Report, *supra* note 15, tbl. 4.

171. *Id.*

172. *Id.* at 1702.

while in at least 5 percent of all involuntary euthanasia cases, the physician failed to discuss either the patient's prognosis, the availability of alternative therapies or palliative care, or the moral propriety of terminating the patient's life.[173] Significantly, the study fails to document how many, if any, of these physicians faced either professional disciplinary sanction or criminal investigation.

If the rate of physician self-reporting for voluntary euthanasia, which is decriminalized, is only 50 percent,[174] the physician self-reporting rate for involuntary and non-voluntary euthanasia, which remains illegal under the criminal code, may be similar or greater. Presumably, the official estimate of 1,000 involuntary euthanasia cases per year may significantly understate the actual incidence of involuntary euthanasia.

In addition, the 1990 Remmelink Report revealed that slightly less than 5,000 patients were killed by terminal sedation without explicit request.[175] Although described as cases of terminal sedation by the report's authors, some of these deaths probably represent instances of involuntary euthanasia.[176] Not surprisingly, although subsequent reports provided aggregated estimates of the number of cases of terminal sedation, the 1995 and 2001 reports do not indicate whether informed consent was obtained.[177] If the actual number of involuntary euthanasia cases in 1990 was closer to 6,000 deaths instead of 1,000, and the relative frequency of involuntary euthanasia remained constant through 2001, then approximately 5 percent of all deaths in the Netherlands result from physicians

173. *Id.* tbl. 4.

174. Sheldon, *supra* note 164.

175. Van der Maas Report, *supra* note 15, at 669–74.

176. Because the researchers relied on documentation provided by the physicians themselves, there is no independent corroboration of their classification of individual cases. SMITH, *supra* note 13, at 111. A physician who knowingly performs involuntary euthanasia may simply indicate that the primary purpose of the treatment was to relieve the patient's pain, while the secondary or ancillary intention was to perhaps hasten death. In other words, the government's classification of marginal cases depends entirely on how the physician characterizes the treatment. The physician, in turn, has a significant incentive to classify marginal situations as cases of terminal sedation, which is essentially unregulated, rather than involuntary euthanasia, which is technically illegal. Of course, the government's hair-splitting contradicts the government's purported goal in legalizing active euthanasia. According to the government's own publications, the primary purpose of euthanasia was to allow physicians to alleviate patient's pain and suffering. To refuse to classify cases where a doctor attempts to relieve *pain* by hastening *death* as something other than euthanasia is somewhat disingenuous.

177. *Id.*

performing non-consensual euthanasia on unwilling or unknowing patients.[178]

For several years, Western media sources have provided anecdotal evidence of widespread euthanasia of mentally retarded or physically deformed infants.[179] The recent admission by the administrators at Groningen Hospital that they have been performing euthanasia on infants, allegedly with parental consent, lends credence to the earlier reports.[180] Following the hospital's disclosure of the new policy permitting infanticide, fresh reports have surfaced that physicians who perform euthanasia on infants engage in "secret deals" with public prosecutors to avoid prosecution.[181] Although Dutch physicians claim that approximately fifteen children are killed at birth each year,[182] other researchers have claimed that as many as 8 percent of all infant deaths, corresponding to 80 children each year, are due to euthanasia.[183] Of the minority of such cases that were reported to local prosecutors, none resulted in a criminal conviction.[184]

Finally, the authors of the Onwuteaka-Philipsen Report noted that the proportion of physicians who had performed an act of involuntary euthanasia decreased between 1990 and 2001.[185] Despite that decrease, however, 13 percent of physician respondents admitted that they could conceivably engage in the termination of a patient without request.[186]

### *D. Other Research Regarding Euthanasia in the Netherlands*

A separate and independent study by the Netherlands Institute for Health Services Research (NIVEL) utilized data from a sample of sixty general practitioners.[187] This trend analysis covered a much broader pe-

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178. *Id.* The figure of 6,000 deaths includes the official estimate of 1,000 cases of "ending of life without explicit request" and 5,000 cases of terminal sedation without request. Since between 120,000 and 140,000 deaths occur each year, roughly 5 percent of all deaths appear to involve non-consensual killings.

179. *E.g.*, Wesley J. Smith, *Now They Want to Euthanize Children in the Netherlands*, WKLY. STANDARD, Sept. 13, 2004, *available at* http://www.weeklystandard.com/Content/Public/Articles/000/000/004/616jszlg.asp (last visited Feb. 22, 2006).

180. Horsnell, *supra* note 1, at 13.

181. Traynor, *supra* note 3, at 3.

182. *Id.*

183. SMITH, *supra* note 13, at 61.

184. Traynor, *supra* note 3, at 3.

185. Onwuteaka-Philipsen Report, *supra* note 15, at 3.

186. *Id.*

187. R.K. Marquet et al., *Twenty Five Years of Requests for Euthanasia and Physician Assisted Suicide in Dutch General Practice: Trend Analysis*, 327 BRIT. MED. J. 201 (2003) [hereinafter NIVEL Report].

riod, from 1977 through 2001, than the government-sponsored surveys.[188] In addition to tracking the overall frequency of euthanasia requests, the trend analysis also traced the reasons that patients made such requests.[189] As such, the study provides a valuable patient-centered complement to the government-sponsored studies, which focused on physician attitudes and practices, not patient concerns.[190]

Regarding the reasons that patients gave for requesting euthanasia or PAS, the NIVEL researchers reported that fear of pain decreased in significance from 1979 through 2001, while general deterioration of health and physical ability rose in importance in the same period.[191] The NIVEL researchers deemed the incidence of dyspnoea (e.g., difficulty with breathing) and hopelessness statistically insignificant.[192] Overall, the NIVEL researchers concluded that the Dutch approach to active voluntary euthanasia did not increase the risk that individuals would request euthanasia before all palliative options were exhausted.[193] Significantly, the NIVEL Report only analyzed patient requests for euthanasia, and therefore did not address questions regarding the frequency or clinical context of involuntary euthanasia in the Netherlands.

### *E. Analysis of the Government's Findings*

The government-sponsored studies suffer from one primary conceptual shortcoming. As the authors of the Onwuteaka-Philipsen Report concede, all three studies were limited to the experiences and attitudes of physicians, not patients.[194] As such, the studies do not provide evidence of either patient views regarding euthanasia and end-of-life treatment decisions or the quality of end-of-life care. Furthermore, the government studies do not address the vitally important issue of what factors influence an individual patient or doctor to consider euthanasia as a treatment option. Therefore, the reports contribute little to the substantive analysis of the merits of the due process requirement of the Netherlands' euthanasia regulations.

One critic of Dutch euthanasia practice, citing the Van der Maas survey and the Commission Report's observation that palliative care training, knowledge, and research in the Netherlands lag behind comparable medical knowledge in other European states, asserts that euthanasia is

188. *Id.*
189. *Id.*
190. *Id.* at 200.
191. *Id.* at 201.
192. *Id.* at 202.
193. *Id.*
194. *See* Onwuteaka-Philipsen Report, *supra* note 15, at 5.

routinely used as an alternative, rather than an infrequent supplement, to palliative care.[195] Similarly, opponents of euthanasia assert that the legalization of euthanasia serves as a disincentive to the Dutch government to invest in palliative care education and may increase the risk of patients requesting euthanasia because of undue influence or duress.[196]

The empirical evidence of euthanasia practice in the Netherlands reveals a number of troubling conclusions. First, the government's narrow definition of euthanasia excludes many deaths that could fairly be classified as passive voluntary euthanasia, active voluntary euthanasia, and active involuntary euthanasia.[197] Second, the fact that fewer than half of all physicians report cases of voluntary euthanasia,[198] which has been a legal requirement of due care since the late 1990s, indicates that the government should not rely on voluntary physician compliance with the statutory due care requirement. Arguably, the self-reporting requirement for voluntary euthanasia patients is the least arduous of the due care requirements. Thus, the failure of almost half of all Dutch physicians to comply with this basic procedural requirement suggests that large numbers of physicians may regularly violate the other requirements of due care, such as waiting for a patient's repeated and persistent request for euthanasia or obtaining a physician consultation prior to performing euthanasia. Finally, the widespread non-compliance with the reporting requirement suggests that the government's purported objective in passing the Termination of Life Act, namely, to promote physician compliance with the legal requirements of due care, has not succeeded.

## V. CRITIQUE OF THE DUTCH ATTEMPT TO REGULATE EUTHANASIA

### *A. Historical Overview of the Moral Debate*

The Netherlands' debate regarding the proper approach to euthanasia regulation reflects the natural tension between individual mortality, traditionally an intensely personal subject, and government policy, which is

195. KEOWN, PERSPECTIVES, *supra* note 27, at 281.

196. *The Dutch Story: Legalization of Euthanasia*, CHRISTIAN CENTURY, May 2, 2001, at 5 n.14.

197. The studies do not consider terminal sedation or the withholding of life-sustaining medical treatment to constitute euthanasia. As previously noted, the characterization of each particular course of treatment as either terminal sedation or active euthanasia is entirely dependant on how each treating physician chooses to classify the patient encounter. Moreover, physicians possess a strong incentive to classify marginal cases as terminal sedation, which is unregulated, rather than involuntary euthanasia, which is nominally illegal. As such, because of the obvious evidentiary concerns, it remains difficult for researchers to draw clear distinctions in many cases.

198. *See* Sheldon, *supra* note 164.

naturally public, open, and impersonal.[199] Whether an individual believes that euthanasia should be outlawed, legalized, or simply unregulated by the state, the debate invariably touches upon profound personal beliefs regarding religion, morality, and the sanctity of life.[200] Consequently, any analysis of the Netherlands' particular approach to euthanasia requires a brief explanation of the moral principles that underlie the public debate.

Virtually every legal system in history recognized the principle that the intentional killing of another individual is usually wrong.[201] It is significant, however, that the rationale for that principle varies dramatically depending upon time and place. The general prohibition against murder may be derived from religious tenets,[202] utilitarian practicality,[203] or other philosophical grounds.[204] Indeed, humanity's historical inability to agree on a universally valid basis for the prohibition against killing underlies modern societies' failure to agree on an appropriate approach to euthanasia.[205]

The euthanasia debate also relates to the question of suicide.[206] Although different cultures believed that suicide could be justified in spe-

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199. GOMEZ, *supra* note 16, at 4.

200. Indeed, once the discussion begins regarding life, death, killing, and suicide, a host of ancillary issues begin to cloud the analysis. The advances in medical technology of the twentieth century resulted in the ability of physicians to preserve some aspects of life, for example, a heart and lower brain functions, almost indefinitely. Conversely, advances in the field of genetics, prenatal screening, and abortion techniques allow physicians and patients to fertilize human eggs outside of the natural womb, diagnose genetic defects, and safely terminate pregnancies. These advances have forced a new generation of bioethicists to reexamine fundamental definitions of life, humanity, and death. *See generally* MCMAHAN, *supra* note 38 (studying a range of moral and philosophical questions relevant to identity, abortion, euthanasia, and advances in bioethics).

201. For example, one of the earliest written collection of laws, the Code of Hammurabi, criminalized murder. Drafted in Babylonia between 1792 and 1750 B.C.E., the Code of Hammurabi prohibited, inter alia, private retribution, revenge, and blood feuds. Interestingly, the Code of Hammurabi arguably represents the first legal recognition of the tort of medical malpractice, inasmuch as the Code established fines for the negligent performance of surgery. *See Code of Hammurabi*, ENCYCLOPAEDIA BRITANNICA PREMIUM SERVICE, http://www.britannica.com/eb/article?tocId=9039076 (last visited Feb. 22, 2006).

202. *E.g.*, Exodus 20:13 ("You shall not murder.").

203. *E.g.*, PETE SINGER, RETHINKING LIFE AND DEATH: THE COLLAPSE OF OUR TRADITIONAL ETHICS 220 (1994).

204. *See, e.g.*, MCMAHAN, *supra* note 38, at 95.

205. As one scholar notes, the moral dilemmas associated with killing and euthanasia are linked because "[v]oluntary and involuntary euthanasia are both types of planned killing." Luke Gormally, *Walton, Davies, Boyd and the Legalization of Euthanasia*, *in* KEOWN, PUBLIC POLICY, *supra* note 23, at 113–15.

206. NEW YORK STATE TASK FORCE, *supra* note 5, at 77.

cific circumstances, the general condemnation of suicide extends back at least to the early Greek philosophers.[207] The Judeo-Christian proscription of suicide resulted in the criminalization of suicide during the Middle Ages, and continues to inform most Western societies' views of, if not their responses to, suicide.[208] Today, few states consider it a felony to commit suicide, however, many states, including the Netherlands, prohibit laypeople from assisting in a suicide.[209]

Aside from the general proscriptions of killing and suicide, the historic prohibition of euthanasia derives from a precept first articulated by the founder of medical ethics, Hippocrates.[210] His Hippocratic Oath, first articulated in the fourth century B.C.E. and repeated by thousands of medical school graduates each year around the globe, includes the injunction, "to give no deadly medicine to anyone if asked."[211] Of course, the Hippocratic Oath is a professional code of ethics, not a rule of law or belief system. Moreover, the Dutch medical community has apparently rejected that aspect of the Oath, at least to the extent that the official position of the KNMG is that euthanasia constitutes a legitimate feature of modern medical practice. However, the Hippocratic Oath and the legacy of traditional medical ethics continue to inform the international debate as well as individual practitioners' attitudes regarding euthanasia.[212]

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207. The Vikings, for example, coveted death in violent battle and allegedly preferred death by suicide over natural causes. NEW YORK STATE TASK FORCE, *supra* note 5, at 78. The Greek philosopher Plato argued that suicide was cowardly, but could be acceptable if an individual was particularly immoral. *Id.* at 78–79. *See generally* THE LAWS OF PLATO (Thomas L. Pangle trans., 1988). Plato's student Aristotle believed that suicide was always morally wrong. NEW YORK STATE TASK FORCE, *supra* note 5, at 78 n.6. *See generally* ARISTOTLE, NICOMACHEAN ETHICS, (Terence Irwin trans., 1999). Feudal Japan's code of *bushido*, on the other hand, made *seppuku*, or ritual suicide, obligatory for the samurai class in certain circumstances. *Seppuku*, ENCYCLOPAEDIA BRITANNICA PREMIUM SERVICE, http://www.britannica.com/ebc/article?tocId=937825 (last visited Feb. 22, 2006).

208. *See, e.g.*, MCMAHAN, *supra* note 38, at 10 (reviewing the approaches of Thomas Aquinas and Rene Descarte to the problem of the soul, as those approaches relate to Catholic and other Christian teachings regarding death and killing); *see also* NEW YORK STATE TASK FORCE, *supra* note 5, at 81–82 (discussing justifications for euthanasia articulated during the late nineteenth century).

209. *See* SR arts. 293–94 (Neth.), *translated in* AMERICAN SERIES OF FOREIGN PENAL CODES, *supra* note 72, at 200.

210. SMITH, *supra* note 13, at 19–20 n.55.

211. *See* TABERS'S CYCLOPEDIC MEDICAL DICTIONARY 832 (C.K. Thomas ed., 16th ed. 1989); *see also* SMITH, *supra* note 13, at 19–20 n.55.

212. RAPHAEL COHEN-ALMAGOR, THE RIGHT TO DIE WITH DIGNITY: AN ARGUMENT IN ETHICS, MEDICINE AND LAW 82 (2001).

Unsurprisingly, most, but not all, belief systems consider *involuntary* euthanasia to be always morally unacceptable.[213] However, an influential group of academics and bioethicists argue that involuntary euthanasia may not only be morally acceptable but actually a moral imperative.[214] Like belief systems in favor of voluntary euthanasia, belief systems that sanction involuntary euthanasia are quite varied. Briefly, some ethicists argue that spending healthcare resources on comatose or vegetative patients, who lack the capacity to either feel pain or desire life, constitutes a crime against those individuals who suffer for lack of medical care.[215] Others argue that infants, comatose patients, or adults with severe cognitive defects, including elderly patients with advanced Alzheimer's disease, are not "persons" and that it cannot be morally wrong to kill non-persons.[216] Finally, if euthanasia represents an appropriate clinical response to the problem of unbearable pain and suffering, then it is morally indefensible to deny that clinical response to infants, comatose patients, or individuals with severe mental retardation simply because those individuals cannot request euthanasia for themselves.[217] Although perhaps shocking or morally repugnant to some, these theories in favor of involuntary euthanasia are internally consistent and therefore no less logically sound than belief systems that disavow involuntary euthanasia.

In the end, the relative merits and shortcomings of the various religious, philosophical, and legal arguments relating to death, suicide, and abortion, could easily fill multiple libraries. However, a few generalities are common to each argument. First, each religious, philosophical, or legal argument constitutes a self-defining belief system that may or may

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213. MCMAHAN, *supra* note 38, at 464 ("[I]nvoluntary euthanasia, by contrast [to voluntary and non-voluntary euthanasia] does involve a violation of the autonomous will of the person who is killed or allowed to die, and it is precisely for this reason that it can never, in practice if not also in principle, be justified.").

214. The group of academics who support involuntary euthanasia include, among others, Princeton University professor Pete Singer, British academic John Harris, and Georgetown University professor Tom Beauchamp. SMITH, *supra* note 13, at 14–17.

215. John Harris, *Euthanasia and the Value of Human Life*, *in* EUTHANASIA EXAMINED: ETHICAL AND LEGAL PERSPECTIVES 20 (John Keown ed., 1995) ("The real problem of euthanasia is the tragedy of the premature and unwanted deaths of the thousands of people in every society who die for want of medical and other resources . . . .").

216. *E.g.*, SINGER, *supra* note 200.

217. Richard Fenigsen, *Euthanasia in the Netherlands*, 6 ISSUES L. & MED. 229, 235–37 (1990) ("Hesitation or refusal [of euthanasia to the newborn, mentally retarded, demented or comatose] would raise doubts whether the advocates of euthanasia are as certain of its benefits as they say."). The United States Supreme Court expressly rejected this equal protection argument in *Vacco v. Quill*, 521 U.S. 793, 808–09 (1997). The Dutch Supreme Court has not, to date, considered the equal protection argument with respect to the Termination of Life Act.

not be compatible with competing belief systems.[218] Second, the degree to which an individual adheres to a particular belief system, aside from environmental or sociological pressures, depends upon an individual's intuition.[219] Third, all modern legal systems, as well as the vast majority of modern belief systems, recognize that the intentional killing of another individual is usually wrong and therefore the practice of euthanasia must be justified as an exception to the general rule.[220] Finally, each belief system answers the questions of why and when euthanasia may or may not be morally permissible; they do not answer the question of who gets to decide.

### *B. Conceptual Approaches to Regulation of Euthanasia*

Generally, there are three primary responses to the moral question of euthanasia. These approaches are the prohibitionist view, the patient-autonomy perspective, and the beneficence principle. Each view constitutes a procedural response to the regulation of euthanasia. As such, these approaches are separate and distinct from the moral, religious, or philosophical justifications that underlie any individual's personal beliefs. Instead, these conceptual approaches answer the question, who gets to decide whether or not to perform euthanasia?

The prohibitionist view considers all forms of euthanasia to be morally unacceptable. Consequently, prohibitionists believe that active euthanasia, whether voluntary or involuntary, should never be legal.[221] This view forecloses any discussion regarding the merits of specific attempts to regulate euthanasia, and therefore adds little insight into the discussion regarding the Netherlands' euthanasia law.

An alternative approach is the patient-autonomy perspective, in which the question of euthanasia relates to an individual's right to self-determination, namely, the right to determine, to the fullest extent possible, the circumstances of one's own death.[222] In this view, the propriety

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218. *E.g.*, KEOWN, PUBLIC POLICY, *supra* note 23, at 80.

219. In other words, at a certain point, an individual's acceptance that a moral distinction does or does not exist between active and passive euthanasia, for example, rests on what the individual intuitively feels. *See* Ladd, *supra* note 33, at 166. Admittedly, this formulation is incredibly unsatisfying; however, the formulation explains why the core philosophical questions of euthanasia, as well as of life itself, remain unsolved despite thousands of years of religious and philosophical discourse.

220. *E.g.*, NEW YORK STATE TASK FORCE, *supra* note 5, at 77–78.

221. *E.g.*, Daniel Callahan & Margot White, *The Legalization of PAS: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 3 (1996).

222. Supporters of euthanasia from the patient's rights point of view frequently frame their arguments in terms of the right to die with dignity. HILL & SHIRLEY, *supra* note 85, at 7–8.

of euthanasia is linked to each patient's individual moral and religious beliefs.[223] Consequently, the decision to permit euthanasia, although guided by societal standards of conduct and the realities of the medical situation, must ultimately rest upon the individual patient's voluntary and affirmative choice.[224] Significantly, the patient-autonomy perspective accommodates the prohibitionist's beliefs, inasmuch as the patient-autonomy advocate does not accept the validity of involuntary euthanasia. Thus, individuals who believe that euthanasia is morally wrong but live in a patient-autonomy system may simply choose not to request euthanasia. A legal regime that strongly adopts patient-autonomy principles may also accommodate the beneficent approach as well. For example, a patient that accepts that the doctor, not the patient, should determine the course of treatment may simply acquiesce to any course of treatment, including euthanasia, which the doctor recommends.

The third general approach to euthanasia, the beneficence principle, states that physicians' primary duty is to cure disease and alleviate suffering.[225] In this view, patient self-determination is ancillary, or perhaps irrelevant, to the primary goal of alleviating suffering.[226] Accordingly, the physician, not the patient, acts as the primary decision maker regarding the proper course of medical treatment.[227] Several additional princi-

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223. *E.g.*, COHEN-ALMAGOR, *supra* note 209, at 82.

224. Patient autonomy may be understood as the manifestation in medical ethics of the more general principle of self-determination on which most modern legal systems are based. Thus, the patient autonomy perspective not only underlies the common law doctrine of informed consent, but also has been adopted by the European Convention on Human Rights. Article 2 of the Convention states, "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court . . . ." Convention on Human Rights, art. 2, Sept. 3, 1953, 213 U.N.T.S. 221.

225. Anthony Fischer, *Theological Aspects of Euthanasia*, *in* EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES 321 (John Keown ed., 1995).

226. In this respect, a purely beneficent approach to euthanasia regulation is incompatible with the patient autonomy perspective. In an overtly beneficent legal regime, once a physician decides that euthanasia is the medically appropriate response to a patient's condition, the patient's consent is irrelevant. A less rigid beneficent regime values patient self-determination, however, when faced with a choice between two contradictory courses of treatment, the beneficent principle tips the balance in favor of the doctor's professional judgment and the standards of accepted medical practice. In other words, in a mixed regime that emphasizes beneficence over patient autonomy, a practitioner may take into consideration the patient's preferences so long as those preferences do not contradict the physician's considered clinical judgment.

227. The beneficence approach to medical ethics is based upon the ethical principles first established by Hippocrates and, therefore, traditionally prohibited euthanasia. More recently, beneficent principles have been used to rationalize both voluntary and involuntary euthanasia. The important feature of the beneficence principle is not whether it per-

ples spring from the beneficent approach to euthanasia. First, the beneficent approach assumes that physicians always act in the best interests of their patients.[228] In addition, the pro-euthanasia physician who operates in a beneficent regime accepts the proposition that certain lives are not worth living and that painless death from euthanasia is more dignified than painful death from terminal disease. Since physicians, not patients, are viewed as the most qualified actors to evaluate the relative value of patients' lives,[229] physicians should be free to perform both voluntary euthanasia and involuntary euthanasia in an overtly beneficent regime.[230]

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mits or precludes euthanasia, but rather that the physician, not the patient, is the most appropriate decision maker. Dieter Giesen, *Dilemmas at Life's End: A Comparative Legal Perspective*, *in* EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES 321 (John Keown ed., 1995).

228. The beneficent principle is best summed up by the expression, "the doctor knows best." One example of how physicians internalize the beneficent approach to medicine is the response given by a Dutch euthanasia advocate, Rob Houtepen. Faced with the question as to whether the existing due care provisions protect against involuntary euthanasia, Dr. Houtepen argued that, although there was a need to improve the notification procedure, if the guidelines are followed, then there is no danger of abuse. Of course, Dr. Houtepen's answer missed the point. It did not occur to the doctor that some physicians might simply prefer to ignore the due care requirements. Dr. Cohen-Almagor's interviews occurred in 1999, one year before the Dutch Ministry of Health implemented more rigorous euthanasia notification procedures and three years before the passage of the Termination of Life Act. *See* Cohen-Almagor, *supra* note 47, at 168.

229. SMITH, *supra* note 13, at 10–19.

230. For example, the bioethicist Roger Dworkin believes that most legal systems' embrace of patient autonomy principles constitutes more "rhetoric" than "fact." Roger Dworkin, *Medical Law and Ethics in the Post-Autonomy Age*, 68 IND. L.J. 727, 727–28 (1993). In a pure patient autonomy regime, patients could auction away internal organs to the highest bidder, agree via contract to pay less for healthcare in return for their waiver of the right to sue for medical malpractice, and request and receive euthanasia on-demand. Such bioethicists also believe that, since the death of some people, for example, a beloved father of a large family, causes greater grief than the death of other people, for example, an anti-social hermit, it is acceptable to measure the value of individual human lives in relative terms. SMITH, *supra* note 13, at 18. It remains unclear whether Dworkin accepts involuntary euthanasia or merely argues for a diminished role for blind adherence to patient-autonomy principles in euthanasia cases. Pete Singer's advocacy in favor of involuntary euthanasia represents a more extreme articulation of the beneficent approach to euthanasia. *See generally* SINGER, *supra* note 194.

### *C. Intersection of Dutch Law and the Conceptual Approaches to Regulating Euthanasia*

Admittedly, few legal systems fully incorporate either the patient-autonomy perspective or the beneficence principle. Rather, most legal systems attempt to strike a balance between patients' rights to determine the course of their own medical care and physicians' prerogatives to provide care in accordance with their professional medical judgment. The Dutch approach to euthanasia reflects this internal balancing act. For example, the Termination of Life Act and an accompanying Ministry of Health, Sports, and Welfare publication assert that the Act's primary purpose is to further the goal of protecting patients' rights and autonomy.[231] Likewise, the 1994 Medical Assistance Act[232] and the country's ratification of the European Convention on Human Rights[233] indicate that the Dutch government is committed to the principle of patient autonomy.

However, ample evidence suggests that beneficence, not patient autonomy, is the primary motivation behind the Dutch approach to euthanasia regulation.[234] For example, only one of the five substantive due care provisions in the Act actually corresponds to the patient's subjective statements and beliefs.[235] The remaining due care provisions address what the physician's convictions must be in order to satisfy the requirements of due care.[236] Other Dutch government statements also suggest that allevia-

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231. For example, the Dutch government asserts, "Thanks to the new Act, doctors and terminally ill people know exactly what their rights and obligations are. . . . The voluntary nature of the patient's request is crucial: euthanasia may only take place at the explicit request of the patient." NETHERLANDS' NEW RULES, *supra* note 5, at 1–2.

232. Koster, *supra* note 83.

233. *See* European Convention for the Protection of Human Rights and Fundamental Freedoms, *opened for signature* Apr. 11, 1950, 213 U.N.T.S. 221 (entered into force Sept. 3, 1953); *see also supra* text accompanying note 224.

234. *See* Gunning, *supra* note 12 ("Many people think that legalizing euthanasia will make them autonomous. But, in fact, it is the doctor who is made free to do as he thinks right. In the end, it is not the patient, but the doctor who decides when life should be ended."); *see also* de Vries, *supra* note 82, at 378 ("[T]he law allows for a medical exception because only doctors are allowed to entertain a request for euthanasia. Another reason for the medical exception stems from the fact that considerations about the request—specifically whether the patient's suffering has been hopeless and unbearable—are medical or clinical considerations and considerations upon which the courts must rely.").

235. "The patient must hold the conviction that there was no other reasonable solution for the situation he was in." Termination of Life Act, ch. 2, art. 2 (1)(d).

236. These due care requirements include the "voluntary and well-considered" request requirement, the "lasting and unbearable" suffering requirement, and the consultation with another colleague requirement, and the requirement that the physician perform the euthanasia according to the prevailing standards of acceptable medical practice. For each

tion of patient suffering, not respect for individual patient autonomy, was the primary motivator behind the Termination of Life Act.[237]

Meanwhile, the Dutch Supreme Court's construction of the *noodtoestand* principle in the *Alkmaar* decision represents a strong commitment to physician beneficence.[238] The supreme court specifically discounted the legal significance of the patient's right to self-determination as the controlling factor in euthanasia cases. That construction indicates that, from a doctrinal point of view, physician beneficence is more important than patient-autonomy principles. Moreover, the overall history of the due care provisions, from the original KNMG guidelines through the Termination of Life Act requirements, indicates that Dutch courts consistently turn to the medical profession to decide what constitutes acceptable euthanasia practice. Indeed, current Dutch euthanasia law requires judges to focus the factual inquiry on the physician's, not the patient's convictions. The law then proceeds to evaluate the physician's convictions according to a standard of conduct developed by the medical community itself. Thus, the case law since 1984 reveals a marked predilection for the beneficent view, as the alleviation of pain, prevailing standards of medical care, and physicians' professional judgments are far more important factors than any individual patient's right to self-determination.[239]

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of these due care provisions, the Act focuses on the physician's convictions, not the patient's. *Id.* ch. 2, art. 2 (1).

237. For example, the government asserts that "[m]ost requests for euthanasia come from patients who are suffering unbearably with no prospect of improvement and see death as the only way out." NETHERLANDS' NEW RULES, *supra* note 5, at 3. However, as the NIVEL study indicated, more patients requested euthanasia because of general quality of life concerns than for fear of pain; fear of pain decreased in significance from 1979 through 2001. Marquet, *supra* note 178, at 201.

238. The Dutch Supreme Court's articulation of the *noodtoestand* principle in the *Alkmaar* decision was that of the conflict between Article 294 of the Dutch Penal Code, the article that prohibits the intentional killing of a patient upon the latter's request, and the physician's professional medical duty to alleviate suffering. Belian, *supra* note 9, at 260.

239. As the *Sutorius* case indicates, an individual's claim of being "tired of life" remains legally insufficient to justify euthanasia. Sheldon, *supra* note 108.

## VI. CONCLUSION

The Dutch approach to euthanasia regulation fails because it relies upon a doctrinal justification for permitting active euthanasia that does not distinguish between voluntary and involuntary euthanasia. Although the Dutch legal system pays lip service to the principle of patient autonomy, the determinative factor in all euthanasia cases remains the alleviation of pain according to prevailing medical standards.[240]

The courts have shifted the focus of the legal inquiry away from the patient's affirmative and voluntary request for euthanasia and towards the physician's professional medical judgment, a self-defining standard that makes the medical community, not the individual patient or the Dutch citizenry at large, the ultimate arbiter of euthanasia policy. Moreover, because the majority of the Termination of Life Act's due care provisions regulate physicians' beliefs, not the patients' wishes, the Act in reality denigrates patients' interests rather than protects them. In other words, by relying on the legal mechanism of *noodtoestand*, and the Dutch Supreme Court's formulation of the *noodtoestand* defense in the *Aklmaar* case,[241] the Dutch courts have institutionalized a legal slight of hand.

In the current legal formulation, euthanasia is legally valid because "[t]he principle of avoiding suffering thus overrides the principle of autonomy."[242] If that is true, then physicians cannot logically deny the benefits of euthanasia to mentally challenged, severely disabled, or comatose patients who lack the capacity to make a formal request. The Dutch medical establishment has already recognized the veracity of that statement, as indicated by the KNMG's recent request to the government for additional involuntary euthanasia guidelines.[243] Notice, even the recent infanticide protocols announced by Groningen Academic Hospital are cloaked in the language of patient autonomy.[244] Yet, to the extent that these cases of involuntary euthanasia involve patients who were never given a chance to formulate or vocalize their own views with regard to euthanasia, the Dutch legal system has engaged in a legal fiction.[245] Once

240. Belian, *supra* note 9, at 267–68.

241. *Id.*

242. Cohen-Almagor, *supra* note 47, at 173–74.

243. *The Dutch Ponder "Mercy Killing" Rules*, CNN.COM, Dec. 1, 2004, http://www.cnn.com/2004/HEALTH/12/01/netherlands.mercykill/index.html.

244. Horsnell, *supra* note 1, at 13.

245. SMITH, *supra* note 13, at 94. Of course, because encephalitic infants are born with only a lower brain stem and no frontal lobes, they cannot, as a matter of medical certainty, ever develop consciousness. Accordingly, the euthanasia of encephalitic infants can never be explained on patient-autonomy principles.

the courts recognize the validity of euthanasia requests by proxy, they will have stripped the concept of informed consent of any meaningful potency.

In addition, Dutch courts have abrogated their responsibility to serve as independent and impartial guardians of the interests of patients. The courts repeatedly defer to the medical judgment of the medical community.[246] This deference has been manifest in the Dutch Supreme Court's articulation of the standard of care in the *Aklmaar* case, the courts' subsequent adoption of the KNMG due care guidelines after 1985, and the codification of those guidelines in the Termination of Life Act. In addition, the Act itself relies exclusively on physician voluntary compliance in order to prevent abuse.[247]

As a practical matter, the empirical evidence indicates that the government's attempt to prevent non-compliance has failed, as less than half of all physicians report cases of active voluntary euthanasia,[248] which is legal, while as many as 5 percent of all Dutch deaths appear to result from the non-consensual killing of patients by their physicians.[249] Despite substantial international criticism of Dutch euthanasia practices, the medical community continues to rationalize any criticism of the Dutch approach to euthanasia.[250]

By doctrinally rejecting the personal-autonomy argument in favor of the prevailing medical standard approach, and relying exclusively on physician self-regulation to prevent abuse, the courts weaken the only ethical barrier to non-consensual killings, namely, the right to informed consent. Since the Dutch legal system purports to recognize the doctrine of informed consent,[251] involuntary euthanasia can never be legally justified because killing an innocent individual who neither requests nor consents to such killing would necessarily infringe upon that individual's fundamental right to justice.[252]

In the end, the balance that the Dutch government has attempted to strike between patient-autonomy principles and physician beneficence has not succeeded. Their approach to euthanasia regulation does not protect vulnerable individuals from potential abuse, fails to provide physicians with incentives to comply with the statutory reporting require-

246. *See generally* Belian, *supra* note 9.
247. Termination of Life Act, ch. 2, art. 2.
248. Sheldon, *supra* note 164.
249. *See supra* text accompanying note 178.
250. *See* Hendin, *supra* note 19, at 238.
251. *See* Koster, *supra* note 83.
252. Phillipa Foot, *Euthanasia*, *in* ETHICAL ISSUES RELATING TO LIFE AND DEATH 33–35 (John Ladd ed., 1979).

ments, and as a practical matter, fails to prevent involuntary euthanasia. Although the Dutch government speaks the language of patient rights, relief from suffering, and death with dignity, it has created a system in which physicians, not patients, control the circumstances of death. If Dutch society believes that involuntary euthanasia is both morally acceptable and socially desirable, then the law should be modified to reflect that conviction.

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