

## **Euthanasia in the Netherlands: Recognizing Mature Minors in Euthanasia Legislation**

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### I. INTRODUCTION

The debate surrounding the right-to-die movement raises a plethora of controversial issues. These issues highlight the continuing struggle between conflicting political, ethical, moral, social, religious and philosophical beliefs within society. The right-to-die movement recognizes several categories of euthanasia, and utilizes various terms in connection with the right-to-die debate, often creating confusion. Therefore, it is helpful to begin by defining these key terms. Euthanasia, simply defined, means a “good death” or “dying well.”<sup>1</sup> Often the term is used to describe a death of a severely ill individual, which has been accelerated or quickened.<sup>2</sup> The term “active euthanasia” involves a conscious and intentional act to terminate the life of a suffering individual.<sup>3</sup> “Active voluntary euthanasia” involves the request by a mentally competent, suffering patient to ensure a quick yet premature death.<sup>4</sup> Conversely, “active involuntary euthanasia” pertains to a premature death of a patient caused by physician intervention, without the

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<sup>1</sup> JENNIFER M. SCHERER, FINAL RIGHTS: AN INTERNATIONAL COMPARATIVE STUDY OF EUTHANASIA REGULATIONS AND RIGHT TO DIE ISSUES 33 (1997).

<sup>2</sup> *Id.* To “accelerate” death is to “bring about at an earlier time, to cause to move faster”; to “quicken” death is to “make more rapid, hasten, accelerate.” WEBSTERS NEW WORLD DICTIONARY, SECOND COLLEGE EDITION 209, 966 (9<sup>th</sup> edition, 1996).

<sup>3</sup> *Id.*

<sup>4</sup> *Id.* Lethal injections or supplying an overdose of medication are forms of intervention that are requested by a suffering patient.

individual's informed consent.<sup>5</sup> "Physician-assisted suicide" involves the physician enabling the patient to commit suicide by providing the necessary means.<sup>6</sup>

The concept of death is universal since death ultimately impacts all individuals. However, the issues that surround death, and whether to allow or prohibit certain forms of conduct, varies from country to country. While the euthanasia controversy emerged long ago, advances in medical technology and increased life expectancy have heightened the debate, as well as increased the desire for individual autonomy when deciding about health care.<sup>7</sup> Specifically, these debates focus on the desire by individuals to determine the manner in which they die and influence the timing of their death. Individual interests are largely based on the desire to relieve unrelenting pain and suffering caused by a terminal illness, and maintaining a certain degree of personal dignity upon facing death; these interests are considered against opponents' concerns, known as the "slippery slope" or "wedge" issues.<sup>8</sup> These "slippery slope"

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<sup>5</sup> *Id.* at 33-34. Informed consent involves making treatment decisions, by giving or withholding consent, based on the information, diagnosis, prognosis and treatment course offered by the physician. *See* JENNIFER M. SCHERER & RITA J. WILSON, *EUTHANASIA AND THE RIGHT TO DIE* 20-21 (Rowman & Littlefield Publishers Inc., 1999).

<sup>6</sup> *Id.* The difference between physician-assisted suicide (PAS) and active voluntary euthanasia is: in PAS the patient administers the drug provided by the physician and in active voluntary euthanasia the physician provides and administers the drug to the patient.

<sup>7</sup> Traci R. Little, *Protecting the Right to Live: International Comparison of Physician-Assisted Suicide Systems*, 7 *IND. INT'L & COMP. L. REV.* 433, 433 (1997). Life expectancy has significantly increased in many industrialized nations as well as in the United States. The life expectancy of men and women in the Netherlands is one of the longest in the world. In comparison, the average life expectancy in the United States in 2000 was 84.4 years. This increase is largely attributable to advances in medical technology, pharmaceuticals and improvements in living and working conditions. *See* SCHERER, *supra* note 1, at 53.

<sup>8</sup> SCHERER, *supra* note 1, at 39-40.

issues include concerns about potential abuse by physicians the health insurance system, members of the patients' family and society in general.<sup>9</sup> In addition, the euthanasia controversy is deeply rooted in struggle between various religious doctrines, social attitudes and philosophical beliefs that vastly diverge concerning "the value and meaning of life, the redemptive virtues of suffering and the moral and societal taboo against the act of suicide, assisting suicide or being directly involved in causing another individual's death."<sup>10</sup>

Patient autonomy may be achieved by the widely divergent choices that are promoted by the right-to-die movement; options that range from palliative care<sup>11</sup> and withdrawal of treatment to physician-assisted suicide and finally euthanasia.<sup>12</sup> Proponents of the right-to-die issues

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<sup>9</sup> *Id.* Opponents of euthanasia "believe that one of the greatest areas for potential abuse and misuse of euthanasia practices lies within the medical community. Those against euthanasia & PAS also believe a physician should not be accorded a godlike power over the life and death decisions of other individuals. Concerns arise because of the possibility of a misdiagnosis or a faulty prognosis for recovery. Another fear stems from the possibility of physicians using euthanasia to cover up medical mistakes that would subject them to malpractice lawsuits or to disguise the fact that they did not provide adequate treatment. Economic factors must also be considered in terms of patients, their families and society." *Id.* at 20-21. Some of these economic factors are not an issue in the Netherlands because of the unique reality that "over 99 percent of the citizens are covered by health insurance and that everyone is insured for the expense of any protracted illness. Thus, no financial incentives exist for the medical community or the family to cease or reduce treatment and benefits for a patient. *Id.* at 53.

<sup>10</sup> *Id.*

<sup>11</sup> Jessica A. Penkower, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment - Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1199 (1996). "Palliative care" is the management of a patients' suffering, addressing their pain and discomfort without dispensing medical treatment that has a curative effect.

<sup>12</sup> *Id.*

advocate for the legalization of both euthanasia and physician-assisted suicide. First, proponents believe that the slippery slope or wedge arguments are based on an irrational desire for certainty in every case. Second, proponents believe there is inadequate evidence to support the opponents' position that the right-to-die options propel society downward, and into a slippery slope of issues. Finally, advocates argue that these choices are morally acceptable, therefore, these options should be available to a patient and legally recognized by society. Those who oppose euthanasia and physician-assisted suicide simply believe that these options should never be available to individuals, regardless of the unique circumstances that confront a terminally ill patient. These diverging views reveal a plethora of competing interests. While countries attempt to balance individual autonomy concurrently with making health-care decisions that protect and promote individual rights, this struggle continues to challenge societies throughout the world.

The international right-to-die movement receives more tolerance than is observed in the United States, and is evidenced by the Netherlands recent victory. On November 28, 2000, the Dutch Parliament approved a bill that will legalize euthanasia, taking the first step toward becoming the only nation to allow physician's to openly assist patient's in terminating their lives.<sup>13</sup> In the Parliament's Lower House, the vote was 104-40 in favor of the legislation; the bill is expected to be presented to the Upper House early next year,

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<sup>13</sup> Anthony Deutsch, *Dutch Parliament OKs Euthanasia*, N.Y. TIMES, Nov. 28, 2000, available at 2000 WL 29583050. Euthanasia and PAS were practiced openly and legally from July 1996 to March 1997 in the Northern Territory of Australia, allowing patients to "prematurely and voluntarily end their lives with the assistance and guidance of a physician." While the law was in effect, four terminally ill individuals received assistance to die. In March 1997, the Andrew's bill overturned the Northern Territory's euthanasia law by a vote of 38-33. SCHERER, *supra* note 1, at 75.

and is expected to win approval to become law.<sup>14</sup> Currently, the Netherlands is the only country to create a defense for euthanasia. By recognizing the criminal defense of *force majeure*, a physician may, under certain conditions, invoke the defense when a patient expressly asks to terminate their life and the physician responds by terminating life.<sup>15</sup> With this pending law, the Netherlands will legalize a set of guidelines passed by legislators in 1993, and allow doctors to perform euthanasia without the concern of prosecution.<sup>16</sup>

This paper examines the pending legislation in the Netherlands that will legalize euthanasia. Additionally, it will discuss reconsidering legislation that was recently withdrawn legislation that would allow children aged 12-16, in situations of hopeless suffering, the right to choose euthanasia without parental consent.<sup>17</sup> Part II provides a brief history of euthanasia. The discussion will focus on the historical development of euthanasia and a deeper understanding about the conflict and ongoing controversy that surrounds the euthanasia issue. In addition, the history of euthanasia in the Netherlands will be addressed.

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<sup>14</sup> SCHERER, *supra* note 1, at 75.

<sup>15</sup> See Little, *supra* note 7, at 435. *Force majeure* was recognized in 1984 and “is a form of duress which constitutes generally recognized grounds for immunity from criminal liability. Article 40 of the Dutch Criminal Code generally states that any person who was compelled by *force majeure* to commit an offense shall not be criminally liable. Duress associated with euthanasia, assisted suicide, or the termination of life without a request applies when a physician is faced with a conflict of duty; the conflict is between a duty to preserve life and a duty to relieve unbearable suffering when the patient has no prospect for improvement. To successfully raise a defense of *force majeure* that allows an immunity from prosecution, the physician must fulfill specified criteria.” Office of Health & Env’t, Royal Neth. Embassy, Washington D.C., *The Termination of Life by a Doctor in the Netherlands* (1995).

<sup>16</sup> Deutsch, *supra* note 13.

<sup>17</sup> Wim Weber, *Dutch Proposal for Children's Right to Euthanasia Withdrawn*, THE LANCET, July 22, 2000, at 322.

Part III will discuss the current guidelines for euthanasia and applicability of those guidelines to new legislation that would confer upon sixteen to seventeen year old minors the right to choose euthanasia without parental consent. In addition, Dutch decisions regarding non-voluntary euthanasia and issues of parental consent will be discussed. Specifically, this part will focus on cases allowing medical treatment for infants who were severely ill or handicapped to be discontinued, the reasoning behind those decisions, and an argument for applying existing euthanasia guidelines to competent minors. Finally, the United States' Mature Minor Doctrine will be analyzed in consideration of the future legislation, to allow sixteen to seventeen year old minors the right to choose euthanasia without parental consent.

Part IV will conclude with a summary of arguments for rewriting the "child paragraph," and amending the pending legislation to allow sixteen to seventeen year old minors the right to choose euthanasia without parental consent, or in express opposition to parental wishes.

Through significant experience regarding euthanasia and pending legislation to legalize euthanasia, the Dutch have the most ambitious euthanasia system in the world. The Netherlands view regarding end-of-life decisions and development of policy to match these views "stems from a unique understanding of contemporary social problems and devising creative approaches to their resolution."<sup>18</sup> The most common factors among countries that support euthanasia or physician-assisted suicide include: "an approach toward self-determination and autonomy expressed through a liberal court system or legislative process, industrialization and a publicly funded health care system."<sup>19</sup> In these countries, the general population has a high life expectancy and access to health insurance, which provides adequate health care.<sup>20</sup>

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<sup>18</sup> SCHERER, *supra* note 1, at 288.

<sup>19</sup> *Id.* at 307.

<sup>20</sup> *Id.*

Furthermore, there is a high degree of support for euthanasia and physician-assisted suicide, as revealed through countries where public-opinion data is available.<sup>21</sup>

The Dutch experience with euthanasia is widely discussed, and will continue to be instructive to other countries considering euthanasia legislation. While the court systems in Japan, Belgium and Colombia have taken steps toward legalizing euthanasia; Germany and Switzerland already tolerate physician-assisted suicide.<sup>22</sup> In the United States, the State of Oregon legalized physician-assisted suicide. However, the United States Supreme Court has not determined whether there is a constitutional right to physician-assisted suicide and the Oregon law is currently under attack by a proposed Federal Bill. Furthermore, several countries that show support for euthanasia, beyond those discussed above: Canada, China, the United Kingdom and Australia all have great support for allowing euthanasia for competent patients. Each will benefit from watching the Dutch experience with legalized euthanasia. As mentioned above, the countries that are most amenable to developing euthanasia legislation are countries that value individual autonomy and self-determination. While the United States values personal liberty rights and individual freedoms as guaranteed by the Constitution, it will be interesting to witness how the United States will respond to the information gained by the Dutch, and their experience with euthanasia.<sup>23</sup>

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<sup>21</sup> *Id.*

<sup>22</sup> *Id.* at 289-290.

<sup>23</sup> SCHERER, *supra* note 1, at 290.

## II. HISTORICAL PREVIEW OF EUTHANASIA AND THE NETHERLANDS EXPERIENCE WITH EUTHANASIA

### A. *Brief History of Euthanasia*

“The term euthanasia was derived from the Greek ‘eu’ meaning well and ‘thanatos’ meaning death.”<sup>24</sup> Following the Roman conquest, the Greeks adopted the Stoic philosophy of death<sup>25</sup> becoming one of the first societies to consider certain forms of suicide.<sup>26</sup> Based on this philosophy, suicide was punishable only when the act was considered irrational, and euthanasia was a common practice.<sup>27</sup> Ancient Greeks and Romans would assist the elderly or infirmed to commit suicide based on their core belief that human beings controlled their own bodies.<sup>28</sup>

Stoic attitudes prevailed until the third century; thereafter, the influence of Christianity began creating intolerance for

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<sup>24</sup> *Id.* at 2. During this period, Greek society recognized the connection between physical illness and mental health. Individuals could seek approval by the state to commit suicide, if a physical illness became a nuisance. If the state then allowed an individual to commit suicide, the magistrates assisted the individual by supplying the poison that would kill them. *Id.*

<sup>25</sup> *Id.* at 4. The Stoic philosophy embraced the position held by Sophocles that “suicide was a general remedy for life’s hardships and burdens.” The Stoics allowed suicide for individuals suffering from lunacy, terminal illness, unbearable pain not associated with an illness, physical disabilities and fear of dishonor. *Id.*

<sup>26</sup> DEREK HUMPHREY & ANN WICKETT, *THE RIGHT TO DIE – UNDERSTANDING EUTHANASIA* 3 (Harper & Row 1986).

<sup>27</sup> SCHERER, *supra* note 1, at 4. During this time, sickness was considered a rational reason to commit suicide. *Id.*

<sup>28</sup> Margaret M. Funk, *A Tale of Two Statutes: Development of Euthanasia Legislation in Australia’s Northern Territory and the State of Oregon*, 14 TEMP. INT’L & COMP. L.J., 149, 149 (2000). *See also* Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 DENV. U.L. REV. 182 (1993).

the arguments supporting suicide.<sup>29</sup> Resistance to euthanasia became widespread as Christian thought and practice dominated the western world.<sup>30</sup> With this growing dominance, the arguments against euthanasia gained momentum and the history of euthanasia became deeply rooted in the history of religious belief.<sup>31</sup> Christian moralists argued that “a human’s life was the sole property of God, and it was His and only His to give and take at His will,”<sup>32</sup> exhibiting the fundamental conviction that supports the opposition to assisted suicide.

In the thirteenth century, Christian opposition to euthanasia peaked when Christian philosopher St. Thomas Aquinas published his *Summa Theologica*.<sup>33</sup> Aquinas denounced suicide as the most serious sin man could commit, a violation of the Commandments, unlawful and contrary to the laws of nature.<sup>34</sup> Conversely, support for euthanasia was reflected in the work of celebrated Catholic, Sir Thomas

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<sup>29</sup> SCHERER, *supra* note 1, at 4.

<sup>30</sup> Funk, *supra* note 28, at 149.

<sup>31</sup> *Id.* Neoplatonist’s argument against suicide was that suicide “hypothesized a disturbance of the soul and of the transition to the afterlife.” The Christian argument was based on “the belief that God had a sort of divine monopoly on life. A human’s life was the sole property of God, and it was his and only his to give and take.” SCHERER, *supra* note 1, at 2.

<sup>32</sup> Funk, *supra* note 28, at 149).

<sup>33</sup> SCHERER, *supra* note 1, at 5. In part, Aquinas relied on the arguments of Aristotle, Plato and the Neo-Platonists for his *Summa Theologica*. While Aristotle “rejected suicide on the basis of man’s civic duty to society,” Aquinas held that “suicide is unlawful because man belongs to his community.” Plato, “rejected suicide because man is a soldier or God,” and Aquinas argued that “suicide went against God because life was a gift from God and subject only to God’s discretion.” *Id.* The Neo-Platonists “believed that suicide disturbs the soul and its passage to the afterlife,” Aquinas argued that “suicide perturbs the soul.” *Id.*

<sup>34</sup> *Id.* at 4.

More, who wrote *Utopia* during this time.<sup>35</sup> More's work argued that patients suffering from a terminal illness or experiencing unrelenting pain should be encouraged to consider suicide.<sup>36</sup>

In the centuries following Christian dominance, medical knowledge increased.<sup>37</sup> This increased knowledge, combined with the Enlightenment period, created a new awareness of the struggles facing terminally ill patients.<sup>38</sup> Individuals began reconsidering the issue of euthanasia for terminally ill patients, indicating a slight shift in attitude toward accepting the practice of euthanasia.<sup>39</sup> During the early 1900's, several pieces of legislation to legalize and regulate euthanasia were introduced in the United States and England. However, they were ultimately defeated.<sup>40</sup> Thereafter, private euthanasia

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<sup>35</sup> *Id.* *Utopia* was written in 1516 and reflected a renewed interest and emphasis in individualism. *Id.*

<sup>36</sup> Funk, *supra* note 28, at 150.

<sup>37</sup> Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 DENV. U.L. REV. 189 (1993). See generally Funk, *supra* note 30. The issue of suicide was scientifically examined during the latter half of the nineteenth century. This research explored the specific biological causes of suicide; the results indicated it is possible that the act of suicide is linked to a genetic defect or chemical imbalance in the brain. SCHERER, *supra* note 1, at 7.

<sup>38</sup> SCHERER, *supra* note 1, at 7.

<sup>39</sup> Funk, *supra* note 28, at 150.

<sup>40</sup> SCHERER, *supra* note 1, at 8-9. In 1906, the Ohio legislature supported a bill to legalize the act of euthanasia. While the bill received 25 percent of the committee vote, the press responded with fierce criticism of the bill and it was ultimately defeated. Similarly, in 1935, England supported the legalization of euthanasia by proposing the "Voluntary Euthanasia Legalization Bill." This bill set forth guidelines to allow any terminally ill individual experiencing significant pain to obtain a euthanasia permit, with which the person could procure a lethal dose of a drug, to be administered by a physician or by the patient. The House of Lords defeated the bill in 1936. *Id.* at 9.

societies were established, in part, due to the failed legislation.<sup>41</sup>

While the issue of euthanasia enjoyed a renewed status through the 1930's and early 1940's,<sup>42</sup> the emergence of Adolf Hitler and his use of the word "euthanasia" to describe his "mass extermination program"<sup>43</sup> shattered any progress toward accepting the benefits of euthanasia for many

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<sup>41</sup> *Id.* at 9. Following the establishment of the British Voluntary Euthanasia Society in 1935, the Euthanasia Society of America was formed in 1938. These societies attempted to fill the gaps left by defeated legislation by addressing, proposing and promoting euthanasia legislation, advocating the rights of terminally ill patients and raising awareness of the euthanasia issue. By 1946, there were over five hundred members in the Euthanasia Society of America. In 1967, the Euthanasia Society of America "developed the country's first living will and created the Euthanasia Education Council to disseminate this information to the public." *Id.* at 9-28.

<sup>42</sup> *Id.* Public opinion data in the United Kingdom and United States reflected the changing perceptions and beliefs surrounding euthanasia. In 1938, the public began recognizing mercy killings as "a way to take control of a hopeless, desperate situation where the legal and medical systems had failed to provide assistance and guidelines." *Id.* at 10. In 1936, the American Institute of Public Opinion revealed that thirty-nine percent of those polled favored "mercy deaths under government supervision for hopeless individuals," and by 1939, the figure had risen to forty-one percent. In addition, both the American Institute of Public Opinion and Gallop Polls revealed that forty-six percent of those polled favored euthanasia. During this time, the United Kingdom conducted a similar poll and found that nearly seventy percent of those polled favored euthanasia. *Id.*

<sup>43</sup> *Id.* at 10- 13. Hitler's mass extermination program included killing "approximately 100,000 men, women and children who were physically handicapped, mentally disabled or genetically inferior in some manner." *Id.* at 11. This program began at the start of World War II, with Hitler designating two physicians to carry out "merciful deaths upon those patients considered 'incurable'." *Id.* at 12. Hitler killed all of these people without the individual's consent and without the awareness that the act was to occur. These tragedies lead to an unfortunate interpretation of euthanasia, and cast a dark shadow on euthanasia legislation. *Id.* at 11-14.

different people.<sup>44</sup> In Nazi Germany, euthanasia was employed to get rid of “men, women and children who were physically handicapped, mentally disabled or genetically inferior in some manner.”<sup>45</sup> Hitler instituted the law of existence, which embodied his belief in the destruction of lesser individuals so that the remaining superior individuals may live better.<sup>46</sup> Following the defeat of Nazi Germany, the General Assembly of the World Medical Association adopted a resolution “suggesting all national medical associations condemn euthanasia under any circumstance.”<sup>47</sup>

Internationally, euthanasia continues to draw much attention and debate. Opponents continue to declare that euthanasia challenges the will of God, and argue that physicians should not have the power to decide between life and death.<sup>48</sup> Conversely, proponents continue to base their position on two fundamental principles: “self-determination and mercy.”<sup>49</sup> Proponents believe that individuals have the right to control the direction of their life. And, if the quality

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<sup>44</sup> Messinger, *supra* note 37, at 192-93.

<sup>45</sup> SCHERER, *supra* note 1, at 11.

<sup>46</sup> GERALD FLEMMING, *HITLER AND THE FINAL SOLUTION*, 20 (1982). Hitler publicly announced these beliefs in 1941. Hitler's program received severe pressure from physicians and clergy and he eventually curbed the program. However, Hitler continued eliminating defective children until 1945. *Id.*

<sup>47</sup> Messinger, *supra* note 37, at 195.

<sup>48</sup> Deutsch, *supra* note 13.

<sup>49</sup> SCHERER, *supra* note 1, at 41-50. Self-determination assumes autonomy and the freedom to be self-governing with respect to choices concerning the self and one's own well-being. Proponents argue that this right applies to one's medical decisions as well as the circumstances and nature of one's death. *Id.* at 41. The principle of mercy is based on notions of compassion, understanding, and kindness toward patients who suffer intractable, untreatable, or intolerable pain. *Id.* at 44. Mercy is granted when a patient's quality of life will never be regained because of an incurable illness, and a physician directly assists the patient in dying. *Id.* at 41-50.

of their life is unbearable, individuals should receive mercy from a physician by direct assistance in the dying process.<sup>50</sup>

*B. Euthanasia in the Netherlands*

The Lower House in the Dutch Parliament approved pending legislation to legalize euthanasia on November 28, 2000.<sup>51</sup> Prior to this pending legislation, euthanasia and

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<sup>50</sup> *Id.* at 41-50.

<sup>51</sup> Deutsch, *supra* note 13. The house approved the bill in a 104-40 vote and will be presented to the Upper House in early 2001. The Netherlands has tolerated euthanasia since 1973, however, this bill will officially legalize euthanasia in the Netherlands upon approval by the Upper House of the Dutch Parliament. *Id.*

This article, as published, was written in January 2001. In recognition of changes in law, the following reflects the changes in the Netherlands since January 2001:

On April 10, 2001, the Dutch approved a law permitting both euthanasia and assisted suicide. And, on April 1, 2002, the law went into effect. In summary, the law requires and allows for the following:

- 1) Requires Due Care: Specifically, that a physician "has terminated a life or assisted suicide with due care." [Chapter II, Article 2, 1.f.]
- 2) An individual may qualify for euthanasia or assisted suicide if a doctor "holds the conviction that the patient's suffering is lasting and unbearable." [Chapter II, Article 2, 1b] And, the law does not require that a patient is terminally ill or that the suffering is based on a physical illness.
- 3) A 16 to 18 year-old minor may request and receive euthanasia or assisted suicide. The law states that a "parent or guardian must have been involved in decision process, but need not agree or approve." [Chapter II, Article 2, 3]
- 4) An incompetent patient may request and receive euthanasia. The individual must be 16 years-old and may request euthanasia in advance in a "written statement containing a request for termination of life" which the physician may carry out. [Chapter II, Article 2, 2.]
- 5) Children aged 12 to 16 years old may request and receive euthanasia or assisted suicide. "A parent or guardian must agree with the termination of life or the assisted suicide." [Chapter II, Article 2, 4]

physician-assisted suicide were regularly practiced and technically illegal in the Netherlands.<sup>52</sup> In 1886, Articles 293 and 294 of the Dutch Penal Code were enacted to distinguish murder from euthanasia, and clearly prohibit euthanasia and assisted suicide.<sup>53</sup> Article 293 prohibits euthanasia as a criminal offense and article 294 prohibits assisted suicide as a criminal offense.<sup>54</sup>

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6) Non-Judicial committees will oversee the practice of euthanasia and assisted suicide by a "Regional Review Committee for Termination of Life on Request and Assisted Suicide" after the death of the patient. [Chapter III]

7) "Burden of Proof" for the practice of euthanasia has shifted from the physician to the prosecutor, who is required to show that "the termination of life did not meet the requirements of due care." [Chapter III, Articles 9 and 10]

8) Residency is not required; therefore, physicians may administer euthanasia to non-residents of the Netherlands.

<sup>52</sup> *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report to the House Judiciary Subcommittee on the Constitution*, 104<sup>th</sup> Cong., 2d Sess. (1996) (Report of Charles T. Canady, Chairman), reprinted in 14 ISSUES L. & MED. 301 (1998) [hereinafter Canady Report]. "Instead of directly legalizing euthanasia and assisted suicide, there has been a gradual series of judicial steps implemented since 1973 that have allowed physicians, conforming to certain guidelines, to go unpunished." SCHERER, *supra* note 1, at 133.

<sup>53</sup> Marian H.N. Driesse, H. van der Kolk, W.A. von Nunen-Forger & E. de Marees van Swinderen, *Euthanasia and the Law in the Netherlands*, 3 ISSUES LAW & MED., 385, 385-86 (1988). Euthanasia and murder receive different punishments, the differences are made clear by Articles 293 and 294. *Id.*

<sup>54</sup> Canady Report, *supra* note 52, at 305-306. Article 293 of the Penal Code states: "He who robs another of life at his express and serious wish, is punished with a prison sentence of at most twelve years or a fine of the fifth category [a maximum of approximately \$50,000]." Article 294 of the Penal Code states: "He who deliberately incites another to suicide, assists him therein or provides him with the means to do so, will, in case suicide follows, be punished with an imprisonment up to three years or a fine in the fourth category." *Id.* at 305.

During World War II, Nazi Germany occupied the Netherlands.<sup>55</sup> Throughout the five-year occupation, many Dutch physicians refused to provide the Nazis with their patients' names, choosing instead to go to concentration camps.<sup>56</sup> These physicians knew that, ultimately, their patients were going to be candidates for the Nazi's euthanasia program and refused to participate.<sup>57</sup> The deep trust that is currently enjoyed between physicians and patients in the Netherlands is largely attributable to these facts, as well as the fact that Dutch physicians never permitted involuntary euthanasia to be practiced.<sup>58</sup> These physician-patient

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<sup>55</sup> SCHERER, *supra* note 1, at 133-135. Hitler's "euthanasia" program officially began with the commencement of World War II. Germans had begun accepting Hitler's message that "those who could not aid the wartime effort were essentially a nuisance, totally useless and simply better off dead." *Id.* at 12. Hitler began killing in 1939, and expanded the program by practicing "euthanasia" in the countries in which they occupied. "However, since these countries were not subjected to years of Hitler's indoctrination techniques regarding the usefulness of those individuals not valuable to the war effort and the inherent betterment of the German population through racial purification, they were not easily subjugated into obeying orders to kill Jews and mentally or physically handicapped individuals." *Id.* at 133 -134.

<sup>56</sup> *Id.* In 1941, Arthur Seyss-Inquart issued the "Order of the Reich Commissar for the Occupied Territories Concerning the Netherlands Doctors," directing the physicians to assist Germany in carrying out the "euthanasia" program. Physicians "refused to follow the order, and many began practicing medicine in a clandestine manner so as not to be persecuted or punished for their unwillingness to comply with Seyss-Inquart's request. Their adamant refusal led Seyss-Inquart to arrest more than a hundred physicians and deport them to concentration camps. *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Id.* at 53-54. The Netherlands has a government-guaranteed health care system, allowing more than 99 percent of the population to be covered by health insurance and maintain a long-term relationship between the physician and the patient. "As a testament to the enduring nature of the relationship between physician and patient, almost half of all individuals who die in the Netherlands die at home under the care of

relationships are the primary reason that the medical profession raised the euthanasia issue during the 1960s. Thereafter, public discussion about euthanasia and physician-assisted suicide in The Netherlands began in 1973.<sup>59</sup>

Without legalizing euthanasia or physician-assisted suicide, small steps had been taken by the Dutch judiciary to allow physicians to go unpunished for euthanasia or assisted suicide provided they followed specific guidelines.<sup>60</sup> In 1973, case law was developed that established criterion for a physician administering drugs that may result in accelerating a patient's death.<sup>61</sup> The criteria requires that the patient have

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their general practitioner." This situation in the Netherlands is unique, and is attributable to the availability of health care services for all citizens and the historical factors leading to the development of trusting physician-patient relationships. *Id.*

<sup>59</sup> *Id.* The unique physician-patient relationship in the Netherlands allowed physicians to witness their patients lives, not just their illness. This perspective gave physicians the opportunity to understand the agony that their patients endured through prolonged illness and painful deaths, and the impetus to raise the issue of practicing euthanasia. *Id.*

<sup>60</sup> Canady Report, *supra* note 52, at 301-303 (1998). Between 1973 and 1984, "a series of inferior court decisions formulated the criteria of 'carefulness' that accorded immunity to physicians who performed a life-terminating act where: (1) the patient was medically considered to be incurably ill; (2) the patient was either physically or psychologically suffering to an unbearable or severe extent; and (3) the patient had previously in writing or orally expressed his or her explicit will that life be terminated and he or she be relieved from suffering." PETER J.P. TAK, EUTHANASIA IN THE NETHERLANDS 24 (1997).

<sup>61</sup> Nederlandse Jurisprudentie 1973 No. 183, District Court Leeuwarden, Feb 21, 1973 *reprinted in* 3 ISSUES L. & MED., 439, 439 (1988) (Dr. Walter Lagerwey trans.). Dr. Geertruida Postma was sentenced in the criminal court at Leeuwarden for administering a fatal injection of morphine to her terminally ill mother, who had begged to die. Dr. Postma was found guilty because the court determined that she had "directly administered a lethal injection with the goal of terminating the patient's life." However, the court suspended her sentence to one week stating, "it was proper to administer pain-relieving drugs to the

an incurable, terminal-illness and be suffering from unrelenting physical or psychic pain as a result of that illness. Furthermore, the goal of the physicians' treatment must be the relief of that patient's physical or psychic pain.<sup>62</sup> The criminal court at Leeuwarden held that a physician who follows the established guidelines when terminating a patient's life, and who then reports the death, will generally be immune to prosecution.<sup>63</sup>

In 1981, the criminal court at Rotterdam established nine new criteria that would permit both assisted suicide and euthanasia.<sup>64</sup> Three years later in 1984, the Supreme Court of the Netherlands held that a physician could apply the doctrine of *force majeure* as a defense against prosecution for

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patient if the goal was the relief of the physical pain, even if death results from the medication." SCHERER, *supra* note 1, at 136. This case suggests legal tolerance for voluntary euthanasia, and was the impetus for establishing the defense of *force majeure*. This doctrine allows physicians who face a conflict of duty between honoring their patients' needs and the law, a defense in performing euthanasia on terminally ill patients. *See generally* Canady Report, *supra* note 52.

<sup>62</sup> Canady Report, *supra* note 52, at 305.

<sup>63</sup> *Id.*

<sup>64</sup> CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 32 (1991). A layperson was convicted of assisting a terminally ill person in suicide. The court at Rotterdam established these nine criteria for permitting assisted suicide and euthanasia: (1) The patient must be suffering unbearably; (2) the patient must be conscious when he expresses the desire to die; (3) the request for euthanasia must be voluntary; (4) the patient must have been given alternatives with time to consider them; (5) there must be viable solutions for the patient; (6) the death does not inflict unnecessary suffering on others; (7) the decision must involve more than one person; (8) only a physician may perform the euthanasia; and (9) the physician must exercise great care in making the decision. However, the court does not state that the person seeking assistance must be terminally ill or that their suffering must be of a physical nature. Canady Report, *supra* note 52, at 307.

euthanasia.<sup>65</sup> The theory of this doctrine is based on the belief that “the doctor’s duty to preserve life should not conflict with the duty to relieve unbearable suffering.”<sup>66</sup> Although this doctrine is susceptible to various interpretations, the court relied strongly on an interpretation that states that a physician’s duty to assist a terminally ill patient outweighs his or her duty to adhere to the law.<sup>67</sup>

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<sup>65</sup> JOHN GRIFFITHS, ALEX BOOD & HELEEN WEYERS, *EUTHANASIA AND THE LAW IN THE NETHERLANDS* 172 (Amsterdam University Press 1998) [hereinafter GRIFFITHS]. The Alkmaar case involved a Dr. Schoonheim who performed euthanasia for a ninety-five year old woman who was in deteriorating health. The court held that “necessity may operate as a defense where a doctor is faced by a conflict of duties both to obey the law and to relieve suffering, and where, ‘according to responsible medical opinion’ measured by the ‘prevailing standards of medical ethics,’ a situation of necessity exists.” Simon Chesterman, *Euthanasia in the Netherlands and Australia*, 47 INT’L & COMP. L.Q. 376 (1998). Article 40 of the Dutch Penal Code, provides a defense “for the person who commits an offense as a result of ‘irresistible compulsion or necessity’.” Therefore, Article 40 is a defense for a physician accused of euthanasia on request.” It is important to note that the Alkmaar case is distinguished from the Rotterdam case. In Alkmaar, the woman was elderly and chronically ill, but not terminally ill as was the patient in Rotterdam. “The Alkmaar case signaled not only that the highest court in the land accepted euthanasia, but also that the court accepted euthanasia in cases where death for the patient was otherwise imminent.” See Canady Report, *supra* note 52, at 309.

<sup>66</sup> Marcia Angell, *Euthanasia in the Netherlands*, 22 NEW ENG. J. MED. 1676 (November 1996). See also Simon Chesterman, *Euthanasia in the Netherlands and Australia*, 47 INT’L & COMP. L.Q. 376 (1998).

<sup>67</sup> Funk, *supra* note 30, at 152. The criteria for establishing a defense of necessity are as follows: “(1) the patient must have made voluntary, carefully considered and persistent requests for euthanasia; (2) the patient must be experiencing intolerable suffering with no prospect of improvement, although it is not necessary that the patient be suffering from a terminal illness or that the suffering be somatic (physical) suffering; (3) the doctor and the patient must have considered and discussed alternatives to euthanasia; (4) the doctor must have consulted at least one other independent doctor who has experience in the relevant field; and (5) euthanasia must have been performed by the doctor.”

Allowing the *force majeure* defense was an important development in the law. Following this development, the Dutch Medical Association, in collaboration with the Nurses Association, instituted the “Guidelines for Euthanasia” in 1986.<sup>68</sup> These guidelines establish the basis for the current practice of euthanasia and physician-assisted suicide. Furthermore, the guidelines provide the requirements a physician must meet to perform both acts and allow a physician to use the Article 40 defense of “necessity” in performing these acts.<sup>69</sup> In January of 1990, the Dutch government commissioned a scientific study about the practice of euthanasia in the Netherlands, which was released in 1991.<sup>70</sup> Known as the Rummelink Report, this data provides a valuable resource on the Netherlands’ experience

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Simon Chesterman, *Euthanasia in the Netherlands and Australia*, 47 INT’L & COMP. L.Q. 362, 376 (1998).

<sup>68</sup> Canady Report, *supra* note 52, at 301-303, 307-309. The “Guidelines for Euthanasia” were established in 1986, following the Rotterdam and Alkmaar cases. These guidelines are as follows: (1) The request for euthanasia must come only from the patient and must be entirely free and voluntary; (2) the patient’s request must be well considered, durable and persistent; (3) the patient must be experiencing intolerable (but not necessarily physical) suffering, with no prospect of improvement; (4) euthanasia must be a last resort, and other alternatives to alleviate the person’s situation must have been considered and found wanting; (5) euthanasia must be performed by a physician; and (6) the physician must consult with an independent physician colleague who has experience in this field. While the guidelines explain these requirements, the criteria remain vague and provide significant discretion to the physicians. *Id.*

<sup>69</sup> *Id.* at 301-02.

<sup>70</sup> SCHERER, *supra* note 1, at 138. The Rummelink study investigated “all medical decisions concerning the end of life,” which consisted of 130,000 deaths in the Netherlands in 1990. The physicians who participated and contributed information, were granted immunity from prosecution for that information. *Id.*

with euthanasia.<sup>71</sup> The report documented that there were about nine thousand requests for euthanasia or physician-assisted suicide each year; of those nine thousand, about one third actually received either euthanasia or assisted suicide.<sup>72</sup> In addition, the study discovered that one-thousand of the deaths reported resulted from euthanasia without consent or non-voluntary euthanasia.<sup>73</sup> These findings were extremely controversial, prompting the Dutch to adopt new guidelines and regulations in 1993.<sup>74</sup>

Without granting a legal right, the Dutch parliament formally supported the right for euthanasia in 1993, by adopting a new set of guidelines and regulations for performing assisted suicide and euthanasia.<sup>75</sup> These new standards require physicians to follow strict guidelines or face potential prosecution.<sup>76</sup> First, a physician is allowed to practice euthanasia when a patient knowingly and persistently requests the procedure and when that patient has unbearable suffering that cannot be relieved.<sup>77</sup> Second, the

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<sup>71</sup> Funk, *supra* note 30, at 151. The survey revealed that out of 130,000 deaths, 49,000 involved a medical decision that may have considered accelerating the patient's death. The debate over the study resulted from the 1,000 cases of termination of life without an explicit request and that the rate of reporting euthanasia was extremely low. In 1991, only 592 cases were reported, less than one quarter of the number of cases of euthanasia and assisted suicide that presumably occurred during that year. Chesterman, *supra* note 67, at 378.

<sup>72</sup> Simon Chesterman, *Euthanasia in the Netherlands and Australia*, 47 INT'L & COMP. L.Q. 379 (1998).

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> SCHERER, *supra* note 1, at 144.

<sup>76</sup> Funk, *supra* note 30, at 152.

<sup>77</sup> Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Memo from the Ministerie van Justitie, Directie Voorlichting, Compulsory Euthanasia Notification Procedure Comes into Force on 1 June (May 11, 1994) [hereinafter Compulsory Notification Procedure Press Release]. Based on the 1986 Guidelines on Euthanasia and the findings of the Rummelink Report, the Dutch government established a new reporting procedure that was codified on June 1, 1994. Thus, the

primary physician is required to consult another physician for a second opinion, and must report the death to the Dutch government.<sup>78</sup> Upon reporting the death, the physician must provide a case history detailing the diagnosis of the patient, the type of treatment given, length of the illness, and the names of the attending physicians.<sup>79</sup> Furthermore, the physician must give a “statement to the effect that the patient’s mental and physical suffering were unbearable and that the situation was at such a point that the patient would not have been able to die with dignity except for euthanasia.”<sup>80</sup> Third, the physician must disclose the name of the physician consulted and a summary of their findings.<sup>81</sup> Fourth, the physician is required to document that the patient made the request for euthanasia based on sufficient discussion with the physician and of his or her own free will.<sup>82</sup> Finally, the physician is required to report the circumstances leading up to the request, any notable influences on the patient, any other options that the patient

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reporting procedure became a “statutory requirement with the July 1, 1994, enactment of section 10(1) of the Act on the Disposal of the Dead (Disposal Act).” These procedures apply to physician-assisted suicide, euthanasia on request and euthanasia without the request. However, these procedures do not make the failure of a physician to report a case, a crime itself. Traci R. Little, *Protecting the Right to Live: International Comparison of Physician-Assisted Suicide Systems*, 7 *IND. INT’L & COMP. L. REV.* 453 (1997).

<sup>78</sup> Funk, *supra* note 30, at 152. *See also* The Right of the Individual or the Common Good? Volume One - Report of the Inquiry by the Select Committee on Euthanasia, May 16, 1995, (visited Dec 28, 2000) available at <http://www.nt.gov.au/lant/rotti/vol1.shtml>, at §4. 1. [hereinafter Right of the Individual].

<sup>79</sup> *Id.* *See also* DEREK HUMPHRY, *LAWFUL EXIT* 27 (1993).

<sup>80</sup> HUMPHRY, *supra* note 79, at 27.

<sup>81</sup> *Id.* at 49.

<sup>82</sup> *Id.* at 48.

might have considered and the method chosen to perform euthanasia.<sup>83</sup>

One of the more recent euthanasia cases was heard by the Dutch Supreme Court in 1994.<sup>84</sup> The case of psychiatrist, Dr. Boudewyn Chabot, involved Dr. Chabot assisting a fifty-one year old patient in suicide.<sup>85</sup> The patient was a physically healthy woman experiencing intolerable psychological suffering.<sup>86</sup> In court, Dr. Chabot used the defense of *force majeure* contending that "intolerable psychological suffering is no different from intolerable physical suffering."<sup>87</sup> The court did not allow Dr. Chabot to use the defense, and found him guilty of assisted suicide.<sup>88</sup> However, the court held that there are physically healthy patients with unbearable psychological suffering which cannot be alleviated, and imposed no punishment.<sup>89</sup> Therefore, this case expanded the

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<sup>83</sup> *Id.* at 49.

<sup>84</sup> Jurgen Woretshofer & Matthias Borgers, *The Dutch Procedure for Mercy Killing and Assisted Suicide by Physicians in a National and International Perspective*, 2 MAASTRICHT J. OF EUROPEAN & COMPARATIVE LAW 2, 7 (1995). The case involved a fifty-one year old woman, Hillie Hasscher who was experiencing intolerable psychological suffering as a result of her divorce and losing both of her sons, one to cancer and the other to suicide. Dr. Chabot consulted with several colleagues and all agreed with his opinion of Ms. Hasscher, however no physician thought it was necessary to examine the patient. Dr. Chabot provided Ms. Hasscher with twenty barbituates, which she dissolved in a glass of syrup. Canady Report, *supra* note 52, at 318-319.

<sup>85</sup> Woretshofer & Borgers, *supra* note 84, at 7.

<sup>86</sup> *Id.* The court stated: "[A] doctor may be in a situation of necessity if he has to choose between the duty to preserve and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care." GRIFFITHS, *supra* note 65, at 81.

<sup>87</sup> Canady Report, *supra* note 52, at 318-319. Dr. Chabot was found guilty, based on his non-compliance with the requirement that he seek an independent physician to examine his patient. *Id.*

<sup>88</sup> GRIFFITHS, *supra* note 65, at 81.

<sup>89</sup> *Id.*

defense of force majeure to cases in which the patient's suffering is not based on physical illness.<sup>90</sup>

*C. Pending Dutch Legislation to Legalize Euthanasia.*

On November 28, 2000, the Lower House in the Dutch Parliament approved a bill to legalize euthanasia, potentially securing the Netherlands as the only nation to legally allow a physician to assist suffering patients in the termination their lives.<sup>91</sup> Currently, the only other countries to tolerate euthanasia or physician-assisted suicide are Switzerland, Colombia and Belgium. In 1995, Australia's Northern Territory approved the Rights of the Terminally Ill Act,<sup>92</sup> to allow the practice of euthanasia. The law was revoked by the

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<sup>90</sup> *Id.*

<sup>91</sup> Deutsch, supra note 13. This bill will legalize the informal guidelines established in 1993.

<sup>92</sup> See Rights of the Terminally Ill Act 1996, (Austl.) available at <http://www.nt.gov.au/lant/rotti/euthact/html> [hereinafter RTI]. The Rights of the Terminally Ill Act was passed on May 25, 1995. The Act "provided a patient suffering from a terminal illness the right to request assistance from a medical practitioner to end the patient's life." The following guidelines were imposed: (1) the medical practitioner must not be influenced by any rewards or threats; (2) The patient must be suffering from a terminal illness for which there is no cure and only palliative care is available, and must be over eighteen years old; (3) the patient must obtain two second opinions, one from a qualified psychiatrist and the second from a non-related medical practitioner; (4) the request must be certified; (5) The patient must understand the advantages and disadvantages of euthanasia as discussed with the medical practitioner; (6) the patient must be informed by the medical practitioner that palliative care is available; and (7) the patient may, at any time, rescind his or her request. While the act permitted some people to terminate their lives, on March 27, 1997, the Euthanasia Laws Act invalidated the Rights of the Terminally Ill Act. See Euthanasia Laws Act, 1997, Austl. Acts ¶ 17.

Federal Parliament in 1997.<sup>93</sup> Proponents of euthanasia were again successful when Oregon voters approved legislation allowing physician-assisted suicide in 1994, by enacting the Oregon Death with Dignity Act which took effect in 1997.<sup>94</sup> Since 1997, the federal government has challenged the statute in *Lee v. State of Oregon*.<sup>95</sup> The District Court in Oregon held in *Lee* that the statute was unconstitutional, thus invalidating the statute.<sup>96</sup> However, the Supreme Court remanded the

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<sup>93</sup> See Euthanasia Laws Act, 1997, Austl. Acts ¶ 17. The court stated: “the Northern Territory did not have the power to make any laws dealing with euthanasia.” Rights of the Terminally Ill Act 1996, (Austl.) available at <http://www.nt.gov.au/lant/rotti/euthact/html>.

<sup>94</sup> See OR. REV. STAT. §§ 127.800-897 (1999). The Oregon Death with Dignity Act was passed on November 10, 1994 and became legal on October 27, 1997. The Act states that “anyone over eighteen who resides in Oregon and who has been diagnosed by two physicians as having a terminal illness, may request lethal medication in writing.” *Id.* at § 127.805(i). The measure also includes a fifteen-day waiting period from the time the request is made to the time the prescription is granted. *Id.* at 127.815(h).

<sup>95</sup> *Lee v. Oregon*, 107 F.3d 1382 (1997). In 1998, physicians prescribed lethal medications for at least 15 patients who died from taking those medications. The plaintiffs’ in *Lee*, a group of terminally ill patients, their physicians and several nursing homes, challenged the constitutionality of the Oregon Death with Dignity Act, claiming that the Act violated the Equal Protection Clause of the Fourteenth Amendment. *Id.* at 1390-1392. The Ninth Circuit Court of Appeals rejected the plaintiffs’ claim stating that the plaintiffs’ had no standing. *Id.* at 1390. The court claimed there was no “injury in fact,” based on the “possibility of patients taking their lives against their true intent.” *Id.* at 1388. Therefore, the court only ruled that the federal courts did not have jurisdiction because there was no standing and did not decide whether, based on the merits, the Death with Dignity Act violated the Equal Protection Clause. *Id.* at 1390. See also Arthur E. Chin, et al., *Legalized Physician-Assisted Suicide in Oregon--the First Year's Experience*, 340 NEW ENG. J. MED. (1999).

<sup>96</sup> *Lee*, 107 F.3d at 1437. The District Court held that the Act violated the Equal Protection Clause of the Fourteenth Amendment of the United States’ Constitution. *Id.*

issue of euthanasia back to the individual states, in the cases of *Washington v. Glucksberg*<sup>97</sup> and *Vacco v. Quill*.<sup>98</sup>

Like the Rights of the Terminally Ill Act in Australia's Northern Territory, the Death with Dignity Act<sup>99</sup> may soon be repealed. On October 27, 1999, the House of Representatives passed the Pain Relief Promotion Bill of 1999,<sup>100</sup> which would repeal the Oregon law if passed in the Senate and signed by the President for violation of the Commerce Clause of the U.S. Constitution. However, the Congress that passed the Pain Relief Promotion Bill was replaced in January, and the bill will now have to be reintroduced to the new Congress.

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<sup>97</sup> *Washington v. Glucksberg*, 521 U.S. 702, 775-77 (1997). (Breyer, J., concurring) Washington State generally permits physicians to administer medication to patients in terminal conditions when the primary intent is to alleviate pain, even when the medication is so powerful as to hasten death and the patient chooses to receive it with that understanding. While the Supreme Court distinguished assistance to suicide from the withdrawal of lifesaving treatment, the court held that assistance to suicide is not a fundamental right protected by the Due Process Clause of the Constitution. *Id.* at 736.

<sup>98</sup> *Vacco v. Ouill*, 521 U.S. 793, 794 (1997). It is widely recognized that the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death if the medication is intended to alleviate pain and severe discomfort, not to cause death. Thus, the Supreme Court distinguished the primary intent to cause death from using palliative care with the intent to relieve pain with prescription drugs. *Id.* at 809.

<sup>99</sup> OR. REV. STAT. §§ 127.800-127.897 (1998).

<sup>100</sup> See Pain Relief Promotion Act H.R. 2260, 106th Cong. § 1 (1999). The Pain Relief Promotion Bill of 1999 specifies that "the dispensing or distribution of controlled substances to assist suicide or euthanasia are not legitimate medical purposes and are not permissible under the Controlled Substances Act." This bill will outlaw physician-assisted suicide as well as allow physicians to provide "aggressive palliative care." *Id.* Thus, dispensation of drugs will be allowed for pain management or to relieve discomfort, however, a physician may be denied his or her registration if they violate this bill. *Id.*

The Dutch legislation legalizing euthanasia recently passed in Parliament's Lower House by a vote of 104-40.<sup>101</sup> Early next year, the bill is expected to win wide approval by Parliament's Upper House and become law.<sup>102</sup> Under the new Dutch law, active euthanasia would remain illegal and punishable unless the physician follows specific procedures: the patient must be experiencing unrelenting and intolerable pain and suffering, be aware of all other medical options available to the patient and have received a second opinion by another physician.<sup>103</sup> In addition, the patient must make the request for euthanasia voluntarily, persistently and independently, and a written report of the process leading up to and carrying out the euthanasia must be maintained.<sup>104</sup> This bill is significant not only because it is likely to become law, but also because it expands the boundaries allowing euthanasia. Specifically, the bill does not require that the patient must be suffering from physical pain, suggesting that intolerable mental suffering could be a sufficient cause, and does not require that the patient's disease be terminal.<sup>105</sup> Furthermore, patients will be allowed to provide a written request to physicians to be used in cases where the patient is later no longer able to decide their course of treatment.<sup>106</sup> This measure will grant a physician the right to use his or her own discretion to determine whether to carry out

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<sup>101</sup> Deutsch, *supra* note 13.

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* Because this law is pending approval in the Upper House of the Dutch Parliament, there is no legislative history on whether the boundaries of the law extend to mental suffering. However, allowing mental suffering as a sufficient cause for performing euthanasia would codify the case of Dr. Boudewijn Chabot. Jurgen Woretshofer & Matthias Borgers, *The Dutch Procedure for Mercy Killing and Assisted Suicide by Physicians in a National and International Perspective*, 2 MAASTRICHT J. OF EUROPEAN & COMPARATIVE LAW 2, 7 (1995).

<sup>106</sup> Deutsch, *supra* note 13.

euthanasia.<sup>107</sup> Under the new law, a committee of at least three people would be assigned to review each case of euthanasia to ensure all guidelines are followed.<sup>108</sup> This committee would include a physician, a lawyer and an expert in medical ethics.<sup>109</sup>

As expected, this pending bill has received both support and opposition from various organizations all over the world. In response to the concerns that patients living in other countries who seek to end their lives will descend upon the Netherlands, Dutch officials emphasized that there are strict standards under the pending law for allowing euthanasia and foreigners would be unable to meet those standards.<sup>110</sup> Wijnand Stevens of the Justice Ministry stated that, “there is no possibility for foreigners to come here for euthanasia; the criteria call for a long-term doctor-patient relationship. The standards are just too strict for that.”<sup>111</sup>

Absent from the pending legislation is a specific allowance for children age twelve to sixteen to choose euthanasia, without the consent of their parents. On July 22, 2000, the Dutch government withdrew the proposed “child paragraph,” giving children faced with incurable suffering and within the specified age group the right to choose euthanasia without their parents consent, and in cases where a child’s parents directly oppose the child’s choice of euthanasia.<sup>112</sup> This “child paragraph” was originally a part of the euthanasia and physician-assisted suicide legislation that was recently passed in the Dutch Lower House, but it faced fierce opposition by both physicians and most members of

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<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* Given that the pending legislation recently passed in the Lower House, I was unable to locate the specific guidelines as referred to in Mr. Deutsch’s article at the time of this writing.

<sup>111</sup> Deutsch, *supra* note 13.

<sup>112</sup> Weber, *supra* note 17, at 322.

the parliament and was withdrawn.<sup>113</sup> Based on the requisite criteria to perform euthanasia that was established in 1993, and expansion of those criteria in the pending legislation, the Dutch Parliament should consider rewriting the “child paragraph” to include sixteen to seventeen year old minors in the pending euthanasia legislation. The next section provides an analysis of the need for an expanded “child paragraph.”

### III. RECOGNIZING MATURE MINORS IN EUTHANASIA LEGISLATION

#### *A. Extending the Pending Euthanasia Legislation to Mature Minors*

The pending Dutch legislation allows a sixteen year-old patient to seek euthanasia, in consultation with their parents; children aged twelve to fifteen may also seek euthanasia but parental consent is required.<sup>114</sup> The requirement of “in consultation with their parents,” for a sixteen year-old patient seeking euthanasia, gives rise to a variety of possible interpretations, and arguably the pending legislation already gives sixteen year-old patients the right to seek euthanasia without parental consent. “In consultation with their parents” may be interpreted that a sixteen year-old minor must only consult with their parents regarding a decision about euthanasia. As written, the law does not require actual parental approval of a minor’s choice, only that the parent must be consulted about a minor seeking euthanasia. The law

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<sup>113</sup> *Id.* The State Council considers the judicial consequences of new legislation. In support of the “child paragraph,” the State Council argued that “all existing legislation grants children 12-16 years of age autonomy in deciding about their medical care.” In opposition, physicians “deemed special legislation for children unnecessary, arguing that it is very rare in practice for the child and parents to disagree in these situations.” *Id.*

<sup>114</sup> *Id.*

specifically stipulates that children aged twelve to fifteen must have parental consent, leaving the clause pertaining to a sixteen year-old minor subject to debate.

In the Netherlands, children aged twelve to sixteen already have autonomy in making decisions regarding their medical care.<sup>115</sup> The Dutch Parliament recognizes that these minor's have the capacity to decide what medical care is in their best interest, but, have not granted minors the right to decide if euthanasia is in their best interest, without parental consent. Although members of Parliament opposed the "child paragraph," the language of the legislation appears to, once again, recognize a minor's capacity and autonomy, and support the right of a sixteen year-old minor to choose euthanasia.

The pending legislation applies different requirements for specific age categories seeking euthanasia; appearing to limit the consent requirement to twelve to fifteen year old children. Therefore, the language of the pending legislation suggests that the Dutch Parliament has already provided a loophole for a sixteen to seventeen year-old minor to exercise this right, without directly legalizing the right. Given the history of the Netherlands experience with euthanasia, it appears that the Parliament is not willing to take an official stand regarding the right of a sixteen to seventeen year-old minor to choose euthanasia without parental consent. Without further interpretation, and clarifying the boundaries of the clause "in consultation with their parents," the potential for abuse appears significant. Arguably, the potential for immediate harm is greater than would be caused by directly recognizing the right, in compliance with stringent guidelines. Based on this recognition, and applying both the standards outlined in the pending euthanasia legislation and the "Guidelines for

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<sup>115</sup> *Id.*

Euthanasia,”<sup>116</sup> the “child paragraph” should be re-written to grant sixteen and seventeen year-old minor’s the right to choose euthanasia without parental consent.

*B. Proposed Guidelines for the Right of a Sixteen to Seventeen Year Old to Choose Euthanasia*

The Dutch Parliament already grants children, twelve to sixteen years of age, autonomy in making decisions about their medical treatment.<sup>117</sup> The right to make decisions about medical treatment indicates a recognition by the Parliament that children as young as twelve years old, possess the capacity and competency to make life altering decisions regarding their health. This acknowledgement of capacity and competency should be transferred to decisions regarding euthanasia. And, a sixteen to seventeen year-old minor will possess the capacity to make these decisions for several reasons. First, a sixteen to seventeen year-old patient will possess greater emotional growth as a result of increased age and a larger collection of experiences, giving him or her a greater ability to make reasonable choices. Second, the reality of coping with illness will facilitate a maturity that may not have been attained until much later in life, giving the minor a higher competency to make life and death choices. With the acknowledgement that a sixteen to seventeen year-old has the capacity to make these decisions and competency to understand the nature of the decision, the guidelines set forth in the pending Dutch legislation to legalize euthanasia can be successfully applied to new legislation. This new “child paragraph,” would grant a sixteen to seventeen year-

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<sup>116</sup> Canady Report, *supra* note 52, at 301-303, 307-309. *See also The Right of the Individual or the Common Good?*, Volume One-Report of the Inquiry by the Select Committee on Euthanasia, May 16, 1995, (visited Dec 28, 2000) available at <http://www.nt.gov.au/lant/rotti/vol1.shtml>, at §4.1 [hereinafter *Right of the Individual*].

<sup>117</sup> Weber, *supra* note 112, at 322.

old minor the right to choose euthanasia without parental consent or in direct opposition of parental wishes.<sup>118</sup>

The guidelines which must be followed are those outlined in the pending Dutch legislation, legalizing physician-assisted suicide and euthanasia.<sup>119</sup> These guidelines codify the Guidelines for Euthanasia,<sup>120</sup> that were established by the Dutch Medical Association in 1986.<sup>120</sup> In addition, the Dutch government has reporting procedures in place that require a physician to complete patient questionnaires and report “all instances a physician assists in suicide, performing euthanasia on request, or terminating a patient’s life without the patient’s consent.”<sup>121</sup>

First, the patient must be experiencing unremitting and unbearable suffering as a result of their illness.<sup>122</sup> As with an adult, a physician can determine whether a sixteen to seventeen year-old minor is experiencing suffering, and if that suffering is unremitting and unbearable for the patient. The stipulated test for a patient’s medical condition requires that the physician assess the patient, and reasonably conclude

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<sup>118</sup> *Id.*

<sup>119</sup> Deutsch, *supra* note 13.

<sup>120</sup> Canady Report, *supra* note 52, at 301. *See also* Right of the Individual, *supra* note 116, at §4.1.

<sup>121</sup> Press Release, Office of Health & Env’t, Royal Neth. Embassy, Washington, D.C., Memo from the Ministerie van Justitie, Directie Voorlichting, Compulsory Euthanasia Notification Procedure Comes into Force on 1 June (May 11, 1994).

<sup>122</sup> Office of Health & Env’t, Royal Neth. Embassy, Washington, D.C., Memorandum from the Ministerie van Justitie, Directie Voorlichting, Consequences of Supreme Council Decree for Prosecution Policy in Relation to Euthanasia and Assisted Suicide [hereinafter Consequences of Prosecution Policy]. “In principles[,] the cause of the suffering and the circumstance of the terminal phase are deemed irrelevant. According to both ministers [i.e., the Ministers of Justice and Public Health], the basic consideration must be the unbearable suffering of the patient concerned without any prospect of improvement.” *Id.* *See also* GOMEZ, *supra* note 64, at 39; Little, *supra* note 7, at 441.

“that the patient was suffering unbearably.”<sup>123</sup> In addition, the physician must further assess the patient’s suffering to discern whether the suffering is “without prospect of improvement.”<sup>124</sup> The Dutch courts require that “extremely strict conditions” be met in an attempt to narrow physician assistance, “requiring that there is no possibility of any form of treatment whatsoever being effective.”<sup>125</sup>

Second, the patient must be aware of all other medical options available.<sup>126</sup> The quality of a patient’s decision is

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<sup>123</sup> Consequences of Prosecution Policy, *supra* note 122. The Dutch do not expressly require that the patient’s medical condition involve a terminal illness, as a requisite for permitting euthanasia. Canady Report, *supra* note 52, at 313.

<sup>124</sup> Consequences of Prosecution Policy, *supra* note 122. Hopelessness of suffering is established by an objective test requiring that “[p]rofessional medical judgment must have established beyond doubt that the patient’s situation is beyond improvement, which is the case when there is no realistic therapeutic perspective.” *Id.* See also Canady Report, *supra* note 52, at 313.

<sup>125</sup> Consequences of Prosecution Policy, *supra* note 122. See also Little, *supra* note 7, at 441.

<sup>126</sup> GOMEZ, *supra* note 64, at 30-32. This concept was addressed when the Supreme Court of the Netherlands heard the 1992 Alkmaar case. *Id.* The physician was acquitted at Alkmaar, then convicted by the Court of Appeals at Amsterdam. The Court of Appeals held the physician was subject to Article 293 because he failed to demonstrate that euthanasia was the only way to alleviate the patient’s suffering. The physician appealed to the Supreme Court, and the court stated that the lower court should have considered the “disfigurement of the patient’s personality and/or further deterioration of her already unbearable suffering,” in order to assess whether there were other options to alleviate her suffering. The court held that “psychic suffering” was an acceptable justification for requesting euthanasia. There is no requirement in the criteria or the court, however, this case seems to imply that a physician must include psychiatric treatment when discussing available medical options with a patient. Canady Report, *supra* note 52, at 308-309. While the Dutch courts require that a physician present all available medical options to a patient, there has been no decision that has expressly interpreted this clause and identified the scope of options that must be presented. GOMEZ, *supra* note 64, at 30, 36.

based on a patient's awareness of the options and competency to make an informed and thoughtful decision.<sup>127</sup> While the Dutch require a patient to thoughtfully consider all available options, there is no express requirement that specifies the competency a patient must possess or factors to consider in assessing that competency, while a patient reaches a decision.<sup>128</sup> The question arises whether a sixteen to seventeen year-old has sufficient competency to be "aware" of all available options, understand those options, and assess the implications and consequence of each option. This criterion may present a difficult hurdle since there are no medical guidelines and little case law to formulate an understanding of how competency is defined.<sup>129</sup> However, this also suggests that the Dutch competency requirement does not exclude a sixteen year-old minor from being considered competent. The definition of "capacity" is "a condition of being able or qualified,"<sup>130</sup> and "competence" is to be "well qualified and capable."<sup>131</sup> As discussed above, the Dutch Parliament already acknowledges a twelve to sixteen year olds' capacity to understand medical choices by allowing these children autonomy in making those choices,<sup>132</sup> and suggesting that the Dutch Parliament also views a sixteen year-old minor as being competent. Therefore, by applying a presumption of competency, a sixteen to seventeen year-old

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<sup>127</sup> Canady Report, *supra* note 52, at 308-309.

<sup>128</sup> Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., *The Termination of Life by a Doctor in the Netherlands (1995)* [hereinafter *Termination of Life*]. The court confirms the five requirements that were outlined by the General Board of the Royal Dutch Medical Association in 1984, however, competency of the patient is not included.

<sup>129</sup> *Id.*

<sup>130</sup> WEBSTER'S NEW WORLD DICTIONARY, SECOND COLLEGE EDITION. 209 (9<sup>th</sup> Edition, 1996).

<sup>131</sup> *Id.*

<sup>132</sup> Weber, *supra* note 17, at 322.

minor can be “aware” of the medical options available, and meet this requirement for requesting euthanasia.

Third, the primary physician must consult with “at least one other physician with an independent viewpoint who must have read the medical records and seen the patient.”<sup>133</sup> While Dutch courts have not specifically addressed the requirement of a secondary medical consultation, the overall purpose is to confirm that the request for euthanasia is both appropriate and genuine.<sup>134</sup> However, the courts appear to emphasize the importance of both the physician and patient understanding the patient’s medical condition, and working together to decide whether the patient qualifies for euthanasia based on those circumstances.<sup>135</sup> The same analysis that was done for the second requirement is appropriate here. A sixteen year-old minor has the competence to enable that minor to understand a corroborating or differing view of his or her case, by a consulting physician, and apply that additional information toward a decision based on their circumstances.

Fourth, the request must be made voluntarily, persistently and independently.<sup>136</sup> In an attempt to assess the voluntary nature of a patient’s request, these three elements are considered: “the physician’s knowledge of the patient, the manner in which the patient makes the request, and the durable nature of the consent.”<sup>137</sup> The Dutch courts have placed great emphasis on the first component: the primary physician must have a relationship with the patient which allows the physician to sufficiently know the patient, and thus determine whether the request is voluntary.<sup>138</sup>

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<sup>133</sup> Termination of Life, *supra* note 128.

<sup>134</sup> Canady Report, *supra* note 52, at 320.

<sup>135</sup> *Id.* See also Termination of Life, *supra* note 128.

<sup>136</sup> Termination of Life, *supra* note 128. See also, Canady Report, *supra* note 52, at 320.

<sup>137</sup> Little, *supra* note 7, at 446.

<sup>138</sup> Termination of Life, *supra* note 128. See also Little, *supra* note 7, at 446. Problems arise when a patient is a referral from another physician, and the primary physician does not know the patient well

Furthermore, Dutch courts require that a patient make the request to a physician in a persistent, definite manner, showing clear resolve.<sup>139</sup> Again, the analysis done for the criteria discussed above is appropriate for this requirement. A sixteen year-old minor has the capacity and competency to understand the nature of a voluntary decision versus a non-voluntary decision, and express his or her choice accordingly. Furthermore, a sixteen year-old minor can understand the type of communication required, delivering a persistent message of intent. The biggest hurdle with this requirement is that the request be independent. The word “independent” requires further interpretation, since a minor child will generally still be living with his or her parents. The possible interpretations include, the requirement for independent thought or independent from outside influence. With the enormous burden that comes with making this type of decision, it is unrealistic to believe that any individual, whether the age of a minor or adult, will not reasonably seek outside opinions and thus be influenced by those opinions. However, a sixteen year-old minor has the capacity to maintain independent thought while processing and

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enough to assess the voluntary nature of the patients request. GOMEZ, *supra* note 64, at 43. The court prefers that a new primary physician know a patient well enough to assess that patient, however, no official requirements have been discussed. *Id.*

<sup>139</sup> Canady Report, *supra* note 52, at 308-309. In 1973, a Dutch court held that performing euthanasia is generally acceptable when “[t]he patient has indicated in writing... that he desires to terminate his life.” GOMEZ, *supra* note 64, at 30. However, prior to the pending legislation, there was no subsequent court decision that addressed the requirement of a writing or made a writing a requisite for using the defense of *force majeure*. *Id.* at 25-37. Furthermore, a physician does need to include a writing in the mandatory report filed, following the performance of euthanasia. Canady Report, *supra* note 52, at 310-314. Therefore, there are no objective requirements established, in statutory guidelines or case precedent, to prevent non-voluntary euthanasia. Little, *supra* note 7, at 445-446.

integrating opinions from outside sources, and reach a thoughtful yet independently minded decision about his or her circumstances.

Finally, there are several attributes inherent to the Netherlands, which provide protection against abuse by physicians, family members or anyone with unfavorable motives.<sup>140</sup> These attributes, combined with the requirement for a physician providing assistance to comply with established reporting procedures, decrease the risks involved in cases of requests for physician assistance. There are no guarantees, however, these attributes and guidelines provide a further buffer against potential abuse.

Upon the patient's death, the physician must report the death.<sup>141</sup> The physician is statutorily required by the Act on the Disposal of the Dead<sup>142</sup> to: "provide a case history detailing the diagnosis of the patient, the duration of the illness, the nature of the treatment given, the names of the attending physicians, and a statement to the effect that the patient's mental and physical suffering was unbearable and that the situation was at such a point, the patient would not have been able to die with dignity except for euthanasia."<sup>143</sup> The physician is also required to state that the patient requested euthanasia from his or her own free will, after adequate consultation and discussion with the physician.<sup>144</sup> The physician must document and communicate the circumstances surrounding the request for euthanasia, any other options the patient may have considered, and any outside influences, which may have affected his or her

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<sup>140</sup> SCHERER, *supra* note 1, at 45-54.

<sup>141</sup> Press Release, Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Memo from the Ministerie van Justitie, Directie Voorlichting, Compulsory Euthanasia Notification Procedure Comes into Force on 1 June (May 11, 1994).

<sup>142</sup> *Id.*

<sup>143</sup> Funk, *supra* note 28, at 153.

<sup>144</sup> DEREK HUMPHRY, *LAWFUL EXIT* 27, 48 (1993). *See also* Funk, *supra* note 28, at 153.

request.<sup>145</sup> The physician must disclose the consulting physician and provide the foundation for their recommendations and conclusions.<sup>146</sup> Finally, the physician must provide information that discloses the method of euthanasia that was performed.<sup>147</sup>

As stated, the concept of individual autonomy or self-determination is the driving force behind the practice of euthanasia in the Netherlands.<sup>148</sup> The Netherlands has one of the highest medical and health standards in the world and enjoys a unique health care system and medical community.<sup>149</sup> Over ninety-nine percent of Netherlands' citizens are covered by health insurance and the government-guaranteed health care system supports the development of long-term relationships between a physician and patient.<sup>150</sup> "Thus no financial incentives exist for the medical community or the family to cease or reduce treatment and benefits for patients."<sup>151</sup> This extraordinary health-care system and development of trusting relationships between physicians and patients is unique to the Netherlands, and enables the practice of euthanasia and physician-assisted suicide with significant safeguards against abuse in place. "Economics simply does not and cannot influence medical decisions at the end of life as the medical institutional system does not stand to profit from these choices and the family of

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<sup>145</sup> Right of the Individual, *supra* note 116, at §4.1.

<sup>146</sup> *Id.*

<sup>147</sup> HUMPHRY, *supra* note 144, at 49. *See also* Funk, *supra* note 28, at 153 (2000).

<sup>148</sup> SCHERER, *supra* note 1, at 147. The concept of individual autonomy is consistent with the idea of "social individualism within an industrialized society." This concept infiltrated the Netherlands in the 1960's and 1970's when the Dutch began seeking and debating about "providing humane ways of dying in the new technological age." *Id.*

<sup>149</sup> *Id.* at 39-40, 45-54, 133-134.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.* at 53.

the patient is not burdened with health care expenses.”<sup>152</sup> Based on the guidelines and protections in the pending Dutch legislation, the inherent protections within the Netherlands, and analysis of how a sixteen year-old minor can meet those guidelines, the “child paragraph” should be rewritten to give sixteen to seventeen year old minors the right to euthanasia.

*C. Non-Voluntary Euthanasia, Issues of Parental Consent*

Allowing voluntary euthanasia in the Netherlands has inevitably led to some cases of non-voluntary euthanasia.<sup>153</sup> Non-voluntary euthanasia is primarily witnessed in the small number of cases involving elderly patients who are incompetent and newborns who are severally handicapped, or are so ill upon birth that the baby will almost certainly have an unlivable life.<sup>154</sup> In response to arguments that these non-voluntary acts were a beginning down the slippery slope,

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<sup>152</sup> *Id.* at 147.

<sup>153</sup> P.J. van der Maw et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 22 HEALTH POL'Y 1 (1992). For a discussion of neo-natal euthanasia, see J. Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL, & LEGAL PERSPECTIVES (J. Keown, ed. 1995). This report indicates that about 1,000 patients' lives were terminated by non-voluntary euthanasia, or without an explicit request in 1990. *Id.* See also *Zaak Stinissen, Gerechtshof Arnhem d.d. 31 October 1989*, 14.1 *Tijdschrift Voor Gezondheidsrecht* 79 (1990); and *Staking toedieng van vocht en voeding onrechtmatig* Court of Appeal Arnhem d.d. 16 January 1990, 14.2 *Tijdschrift Voor Gezondheidsrecht* 167 (1990). The *Stinissen* case did not condone non-voluntary euthanasia, however condoned the withdrawal of treatment for a woman who died after sixteen years in a coma, following the withdrawal of food and fluids. *Id.*

<sup>154</sup> Henk Jochemsen, *Life-Prolonging and Life-Terminating Treatment of Severely Handicapped Newborn Babies: A Discussion of the Report of the Royal Dutch Society of Medicine on "Life Terminating Actions with Incompetent Patients, Part I Severely Handicapped Newborns*, 8 ISSUES IN LAW AND MEDICINE 452, n.2 (1992).

the Dutch Parliament formalized reporting guidelines that physicians must meet, providing a safeguard against abuse in these non-voluntary cases.<sup>155</sup>

Decisions regarding the termination of newborns, who are severally handicapped or have little prospect of a viable life, involve questions such as what constitutes an intolerable life.<sup>156</sup> Considerations include parameters such as the child's life expectancy, capacity to communicate, extent of suffering, and degree of independence the child will enjoy.<sup>157</sup> In addition, these decisions require that the physician assess and comply with several criteria before any act is performed, providing a measurable safeguard against abuse.<sup>158</sup> The

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<sup>155</sup> Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Memo from the Ministerie van Justitie, Directie Voorlichting, Compulsory Euthanasia Notification Procedure Comes into Force on 1 June (Press Release dated May 11, 1994). Prior to 1989, there were no court decisions permitting non-voluntary euthanasia. Therefore, each case that was reported would be prosecuted to permit the court to examine whether the physician could use the *force majeure* defense. *Id.*

<sup>156</sup> Jochemsen, *supra* note 154, at 452, n.2.

<sup>157</sup> *Vonnis Arrondissementsrechtbank te Alkmaar d.d. 26 April 1995*, in the case against P, 19.5 *Tijdschrift Voor Gezondheidsrecht* 292-301 (1995); *Vonnis Rechtbank te Groningen d.d. 13 November 1995*, in the case against K, 3.1 *Pro Vita Humana* 29-32 (1996). Both cases were appealed by the Prosecutor to the Courts of Appeal, in Amsterdam and Leeuwarden, respectively. See *Arrest Gerechtshof te Amsterdam d.d. 7 November 1995*, in the case against P, 3.1 *Pro Vita Humana* 25, 18 (1996); *Arrest Gerechtshof te Leeuwarden d.d. 4 April 1996*, in the case against K, 20.5 *Tijdschrift Voor Gezondheidsrecht* 284, 19 (1996).

<sup>158</sup> See *Arrest Gerechtshof te Amsterdam d.d. 7 November 1995*, in the case against P, 3.1 *Pro Vita Humana* 25, ¶ 8 (1996). See also *Arrest Gerechtshof te Leeuwarden d.d. 4 April 1996*, in the case against K, 20.5 *Tijdschrift Voor Gezondheidsrecht* 284, ¶ 9 (1996). Both cases provide guidelines for physicians to follow "in cases of life termination without an explicit request." See Jochemsen, *supra* note 154, at 452, n.2. These guidelines are in addition to the guidelines established for reporting cases of performing euthanasia. Press Release, Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Memo from

requirements include: (1) assessing whether the suffering is intolerable; (2) determining there are no viable alternatives; (3) parental agreement; (4) team discussion; (5) independent consultation; and (6) responsible practice by the physician.<sup>159</sup> In general, a physician must be certain about the prognosis of the child and determine that there is no real chance of survival.<sup>160</sup> And, there is ongoing debate about how a

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the Ministerie van Justitie, Directie Voorlichting, Compulsory Euthanasia Notification Procedure Comes into Force on 1 June (May 11, 1994).

<sup>159</sup> *Vonnis Arrondissementsrechtbank te Alkmaar d.d.* 26 April 1995, in the case against P, 19.5 *Tijdschrift Voor Gezondheidsrecht* 292-301 (1995); *Arrest Gerechtshof te Amsterdam d.d.* 7 November 1995, in the case against P, 3.1 *Pro Vita Humana* 25, ¶ 8 (1996). In the case of Doctor P. in Alkmaar, a baby was suffering from spina bifida, brain damage, hydrocephalus and a spinal cord lesion. The specialists determined from her behavior that she was suffering extreme pain. *Id.* The physician's did not operate because of her poor prognosis, and concluded that the baby could not be treated. *Id.* The parents asked for the termination of her life because they did not want their child to suffer. *Id.* The baby was killed by P., after consulting with other physicians, three days after she was born. *Id.* The court held that "the life-termination in this case was the most appropriate course of action," and allowed the physician to use the *force majeure* defense. *Id.* at 294. The court focused on whether the choice not to operate violated the requirement of "suffering that could not be alleviated in a medically meaningful way," finding that the palliative treatment in this case was meaningless. *Id.* The court recognized that the parents gave consent to kill the child, however, did not make the express request of the parent a requirement for terminating a child's life. See Jochemsen, *supra* note 154, at 452-454 (1992).

<sup>160</sup> *Vonnis Rechtbank te Groningen d.d.* 13 November 1995, in the case against K, 3.1 *Pro Vita Humana* 29-32 (1996); *Arrest Gerechtshof te Leeuwarden d.d.* 4 April 1996, in the case against K, 20.5 *Tijdschrift Voor Gezondheidsrecht* 284, ¶ 9 (1996). The Groningen case involved a newborn with a syndrome that manifested itself in deformities of the face, skull, hands, heart and heart damage and kidney malfunction. The baby was diagnosed as nonviable and expected to die within six months to a year. The parents took the child home, and within one week tissue began coming out of the child's skull, causing the child severe pain. After several days, the parents gave explicit consent to end the

physician decides when the treatment to alleviate suffering is medically futile. Currently, physicians in the Netherlands interpret this requirement to apply when an “unlivable life prognosis makes life-sustaining treatment medically futile.”<sup>161</sup>

When a physician carries out euthanasia for an infant, parental consent is required.<sup>162</sup> In these cases, the non-voluntary aspect of euthanasia refers to the patients’ lack of competence to communicate intentions and ultimately a choice. The newborn is incompetent, requiring parental involvement to serve their best interest and provide consent for what is in their best interest. While a team of physicians is the primary influence in a decision about euthanasia, there are documented cases of children with non-terminal diseases where the parent chose not to treat the child, and the child died.<sup>163</sup>

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child’s life by lethal injection. The court accepted the defense of *force majeure* for performing euthanasia, and distinguished the issue of parental consent versus parental request to end the child’s life. The court stated that explicit consent is not necessary for a physician to use the defense of *force majeure*. *Id.* at ¶ 19.

<sup>161</sup> See Jochemsen, *supra* note 154, at 452. The reasoning of both courts in the case of K., and P., was the following: “(1) on the basis of experts, the infant has disorders that will lead to a natural death unless treated; and (2) the physician considers medical treatment aimed at saving the life of the infant as medically futile or disproportionate.” *Id.* See also *Vonnis Rechtbank te Groningen d.d.* 13 November 1995, in the case against K, 3.1 Pro Vita Humana 29-32 (1996).

<sup>162</sup> *Vonnis Arrondissementsrechtbank te Alkmaar d.d.* 26 April 1995, in the case against P, 19.5 Tijdschrift Voor Gezondheidsrecht 292-301 (1995); *Arrest Gerechtshof te Amsterdam d.d.* 7 November 1995, in the case against P, 3.1 Pro Vita Humana 25, ¶ 8 (1996). See also *Vonnis Rechtbank te Groningen d.d.* 13 November 1995, in the case against K, 3.1 Pro Vita Humana 29-32 (1996). *Arrest Gerechtshof to Leeuwarden d.d.* 4 April 1996, in the case against K, 20.5 Tijdschrift Voor Gezondheidsrecht 284, ¶ 9 (1996).

<sup>163</sup> Canady Report, *supra* note 52, at 323. A six-year-old with juvenile diabetes mellitus needed insulin injections to prevent

While parents are required to give consent to serve the best interest of an incompetent child, these cases show that no safeguard will prevent abuse in all situations. Furthermore, these cases give support for the argument that in the case of a sixteen-year-old minor, that minor is presumed and should be recognized as competent, as discussed above. First, the minor is presumed competent and therefore able to provide the requisite consent regarding his or her own life. Second, a sixteen year-old minor is competent to assess the information that is relevant to his or her consideration of euthanasia, and decision about what treatment is in their best interest. Therefore, the requirement that a minor's parent provide consent for an incompetent patient is not applicable.

A competent sixteen year-old is capable of determining whether medical treatment, based on their circumstances and prognosis, is medically futile and communicating the option that is in their best interest. Cases, which show a parent refusing to treat a child who is ill, though not terminally ill, illustrate that the potential for abuse also exists in issues of parental consent. Requiring consent from a parent does not always serve the best interest of the child, and can lead to abuse on a case by case situation by serving the parents' interests and not interests of the child or minor. However, strict guidelines in euthanasia legislation will address all sixteen to seventeen year-old minors, by providing statutorily mandated criteria for allowing euthanasia. Therefore, these guidelines will protect all sixteen to seventeen year-olds from choosing euthanasia when it is without justification or in their

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disturbances in his metabolism. The boy was of average intelligence and his parents would not treat the child, resulting in his death. This case reflects a concern maintained by opponents to euthanasia that people with disabilities will be abused because of the attitude that they are not worth treating, and is perpetuated by a tolerance for performing euthanasia. Richard Fenigsen, *Physician-Assisted Death in the Netherlands: Impact on Long-Term Care*, 11 *ISSUES IN LAW & MED.* 283, 287-89 (1995).

best interest, and address the risk of abuse by issues of parental consent. While parental consent may be necessary for incompetent patients, a competent child can provide his or her own consent. This consent, in accordance with legal guidelines, removes the need for parental consent and provides more protection from abuse than is created by requiring parental consent.

#### *D. Use of the Mature Minor Doctrine*

The Mature Minor Doctrine, developed and utilized in the United States, can be used as another guideline for determining whether a sixteen year-old minor is competent to make decisions regarding euthanasia. The Mature Minor Doctrine is a legal concept, relatively new in application, which allows some terminally ill minors to refuse medical treatment without parental consent.<sup>164</sup> In general, courts have

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<sup>164</sup> Susan C. Lonowski, *Recognizing the Right of Terminally-Ill Mature Minors to Refuse Life-Sustaining Medical Treatment. The Need for Legislative Guidelines to Give Full Effect to Minors' Expanded Rights*, 34 U. LOUISVILLE J. FAM. L., 421 (1996). "Traditionally, the law has recognized children as incompetents, unable to make life-sustaining treatment decisions on their own behalf." *Id.* See also Jennifer Fouts Skeets, *In re E.G.: The Right of Mature Minors in Illinois to Refuse Lifesaving Medical Treatment*, 21 LOY. U. CHI. L.J. 1199, 1204 (1990). The court has held that a minor does not have the legal capacity to withhold or give consent to medical procedures, however the Mature Minor Doctrine provides an exception to this rule. See Susan D. Hawkins, *Protecting the Rights and Interests of Competent Minors In Litigated Medical Treatment Disputes*, 64 FORDHAM L. REV. 2100-01(1996). While only a few states have recognized the Mature Minor Doctrine, those states have "eliminated the parental consent requirement for medical treatment and now allow a 'mature minor' to make his or her own medical treatment decisions." See Christine M. Hanisco, *Acknowledging the Hypocrisy: Granting Minors the Right to Choose Their Medical Treatment*, 16 N.Y.L. SCH. J. HUM. RTS. 899, 899 (2000). The Supreme Court has held that the states are the "final guarantors of matters relating to personal privacy, not the federal

not extended the common law doctrine of informed consent to children, citing two reasons that children do not share the right to informed refusal with adults.<sup>165</sup> First, courts adhere to the belief that children are not competent to make such enormous decisions regarding their lives.<sup>166</sup> Second, courts rely on the assumption that parents will collaborate with physicians to make decisions that are in the best interest of

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government,” however, a state may intervene in the case of children by showing a “significant” state interest that outweighs the child’s rights rather than a “compelling” state interest. *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 427 n. 10 (1983). The case of Benny Argelo was the first case that established that a “minor” could refuse medical treatment on his or her behalf. Lonowski, *supra* at 430, n. 60. While court records are closed due to confidentiality laws, the Supreme Court’s interpretation of Florida’s constitutional right to privacy was a significant factor in the decision. *Id.* See *In re Barry*, 445 So.2d 365-70 (Fla. Dist. Ct. App. 1984) where the court “reaffirmed that the constitutional right to privacy affords a competent adult suffering from a terminal illness the right to refuse extraordinary medical treatment where all affected family members consent.” See also Lonowski, *supra* at 427, n.41. See also *In re T.W.*, 551 So. 2d 1186-1193 (Fla. 1999), where the court held that “the right of privacy extends to every natural person and that there is no differentiation between adults and minor’s with respect to privacy rights because minor’s are natural persons within the meaning of Article I Section 23 of the Florida Constitution. *Id.* See also Lonowski, *supra* at 427, n.43. See also *Argelo*, 568 So. 2d 4 (Fla. 1990), where the court determined that the state did not have a significant interest sufficient to outweigh the right to privacy afforded to Benny and allowed his refusal to further experimental treatment for his malfunctioning liver. See Lonowski, *supra* at 423, n.7. See also, Christine Gorman, *A Sick Boy Says “Enough!”*, TIME, June 27, 1994, at 65. The court probably used factors outlined in the Browning case to determine whether the state had a significant interest: “(1) preservation of life; (2) protecting the interests of innocent third parties; (3) prevention of suicide; and (4) maintaining the ethical integrity of the medical profession.” See *In re Barry*, 445 So. 2d 365 (Fla. 1984). The court granted Benny the right to refuse further medical treatment, however, it is unclear the extent to which a right to privacy will further impact the right of terminally-ill children to refuse life-sustaining medical treatment.

<sup>165</sup> Lonowski, *supra* note 164, at 431, n.164 (1996).

<sup>166</sup> *Id.* at 432.

the child.<sup>167</sup> Therefore, the Mature Minor Doctrine is a recognized exception to the general rule requiring consent by a parent for medical treatment.<sup>168</sup>

The Mature Minor Doctrine allows a minor the right to consent to or refuse specific medical treatment, when the minor can demonstrate that they comprehend the nature and consequences of the proposed treatment.<sup>169</sup> While some courts have not applied the doctrine when there is evidence of immaturity, courts generally hold that the doctrine is applicable because the right to make these decisions does not depend on age.<sup>170</sup> In applying this doctrine, the majority of courts have held that the minor must “prove he or she is mature enough to appreciate the consequences of his or her decision, and mature enough to exercise the judgement of an

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<sup>167</sup> *Id.*

<sup>168</sup> *Id.* at 432, n.71.

<sup>169</sup> *Id.*

<sup>170</sup> See e.g., *Hodgson v. Minnesota*, 497 U.S. 434 (1990). See also *Lonowski*, *supra* note 164, at 432 (1996). See *In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989). The Illinois Supreme Court recognized the common law right of a minor to refuse medical treatment. E.G. was a girl, seventeen and a half years old, who needed blood transfusions to treat acute nonlymphatic leukemia. *Id.* at 323. Both E.G. and her mother refused consent to the blood transfusions based on their views as Jehovah’s Witnesses, that receiving blood violated the prohibition of consuming blood that is in the Bible. See *In re E.G.*, 549 N.E.2d at 323. The court recognized that the United States Supreme Court has not recognized the right of a minor to refuse life-sustaining medical treatment, and based their decision on Illinois statutes and case law. *In re E.G.*, 549 N.E.2d 322 at 325-28 (Ill. 1989). The court concluded that in absence of a statute, a minor could refuse medical treatment, with judicial approval. *Id.* at 327. The court stated that a judge should decide “whether a minor is mature enough to make health care choices on her own,” and maintained that this right must be considered and balanced against the four state interests outlined in *Browning*, and discussed above. *Id.* at 328.

adult.<sup>171</sup> The standard of proof that is required for the rule to apply differs from court to court, however most courts rely on two established standards: (1) “clear and convincing” evidence of a minor’s maturity; and (2) use of the common law “Rule of Sevens.”<sup>172</sup> Using the “Rule of Sevens,” courts have held that there is a presumption that a teenager, older than fourteen, possesses the capacity to provide informed consent regarding their medical treatment.<sup>173</sup> What constitutes a show of “clear and convincing” remains undecided, however scientific research and evidence have provided some guidelines for various courts.<sup>174</sup>

Scientific Research shows that by age twelve, formal operational thought emerges, therefore a fourteen year-old minor usually possesses adequate reasoning ability to make

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<sup>171</sup> *Bellotti v. Baird*, 443 U.S. 622, 632 (1979); *see also In re E.G.*, 549 N.E.2d at 327; *Long Island Jewish*, 557 N.Y.S.2d at 243. The Massachusetts Appeals Court provides the most recent case regarding a minor’s right to refuse medical treatment. *See In re Rena*, 705 N.E. 2d 1155 (Mass. 1999). The Court vacated the lower court’s decision to order a seventeen year-old Jehovah’s Witness to receive blood transfusions. *Id.* The court used the test outlined in *Browning* to evaluate the minor’s maturity, and directed judges to also consider his or her religious convictions and the testimony of the minor to determine the minor’s wishes. *Id.* at 1157.

<sup>172</sup> *Id.* *See also Gulf & S.I.R. Co. v. Sullivan*, 119 So. 501, 502 (Miss. 1928). “To reflect the minor’s reasoning abilities as they evolve through different stages of his or her development, capacity sometimes has been determined by the “Rule of Sevens.” *Id.* “The Rule of Sevens provides that under the age of seven, a child has no capacity; between the ages of seven and fourteen, there exists a rebuttable presumption that the minor has no capacity; and between the ages of fourteen and twenty-one, there exists a rebuttable presumption that the individual has capacity.” *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987). *See also Lonowski*, *supra* note 164, at 433, n.80.

<sup>173</sup> *Cardwell*, 724 S.W.2d at 745. *See also Lonowski*, *supra* note 164, at 433. The court distinguishes this age “based on recognition that children usually possess reasoning ability by this age.” *Id.*

<sup>174</sup> *See In re E.G.*, 549 N.E.2d at 327-28. *See also Lonowski*, *supra* note 164, at 433.

decisions regarding medical treatment.<sup>175</sup> By the age of fifteen, researchers indicate that most minors will demonstrate evidence of full adult competence.<sup>176</sup> Furthermore, children between eleven and fourteen possess mature decision making ability, however this ability heavily relies on the complexity of the issue and situational factors.<sup>177</sup> Finally, research suggests that most children below the age of eleven do not possess the capacity to provide informed consent.<sup>178</sup>

For the reasons discussed above, the Dutch Parliament should consider rewriting the “child paragraph,” giving the right to choose euthanasia to minor’s who reach sixteen to seventeen years of age. Minor’s reaching fifteen years of age and older are “capable of providing informed consent, which includes the right to refuse life-sustaining medical treatment,”<sup>179</sup> by demonstrating traits of full adult competence.<sup>180</sup> Therefore, a sixteen year-old minor can possess full adult competence, enabling a minor to apply the same competence to a decision about euthanasia as he or she

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<sup>175</sup> See *supra* note 164, at 433, n.83. See also *In re Swan*, 569 A.2d 1202 (Me. 1990). The Maine Supreme Judicial Court recognized that a minor has a right to refuse life-sustaining medical treatment. Chad Swan was left in a vegetative state following a car accident, nine months before his eighteenth birthday. The court found clear and convincing evidence that Chad had expressed his desire not to be maintained on life-sustaining medical equipment prior to the accident, on more than one occasion, and that these statements were controlling. *Id.* at 1204-1205. The court noted the presumption that minor’s over fourteen years old are competent and allowed his parents to decide whether to use the life-saving medical treatment. *Id.* at 1205-1206.

<sup>176</sup> Richard E. Redding, *Children’s Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 726 (1997). See also Lonowski, *supra* note 164, at 431.

<sup>177</sup> Redding, *supra* note 176, at 726.

<sup>178</sup> *Id.*

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

brings to decisions about medical treatment. Furthermore, the Parliament can explicitly stipulate in the legislation, that the minor must show evidence of maturity, beyond what is presumed for decisions regarding medical treatment. The guidelines established by the application of the Mature Minor Doctrine could provide both support and assistance to the Dutch Parliament in this determination. Establishing criteria for maturity will safeguard against a minor utilizing this right without the requisite competence, and afford those minors' showing maturity, the right to choose euthanasia without parental consent.

#### IV. CONCLUSION

In July, the Dutch government withdrew a portion of the pending legislation to legalize euthanasia; the proposed "child paragraph" gave children aged twelve to sixteen who experience constant suffering, the right to choose euthanasia without parental consent. Based on the arguments presented, the Dutch Parliament should rewrite the "child paragraph," and allow sixteen to seventeen year old minor's the right to choose euthanasia, without parental consent. The Parliament should recognize that parental consent is unnecessary when a patient is competent and mature, and integrate the proposed criteria to request euthanasia into a new "child paragraph." Furthermore, the Parliament can utilize the guidelines that are developed from Mature Minor Doctrine to create new requirements for a minor to show the maturity and competence of an adult, while safeguarding against abuse. Integrating a new "child paragraph" will expand the right of self-determination for a sixteen to seventeen year-old minor and allow those minors' to realize the rights afforded to those with full adult competence. In a country that clearly values autonomy and already recognizes the right of a minor to decide about medical care, the next step is to recognize the

rights of these minor's to choose euthanasia without parental consent.

With pending legislation to legalize euthanasia, the Dutch have the most ambitious euthanasia system in the world. Upon approval by the Upper House in the Dutch Parliament, the Netherlands will become the only nation to legally allow a physician to assist a suffering patient to terminate their life. While countries such as Japan, Belgium, Columbia, Germany and Switzerland have taken steps in the right-to-die movement, the Dutch experience will continue to be instructive in considering future legislation. The right-to-die movement is strong; however, there are a plethora of issues surrounding this ongoing debate. The Dutch experience with euthanasia will continue to add to this debate, educate other countries that value individual autonomy about the practice of euthanasia and provide a valuable example of how a society is affected by the legalization of euthanasia.

