
*Physician-Assisted Suicide and
Euthanasia in the Netherlands: A
Report to the House Judiciary
Subcommittee on the Constitution**

Executive Summary

This report examines legal developments and policy arguments in the Netherlands which, in the past 23 years, have led from toleration of the practice of physician-assisted suicide for physically-suffering, terminally-ill, competent patients to the judicial and medical sanctioning of the non-consensual termination of patients' lives.

Since 1886, the Dutch Penal Code has prohibited assisted suicide and euthanasia. However, in the 1970s the Dutch courts began to tolerate physician-assisted suicide and euthanasia for terminally-ill, competent patients. By the early 1980s, the medical profession and courts in the Netherlands had established guidelines for physicians to perform assisted suicide and euthanasia. In 1984, the Supreme Court of the Netherlands accepted physician-assisted suicide and euthanasia, not only for terminally-ill patients, but also for chronically-ill or elderly patients whose deaths were not otherwise imminent.

In 1986, the Dutch medical association in collaboration with the nurses association established official "Guidelines for Euthanasia." These official Guidelines form the basis for the current practice of physician-assisted suicide and euthanasia in the Netherlands. The Guidelines list five criteria for physicians to meet before engaging in assisted suicide or euthanasia. First, a voluntary request from the patient is required. Second, the request must have been well considered by the patient. Third, the patient must have a "persistent desire for death." Fourth, the suffering of the patient must be unacceptable. And fifth, the physician must consult with another colleague. Although the

*A report of Chairman Charles T. Canady, to the House Judiciary Subcommittee on the Constitution, of the Committee on the Judiciary, House of Representatives, One Hundredth Fourth Congress, Second Session, September 1996.

criteria are explained in the Guidelines and in a report on which the Guidelines were based, the criteria remain vague and ambiguous and leave a great deal of discretion to physicians.

Although the Guidelines specifically require that a patient voluntarily request physician-assisted suicide or euthanasia, the Rummelink Report, a study of the practice of physician-assisted suicide and euthanasia, confirmed that non-voluntary euthanasia was being widely performed in the Netherlands. The Report cited that in 1990 there were 2,300 cases of euthanasia at the patient's request, 400 cases of physician-assisted suicide, and more than 1,000 cases in which physicians terminated patients' lives without their consent. Fourteen percent of the patients who were killed without consent were fully competent, and eleven percent were partially competent. These were patients who could have made their own decisions about whether to live or die but were never given the opportunity to decide for themselves.

Based on the findings of the Rummelink Report and the 1986 "Guidelines on Euthanasia," the Dutch Government established, and both Houses of Parliament approved, a new reporting procedure which was codified and became effective on June 1, 1994. The new procedure requires physicians to fill out questionnaires and report to a coroner all cases in which they assist in suicide, perform euthanasia on request, or terminate a patient's life without the patient's consent. The failure of a physician to report one of these cases is not a crime in itself.

In 1984, the Dutch Supreme Court decided that mental suffering, as well as physical suffering, can justify a physician assisting a patient in suicide. Dr. Boudewijn Chabot, a psychiatrist, assisted a fifty-year-old healthy woman in suicide because she refused treatment for her depression and wished to die. The Court held that there are physically healthy patients whose unbearable mental suffering cannot be alleviated; and therefore, physician-assisted suicide can be an alternative for a patient who is suffering mentally.

The new reporting procedure also acknowledges the practice of physician-assisted suicide for patients who are suffering mentally. The questionnaire to be submitted to the coroner includes a specific section for such cases.

The acceptance in the Netherlands of a right to physician-assisted suicide for terminally-ill, competent patients has led the Dutch to embrace physician-assisted suicide for the chronically-ill, the elderly and those who are suffering mentally. Even more alarming, the Dutch acceptance of physician-assisted suicide has led to voluntary and non-voluntary euthanasia.

Recent legal developments in the United States have driven this country to a crossroads—similar to that faced in the Netherlands in the 1970's and early 1980's—regarding whether physician-assisted suicide will be an accepted practice. The lessons to be learned from the Dutch experience are

instructive, sobering, and should serve as the vital predicate to an informed discussion about public policy or legislation which may be needed to address this important issue.

Introduction

This report examines legal developments and policy arguments in the Netherlands which, in the past 23 years, have led from toleration of the practice of physician-assisted suicide for physically-suffering, terminally-ill, competent patients to the judicial and medical sanctioning of the non-consensual termination of patients' lives. Recent legal developments in the United States have driven this country to a crossroads—similar to that faced in the Netherlands in the 1970s and early 1980s—regarding whether physicians assisting patients in suicide will be accepted practice. The lessons to be learned from the Dutch experience are instructive, sobering, and should serve as the vital predicate to an informed discussion about public policy or legislation which may be needed to address this important issue.

Recent United States Circuit Court Opinions

In the United States, thirty-five states currently have statutes prohibiting assisted suicide. An additional eight states recognize assisted suicide as a common law crime. However, these prohibitions are being challenged. Two federal circuit courts of appeals have recently held that assisted suicide is a right that cannot be denied competent, terminally-ill persons.

On March 6, 1996, in *Compassion in Dying v. State of Washington*, the United States Court of Appeals for the Ninth Circuit found a “liberty interest in determining the time and manner of one’s own death.”¹ A Washington statute prohibited promoting or aiding the suicide of another. The Ninth Circuit struck down the “or aids” portion of the statute as it applies to competent, terminally-ill persons. The court held “that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment.”²

Although the holding of the Ninth Circuit in *Compassion* is confined to competent, terminally-ill persons, the court suggests that the “right” to physician-assisted suicide should be expanded to other individuals. The court claims that “seriously impaired” persons who are not terminally-ill will benefit from a “right” to physician-assisted suicide because “if they are not afforded the option to control their own fate, they like many others will be compelled,

¹*Compassion in Dying v. State of Washington*, 79 F.3d 790,793 (9th Cir.) (En banc), [reversed, 117 S. Ct. 2258, 2293 (1997)].

² *Id.* at 793-94.

against their will, to endure unusual and protracted suffering.”³ Furthermore, the Ninth Circuit specifically endorses allowing surrogates to consent to physician-assisted suicide on behalf of the patient.⁴ The court does not explain how a patient who is not competent to decide whether to commit suicide would have the ability to actually commit suicide, even with a physician’s assistance.

On April 2, 1996, in *Quill v. Vacco*, the Second Circuit Court of Appeals struck down the New York statutes criminalizing assisted suicide as violative of the Equal Protection Clause of the Fourteenth Amendment.⁵ Unlike the Ninth Circuit, the majority in the Second Circuit specifically refused to call assisted suicide a fundamental right.⁶ But the court found that the New York law did not treat “similarly situated” persons alike. The court stated, “those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.”⁷

Not only did the Second Circuit decide that the New York statutes were not rationally related to any legitimate state interest, but the court determined that the state had *no* interest in prolonging a life that was soon to end. The court asked the question, “But what interest can the state possibly have in requiring the prolongation of a life that is all but ended?” The court then answered its own question, “None.”⁸

At a hearing before the Constitution Subcommittee of the United States House Judiciary Committee, held to examine the Second and Ninth Circuit cases, the subject of physician-assisted suicide and euthanasia in the Netherlands was raised repeatedly. Witnesses argued that the Dutch experience demonstrates the inevitable slide down the slippery slope that begins when a society sanctions physician-assisted suicide.⁹ The witnesses explained that the legalization of physician-assisted suicide leads to euthanasia; that the same justifications for taking the lives of the terminally-ill justify taking the lives of the chronically-ill; that once a country legitimizes killing those who suffer physically at their request, the country will allow killing those who suffer mentally; and that when a society allows euthanasia

³ *Id.* at 825.

⁴ *Id.* at 833.

⁵ *Quill v. Vacco*, 80 F.3d 716, 727, 731 (2d Cir.) (1996), [*reversed*, 117 S. Ct. 2293 (1997)].

⁶ *Id.* at 724.

⁷ *Id.* at 729.

⁸ *Id.* at 729-30.

⁹ Assisted Suicide In The United States: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 104th Cong., 2nd Sess. (1996) [hereinafter *Hearing*].

for those who request it, involuntary euthanasia for any life the society deems not worth living is not far behind.

The United States Supreme Court will most likely hear the Second and Ninth Circuit cases on physician-assisted suicide during its 1996-1997 term. The Netherlands is the only country in the world that allows its physicians to intentionally take human life, and the Dutch situation provides a vivid illustration of the slippery slope that should give any government pause. As the United States Supreme Court decides whether to strike down state statutes prohibiting physician-assisted suicide and legislatures decide how to respond to the corresponding public policy debate, the development of Dutch law and the current practice of euthanasia in the Netherlands should be closely examined.

The Dutch Penal Code

Since 1886, Articles 293 and 294 of the Dutch Penal Code have prohibited euthanasia by request and assisted suicide.¹⁰ Article 293 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]."¹¹ Article 294 prohibits assisted suicide. The Article states: "He who deliberately incites another to suicide, assists him therein or provides him with the means, is punished, if the suicide follows, with a prison sentence of at most three years or a fine of the fourth category [a maximum of approximately \$12,500]."¹²

The Dutch Penal Code recognizes a difference between taking life against an individual's will and taking life at the request of the individual and decreases the punishment for the latter. In the first circumstance, the law punishes both the crime of taking the life from the individual and the crime of taking a life from the community. In the second circumstance, the law punishes only for the crime against the community. The Explanatory Memorandum for Articles 293 and 294 clarifies:

The assent cannot abrogate the criminalization of taking a life, but [can] give it a wholly different character. The law as it were no longer punishes the attack against the life of a particular person, but the violation of the respect which is due human life in general, regardless of the motive of the perpetrator. Crime against life remains, the attack on the person is abrogated.¹³

¹⁰Marian H.N. Driessé et al., *Euthanasia and the Law in the Netherlands*, 3 ISSUES IN LAW & MED. 385, 385-86 (1988).

¹¹*Id.* at 386.

¹²*Id.*

¹³*Id.* at 387 (quoting Mr. H.J. Schmidt, *Geschiedenis van het Wetboek van Strafrecht* (History of the Penal Code of 1881, Vol. II, p. 440)).

Clearly, the drafters of the Penal Code valued human life for the entire society not just the individual. In 1986, the Attorney General of the Supreme Court of the Netherlands, J. R Emmelink, affirmed that there are two values to human life, "on the one hand the value it has for the community, on the other the value it has for the individual."¹⁴ He further explained about Articles 293 and 294: "That the lawgiver was not wrong in regarding respect for life worthy of protection is understandable; where respect for life wanes, the corrosion of life as the right of the person is near at hand."¹⁵

Articles 293 and 294 have remained unchanged since 1886. The statutory prohibitions against assisted suicide and euthanasia have never been abolished or amended; however, Dutch courts in cooperation with the medical profession have gradually created an atmosphere in which physicians practice both assisted suicide and euthanasia with impunity.

The Beginning of Euthanasia in the Netherlands

The public discussion of euthanasia and assisted suicide began in the Netherlands in 1973. The criminal court at Leeuwarden sentenced a physician for administering a fatal injection to her mother. The court established criteria for the administering of drugs which could shorten a patient's life, but required the goal of the treatment to be relief of physical or psychic pain. The court required that the patient be suffering unbearable physical or psychic pain from an incurable, terminal-illness.¹⁶ The physician in the case was found guilty because she had directly administered a lethal injection with the goal of terminating the patient's life. Still, the court imposed only a suspended prison sentence of one week.¹⁷ The court's actual decision did not go further than permitting an earlier death as a side effect of pain alleviation, but the suspended two week sentence suggested legal tolerance for euthanasia.¹⁸

Also in 1973, the medical profession's primary representative organization, the Royal Dutch Medical Association (KNMG), issued a statement that paralleled the Leeuwarden court decision. The statement concluded that euthanasia should remain prohibited under Article 293, but that combating pain and discontinuing futile treatment could be justified, even if the patient died as the result of the act or omission.¹⁹

¹⁴Barry A. Bostrom and Walter Lagerwey, *The High Court of the Hague Case No. 79065, October 21, 1986*, 3 ISSUES IN LAW & MED. 445, 449 (1988) [hereinafter *Hague Court*].

¹⁵*Id.* at 448-49 (quoting *Nederlandse Jurisprudentie* 1987, No. 607, High Court (Penal Chamber), Oct. 21, 1986, No. 79065, 2130).

¹⁶*Nederlandse Jurisprudentie* 1973 No. 183, District Court Leeuwarden, Feb. 21, 1973 (reprinted in 3 ISSUES IN LAW & MED. 439, 439) (1988) (Dr. Walter Lagerwey trans.).

¹⁷*Id.*

¹⁸*Cf.* CARLOS F. G. OMEZ, R EGULATING DEATH: E UTHANASIA AND THE CASE OF THE NETHERLANDS 31 (1991).

¹⁹*Id.* at 31-32.

From Assisted Suicide to Active Euthanasia

Eight years later in 1981, the court at Rotterdam convicted a layperson of assisting a terminally ill person in suicide. In the court's decision, nine criteria were listed that, if met, would justify not only assisted suicide, but also the performance of active 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. The defendant in the case was convicted because he was not a physician.²⁰

Since the Rotterdam case, active euthanasia has been an accepted practice in the Netherlands, but the debate about which is preferable, physician-assisted suicide or euthanasia, is still going on today. Many Dutch physicians see no moral difference between assisted suicide and euthanasia and argue that a lethal injection is more foolproof than a prescription. Dr. Herbert Cohen, a doctor who practices euthanasia, says, "This method seems more emotional, harsher [than assisted suicide], but it is less open to error."²¹ Conversely, some physicians argue there is a moral difference between the two practices. Dr. Robert Dillman, a member of the ethics committee of the KNMG, states, "In the past we said that all things being equal, there was no difference between mercy killing and assisted suicide. But in practice, doctors say this is not the same, that there is a difference if a doctor gives a lethal injection or an intravenous drip and, on the other hand, if the patient drinks a potion. Doctors regularly signal that they prefer the patient to do it if possible."²²

From Terminally Ill to Chronically Ill

In 1982, the court at Alkmaar considered the case of a physician who euthanized a ninety-five year old woman who was in deteriorating health. The court found that the patient had a broad right to self-determination and that her request for euthanasia fell within that right.²³ Although the court record does not specify an illness from which the patient was suffering, the court declared, "The patient experienced life as unbearable!"²⁴ The physician in the case was

²⁰*Id.* at 32.

²¹Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killing*, N.Y. TIMES, Sept. 11, 1995, at 11.

²²*Id.*

²³GOMEZ, *supra* note 18, at 35.

²⁴DRIESSE, *supra* note 10, at 394.

acquitted, but then was convicted by the Court of Appeals at Amsterdam. The appeals court argued that the physician was subject to Article 293 and had failed to show that he fell under an exception to the code because he could not demonstrate that he was unable to alleviate the patient's suffering in a way other than euthanasia.²⁵ The physician appealed to the Supreme Court.

The KNMG changed its official stance shortly before the decision of the Supreme Court in the Alkmaar case, and since then, has taken an active role in legitimizing euthanasia in the Netherlands.²⁶ The association released a report describing criteria which, if met, would justify euthanasia. The criteria in the report were very similar to the criteria subsequently discussed by the Court.²⁷

In 1984 the Supreme Court of the Netherlands heard the Alkmaar case. The Court held that "necessity" pursuant to Article 40 of the Penal Code is a defense for a physician accused of euthanasia on request. Article 40 of the Dutch Penal Code provides a defense for a person who commits an offense as a result of "irresistible compulsion or necessity."²⁸ The Court determined that the appeals court erred by not examining "whether, according to well-considered medical judgement and in accordance with medico-ethical norms, [the euthanasia] was a matter of emergency,"²⁹ and was therefore, covered by the defense of necessity. The Court stated that the lower court should have considered:

whether and to what extent according to professional medical judgement an increasing disfigurement of the patient's personality and/or further deterioration of her already unbearable suffering were to be expected; whether it could be expected that soon she would no longer be able to die with dignity under circumstances worthy of a human being; whether there were still opportunities to alleviate her suffering.³⁰

In the Rotterdam case, the patient was terminally ill. The Alkmaar case involved a woman who was elderly and chronically ill, but not terminally ill. 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 not otherwise imminent.

In 1985, the State Commission on Euthanasia, which had been formed and charged with recommending legislative reforms on euthanasia, released a report. The majority of the commission believed that there were circumstances

²⁵GOMEZ, *supra* note 18, at 36.

²⁶John Keown, *Some Reflections on Euthanasia in the Netherlands* 193, 198 in EUTHANASIA, CLINICAL PRACTICE AND THE LAW (Luke Gormally ed. 1994).

²⁷*Id.*

²⁸*Id.* at 195.

²⁹*Id.* at 195 n.10.

³⁰*Id.* at 195-96.

under which euthanasia was justifiable.³¹ The report suggested that euthanasia be restricted to cases in which the patient, who voluntarily consented, was suffering unbearably and had no other medical alternative. Although some members of the commission wanted euthanasia restricted to those patients who were dying, the report did not include such a recommendation. The report also suggested that there were cases, such as persistent vegetative state, in which the patient did not consent to the euthanasia, but the act would be justified.³² The actual legislative reform recommended by the commission was amending Article 293 to allow euthanasia for competent, conscious patients who request the act. No such legislation passed, and euthanasia technically remained punishable.

In 1986, the Supreme Court heard its second case on euthanasia. The case involved a physician who administered a lethal dose of morphine to a seventy-three-year-old woman at her request who was chronically ill in the advanced stages of multiple sclerosis.³³ The district court found the accused guilty but because of mitigating circumstances, imposed no punishment. The appellate court affirmed the judgment of the district court but imposed a suspended sentence of two months with two years of probation. The Supreme Court vacated the sentence and referred the case to a lower court for further action consistent with its opinion. While the Court refused to go so far as to set aside Article 293 for physicians, it explicitly held that euthanasia could be justified for a non-terminal patient if the patient was under dire distress or if the physician was acting out of necessity and mental duress.³⁴

Also in 1986, the KNMG in collaboration with the National Association of Nurses established "Guidelines for Euthanasia."³⁵ The Guidelines are based on the 1984 report of the KNMG. The definition of euthanasia in the Guidelines is the generally accepted definition in the Netherlands: "'euthanasia' only covers intentional mercy killing on request, and the act is always an 'active' one."³⁶ Under this definition, non-voluntary mercy killing is not considered to be euthanasia. The Guidelines also exclude from the definition of euthanasia: withdrawal or withholding medically futile treatment;

³¹GOMEZ, *supra* note 18, at 45.

³²*Id.*

³³*Hague Court, supra* note 14, at 445.

³⁴*Id.* at 446.

³⁵Royal Netherlands Society for the Promotion of Medicine and Recovery, Interest Association of Nurses and Nursing Aids, *Guidelines for Euthanasia*, 3 ISSUES IN LAW & MED. 429 (1988) (Walter Lagerwey trans.) [hereinafter *Guidelines*].

³⁶Jürgen Wöretshofer and Matthias Borgers, *The Dutch Procedure for Mercy Killing and Assisted Suicide by Physicians in a National and International Perspective*, 2 MAASTRICHT J. OF EUROPEAN AND COMPARATIVE LAW 2, 7 (1995).

treatment to alleviate pain and suffering that has the side effect of the patient dying sooner; and the patient refusing to consent to treatment.³⁷

It is important to closely examine the Guidelines because they form the basis for the current practice of physician-assisted suicide and euthanasia in the Netherlands. There are five criteria that serve as the 1986 Guidelines for justifying euthanasia: “voluntariness,” “a well considered request,” “persistent desire for death,” “unacceptable suffering,” and “collegial consultation.”³⁸ The report and subsequent Guidelines contain some explanation of the type of care sufficient to meet the criteria, but even with the explanation provided, the criteria are vague and in some cases ambiguous.

Regarding voluntariness, the report on which the Guidelines were based stresses that the physician should have a number of conversations with the patient in order to ensure that the request for death is not the result of pressure by others.³⁹ However, the actual Guidelines state, “It is of great importance that there be *a* conversation with only the patient in order to verify voluntariness.”⁴⁰

The Guidelines do not rule out euthanizing a patient who requests it because she is a nuisance to her family. One well-known Dutch physician, Herbert Cohen, has indicated that he is willing to euthanize patients who request death to alleviate the burden on their families. Asked about whether he would refuse to euthanize a patient in such a situation, Dr. Cohen answered:

I . . . think in the end I wouldn't, because that kind of influence—these children wanting the money now—is the same kind of power from the past that . . . shaped us all. The same thing goes for religion . . . education . . . the kind of family he was raised in, all kinds of influences from the past that we can't put aside.⁴¹

During the hearing on assisted suicide before the Constitution Subcommittee, Dr. Herbert Hendin, M.D., a psychiatrist who is the president of the American Suicide Foundation, told the story of a Dutch wife who no longer wanted to take care of her sick husband: “She gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to be killed. The doctor, though aware of the coercion, ended the man's life.”⁴² This story is especially alarming when one considers that research has found that in the Netherlands

³⁷*Guidelines*, *supra* note 35, at 431.

³⁸*Id.* at 431-33.

³⁹Keown, *supra* note 26, at 199.

⁴⁰*Guidelines*, *supra* note 35, at 431 (emphasis added).

⁴¹Keown, *supra* note 26, at 203.

⁴²*Hearing*, *supra* note 9, at 102 (statement of Dr. Herbert Hendin).

requests for euthanasia came more frequently from families than from patients.⁴³

Furthermore, the Guidelines do not discourage doctors from raising euthanasia as a treatment option. During the assisted suicide hearing, Dr. Hendin discussed the fact that more than half the physicians in the Netherlands considered it appropriate to raise euthanasia as an option for their patients. He explained that “[Dutch doctors] seemed not to recognize that the doctor was also telling the patient that his or her life was not worth living, a message that would have a powerful effect on the patient’s outlook and decision.”⁴⁴

Yale Kamisar, a University of Michigan Law School professor, points out the vulnerability of people who are seriously ill. He asks:

In a suicide-permissive society, in a climate in which suicide is the “rational” thing *to do*, or at least a “reasonable” option, will it become the unreasonable thing *not to do*? The noble thing *to do*? In a society unsympathetic to justifying an impaired or dependent existence, a psychological burden may be placed on those who do not think their illness or infirmity is reason for dying. The presence of a socially approved option becomes a subtle pressure to request it.⁴⁵

With regard to the criteria of “a well considered request” and “persistent desire for death,” the Guidelines stress that the patient should be well informed and able to weigh alternatives, and the request for euthanasia should not be “the result of a temporary depression.”⁴⁶ A survey taken in 1990 by a well-known euthanasia advocate in the Netherlands shows that these criteria are either misunderstood or disregarded by doctors. The survey found that in 13 percent of the cases the interval between the first request for euthanasia and its performance was one day or less; in 35 percent of the cases the interval was a week or less; and in another 17 percent of the cases the interval was two weeks or less. The survey also found that patients made only *one* request in 22 percent of the cases.⁴⁷

In his new book, *Seduced by Death*, Dr. Hendin explains the danger of the supposed right to self-determination for patients who request euthanasia, and how important it is for physicians to resist taking those requests at face value. He writes:

Depression, often precipitated by discovering one has a serious illness, exaggerates the tendency toward seeing problems in black or white terms.

⁴³Barry A. Bostrom, *Euthanasia in the Netherlands: A Model for the United States?* 4 ISSUES IN LAW & MED. 467, 477 (1989).

⁴⁴Hearing, *supra* note 9, at 102.

⁴⁵Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?* HASTINGS CENTER REP., (1993) 23, 3:32-41, at 37.

⁴⁶Guidelines, *supra* note 35, at 432.

⁴⁷Keown, *supra* note 26, at 204-05.

Solutions or even alternative possibilities are not considered. When a patient finds a doctor who shares the view that life is worth living only if certain conditions are met, the patient's rigidity is reinforced.

Strikingly, the overwhelming majority of those who are terminally ill fight for life to the end. Some may voice suicidal thoughts in response to transient depression or severe pain, but these patients usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive.⁴⁸

Statistics support Dr. Hendin's statement. More people who mistakenly thought they had cancer committed suicide than people who had cancer, and more people waiting for HIV testing results consider suicide than people who are HIV-positive.⁴⁹ There is an understandable tendency for people who learn they may have a terminal illness to become irrational or panic. A request for euthanasia or assistance in suicide is a result of that panic.

The Guidelines define the next criteria, "unacceptable suffering," to mean, "The patient must experience his suffering as persistent, unbearable, and hopeless," and it suggests that the physician consider "whether the patient presently will not be able to die in a dignified manner."⁵⁰ The report on which the Guidelines were based goes into greater detail on the subject of suffering. John Keown, former director of The Center for Health Care Law at The University of Leicester in England, summarizes the report's discussion in the following way:

Suffering, says the Report, can have any of three causes: first, pain; secondly, a physical condition or physical disintegration without pain; and thirdly, suffering without any physical complaint which could be caused either by 'social factors and the like' in a healthy person or by a 'medical-psychiatric syndrome.' Pain, the Report continues, can be controlled to such an extent that, in general, it is not a primary cause of unbearable suffering. And as to suffering caused by social factors, a doctor usually cannot assess the unbearability of the patient's situation or the prospects of its alleviation.⁵¹

The report admits that the concept of "unacceptable suffering" is imprecise and not conducive to objective verification.⁵² This admission is somewhat troubling when one considers that patients' lives depend on their doctor's assessment of whether their suffering is "unacceptable." The report

⁴⁸HERBERT HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CURE* 24-25 (1996).

⁴⁹*Id.* at 180.

⁵⁰*Guidelines, supra* note 35, at 432.

⁵¹Keown, *supra* note 26, at 200.

⁵²*Id.* at 205.

also concludes that it is not reasonable to refuse to euthanize a patient who is not dying, if he is suffering unbearably.⁵³

The collegial consultation criteria in the Guidelines states, “The doctor is to consult with at least one colleague about the request of the patient.”⁵⁴ The Guidelines do not recommend that the colleague speak personally to or examine the patient, nor do they specify the scope of the consultation. In fact, there is no requirement that the colleague consulted actually agree with the doctor’s assessment of the situation or his decision to euthanize. The Guidelines discuss favorably consultation with nursing assistants, psychologists and clergy, but specify that the physician may not delegate the act of euthanasia.⁵⁵

The Guidelines made clear the fact that euthanasia was still against the law. But they also made clear that physicians could practice euthanasia under the Guidelines and not fear prosecution. In a section titled, “Possible Juridical Consequences,” the Guidelines stated, “In general, the Public Prosecutor does not initiate a prosecution unless the demands for appropriate medical care have not been met or if there is any doubt about that.”⁵⁶ The section also made clear that because physicians and other health care workers are entitled to professional secrecy, they are not obligated to report euthanasia.⁵⁷

Overall, the Guidelines give an enormous amount of discretion to doctors, and, consequently, give very little protection to patients. The Guidelines established no independent check on doctors’ decisions to euthanize their patients. Only a doctor can perform euthanasia in the Netherlands, and only the doctor knows all the circumstances under which the euthanasia was performed. In other words, he controls the evidence.

By the end of 1986, the legal status of euthanasia and the care required to carry out the practice of euthanasia was not completely clear; but both the Court and medical community had made it clear that it was acceptable to euthanize patients who requested it, even if they were not terminally ill.

From Voluntary to Non-Voluntary

In 1985, a Dutch physician was convicted of killing several nursing home patients without their consent. He was sentenced to one year of imprisonment, but his conviction was quashed because police officers had unlawfully seized medical documents from the doctor. In the end, the doctor was awarded the equivalent of \$150,000 by the court for “injury to his

⁵³*Id.* at 200.

⁵⁴*Guidelines, supra* note 35, at 433.

⁵⁵*Id.* at 433, 435.

⁵⁶*Id.* at 436.

⁵⁷*Id.* at 437.

reputation.”⁵⁸ Although the doctor was originally convicted for illegal euthanasia, the ultimate outcome of the case set the stage for non-voluntary euthanasia to become an accepted practice.

In 1989, the Dutch Supreme Court heard the case of a physician who gave a lethal injection to a newborn baby with Down syndrome. The child was born with an intestinal atresia, a relatively common and repairable problem. The issue for the Court was whether the physician’s objection to being prosecuted was justifiable. The Court decided that since the child would have experienced very serious suffering after surgery, it was not likely that the physician would be convicted if his case went to court, and therefore, his objection to prosecution was justified.⁵⁹ This case effectively extended the necessity defense to non-voluntary euthanasia.

A study commissioned in January of 1990 confirmed that non-voluntary euthanasia was being widely performed in the Netherlands. The Dutch Government formed a commission to study the practice of euthanasia, assisted suicide and other end of life decisions in the Netherlands.⁶⁰ The Attorney General of the Supreme Court of the Netherlands, Professor Rummelink, appointed and chaired the commission. The commission surveyed physicians about “the practice of action and inaction by a doctor that may lead to the end of a patient’s life at this patient’s explicit and serious request or otherwise,”⁶¹ and published its findings, the Rummelink Report, in September of 1991.

The commission found that in 1990 there were 2,300 cases of euthanasia (defined as “the deliberate termination of another’s life at his request”⁶²), 400 cases of assisted suicide, and more than 1,000 cases of life termination without an explicit request.⁶³ The last number, the euthanizing of 1,000 patients without their request, was somewhat unexpected by the commission. Still the commission justified these “deliberate life-terminating actions without explicit request” by stating, “The ultimate justification for the intervention is in both cases the patient’s unbearable suffering. So, medically speaking, there is little

⁵⁸Ph. Schepens, M.D., *Euthanasia: Our Own Future?* 3 ISSUES IN LAW & MED. 371, 377 (1988); see also Keown, *supra* note 26, at 209.

⁵⁹H.J.J. Leenen and Chris Ciesielski- Carlucci, *Force Majeure (Legal Necessity): Justification for Active Termination of Life in the Case of Severely Handicapped Newborns after Forgoing Treatment*, 2 CAMBRIDGE Q. OF HEALTHCARE ETHICS 271, 272 (1993).

⁶⁰PAUL J. VAN DER MAAS, ET AL., *MEDICAL DECISIONS CONCERNING THE END OF LIFE* (Amsterdam: Elsevier Science Publishers (1992)) (translated in HEALTH POLICY, Special Issue Vol. 22/1&2 1992) [hereinafter Rummelink Report].

⁶¹MINISTERIE VAN JUSTITIE, NETHERLANDS, *OUTLINES REPORT COMMISSION INQUIRY INTO MEDICAL PRACTICE WITH REGARD TO EUTHANASIA* (1990) [hereinafter COMMISSION OUTLINE].

⁶²*Id.* at 1.

⁶³Rummelink Report, *supra* note 60, at 193-94.

difference between these situations and euthanasia, because in both cases patients are involved who suffer terribly.”⁶⁴

The commission did not address the fact that the criterion of “unbearable suffering” had in the past been a subjective measurement made by the patient. Nor did the commission address their finding that 14 percent of the patients who were euthanized without consent were fully competent and 11 percent were partially competent.⁶⁵ These were patients who could have made their own decisions about whether to live or die.

A close examination of the Rummelink Report shows that the 1,000 cases of euthanasia without request are only the tip of the iceberg. The report confirms the alarming proclivity of Dutch physicians to make decisions about administering treatment or withholding treatment with the intent of ending their patients’ lives without the consent of the patient. In 36 percent or 8,100 of the cases of patients who died of a morphine overdose, one of the physician’s intentions, or his only intention, was to end the life of the patient. (It is unclear how the commission distinguishes these intentional morphine overdoses from the cases of “deliberate life-terminating actions without explicit request.”) In over 50 percent or 4,941 of these cases, the physician administered the overdose without the patient’s consent.⁶⁶ In other words, almost 5,000 Dutch patients in 1990 had their lives intentionally ended by a physician who did not obtain their consent. A full 27 percent of these non-consenting patients were fully competent.⁶⁷ The report also found that in 25,000 cases, physicians withheld or withdrew potentially effective life-prolonging treatment without the patient’s consent.⁶⁸

In a British medical journal, several Dutch euthanasia advocates justified making decisions to end a patient’s life without the patient’s request. They wrote, “Another reason may be that older patients (and their spouses) often expect the doctor to ‘do what is best’ and in extreme situations patient and family may expect the physician to act as a sort of proxy decision maker.”⁶⁹

Although physicians so often neglected to include the patient in decision-making regarding terminating the patient’s life, the commission argued that their report showed that physicians followed a scrupulous standard of care in making end of life decisions.⁷⁰ Ironically, the commission did recognize that

⁶⁴COMMISSION OUTLINE, *supra* note 61, at 3.

⁶⁵Rummelink Report, *supra* note 60, at 61 (see Table 6.4).

⁶⁶*Id.* at 75.

⁶⁷*Id.* at 74.

⁶⁸*Id.*

⁶⁹Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196 (1993).

⁷⁰COMMISSION OUTLINE, *supra* note 61, at 4-5.

physicians were not all familiar with the type of care required to administer active euthanasia. The commission stated:

The research report shows that not all doctors are familiar with the exact type of scrupulous care that is required when euthanasia is administered. Usually, there are great differences in the extent to which doctors meet these requirements. The commission is of the opinion that this faulty observance of the required scrupulous care does not agree with the careful decision process concerning a patient's request for active termination of his life.⁷¹

Based on the findings of the Rummelink Report and the 1986 Guidelines on Euthanasia, the Government established, and both Houses of Parliament approved, a new reporting procedure which was codified and became effective on June 1, 1994. The reporting procedure applies to euthanasia on request, assisted suicide and euthanasia without the request of the patient.⁷² When a physician engages in one of these acts, he must fill out a questionnaire and notify the coroner.

The requirements for the practice of euthanasia in the Netherlands must still be derived from court cases which generally follow the 1986 Guidelines on Euthanasia published by the KNMG. The questionnaire established to meet the new reporting requirements is related to the Guidelines.⁷³ The questionnaire is divided into five sections. The first section contains questions about the history of the patient's illness and whether the illness is physical or psychiatric. The second section contains questions about the request for euthanasia. The third section contains questions for cases in which there was no request. The fourth section deals with the physician's consultation with a colleague. And the fifth section, contains questions about the actual performance of euthanasia.⁷⁴

The new reporting procedure does not bring about any fundamental change in the legality of euthanasia in the Netherlands. Euthanasia technically remains illegal under Article 293 of the Dutch Penal Code. However, as in the past, it is rare that a physician would be prosecuted for a violation of Article 293. If a prosecutor has reason to believe that a physician has not followed the Guidelines closely enough to claim the defense of necessity, the prosecutor must bring the case before the General Prosecutors. In general, prosecutors are free to make decisions about whether to prosecute, but in cases of euthanasia the General Prosecutors must agree to any prosecution.⁷⁵ The purpose of the

⁷¹*Id.* at 4.

⁷²Wöretshofer and Borgers, *supra* note 36, at 10.

⁷³Gerrit van der Wal and Robert J.M. Dillmann, *Euthanasia in the Netherlands*, 308 BRITISH MED. J. 1346, 1347 (1994).

⁷⁴Wöretshofer and Borgers, *supra* note 36, at 10-11.

⁷⁵*Id.* at 11.

reporting requirements is to protect doctors from prosecution and to gather information about the practice of euthanasia by physicians.⁷⁶ The requirements are much less concerned with protecting patients.

Questions have been raised as to whether physicians will report when they terminate a patient's life. The failure to report euthanasia is not an offense under the reporting procedures,⁷⁷ and the physician who reports the life-terminating action is the same physician who will be prosecuted if his action is judged to be wrongful. The Rummelink Report found that doctors did not reveal to prosecutors cases of active termination of life without the patient's request.⁷⁸ Furthermore, prior to the Rummelink Report, cases of euthanasia were rarely reported. Only 122 cases were reported in 1987; 181 in 1988; 336 in 1989; and 454 in 1990.⁷⁹ If one conservatively estimates 2,000 cases of euthanasia per year, it would mean that even in the year when the most cases were reported, they were under-reported by 70 percent.⁸⁰

After examining the Rummelink Report and the new reporting requirements, Henk Jochemsen, Ph.D., director of the Lindeboom Institute for medical ethics in the Netherlands, argued, "It is evident, therefore, that a practice of terminating patients' lives is continuing which is not adequately controlled by the legal authorities and that the new law will simply confirm and perhaps even encourage this practice."⁸¹

From Physical Illness to Mental Suffering

The most recent Dutch Supreme Court decision on euthanasia was the 1994 case of Dr. Boudewijn Chabot, a psychiatrist. Dr. Chabot assisted one of his patients, who was a fifty-year-old physically healthy woman, in suicide. Dr. Chabot describes his patient, Mrs. B, in this way:

She was a 50-year-old social worker. She was also a painter in her spare time. She was divorced. She had been physically abused by her former husband for many years. She had two sons. One son, Peter, died by suicide in 1986, at the age of 20. She then underwent psychiatric treatment for a marriage crisis following his suicide. At that time, she strongly wished to commit suicide, but decided that her second son, Robbie, age 15, needed her as a mother.

Her son, Robbie, died of cancer in 1991, at the age of 20. Before his death she decided that she did not want to continue living after he died.

⁷⁶*Id.* at 21.

⁷⁷*Id.* at 20.

⁷⁸Rummelink Report, *supra* note 60, at 65.

⁷⁹Keown, *supra* note 26, at 207.

⁸⁰*Id.*

⁸¹H. Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. OF MED. ETHICS 212, 215-16.

She attempted suicide, but did not succeed. On July 13, 1991, she wrote to a social worker at the academic hospital where her second son died of cancer; she asked for a contact and for pills, so that she could kill herself. She had bought a cemetery plot for her sons, her former husband, and herself; her only wish was to die and lie between the two graves of her sons.⁸²

Mrs. B objected to both bereavement therapy and anti-depressant drugs, consequently Dr. Chabot administered no treatment but assisted her in suicide. Dr. Chabot contends, "Intolerable psychological suffering is no different from intolerable physical suffering."⁸³ In his case, the Court reaffirmed that the defense of necessity applies in cases of euthanasia and described the circumstances surrounding an act of necessity:

"[T]he perpetrator of this act, must have had to choose between mutually conflicting obligations and chosen the most important one. A physician can in particular be in a state of necessity, when he has to choose between, on the one hand, the obligation to preserve life and, on the other hand, the obligation of a physician to do everything possible to relieve unbearable suffering, for which there is no prospect of improvement whatsoever."⁸⁴

The Court further held that there were physically healthy patients whose unbearable psychological suffering could not be alleviated and extended the defense of necessity to cases in which there is no physical illness. Ultimately, the Court did find Dr. Chabot guilty because he did not arrange for an independent physician to examine Mrs. B in person, but it imposed no punishment.⁸⁵ Commenting on the case, George Annas, a health-law professor at Boston University, said, "If you're worried about the slippery slope, this case is as far down as you can get."⁸⁶

Physician-Assisted Suicide and Euthanasia in Practice

Statistics and analysis of the Dutch experience show the slide down the slippery slope in the Netherlands. However, case studies add a graphic illustration of how lives are affected. Carlos Gomez, M.D., Ph.D., a professor at the University of Virginia School of Medicine, interviewed a number of Dutch physicians in 1989 about their euthanasia practice. Dr. Gomez was able to publish 26 case studies in a book, *Regulating Death*. Interestingly, twenty-one of the cases were not reported to the prosecutor. The following is Dr. Gomez's account of a case about which he interviewed a general practitioner.

⁸²Interview with Arlene Judith Klotzko and Dr. Boudewijn Chabot, CAMBRIDGE Q. OF HEALTHCARE ETHICS 240-41 (1995) [hereinafter Cambridge Quarterly Interview].

⁸³Anastasia Toufexis, *Killing the Psychic Pain*, TIME, July 4, 1994, at 61.

⁸⁴Wöretshofer and Borgers, *supra* note 36, at 12.

⁸⁵Cambridge Quarterly Interview, *supra* note 82, at 239.

⁸⁶Toufexis, *supra* note 83, at 61.

The portions of the interview in quotation marks are the actual words of the doctor.

The patient was an 89-year-old widow, who lived by herself. She had suffered a stroke six years previously, from which she had partially recuperated. She came in to this doctor's care shortly after her return from the hospital when she moved to a smaller house in another neighborhood. She had, since her return, become increasingly unable to care for herself. For "about three years," she had asked the doctor about euthanasia and once had threatened to kill herself if the doctor did not accede to her request. The doctor had suggested psychotherapy, which she declined, and at one point the doctor tried her on anti-depressant medication ("which I am never sure she would take"). The family doctor had contacted the visiting nurse in the area asking her to visit this patient on a regular basis. The GP had also arranged for the local welfare department to send a part-time aide to help the patient with cooking and heavier tasks. The patient's mood would lift periodically, but she mentioned euthanasia "almost every time she would visit me."

The woman's requests became so persistent that the doctor agreed to accede if she told a son (who lived a good distance away). The woman refused and said her son had nothing to do with this matter. The patient then called a neighbor, who came with the patient to visit the physician. The neighbor helped the woman plead her case and suggested that if this doctor would not perform euthanasia, the neighbor would help the patient find another doctor who would. The doctor finally agreed and, a week later, euthanized the patient in her home (no one else was present) by giving her a solution of orphenadrine and pentobarbital to drink. She died within the half hour after drinking the solution. The doctor then notified the son that evening that his mother had passed away suddenly but did not tell him of the circumstances. The cause of death was listed as "cardiac arrest"; the public prosecutor was not notified.⁸⁷

The practice of physician-assisted suicide and euthanasia in the Netherlands has changed the mind-set of many Dutch physicians. Those physicians now believe that a life with limits is a life that is not worth living. Richard Fenigsen, M.D., Ph.D., a retired cardiologist from the Netherlands, tells a heartbreaking story about one of his patients he lost as a result of another physician's view of a "limited life":

Mrs P. was a seventy-two-year-old widow who, after a bad myocardial infarction, was left with a grossly enlarged heart and congestive heart failure. She was treated with digoxin, a diuretic, and aldosterone antagonist, and an anticoagulant and for a whole year had almost no symptoms at rest. True, she needed help with cleaning the house, and her

⁸⁷GOMEZ, *supra* note 18, at 72.

only exercise was walking a few blocks. One night her breathlessness recurred; this required adding a third pillow and an increased dosage of the diuretic. Another time she complained of dizziness, which turned out to be due to a fall in blood pressure in an upright posture; she was taught the necessary precautions. Mrs. P. was an extremely nice, mild-tempered lady who never showed any impatience and complied with the doctor's every order and advice. Barring some clot or a sudden disturbance in heart rhythm (both of which could of course occur), she might have remained for years in the condition she was in. When she once failed to appear at the outpatient clinic, I was very much worried. Responding to my inquiry, her family physician, Dr. De K., paid me a visit. He had had a talk with Mrs. P., he said, and explained the situation to her: This wasn't going to be any better, and living such a limited life, with all those pills, made no sense at all. Mrs. P. accepted everything he said. He stopped her pills, and three days later she died. My only answer was to nod; I couldn't emit a sound. I was overcome by deep sorrow. It returns every time I think of Mrs. P.⁸⁸

Elderly people are vulnerable in the Netherlands. They are demoralized by and frightened about euthanasia in their country. In 1987, J. H. Segers, M.D., a family doctor in Huizen, investigated the attitudes of the elderly with regard to euthanasia. The doctor found that 60 percent of older people were afraid that their lives could be ended against their will.⁸⁹ Forty-seven percent of seniors living in their own homes and 93 percent who were living in senior citizen's homes were opposed to euthanasia.⁹⁰

However, it is not just the elderly who are vulnerable in the Netherlands. In his book, Dr. Gomez describes a case in which a much younger patient was euthanized by a doctor in a hospital:

The patient was a 28-year-old woman with leukemia (the physician did not remember the specific type). She had been in remission for approximately one year, when she suffered a "cell explosion [blast crisis?]" and was brought to the hospital by her husband and her parents. During her remission, while she was at home, she and her husband had spoken with the family doctor "many times about euthanasia; this I am sure of . . . because I saw the doctor's records myself." The patient had indicated that if the remission failed, she did not want to undergo induction again . . . and did not want to linger in a hospital bed while she died.

Upon admission, she again declined therapy, and asked that her request be honored: "Why did not the family doctor do this? You see sometimes

⁸⁸Richard Fenigsen, M.D., Ph.D., *Physician-Assisted Death in the Netherlands: Impact on Long-Term Care*, 11 ISSUES IN LAW & MED. 283, 294-95 (1995).

⁸⁹J.H. Segers, M.D., *Elderly Persons on the Subject of Euthanasia*, reprinted in 3 ISSUES IN LAW & MED. 407, 422 (Walter Lagerwey trans.) (1988).

⁹⁰*Id.* at 421.

people who leave this responsibility to others; there is always the problem too of families who see death as something in a hospital, not the house.” The terminal-care team interviewed the family doctor and the family and quickly approved the request. The patient’s husband, parents, and family pastor were in the room when the physician first proffered an oral euthanatic: “This was a serious mistake on my behalf; she was really even too weak to keep the liquid in her mouth; it was an ugly event.” The physician then started an IV drip of pentobarbital, and when the patient fell unconscious, the parents and pastor left the room, and the husband came to sit near her: “This case, with one who is so young, you remember very well; I went slowly, then after the rest had left, I told the husband, ‘Now it is time,’ and he kissed the hand of his wife and went outside.” The physician then administered curare, and the patient died.

The prosecutor who investigated this case interviewed the physician and the family, “which was ridiculous, every time there are different rules,” but subsequently the prosecutor dismissed the case.⁹¹

Dr. Gomez also describes two cases in which the patient did not consent to the euthanasia. Following is his account of one of the cases:

A 56-year-old man was brought into a hospital emergency room with massive internal injuries following a car accident. A member of the intensive-care staff [the narrator] was called to the emergency room by the surgeon on call. “The surgeon asked what was to be done here? Should there be an operation with such damage to the chest and the brain? Soon there would be family outside. There would soon be no [brain] signals for a neurologist to see; do you put the patient on a respirator?” The physician suggested that the matter end quickly: “I said, the heart will stop in some time, but if the family comes sooner, they must wait for this; it is a terrible situation.” The physician, acting unilaterally, gave an injection of potassium chloride: “I think the surgeon and the nurse knew what I was going to do, but they were not there; a few minutes later, after the patient is dead, the nurse comes to ask, Is it over? I say yes, and [the nurse] comes to fix the body.”

The physician did not actually consider this a case of euthanasia but of bringing on “what was surely going to happen, but perhaps after some hours.” When the family arrived, they were told the patient had expired from his wounds shortly after being brought to the hospital. “In cases such as this, it is not like other cases of euthanasia; the death was at the door, and he would soon come in no matter what we did; in other cases, you know that death is near but do not know when it will come; [this latter situation] is what is euthanasia.”⁹²

⁹¹GOMEZ, *supra* note 18, at 79-80.

⁹²*Id.* at 85-86.

This physician not only gave a lethal injection to a patient without his consent, but the physician did not even wait to give the family the opportunity to decide the course of the patient's treatment.

When researching his book, Dr. Herbert Hendin also interviewed a number of Dutch physicians and other euthanasia advocates regarding euthanasia practices. One lawyer who represents physicians prosecuted for euthanasia explained to Dr. Hendin that doctors put patients to death without their consent for a variety of reasons. Dr. Hendin writes, "[The lawyer] knew of one case where a doctor had terminated the life of a nun a few days before she otherwise would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death."⁹³ Apparently, the doctor had as little respect for the right to self-determination as he had for religious freedom.

There is very little documentation on how many children are euthanized each year in the Netherlands, but actual cases show the reality of the situation. Dr. Fenigsen describes several cases in which parents decided not to treat or to euthanize their newborn babies or young older children. He writes:

A girl born prematurely, in the thirty-second week, recovered from an infection, but there was a suspicion of intracranial bleeding. This was followed by accumulation of intracranial fluid. The parents refused to allow the insertion of a drainage tube or shunt. On the thirtieth day after birth the child was killed by the pediatrician with injections of a morphine-like drug and potassium chloride. . . .

Danny had spina bifida and hydrocephalus but was in fair general condition. No drainage tube to relieve the hydrocephalus was inserted. Once Danny seemed to have some abdominal pain, and another time he apparently felt not quite well for two consecutive days. This prompted the parents to ask for euthanasia. With this purpose the child was admitted to Rainier de Graaf Hospital in Delft. One of the nurses opposed the decision, and on the next day she and her husband offered to adopt the child. The offer was rejected. On August 19, 1990, Danny, then aged three and one-half months, was killed with drugs administered by intravenous drip. The nurse was reprimanded because by involving her husband in the adoption offer she violated professional confidentiality. . . .

This six-year-old boy's intelligence seemed below average. His upbringing presented some problems. He lived with his parents and attended a school for children requiring special care. Then juvenile diabetes mellitus was discovered. Patients with this type of diabetes must receive injections of insulin; otherwise they develop severe disturbances in metabolism (ketoacidosis), become comatose, and die. The family physician did not ask the parents for permission to start the insulin

⁹³HENDIN, *supra* note 48, at 79.

treatment. Instead, he asked them whether their son should be treated. The parents chose not to treat the child, and the boy died.⁹⁴

Dr. Fenigsen worries about the long-term effect of the permissive attitude in the Netherlands toward euthanasia for people with disabilities. There seems to be little tolerance for disabled children and the parents who raise them. In fact, Professor J. Stolk, a specialist in mental retardation at the Free University in Amsterdam, has documented cases where parents of disabled children are rebuked. For example, parents have heard statements such as: “What? Is that child still alive?”; “How can one love such a child?”; “Nowadays such a being need not be born at all”; “Such a thing should have been given an injection.”⁹⁵ It is demoralizing and frightening for parents to hear such things about the children for which they care.

This intolerance is the reason for the disabled community being so vehemently against physician-assisted suicide. People with disabilities in the United States fear a society which subjectively judges which lives are worth living. In order to assert their opposition to assisted suicide, 41 representatives of disability rights groups signed a petition that was delivered to the Constitution Subcommittee. The representatives requested that Congress take steps to ensure that physician-assisted suicide remains illegal.⁹⁶

Conclusion

Clearly, witnesses at the Constitution Subcommittee hearing on physician-assisted suicide were correct about the lesson provided by the practice of euthanasia in the Netherlands. Dr. Hendin, accurately describes the Dutch experience with euthanasia:

The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for people who are terminally ill to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to involuntary euthanasia (called “termination of the patient without explicit request”).⁹⁷

The Dutch experience vividly shows how judicial sanctioning of physician-assisted suicide for terminally-ill patients motivated by supposedly high ideals such as the right to individual self-determination and the “compassionate” alleviation of physical suffering can easily lead to the unchecked nightmare of non-consensual termination of human life. Simply put, an individual’s so-called “right to die,” over time, can be transformed into a demand by society that certain individual’s have a “duty to die.” This is the

⁹⁴Fenigsen, *supra* note 88, at 287-89.

⁹⁵*Id.* at 290.

⁹⁶Hearing, *supra* note 9, at 60-63.

⁹⁷HENDIN, *supra* note 48, at 23.

slope down which the Netherlands has slid. The tragedy of the situation in the Netherlands should serve as a graphic reminder to courts and legislatures in this nation that there is no way to regulate euthanasia. There is no way to stop the slide once a society steps onto the slippery slope by legalizing physician-assisted suicide.