Euthanasia and Other Types of Lifeshortening Medical Decisions in the Netherlands

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Introduction

For centuries, people of various religious beliefs and cultural backgrounds have sought to address the issue of death as an inevitable event. They have tried to make death easier to understand. Fear of the unknown has often pervaded open discussions on death and dying.

Today, advances in the fields of technology have brought about numerous means to artificially prolong life. This has caused great concern in many societies giving rise to questions such as whether there is a need for intervention through medical decissions, either to prolong life through artificial means or to terminate a person's life when there is no longer any sound hope for a meaningful life.

While in other countries discussions have focused on non-treatment decissions, in the Netherlands euthanasia[1] has been at the center of public debate since the early 1970s. This debate has attracted much international attention.[2] The resulting Dutch policy regarding euthanasia is controversial and has aroused passionate reactions.[3]

Several years of social and scientific debates in Dutch society led to the enactment of a law by means of which euthanasia was legalized under certain specified rules.[4]

Opponents of euthanasia assert that society is responsible for providing access to good hospital care so as to insure one who is dying people is cared for properly. These opponents hold that it is

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[1] The term *euthanasia*, also called *mercy killing*, in this report is used to describe any form of termination of life by a doctor at the express wish of a patient who is suffering an unbearable illness without the prospect of improvement.

[2] P. J. van der Maas, et al, *Euthanasia and other medical decisions concerning the end of life*, 338 THE LANCET 669 (Sept. 14, 1991).

[3] J. Woretshofer & M. Borgers, 2 MAASTRICHT JOURNAL OF EUROPEAN AND COMPARATIVE LAW 4 (No. 1, 1995).

[4] Law of Dec. 2, 1993, STAATSBLAD (official law gazette of the Netherlands, Stb.) 643; and Decree of Dec. 7, 1993, Stb. 668. The Law entered into force on June 1, 1994.

immoral to terminate a person's life just because society is unable to provide the appropriate resources to ensure a system of intensive care for a dying patient.[5]

On the other hand, proponents of euthanasia emphasize that not all people facing death want hospital care. While such care is beneficial for the vast majority of people who are dying, such care is not always the appopriate response for everyone. Thus it would not be the solution for those who have no hope of recovery or who believe, for whatever reason, that death is the only solution to their problems.[6]

The debate on euthanasia in the Netherlands has brought about a growing consensus by focussing on competent patients who request that a physician either assist them in taking their own life "assisted suicide" (see below for definition) or actively to end their life for them, i.e., the active termination of the patient's life upon request.[7] However, it seems that discussions that have taken place outside of the Netherlands regarding the Dutch policy on euthanasia and its relevance to the development of policy in other countries has been dominated by misunderstandings.[8]

The purpose of this study is, therefore, to bring about a better understanding of Dutch policy of euthanasia, of the openess of the system, and the regulations which cover the subject in the Netherlands. In order to achieve this goal, this report provides some background information on the debates that led to the enactment of the 1993 Law. Questions relating to the definition of the term *euthanasia* and the various forms thereof are also discussed.

The ethical aspects of euthanasia and views that have been expressed in that regard are considered. Then the Law on Euthanasia is presented and the manner in which the Law is applied is describedd. These discussions are followed by a case study. A comparative study regarding the position of selected countries with respect to euthanasia or assisted suicide is also been provided.

Background

The increasing possibilities of medical treatment and the fast development of, technical means have created the possibilities to extend a patients life. Very often this extension of life only seems to prolong the patient's suffering. Consequently many people have become aware of the fact that trying to postpone death does not always add anything to the wellbeing of the patient involved. This is the main reason why, beginning in the 1970s, the topic of euthanasia became the centre of public debate in the Netherlands.

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5 Dutch authors, note 1, Woretsh. , Canadian 17-19

6 Dutch, Ca. 21.

7 M. A. M. de Wachter, *Euthanasia in the Netherlands*, HASTINGS CENTER REPORT 1 (Mar.-Apr. 1992).

8 van der Maas, *supra* note 2, at 5.

The debate was really sparked by a case on euthanasia that was brought before a Dutch criminal court.[9] In this case a physician was prosecuted for ending her mother's life with an overdose of morphine. Even though the doctor was found guilty and convicted to a symbolic and conditional punishment, for the first time criteria were set in the sentence for the performance of non-criminal euthanasia (see below). During the trial, an open letter was delivered to the Minister of Justice. It was signed by eighteen doctors who stated that they had committed the same *offence* at least once.

In the same year (1973) the Netherlands Society for Euthanasia was formed, nearly 40 years after the Btitish Voluntary Euthanasia Society, which was founded as early as 1935 by George Bernard Shaw, H.G. Wells and others. The Dutch Society has pleaded repeatedly for legalization of euthanasia in the Netherlands.[10] During the next years many statements and articles were published in the Netherlands by political parties, individual doctors, lawyers and ethicists.

In the mean time, the Royal Netherlands Medical Association issued its first opinion on euthanasia in 1973 and revised it in 1984.[11] It stressed the fact that in a pluralistic society there will always be differing opinions on matters such as abortion and euthanasia. It further stated that if a doctor wanted to grant his patient's wish to have his life ended, it would be proper for the doctor to perform euthanasia, provided the patient's condition fulfilled certain criteria and provided the doctor followed certain guidelines.

If a doctor would reject euthansia on principle the Association further held that in such case it can be expected from the doctor that he gives the patient concerned an opportunity to contact a colleague at the earliest possible stage.

In 1982 a State Commission on Euthansia was set up to make recommendations to the Government on future policy.[12] The majority of the members of the panel advocated in their final report submitted in 1985 a change of the provisions of the CRIMINAL CODE so that euthanasia would no longer be a criminal act. In that case, doctors would be allowed to practice euthanasia under conditions similar to those that were developed by the courts in the Netherlands (see below). The patient would have to be in a hopeless situation with no prospects of improvement. The hopelessness has to be based on medical facts and on the judgement of the patient about his situation and his perspectives. *Euthanasia* was defined as: the deliberate termination of life by a doctor at the request

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[9] District Court Leeuwarden, Feb. 21, 1973, NEDERLANDSE JURISPRUDENTIE (Dutch Jurisprudence, NJ), 183.

[10] E. Borst-Eilers, Vice-President of the Health Council of the Netherlands, speach delivered on Euthanasia in the Netherlands, The Hague, Aug. 7, 1991.

[11] S. Verbogt, HOOFDSTUKKEN OVER GEZONDHEDSRECHT, 160 (4th ed., Arnhem, Gouda Quint BV, 1992).

[12] *Id*. at 162.

of the person concerned. The patient's request is very important, it emphasises the right to self determination which has been developed in Dutch health law as a legal right.[13]

To date the State Commission's Report was the most far-reaching statement on euthanasia to emanate from a Government body. It included a model bill that was designed to complement the proposed reform. It appeared that if euthanasia were to be performed under certain circumstances, the practice would be accepted in the Netherlands. However, in the same year the above-mentioned report was published a well known criminologist published an article entitled *Euthanasia: Suicide of Ill People and Old People*. The opponents of euthanasia won territory.[14]

In the following years several careful proposals of law on the subject of euthanasia were drafted by the Commission ? and the Government. No consensus could be reached about the form the legislation was to take on this very sensitive topic. One proposal for legislation went quite far in the parliamentary procedure but a governmental crisis led to the scrapping of this proposal.

Definition-various categories of euthanasia

Euthanasia is popularly taken to mean any form of termination of life by a doctor. However under Dutch law the definition is narrower. It means the termination of life by a doctor at the express wish of a patient. The request must be voluntary, explicit and carefully considered and it must have been made repeatedly. Moreover, the patient's suffering must be unbearable and without any prospect of improvement.[15]

An action by a doctor to terminate a patient's life may be divided into three categories:

- the termination of life at the request of the patient (euthanasia);
- assisted suicide: the doctor supplies a drug which the patient takes himself; and
- the termination of life without a request from the patient.

All three actions stated above are technically illegal under the CRIMINAL CODE as follows:

*** Article 293**

Any person who takes another person's life at that person's express and earnest request shall be liable to a maximum term of imprisonment of twelve years or a fine of the fifth category.

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[13] Law on the Medical Treatment Agreement, Law of Nov. 17, 1994, Stb. 837; *see also*, H. J. J. Leenen, HANDBOEK GEZONDHEIDSRECHT, DEEL I, RECHTEN VAN MENSEN IN DE GEZONDHEIDSZORG 31 (3d. Ed., Samson H.D. Tjeenk Willink, 1994).

[14] C. I. Desaur, EUTHANASIE: DE ZELFMOORD OP ZIEKEN EN BEJAARDEN 913 (Delikt en Delinkwent, 1985).

[15] Government of the Netherlands, *The termination of Life by a Doctor in the Netherlands*, May 1995, VB20 / 2E, at 1.

*** Article 294**

Any person who intentionally incites another to commit suicide, assist him in the act or provides him with the means to commit suicide shall, if suicide follows, be liable to a maximum term of imprisonment of three years or a fine of the fourth category.

*** Article 287**

Any person who intentionally takes another person's life shall be guilty of manslaughter and liable to a maximum term of imprisonment of fifteen years or a fine of the fifth category.

*** Article 289**

Any person who intentionally and premeditately takes another person's life shall be guilty of murder and liable to life imprisonment or to a determinate term of imprisonment not exceeding twenty years or a fine of the fifth category.

Thus it is only by means of a special law on euthanasia that a doctor can circumvent the law and legally terminate a life.

Finally, it should be pointed out that pain relief administered by a doctor may also shorten a patient's life. As is the case in other countries, this is seen as a normal medical decision in terminal care and not as euthanasia. Examples of this are:

- stopping a life-sustaining treatment that has become medically pointless; and
- stopping a treatment or not starting treatment at the patient's explicit request and alleviating pain with increasing dosages of opiates that are necessary to end pain but which might also shorten the patient's life.

Ethical aspects of euthanasia

In the search for a legal solution to euthanasia and assisted suicide, the debate in the Netherlands centered around ethical and moral considerations. The increasing possibilities of medical science and technological developments often help to restore health and prolong life. In some situations, however, medical advances often seeme to prolong suffering. Many people, doctors included, have become aware of the fact that trying to postpone death does not always add anything to a patient's wellbeing.[16]

Very often allowing death to take its course is more humane and more in line with a doctor's commitment than the prolonging of treatment by taking heroic measures. In the view of some,[17] it

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[16] J. Kits Nieuwenkamp, Excerpt from paper The Dutch Perspective: Euthanasia in the Netherlands, at 2.

[17] D. Callahan, *Medical futility, medical necessity: the problem without a name*, 4 HASTINGS CENTER REPORT 30-35

seems best to allow the patient to die in cases where the patient does not want to continue treatment. However, it is quite a different matter to actively bring about a patient's death. Many people feel that no one should cross this line.

Other people in society, on the other hand, feel that euthanasia, if it is administered under strict conditions, is an act of ultimate compassion. They feel that such an act fits very well in a doctor's duty to stand by his patient in his most difficult hour. A Dutch ethicist expressed it in this way:

> ...if suffering has become so terrible and so unbearable that human life as it were sinks through the bottom of a minimum of human dignity, the patient involved has a definite case to ask for euthanasia. This ultimate deed of the patient's doctor, if granted, does not cause harm to him but is beneficial in the full sense of the word.[18]

In the last twenty years many statements and articles have been published in the Netherlands by political parties, laymen, individual doctors, lawyers and ethicists. The church also has taken part in the discussion. In 1972, the Dutch Reformed Church Synod published a pastoral manual entitled *Euthanasia: Meaning and Boundaries of Medical Treatment*. Using the then-common terminology of active and passive euthanasia, the manual set the question of euthanasia within the broader context of the secularization of the human image and developments in medical technology. Finding that such technology has made prolonging life problematic, the Synod concluded that quality of life is more important than length of life. The Synod also called attention to the problem of suicide, especially among the elderly, and questioned whether the wish to die should under all circumstances be denied.[19] The manual urged compassionate care for the dying and allieviation of pain, even at the risk of hastening death. The Synod held that when the patient can no longer communicate or participate in relationships medical treatment may be ceased. It concluded that the distinction between active and passive euthanasia is more psychological than ethical. Most Dutch Reformed Churches would restrict euthanasia to borderline and emergency situations, and only a minority would reject euthanasia absolutely.

In contrast, the Roman Catholic Church of the Netherlands rejects euthanasia altogether.[20] The position of the Catholic Church is reflected in a 1985 pastoral letter written by the Dutch bishops entitled *Suffering and Dying of the Sick*. Recognizing the tremendous power of technology to prolong life, the bishops held that a patient has the right to refuse medical treatment:

> ...one ought to renounce senseless prolonging of the dying process by forms of treatment that can no longer lead to the improvement or relief.

(1991).

[18] Kuitert, *supra* note 16, at 4.

[19] *Supra* note 7, at 5.

[20] Id. at 6.

It should be undestood that in an ethical discussion morality is reflected. Autonomy is typically a principle connected with the patient's right for euthanasia. In patient's rights, autonomy is a central principle. In terms of law, the principle of autonomy is closely linked to the right of self determination. If we leave a patient in his worth, including his wish to die with dignity, he or she is granted such autonomy. As stated above, the right of self determination has been developed in Dutch health law as a legal right.[21]

Euthanasia is a liberty, not a right one can claim. Nobody can be obliged to either undergo or to participate in the administering of euthanasia; no one is obliged to act against his or her conscience.

The 1990 Commission of Inquiry into Medical Practice with Regard to Euthanasia

In 1989 a new Dutch coalition government was formed. It consisted of socialists and christian democrats. The political parties represented in this Government deemed it necessary to obtain more knowledge about the actual occurrence of euthanasia before deciding on legislation. In January 1990, a Committee was appointed and chaired by Professor Remmelink, Attorney-general at the Supreme Court of the Netherlands. The Commission's assignment was to report to the Government on the state of affairs regarding 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.[22]

For the purpose of the study, a large number of physicians from different disciplines were interviewed about their experience with euthanasia and other medical decisions. Several were reluctant to cooperate, because they were unsure whether the information they provided would expose them to punishment. To encourage cooperation, the Government guaranteed that those physicians who disclosed information would be immune from prosecution.

The physicians were also asked to participate in a prospective study by completing a questionnaire for every patient in their care who died within six months of the interview. The National Statistics Bureau studied a sample 7,000 deaths going by the cause-of-death forms that had been filed. For this part, the researchers had to go back to the doctors involved. Again, complete anonimity was guaranteed to these physicians.

The Ministry of Justice agreed on a "notification or reporting procedure" for cases of euthanasia and assisted suicide. Again, the Ministry guaranteed immunity to participating physicians and thereby encouraging their cooperation. This procedure also harmonized prosecution policies in the various regions of the country and eliminated certain investigative practices, such as the interrogation of relatives within hours of a patient's death.

In this procedure the doctor informs the medical examiner by means of a detailed questionaire. Compliance with this procedure warranted a review by the Public Prosecutor who if necessary contacts the State Inspectorate for Health. The Public Prosecutor reviews the case according to the existing legal norm and the explanation thereof given in jurisprudence.

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[21] *Supra* note 13.

[22] Ministry of Welfare, Health and Culture of the Netherlands, *Medical Practice with regard to Euthanasia and Related Medical Decisions in the Netherlands: Results of an Inquiry and the Governments View*, VDB 92-034.

Since in common usage the term *euthanasia* is used to describe dissimular situations, the commission and researchers involved chose as their working definition the interpretation of the Government Commission Euthanasia in its final report of 1985 (see above) in which *euthanasia* was defined as the deliberate termination of life by a doctor at the request of the person concerned.

The Remmelink Commission did not limit itself to euthanasia and assisted suicide. The objective of the Commission's inquiry was also to acquire an overview of all potentially lifeshortening medical decisions with regard to the end of life. This meant that all situations in which doctors make decisions that are (also) intended to end a patient's suffering by bringing about the end of a patient's life, or in which the hastening a patient's death is at least taken into account.[23]

The Commission published its findings in September 1991. From the research data, it was concluded that nearly all the doctors in the Netherlands involved in patient care are faced with various medical decisions with regard to the end of life. These decisions belong to the normal field of activity of every doctor who is frequently confronted with death. Decisions to carry out euthanasia only make up a fraction of all these decisions.

Of all the different doctors surveyed, general practitioners were most frequently faced with requests for the termination of life. Doctors in nursing homes carried out euthanasia less frequently. On the other hand, the research report showed that the discontinuance of life prolonging treatment or not starting treatment, without an explicit request by the patient, frequently occurred in nursing homes.

These cases involved for the most part very old or demented patients. Consultations are mede with relatives and the nursing staff and a decision is made not to treat, or to end treatment for a fatal disorder, such as cardiac arrest or pneumonia. The Commission spoke in such cases about "leaving nature to its own devices."

The most important finding was that doctors in the Netherlands exercise extreme caution in dealing with matters of life and death. The research result showed that it often happens that a doctor does **not** comply with a request for the termination of life because he finds an alternative to euthanasia.

The Commision further pointed out that there is no proof whatsoever in the research results for the suggestion that a lack of funds is a cause for the administration of euthanasia. The unbearable suffering and/or the natural desire to die peacefully were the primary reason Dutch doctors cited in carrying out euthanasia.

Each case in which euthanasia is carried out must, according to the Commission, be reviewed by another doctor other than the one in attendance. To that end it was thought necessary that cases of euthansia be reported. The Commission further thought it necessary that the reporting procedure also would be applied to the active medical interventions to shorten life without the patient's request or permission.

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[23] *Id*. at 4.

The Commissions assignment was not to submit proposals for future legislation. Its task was to increase, to deepen and to specify the understanding of medical actions with regard to the end of life. It advised the Government to convert the voluntary notification procedure, in effect since November 1990, into a statutory one, herewith creating an opportunity to review a doctor's action.

In an opinion on the commission's report,[24] the Government of the Netherlands underlined its definite task with regard to euthanasia and other medical decisions with regard to the end of life. It accepted responsibility for the effective protection of human life, also in its vulnarable last stage. The Government further stated that it could not ignore the desire of patients to die with dignity and to shorten their unbearable suffering.

The Government announced it would give a legal basis to the notification or reporting procedure in the form of a statutary questionnaire. Euthanasia and assistance with suicide would remain a crime, but it could be a justified act when performed "in a situation of necessity." Once both Houses of Parliament had approved the new notification procedure and the amendment of the Law on Undertaking, the procedural reporting rules entered into force on June 1, 1994.[25]

Law and practice

As stated above, euthanasia and assisted suicide remain in the CRIMINAL CODE under the new law and remain punishable. However, they will not be prosecuted if the acts performed according to particular guidelines. A formal legal status was given to a procedure which was already in operation without adding new elements. In the Law on Undertaking[26] there is a provision according to which a case of unnatural death must be reported by a physician to the coroner in a so-called "notification procedure."

Unnatural deaths are considered:

- euthanasia;
- assistence in the committing of suicide;
- active termination of life without the request of the patient; and
- an unnatural death caused by something else (for example a traffic accident).

For these cases the notification procedure applies and the physician must inform the coroner (who is also a physician) and fill out a questionnaire.

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[24] *Supra* note 14, Opinion of the Government of the Netherlands on the Commission Report Concerning Medical Decisions with regard to the End of Human life, at 9.

[25] *Supra* note 3.

[26] *Id*.

The notification procedure contains approximately fifty criteria on the basis of which the doctor draws up his report. The criteria are grouped into five sections. Section One deals with the health history of the patient. Since a longstanding relationship between physician and patient is very common in the Netherlands, this overview is often quite thorough. The physician is asked when he would have expected that the patient would have died if he would not have performed euthanasia, assisted with suicide or shortened the life of the patient without the latter's explicit request. This overview may also include information about the mental health of the patient which is important for the next section.

Section Two deals with the request for euthanasia and patients with a physical illness are explicitely differentiated from patients with a psychiatric illness. The report must show how the request was made, whether the patient made the request freely, explicitely and repeatedly. It must also state when the request was made, for example in a living will.

Section Three deals with the shortening of a patient's life without the patient's request. The physician is asked here why no request was made and whether the patient had expressed his or her opninion at an earlier time about the actively shortening of life.

Section Four deals with the consultation of the attending physician with one or more other independent physician(s). It has to be reported what their capacity is and whether or not they were involved in the treatment of the patient. All these criteria tend to assure that the consulted physicians are sufficiently capable of giving an independent opinion. *Consultation* in this sense means that the consulted physician has read the medical records and seen the patient concerned.

Section Five deals with the act of euthanasia. For example one question is meant to establish the kind of means used. Another is designed to make sure that the attending physician was personally present when the patient died.

With respect to patients who have a psychiatric illness, a special section in the notification procedure must be answered in order to obtain additional information. For example, in case a patient does not want to undergo further treatment, the expert physician to be consulted has to be a psychiatrist or someone with knowledge about the patient's mental state.

The Ministers of Health and Justice have stated in Parliament that it is their opinion that given the very strict requirements, the lives of psychiatric patients may only be terminated in very exceptional situations.[27]

The notificaton procedure means to secure careful conduct by the physician and only provides procedural rules. It is based on a list of criteria which serve as guidelines for assessing the thoroughness and caution exercised by a doctor who has terminated the life of a patient whose suffering was unbearable and for whom there was no prospect of improvement.

The coroner, after inspecting the corpse, informs the prosecutor in his region what the cause of death was and that he has received a completed questionnaire from the physician. The prosecutor

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[27] *Supra* note 15.

who assesses the reported cases of the termination of life by a doctor then decides whether or not to prosecute. He also assesses whether the physician can invoke *force majeure*.

Over the last 20 years, criteria have been developed in case law containing the view that although euthanasia is not a part of regular medical care, and is still subject to the CRIMINAL CODE, a physician will not be found guilty if he performs euthanasia according to particular requirements with respect to carefull medical practice. The list of questions to be answered by the physician when reporting to the coroner relate to the requirements of careful medical practice and help determine whether the physician exercised due care.

If the physician's professional duty to alleviate suffering prevails over the duty to preserve life, the defense is based on the fact that he acted in a state of necessity and, therefore, can invoke *force majeure*.

Force majeure constitutes generally recognized grounds for immunity from criminal liability, which are defined in Article 40 of the CRIMINAL CODE of the Netherlands and which apply in the case of all offences.[28]

In the courts it has been developed that a physician acted in a state of necessity when he has to chose, on the one hand, the obligation to preserve life and, on the other hand, the obligation to do everything posiible to relieve unbearable suffering for which there is no prospect of improvement.[29] This may result in the termination of life in which a physician can invoke *force majeure* in order to be immune from prosecution.

In order to qualify for immunity from prosecution, a physician must have fulfilled all the criteria relating to care and thoroughness in the statutoy notification procedure and *force majeure* must also apply.

These criteria first developed by the General Board of the Royal Dutch Medical Association in 1984[30] and then confirmed in court decisions can be summarised as follows:

1. The patient's request for euthanasia or assisted suicide must have been voluntary, carefully considered, persistent and made without outside pressure.[31] The attending physician must know the patient well enough to assess whether the request is indeed voluntary and well considered.

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[28] Art. 40 reads as follows: "Any person who was compelled by force majeure to commit an offence shall not be criminally liable."

[29] Supreme Court of the Netherlands, June 21, 1994, NJ, 1994, 656.

[30] *Supra* note 11.

[31] District Court Alkmaar, May 10, 1983, NJ 1983, 407; District Court Groningen, Mar. 1, 1984, NJ 1984, 450; Dictrict Court The Hague, Aug. 6, 1985, NJ 1985, 708.

2. The doctor and the patient must have considered and discussed alternatives to alleviate the suffering. These alternatives must have been found ineffective, unreasonable or unacceptable to the patient.[32] The patient must have adequate information about his medical condition, the prognosis and alternate treatments.

3. There must be unbearable and unacceptable suffering which according to prevailing medical decision is without prospect of improvement.

4. The attending physician must have consulted at least one other physician for an independent opinion. The consulted physician has to give his opinion about the patient's medical situation.

Based on these criteria that have been laid down in case law and on the questionnaire in the notification procedure, the general prosecutors decide whether a case of euthanasia or assistance in committing suicide should be prosecuted.

As stated above, the statutory notification procedure not only applies to euthanasia and assistance in committing suicide, but it is also extended to cases in which a doctor actively ends the life of a patient *without* the patient's explicit request.

The Commission's study[33] did not limit itself to euthanasia and assisted suicide. It also explored medical decisions such as withdrawal or witholding treatment or the alleviation of pain in such dosages that the risk of shortening the patient's life is considerable.

The Commission recommended and the Government agreed that most of these decisions concerning the end of life can be considered normal medical practice and, therefore, should not be punishable. For example, the following medical actions were considered as normal medical practice and do not fall within the definition of *euthanasia*:

- stopping a treatment or not starting a treatment that has become medically pointless. This also holds true in those cases where stopping the treatment means that death will probably come a few days sooner. As long as the patient is still competent, such a decision should be taken by the patient and the doctor together;

- stopping a treatment or not starting a treatment on the patient's explicit request. If the patient is well informed and refuses treatment, the doctor should respect the paient's wishes; and

- alleviating pain with increasing dosages of opiates that are necessary to kill pain but which might at the same time shorten the patient's life.

The Royal Dutch Medical Association provides ethical guidance to physician's facing such decisions, and certain medical criteria must be followed with respect to consultation and safeguards. However, the Government has taken the position that ending a patients life *without* his explicit request

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[32] District Court Groningen, Mar. 1, 1984, NJ 1984, 450.

[33] Ch. V.

cannot be considered normal medical practice. The new notification procedure has been extended to these cases. The Ministry of Justice has announced that as a general rule, physicians reporting such cases will have to face prosecution. It is then up to the court to assess the doctor's invocation of *force majeure*. The courts will have to decide whether or not the death of the patient without his/her consent is acceptable.

Cases - judicial practice

The unique manner in which the Dutch Parliament has taken in its approach to euthanasia and assisted suicide illustrates the importance of case law in judicial practice in the Netherlands. Independent prosecutors rely in their decision on whether or not to prosecute mainly on the above-mentioned criteria that were mainly derived from court decisions.

Many older Dutch physicians recall a highly publicized 1957 case in Great Britain.[34] Dr. Bodkin Adams, a British general practitioner, was accused of murder when he was eased the death of rich old ladies. His acquittal implicitely acknowledged the acceptability of adminstering *fatal doses* of drugs to the dying.

In the Netherlands the debate was sparked in 1973 by a court case in which a female general practitioner was prosecuted for ending the life of her 78 year old mother with an overdose of morphine.[35] The mother who was in a nursing home had suffered a cerebral haemorrhage, was partly paralyzed, had trouble speaking, was deaf and had repeatedly expressed a wish to die. The daughter and her husband, also a physician, had more than once informed the patient that they could not comply with her request to relieve her from her suffering. The mother became more and more rebellious and distant towards both of them. Yet at a certain moment the daughter administered the deadly injection. The daughter admitted that she had ended her mother's life and that she believed she had done the right thing.

Although the judge gave a suspended sentence of one week's imprisonment and probation for one year, for the first time criteria were set for the performance of non-criminal euthanasia.
In its decision, the court stated that euthanasia would be acceptable if:

- the patient is incurable ill;
- the patient is suffering unbearably;
- the patient has requested the termination of his life in order to be relieved of his suffering; and
- the termination of the patient's life is performed by the doctor who treats the patient or who is in close touch with him.

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[34] *Supra* note 10, at 3.

[35] *Supra* note 9.

The testimony of an expert witness, the Inspector of Health, played a large role in the verdict. He declared that the average physician in the Netherlands no longer considers it right to preserve the life of a patient if the above-mentioned criteria are met.

Eight years later a district court had to give a verdict in a case of *assisted suicide*.[36] The suspect in this case (not a physician) had supplied the means to commit suicide and assisted the person in committing suicide. In this case, the court established criteria under which the giving of assistance would not be a criminal act as follows:

- physical or psychological suffering has to be experienced as unbearable by the person himself;
- this suffering as well as the desire to die must be durable;
- the decision to terminate one's life must be taken voluntarily;
- the person must have a good understanding of the situation in which he or she is, including an awaareness of the alternatives available;
- there can be no other reasonable solution available that could bring improvement in the situation;
- the death of the person can not bring about unnecessary grief to others;
- the decision to give assistance cannot be made one acting alone;
- a physician must allways be involved in the decision to give assistance and must prescribe the means to be used; and
- the decision to give assistance and the assistance itself must have been carefully taken and well considered in which collegiate consultation by the physician has taken place, this could include the consultation of another expert such as a psychiatrist, psychologist or a social worker.

The first case that was adjudicated on euthanasia by the Supreme Court of the Netherlands was not heard until 1984.[37] In this case, the defendant, the family doctor had given a series of injections resulting in the death of his patient, a 95 year old woman who was seriously ill with no chance of improvement.

When she was 93, the woman had discussed her deteriorating condition with her physician at length. In 1980 the patient signed a living will, stating that she requested what was then called active euthanasia, if she were to be in such a condition that no recovery to a reasonable and dignified state of life was to be expected.

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[36] District Court Rotterdam, Dec. 1, 1981, NJ 1982, 63.

[37] Supreme Court of the Netherlands, Nov. 27, 1984, NJ 1985, 106.

She fractured her hip at age 94, suffered hearing and vision loss, and at times was unable to speak or articulate. The weekend before her death, the patient suffered substantial deterioration, was unable to eat or drink, and lost consciousness. The woman had asked her doctor several times to put an end to her agony. After she regained consciousness, she declared that she did not want to experience anything like that again and with great emphasis asked for euthanasia. The physician had discussed the matter several times with his assistant physician and with the patient's son, both of whom approved such measures.

After a last conversation with the patient in which she declared as her final wish "to die as soon as possible," the doctor decided to comply with her wishes. In his opinion, life had become a heavy burden to the patient whose suffering was unbearable. The physician was acquited of murder in the District Court of Alkmaar, but the verdict was revoked by the Court of Appeal in Amsterdam and the the doctor was convicted of murder without imposing a penalty. The Supreme Court reversed the decision made by the Appeal Court and ruled that this Court had not given sufficient reasons for its decision and had not sufficiently looked into the physician's "conflict of duties."

The Supreme Court held that, as a general rule, euthanasia can be regarded as a non-criminal act when, according to responsible medical judgement, and taking into acount of the rules of medical ethics, there is a case of necessity. In such a case there is a conflict between the need to save a patient's life and the need to help the patient to die at his request. Thus an otherwise criminal act becomes justifiable.

The Supreme Court's decision made an allowance for legally acceptable euthanasia on request. The influence of the Court's decision was noticable in the report by the State Commission in 1985[38] as well as in subsequent legislative proposals to legalize euthanasia. In 1985[39] other euthanasia cases were decided by lower courts in Rotterdam and The Hague. In both cases the invocation of a situation of "emergency" (in the sense that the defendant carefully balanced the conflicting duties and interests and made a decision which could objectively be justified taking into account the special circumstances) was accepted and the charges against the physicians were dismissed. However, in the Rotterdam case the doctor was fined for falsely stating on the birth certificate that the patient died of a natural death.

In the same year a district court convicted a physician who had killed a number of patients in a nursing home.[40] The doctor was convicted of murder and falsification of a document (the death certifcate). The central question in this case was whether there was a request of the patients involved. The request of the patient must be well considered and consistent. In three of the cases the court decided that this requirement had not been met.

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[38] *Supra* note ?, at 13.

[39] District Court Rotterdam, Mar. 20, 1985, Tijdschrift voor Gezondheidsrecht (TvGR) 1985/44; District Court The Hague, June 21, 1985, TvGR 1985/52.

[40] District Court The Hague, Aug. 7, 1985, TvGR 1985/53.

The court ruled that not only there was not a clear request there was also not overwhelming evidence that there was unbearable suffering, even though the patients were unconscious.
Also, no consultation had taken place with another physician. However, the appelate court reversed the verdict because of mistakes made by the prosecution.[41]

This so-called *de Terp Case* was much cited in international literature because of the acquittal of the physician. In this case the prosecution had erred and brought files before the court which were not admissable because of medical secrecy. Documents with medical information about the patient, reports from nurses and medical administrative reports were confiscated. This evidence was illegally obtained. The court had to dismiss the case, not because it accepted the actions of the doctor, but because the requirements in the CODE OF CRIMINAL PROCEDURE had not been met.

The Inspector of Health filed a complaint with the Medical Disciplinary Board against the physician. As a result, the Board adopted the criteria that must be met in order for a person to be immune from prosecution for euthanasia. These include:

- an explicit request made by the patient;
- an indepth and repeated consulation with the patient;
- a consulation with an independent colleague by the physician; and
- a detailed reporting procedure.

The Disciplinary Board concluded that none of these conditions had been met and a penalty for criminal activity was imposed.[42]

In another case a psychiatrist performed euthanasia on a 75 year old friend. The friend had suffered for decades from multiple sclerose and did not want to become more handicapped than she already was and wanted to die as soon as possible. She had not discussed this with her family physician, because he was against euthanasia for religious reasons.

After the psychiatrist had in vain discussed alternatives for a more bearable life, she started considering her friend's request. She took three months to make the decision. In the meantime she consulted with several physicians, a minister and an anesthesiologist and a pharmacist about the methods used in euthanasia. These were all people that knew the person who wanted to die. She also had several conversations with her friend and even set the day and the time. After having performed the euthanasia, she immediately informed the friend's physician and the general prosecutor.

The district court found the psychiatrist guilty, but no penalty was imposed. The appelate court imposed a two-month conditional prison term.[43]

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[41] Appelate Court The Hague, Nov. 12, 1986, TvGR 1987/11.

[42] H. J. J. Leenen, HANDBOEK GEZONDHEIDSRECHT, Deel 1, Rechten van de Mens in de Gezondheidszorg 286 (3d. ed., Samson H.D. Tjeenk Willink, Alphen aan den Rijn, 1994).

In 1987 the District Court in Rotterdam[44] charged a nurse who had terminated the life of severely mentally handicapped patient with murder. There was obviously no request for euthanasia. However, the patient's medical condition was worsening every day. The patient could not walk or communicate, had to be fed artificially, and the patient's life expectancy was very short. The nurse could not agree with the policy of administering painkillers and acted under great psychological pressure. The court convicted the nurse to a prisonterm of twelve months.

The Appeals Court confirmed the lower court's decision but reduced the prisonterm.[45] It considered the heavy workload of the nurse, the patient's short life expectancy, and the patient's poor quality of life. Even the harmful consequences the convicted person had endured as a consequence of the court case were taken into consideration.

The question whether severe mental or psychological suffering can be a ground for the suicide assistance has been very controversial in the Netherlands. Most people agree that suffering can be as exhaustive and unbearable when it has psychiatric roots as when it is caused by a terminal physical illness.[46]

Some members of the State Commission,[47] even though they underwrote the final report of its Commission, did not agree that a mental situation without prospect of improvement was a ground for the non-punishable performance of euthanasia. Many others, however, disagreed. The Dutch courts have dealt with several cases involving physicians who have provided suicide assistance brought about by psychiatric or mental suffering.

In one case, a psychiatrist was charged with assisting the suicide of a 50-year old patient who had a 25-year history of depression and alcohol abuse.[48] In the last years of her life, the patient experienced serious bouts of depression and engaged in several unsuccesful suicide attempts. She drank household cleanser which damaged her voice; she set herself on fire; and a few months after that, she jumped out of a second story window. She also consumed an overdose of sedatives obtained by falsifying a prescription.

The patient had made repeated requests to the psychiatrist and the family physician for assistance in committing suicide. The psychiatrist could not find treatment modalities that could ease her distress. Furthermore it was clear that the patient desperately wanted to die. She also wanted to die for the sake of her family because she felt that she wanted to end the constant stress her condition

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43 District Court Leeuwarden, Oct. 11, 1984, TvGR 1985/17.

44 Mar. 31, 1987, TvGR 1988/1.

45 The Hague, Oct. 25, 1988, TvGR 1989/13.

46 Leenen

47 *Supra* note ?

48 Appelate Court The Hague, May 25, 1993, TvGR 1993/52.

imposed on them. She also had a clear understanding of her situation and was mentally competent to ask for medical assistance to end her life.

The woman's clergyman was also brought into the case by the woman's doctors. He too was of the opinion that the case was hopeless, and that the physicians were entitled to assist the patient in her determined attempts to die. The Appelate Court ruled that in general it cannot be said that psychiatric patients cannot have an opinion or express this opinion. The court rejected the argument that psychiatric patients were by definition incompetent to qualify for euthanasia. However, the legal requirement of "consultation with another colleague" can only be met if the colleague is a psychiatrist and if he or she has personally examined the patient. The legal procedings against the psychiatrist were dismissed.

In the same year (1993) a report was published by the Medical Inspectorate for Mental Public Health entititled: " The notification procedure euthanasia and assistance in committing suicyde and psychiatric patients."[49] This report rejected the difference between physical and psychological suffering with respect to the giving of assistance to commit suicide to psychiatric patients.

The Supreme Court followed the majority opinion of the State Commission and the above-mentioned report and accepted the fact that a psychiatric patient, when the general criteria for euthanasia and additional requirements for psychiatric patients are met, is not excluded from euthanasia or suicide assistance.

In this most publicized so-called *Chabot Case*, it was the first time that the Supreme Court was called upon to decide on euthanasia performed on a patient who suffered from a psychiatric illness.[50] This case concerned a 50 year old social worker who was in a state of severe suffering and had become very depressed after one of her sons committed suicide following a broken love affair. The only other son died four years later of cancer. On the day he died the lady attempted suicide. Her marriage ended in divorce. After unsuccesful attempts to obtain lethal doses of drugs, she contacted the Dutch Society of Voluntary Euthanasia who referred her to Dr. Chabot, a psychiatrist.

Dr. Chabot had helped many suicidal patients find reason to get on with their lives. Even though at the first session the patient was quite insistent that life had no prospects for her and that her continued existence was intolerable, she did agree to enter into a therapeutic relationship with the psychiatrist.

The patient refused anti-depressants and bereavement therapy and told her pychiatrist that she was who she was and that she could not envision becoming a different person and maintained her unwavering determination to die. The psychiatrist consulted a number of experienced colleagues who reviewed the transcripts of the therapy sessions. The psychiatrists also concluded that it was a hopeless case before he complied with the urgent request of the woman to assist her with suicide.

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[49] Id. Leenen, at 293.

[50] Supreme Court, June 21, 1994, NJ 1994, 656.

In the Court of First Instance the psychiatrist appealed on necessity and invoked *force majeur*, which is the legal basis of all decisions on euthanasia and suicide assistance and was acquited. The Court of Appeal followed the decision of the first court. Subsequently the case came before the Supreme Court which did not recognize *force majeure* as grounds for immunity from prosecution in this case and found the suspect guilty of assisting the patient to commit suicide.

Even though the psychiatrist was found guilty, punishment was waived. The Supreme Court accepted the principle that mental suffering could be sufficient to justify assisted suicide, but added that a number of additional requirements have to be met. Extreme cautioussness is required which leads to additonal criteria to make sure that the request of the patient is free and deliberate and that there actually is no alternative to end the severe suffering.

The Supreme Court stressed that the psychiatrist should have had another independent expert personally examine the patient. They should have formed an opinion of the extent of the patient's suffering, the character and motivation of the request, the prospect of improvement, and possible alternative solutions.

Even though it appears that because of this decision the cases in which euthanasia is allowed are being extended, the extra criteria set should be seen as a limitation upon the performance of euthanasia. In case of a physically suffering patient, it can be objectively established that there is no prospect for improvement. Such a determination cannot be made for psychiatric patients. Especially since the Supreme Court set the requirement that there must be no possibility of any form of treatment whatsoever being effective.

The Inspector for Public Health initiated a complaint against the psychiatrist for the Medical Disciplinary Board.[51] The Board had to determine whether the psychiatrist acted in accordance with the professional standards befitting a practising psychiatrist. The Board questioned whether there was unbearable and long-lasting suffering without prospect of improvement and whether or not consultation should have been arranged with other experts who should have personally examined the patient. It ruled that other important aspects had also been neglected, for example the short distance of time between the facts that caused the patients psychiatric illness, the request for euthanasia, and committing the deed.

In the Board's view there was a reasonable alternative, namely psychiatric treatment. It also found that the patient's request for euthanasia could have been biased by the psychiatric illness. The Board ruled in April 1995 and the psychiatrist was reprimanded.

The Minister of Justice had to answer questions in Parliament about these two decisions. He stressed that from both decisions in this case it can be learned that the assistance of a patient to commit suicide whose suffering is not caused by physical causes can only be done in rare situations. The Minister saw no reason, in light of the decisions, which might make the performance of euthanasia or suicide assistance nearly impossible for patients who suffer psychologically to adjust the prosecution policy or to amend the points in the notification procedure.[52].

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51 *Supra* note 15.

52 Nederlands Juristenblad, May 12, 1995, No. 19, at 726.

Comparative overview

The Netherlands has been immersed in an emotional debate about euthanasia for two decades. Some experts have likened the evolution toward legalizing euthanasia in the Netherlands to the gradual acceptance of legalized abortion in many Western countries. However, it appears that the Netherlands has sustained a leading role. It possibly has the most lenient policy with respect to this topic.

In Canada a number of court decisions established the right of some persons to make some decisions regarding their own medical treatment, and Canadian case law strengthened the right of individuals to refuse and withdraw treatment. The events received considerable media attention and prompted many Canadians to consider end-of-life decisions. The focus became more and more to consider assisted suicide and euthanasia. In 1993 the Canadian Medical Association published a number of papers on these issues.

In that context, a Special Committee of the Senate was set up in 1994 who was given the task to examine and report on the legal, social and ethical aspects of euthanasia and assisted suicide. The goal of the Committee was to set the stage for a full and open national debate and to help the public develop a better understanding of this very complex subject. It dealt not only with assisted suicide and euthanasia but also with many other aspects regarding medical and health-care practices. The Committee submitted its final report fourteen months later in June 1995.[53]

Assisted suicide is a criminal offence under the Canadian CRIMINAL CODE. With respect to this offence, a majority of the Committee recommended that this section of the CODE remain intact and that research be undertaken to ascertain how many people are requesting assisted suicide, why it is being requested, and whether there are any alternatives that might be acceptable to those who make the requests. A minority of the Committee recommended that an exemption be added to the provision on assisted suicide in the CRIMINAL CODE. It would follow clearly defined safeguards designed to protect individuals who assist in another person's suicide. They also recommended, that in order to avoid abuse, procedural safeguards must provide for review before and after the act of assisted suicide.[54]

With respect to euthanasia, the Committee differentiated between three forms of euthanasia in its recommendation. It recommended that the prohibition against involuntary euthanasia (euthanasia for example done against the wishes of a competent individual) continue under the present murder provisions in the CRIMINAL CODE.[55]

For the involuntary euthanasia (euthanasia for example done without the kowledge of the wishes of a patient), the Committee recommended that it also remain a criminal offence. However, the CRIMINAL CODE should be amended to provide for a less severe penalty in cases where there is the

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[53] Report of the Special Senate Committee on Euthansia and Assisted Suicide, *Of Life and Death*, June 1995.

[54] *Id*. at 74.

[55] *Id*. at 89.

essential element of compassion or mercy. In order to limit the cases in which a less stringent sentence would be available, the essential elements of compassion and mercy must be clearly and narrowly be defined.[56]

For voluntary euthanasia performed in accordance with the wishes of a competent individual, the Committee had different views. The majority recommended that this form of euthanasia remain a criminal offence; however, they felt that the CRIMINAL CODE should be amended to allow for a less severe penalty similar to that provided for involuntary euthanasia in cases where there is the essential element of compassion or mercy.

A minority of the Committee recommended that the CRIMINAL CODE be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide. Clearly defined minimum safeguards should be added. A minority also recommended that if voluntary euthanasia remains a criminal offence, the CRIMINAL CODE be amended to provide for a less severe penalty similar to the penalty for involuntary euthanasia.[57]

In France and Great Britain the subject of mercy killing and assisted suicide are still too sensitive for legislation. In Ireland, where euthanasia is illegal, the Supreme Court allowed the removal of tubes from a woman who had been in a coma for 23 years after a succesful battle of the family of the patient. The Court stressed that the removal of the tubes was not the equivalent of euthanasia.[58]

In neighbouring Germany, the discussion on euthanasia remains taboo because of echoes from the Nazi era, and acts of euthanasia potentially fall under one of three categories: murder, manslaughter or homicide at the request of the person to be killed. There is, however, no specific provision prohibiting assisted suicide in the German PENAL CODE. However, it is fundamental, in order to be exempt from liability, that the final act that causes death be committed by the person who wants to die. Also, the person must be informed, able to exercise control over his or her actions, act freely and responsibly and without coercion.[59]

In Australia, the law with respect to euthanasia and assisted suicide was rather uniform in all jurisdictions until May 1995. Euthanasia was considered as an act deliberately undertaken to bring about the death of a person and was treated as murder. Assisted suicide was treated as an offence. However on May 25, 1995, the Northern Territory State passed a Bill that gives terminally ill persons the right to request assistance from a medically qualified person to voluntarily terminate their life.

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[56] *Id*. at 88.

[57] *Id*. at 88.

[58] Agence France Presse, Sept. 21, 1995.

[59] Report of the Special Senate Committee of Canada on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995, at A-164.

This may be done if a number of conditions are met: severe pain and suffering, a cooling-off period, second opinion, written request etc. Such assistance is provided by a medical practitioner.[60]

The implementation was delayed while additional amendments were sought. The amendments, which passed on February 20, 1996, included clarification of the qualifications which medical practitioners would need to possess and the standard required of interpreters for patients who have English as a second language. The legislation which is to take effect in April 1996 is the first pro-euthanasia law enacted in any of Australia's eight state or territory governments.[61]

Even though the Swedish CRIMINAL CODE does not have an express provision dealing with assissted suicide, assisting someone to commit suicide could result in a charge under the murder or manslaughter provisions of the.CODE Also, acts of euthanasia are dealt with under the murder and manslaughter provisions of the CODE. However in August 1995 a case in which a 69 year old mother assisted her 37 year old daughter to commit suicide sparked a legal and moral controversy in Sweden. The daughter had been ill for eight years with Huntington's disease, which had already killed her brother, father and grandfather. Over a three-year period, she had tried several times to take her own life, and the mother finally agreed to assist her. She provided her daughter with a mixture of pills and alcohol that were consumed over a period of 12 hours. The prosecutor decided to prosecute the mother for manslaughter, rather than for murder. The District Court rejected the prosecutor's contention that a crime had been committed and acquited the mother,[62] and the prosecutor appealed. The Appeal Court, however, agreed with the judgement of the District Court. The Prosecutor General has decided not to take the case in the Supreme Court of Sweden.[63]

In the United States approximately thirty of the fifty states have statutes which specifically prohibit suicide assistance. Those states which do not proscribe assisted suicide by a specific statute treat such conduct as murder or manslaughter under the general criminal law statutes.[64] In every state all forms of euthanasia are clasified as murder, even when performed at the victim's request or with the vistim's consent.[65]

However, in a number of states the prohibitions against assisted suicide have been challenged in the courts. Most recently the drive to legalize assisted suicide gained strenth when on April 2, 1996, the 2nd U.S. Circuit Court of Appeals struck down a New York statute that makes it a crime for physicians to help their patients end their lives. This decision came after March 1996 when a federal appeals court in San Francisco overturned a Washington state law that made physician-assisted suicide

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60 *Id*. at A-164 and Reuters World Service, May 25, 1995.

61 FINANCIAL TIMES (Feb. 21, 1996).

62 THE WORLD LAW BULLETIN, Law Library of Congrees, Dec. 1995, No. 95.12, at 7.

63 SVENSKA DAGBLADET, Apr. 25, 1996, at 10.

64 *Supra* note 53, at A-153.

65 *Id*.

a felony. The judge ruled that the right to control "the time and manner of one's death outweighed the state's duty to preserve life when that life is one of pain and helplessness and that the law that was struck down violated the 14th Amendment's implicit guarantee of personal liberty. The decisions from two coasts and based on two distinctive constitutional grounds have put the issue on the national agenda.[66]

Washington state officials have stated that they will appeal the groundbraking federal appeals court decision permitting physician-assisted suicide.[67] Also on March 8, 1996, a Michigan jury acquitted Jack Kevorkian of assisting in two suicides and violating a now expired state law that outlawed the practice. The jury's acquittel, the second in two years for Kevorkian, is certain to intensify the national debate over whether terminally ill people should be allowed to take their own lives with the help of a physician.[68]

These decisions indicate that the United States Supreme Court is likely to face the issue before the end of the year. In the meantime, the whole question of physician assisted suicide and the state's role in permitting or banning it is also becoming a focus of debate in state legislatures. In several states efforts are being made to reform the assisted suicide and euthanasia legislation through a variety of methods of approach.[69]

Oregon is the only state in the country that has enacted legislation legalizing a form of aid in dying in the so-called Death with Dignity Act. But this measure is blocked by a court challenge. A state-wide referendum created this Law which allows qualified patients to request prescriptions for medication to end their lives provided that certain conditions are met.

Conclusion

The subject of euthanasia in the Netherlands has attracted substantial world-wide attention. The practice in the Netherlands is regarded as a distressing act to be avoided if possible, but it is sometimes deemed acceptable. Court cases illustrate that euthanasia is not performed on a whim but after long deliberation.

The Netherlands has tried through its legislation with respect to euthanasia and assisted suicide to take an a-typical product of legislation through which both the protection of human life and the respect for the desire to die with dignity and shortening unbearable suffering and pain for those persons who chose to do so are served.

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66 THE WASHINGTON POST (Apr. 3, 1996), at A1.

67 *Assisted Suicide Ruling Sought*, LOS ANGELES TIMES (Mar. 26, 1996), at ?

68 *The Washington Post* (Mar. 9, 1996).

69 The number of states that have considered assisted suicide bills has grown from three in 1993 to 17 last year. THE WASHINGTON POST (Apr. 4, 1996), at A18.

Dutch legislation reflects the efforts of the Government and the Parliament to find a balance between an affirmation of the rules and concepts as they have been developed in the courts, by advisory committees, the legal doctrine and a pluralistic society.

The aim of the newly established reporting procedure is to scrutinize every case of euthanasia and assisted suicide. This will assure the continuing possibilities for openly discussing and reviewing such medical actions.

The question of euthanasia will not be totally resolved by legislation. There will always be border-line cases and the debate will continue. In this matter, a doctor's actions should be continuously tested through the courts, by a prosecutor, and in the press. In the Coalition Agreement, the parties participating in the Goverment concurred on evaluating the existing euthanasia policy later in 1996. At this time, they will determine whether or not the CRIMINAL CODE needs to be amended.[70]

Only time can show whether the political and moral discussions on euthanasia have ended. But as the old chairman of the Commission of Inquiry into Medical Practice with Regard to Euthanasia at the presentation of the report to the Government so clearly stated: "The question of euthanasia is a very complicated matter and that should and will stay like that."[71]

Prepared by Karel Wennink
Senior Legal Specialist
Directorate of Legal Research
Law Library of Congress
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[70] NRC/Handelsblad, Dec. 22, 1995, at 1.

[71] Ars Aequi, 43, Sept. 9, 1994, at 600.