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# A Dutch Perspective: The Limits of Lawful Euthanasia

*Dr. Ubaldus de Vries\**

## I. INTRODUCTION

Discussions of euthanasia in the Netherlands and elsewhere often revolve around the question of whether a right to euthanasia should be recognized. Should a person have a right to require or permit another to assist him in the execution of his decision to die? The majority of people in the Netherlands have a moderate opinion, opining that persons have a right to euthanasia, but only in specific circumstances such as in illness accompanied by hopeless and unbearable suffering.<sup>1</sup> Thus, in “rights-based” language, the right to assisted suicide is considered a qualified right.<sup>2</sup>

In the Netherlands, the introduction of the euthanasia legislation in 2001 polarized the debate over whether a right to euthanasia should exist. On one side of the debate are people who demand complete freedom for individuals to choose their own destiny, and furthermore demand that all necessary assistance in carrying out the decision be available to such individuals.<sup>3</sup> On the other side of the debate, an increasing minority fears

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1. In 2001, just weeks prior to the enactment of the legislation allowing doctors to perform euthanasia to relieve hopeless and unbearable suffering, the Minister of Health stated that eighty percent of Dutch people supported the possibility of euthanasia as an option to relieve patients from unbearable and hopeless suffering. TK 2000-2001, 262125 [Parliamentary Debates (Second Chamber), parliamentary year 2000-2001, no. 262125].

2. Proponents argue the right to assisted suicide stems from the right to self-determination and individual autonomy. See, e.g., H.J.J. LEENEN, HANDBOEK GEZONDHEIDSRECHT—DEEL 1 RECHTEN VAN DEMENS IN DE GEZONDHEIDSZORG [TEXTBOOK ON HEALTH LAW: PART 1 HUMAN RIGHTS IN HEALTH CARE] 260 (3d ed. 1994).

3. This point of view is entertained by those who have a humanist outlook on life. See generally P.V. ADMIRAAL EUTHANASIE EN DE EED VAN HIPPOCRATUS HERINNERINGEN VAN

that limits have been breached and that Dutch society has gone too far.<sup>4</sup>

It is wrong to suggest though that *legal and judicial* inquiry in the Netherlands has employed a rights-based dialectic to legislate for lawful euthanasia. On the contrary, this inquiry has ignored such an approach as it has done on previous occasions.<sup>5</sup> Dutch law does not have a strong rights-based judicial tradition such as that which exists in many other jurisdictions. For example, Irish and American jurisdictions emphasize constitutional judicial review.<sup>6</sup> Unlike the Irish and American legislatures, the Dutch legislature has not employed a rights-based dialectic because the Netherlands bans constitutional judicial review.<sup>7</sup> Thus, individuals cannot assert their constitutionally guaranteed human rights if this would mean a review of parliamentary or primary legislation.<sup>8</sup>

Another difference between the Netherlands and more rights-based jurisdictions is that the Dutch courts have not adopted the unenumerated rights doctrine such as has developed in the United States, Ireland, and, to a lesser extent, England.<sup>9</sup> Rather, in the Netherlands, the judicial inquiry has

EEN ANESTHESIOLOG (1998). Nevertheless, the proponents of complete freedom also consider their position to be unrealistic to a certain extent. See, e.g., MP Wessel-Tuinstra in Vaste Commissie voor Justitie en voor de Volksgezondheid, *Euthanasie*, UCV 53, at 14.

4. See, for example, the essays collected in HANS ACHTERHUIS ET AL., *ALS DE DOOD VOOR HET LEVEN [A MORTAL FEAR FOR LIFE]* (1995). A historical account of the development of society's acceptance of euthanasia was published in 2002. See JAMES KENNEDY, *EEN WELOVERWOGEN DOOD—EUTHANASIE IN NEDERLAND [A WELL-CONSIDERED DEATH: EUTHANASIA IN THE NETHERLANDS]* (2002).

5. The debate over the legalization of abortion had a criminal perspective and found its rationale in considerations of health and professional discretion. See J. REMMELINK, HAZEWINKEL-SURINGA'S INLEIDING TOT DE STUDIE VAN HET NEDERLANDSE STRAFRECHT [INTRODUCTION TO DUTCH CRIMINAL LAW] 368 (13th ed. 1994).

6. See RAY BYRNE & JAMES P. MCCUTCHEON, *THE IRISH LEGAL SYSTEM* 545 (3rd ed. 1996). In the United States, the emphasis on rights and individualism has succinctly been examined in MARY ANN GLENDON, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE* (1991).

7. See GRONDWET NED. [Constitution] art. 120.

8. Rights can be enforced by reference to the Convention of Human Rights and Fundamental Freedoms, GRONDWET NED. arts. 93 & 94, but this seems unlikely to happen with respect to euthanasia and assisted suicide as far as the Netherlands is concerned. For further insights see the comments of the Advocate-General in *Euthanasia I*, HR 27 Nov. 1983, N.J. 1985, 106. It remains to be seen what the impact will be of rulings of the European Court of Human Rights on euthanasia, such as its decision in *Pretty v. United Kingdom*, Unreported, Eur. Ct. H.R., 29 Apr. 2002. The anomaly between the prohibition of constitutional review and Convention review cannot be easily explained and will not be further addressed. However, there is growing support to abandon the prohibition of constitutional review. Indeed, the Dutch Supreme Court allowed judicial review by reference to general principles of law. *Harmonisatiewet*, HR 14 Apr. 1989, NJ 1989, 469.

9. In Ireland, a right to life and death was recognized in *Re A Ward of Court* [1995] 2 I.L.R.M. 401. In England, the decision in *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789 is illustrative. Neither case sanctioned euthanasia as a legitimate method to end life but allowed for the withdrawal of treatment in respect of patients in a (near) permanent

focused on euthanasia from a criminal law perspective in which these rights, such as the right to bodily integrity, and the right to self-determination and autonomy, are implicitly embedded. This inquiry places the person who carries out euthanasia or assists in a suicide at the center of the euthanasia debate, rather than the person who is seeking death. Dutch courts have created an exception to the crime of euthanasia and assisted suicide by carving out the “necessity defense” for doctors.<sup>10</sup> Accordingly, the judicial inquiry thus far has primarily revolved around the doctor and the boundaries of the doctor-patient relationship.

Although the necessity defense evolved from case law, it has now been codified.<sup>11</sup> A determining criterion for lawful euthanasia is the extent of suffering of the person seeking death. Even though the nature and extent of suffering is the foundation of the exception and the legislation, the suffering criterion has not been further defined in the legislation and its interpretation remains at the discretion of the courts. One important issue that arises when considering whether euthanasia is lawful is whether the suffering must stem from a clinical cause. On Christmas Eve of 2002, the Dutch Supreme Court reversed a decision of a regional court that had extended the criterion of hopeless and unbearable suffering to include so-called “existential suffering.”<sup>12</sup> Although the lower court decision was reversed, it indicated the willingness of some regional courts to allow for euthanasia on demand and implied that lawful euthanasia may no longer need to constitute a *medical* exception.

This article seeks to explain the Dutch perspective, which differs from the rights-based perspective that is employed in the United States. The United States legal system embraces a culture of rights and individualism.<sup>13</sup> Thus, ethical issues, such as abortion<sup>14</sup> and recently, the decriminalization of homosexual acts between consenting male adults,<sup>15</sup> are addressed within the judicial forum, where one person claims the violation or vindication of a

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vegetative state. In England this was confirmed in *Regina (Pretty) v. Director of Public Prosecutions, Secretary of State for the Home Department*, [2001] U.K.H.L. 61.

10. Cf. Euthanasia I, HR 14 Nov. 1984, N.J. 1985, 106; Euthanasia II, HR 21 Oct. 1986, N.J. 1987, 607. The decision in *Chabot*, HR 21 June 1994 N.J. 1994, 656 expanded the necessity defense.

11. Cf. Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (Stb. 2001, 194) [The Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2001], available at <http://www.nvve.nl/english/info/euthlawenglish.doc>.

12. See Brongersma, HR 24 Dec. 2002 (LJN AE8772), available at <http://www.rechtsspraak.nl>. Existential suffering is referred to in this article as “non-medical” euthanasia.

13. Cf. GLENDON, *supra* note 6.

14. *Roe v. Wade*, 410 U.S. 113 (1973).

15. *Lawrence v. Texas*, 539 U.S. 558 (2003).

right, be it the right to self-determination, privacy, or otherwise. It is in this context that euthanasia, arguably, is referred to as right that can be enforced against the state. The Dutch perspective is quite different. The Netherlands embraces a culture of pragmatism and consensus-building and prefers ethical issues to be addressed through the political process.<sup>16</sup> Accordingly, euthanasia has been addressed within both the political and the judicial process. Prior to the 2001 legislation, euthanasia was a criminal offense and doctors who assisted their patients were prosecuted. The courts found opportunities within the criminal law to exonerate doctors without explicitly making a statement about the need for lawful euthanasia. This decision was left to the politicians.<sup>17</sup>

This article first reviews the body of case law and the subsequent legislation that allows for euthanasia in certain circumstances. The law has created a medical exception that has made hopeless and unbearable suffering the foundation of lawful euthanasia. Because “suffering” is the root of the exception, an analysis of the judicial interpretation of “suffering” is merited. The analysis will show that judicial interpretation has reached its limits, and by implication, the limits of lawful euthanasia have been reached. The limits of lawful euthanasia are then further explored with a particular emphasis on the role of the doctor and his duty to report cases of euthanasia. The many problems that exist are addressed before concluding that Dutch law is at a crossroad: the courts must either extend lawful euthanasia to include “non-medical” cases of euthanasia or maintain the status quo which limits euthanasia to cases involving illness with hopeless and unbearable suffering. This article concludes that, as life itself develops, so, too, develops one’s perspective on death and dying and the treatment at life’s end—that it is inevitable that to choose to die becomes as much a part of an individual’s life as one’s choice to live.

## II. EUTHANASIA AND THE NECESSITY DEFENSE

Discussions on euthanasia began in earnest in 1972 when a local court found a doctor who had euthanized her mother guilty of murder. The decision set the scene for a broad national debate about whether people, for reasons of illness and suffering, are entitled to die in a humane fashion. As the Netherlands does not have a system of constitutional judicial review,

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16. For an English language account of Dutch legal culture see FREEK BRUINSMA, *DUTCH LEGAL CULTURE* (1994).

17. Indeed, the Supreme Court stated more than once that it could not rule on the lawfulness of euthanasia in general in the absence of broad societal consensus. See *Euthanasia I*, HR 14 Nov. 1984, N.J. 1985, 106; *Euthanasia II*, HR 21 Oct. 1986, N.J. 1987, 607.

cases arguing a *right* to euthanasia cannot be brought before the court. The rights debate in the Netherlands is a political debate, taking place in all forums but the judicial forum. However, in the context of euthanasia, the courts saw an opportunity to express opinions on the matter when asked to consider the actions of doctors who had taken the life of a patient on the basis of what, to the doctors, appeared to be sound medical grounds. These decisions gave an authoritative impulse to the debate and set the scene for the eventual legislation, the first of its kind in the world permitting euthanasia under certain circumstances. These judicial decisions focused on whether doctors, having committed a crime by taking the life of a patient, could be exonerated for their actions with an appeal to the necessity defense. This defense—the necessity defense—is analyzed.

#### *A. Euthanasia: Criminal Offense*

Prior to the enactment of the Euthanasia Act of 2001, section 293 of the Dutch Criminal Code prohibited the taking of another's life at his request.<sup>18</sup> Section 294 prohibited forcing another to commit suicide, or assisting another upon request to commit suicide, or providing upon request the means to commit suicide. The crime in section 293 was called euthanasia, and in section 294, assisted suicide. In the literature, however, both courses of action are referred to as euthanasia: a deliberate commission or omission to shorten another's life at his or her request.<sup>19</sup> The person so requested either provides the other the means to commit suicide or physically administers the means himself. Although providing the means and actually administering the means are fundamentally different courses of actions, Dutch courts have not attempted to distinguish between them when called upon to determine the lawfulness of the action.

People compare euthanasia with murder because both involve the deliberate and premeditated taking of life. However, a person's request for death gives the act of euthanasia a totally different character than murder. The criminal elements are different in cases of euthanasia than in cases of murder. In cases of euthanasia, the intent of the person carrying through with the action may be regarded as being directed toward life, or the sanctity of life, as compared to murder where the person carrying through with the action has malicious intent toward the individual he seeks to kill and, by implication, has a complete disregard for the sanctity of life. In all cases of euthanasia, the patient is *compos mentis* (of sound mind and reason) and voluntarily seeks the assistance of a doctor to end his life. The

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18. WvS § 294 [Dutch Criminal Code].

19. See LEENEN, *supra* note 2. See also JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN THE NETHERLANDS 17 (1998).

discussion here does not focus on passive euthanasia, withdrawal of treatment, or involuntary euthanasia. These courses of action pose additional moral and ethical dilemmas which ought to be addressed separately.

### B. *What is the Necessity Defense?*

As discussed, in the Netherlands euthanasia is a crime out of which the courts have carved a narrow exception in cases of illness accompanied by unbearable and hopeless suffering. In these cases, a doctor may plead the necessity defense. The defense of necessity arises under Dutch law when a person is confronted with conflicting duties in reaching a particular goal.<sup>20</sup> The classic example involves an optician who sold a man a pair of spectacles after closing time.<sup>21</sup> The optician argued that he was confronted with a dilemma. On the one hand, he had a duty to obey the law, but on the other hand, he felt himself obliged *as an optician* to assist the man, as the man would have been completely helpless without his spectacles.<sup>22</sup> The court held that the optician made a justifiable choice to violate the law in order to attain some higher good. The court accepted that the optician had acted proportionally and that there were no less radical means, no viable alternatives, which he could have used to solve the dilemma.

It is important to note that the court emphasized the optician's status as a professional man when considering his conflict of duties.<sup>23</sup> The court held that the optician's social and professional integrity, as well as his obligations to the patient, outweighed his legal responsibility to adhere to the closing time regulations.<sup>24</sup> Therefore, the holding is evidence that the court attached some importance to the special position of the optician, whose duties to his patients reached over and beyond those duties that were common to all.<sup>25</sup> This last observation is important for doctors with respect

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20. WvS § 40 [Dutch Criminal Code]. The necessity defense may also arise under Dutch criminal law when the accused claims to have violated the law because of some physical or psychological external constraint or duress. The external constraint or duress is of such a force that it compels the accused to violate the law. Thus, for example, a person who is asked to hand over a sum of money he holds in trust for another at gunpoint can do so without incurring the wrath of criminal law. In these circumstances, the free will of the person is lost as a result of external pressure. See, e.g., Rb. Utrecht, 12 Dec. 1994, N.J. 1996, 245.

21. HR 15 Oct. 1923, N.J. 1923, 1329. Under the bylaws of Amsterdam, shopkeepers had to close their shops at six in the evening. Violation of the bylaw was a criminal offense. See Verordening op de Winksluiving [Bylaw on shop closing hour] art. 9.

22. HR 15 Oct. 1923, N.J. 1923, 1329.

23. *Id.*

24. *Id.*

25. In Dutch law this is referred to as *Garantenstellung*.

of euthanasia because in the debate about lawful euthanasia doctors are regarded as the appropriate professionals to whom euthanasia maybe entrusted.<sup>26</sup>

Thus, there are two criteria to the necessity defense, as interpreted authoritatively by the Supreme Court in the *Optician* case. First, a physician must be presented with a conflict of duties. Second, in deciding whether to obey the law, a physician must consider whether the means he will use are proportionate to the goal and whether there are alternative means by which this goal may be achieved. In addition, when considering the elements, the courts will take into account the status of the person who has entered into a conflict of duties. How do these criteria apply in cases of euthanasia?

The courts first addressed euthanasia in 1973.<sup>27</sup> At that time, the *Leeuwarden* court held that a doctor who had taken the life of her mother upon her request was guilty of the crime of euthanasia. However, the court did not impose a sentence.<sup>28</sup> Defense counsel appealed to the necessity defense, but the court rejected the argument. Although rejecting the necessity defense in that case, the court stated that there could be circumstances in which a necessity defense could be successful. The *Leeuwarden* decision set the stage for the debate surrounding euthanasia that was to follow, in and outside the courtroom.

A decade later, the Supreme Court finally accepted the necessity defense.<sup>29</sup> In *Euthanasia I*, a ninety-four-year-old woman had a chronic physical illness which caused her unbearable suffering. As far as she was concerned, her suffering would only be relieved if she could die in a humane manner.<sup>30</sup> Her family doctor fulfilled her request and gave her a lethal potion.<sup>31</sup> He was charged and prosecuted under section 293 of the Dutch Criminal Code.<sup>32</sup> In court, the doctor argued that his patient's wish to die presented a conflict of duties. On the one hand, he had a legal duty to preserve life, as implied under section 293; on the other hand, he had a professional duty to his patient to relieve her suffering. In the doctor's opinion, to fulfill the latter would only result in his patient's death, thereby

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26. See KENNEDY, *supra* note 4, at 128-35.

27. Rb. Leeuwarden, 21 Feb. 1973, N.J. 1973, 183. There had been previous cases, for example Rb. Utrecht, 11 Mar. 1952, N.J. 1952, 275. However, the 1973 case sparked the debate that has continued ever since. See KENNEDY, *supra* note 4, at 24. The 1952 case was the first case involving a doctor.

28. Rb. Leeuwarden, 21 Feb. 1973, N.J. 1973, 183, at 561.

29. HR 14 Nov. 1984, N.J. 1985, 106.

30. *Id.* at 455.

31. *Id.* at 456.

32. *Id.* at 453.

breaching his legal duty and violating section 293. Accordingly, the doctor relied on the defense of necessity to argue his innocence. However, had he entered into a conflict of duties and if so, had he acted proportionally?

### 1. A Conflict of Duties

An analysis of the case law shows that only doctors are ever held to be in a position where they can be confronted with a conflict of duties.<sup>33</sup> One reason for this unique application of the conflict of duties doctrine lies in the specific nature of the doctor-patient relationship and the status of the doctor as a professional. The courts accept that there is a special relationship between the doctor and patient and, consequently, focus on how a doctor acted in a given situation to conclude whether he could have acted differently. If he could have acted differently and thereby meet the patient's needs without harming (i.e. killing) the patient, he did not enter into a conflict of duties.

Therefore, it remains worthwhile to consider how a doctor enters into a conflict of duties. When a patient initially consults a doctor, the doctor first considers whether he can be of assistance to the patient or whether the patient should be referred elsewhere, to a specialist, for example. This is a clinical and professional consideration which is part of the on-going professional relationship between the doctor and patient.<sup>34</sup> Thus, the conflict of duties criterion of the necessity defense is primarily about the extent of the doctor-patient relationship and requires a determination of what the doctor is able to do for the patient.

Next, the doctor considers whether he can assist the patient and by what means he will do so. This consideration illustrates that a conflict of duties, a moral or ethical dilemma, is not legal in nature, but rather arises out of the pre-existing relationship between doctor and patient. In other words, the doctor's consideration of what is best for the patient does not stem from a statutory code or judge-made law.

Case law reveals the extent to which the doctor-patient relationship impacts a court's analysis of the necessity defense. In *Euthanasia II*,<sup>35</sup> where the Supreme Court affirmed the decision in *Euthanasia I*, the lower court held that the necessity defense had to fail because the doctor had put himself into a position of *culpa in causa*, meaning that the doctor, through

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33. In cases, where persons other than doctors pled the necessity defense, the defense was not accepted. Indeed, no defense was accepted at all. See, e.g., Rb. Utrecht, 11 Mar. 1952, N.J. 1952, 275; Rb. Den Bosch, 10 June 2003 (LJN AF9725), available at <http://www.rechtspraak.nl>.

34. For example, in *Euthanasia I*, the woman had been the doctor's patient since 1976.

35. HR 21 Oct. 1986, N.J. 1987, 607.

his own free will, placed himself in a position where he was confronted with a conflict of duties.<sup>36</sup> Thus, based on the lower court's reasoning, in order to rebut the necessity defense presumably one need only argue that a doctor places himself voluntarily into a position that may present a conflict of duties. In other words, by voluntarily placing oneself into a situation where a conflict of duty ultimately arises, the necessity defense cannot be argued.

However, it is respectfully suggested that this proposition is invalid since it ignores the unique position of a doctor.<sup>37</sup> The Supreme Court recognized the special position of professionals in the *Optician* case.<sup>38</sup> There, it had attached some importance to the special position of the optician and his professional duties, holding that those duties outweighed the generic legal responsibility to close the shop at a specific time applicable to all shopkeepers. Similarly, the specific nature of the doctor-patient relationship obliges a doctor to take into account all that is in his sphere of knowledge and expertise to guide his decisions as the patient's case develops. Accordingly, a doctor does not always voluntarily put himself into a conflict of duties but rather a conflict of duties may arise as a patient's case progresses.

For example, in *Euthanasia II*, the patient had, on previous occasions, expressed a desire for euthanasia as an option for relieving her pain. The doctor knew she had signed a living will. As her physical situation worsened and her suffering increased, euthanasia became a more realistic option. Thus, in situations such as that, there comes a point in time when a doctor cannot forsake his patient and must confront that which the patient desires, however irrational or unreal those desires might seem. It is perhaps then that a doctor enters involuntarily and even unwillingly, but necessarily and unavoidingly, into the conflict of duties, which is the subject of debate. The conflict is heightened by the physician's knowledge that the patient confronts him voluntarily, persistently, and sincerely with the wish to die.<sup>39</sup>

But what happens when, unlike in the *Euthanasia I* and *II* cases where there was a long-standing doctor-patient relationship, a patient specifically consults a doctor for the sole reason of euthanasia and there is no a pre-existing relationship? Would this type of situation prevent a physician from arguing the necessity defense? While this may be a logical conclusion,

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36. See J. REMMELINK, HAZEWINKEL-SURINGA'S INLEIDING TOT DE STUDIE VAN HET NEDERLANDSE STRAFRECHT 310-11 (14th ed. 1995).

37. The Supreme Court did not address this argument in its decision in *Euthanasia II*.

38. HR 15 Oct. 1932, N.J. 1932, 1329.

39. Of course, I do not suggest here that a doctor is obliged to assist. If a doctor is opposed to euthanasia he can indicate this to his patient. It is generally accepted that in such instances a doctor should refer the patient to another who is not opposed to euthanasia per se.

such a conclusion would not do justice to the professional integrity of a doctor. At that point, the doctor is not concerned with the request for euthanasia but rather with the question of whether he can relieve the patient's suffering; the request is a cry for help. The physician must form a medical opinion of the patient's condition and request. On the basis of this opinion, he must decide and discuss with the patient whether euthanasia is a realistic option. This next stage involves medical as well as ethical considerations. If the consideration leads to the unavoidable conclusion that euthanasia is the only realistic option, under the current legal context, the physician will have entered into a conflict of duties once the patient requests euthanasia.<sup>40</sup>

Of course, under the current legal framework, the patient's request for euthanasia must stem from a medically indicated condition. Outside the boundaries of medical knowledge, a doctor may not entertain a person's wish to die because in that scenario he is no longer acting as a doctor and thus, there is no doctor-patient relationship. Thus, it is clear that the patient-physician relationship has boundaries defined by the medical nature of patient's complaint and within those boundaries the doctor may be confronted with a conflict of duties. Beyond those boundaries, it can no longer be said that a doctor enters into a conflict of duties because he is acting outside the scope of the doctor-patient relationship.

## 2. Proportionality

The second criterion that must be met for a successful appeal to the necessity defense demands that the means used are proportionate to the aim and that one has considered the availability of less radical means.<sup>41</sup> In the context of euthanasia, this means that the doctor must have considered the lethal potion to be proportionate to the aim of relieving the suffering of the patient in the absence of less radical means, such as alternative forms of palliative care.

Is a lethal potion a proportionate means to relieve suffering? It is a strange question to ask, but to not ask the question would be to ignore the

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40. The doctor's professional integrity and obligations demands that he *must* enter into such a situation. For example, see the arguments of counsel for the accused in *Euthanasia II*, HR 21 Oct. 1986, N.J. 1987, 607, at 2119. Thus, the court demands that the doctor makes a realistic and considered judgment regardless of what the general opinion in society on euthanasia would be, contrary to what others have thought this to mean. See also, for example, T. Schalken in his annotation to the *Chabot* case, H.R. 21 June 1994, N.J. 1994, 656 (ann. TS), and G.E. Mulder in his annotation to *Euthanasia II*, H.R. 21 October 1986, N.J. 1987, 607 (ann. GEM). These interpretations leave the doctor with a large element of discretion. PETER RIJPKEMA, RECHTERSRECHT 172 (2001).

41. See WvS art. 40 [Dutch Criminal Code]; HR 15 Oct. 1923, N.J. 1923, 1329.

context in which a doctor attempts to relieve suffering: confrontation with a patient suffering intolerably without any hope of improvement of this condition. This context was not yet recognized in 1973.

In that first euthanasia case,<sup>42</sup> the court accepted evidence that there was consensus among doctors to fulfill patients' wish to die through the administration of increasing doses of pain relieving medication.<sup>43</sup> The doctors knew that the consequence of increasing the doses of pain medication would accelerate the death of these patients.<sup>44</sup> The court held, therefore, that increasing the pain medication could constitute a less radical alternative form of treatment for terminally ill patients.<sup>45</sup> However, the doctor on trial had not followed this course of action. Instead, the doctor deliberately administered a lethal dose of drugs, with the intention to cause the death of the patient in order to relieve her suffering.<sup>46</sup> By following this course of action, the court held that the doctor had forfeited the necessity defense.<sup>47</sup> The court held that the administration of a *lethal* dose of drugs was not proportionate to the stated aim: relieving the patient's suffering.<sup>48</sup>

The court's position illustrated the omission-commission dichotomy with which many other courts appear to struggle.<sup>49</sup> In omission cases, the doctor's intention in administering increasing pain medication is to relieve the patient's pain and not to kill him, even though death is the known consequence. This course of action is often accompanied with withdrawal of treatment, including nourishment; the omission, then, causes the patient's death.<sup>50</sup> Courts are willing to accept such a course of action. However, the doctor in the *Leeuwarden* case went a step further and actually killed the patient by administering a lethal amount of medication—a commission. For the court, this was one step too far.<sup>51</sup>

Another decade passed before the courts in the Netherlands accepted that, from a criminal law perspective, there is no difference between a passive course of action and an affirmative course of action, at least when

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42. Rb. Leeuwarden, 21 Feb. 1973, N.J. 1973, 183.

43. *Id.* at 558.

44. This was called "passive euthanasia."

45. Rb. Leeuwarden, 21 Feb. 1973, N.J. 1973, 183, at 558.

46. *Id.*

47. *Id.* at 560.

48. *Id.*

49. *See, e.g.*, *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789 (U.K.); *A (Children)* [2000] E.W.C.A. Civ. 254 (22 Sept. 2000) (The "Siamese twin" case) (U.K.). *See also* *Re A Ward of Court* [1996] 2 I.L.R.M. 401 (Ir.).

50. Normally, consent is given, either by the patient (through a living will) or his next of kin, to discontinue treatment.

51. Rb. Leeuwarden, 21 Feb. 1973, N.J. 1973, 183. Courts outside the Netherlands also have refused to condone this act. *See supra* note 50.

the result—death—is considered. Thus, in *Euthanasia I* decided in 1984, the court accepted the doctor's evidence that the patient's suffering was hopeless and unbearable as a result of her worsened psychological and physical state.<sup>52</sup> The patient's desire to die had been sincere, persistent, and voluntary. No other realistic treatment options were available that could relieve the suffering without ending in her death. The doctor had consulted his assistant, who had seen the patient and who confirmed the doctor's conclusions. For the court, this was also proof that the doctor had acted in accordance with current medical and ethical standards and his medical skill and knowledge.<sup>53</sup> The court of appeal held that the necessity defense had to fail because palliative care remained an option, but the Supreme Court overruled the decision.<sup>54</sup> According to the Supreme Court, this decision ignored the skill, expertise and knowledge of the doctor, *as a doctor*, when he came to his decision that euthanasia was all that was left as a realistic option to relieve the suffering of his patient.<sup>55</sup>

The decision of the Supreme Court was affirmed in *Euthanasia II*,<sup>56</sup> and expanded upon in *Chabot*.<sup>57</sup> It prompted a nation-wide debate about the legalization of euthanasia in cases of hopeless and unbearable suffering. It would eventually lead to the enactment a legislative framework.

### III. THE LEGISLATION

The current legislative framework came into force in 2001. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2001 has codified the criteria developed by the Supreme Court in *Euthanasia I*, allowing an appeal on the necessity defense.<sup>58</sup> It is outside

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52. HR 14 Nov. 1984, N.J. 1985, 106, at 459.

53. At the time, the Royal Dutch Medical Association had formulated its position on euthanasia. The Association accepted euthanasia as an option for patients whose suffering is hopeless and unbearable. The doctor had to determine whether the death wish, which was a result of the suffering, was sincere, persistent, and voluntary. This depended on the nature and extent of the suffering as well as the availability of alternatives. The doctor also had to consult another doctor, who had to confirm the suffering and the merits of the patient's request. See Report of the Euthanasia Comm., *Vision on Euthanasia*, in EUTHANASIA IN THE NETHERLANDS RMDA 12 (1994). The Association also pointed out that it was irrelevant whether the suffering stemmed from a terminal illness. The Association also did not ascribe an overriding importance as to whether death was imminent, since this would not sufficiently recognize how the patient experienced the suffering. *Id.*

54. HR 14 Nov. 1984, N.J. 1985, 106, at 459.

55. *Id.* at 460.

56. HR 21 Oct. 1986, N.J. 1987, 607.

57. HR 21 June 1994, N.J. 1994, 656.

58. Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (Stb. 2001, 194) [The Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2001].

the scope of this article to give a comprehensive review of the legislation and a cursory summary of the main points suffices.

The Act amends sections 293 and 294 of the Dutch Criminal Code. Subsection 2 of both Sections 293 and 294 states that euthanasia or assisted suicide is not unlawful if and when a doctor, who fulfilled a death request, has adhered to the due care criteria set out in the Act, and has notified the local coroner of his actions conform the Burial Act, 1992.<sup>59</sup> To adhere to due care under Section 2 means:

- The doctor must have been convinced that the patient's request was sincere and voluntary;
- The doctor must have been convinced that the patient's suffering was both hopeless and unbearable;
- The doctor must have consulted with the patient about his situation and his prospects;
- The doctor and the patient together must have come to the conclusion that no alternative is realistically available;
- The patient must have been seen by at least one impartial doctor, who must have given his opinion, in writing, about the first four criteria; and
- The doctor must have carried out the euthanasia, or assisted with the suicide, with due care.

In addition to setting forth the criteria for due care, the Act introduces statutory ethics committees,<sup>60</sup> whose task it is to assess the doctor's conduct on the basis of the information he has provided to the local coroner. There are six regional committees which operate independently.<sup>61</sup> Each committee consists of a lawyer, a doctor, and an ethicist. If a committee determines that a doctor has acted in accordance with the criteria, the matters ends there.<sup>62</sup> On the other hand, if the committee believes that a doctor did not

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59. Wet op de lijkbezorging, § 7(2), 1991 (Stb 2001, 194) [Burial Act, 1991]. The doctor is required to notify the local coroner, fill in a form, and provide details about the act and the manner in which he has adhered to the due care criteria. The form is specified by law. See Vaststellingsbesluit formulieren bedoeld in de Wet op de lijkbezorging betreffende overlijden ten gevolge van niet-natuurlijke oorzaak (No. 5133202/01/6 –6 Mar. 2002) [Decision to determine use of forms as meant in the Burial Act with respect to death by unnatural causes].

60. Prior to the legislation, these committees already existed; they now have statutory recognition.

61. The Minister appoints their members but has no control over the decisions they take. See Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (Stb. 2001, 194) [The Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2001], art. 4.

62. See *id.* arts. 8-10.

act with due care, it may notify the district attorney, who can take action at his discretion.<sup>63</sup> However, a doctor's duty to report has been a recurring problem. Statistics show that perhaps as many as fifty percent of cases remain unreported. It is unclear what type of cases these are but this lack of reporting is an impediment to the efficient operation of the legislation.

#### A. A Medical Exception to Euthanasia but Not a General Exception

This article suggests that the law allows for a medical exception because only doctors are allowed to entertain a request for euthanasia. Another reason for the medical exception stems from the fact that considerations about the request—specifically whether the patient's suffering has been hopeless and unbearable—are medical or clinical considerations and considerations upon which the courts must rely.<sup>64</sup> Indeed, the courts do not consider whether the patient's suffering was hopeless and unbearable but rather consider whether the doctor could have reasonably come to this conclusion.<sup>65</sup> The nature and extent of a patient's suffering informs the doctor about the proportionality of his actions and the availability of any reasonable alternatives. The courts have not gone so far as to allow for a *general* exception for euthanasia because of a fear that this would take the country down the path to the right to euthanasia on demand. However, the courts reinforced the position that euthanasia should be allowable in cases of unbearable and hopeless suffering in 1973,<sup>66</sup> 1984,<sup>67</sup> 1987,<sup>68</sup> and in 1994.<sup>69</sup> These cases were considered during the drafting of the legislation and it became clear that, because of the distinct set of circumstances of each case, each euthanasia case would have to be judged on its merits and a "one

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63. Much can be said about the operation of the ethics committees, but this is outside the scope of the article. For more information, see the annual report of the committees, Annual Report 2001, *Regionale Toetsings-Commissies Euthanasie*, Arnhem 2002 [Statutory Ethics Committee on Euthanasia]. See also H.J.J. Leenen, *Toetsingscommissies zijn onbescheiden* [Ethics committees are not modest], NRC HANDELSBLAD, 23 May 2002. Professor Leenen fears that the committees will apply and interpret the criteria with too much discretion and freedom. He proposes, instead, that the committees consider a request prior to the doctor carrying it out. His comments suggest something else: that there is also a danger that the committees operate too autonomously and too independently from each other, which may cause a disparity of opinion as to what is lawful and unlawful euthanasia.

64. See also the observation by Lord Steyn in *Regina (Pretty) v. Director of Public Prosecutions, Secretary of State for the Home Department*, [2001] U.K.H.L. 61 (U.K.), at consideration no. 55.

65. Euthanasia I, HR 14 Nov. 1984, N.J. 1985, 106; Euthanasia II, HR 21 Oct. 1986, N.J. 1987, 607.

66. Rb. Leeuwarden, 21 Feb. 1973, N.J. 1973, 183.

67. Euthanasia I, HR 14 Nov. 1984, N.J. 1985, 106.

68. Euthanasia II, HR 21 Oct. 1986, N.J. 1987, 607.

69. Chabot, HR 21 June 1994, N.J. 1994, 656.

size, fits all” law would not suffice. Accordingly, the legislation established the regional ethics committees.

So far, the legislation has overtly recognized what is really a matter of common medical knowledge. Conscientious doctors have always regarded the alleviation of suffering as one of their primary medical objectives. The usual paradigm in which this operates is referred to as the doctrine of “double effect.” This doctrine represents the position that the administration of medication is intended to relieve suffering but recognizes, as an unwanted side effect, the acceleration of death. Instead of holding onto the doctrine of double effect, Dutch legislation and the judiciary has recognized that at some stages of acute suffering life should not be artificially continued.

The question at this point then is to what extent doctors are qualified to determine the adequacy of a patient’s request. Having medicalized lawful euthanasia, it appears that the intention of the legislature has been to restrict euthanasia to medically necessary instances. The degree of patient suffering is the determining factor. An examination of the case law is required to understand the judicial interpretation of hopeless and unbearable suffering, the criterion by which necessary euthanasia is judged, and to clarify the justification for lawful euthanasia.

### B. “Hopeless and Unbearable Suffering”

Prior to 1994, most, if not all euthanasia cases involved patients whose suffering stemmed from a physical cause and who were in the later stages of a terminal disease, described as their “dying phase.”<sup>70</sup> Death was certain to follow; euthanasia anticipated death, as it were. It also meant that the patients’ suffering was, on the whole, physical. Because the wish to die was based on this physical suffering, doctors could more objectively determine the hopeless and unbearable nature of the suffering.<sup>71</sup> These cases were referred to as “classic euthanasia cases.”

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70. Indeed, statistics from 1996 show that the majority of patients, whose death wish was fulfilled, suffered from a terminal illness and had a life expectancy of less than three weeks. See G. VAN DER WAL & P.J. VAN DER MAAS, EUTHANASIE EN ANDERE MEDISCHE BESLISSINGEN ROND HET LEVENSEINDE [EUTHANASIA AND OTHER END-OF-LIFE DECISIONS] (1996); CENTRAAL BUREAU VOOR DE STATISTIEK (CBS), HET LEVENSEINDE IN DE MEDISCHE PRAKTIJK, CBS, Voorburg/Heerlen (1996). The 2001 Annual Report of the Regional Ethics Committees confirms these findings. In 2001, there were 2054 reports of euthanasia. In 1941 cases, the patient suffered from a physical illness, of which cancer was the dominant illness (1817 cases). The Report also shows that in 1761 cases, the family doctor was the dominant actor. See Annual Report 2001, *supra* note 63, at 12.

71. This point was emphasized by both the Supreme Court and the court appointed witnesses in the *Brongersma* case, HR 24 Dec. 2002 (LJN AE8772), available at <http://www.rechtsspraak.nl>.

This changed in 1994. In the *Chabot* case,<sup>72</sup> Dr. Chabot, a psychiatrist, diagnosed a patient with depression absent psychotic symptoms.<sup>73</sup> After meeting with the patient many times, Dr. Chabot concluded that in his clinical judgment the only way to relieve her suffering was a course of treatment that would result in her death, a desire that she had had for a long time. Colleagues supported him in this view. Dr. Chabot assisted her in her suicide by providing her with a lethal potion, which she drank herself.<sup>74</sup>

Dr. Chabot was prosecuted, but was acquitted by both the trial and appellate courts.<sup>75</sup> On appeal to the Supreme Court, the prosecution submitted three arguments in favor of a conviction. First, the prosecution maintained that in the absence of a physical, terminal illness, euthanasia could never be lawful.<sup>76</sup> Second, considering the nature of the suffering, the prosecution submitted that the patient was too psychologically disturbed to have formulated a voluntary wish to die.<sup>77</sup> Third, the prosecution asserted that the doctor failed to consult other professionals contrary to what due care demands.<sup>78</sup> The Supreme Court rejected the first two arguments, but accepted the third.<sup>79</sup> Dr. Chabot was found guilty, however no sentence was imposed.<sup>80</sup>

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72. Chabot, HR 21 June 1994, N.J. 1994, 656.

73. Dr. Chabot had relied on DSM III R (Diagnostic Statistical Manual), as used by the American Psychiatry Association. For more details about the diagnosis and the case, see B.E. CHABOT, ZELF BESCHIKT [SELF DETERMINED] (1995). The patient's story shows that Dr. Chabot was confronted with a woman *in extremis*. The patient had married into an unhappy marriage at the age of twenty-three and had had two children. In 1986, her eldest son committed suicide. This affected the patient deeply and her marriage problems worsened. She also started to express her wish to die, but also expressed that she would not take her own life until her youngest son could fend for himself. She underwent psychiatric treatment but this was of no avail. Her father died in 1988 and she divorced from her husband in 1990. In that same year, her youngest son was involved in a traffic accident. While in the hospital, the doctors discovered a malignant tumor; he died shortly after. Hours after the death of her youngest son, the patient attempted suicide but was unsuccessful. From then on, she became completely preoccupied into her own death. She wanted to die in a dignified manner and eventually came into contact with Dr. Chabot via the Dutch Society for Voluntary Euthanasia.

74. Chabot, HR 21 June 1994, N.J. 1994, 656, at 108.

75. Hof Leeuwarden, Unreported, 30 Sept. 1993.

76. HR 21 June 1994, N.J. 1994, 656, at 3147.

77. *Id.* at 3148.

78. *Id.*

79. *Id.* at 3152-53.

80. *Id.* at 3156. For an English transcript of the Supreme Court judgment, see John Griffiths, *Assisted Suicide in the Netherlands: The Chabot Case*, (1995) M.L.R., 232. See also Ubaldus de Vries, *The Chabot Case: Psychological Suffering and Physician-Assisted Suicide*, in LEADING CASES OF THE TWENTIETH CENTURY (Eoin O'Dell ed., 2000)

## 1. The Causes of Suffering

The importance of the *Chabot* case is the Court's rejection of the first two arguments. The Court refused to distinguish between psychological and physical suffering, as proposed by the prosecution.<sup>81</sup> The prosecution argued that unless the suffering is physical, the Court must opt for the preservation of life.<sup>82</sup> The Court concluded this parameter was too restrictive because it ignored the manner in which a patient experienced suffering.<sup>83</sup> Furthermore, the necessity defense involved an *ex post facto* analysis to determine the lawfulness of a doctor's clinical and professional judgment of the patient's suffering, but not the cause or causes of the suffering.<sup>84</sup> Indeed, the Court held that the cause of the suffering does not bear any real relation to how the suffering is experienced. The Court also held that a patient does not need to be in a "dying phase" because the underlying clinical cause does not need to amount to some terminal illness.<sup>85</sup>

Since the Court refused to distinguish a physical condition from a psychological condition, the Court, in effect, ignored the traditional Cartesian distinction between body and mind (*res extensa - res cogitans*) and, by implication, the distinction between physical and psychological suffering. The Advocate General,<sup>86</sup> A.G. Meijers, in his opinion, pointed out that human experience and philosophical insight regard such a distinction as artificial. This artificial distinction does not assist in answering the question of how suffering and its hopelessness is experienced by the patient himself—a subjective answer—or how suffering and hopelessness can be determined objectively by doctors with reference to current medico-ethical considerations.<sup>87</sup> The distinction, thus, disregards the fact that physical suffering can also have a psychological effect, which can influence the rationality of a decision. Similarly, psychological suffering does not necessarily undermine a person's rational powers.

The Court's departure from the Cartesian paradigm has enormous implications for the lawfulness of euthanasia under the necessity defense. The analysis becomes less clinical, less objective, and less hypothetical because more weight is given to the patient's subjective experiences of

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81. HR 21 June 1994, N.J. 1994, 656, at 3151.

82. *Id.* at 3147.

83. *Id.* at 3151.

84. *Id.*

85. *Id.*

86. In the Dutch legal system, the Supreme Court takes into consideration the advice given by Advocate Generals, who proffer an independent, and a more academic, analysis of the legal problem. The advice is non-binding, but often relied upon by the Supreme Court.

87. The A.G. followed Annotator Hart in HR 28 May 1991, N.J. 1991, 784.

suffering. However, as long as there *is* an illness that causes the suffering, the Court's analysis remains objective enough to involve a clinical judgment. This makes the suffering medical and an appeal to the necessity defense justly survives.

## 2. The Nature of the Request

Can it be true that patients whose suffering is on the whole psychological cannot make decisions to end their life voluntarily? In other words, is such a patient *compos mentis* to make such decision? In *Chabot*, the prosecution argued that the mental state of the patient cast doubt on her autonomy and freedom to make decisions, including her wish to die. The nature of the suffering, thus, was crucial in determining the nature of the wish to die. If the suffering was determined to be psychological, too much doubt would remain as to the voluntary nature of the death wish and the doctor should not have acceded to it. In effect, the prosecution argued that any suffering which is psychological in nature would undermine the free will of the patient and would make her decision involuntary.

It could be argued that what was meant by the prosecution was that a desire to die can be a symptom of the illness, such as in common depression. As a symptom, the desire to die can be treated and thus, euthanasia in that circumstance would be unlawful. The desire to die stems from the patient's suffering, but not from the illness that is the cause of the suffering. If this is the case, one must agree with the prosecution that the suffering could cast doubt on the patient's mental state and on the ability to make decisions. However, in that circumstance, the patient's decision is not *ipso facto* invalid. The connection between free will and its suppression by a suffering mental state demands a clinical determination. A mentally ill patient, such as the patient in *Chabot*, desires to die because of the mental pain suffered. In comparison, a terminal patient's desire to die is derived from suffering as well as knowledge that death is imminent. In that circumstance, the suffering is both physical and psychological; both the illness and the suffering bear upon the patient's decision and the doctor's diagnosis. Accordingly, it would be illogical to say that the free will in the latter is preserved and not in the former. Neither patient is able to come to a decision in "complete freedom," which the prosecution maintained should be the criterion for determining whether the necessity defense should prevail.

Indeed, the Supreme Court held that there is no such thing as complete freedom.<sup>88</sup> Psychiatric patients, as much as somatic patients, are able to

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88. HR 21 June 1994, N.J. 1994, 656, at 3152. The House of Lords in England held similarly in *In Re C [Adult: Refusing of Medical Treatment]* [1994] 1 W.L.R. 290. In that

arrive at autonomous decisions. The prosecution failed to understand the meaning of freedom, which is connected to a person's mental state. Of course, there is a point where the mental state prevents a person from acting autonomously, but this remains a clinical determination. The Court nonetheless agreed with the prosecution that the determination of whether a decision is made autonomously must be a careful one.<sup>89</sup> As a result, the Court held that Dr. Chabot failed to meet the criteria of the necessity defense because he had not consulted other doctors who had seen the patient themselves.

### 3. Suffering as the Foundation of the Defense

The Supreme Court in *Chabot* gave express recognition to the belief that in order to assess suffering, it must be abstracted from its cause.<sup>90</sup> On one hand, the case suggests that the decision of any patient who is sufficiently *compos mentis* to formulate a wish to die should be respected. On the other hand, the case suggests that the patient displayed sufficient capacity to consent to the sort of palliative treatment that actually ended her life. As to the latter view, the Court made a realistic and humane judgment when it recognized a cautious professional approach to an extreme situation. In doing so, the Court demanded that the patient be carefully and properly informed of all the available options as well as allowed to come to a decision to take the only available palliative option.

#### C. Suffering in the Absence of a Clinical Cause

It was believed that the 2001 legislation would end the debates surrounding the practice of euthanasia or at least would provide a degree of certainty as to the lawfulness of euthanasia and assisted suicide. However, at the same time the legislation was passed in parliament, the *Brongersma* case appeared before a regional court. A discussion about the boundaries of lawful euthanasia and, by implication, the boundaries of the doctor-patient relationship, was again highlighted in this case.

In *Brongersma*, a doctor assisted in the suicide of an elderly man, who had not had any illness but whose suffering the doctor believed to be hopeless and unbearable.<sup>91</sup> Mr. Brongersma, a former lawyer and Senator

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case, a paranoid schizophrenic patient refused to consent to the amputation of his gangrenous leg. The court held that a doctor must consider whether the patient's capacity is so reduced by the patient's mental illness that he does not sufficiently understand the purpose and effects of the treatment.

89. See also Annual Report 2001, *supra* note 63, at 15.

90. HR 21 June 1994, N.J. 1994, 656, at 3150-51.

91. Rb. Haarlem, 30 Oct. 2000 (LJN AD7926), available at [www.rechtsspraak.nl](http://www.rechtsspraak.nl).

who had been a supporter of death on request, had been consulting the doctor since 1986.<sup>92</sup> He signed a living will in 1984, which he renewed in 1994 and 1998. In 1998, Mr. Brongersma had had some physical complaints and told his doctor that he suffered under his physical deterioration and the senselessness of his existence.<sup>93</sup> In fact, Mr. Brongersma had attempted suicide in 1996.<sup>94</sup> Mr. Brongersma and his doctor discussed his desire to die and the possibility of assisted suicide in more detail during eight subsequent interviews.<sup>95</sup> In addition, a psychiatrist evaluated the Mr. Brongersma and concluded that he did not suffer from any psychiatric illness which could have explained the desire to die. Another doctor confirmed that the Mr. Brongersma's desire to die was sincere and voluntary. In April 1998, Mr. Brongersma committed suicide assisted by his doctor.<sup>96</sup>

### 1. Existential Suffering

An issue of first impression, the *Brongersma* case posed the question of whether euthanasia or assisted suicide is lawful in the absence of a clinical illness that causes the patient to suffer hopelessly and unbearably. The case concerned "existential suffering," which was defined by one of the experts at the trial as the unbearable suffering of life in the absence of any clinical cause and without hope of any improvement.<sup>97</sup> One may refer to it as "non-medical euthanasia." If the Court recognized non-medical euthanasia, it would effectively mean that the Supreme Court would recognize the practice of euthanasia outside the realm of the doctor-patient relationship. Considering its own case law, as well as the parliamentary history of the Euthanasia Act of 2001, the Court refused to deem this lawful. To clearly understand the Supreme Court judgment it is important to analyze the judgments of the trial court and the court of appeal.

The trial court held that a clinical cause was not a necessary condition, deviating from what was established case law of the Supreme Court.<sup>98</sup> The trial court held that since the patient's suffering appeared to have no direct physical cause and that the patient had not been in a "dying phase," a more careful determination of the suffering was warranted, along the lines of that

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92. *Id.* at 3.

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. Rb. Haarlem, 30 Oct. 2000 (LJN AD7926), at 5.

98. *Cf.* Euthanasia I, HR 14 Nov. 1984, N.J. 1985, 106; Euthanasia II, HR 21 Oct. 1986, N.J. 1987, 607; Chabot, HR 21 June 1994 N.J. 1994, 656.

required by the Supreme Court in *Chabot*.<sup>99</sup> The trial court then departed from the customary analysis (which entailed a determination of an objective and clinical consideration of the hopelessness and unbearableness of the patient's suffering) and considered instead how the patient himself had experienced his suffering.<sup>100</sup> The trial court stated that unbearable suffering—contrary to its hopelessness—is subjective because it consists of both situational and personal elements.<sup>101</sup> This being so, the trial court stated it had limited opportunity to test whether the doctor could have reasonably come to the conclusion that the suffering had been unbearable.

Accordingly, the trial court asked expert witnesses to place the nature of this kind of suffering in a wider theoretical context. One expert opined that the absence of a serious illness does not imply that a person necessarily experiences a healthy or happy life.<sup>102</sup> She explained that a person could consider his quality of life to be bad as a result of, for example, the physical and psychological deterioration that can come with old age.<sup>103</sup> This deterioration is ongoing and cannot always be treated, for example, with geronto-psychiatric care. Another expert agreed and stated that the suffering, such as experienced by Mr. Brongersma, could be characterized as the absence of any perspective on improving one's position and may indeed be unbearable to bear.<sup>104</sup> According to the expert, evaluating whether or not such suffering is "authentic" or "real" depends on the character of the patient, his personality, and integrity.<sup>105</sup> As far as the experts could interpret the facts, they believed that Mr. Brongersma's suffering had been authentic.

It is interesting to note the choice of language used by the experts. In previous cases "suffering" was referred to as "clinical suffering," which could be objectively determined since it derived from a clinical cause. In the absence of such a clinical cause, the suffering becomes more difficult to determine objectively; in fact, the suffering is utterly subjective. In cases of suffering that do not stem from a clinical cause, the expert must ask whether the suffering is "real," i.e. whether the patient is serious about his state of life and his request to die or whether his "suffering" is really a cry for attention or help. According to this view it may be argued that, in cases of existential suffering, the desire to die is encapsulated, disguised, or

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99. Rb. Haarlem, 30 Oct. 2000 (LJN AD7926), at 4.

100. The court hinted that it could use the "substitute judgment test" in considering how the patient experienced suffering.

101. Rb. Haarlem, 30 Oct. 2000 (LJN AD7926), at 4.

102. *Id.* at 4.

103. *Id.* at 4-5.

104. *Id.* at 5.

105. *Id.*

represented by the suffering. It perhaps exposes a belief on the part of the expert that euthanasia on demand cannot be honored but a request on the basis of suffering of any type, whether existential or clinical, can. However, with all due respect to such experts, this appears to be wishful dialectic.

The experts' conclusion at the trial was that a person can suffer without illness. While this was not a new concept, the trial court concluded that the doctor could justifiably rely on the necessity defense in such a circumstance. The court accepted existential suffering as a ground for lawful euthanasia by doctors and accordingly, concluded that the underlying clinical cause was really irrelevant. However, is this what was originally intended by the Supreme Court when it constructed the necessity defense in *Euthanasia I*? Doesn't a review of the case law, as well as the legislation, require the conclusion that what is meant by "suffering" is suffering as a result of some physical or psychological illness (clinical suffering)? Any other interpretation would place lawful euthanasia outside the realm of medicine and the doctor-patient relationship since the suffering need not be based on a clinical cause and the determination of suffering would no longer require a clinical determination. Or is this too traditional an approach toward suffering and toward the function of a doctor, particularly a family doctor?

## 2. Outside the Medical Realm

Unlike the *Broggersma* trial court, the court of appeal held on to the traditional approach and overruled the trial court.<sup>106</sup> The court thought it was unclear whether the doctor found himself in a conflict of duties when suffering was other than medical or clinical.<sup>107</sup> The court was hesitant to comment on the role and function of doctors confronted with a request to die on the basis of existential suffering. Does existential suffering belong to the domain of traditional medicine? If not, a doctor could not enter into a conflict of duties when presented with a request to end one's life on the basis of existential suffering. To answer this fundamental question, the court ordered a preliminary judgment and appointed two expert witnesses whose task it was to answer three questions for the court: (1) whether a doctor could legitimately honor a request for euthanasia in the absence of any physical or psychological illness; (2) whether it is part of a doctor's function to assist people, whose suffering is primarily characterized by psychological factors, such as the daily experience of an empty and lonely

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106. Hof Amsterdam, 6 Dec. 2001 (LJN AD6753), available at <http://www.rechtspraak.nl>.

107. Hof Amsterdam, 8 May 2001 (LJN AD1474), at 3.

existence and the fear that it may continue for many years; and (3) whether there is a consensus among doctors about the answer to these three questions.<sup>108</sup>

The Supreme Court adopted many of the considerations of the court of appeal, in particular, the opinions of the two experts.<sup>109</sup> The experts concluded that the answers to the first two questions were one of opinion about which there was not yet a consensus among doctors.<sup>110</sup> Indeed, no information could be derived from statistics or opinion polls. Discussion of this type of case had only recently begun. Both experts believed that a doctor should not assume that he is permitted to honor a request to die based on existential suffering or that it is part of a doctor's duty to assist such persons in their quest for death.<sup>111</sup> One of the experts, Professor Legemaate, stated that doctors could only legitimately honor such a request when the suffering derived from a physical or psychological cause. Thus, as far as he was concerned lawful euthanasia should be restricted to cases that are medically or clinically indicated. The other expert, Professor Spreeuwenberg, agreed stating that cases such as the *Brongersma* case did not belong within the professional remit of doctors. Hence, there could never be an obligation on the part of doctors to assist people with a death wish based on existential suffering. Professor Spreeuwenberg stated that it is a doctor's duty to consider whether the symptoms of a patient's suffering are caused by an illness in order to determine whether the case falls within the realm of medicine.<sup>112</sup> If so, euthanasia may be justified.

The Supreme Court, in confirming the appellate court's decision, drew a demarcation line with regard to the professional duties of a doctor. The Court held that questions about life and existential suffering fall outside a doctor's professional competence.<sup>113</sup> Indeed, the experts attested that not much was known about such questions. According to the Court that meant that a desire to die, inspired by such suffering, is not a request that a doctor can entertain under the current legal framework; if he entertains such requests, he is not acting as a doctor and thus cannot be protected by the necessity defense.<sup>114</sup> The Court held that life problems are not medical

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108. Hof Amsterdam, 6 Dec. 2001 (LJN AD6753), at 6.

109. *Brongersma*, HR 24 Dec. 2002 (LJN AE8772), available at <http://www.rechtsspraak.nl>. One of the experts, John Legemaate, is a professor of health law at the Erasmus University of Rotterdam. The other expert, Cor Spreeuwenberg, is a professor of integrated health care for chronically ill people at the University of Maastricht.

110. HR 24 Dec. 2002 (LJN AE8772), at 9.

111. *Id.* at 9, 10.

112. *Id.* at 10.

113. *Id.* at 16.

114. *Id.*

problems; the doctor is not a specialist on questions concerning existence such as, for example, hopeless despair, loneliness, or existential suffering caused by the inability to adapt to a new situation.

#### *D. Justification for Euthanasia*

The decisions in *Chabot* and *Brongersma* have, for the first time in a legal context, raised the question of whether death is “natural.” Is death a consummation of life that arrives in its own good time? In considering this, the courts have recognized that death has political, social, and economic repercussions. Society may wish to consider that death is an inevitable goal to be attained, with the maximum of dignity, care, and painlessness when all alternative methods of coping with life and its attendant inflictions have been exhausted. If so, then society must adjust its political, economic, and religious prejudices to provide this particular form of intervention. Dutch society has gone a long way to adapt its prejudices. Lawful euthanasia is firmly rooted within medicine and, by implication, the doctor-patient relationship. This means that euthanasia must remain based on medical considerations about causes and suffering. Euthanasia is an exception to a general rule—an option to an extreme situation—rather than the general rule itself. A justification for this exception is found in the medical context itself, with reference to the role of the doctor, serving the interests of the patient, and the nature of the doctor-patient relationship, in which a confidential discussion about life and death usually takes place.

#### IV. AUTONOMY AND THE DOCTOR-PATIENT RELATIONSHIP

The principle of autonomy and the attendant right to self-determination each refer to a person having the freedom to determine what he or she can do with life. Both principles permit people to follow a particular conception of the good life, but by no means can it be said that people enjoy total autonomy. Restrictions are necessarily in place since autonomous acts may harm others, cause them offense, or are so morally reprehensible as to be prohibited by law. Furthermore, individual actions often require dependence on others. This dependency takes many forms. Does autonomy go as far as to include the freedom of one person to ask another to kill him? Here, autonomy does not refer to the freedom to end one’s own life. Suicide is the act that gives expression to this freedom and is not legally prohibited in most countries, including the Netherlands.<sup>115</sup> Rather, autonomy appears to refer to whether one person can ask another to

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115. The Dutch Criminal Code does not recognize suicide as a criminal offence. Nor is the crime of “suicide” found in the criminal status of other Western European countries, such as Belgium, France, the U.K., and Ireland. In some U.S. states suicide is a crime.

lawfully assist him to die. But, can autonomy be extended to others? It is argued that criminalizing the person who carries out euthanasia or assists in a suicide obstructs the autonomy of the person seeking death.<sup>116</sup> This argument lends itself to the proposition that “the state must not do anything that obstructs the exercise of what is regarded as a fundamental freedom.”<sup>117</sup>

In the context of euthanasia, the dependency takes shape within the doctor-patient relationship. The consensus in the Netherlands, beginning in the 1980s and continuing through today, sees the doctor as the only suitable person to whom euthanasia and decisions about life and death can be trusted.<sup>118</sup> The doctor is assumed to be the instrument by which death is achieved. However, this assumption fails to do justice to the role of the doctor in the doctor-patient relationship. It fails to address the context with which autonomy has been embedded within medicine. The language of autonomy is necessarily different in the medical context, as society is uncomfortable in imposing upon doctors a duty to kill. Autonomy, here, refers to the right to decide what is to be done to one’s body, i.e. the right to bodily integrity, and demands that doctors serve the patient’s best interests. The context must seek to reconcile the dialectic of the patient (the right to die based on the principle of autonomy) with the dialectic of the doctor (the freedom to serve his patient’s best interests). These different notions of autonomy must be reconciled.

Thus, within the doctor-patient relationship, the patient’s autonomy involves the patient defining his own needs and determining the nature of the satisfaction of those needs (a patronage system or patient-centered model).<sup>119</sup> Others consider the relationship to represent a so-called collegiate system or doctor-centered model. In this system, the doctor determines the needs of the patient and the manner in which they are satisfied.<sup>120</sup> The notions of consent and informed consent illustrate that the doctor-patient relationship is actually a mix of the two extremes. The patient is recognized as a party to the relationship and is not regarded as a mere object of the relationship. The moral notion of autonomy is expressed in the legal notion of consent as the former implies that patients decide if

116. Cf. H.J.J. LEENEN, RECHTEN VAN MENSEN IN DE GEZONDHEIDSZORG, EEN GEZONDHEIDSRECHTELIJKE STUDIE 27-33 (1978).

117. See GRIFFITHS ET AL., *supra* note 19, at 168.

118. KENNEDY, *supra* note 4, at 128-35.

119. Cosmetic surgery for aesthetic reasons where the patient defines his own needs, may be a case in point.

120. See, e.g., B.S. TURNER, MEDICAL POWER AND SOCIAL KNOWLEDGE 136-37 (1987); T.J. JOHNSON, PROFESSIONS AND POWER 45-46 (1972). See also Ubaldo de Vries, Professional Negligence Reconsidered 128 (1996) (unpublished Ph.D. dissertation, Dublin City University, Ireland) (on file with the Dublin City University Library).

they want a certain form of medical treatment administered to them. Thus, no person can be treated if that person does not consent to such treatment. The patient can only consent if he is also properly informed about the alternative treatment options and their effects.<sup>121</sup>

The law of informed consent has allowed people to refuse treatment or have treatment withdrawn with the possible, or intended, consequence that death will follow.<sup>122</sup> Indeed, autonomy in medicine gives shape and recognition to an individual right to bodily integrity; autonomy is a shield against unlawful invasion of the body, not a sword by which people can demand the invasion of the body.<sup>123</sup>

How does this conception of autonomy apply to euthanasia? As mentioned above, there is consensus that doctors are best equipped to deal with issues of life and death.<sup>124</sup> This may inform interpretations of the notion of autonomy. Within the doctor-patient relationship, autonomy cannot be regarded as a patient having the right to have a doctor assist him in the materialization of his wish to die. Rather, autonomy means the freedom to consult with a doctor about the options of treatment at life's end and the ability to understand and consent to an option that may deliberately and intentionally end life. From this, it follows that autonomy cannot be the basis on which to justify an overt right to euthanasia on demand.<sup>125</sup>

The language in which autonomy has been dressed up may have given rise to the expectation that one may demand euthanasia. However, those who adopt the language of autonomy have failed to recognize that doctors who are confronted with a patient who has a sincere wish to die are not in a position to cater solely to the patient's desires. Medical ethics require that, regardless of what the law demands, doctors make a clinical and professional judgment about the validity of the request to die and the

121. See Dutch Civil Code, Book 7, art. 450. See also Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. GAOR, 3rd Sess., U.N. Doc A/810 at 71 (1948), available at <http://www.un.org/Overview/rights.html> (recognizing basic human rights); The International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, available at [http://www.unhchr.ch/html/menu3/b/a\\_ccpr.htm](http://www.unhchr.ch/html/menu3/b/a_ccpr.htm); Council of Europe, The European Convention of Human Rights (1950), available at <http://www.hri.org/docs/ECHR50.html>. In England, the decision in *Sidaway v. Bethlem Royal Hosp. Governors*, [1985] 1 All E.R. 643, is illustrative of informed consent. For the Canadian perspective, see *Reible v. Hughes* [1978] 21 Q.R. 2d. 14, and for the United States perspective, see the classic case of *Canterbury v. Spence*, 464 F.2d. 772 (1972).

122. See, e.g., *In re T. (Adult: Refusal to Treatment)* [1993] Fam. 95 at 115-16 (U.K.).

123. The latter interpretation may represent the socio-economic right to health care, which cannot be easily enforced in court.

124. KENNEDY, *supra* note 4, at 128-35.

125. This line of thinking is similar to the line of thinking used to analyze the conflict of duties faced by physicians. See *supra* Section II.B.1.

possibility of euthanasia or assisted suicide. This limits the role and function of the doctor. The Supreme Court in *Brongersma* took issue with the doctor-patient relationship when regarding patients whose suffering was primarily existential. The Court accepted that a doctor, particularly a family doctor or general practitioner, must seriously consider any type of suffering, including existential suffering. In these cases, his role is nonetheless restricted to providing care and directing patients to those who are able to help them dealing with their existential suffering. It would be wrong to suggest that the doctor is capable of judging suffering of this kind or is able to discuss the availability of alternative options for treatment of existential suffering because, as the experts attested, there is no scientifically justified medical insight.<sup>126</sup>

## V. CONCLUSION

This article reviewed the current Dutch law on euthanasia and physician-assisted suicide, explaining and arguing that the limits of lawful euthanasia are drawn by courts' interpretation of the necessity defense under Dutch criminal law. The defense requires the doctor to interpret the nature of a patient's suffering and the means that can be used to relieve this suffering. Thus, a doctor is said to be in a conflict of duties when he is confronted with a patient who, because of his suffering, expresses a wish to die. If the suffering is both hopeless and unbearable, euthanasia or assisted suicide is an appropriate response in the absence of any alternative to relieve suffering. Whether the suffering is both hopeless and unbearable demands a clinical or medical determination. This means that the suffering must have been caused by an underlying physical or psychological illness.

The courts have not accepted that suffering can be, independent from a clinical cause, a justification for euthanasia or assisted suicide in all cases. Thus, there is no room to interpret the necessity defense as allowing for euthanasia in cases of existential suffering. This kind of suffering is not regarded as "medical" and treating it does not belong to the duties of a doctor. By not accepting euthanasia for existential suffering, courts have shown that they are not willing to allow people other than physicians to argue the necessity defense. The defense creates a *medical* exception only. This also follows from the legislation, which emphasize the duties of a doctor, expressed in the due care criteria to which he should adhere.

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126. The court appears to keep the door open for lawful euthanasia if and when there is a consensus among doctors as to whether existential suffering is suffering of a medical or clinical nature. If so, it may well be that the necessity defense could extend to such cases. The court's comment illustrates also the importance of the medical profession in the whole of the euthanasia debate. This, however, is a subject for a different article.

The current legal position, allowing euthanasia only in those cases of hopeless and unbearable suffering, does not recognize an overt legal right to euthanasia in the Netherlands. All that is recognized is that in certain extreme situations, life need not be unnecessarily prolonged against the wishes of the patient. Euthanasia, thus, is an exception to the rule that prohibits the taking of life whatever the cause or reason. Justifications for the current position are found in the meaning of individual autonomy and the right to self-determination, the nature of the doctor-patient relationship, and the role of the doctor. Within the doctor-patient relationship, autonomy is understood as the right to consent to treatment such as proposed by a doctor. It does not mean the right to ask from the doctor whatever a patient desires. The doctor must act, and does act, on the basis of what he believes is in the best interest of the patient. His medical skill and knowledge, as well as medical ethics, informs him and helps him to determine what is in the best interests of the patient. The patient can agree or disagree. However, sometimes the best interest of the patient might be a course of action that actually results in the death of the patient. The doctor, not so much on the basis of the wishes of the patient, but rather on the basis of clinical and medico-ethical considerations in which the patient is obviously involved, decides upon this course of action. This also means that there are limits of what a doctor can do. Anything that falls outside the medical realm, such as, for example, cases of existential suffering, cannot provide sufficient grounds to come to a determination that leads to euthanasia or assisted suicide.

This analysis of Dutch position on medical euthanasia illustrates that the matter is not settled in the Netherlands. There are many problems with the current position. It is outside the scope of this article to discuss all of the issues that stem from the current position and this article merely sought to provide a descriptive analysis of the law. The main problem that the law faces is the unwillingness of doctors to report cases of euthanasia, which they are obligated to do under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2001.

In light of this, Dutch law is at a crossroad. The criminal law perspective can only cater to the so-called “classic” or “medical” cases of euthanasia. The question becomes what Dutch society wants with respect to non-medical cases of euthanasia, such as the *Brongersma* case. Is Dutch society heading toward euthanasia on demand?