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ARTICLE: EUTHANASIA IN THE NETHERLANDS: THE LEGAL FRAMEWORK

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SUMMARY:

... Two articles of the Criminal Code explicitly prohibit
euthanasia: Article 293 prohibits killing a person at his or her
request ("Any person who takes another person's life at that person's
express and earnest request shall be liable to a term of imprisonment
not exceeding twelve years or a fine of NLG 100,000"); Article 294
prohibits assisted suicide ("Any person who intentionally incites
another person to commit suicide, assists him in the act or provides
him with the means to commit suicide shall, if suicide follows, be
liable to a term of imprisonment not exceeding three years or a fine of
NLG 25,000"). ... The law contains special provisions dealing with
requests from minors for termination of life and assisted suicide. ...
The campaign to legalize physician-assisted suicide in the Netherlands
began in 1973 with this case, in which a family doctor was prosecuted
for giving a lethal injection of morphine to her mother, who lived in a
nursing home. ... She persisted in her requests for assisted suicide.
... The recommended extensive evaluation would assure that only
competent patients have access to assisted suicide. ...

TEXT:

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Introduction

The three relevant categories of Dutch doctors who are involved in
the practice of euthanasia are General Practitioners (GPs), nursing-
home doctors, and specialists. Every person in the Netherlands has a

more or less permanent relationship with a GP, who provides primary health care and is the point of entry for specialist care. GPs have the most extensive experience with euthanasia insofar as they discuss it most frequently with their patients, they receive two-thirds of all requests, and they are generally the most willing to perform it (about 90% of Dutch doctors have either practiced euthanasia or would be willing to do so). n1 The level of experience with euthanasia among specialists is about half that of GPs (with 3% of all deaths in their practice attributable to euthanasia). By contrast, euthanasia plays a small role in the practice of nursing-home doctors, who receive relatively few requests (only a fifth of them have ever honored one). n2

The KNMG (Dutch Royal Medical Association) Guidelines speak of "persistent request". A request made on impulse or as a result of a temporary period of depression should not be honored. The request must have been discussed repeatedly and thoroughly a number of times during several conversations. However, van der Wal and colleagues conducted [*320] a survey among a random sample of family doctors, showing that in 22% of cases the request was made only once. n3

The rate of record keeping n4 and written requests n5 in euthanasia cases improved during the 1990s, but the situation is still unsatisfactory. There are now written requests in about 60% and written record keeping in some 85% of all cases of euthanasia. n6 A most troubling phenomenon is the significant number of unreported euthanasia cases. Since November 1990, new state regulations require physicians to report cases of euthanasia to the local coroner and the public prosecutor. The number of reports rose from 454 cases in 1990 to 591 in 1991, to 1323 in 1992, to 1318 in 1993, and to 1424 in 1994. In 1999, the total number of reports was 2216. n7 This considerable increase suggests that more physicians are willing to acknowledge and report their actions, having seen that their colleagues are not being prosecuted for performing euthanasia. At the same time, the Rammelink Commission appointed by the Dutch government in 1990 to investigate the issue of "medical decisions concerning the end of life" (MDEL) detected 2300 cases of euthanasia, which means that about half are still unreported. n8 John Griffiths argues that the reporting rate for euthanasia n9 was 18% in 1990, and that by 1995 it had risen to 41%. A situation in which less than half of all cases are reported is unacceptable from the standpoint of effective control. n10

The Dutch approach to euthanasia is said to reflect an open attitude towards tackling a difficult moral issue. For the past twenty years, the debate has been discussed openly in all circles of society. It has been [*321] considered in the Parliament, addressed by the courts, debated in religious institutions, and has required the constant attention of the Royal Dutch Medical Association. It continues to be a focus of the media, and polls have been conducted from time to time to examine public attitudes on this issue.

Despite this apparent openness, the 1990 comprehensive study of MDEL shows that 22% of physicians feel that they should not always be

required to report euthanasia as unnatural death. The legal ambiguity that existed for twenty years made Dutch doctors feel uncomfortable with reporting euthanasia, citing prosecution as an objection. They emphasized that they would be prepared to report euthanasia as such, but did not wish to be considered as a suspect in a criminal act. Thus, the uncertainty of what might happen to the physician was considered an obstacle to reporting an unnatural death. n11 To address this issue, a careful, clearly stated procedure was needed, one that would be explicitly recognized under the law.

The aim of this paper is to outline the legal framework of euthanasia in the Netherlands and to analyze the leading court cases involving adults. I will first explain the legal ambiguity that existed in the Netherlands until the enacting of the euthanasia law on April 10, 2001 which is supposed to come into effect sometime during 2002 and then discuss how did the courts treat cases of mercy killings.

I. The Legal Framework

The legal ambiguity was the result of prohibiting euthanasia under the law while allowing the practice under certain circumstances. Two articles of the Criminal Code explicitly prohibit euthanasia: Article 293 prohibits killing a person at his or her request ("Any person who takes another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fine of NLG 100,000"); Article 294 prohibits assisted suicide ("Any person who intentionally incites another person to commit suicide, assists him in the act or provides him with the means to commit suicide shall, if [*322] suicide follows, be liable to a term of imprisonment not exceeding three years or a fine of NLG 25,000"). n12

Despite these legal provisions, the courts have held that Article 40 of the Criminal Code ("Any person who was compelled by force majeure to commit a criminal act shall not be criminally liable") n13 provides a defense to doctors charged under Articles 293 and 294. The overmacht defense, which, like force majeure, translates as overpowering force, envisions a case of urgency whereby the accused is driven by his or her conscience to commit an offence that amounts to a lesser evil than would have ensued had events been permitted to run their course. n14 As such, the accused decided to make the deliberate moral choice to break the law because the force of circumstances precluded delaying action. However, the defense does not stand if there was a reasonably available option whereby the accused could have avoided the commission of the offence. n15

A major step was taken in 1990 on behalf of physicians practicing euthanasia. In soliciting for the approval and cooperation of the Royal Dutch Medical Association with the R Emmelink study, the Ministry of Justice not only promised legal immunity for physicians participating in the national investigation, but it also agreed to proclaim a notification procedure that included the following

elements:

(i) The physician performing euthanasia does not issue a declaration of a natural death and informs the local medical examiner by means of an extensive questionnaire;

(ii) The medical examiner reports to the district attorney;

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(iii) The public prosecutor decides whether a prosecution must be started. As a general rule, cases in which the doctor has complied with the requirements for euthanasia would not be prosecuted. n16

The notification procedure was granted formal legal status by a procedural law that came into force on June 1, 1994. According to this law, a physician performing euthanasia in compliance with the criteria that have been developed in case law and medical ethics will, as a general rule, not be prosecuted. n17

On November 28, 2000, the Dutch Lower House of parliament, by a vote of 104 for and 40 against, approved the legalization of euthanasia. n18 On April 10, 2001 the Dutch Upper House of parliament voted to legalize euthanasia, making the Netherlands the first and at that time only country in the world to legalize euthanasia. Forty-six members of the 75-seat Senate voted for the Termination of Life on Request and Assistance with Suicide Act; twenty-eight voted against; one member was not present. The new legislation makes it legal to end a patient's life, subject to the following criteria: the patient must be suffering unbearable and unremitting pain, with no prospect of improvement. n19 The patient must make a sustained, informed and voluntary request for help to die. All other medical options must have been previously exhausted. n20 A second medical opinion must be sought to confirm diagnosis and prognosis. n21 The termination of life must then be carried out in a medically appropriate care and attention. The physician is obliged to report the death to the municipal pathologist, specifying whether the cause of death was euthanasia or assisted suicide. n22

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Doctors will be immune from prosecution for helping a patient to die, as long as they follow this set of Guidelines. They will still report cases of voluntary euthanasia to the coroner and a regional panel, who can recommend prosecution leading to a prison sentence of up to 12 years if the Guidelines have not been followed. n23

This new Act changed the emphasis on who should prove guilt or innocence if the code of practice is breached. Previously, the onus was squarely on the doctors to prove that they had followed the Guidelines and were therefore innocent of any offence. However, the new law shifts the responsibility for proving guilt to the regional panels. n24

The law contains special provisions dealing with requests from minors for termination of life and assisted suicide. The most controversial aspect of the original act was that incurably ill minors between the ages of 12 and 16 may request and receive help to die, with the agreement of their parents. n25 In exceptional circumstances, doctors may even be able to help the child to die without parental consent, although such cases are likely to be rare. n26 Persons of 16 to 18 years of age would be able to request euthanasia without recourse to their parents' approval. n27

In July 2000, in response to critical questions by members of parliament, the Cabinet dropped the provision that euthanasia requests by minors between 12 and 16 years in exceptional cases could be granted without the parents' consent. Some analysts viewed this retreat as a maneuver to win approval for other controversial provisions of the new legislation, such as legalizing euthanasia for victims of Alzheimer's disease. n28 Still, allowing euthanasia for minors 12 years of age and older seriously overestimates the capacity of minors to evaluate the meaning [*325] and consequences of a request to die. n29 It places an unacceptable burden on these young people and may well disturb society's confidence in the relationship between physicians, parents and children. Jochemsen rightly says that unless we are prepared to give minors the right to do everything else in life that an adult can do, giving them the right to end life seems out of place. n30

The new law also establishes a legal basis for advance euthanasia declarations via a type of living will in which competent patients would request euthanasia in the event they become mentally incompetent. Though such a statement does not imply that a physician has a duty to perform euthanasia, it provides the legal opening to end the life of incompetent patients who had signed such a document.

II. Leading Court Cases

The first case in which a physician was found guilty under Article 293 but not punished took place in the early 1950s. It concerned a patient who had been suffering from advanced tuberculosis and had for some time been urging his brother, who was a physician, to end his misery. Finally, the brother administered painkillers and sleeping pills and killed the patient. The physician was prosecuted, convicted and received a one-year probation. Apparently, the court considered the relationship between the physician and his brother, as well as the patient's terminal illness, as mitigating factors. n31 However, it was not until the Postma case that the euthanasia movement was really put in motion.

A. Postma

The campaign to legalize physician-assisted suicide in the Netherlands began in 1973 with this case, in which a family doctor was prosecuted for giving a lethal injection of morphine to her mother, who lived in a nursing home. n32 Ms. Postma, a 78-year-old widow, had been [*326] in a nursing home since a cerebral hemorrhage had left her paralyzed on one side. On several occasions, she had asked her daughter to end her life. She had also spoken of not wanting to live any more to her other daughter and to the nursing home staff. Finally, after many repeated requests, her daughter acquiesced in the presence of the daughter's husband, who was also a physician. She was promptly charged with manslaughter, which stirred up a great deal of public sympathy for the daughter. After two years, the court found her guilty under existing law, ruling that the lethal injection was not a reasonable means to put an end to her mother's suffering. At the same time, the court acknowledged that doctors are not obliged to prolong life at any cost and that under certain conditions it can be legitimate to use medication with the intention of shortening life. Consequently, the verdict was very lenient, with Dr. Postma given a conditional jail sentence of one week with a one-year probation. Later, even that sentence was suspended. n33

Undoubtedly, this was a highly emotional case. The procedure, however, was very problematic. From the details of the case it seems that no independent physician was consulted and that all decisions remained in the family. The extent to which close members of the family are able to make unbiased, non-partisan and professional decisions is questionable. The control mechanisms of the euthanasia practice require including uninvolved professionals.

Following the Postma decision, the KNMG issued a statement that the administration of pain relieving drugs and the withholding or withdrawal of futile treatment could be justified even if it resulted in death. n34 In 1981, a lay volunteer, named Ms. Wertheim, assisted in the suicide of a non-terminally ill patient, who on many occasions had expressed her wish to die. n35 The patient's GP had refused to accede to her request and had referred her to Ms. Wertheim, who, after a few meetings, assisted with the patient's suicide. She was prosecuted in the Rotterdam Criminal Court, which acknowledged the patient's right to [*327] self-determination and set forth standards for non-criminal aid in dying. n36 The most noteworthy of these were that a patient requesting the aid need not be terminally ill, but need only be experiencing unremitting physical and mental suffering, n37 and that a doctor must be involved in the decision and must determine the method to be used. As a jail sentence would have been too much of a burden for the 76-year-old Ms. Wertheim to bear, she was given a conditional sentence of six months subject to a one-year probation. n38

B. Schoonheim

The first acquittal of a doctor committing euthanasia took place in 1983 and was upheld by the Supreme Court (called Hoge Raad) in the Schoonheim case in 1984. The case concerned Maria Barendregt, a 95-year-old bedridden patient who was totally dependent on the nursing

staff for her bodily needs and who continuously expressed her desire to die. Her doctor consulted with another physician, who concurred that the patient was unlikely to regain her health. However, although the patient was suffering, her illness was not terminal. The Alkmaar Court diverged from the existing criteria of continuous and unbearable suffering of a physical and spiritual nature n39, and instead required the defense to show that the patient was only under continuous suffering and that euthanasia could be justified solely on the basis of psychological suffering. n40 The prosecution appealed to the Court of Appeals in Amsterdam, which, in turn, rejected Schoonheim's defense and found him guilty, holding that his conduct constituted an offence under Article 293 of the Penal Code. n41 At the same time, the Court used its discretion not to impose any punishment, given the judges' assessment that the doctor acted with integrity and due caution. n42 On further appeal, the Supreme Court affirmed the appellate court's absence of material illegality analysis. n43 [*328] However, it remanded the case to the Court of The Hague to determine if Schoonheim's conduct was justified under the defense of necessity (Article 40). n44 The Court accepted the doctor's defense that he faced a conflict of responsibilities between preserving the patient's life and alleviate suffering. In cases where the doctor is confronted by such a conflict and the objective circumstances justify shortening the patient's life, the resolution of the conflict might necessitate the performance of euthanasia. This decision would have to be reached on the basis of the doctor's responsible medical opinion, as measured by the prevailing standards of medical ethics. n45 The Hague Court of Appeals acquitted Schoonheim, deeming that he had properly resolved his conflict of duties. n46

The reading of the details of this case suggest that there were compelling reasons to perform euthanasia. First, the patient's decision was voluntary. Mrs. Barendregt agonized over her progressive degradation as she became steadily less able to communicate with her loved ones and the medical staff. By the last week of her life, she was no longer able to take liquids or to speak, and she was suffering from periodic lapses of consciousness. However, when she regained some ability to communicate, she adamantly expressed her horror at the fact that she was still alive. Available medical treatment did not seem to help her. Mrs. Barendregt was fully aware of her condition, which brought her to pray for death. There was no indication that her family exerted pressure on her to die. She was the one who begged her son to urge the physician to end her life at the earliest possible moment. The patient had a long farewell with her son and daughter-in-law, at which time she expressed her gratitude to Dr. Schoonheim for his devoted care and for agreeing to terminate her life. Finally, the case was documented, as it should be.

Having said that, the decision-making process remains somewhat questionable. Although it involved Mrs. Barendregt, her son, and the two physicians, more should be done to verify the patient's diagnosis [*329] and to see that euthanasia is the last resort, after exhausting all treatment alternatives. If the series of talks involved only Dr. Schoonheim and his assistant, a young physician working in his office, then it contravenes the requirement of independent counseling. In order to minimize misdiagnosis and to allow the discovery of other medical

options, the decision-making process should include a second opinion provided by a specialist who is not dependent on the first doctor, either professionally or otherwise. Furthermore, it is preferable to broaden the decision-making team to include a lawyer, who can examine the legal aspects of the case; a social worker, who can assess the relationships within the family and verify that the euthanasia request is voluntary and free of coercion; and a psychologist, who can evaluate the patient's frame of mind. Possibly a public representative should be included as well. This extra caution should ensure that the right to die with dignity does not become a duty.

C. Admiraal

The decision in Schoonheim was followed by the Pols case, n47 and these two court rulings led to a series of judicial decisions through which the conditions and limitations of the defense were gradually worked out. In 1985, the District Court of The Hague acquitted Dr. Pieter Admiraal for the charge of offence under Article 293. The case concerned Karin L., a 34-year-old patient who had been afflicted with multiple sclerosis since 1976. The progressive deterioration of her condition led to a nursing home admission in 1981. By mid-1983, she was completely paralyzed except for the movement of her left hand. Karin was dismayed by her state of total dependency, remarking that she could not even brush away a fly. Despite the fact that Karin's condition was not defined as "terminal," she could barely swallow or speak above a whisper, her sight was failing, and she was experiencing intractable bone pain. Her breathing was becoming more labored, and although she feared suffocation, Karin was appalled at the thought of artificial ventilation. She repeatedly asked to die, knowing that her intolerable condition bore no prospects for improvement. She asked her nursing home physician to end her life, and when he refused she approached the [*330] Dutch Euthanasia Society for help. Then Dr. Admiraal entered the scene.

The decision-making process was extensive but not flawless. Dr. Admiraal consulted with the terminal care team at his hospital, which cannot be deemed as independent. There were a number of sessions in which he and the team conferred with Karin and her parents. At Dr. Admiraal's request, her family physician of thirty years had a long talk with Karin about her request for euthanasia. The family pastor was also consulted and informed Karin that he did not oppose her decision. n48 On November 4, 1983, Dr. Admiraal performed euthanasia with Karin's family at her bedside. He then reported the case to the police as an unnatural death.

The public prosecutor responded by charging him with failure to consult an expert neurologist on multiple sclerosis prior to acting. The District Court disagreed, holding that Dr. Admiraal had scrupulously complied with the euthanasia Guidelines stipulated by the Supreme Court in the Schoonheim case. n49 The Court ruled that when confronted by a situation of necessity, he had carefully weighed the conflicting duties and made a justifiable choice. n50 All of the factors supporting Dr. Admiraal's actions convinced the Court to

discount the importance of independent consultation with a neurologist and to acquit him.

Although Karin had thought about ending her life for some time, it was said that she initially decided against taking extreme measures only because she did not want to traumatize her parents. n51 In the end, the decision to die was undoubtedly made voluntarily. Clearly, her pain was not only physical but mental as well. After seven years of struggling with the disease, Karin was simply exhausted and did not want to continue living such a dependent life.

D. Duintjer

That same year, on October 4, 1985, 50-year-old Martha N. died after ingesting a lethal dose of cyclobarbitol provided by her psychiatrist, Dr. [*331] Duintjer. Martha had a history of depression and alcohol abuse dating back about 25 years. She was diagnosed as suffering from a character neurosis, with depressive and dependent traits and a strong self-deprecation leading to suicidal ideation. During 1983-1984, she tried to commit suicide three times, unsuccessfully. She decided to isolate herself in her bedroom, often denying access to her husband and children.

Martha repeatedly asked Dr. Duintjer and her family physician, Dr. W., to assist in her suicide, describing her own life as "one big black hole." Dr. W. arranged for Martha's pastor to talk to her, and after about a dozen meetings he reported that he had come to believe that her case was hopeless and that the physicians were morally entitled to assist in her death. On October 3, 1985 she signed the following statement: "I declare that life has no more value to me and that I voluntarily and in full consciousness, at my time and with the method of my choice, wish to end this life." When Dr. Duintjer reported the assisted suicide, the public prosecutor charged him with aiding suicide under Article 294. n52

The Court found that the medico-legal criteria had been satisfied: The patient was mentally competent and was acting out of her free will; she had made persistent requests to die; and there were no alternative measures that could relieve her intolerable suffering. The prosecution appealed the decision, but the acquittal was upheld by the Hague Court of Appeals. The appellate Court rejected the prosecution's argument that psychiatric patients were by definition mentally incompetent to qualify for assisted suicide. The Court held that Martha was mentally competent and that there were no treatment prospects likely to better her situation. The Court admonished the accused for failing to consult a physician not involved in the patient's treatment. However, it let the verdict stand because of the compelling testimony by psychiatrists and psychologists, who had been treating her for years, that Martha's suffering was indeed unbearable and irremediable. n53

It was said that her husband and children were caring and supportive over the years but that Martha was still unhappy and preferred not to have their company. It was also said that she desperately wanted to die, not only for her own sake but also to put an end to the constant stress [*332] and turmoil that her condition imposed upon her family. n54 This sort of consideration deserves special attention to ensure that the patient's decision is not a result of familial or environmental pressures. The description of the case does not mention the option of moving Martha out of her house to a new location. Perhaps there were other available options to rescue Martha from her depression. The extent to which we can speak of "free will" in a deeply depressed person is an open question.

Moreover, the decision-making process was insufficient. The two doctors that were heavily involved in her treatment did not consult another physician, who could have brought a fresh outlook and new insight to the situation. It was appropriate to involve the pastor, but it is still unclear why another professional psychiatrist was not consulted. Here it must be stressed that it is preferable to include members of the relevant professions (social work, psychology, and law), as well as a public representative.

E. Dr. K

Mrs. M., a 73-year-old patient with multiple sclerosis, started talking about euthanasia upon suffering a major deterioration in her health. She had lived a difficult life, but always had continued fighting to gain control over her life. In 1982, fighting seemed to be totally useless. Unable to change the course of her disease, she refused any of the alternative medications proposed by Dr. K., her psychiatrist and friend. On August 4, 1982, Dr. K. committed euthanasia on Mrs. M. and informed her action to the prosecutor. n55

On March 1, 1984, the District Court of Groningen argued that it is possible to find some criminal act not liable to punishment if it is a medical action, if it is necessary for medical reasons or of critical importance for adequate medical care, and if it is required by prudent medical science. Whether this is the case depends on five preconditions. Accordingly, euthanasia may be performed:

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1. by a physician after consultation with another physician, who has personally seen the patient;

2. on a patient whose condition is irreversible and who is suffering unbearably;

3. when the explicit and earnest request can be considered lasting and based on a proper evaluation by the patient of his/her own condition and the available alternatives;

4. when the patient does not think that there is a reasonable alternative;

5. when all other requirements of prudence are fulfilled. n56

In this case, the first precondition was not fulfilled. Dr. K. had merely informed other physicians and discussed the case of Mrs. M. with them. However, none of these physicians had actually seen the patient. It is also questionable as to whether the requirements of prudence were fulfilled. The psychiatrist evidently knew her patient well, but at the same time she was a personal friend of Mrs. M. This friendship might have overshadowed her judgment and ability to make a decision free of biases. As in Postma, the control mechanisms of the euthanasia practice should include independent, uninvolved professionals. Dr. K. was found guilty and liable to punishment. Upon appeal to the High Court of Leeuwarden, the Court affirmed the conviction under Article 293 of the Criminal Code. Dr. K. further appealed to the Supreme Court, and the conviction was affirmed yet again. n57

F. Kors

On October 31, 1990, Maria S. was assisted to die by her longtime pediatrician, Dr. Kors. Maria was a 25-year-old anorexic, weighing no more than 19 kilos. She persisted in her requests for assisted suicide. Determined to die, Maria had resolved to refuse further tube feeding and hospitalization. She was vomiting incessantly and experiencing severe stomach pains. In light of her condition, Dr. Kors decided to help her. After 16 years of treatment, he saw no likelihood that her condition would improve. Dr. Kors consulted a psychiatrist, who had seen Maria on numerous occasions and reported that Maria was mentally competent and that there were no treatment options that held the prospect of easing her suffering.

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Maria's decision to opt for death was influenced by her familial circumstances. At about the time that she managed to achieve something in her life - graduating from high school and finding work as a lab technician - her parents divorced. Then her younger brother Ernst became seriously depressed, and some years later he committed suicide. At his funeral, six months before her own death, Maria announced her intention to follow suit. She told Dr. Kors: "When Ernst died, I knew that finally I was allowed to go as well. I cannot go on any longer. I want salvation now. Therefore, I am asking you as a friend to help me. Please help me." n58

When Dr. Kors finally agreed to provide the drugs to enable her to commit suicide, Maria signed her last will and then arranged for a videotape in which she explained the reasons for ending her life. Dr. Kors reported her death to the authorities, and the public prosecutor responded by charging him with aiding her suicide under Article 294. n59

The Court was satisfied with the evidence that the medico-legal Guidelines had been fulfilled: The patient was free of psychosis and was otherwise mentally competent; her wish to die was well considered, persistent and free; her suffering was relentless and intolerable; and there were no reasonable treatment regimens to ameliorate her condition. The Court accordingly granted the motion to dismiss the appeal of the public prosecutor. n60

The last case to be examined also resulted from exceptional familial circumstances that led the patient to request assistance in dying. n61 As it is a highly controversial case, I will review it in more detail. Like all of the previous cases, this case also involved a woman. n62 Unlike the other [*335] cases, however, it was the first time that the Supreme Court considered assisted suicide for a psychiatric patient. It should be noted that physician-assisted suicide in psychiatric practice has been estimated to occur two to five times a year in the Netherlands. n63

G. Chabot

Unlike Martha N. and Maria S., Hilly Bosscher was a 50-year-old patient with no history of psychiatric disorder. She wanted to die because she felt that her life had lost its meaning after the death of her two sons: Peter from suicide at the age of 20, and Robbie five years later from cancer, also at the age of 20. In May 1991, on the day of Robbie's death, Mrs. Bosscher tried to commit suicide, unsuccessfully. After her personal family doctor, as well as some other people she knew, refused to help her commit suicide, she approached the Dutch Society of Voluntary Euthanasia for help, and they referred her to a psychiatrist, Dr. Chabot. n64

Dr. Chabot conducted a "trial therapy" with Mrs. Bosscher, consisting of a series of thirty sessions of 55 minutes each over a two-month period. However, Mrs. Bosscher told Dr. Chabot that she was not prepared to undertake the commitment to work with him to change her bleak outlook on life. In her personal diary she wrote:

I have lost everything and will never get it back. I do not want to become another person than I was when I was a mother and happy. It is finished, it is all over. For me alone there is no purpose in life. I know who I am or what I am. To become so different that I will want to or have to live means to me that I have to lose again. I am not allowed to be who I am or was. That's not right. n65

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In a letter to Dr. Chabot in September 1991, after he told her that he would assist in her suicide, Mrs. Bosscher wrote:

I feel so 'happy' with the help in dying I'll receive. I got everything in my life with which I couldn't possibly live any further. Am I egoist to not want, nor not to be able, to live on? Not having the urge or power to endure, to fight? I am certainly making life difficult for you. You told me that was none of my business. You wanted to 'invest' in me (I don't know how to express this in a better way). You are a psychiatrist, and as such you tried everything to hold me. But I feel you tried as a human being as well. I must have been a heavy load to take on. n66

I asked Dr. Chabot what Mrs. Bosscher meant by her use of the term "invest." In his personal letter, Chabot's response was that Mrs. Bosscher felt that he really wanted her to go through her vale of grief. He offered her intensive grief therapy, not just in an impersonal way but also in a way that showed he cared about her as a human being. Mrs. Bosscher "was not just an egocentric who could not perceive" Chabot's intentions; "she had felt that, as a professional, I wanted 'to invest' (time, energy, sharing her pain, etc.) in her." This she could not or would not accept. n67

The short but intense acquaintance with Mrs. Bosscher (from August 3 to September 7, 1991) led Dr. Chabot to conclude that she was a mentally competent person whose freedom of choice was not constricted by mental illness. In his opinion, Mrs. Bosscher had been suffering from a complicated grief process for five years following the suicide of her son, Peter, in 1986. Chabot did not see any psychiatric illness, clinical depression, trace of psychosis, or personality disorder. He believed that for her, there was no future without her children. He accepted that suicide was the only option to end Mrs. Bosscher's misery and was convinced that she would kill herself in any event, with or without his help. Chabot tried to give her antidepressant medication but she refused, saying that "the only sense life has got for me now is to find my way to Peter and Robbie through a dignified death." n68

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Strangely, in his discussion with Arlene Klotzko, Chabot said that he did insist on a trial with antidepressants before he agreed to assist in her suicide. n69 Yet, later in the same discussion, when asked whether Mrs. Bosscher rejected the option of antidepressant medication, Chabot answered: "This question I consider to be very tendentious given her grief. I hope that no pill will be discovered that will prevent or cure grief. Certainly, antidepressants don't cure grief." n70 I asked Dr. Chabot about this puzzle, and his answer was that he did insist on antidepressants for the few symptoms of depression that he noticed. He felt that the patient should give them a serious try. But, Chabot explained, depression is not identical with grief. It was Mrs. Bosscher's grief that he considered to be by far the most important in her wish to die. Chabot testified that he has had quite a lot of experience in grief therapy and has been successful in

that field, "but never with pills." Hence, urging Mrs. Bosscher to try antidepressants for what Chabot conceived as "mild depression" seemed to him perfectly compatible with his hope that there would be no medicine discovered that by itself (Chabot's emphasis) would cure grief. n71

Dr. Chabot had transcribed all the sessions with Mrs. Bosscher, which he sent to four psychiatrists and a clinical psychiatrist. He also consulted a family physician and a theologian-ethicist. He then held lengthy telephone conversations with the consultants, four of whom he met with in person. He asked one of the psychiatrists to meet with Mrs. Bosscher in person, but the colleague declined because Dr. Chabot's extensive documentation of the case had convinced him that it was not necessary. All save one reported that it was unlikely that anything could be done to make Mrs. Bosscher's life bearable and that they would support his decision to assist in her suicide. The psychiatrist who expressed a contrasting view thought that Mrs. Bosscher's condition was not hopeless and that Dr. Chabot should persist in treating her. n72

[*338]

In a personal communication, Dr. Chabot wrote that the account of the case, as described by Barney Sneiderman and Marja Verhoef, is accurate. n73 The immediate questions that come to mind are: Why did the four experts, who read the detailed transcripts, take the time to meet with Dr. Chabot but not see a need to meet with Mrs. Bosscher? In other words, if the transcripts were so straightforward, to the extent of making a meeting with the patient redundant, why was there a need to meet with the doctor? Furthermore, was the lone dissenter asked to meet with Mrs. Bosscher? What was his reaction? Did he refuse as well? Maybe he could have saved her life.

Hendin argues that Chabot asked only Dr. Frank van Ree, one of the few Dutch psychiatrists publishing on assisted suicide, to see Mrs. Bosscher. Van Ree felt that this was unnecessary. n74 If this information is correct, it is like inviting the "right" answer rather than seeking professional evaluation of the patient's condition. Later, the court asked van Ree why he did not see the patient. Van Ree explained that he felt he knew the case and that it would only cause the patient further pain to be seen again by someone else. Presumably, Hendin writes, it was less harmful to Mrs. Bosscher to help her commit suicide. n75

Given the near unanimity of opinion, Dr. Chabot felt assured that he could in good conscience assist Mrs. Bosscher's suicide. Sneiderman and Verhoef wrote that still Chabot sought further counsel from Dr. V., a family physician whose clinical judgment he highly respected. After lengthy discussions on the case, Dr. V. agreed that Mrs. Bosscher's frame of mind precluded any change of heart. However, he was not asked to examine the patient. n76

This is striking and strange. Why not? It seems that the purpose of the meeting was to calm the conscience of Dr. Chabot and to reassure his decision, rather than to seek an independent and free opinion. It seems that Dr. Chabot was seeking not just any opinion, but a certain opinion, namely, one that conformed to the decision that he apparently had already made to help Mrs. Bosscher end her life.

[*339]

On September 28, 1991, Dr. Chabot assisted Hilly Bosscher to commit suicide and subsequently stood trial. This was a little over two months after their first meeting and about four months after the death of her younger son. The Assen District Court acquitted him in April 1993 after becoming convinced that Mrs. Bosscher was experiencing long-term psychic suffering that for her was unbearable and unremitting.

Four of the clinical experts consulted by Dr. Chabot appeared as witnesses for the defense. They all testified that the case was so well documented that it was "highly unlikely" that any new information would have been gained by interviewing the patient. The Court then consulted three additional experts who provided written testimonials. None of the seven experts expressed disagreement with Dr. Chabot's role in Mrs. Bosscher's suicide, n77 a fact which critics of the Dutch policy on euthanasia may take to be worrisome and disturbing.

The Appeal Court of Leeuwarden upheld Dr. Chabot's acquittal, but on June 21, 1994, the Supreme Court reversed the decision and convicted Dr. Chabot under Article 294 of the Penal Code. The Supreme Court accepted the contention of the public prosecutor that the defense of overmacht was not allowable because none of the experts consulted by Dr. Chabot had personally examined the patient. The Supreme Court held that in non-somatic cases (i.e., cases that have to do with the psychological rather than the physiological condition of the patient), the absence of a face-to-face examination leads to the conclusion that, as a matter of law, the physician may not have truly acted in a state of necessity. Thus, personal contact between consultant and patient constituted a pre-condition to the acceptance of the overmacht defense in such a case.

Although Dr. Chabot was found guilty under Article 294 of the Penal Code, the Supreme Court exercised its prerogative under Article 9(a) of the Criminal Code not to impose any punishment or other measure in light of the character of the defendant and the circumstances in which the offence was committed. n78 However, the Amsterdam Medical Disciplinary Court found Dr. Chabot guilty of professional misconduct and imposed the sanction of reprimand. The Disciplinary Court's ruling [*340] was based on three accounts: (1) Chabot was faulted for not insisting on therapy as an alternative to assisted suicide. The patient's refusal of treatment should have been a reason for Chabot to refuse the request; (2) Chabot failed to arrange for Mrs. Bosscher to be personally examined by another consultant, a failure which amounted to an ethical breach of duty; and

(3) Chabot had not adequately preserved his professional distance, particularly in light of the frequency and length of his sessions with Mrs. Bosscher and the fact that these took place at his home. n79 Dr. Chabot himself regrets his failure to arrange consultation in person with Mrs. Bosscher. n80

Conclusion

Between 1981 and 1997, there were 20 prosecutions against physicians that ended with a judicial verdict. In nine of these cases, the doctor was found guilty. No punishment was made in three cases and in the other six the doctor was given a conditional sentence without imprisonment. In a few cases, a fine was imposed because the death had been incorrectly reported as natural. n81

In 2000, a court in Haarlem considered the case of Edward Brongersma, an 86 year old man who had first made a written euthanasia declaration in 1984. He had expressed his wish to die to his GP, Dr. Philip Sutorius, on at least eight occasions. A month before his suicide in April 1998 he said that death had "forgotten" him, his friends and relatives were dead, and he experienced "a pointless and empty existence." n82 A second medical opinion confirmed that he was suffering hopelessly, and a psychiatrist said he had no treatable psychiatric illness. However, the public prosecution had called for the GP to be given a [*341] three month suspended prison sentence. The prosecution recognized that Dr. Sutorius fulfilled all the legal criteria but one: "hopeless and unbearable suffering." Therefore, the patient's request should have been refused. The court did not penalize Dr. Sutorius, saying that the patient was obsessed with his "physical decline" and "hopeless existence" and therefore was suffering "hopelessly and unbearably". A spokesman for the Royal Dutch Medical Association reacted to the court judgment by saying that the definition of "unbearable suffering" had been stretched too far and that "what is new is that it goes beyond physical or psychiatric illness to include social decline." Justice minister Benk Korthals has said that being "tired of life" is not sufficient reason for euthanasia. n83

Another recent case, van Oijen, involved a 84-year old patient in a nursing home who unquestionably experienced unbearable suffering but there was no request for euthanasia on the part of the patient. She became more and more weak and was suffering as a result of deteriorating physical condition. One of the patient's daughters told the physician, Wilfred van Oijen, that he must do something about her but van Oijen did not for a while because she explicitly told him that she did not want to have euthanasia. One day, van Oijen came to visit his patient and saw her unconscious and lying in her dirt. Then, when he saw her in this state, he caused her death by lethal injection. Van Oijen failed to consult a colleague and reported the death of his patient as natural death. However, his conduct was brought to the attention of the legal authorities and the case came before the court. The Amsterdam court said that Dr. van Oijen had made "an error of judgment" but had acted "honorably and according to his conscience," showing compassion in what he considered the interests of his patient.

Thus, although van Oijen was convicted of murder he was not penalized for his action. n84

The combination of these two cases show that it is possible to compromise either of the absolutely important preconditions of patient's voluntariness or of unbearable suffering and still the physicians would not be punished. So long as the Dutch think that there was a reasonably good reason to infringe a certain Guideline, then they show sympathy for the physician's conduct even when it involves the killing of a [*342] patient. My view of those two cases is highly critical. Instead of investing efforts to improve the patient's living conditions physicians opt to perform euthanasia. In the first case, Sutorius should have walked away whenever his patients had started to raise the issue of euthanasia, by this showing Brongersma that this is not an issue to ponder. Undoubtedly this is the result of a very permissive culture of euthanasia. I never heard of a similar case in Israel, or in any other country for that matter. Physicians should not fulfill all patients' requests. Sometimes they must withstand their patients' pressure and explain in an unequivocal manner that they must remain loyal, first and foremost, to their conscience.

The second case is also highly disturbing. Instead of investing more time and effort to improve his patient's quality of life, van Oijen simply killed her. Dying patients deserve more care, not a syringe full of poison. No healthcare system should allow physicians to walk in medical departments with a ready-to-inject syringe and finish off patients, even if they are in great suffering. Just imagine that each of the hundreds medical personnel will kill only one patient deemed to be suffering. Hospitals would become slaughterhouses. Van Oijen should stay away from the medical profession.

A final note: In 1997, Linda Ganzini and colleagues conducted a study among board-certified forensic psychiatrists in the United States. The study showed that many psychiatrists would support procedural and legal safeguards for patients choosing assisted suicide. For the majority of respondents, a patient requesting assisted suicide would be found competent after an evaluation by two independent examiners, followed by judicial or local administrative review, rendering a determination of competence at a clear and convincing level of proof. The recommended extensive evaluation would assure that only competent patients have access to assisted suicide. The presence of major depression would automatically result in a finding of incompetence. n85

FOOTNOTES:

n1 John Griffiths, Alex Bood, and Helen Weyers, *Euthanasia and Law in the Netherlands*, 213, (Amsterdam: Amsterdam University Press, 1998).

n2 John Griffiths, *Effective Regulation of Euthanasia and Other Medical Behavior that Shortens Life*, in Ejan Mackaay (ed.), *Uncertainty and the Law* 72-73 (Montreal: Editions Themis, 1999).

n3 G. van der Wal, J.Th.M. van Eijk, H.J.J. Leenen and C. Spreeuwenberg, *Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?*, 9 *Family Practice* 112, no.2 (1992).

n4 A doctor has an obligation to maintain a full dossier on every patient and to accurately record therein what he or she does and why. Keeping adequate records is a general requirement of medical practice, and specifically is one of the requirements of careful practice in the case of euthanasia.

n5 Gerrit Kimsma notes in his comments on a draft of this paper that written requests for euthanasia are preferable but not mandatory. Another acceptable solution is a witness.

n6 See, Griffiths, *supra* note 3, at 74.

n7 I thank Henk Leenen for this piece of information.

n8 Henk A.M.J. ten Have, *Euthanasia: The Dutch Experience*, *Annals de Real Academia nacional de Medicina*, Tomo CXII 436-37 (Madrid, 1995).

n9 Reporting, as opposed to record keeping, refers to the requirement that a doctor report a case of euthanasia to the authorities as an unnatural death.

n10 See, Griffiths, *supra* note 3, at 74-75.

n11 P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and other Medical Decisions Concerning the End of Life*, *Health Policy Monographs* 98 (Amsterdam: Elsevier, 1992).

n12 Netherlands Ministry of Foreign Affairs - APPENDICES. For further reading, see H.J.J. Leenen, *Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands*, 8 *Health Policy* 197-206 (1987); J.K.M. Gevers, "Legal Developments Concerning Active Euthanasia on Request in the Netherlands", 1 *Bioethics* 156-162, no. 2 (1987).
http://www.bz.minbuza.nl/English/Policy/c_eutheng-app.html#

n13 http://www.bz.minbuza.nl/English/Policy/c_eutheng-app.html#

n14 Barney Sneiderman and Marja Verhoef, *Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases*, 10 *Alberta Law Review* 376 no. 2 (1996).

n15 *Id.* In England and Canada, the defense of medical necessity has been recognized in abortion cases (see *R. v. Bourne* [1938] 3 All E.R. 615 and *R. V. Morgentaler*, [1975] 20 C.C.C. 2d, 449), but it is not available in euthanasia cases. See *R. v. Cox* [1992], unreported. R. Porter, "Doctor convicted of attempted murder," *Sunday Telegraph* (September 20, 1992), and the Latimer case, <http://www.cnn.com> (November 5, 1997); Reuters, Toronto, "Canada farmer gets two years for mercy killing of daughter" (December 1, 1997).

n16 Robert J.M. Dillmann and Johan Legemaate, *Euthanasia in the Netherlands: The State of the Legal Debate*, 1 *European J. of Health Law* 84 (1994).

n17 See, Griffiths, Bood and Weyers, *supra* note 1, at 308-313, for a translation of the law.

n18 *Holland Legalizes Voluntary Euthanasia*, Nov. 28, 2000, *The Voluntary Euthanasia Society News*, [http:// www.ves.org.uk/cgi-bin/](http://www.ves.org.uk/cgi-bin/)

n19 Tony Sheldon, "Netherlands Gives More Protection to Doctors in Euthanasia Cases," 321 *British Medical Journal* 1433 (Dec. 9, 2000).

n20 *Holland: New Law on voluntary euthanasia*, August 13, 1999, *The Voluntary Euthanasia Society News*. [http:// www.ves.org.uk/](http://www.ves.org.uk/)

n21 *Id.*

n22 *Dutch Parliament Votes to Legalize Euthanasia*, Reuters November 28, 2000; *The Netherlands: Bill on Euthanasia and Assisting Suicide in the Netherlands*, 5 *European J. of Health Law* 299-324 (1998); Tony Sheldon, "Netherlands Gives More Protection to Doctors in Euthanasia Cases," 321 *British Medical Journal* 1433 (December 9, 2000); Rory Watson, *MEPs Try to Mobilise Public Opinion against Extension of Euthanasia*, 322 *British Medical Journal* 638 (March 17, 2001).

n23 See, *Voluntary Euthanasia Society article*, *supra* note 21.

n24 *Id.*

n25 *Id.*

n26 Id.

n27 Minderjarige mag euthanasie vragen, NRC Handelsblad July 10, 1999, at 3. See also Marilyn Gardner, Dutch poised to legalize euthanasia, The Christian Science Monitor June 30, 2000. <http://www.csmonitor.com/durable/2000/06/28/text/pls4.html>, Id., supra note 21.

n28 Dutch call off aided suicide for children, The International Herald-Tribune and The Associated Press, July 15, 2000.

n29 Henk Jochemsen, Update: The Legalization of Euthanasia in the Netherlands, 17 Ethics & Medicine 12, no.1 (2001).

n30 Id.

n31 Jim Persels, "Forcing the Issue of Physician- assisted Suicide," 14 J. Legal Med. 105 (1993), citing note 99.

n32 Id.

n33 Charles F. McKhann, A Time to Die: The Place for Physician Assistance 122 (New Haven, Conn.: Yale University Press, 1999). The Postma case was the best known prosecution during this period of a person who killed another at the latter's request, but it wasn't the only one. There were at least three other prosecutions for violations of Articles 293 or 294. Cf. Carlos F. Gomez, Regulating Death 28-32 (New York: The Free Press, 1991); also see Griffiths, Bood and Weyers, supra note 1, at 53.

n34 <http://www.euthanasia.org/dutch.html>

n35 See Persels, supra note 31, at 106.

n36 Id.

n37 Id.

n38 Id; See Griffiths, Bood and Weyers, supra note 1, at 58-59. See also <http://www.euthanasia.org/dutch.html>

n39 See Persels, supra note 31, at 107.

n40 Id.

n41 Id.

n42 Id.

n43 Id.

n44 Id.

n45 *Nederlandse Jurisprudentie*, no. 106 (1985). See also, Griffiths, Bood and Weyers, *supra* note 1, at 18-19, 62-63, 322-328; See also, Sneiderman and Verhoef, *supra* note 14, at 388-392; Julia Belian, *Deference to Doctors in Dutch Euthanasia Law*, 10 *Emory Int'l. L. Rev.* 255-295 (Spring 1996), in URL: <http://www.law.emory.edu/EILR/volumes/spring96/belia>.

n46 <http://www.euthanasia.org/dutch.html>

n47 The case is described in detail by Griffiths , Bood and Weyers, et al, *supra* note 1, at 63-65.

n48 *Ibid.*

n49 See Persels, *supra* note 31, at 107.

n50 *Nederlandse Jurisprudentie* no. 709 (1985); Griffiths et al., *supra* note 1, at 66-67.

n51 See Sneiderman and Verhoef, *supra* note 14, at 392.

n52 Sneiderman, *supra* note 14, at 396-97.

n53 *Id.* at 398.

n54 *Id.* at 397.

n55 Jos Welie, *The Medical Exceptions: Physicians, Euthanasia and the Dutch Criminal Law*, 17 *J. Med. & Phil.* 419, 430 (1992).

n56 *Id.* at 431.

n57 *Id.* at 431-32.

n58 Sneiderman, *supra* note 14, at 393-94.

n59 *Id.* at 393-95.

n60 *Id.* at 396.

n61 Two important precedents, Prins and Kadijk, are not considered here because the scope of this paper is limited to adults whereas they were concerned with the termination of life of severely defective newborn babies. Cf. Griffiths et al., *supra* note 1, at 83-4, 341-51. For further deliberation, see A. van der Heide et al., *Medical End-of-Life Decisions Made for Neonates and Infants in the Netherlands*, 350 *Lancet*, 251-255 no. 9070 (1997); Henk Jochemsen, *Dutch Court Decisions on Nonvoluntary Euthanasia Critically Reviewed*, 13 *Issues in L. & Med.* 447, 450-58 (1998); Arlene Judith Klotzko, *What Kind of Life? What Kind of Death? An Interview with Dr. Henk Prins*, in *Asking to Die* 388-406 (David C. Thomasma, et al. eds., Dordrecht: Kluwer Academic Publishers, 1998).

n62 Dr. Herbert Hendin, a well-known practitioner of euthanasia in the Netherlands, explains that all of the cases that have broken new ground in Dutch law involved women by saying that women can make an appeal to a doctor that is stronger, more existential. See Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 *Issues in L. & Med.* 123, 137 (1994). In general, more euthanasia cases are found in women than in men. Cf. Gerrit van der Wal and Paul J. van der Maas, *Empirical Research on Euthanasia and Other Medical End-of-Life Decisions and the Euthanasia Notification Procedure*, in *Asking to Die* 157 (David C. Thomasma, et al. eds., Dordrecht: Kluwer Academic Publishers, 1998).

n63 Johanna H. Groenewoud et al., *Physician-assisted Death in Psychiatric Practice in the Netherlands*, 336 *New England Journal of Medicine* 1795, 1797 (1997).

n64 Herbert Hendin, *Seduced by Death* 60-61 (New York: W.W. Norton, 1997).

n65 Sneiderman, *supra* note 14, at 400. For further account, see Hendin, *supra* note 62, at 145-52.

n66 I am grateful for Dr. Chabot for sending me excerpts from Mrs. Bosscher's farewell letter (on July 16, 2000).

n67 Letter from Dr. Boudewijn Chabot, to Author (Aug. 14, 2000) (on file with author).

n68 Interview with Arlene Judith Klotzko and Dr. Boudewijn Chabot, 4 Cambridge Q. of Healthcare Ethics 241-42 (1995) [hereinafter Cambridge Quarterly Interview].

n69 Id. at 244.

n70 Id. at 246.

n71 Letter from Dr. Boudewijn Chabot to Author, *supra* note 67.

n72 Sneiderman, *supra* note 14, at 402. According to Hendin, two of the experts did not recommend Dr. Chabot to assist in her suicide. See Hendin, *supra* note 62, at 147. I asked Chabot about this discrepancy, and he explained "both Sneiderman and Hendin are right; they simply refer to different moments in the process." Sneiderman refers to the period when Mrs. B. was still alive, whereas Hendin refers to the later phase, when the Medical Disciplinary Board invited another expert to give his opinion and he disagreed with Chabot. Strictly speaking, this latter expert was not consulted by Chabot. Letter from Dr. Boudewijn Chabot to Author, *supra* note 67.

n73 Personal Communication by Dr. Chabot, dated June 5, 1999.

n74 Hendin, *supra* note 62, at 147. See also Cambridge Quarterly Interview, *supra* note 61.

n75 Hendin, *supra* note 62, at 150.

n76 Sneiderman, *supra* note 14, at 402.

n77 Sneiderman, *supra* note 14, at 403. See also Gene Kaufmann, State v. Chabot: A Euthanasia Case from the Netherlands, 20 Ohio N.U. L. Rev. 815 (1994).

n78 656 *Nederlandse Jurisprudentie* (1994); John Griffiths, Assisted Suicide in the Netherlands: The Chabot Case, 58 Mod. L. Rev. 232, 239 (1995).

n79 John Griffiths, *Assisted Suicide in the Netherlands: Postscript to Chabot*, 58 Mod. L. Rev. 895, 896 (1995). See also http://www.bz.minbuza.nl/English/Policy/c_eutheng-A.htm.

n80 Cambridge Quarterly Interview, *supra* note 68.

n81 Simon Chesterman, *Last Rights: Euthanasia, the Sanctity of Life, and the Law in the Netherlands and the Northern Territory of Australia*, 47 Int'l & Comp. L.Q. 362, 377-78 (April 1998). For further discussion on euthanasia in the Netherlands, see Raphael Cohen-Almagor, *An Outsider's View on the Dutch Euthanasia Policy and Practice*, 17 Issues L. & Med. 35 (2001). Alternatively, see also Raphael Cohen-Almagor, *The Right to Die With Dignity: An Argument in Ethics, Medicine, and Law*, ch.7 (NJ.: Rutgers University Press, 2001).

n82 Tony Sheldon, *Dutch GP Cleared after Helping to End Man's 'Hopeless Existence'*, 321 Brit. Med. J. at 1174 (2000).

n83 *Id.*

n84 Cf. Tony Sheldon, *Dutch GP Found Guilty of Murder Faces No Penalty*, 322 Brit. Med. J. at 509 (2001).

n85 Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 Am. J. Psychiatry at 599. (2000).