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# A COMPARATIVE ANALYSIS OF THE RIGHT TO DIE IN THE NETHERLANDS AND THE UNITED STATES AFTER *CRUZAN*: REASSESSING THE RIGHT OF SELF- DETERMINATION

Julie A. DiCamillo\*

## INTRODUCTION

The development of medical technology has enabled the medical profession to prolong life, using life-sustaining treatment, to an extent that has never before been possible.<sup>1</sup> When life-sustaining treatment is the only means by which one is kept alive, the individual confronts a choice between continuing to live through the use of life-support and allowing a natural death to occur.<sup>2</sup> The freedom to choose to forego unwanted medical treatment, however, is not an absolute right.<sup>3</sup> The freedom must be balanced against the state's interest in preserving the sanctity of human life, as well as by other interests that the state considers important.<sup>4</sup>

The debate in the United States focuses on an individual's right to forego unwanted life-sustaining treatment, or passive euthanasia.<sup>5</sup> More recently, a related debate in the United States has concentrated

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1. John L. Capone, *Bartling v. Superior Court: The Final Transgression of A Patient's Right to Die?*, 35 CASE W. RES. 764, 764 (1985).

2. See *infra* notes 149-53, 165-67, 180-87, 190-91 and accompanying text (discussing cases involving an individual's choice to forego life-sustaining treatment).

3. See *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2852-54 (1990) (explaining the countervailing state interest in preserving life).

4. James Bopp, *Nutrition and Hydration for Patients: The Constitutional Aspects*, 4 ISSUES IN LAW & MED. 3, 22 (1988).

5. Mustafa D. Sayid, Note, *Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States*, 6 B.C. INT'L & COMP. L. REV. 533, 556 (1983). The term euthanasia derives from the Greek words "eu," meaning painless and easy, and "thanatos," meaning death. *Id.* at 536. Black's Law Dictionary defines euthanasia as an "act or practice of painlessly putting to death persons suffering from [an] incurable and distressing disease as an act of mercy." BLACK'S LAW DICTIONARY 554 (6th ed. 1990). The term "passive euthanasia" refers to the withdrawal of life-sustaining treatment from a terminally-ill patient. See Sayid at 539 (defining passive euthanasia).

on active euthanasia.<sup>6</sup> Active euthanasia is defined as an individual's wish to take active measures to end one's life when a grave illness has caused pain and suffering.<sup>7</sup>

While the controversy in the United States primarily centers on passive euthanasia, with active euthanasia recently becoming more widely discussed, the debate in the Netherlands focuses largely on the issue of active euthanasia.<sup>8</sup> Although euthanasia is technically illegal in the Netherlands, no prosecutions result if certain guidelines are followed.<sup>9</sup> This policy contrasts sharply with those of most other countries, where active euthanasia is less tolerated.<sup>10</sup> The implementation of this policy

6. See *infra* notes 208-34 and accompanying text (discussing the issue of active euthanasia in the United States).

7. See Sayid, *supra* note 5, at 539 (defining active euthanasia as the affirmative act of rendering a life-terminating agent). In addition to the distinction between active and passive euthanasia, a distinction is also made between voluntary and involuntary euthanasia. *Id.* at 536-37. Voluntary euthanasia involves consent by the patient or by the patient's family speaking on behalf of the patient. *Id.* Involuntary euthanasia occurs when the patient is unable to consent. *Id.* at 537.

In the United States, the active-passive distinction is irrelevant in determining an individual's liability for involuntary euthanasia. Dana E. Hirsch, Note, *Euthanasia: Is It Murder or Mercy Killing? A Comparison of the Criminal Laws in the United States, the Netherlands and Switzerland*, 12 LOY. L.A. INT'L & COMP. L.J. 821, 824 (1990). Involuntary euthanasia constitutes homicide because it involves the taking of another's life against that person's will. *Id.* However, the active-passive distinction is more important in an analysis of voluntary euthanasia. *Id.* While active euthanasia in the United States is typically classified as murder, passive euthanasia is permitted in most states. See *id.* at 824-26 n.22 (stating that the following states have held that a patient may refuse medical treatment: Arizona, California, Connecticut, Florida, Illinois, Maine, Massachusetts, New Jersey).

8. See *infra* notes 27-104 and accompanying text (discussing the issue of active euthanasia in the Netherlands).

9. Judgment of Feb. 21, 1973, District Court Leeuwarden N.J. 1973, No. 183, (Neth.), reprinted in part in *Euthanasia Case Leeuwarden-1973*, 3 ISSUES IN LAW & MED. 439 (1988) [hereinafter *Leeuwarden*]; see *infra* notes 33-42 and accompanying text (discussing *Leeuwarden* decision).

10. Ph. Schepens, *Euthanasia: Our Own Future?*, 3 ISSUES IN LAW & MED. 371, 381 (1988). Traditionally, euthanasia has not been popular in Europe outside the Netherlands. *Id.* This is due largely to the ethical codes of the national medical associations, which are strict in their opposition to euthanasia. *Id.* Although the European Code of Ethics represents an ambivalent view regarding euthanasia, the European Community Medical Association and its Standing Committee strongly rejected efforts by Dutch pro-euthanasia physicians who sought to gain European support. *Id.* at 381-82.

Recent developments have reflected growing dissatisfaction with the ban on active euthanasia. The European Parliament has adopted a resolution allowing doctors to comply with the express and repeated requests of competent patients to end their lives. *What is the 'good death'?*, THE ECONOMIST, July 20, 1991, at 21. The full Parliament is to debate whether the proposal should become a directive for the countries of the European Community. *Id.*

In England, euthanasia remains illegal despite attempts to enact enabling legislation. See Peter Doherty, *Euthanasia and the Right to Die*, LAW AND JUSTICE 60, 63-65 (1983) (discussing the right to die in Great Britain). The British Parliament failed to

has not been without problems.<sup>11</sup> In some cases involuntary deaths have

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enact the bills due largely to vague definitions of terms and administrative problems. *Id.*; see also B. Sluyters, *Euthanasia in the Netherlands*, 57 MEDICO-LEGAL J. 34, 34-35 (1989) (discussing euthanasia in Great Britain and the Netherlands). The British Medical Association has clearly condemned active euthanasia. *Id.*

The Penal Codes of Switzerland and Germany are unique in that they consider motive to be a key element in determining culpability. See Sayid, *supra* note 5, at 547 (discussing German and Swiss Penal Codes). These countries take into account the actor's motive in determining the severity of the substantive crime and in sentencing the individual. *Id.* Therefore, if applied to euthanasia, a court of law would look at the totality of the circumstances surrounding the termination of life and not just at the act itself. *Id.* at 548. These countries adhere to the theory that the motive for the criminal conduct reflects the character of the actor, and, therefore, is a reliable indication of whether the actor will repeat the criminal act. *Id.* at 549. Both the Codes of Switzerland and Germany mitigate the penalty of an individual who performs euthanasia if the deceased requested death. *Id.* at 548-49.

Under the German Penal Code, one can be convicted of murder only if one commits the killing with "base motives," which are construed as crimes committed out of greed, lust for killing, or to satisfy a sexual urge. *Id.* at 550. Therefore, because a physician who performs euthanasia presumably does so out of sympathy and desire to help others ease their suffering, the physician would not be convicted for murder. *Id.* at 550-51. Rather, the physician would be convicted as a "manslayer," which carries a much shorter term. *Id.*

The Swiss Penal Code also places emphasis on motive. A "depraved mind" is considered a true indication of a murderer. *Id.* at 551. The Swiss Penal Code allows the court to consider honorable motives directly in mitigating the sentence. *Id.* This is in contrast to the German Penal Code, where an honorable motive is taken into account as an extenuating circumstance. *Id.* at 552. Furthermore, both the Swiss and German Penal Codes contain provisions allowing for mitigated sentences for homicides committed upon request. *Id.* at 552-53.

Outside Europe, euthanasia has generally been viewed in a negative light. For example, in Canada, the Criminal Code effectively makes euthanasia illegal. Fran Carnerie, *Euthanasia and Self Determinism: Is There a Charter Right to Die in Canada?*, 32 MCGILL L.J. 300, 308-12 (1987). A constitutional debate has arisen as to whether the Canadian Charter of Rights and Freedoms guarantees an implicit right to die. See *id.* at 310-12 (arguing that the Charter implicitly guarantees an individual's right to terminate life-sustaining treatment).

While surveys indicate that a majority of Chinese support the practice of euthanasia, and while legislative proposals for its legalization have been presented, fear of abuse resulting from legalization has curtailed its enactment into law. *Mercy Killing Doctor Awaits Judgment - China Debates*, Reuters Library Report, Aug. 28, 1990, available in LEXIS, Nexis Library, Omni File. Despite the illegal status of euthanasia, a court in China decided its first case in May 1991, reaching a finding of not guilty in a mercy killing, following four years of legal debate. *Chinese Court Finds Mercy Killers Innocent In Landmark Case*, Reuters Library Report, May 8, 1991, available in LEXIS, Nexis Library, Omni File. A physician administered lethal injections to a woman who suffered from a painful illness, after her son requested the physician to do so to end her misery. *Id.* Both the physician and the woman's son were found not guilty. *Id.*

The Dalai Lama, the leader of Tibetan Buddhism, has expressed the view that euthanasia should be performed only when it is in the patient's best interest or when it benefits "larger society." *Dalai Lama Says Abortion, Euthanasia Sometimes Okay*, Reuters Library Report, Apr. 1, 1991, available in LEXIS, Nexis Library, Omni File.

11. See *infra* notes 77-104 and accompanying text (discussing the problems associated with loosely enforced provisions allowing active euthanasia).

resulted where physicians have administered death-inducing drugs without the individual's consent.<sup>12</sup>

Although one may contrast the United States' passive euthanasia debate with the Dutch active euthanasia controversy, the distinction between passive and active euthanasia is one that some scholars argue is illusory.<sup>13</sup> They assert that no substantive difference exists between passive and active euthanasia because both ultimately result in death.<sup>14</sup> Thus, the logical corollary of allowing passive euthanasia is to permit active euthanasia as well.

Perhaps more important than attempting to reconcile the difference in Dutch and American debates is understanding that the entire euthanasia controversy has a common underlying theme: the impact on an individual's right of self-determination. In the Netherlands, the acceptance of active euthanasia recognizes an individual's right of self-determination.<sup>15</sup> In contrast, the illegal status of active euthanasia in the United States<sup>16</sup> does not recognize such a right. When addressing passive euthanasia, many states acknowledge the role of a surrogate decisionmaker in exercising an incompetent individual's right of self-determination.<sup>17</sup> The United States Supreme Court, however, has ruled that a state may require a high evidentiary burden to demonstrate the individual's own wishes prior to recognizing the authority of a surrogate decisionmaker.<sup>18</sup> Thus, an individual's right of self-determination is not assured, even where passive euthanasia is permitted.

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12. I. van der Sluis, *The Practice of Euthanasia in The Netherlands*, Lecture given at Conference on Euthanasia and the Future of Medicine, Clark University, Worcester, Massachusetts, Oct. 24-25, 1988, *printed in 4 ISSUES IN LAW & MED.* 455, 460-61 (1988); *see infra* notes 86-92 and accompanying text (discussing euthanasia without the individual's consent).

13. *See* Sayid, *supra* note 5, at 539-40 (stating that many commentators question the distinction between active and passive euthanasia). Other scholars take the opposing view that a distinction should be made between an act and an omission to act. *Id.* at 540. While passive euthanasia can be considered an omission to act (an omission to maintain life-support), active euthanasia is an affirmative act of killing. *Id.*

However, one can also argue that the removal of life-support is itself an affirmative act. Lynn T. Nerland, Note, *A Cry For Help: A Comparison of Voluntary, Active Euthanasia Law*, 13 HASTINGS INT'L AND COMP. L. REV. 115, 117 (1989).

14. *See* Sayid, *supra* note 5, at 539-40 (stating that there is no distinction between active and passive euthanasia because the outcome is identical for both).

15. *See infra* notes 27, 62, 72 and accompanying text (describing the right of self-determination recognized by courts in the Netherlands).

16. *See infra* note 210 and accompanying text (discussing the illegal status of active euthanasia in the United States).

17. *See infra* notes 180-92 and accompanying text (discussing state cases recognizing the authority of a surrogate decisionmaker).

18. *See infra* note 146-47 and accompanying text (describing the holding of a recent Supreme Court decision).

This note offers a comparison of the issues surrounding the right to die debate in the United States and the Netherlands. Insofar as the issues in both countries ultimately concern an individual's right of self-determination, a comparison of the impact of euthanasia law on the right of self-determination is merited. Part I examines the active euthanasia movement in the Netherlands, focusing on the Dutch Penal Code, case law, and euthanasia in practice.<sup>19</sup> Part II explores the right to die debate in the United States, with an analysis of case law and recent legislation on the issue of passive euthanasia, and a survey of recent developments surrounding the issue of active euthanasia.<sup>20</sup> With regard to passive euthanasia, Part III proposes that an individual's right of self-determination can be best maintained if family members or other surrogate decisionmakers are permitted to exercise the patient's right to refuse treatment when the individual is incompetent to do so.<sup>21</sup> Part III also suggests guidelines for legalizing active euthanasia.<sup>22</sup> The Dutch experience serves as a useful basis for developing a system of legalized active euthanasia. Legalization, however, need not give rise to the types of abuses manifested in the Netherlands. Part III describes a system through which abuses can be kept to a minimum while safeguarding an individual's right of self-determination.<sup>23</sup>

## I. THE NETHERLANDS: LAXITY IN ENFORCING GUIDELINES PERMITTING EUTHANASIA

### A. THE DUTCH PENAL CODE AND THE FIRST EUTHANASIA CASE

In the Netherlands, many people adhere to the tenet that any type of behavior is tolerated, provided that it does not harm another person.<sup>24</sup>

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19. See *infra* notes 24-104 and accompanying text (examining active euthanasia in the Netherlands).

20. See *infra* notes 105-234 and accompanying text (analyzing euthanasia issues in the United States).

21. See *infra* notes 241-47 and accompanying text (proposing that surrogate decisionmakers should be able to exercise an incompetent individual's rights).

22. See *infra* notes 250-60 and accompanying text (proposing guidelines to minimize abuses of legalized active euthanasia).

23. See *infra* notes 248-60 and accompanying text (describing a program for active euthanasia).

24. See Peter Zisser, Note, *Euthanasia and the Right to Die: Holland and the United States Face The Dilemma*, 9 N.Y.L. SCH. J. INT'L & COMP. L., 361, 363 (1988) (describing Dutch culture). Prostitution and drug use are among the types of conduct that fall within the ambit of this concept. *Id.* The Dutch have traditionally tolerated these activities, subject to certain guidelines. *Id.* Prostitution is limited to a "red light" district in Amsterdam. *Id.* Drug use, although previously allowed in a particular geographic area in Amsterdam, has been further limited and monitored in recent years. *Id.*

The Dutch have adopted a cultural view that all problems ought to be confronted openly, regardless of the inherent complications in doing so.<sup>25</sup> Furthermore, the Dutch have been inclined to incorporate the resolution of a problem into the law.<sup>26</sup> The practice of euthanasia in the Netherlands, which is based on the right of self-determination,<sup>27</sup> has been approached in such a manner.<sup>28</sup>

The Dutch Penal Code, article 293, prohibits euthanasia;<sup>29</sup> article 294 outlaws assisted suicide.<sup>30</sup> Nevertheless, thousands of cases of euthanasia occur annually in the Netherlands<sup>31</sup> and the doctors who per-

25. Zisser, *supra* note 24, at 363.

26. *Id.*

27. See *infra* notes 62, 72 and accompanying text (discussing Dutch case law permitting the practice of euthanasia based on the right of self-determination).

28. Zisser, *supra* note 24, at 363.

29. Marian H.N. Driesse et al., *Euthanasie en het recht in Nederland [Euthanasia and the Law in the Netherlands]*, in OP LEVEN EN DOOD [A MATTER OF LIFE AND DEATH], translated in part in Marian H.N. Driesse et al. *Euthanasia and the Law in the Netherlands*, 3 ISSUES IN LAW & MED. 385, 386 (1988) [hereinafter Driesse]. The Dutch Penal Code describes euthanasia and its punishment as follows: "He who robs another of life at his express and serious wish, is punished with a prison sentence of at most twelve years or a fine of the fifth category." The fine consists of approximately 50,000 U.S. dollars. *Id.*

30. Driesse, *supra* note 29, at 385-86. Article 294 of the Dutch Penal Code provides a prison sentence for assisted suicide: "He who deliberately incites another to suicide, assists him therein or provides him with the means, is punished, if the suicide follows, with a sentence of at most three years or a fine of the fourth category." *Id.*

In the opinion of some scholars of the Dutch Penal Code, Articles 293 and 294 reflect the general climate of the late nineteenth century. *Id.* Charles Darwin developed the theory of evolution in the middle of the nineteenth century, which gave rise shortly thereafter to Social Darwinism. *Id.* This theory contemplated that man's interference with natural selection caused the destruction of the human race. *Id.* During the period in which the Dutch Penal Code was enacted, the suicide rate in Europe was high and many expressed a wish to die. *Id.* Thus, the lawmakers, while recognizing the qualitative distinction between murder and euthanasia, had as their objective the punishment of blatant manifestations of disrespect for human life. *Id.* at 386-87.

31. See Richard Fenigsen, *A Case Against Dutch Euthanasia*, 19 HASTINGS CENTER REP. 22, 22 (1989) (discussing estimates of instances of Dutch euthanasia). No precise figure is available for the number of cases of voluntary, active euthanasia performed annually. *Id.*

While general practitioners perform an estimated 5,000 cases each year, an estimated 6,000-10,000 are performed by physicians in hospitals. *Id.* Some authorities, however, have alluded to figures as high as 18,000-20,000 cases of euthanasia per year. *Id.*

To illustrate the magnitude of euthanasia in the Netherlands, these cases account for a significant portion of the approximate 120,000 deaths that occur annually. See C.I. Dessaur & C.J.C. Rutenfrans, *Mag De Dokter Doden? [May the Doctor Kill?]* (Dr. Walter Lagerwey trans., 1986), reprinted in part in C.I. Dessaur & Rutenfrans, *The Present Day Practice of Euthanasia*, 3 ISSUES IN LAW & MED. 399, 399 (1988) (discussing total deaths and total cases of euthanasia, both voluntary and involuntary in the Netherlands).

Interestingly, 81 percent of Dutch general practitioners have performed active euthanasia at least once during their careers. Fenigsen, *supra* at 22. Moreover, 28 percent of

form them almost always go unprosecuted.<sup>32</sup> In 1973, the Leeuwarden District Court decided the first case dealing with euthanasia.<sup>33</sup> In that case, a physician administered a fatal dose of morphine to her seventy-eight year old mother who had been paralyzed by a stroke.<sup>34</sup> The physician's mother had repeatedly expressed her wish to die.<sup>35</sup> Although the court convicted the physician, she was sentenced to just one week in jail.<sup>36</sup> The court ruled that active voluntary euthanasia is not a punishable offense if certain conditions are met.<sup>37</sup> First, it must concern a patient who is incurable because of illness or accident.<sup>38</sup> Second, the patient must consider the suffering (either physical or spiritual) to be intolerable.<sup>39</sup> Third, the patient must express in writing a wish to terminate his or her life.<sup>40</sup> Fourth, a physician must make a medical determination that the dying phase has set in.<sup>41</sup> Finally, the action must be taken by or in consultation with the attending physician or specialist.<sup>42</sup>

The Leeuwarden Court held that if the patient satisfied the five conditions, the doctor could administer life-shortening agents to alleviate

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this group of doctors perform active euthanasia on two patients annually, and 14 percent perform euthanasia on three to five patients annually. *Id.*

Active euthanasia ends the lives of 11.2 percent of Dutch AIDS patients. *Id.*

32. See Fenigsen, *supra* note 31, at 23 (stating that each year, public prosecutors investigate only eleven of 5,000-20,000 euthanasia cases). The low rate of prosecution is partially attributable to a high incidence of falsifying death certificates. See Barry A. Bostrom, *Euthanasia in the Netherlands: A Model for the United States?*, 4 ISSUES IN LAW & MED. 467, 482 (1985) (discussing reasons why so few cases of euthanasia are actually prosecuted). The low prosecution rate is also a function of the difficulties that arise when the Public Prosecutors are cast into the role of quasi-legislators, attempting to determine whether the physicians acted within the guidelines of permissible euthanasia. *Id.*

33. *Leeuwarden*, *supra* note 9, at 439. The judicial system in the Netherlands consists of four levels. Zisser, *supra* note 24, at 365 n.53. First, the Cantonal Court adjudicates minor offenses, including most civil cases. *Id.* There are sixty-two Cantonal Courts, broken down geographically. *Id.* Second, the District Court adjudicates criminal cases involving felonies, civil cases outside the jurisdiction of the Cantonal Courts, and all appeals from Cantonal Courts. *Id.* There are nineteen District Courts, each overseeing three or four Cantons. *Id.* Third, five Courts of Appeals adjudicate appeals from the District Courts. *Id.* Finally, the Supreme Court is the court of final resort and decides only issues of law. *Id.*

34. *Leeuwarden*, *supra* note 9, at 440-41.

35. *Id.*

36. *Id.* at 442.

37. See *id.* at 439 (describing five conditions required for euthanasia to be performed legally).

38. See *id.* (explaining the condition that the patient must suffer from an incurable medical illness).

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*



the patient's suffering.<sup>43</sup> The court, however, drew a distinction between medicine administered to relieve suffering, a side effect of which is the death of the patient,<sup>44</sup> and medicine administered in a large dose for the purpose of inducing death.<sup>45</sup> The court's decision proved to be quite limiting;<sup>46</sup> the doctor could prescribe medicine only to alleviate suffering, although death would be the ultimate effect.<sup>47</sup> Furthermore, the court's guidelines required an incurable illness, a written request, and a terminal condition.<sup>48</sup> Thus, although the court took initial steps in allowing euthanasia, it greatly restricted the circumstances under which it would be permitted.<sup>49</sup>

#### B. CONDITIONS REQUIRED BY SUBSEQUENT COURT DECISIONS

In all Dutch cases decided between 1973 and 1983, the courts demanded two conditions to allow euthanasia to be performed.<sup>50</sup> First, the request to die must be a product of the patient's free will.<sup>51</sup> Second, the patient must consider the condition to be intolerable.<sup>52</sup> Some courts added a third condition compelling the physician to confer with a colleague.<sup>53</sup> Since 1984, the courts have standardized their criteria to include all three conditions.<sup>54</sup>

The Dutch Medical Association (Royal Netherlands Association for the Promotion of Medicine (KNMG)), in cooperation with the Nurses' Union, expanded and refined the judicial guidelines.<sup>55</sup> Their guidelines

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43. See Bostrom, *supra* note 32, at 474 (providing an analysis of the *Leeuwarden* decision).

44. *Id.*

45. *Id.*

46. *Id.*

47. See *id.* (analyzing the effect of the court's ruling).

48. *Id.*

49. See *id.* (evaluating the effect of the *Leeuwarden* decision). In 1981, the District Court in Rotterdam adopted criteria similar to those set forth by the court of Leeuwarden, but applied them instead to the crime of assisted suicide. Zisser, *supra* note 24, at 366.

50. M.A.M. de Wachter, *Active Euthanasia in the Netherlands*, 262 JAMA 3316, 3317 (1989).

51. *Id.* The patient must initiate the request for euthanasia. *Id.* In addition, the family cannot pressure the patient to request euthanasia, and the patient's requests must be persistent and consistent. *Id.* A patient's mere wish to die is insufficient to satisfy the required conditions. *Id.*

52. *Id.* A medical determination of the patient's suffering is required to avoid the subjectivity inherent in the patient's own assessment of pain. *Id.*

53. *Id.*

54. *Id.* In addition, some courts have required other criteria, such as the existence of an incurable disease or that the patient's death must not impose undue suffering on others. *Id.*

55. Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG) [The Royal Netherlands Association for the Promotion of Medicine] and

require neither the patient to be near death due to a terminal illness, nor the patient's wishes to be in writing.<sup>56</sup> Therefore, the KNMG and the Nurses' Union lack criteria that can be confirmed as a precaution against abuses of euthanasia.<sup>57</sup> One authority has noted, however, that compared to certain legislative proposals for the performance of euthanasia, the guidelines appear to be conservative in their requirements.<sup>58</sup> Some legislative proposals for legalizing euthanasia have advocated a more liberal approach in allowing euthanasia than have the Dutch Medical Association guidelines.<sup>59</sup>

### C. RULING BY THE SUPREME COURT OF THE NETHERLANDS

In 1984, the Supreme Court of the Netherlands heard its first case on euthanasia.<sup>60</sup> The Alkmaar District Court had acquitted a doctor who terminated the life of an elderly patient who had requested death.<sup>61</sup> In reaching its decision, the court relied heavily on the pa-

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Het Beterschap belangenvereniging voor verpleegkundigen en verzorgenden [Recovery, Interest Association of Nurses and Nursing Aids], *reprinted in Guidelines For Euthanasia*, 3 ISSUES IN LAW & MED. 429, 431-33 (1988). The guidelines established by the KNMG and the Nurses' Union require five elements. First, the request for euthanasia must be voluntary and must be made by a patient competent to articulate his or her wishes. *Id.* Second, the request must be well-considered and alternative options must be examined. *Id.* Third, the patient must persistently express a wish to die. *Id.* Fourth, the patient must experience "persistent, unbearable, and hopeless" suffering. *Id.* Fifth, the doctor must consult with at least one other doctor regarding the patient's request to terminate life. *Id.*

56. See Bostrom, *supra* note 32, at 472 (examining the guidelines proposed by the Dutch Medical Association and the Nurses' Union).

57. *Id.*

58. *Id.*

59. See *id.* (describing alternative proposals for legalizing euthanasia). For example, the General Health Council issued a "Proposal of Advice Concerning Carefulness Requirements In The Performance of Euthanasia." *Id.* at 472. This proposal presented the following guidelines: (1) the doctor must notify the patient of the diagnosis and possible medical treatments; (2) both the doctor and the patient must understand the request for death to be voluntary; (3) the doctor may perform euthanasia on an incompetent patient if the patient had previously prepared a written request; (4) the doctor must discuss the situation with a colleague; (5) the doctor must keep a record of the case for five years; (6) if the patient is under sixteen years of age, euthanasia may be performed without parental consent if the minor asserts a valid objection to the doctor notifying them. *Id.* at 472-73.

This far-reaching proposal allows euthanasia to be performed on individuals who are not terminally ill, those who are incapable of making a decision regarding their health, and those who are under sixteen years of age without parental approval. See *id.* at 473 (interpreting the proposal of the General Health Council). Moreover, the proposal does not require intolerable suffering or imminent death. *Id.*

60. J.K.M. Gevers, *Legal Developments Concerning Active Euthanasia On Request in the Netherlands*, 1 BIOETHICS 156, 159 (1987).

61. Feber, *De wederwaardigheden van artikel 293 van het Wetboek van Strafrecht vanaf 1981 tot heden* [The Vicissitudes of Article 293 of the Penal Code from 1981 to

tient's right of self-determination.<sup>62</sup> On appeal, the Amsterdam Court of Appeals reversed the Alkmaar decision and found the doctor guilty, but set no punishment.<sup>63</sup>

The Supreme Court of the Netherlands vacated the decision by the Amsterdam Court of Appeals, stating that the latter had failed to examine whether an emergency existed according to conscientious medical opinion under the current guidelines of medical ethics.<sup>64</sup> The Supreme Court then referred the case to the High Court of the Hague.<sup>65</sup> In doing so, the Supreme Court requested that the High Court of the Hague assess whether euthanasia may be considered legal in a situation of necessity, based on an "objective medical perspective."<sup>66</sup> The High Court of the Hague gave its judgment in 1986 and acquitted the doctor.<sup>67</sup> In assessing the instructions by the Supreme Court, it held that euthanasia may be justified if the patient is in dire distress<sup>68</sup> and wishes to "die with dignity."<sup>69</sup> In reaching its decision, however, the Court substituted the term "reasonable medical insight" for "objective medical perspective," the term used by the Supreme Court.<sup>70</sup>

According to the Advocate General at the Court of Justice in The Hague, the court decision expands the group of individuals who can undergo euthanasia by requiring that a patient must wish to "die with dignity."<sup>71</sup> "Dying with dignity" is a determination made by the patient, thus recognizing the patient's right of self-determination.<sup>72</sup> The Advocate General expressed fear that the decision would lead to wide-

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*the Present*], in *Euthanasie Knelpunten In Een Discussie [Euthanasia: Bottlenecks in a Discussion]* 54-81, reviewed in Abstracts, 3 ISSUES IN LAW & MED. 455, 456 (1988).

62. *Id.*

63. *Id.* at 457.

64. *Id.* at 457-58.

65. *Id.* at 458.

66. *See id.* (discussing the issues that the Supreme Court requested the High Court of the Hague to address).

67. *Id.* at 462.

68. Judgment of Oct. 21, 1986, High Court (Penal Chamber) N.J. 1987, no. 607 (Neth.), reviewed in Nota Bene, *The High Court of the Hague, Case No. 79065, Oct. 21, 1986*, 3 ISSUES IN LAW AND MED. 445 (1988). *See also* Barry Bostrom & Walter Lagerway, *Court of the Hague (Penal Chamber) Apr. 2, 1987*, 3 ISSUES IN LAW AND MED. 451, 451-52 (1988) (stating that in a later case, the Court held that when death results from active euthanasia, the death certificate cannot state natural cause as the cause of death). The Court reasoned that if euthanasia is to be practiced, it must be done openly, in order to facilitate investigations if necessary. *Id.*

69. *See* Feber, *supra* note 61, at 461-63 (discussing the decision by the High Court of The Hague).

70. *Id.*; *see also infra* note 75 and accompanying text (comparing the reasonable and objective standards).

71. *See id.* at 461 (analyzing the effect of the court's ruling).

72. *Id.* at 461-63.

spread occurrences of euthanasia.<sup>73</sup> In his opinion, the ruling produces a flexible standard that could result in a more widespread practice of euthanasia.<sup>74</sup> By adopting the standard that euthanasia should be performed using "reasonable" rather than "objective" medical insight, what is deemed "reasonable" is somewhat subjective and may vary among medical experts.<sup>75</sup>

#### D. DUTCH EUTHANASIA IN PRACTICE

Dutch case law provides that if physicians act within the guidelines set by the courts, they will not be prosecuted despite the Penal Code's sanction on euthanasia.<sup>76</sup> It must be reiterated, however, that in actual practice very few doctors are prosecuted regardless of whether the guidelines are strictly followed.<sup>77</sup> Although the courts have taken a fairly liberal stance by allowing euthanasia under certain circumstances, the Penal Code directly conflicts with the courts' tolerance of euthanasia.<sup>78</sup>

Several groups have unsuccessfully attempted to change the Penal Code to bring it into compliance with the actual practice of euthanasia.<sup>79</sup> For example, several government officials, as well as the Royal Netherlands Association for the Promotion of Medicine (KNMG) and the Nurses' Union, have tried to legalize euthanasia.<sup>80</sup> Despite the lack of formal legislation, however, euthanasia is a generally accepted prac-

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73. See *id.* at 461 (expressing Feber's fear that euthanasia will become extensive). Feber worries that if courts in the Netherlands allow euthanasia in cases of mental anguish, it will greatly increase the number of euthanasia cases. *Id.* This is particularly likely because the courts have generally remained conservative in the face of growing public acceptance of euthanasia. *Id.*

74. *Id.* at 462-63.

75. See *id.* (discussing the implications of the decision by the High Court of The Hague).

76. See *supra* notes 37-42, 50-57 and accompanying text (examining the judicially-imposed guidelines and those of the KNMG).

77. See Fenigsen, *supra* note 31, at 23 (noting the limited prosecution of euthanasia in the Netherlands). Despite the occurrence of 5,000 to 20,000 cases of euthanasia annually, public prosecutors investigate approximately eleven cases per year. *Id.*

78. See *supra* notes 29-30, 37 and accompanying text (discussing the Dutch Penal Code and the *Leeuwarden* decision setting forth guidelines under which euthanasia is permitted).

79. See Schepens, *supra* note 10, at 374-76 (discussing efforts to legalize euthanasia in the Netherlands).

80. In 1984, a member of Parliament unsuccessfully introduced a bill that would legalize euthanasia. *Id.* at 375. In 1985, the State Commission on Euthanasia recommended changing the Penal Code to provide that a doctor who practiced euthanasia should not be punished if certain conditions were met. *Id.* In addition, the Dutch Minister of Justice and the Minister of Well-Being, Public Health and Culture sent a letter with a draft bill to the President of the Lower Chamber of Parliament. *Id.* This effort was also unsuccessful. *Id.* at 375-76.

tice.<sup>81</sup> Physicians, hospital boards, nurses, Health Ministry administrators, and some judicial and political officials have openly accepted it.<sup>82</sup>

The acceptance of euthanasia may appear to be a positive step toward recognizing the rights of individuals to choose their own fate.<sup>83</sup> The High Court of The Hague, in accordance with the Supreme Court's instructions, recognized an individual's right of self-determination when it held that a physician can perform euthanasia when a patient is in "dire distress" and expresses a wish to die.<sup>84</sup> Several scholars of Dutch euthanasia believe that the acceptance of euthanasia in the Netherlands, however, has led to abuses that have resulted in an ironic reversal of individual autonomy for some.<sup>85</sup> Involuntary euthanasia is not an uncommon occurrence,<sup>86</sup> despite the guideline requirements that the patient must request it.<sup>87</sup> In many instances, the patient has not clearly expressed a wish to die.<sup>88</sup> Not infrequently, family members request euthanasia for the patient without the patient's consent.<sup>89</sup>

Some experts on Dutch euthanasia assert that voluntary euthanasia is inextricably connected to involuntary euthanasia.<sup>90</sup> Two Dutch scholars have reported that a startling ninety percent of euthanasia cases are

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In 1987, the KNMG and the Nurses' Union issued a joint proposal unequivocally advocating active euthanasia and detailing an allocation of duties between nurses and physicians. *Id.* at 378. Furthermore, in 1987 the Royal Netherlands Society for the Promotion of Pharmacy, an organization that includes most of the pharmacists in the Netherlands, distributed a pamphlet containing all the drugs and mixtures that could be used to perform euthanasia. *Id.* The Society designed the pamphlet for use by members of the KNMG. *Id.*

81. *Id.* at 378.

82. *Id.*

83. See Gevers, *supra* note 60, at 156-57 (stating that if the decision to perform euthanasia is made by a knowledgeable, coherent patient, no legal difficulties arise).

84. See *supra* notes 71-72 and accompanying text (discussing the right of self-determination recognized by the High Court of the Hague in its ruling expanding the group of individuals that can undergo euthanasia).

85. See Bostrom, *supra* note 32, at 477 (stating that the widespread practice of euthanasia has caused some to worry that it has become involuntary).

86. See van der Sluis, *supra* note 12, at 460-61 (elaborating on several accounts of involuntary euthanasia).

87. See *supra* notes 37-42, 51-57 and accompanying text (detailing euthanasia guidelines).

88. See van der Sluis, *supra* note 12, at 461 (detailing an account of euthanasia coaxed by the wife of a cancer patient).

89. *Id.* at 462. Family members may address the subject of euthanasia with the physician without the patient's knowledge. *Id.* (citing C. Spreeuwenberg, Huisarts en Stervenshulp (1981) (unpublished doctrinal thesis at Utrecht)).

90. See Fenigsen, *supra* note 31, at 24 (discussing the phenomenon of involuntary euthanasia); see also Schepens, *supra* note 10, at 378-79 (indicating the danger of involuntary euthanasia). Some doctors have become autonomous judges deciding who should live and who should die. *Id.* at 379. Such physicians are usually found innocent if brought to trial because they have followed the correct guidelines for the practice of euthanasia. *Id.*

involuntary.<sup>91</sup> Yet another scholar has labeled Dutch euthanasia "uncontrollable."<sup>92</sup>

One survey of older persons interviewed in nursing homes indicated that between fifty and sixty percent feared involuntary euthanasia, and ninety-five percent opposed its legalization.<sup>93</sup> One study of Dutch euthanasia indicated that voluntary euthanasia is accompanied by crypthanasia, described as active euthanasia on sick people without their consent.<sup>94</sup> The acceptance of euthanasia has resulted in the involuntary deaths of broader categories of patients who do not meet the guideline requirements.<sup>95</sup> Such occurrences are well known in medical

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91. See Dessaur & Rutenfrans, *supra* note 31, at 402 (discussing euthanasia statistics in the Netherlands). According to these scholars, the arguments put forth by proponents of the movement to legalize euthanasia are invalid. *Id.* at 405. For example, proponents have typically argued that euthanasia should be made statutorily legal to reflect its daily practice. *Id.* The scholars point out, however, that such an argument must fail because it would be senseless to argue, by analogy, that murder should be legal because of the frequency of its occurrence. *Id.* More importantly, the scholars argue that widespread use of involuntary euthanasia should not be used to substantiate a legitimate need for the legalization of voluntary euthanasia. *Id.* Furthermore, the guidelines already established by the legal system will protect physicians involved in euthanasia that is actually voluntary.

92. See Bostrom, *supra* note 32, at 477 (quoting the author's view).

93. *Id.* In response to this fear and opposition, The Netherlands Patient Organization was formed, which serves to alert ill persons and their families that involuntary euthanasia is performed in some hospitals. *Id.* at 478.

94. See Fenigsen, *supra* note 31, at 25 (describing crypthanasia). According to two polls, 77% of the Dutch public approves of involuntary euthanasia. *Id.* A book by H.W.A. Hilhorst, titled EUTHANASIA IN THE HOSPITAL (in Dutch), includes the results of euthanasia studies conducted in eight hospitals. *Id.* The author discusses cases of involuntary, active euthanasia on adults and children, and concludes that crypthanasia is not a phenomenon that occurs only sporadically. *Id.*

At a senior citizens' home at the Hague, for example, a doctor killed 21 men and women without their consent. van der Sluis, *supra* note 12, at 463. The doctor believed he acted in a beneficial way, helping the elderly die peacefully and painlessly. *Id.*

The doctor pleaded guilty to only five of the 21 killings, was accused of only four, and convicted of only three. Fenigsen, *supra* note 31, at 25. The vice-president of the KNMG and the former attorney general at the Supreme Court supported the doctor. *Id.* Similarly, four nurses who admitted killing several unconscious patients in a hospital received support from the hospital and other groups. *Id.* The Amsterdam court released the nurses from custody, concluding that their conduct was the result of humane considerations to alleviate the patients' suffering. *Id.*

Thus, it is apparent that several of the Netherlands' highest authorities feel little disdain for euthanasia and may even look upon it favorably. *Id.* The advisor to the Dutch government on judicial aspects of euthanasia stated that the government decided to keep cases of crypthanasia out of the prohibitive reach of the criminal code. *Id.* Further, the Dutch Society for Voluntary Euthanasia advocates active euthanasia on demented elderly, unconscious victims of road accidents, and some handicapped children. *Id.* at 25. A scholar of Dutch euthanasia noted the "widely shared convictions that people's lives may be cut short whenever there are good reasons for doing so." *Id.* at 26.

95. See Bostrom, *supra* note 32, at 473 (arguing that euthanasia, as practiced in the Netherlands, far exceeds the KNMG guidelines). But see Henk Rigter, *Euthanasia*

circles.<sup>96</sup> There exists a widespread practice of intentionally denying certain groups of people needed medical care.<sup>97</sup> Handicapped babies, the elderly, and single people without close family are among those whose lives have been taken against their will.<sup>98</sup> Euthanasia advocates rationalize these deaths on grounds that the individual's best interest is served.<sup>99</sup> They further argue that society should not be burdened with keeping such groups of people alive.<sup>100</sup>

In summary, although euthanasia is technically illegal in the Netherlands, physicians will not be prosecuted if they act within judicially created guidelines.<sup>101</sup> In practice, however, fewer prosecutions occur under the guidelines than should.<sup>102</sup> Although some authorities deny that euthanasia has been abused to the point that involuntary euthana-

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*in the Netherlands: Distinguishing Facts from Fiction*, 19 HASTINGS CTR. REP. 31, 32 (Jan./Feb. 1989) (repudiating the view that active euthanasia is widespread and uncontrollable).

96. See Bostrom, *supra* note 32, at 480 (asserting that the prevailing attitude is reflected in the pressure placed on patients to voluntarily request euthanasia). Physicians who are strong advocates of euthanasia often convince their patients that their futures will be long and painful, and that death would be a less painful solution. *Id.* The patient inevitably becomes distraught and may, under these circumstances, "voluntarily" choose to die. *Id.*

97. See Fenigsen, *supra* note 31, at 24 (discussing the intentional denial of medical treatment to certain groups of people).

98. See *id.* at 24 (citing examples where certain groups of people were intentionally denied medical treatment). With regard to euthanasia performed on handicapped babies, an analogous debate in the United States concerns women having abortions after discovering that their child will be handicapped. See *Spencer v. Seikel*, 742 P.2d 1126, 1128-29 (Okla. 1987) (holding a physician not liable on a negligence theory for failing to disclose material information concerning abortion as a course of treatment after discovering that the woman's fetus suffered a severe brain development abnormality). See also *Learning Terrible Truths; Heart Wrenching Choices After Testing Fetuses For Gene Defects*, NEWSDAY, Oct. 22, 1990, at 7 (discussing a woman's choice to have an abortion after being informed by her doctor that her baby suffered from a serious chromosome abnormality).

99. See Fenigsen, *supra* note 31, at 24 (discussing typical justifications offered by doctors in favor of euthanasia).

100. *Id.*

101. See Leeuwarden, *supra* note 9, at 439 (discussing the requirements for legally performing euthanasia). See also *supra* notes 50-54 and accompanying text (discussing euthanasia guidelines).

102. See *supra* note 32 (explaining why few prosecutions occur).

sia has become a problem,<sup>103</sup> the perceptions and assessments of those who believe the contrary<sup>104</sup> should not be cursorily discounted.

## II. EUTHANASIA IN THE UNITED STATES: A CLASH BETWEEN JUDICIAL RESTRAINT AND POPULAR PREFERENCE

### A. PASSIVE EUTHANASIA, OR THE RIGHT TO HAVE LIFE-SUSTAINING TREATMENT REMOVED

#### 1. *Sources of the Right to Refuse Treatment*

The right to refuse medical treatment stems from two sources: the common law right of bodily self-determination,<sup>105</sup> and the constitutional right to privacy.<sup>106</sup> The right of bodily self-determination reflects the concept that individuals have an interest in being free from invasions of their bodily integrity.<sup>107</sup> At common law, nonconsensual touching constituted a battery.<sup>108</sup> The doctrine of informed consent developed to protect an individual's interest in bodily integrity.<sup>109</sup> Informed consent stipulates that a patient must be able to reason and make vol-

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103. See Rieger, *supra* note 95, at 31 (repudiating the existence of widespread abuses of euthanasia). In response to those who may believe that economic motives in reducing health care costs are intertwined with the practice of euthanasia, at least one authority has disputed this belief. *Id.* at 32. Because the Netherlands has a well-funded health care system, physicians do not have an economic motive to reduce costs by advocating euthanasia. *Id.*

104. See *supra* notes 85-100 and accompanying text (describing the view that euthanasia in the Netherlands has been abused).

105. See *infra* notes 107-11 and accompanying text (describing the right of self-determination); see also *supra* notes 27, 62, 72 and accompanying text (asserting that the right to terminate one's life is based on the right of self-determination in the Netherlands).

106. See generally *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (explicating sources of the right to refuse treatment). In addition, the right to refuse medical treatment is sometimes based on the constitutional right to religious freedom. See Hirsch, *supra* note 7, at 827 (discussing the right of self-determination, the constitutional right to privacy, and the constitutional right of religious freedom as sources of the right to refuse treatment).

107. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977) (noting that "the law recognizes the individual interest in preserving 'the inviolability of his person'") (citation omitted). As early as 1914, Judge Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ." *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

108. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS*, § 9, at 39 (5th ed. 1984) (discussing the tort of battery).

109. See *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985) (discussing the doctrine of informed consent).



untary judgments, and that the patient must clearly understand the nature of the illness, including the risks and benefits of alternative treatments.<sup>110</sup> Several state courts have based the right to refuse life-sustaining treatment on the common law right of informed consent.<sup>111</sup>

The second source of the right to refuse medical treatment lies in the constitutional right to privacy.<sup>112</sup> Although the Constitution does not explicitly enumerate a privacy interest, the courts have recognized such a privacy right in certain circumstances.<sup>113</sup> The California Court of Appeals in *Bouvia v. Superior Court*,<sup>114</sup> for example, held that the Constitution guarantees the privacy right of a competent adult to refuse medical treatment, even when the treatment could save or prolong life.<sup>115</sup> Several courts have recognized the right to refuse life-sustaining treatment based on the constitutional right to privacy.<sup>116</sup> An individual's right to refuse medical treatment, however, is not absolute,<sup>117</sup> and must be balanced against the interests of the state.<sup>118</sup>

110. *Id.*

111. See, e.g., *In re Estate of Longeway*, 549 N.E.2d 292, 301 (Ill. 1989) (holding that the common law right to refuse medical treatment includes the termination of artificial nutrition); *In re Gardner*, 534 A.2d 947, 951 (Me. 1987) (holding that an individual's right to refuse life-sustaining treatment is rooted in the common law doctrine of informed consent); *In re Storar*, 420 N.E.2d 64, 70 (N.Y.) (relying on *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), in asserting the common law right to decline medical treatment, except in cases where the patient is unconscious and where it is necessary to operate before consent can be obtained), *cert. denied*, 454 U.S. 858 (1981).

112. See *Conroy*, 486 A.2d at 1222 (discussing the constitutional right of privacy in relation to the right to make decisions concerning one's body). The right to privacy was first articulated in *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965), which held that married couples may use contraceptives. The Supreme Court extended this right to a woman's choice to terminate a pregnancy in *Roe v. Wade*, 410 U.S. 113, 153 (1973).

113. See, e.g., *Eisenstadt v. Baird*, 405 U.S. 438, 454 (1972) (extending the constitutional right to privacy to nonmarried persons' freedom to use contraception).

114. 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

115. *Id.* at 301. Prior to recognizing a constitutional privacy interest, the Supreme Court recognized a liberty interest in refusing undesired medical treatment. See *Jacobson v. Massachusetts*, 197 U.S. 11, 27-28 (1905) (weighing an individual's liberty interest in refusing smallpox vaccination against the state's interest in preventing disease).

116. See, e.g., *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225 (Cal. Ct. App. 1984) (holding that a patient's right to refuse treatment originates in the constitutional right to privacy); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (holding that the right to refuse treatment is based on a constitutional right to privacy); *In re Quinlan*, 355 A.2d 647, 660, 664 (N.J.) (holding that a patient's guardian may, on the patient's behalf, exercise the patient's constitutionally-based right to refuse life-sustaining treatment), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976).

117. *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985).

118. See *id.* (discussing countervailing state interests in the preservation of life).

## 2. Countervailing State Interests

Courts have typically identified four state interests that must be balanced against an individual's right to refuse medical treatment: the preservation of life,<sup>119</sup> the prevention of suicide,<sup>120</sup> the safeguarding of the medical profession's integrity,<sup>121</sup> and the protection of innocent third parties.<sup>122</sup> The most significant state interest is preserving life,<sup>123</sup> which is composed of two aspects, the state interest in preserving the sanctity of life in general, and the state interest in preserving a particular individual's life.<sup>124</sup> The state's interest in prolonging life must be balanced against an individual's freedom to reject intrusions on bodily integrity and the right to privacy.<sup>125</sup> As the Supreme Court of New Jersey indicated in *In re Quinlan*,<sup>126</sup> the state's interest in preserving life is overcome by the individual's right to privacy as the chances for recovery decline and as the level of bodily invasion increases.<sup>127</sup>

The state's interest in preserving life gives rise to its interest in protecting people from self-destruction, i.e., suicide.<sup>128</sup> The decision to decline life-sustaining treatment, however, is not necessarily an attempt

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119. See *id.* (discussing the state's interest in limiting a person's right to refuse medical treatment).

120. *Id.*

121. *Id.*

122. *Id.*

123. See *id.* (citing The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 23, 32 (1983) [hereinafter President's Commission Report]). Congress established the President's Commission in 1978 for the purpose of proposing guidelines for resolving issues relevant to the right to die debate. *Id.* at 1220. The Commission stated the issue precisely: "Once someone realizes that the time and manner of death are substantially under the control of medical science, he or she wants to be protected against decisions that make death too easy and quick as well as from those that make it too agonizing and prolonged." *Id.* (quoting President's Commission Report at 23).

124. *Id.* at 1223. The state interest in preserving life will not normally outweigh an individual's right to determine life-sustaining treatment when the individual is competent to make the decision. *Id.* Because the life that the state seeks to protect is the life who is making the decision, the state is not attempting to protect a life that cannot protect itself. *Id.* Assuming that the "'sanctity of individual free choice and self-determination [are] fundamental constituents of life,' the value of life may be lessened rather than increased 'by the failure to allow a competent human being the right of choice.'" *Id.* (quoting Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977)).

125. *Saikewicz*, 370 N.E.2d at 427.

126. 355 A.2d 647 (N.J.), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976).

127. *Id.* at 664.

128. *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985).

to commit suicide.<sup>129</sup> Exercising the right to decline treatment reflects an individual's wish to end life in a personally preferred manner.<sup>130</sup> A wish to decline treatment is not necessarily a wish to die, but a wish to be free of unwanted medical treatment.<sup>131</sup>

The third state interest, maintaining the integrity of the medical profession, seeks to ensure that proper medical care is given to those in need.<sup>132</sup> The physician-patient relationship is analogous to a fiduciary relationship whereby the physician has a broad duty to care for the patient.<sup>133</sup> Encompassed within this duty is the physician's obligation to administer life-sustaining nutrition and hydration when necessary.<sup>134</sup> When a physician-patient relationship exists and the patient is dependent on the physician, the state may not deprive a person of the physician's care arbitrarily.<sup>135</sup> Medical ethics, however, do not mandate medical intervention to sustain life at all costs.<sup>136</sup> As the New Jersey Supreme Court noted in *In re Conroy*,<sup>137</sup> there are certain instances when a physician's most appropriate role may be to ease the process of dying, rather than to prolong a painful death.<sup>138</sup>

The state may also have an interest in protecting third parties from the adverse effects of an individual's decision to forego medical treatment.<sup>139</sup> When the health and safety of innocent third parties may be jeopardized, courts will generally give less weight to the individual's right of self-determination.<sup>140</sup> For example, the state may require individuals to undergo medical procedures to protect the public health.<sup>141</sup>

The right of self-determination normally outweighs the foregoing state interests when the situation involves an individual who is compe-

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129. See *id.* (articulating the nuances of the wish to decline life-sustaining treatment).

130. *Id.*

131. *Id.* Specifically, the court stated: "People who refuse life-sustaining medical treatment may not harbor a specific intent to die; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering." *Id.* (citations omitted).

132. Bopp, *supra* note 4, at 5.

133. *Id.*

134. See *id.* (describing the physician-patient relationship). Bopp argues that permitting physicians to withhold nutrition from the patient would undermine the trust that is the traditional keystone in the patient-physician relationship. *Id.*

135. See *id.* at 16 (defending a patient's right to receive medical treatment).

136. *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985).

137. 486 A.2d 1209 (N.J. 1985).

138. *Id.* at 1224-25.

139. *Id.* at 1225.

140. *Id.*

141. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (upholding a Massachusetts law imposing punishment for failure to be vaccinated against the smallpox epidemic).

tent to make health care decisions.<sup>142</sup> When an incompetent individual is involved, however, the situation is less easily resolved because the individual is unable to exercise the right to accept or refuse medical treatment.<sup>143</sup>

### 3. *The Right of Incompetent Individuals to Forego Life-Sustaining Treatment*

#### a. The Supreme Court Decision

In *Cruzan v. Director, Missouri Dep't of Health*,<sup>144</sup> Nancy Cruzan sustained severe injuries in an automobile accident, and later lapsed into a persistent vegetative state.<sup>145</sup> The United States Supreme Court addressed the issue of whether a state may require clear and convincing evidence that such an incompetent individual would have wanted life-sustaining treatment withdrawn.<sup>146</sup> The Court held that a state may require such a standard of proof prior to terminating medical treatment.<sup>147</sup> Therefore, when a state so requires, a patient's family must present clear and convincing evidence of the patient's wishes before making a decision on the patient's behalf.<sup>148</sup>

In reaching its decision, the Court first assessed whether an individual possesses a constitutional right to refuse treatment.<sup>149</sup> Noting that lower courts typically rely on either the doctrine of informed consent or on the constitutional right to privacy, the Court found that a competent person possesses a liberty interest in refusing treatment under the due process clause of the fourteenth amendment.<sup>150</sup> When the individual is

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142. *Conroy*, 486 A.2d at 1225.

143. *Id.* at 1227. Surrogate decisionmakers, acting on behalf of the incompetent patient, must attempt to exercise the full scope of an individual's right of self-determination, which includes both the right to employ or refuse life-sustaining treatment. *Id.*

144. 110 S. Ct. 2841 (1990).

145. *Id.* at 2844-45. A patient in a persistent vegetative state exhibits motor reflexes, but possesses no cognitive abilities. *Id.* at 2842.

146. *Id.* at 2851-52.

147. *Id.* at 2856.

148. *Id.* Justice Rehnquist asserted that since there is no guarantee that the views of close family members would be the same as the patient's, the Constitution does not require the state to accept the decision of a surrogate. *Id.*

149. *Id.* at 2846.

150. *Id.* at 2851. Relying on *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), the Court in *Cruzan* stated that, "[a]lthough many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." *Id.* at 2851 n.7. *But see id.* at 2860-63 (Scalia, J., concurring) (asserting that constitutional rights are not implicated because termination of life-sustaining medical treatment constitutes assisted suicide, which the states are authorized to prevent). This issue was also raised by the dissenting judge in *Brophy v.*

incompetent, however, the "hypothetical"<sup>151</sup> right must be exercised on the patient's behalf.<sup>152</sup> The Court weighed the patient's liberty interest against Missouri's countervailing interests in holding that the state could impose a "clear and convincing" standard of proof before a surrogate could carry out the patient's wishes.<sup>153</sup>

The state of Missouri relied primarily on its interest in preserving life to justify its imposition of the clear and convincing standard of proof.<sup>154</sup> The Court reasoned that the state was entitled to safeguard against abuses of the right to refuse life-sustaining treatment in cases concerning surrogate decisionmakers.<sup>155</sup> For example, the possibility exists that some families would decide to withdraw life-sustaining treatment out of selfish motives.<sup>156</sup> The Court concluded that Missouri could impose a clear and convincing standard of evidence to avoid this problem.<sup>157</sup>

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New England Sinai Hosp., 497 N.E.2d 626 (Mass. 1986), where the court held that the wife of a nonterminally-ill, incompetent man in a persistent vegetative state could decide to order the withdrawal of feeding tubes on his behalf. *Id.* at 638-40. The dissenting judge argued that the majority opinion essentially allowed a suicide to occur. *Id.* at 642-43 (Lynch, J., dissenting).

151. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2852 (1990). Although the majority believed that an incompetent individual possesses the right to refuse treatment, the court labeled it "hypothetical" because the individual is incapable of exercising the right. *Id.*

152. *Id.* at 2852. The Court also held, however, that the Constitution does not require the state of Missouri to accept the substituted judgment of close family members when proof of the patient's own wishes is lacking. *Id.* at 2855.

153. *Id.* at 2852-54. The Court, quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982), stated that "[w]hether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Id.* at 2851-52.

154. *Id.* at 2852-53. The Court emphasized the extremely personal nature of the decision to withdraw life support medical treatment. *Id.* It stated that in order to protect the personal nature of the right, the heightened evidentiary standard adopted by the state of Missouri was appropriate. *Id.* If such a standard were not imposed, the state's ability to protect its interest in preserving life would not be carried through effectively. *Id.* As support for this reasoning, the Court used as an example a situation in which the family would not seek to protect the patient's best interests, but its own interests. *Id.* at 2853 (citing *In re Jobes*, 529 A.2d 434, 477 (N.J. 1987)). In *In re Jobes*, the New Jersey Supreme Court cautioned that "whenever a health-care professional becomes uncertain about whether family members are properly protecting a patient's interests, termination of life sustaining treatment should not occur without the appointment of a guardian." *Jobes*, 529 A.2d at 447.

155. *Cruzan*, 110 S. Ct. at 2853. The Court also stated: "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Id.*

156. *Id.* See *supra* note 154 (noting the possibility that family members may not act in the patient's best interests).

157. *Cruzan*, 110 S. Ct. at 2854. The evidence presented in support of the argument that Nancy Cruzan would have wanted to terminate life support consisted pri-

Justice Sandra Day O'Connor, in a concurring opinion, noted that individual states may develop procedures to safeguard the liberty interests of those who become incompetent.<sup>158</sup> She pointed out that many states do in fact recognize the need for procedural safeguards and often implement the use of "living wills."<sup>159</sup> A living will establishes an individual's preference for withholding life-support medical treatment in the event that one becomes unable to express one's wishes.<sup>160</sup> Several states have enacted durable power of attorney statutes authorizing an individual to appoint a surrogate to make medical decisions in the event that one becomes unable to do so.<sup>161</sup>

Although the ability of the states to recognize the authority of surrogate decisionmakers constitutes a safeguard of an incompetent individual's right to refuse treatment, the decision in *Cruzan* nevertheless permits a state to exert influence on a personal, private matter.<sup>162</sup> The counterargument to the majority's ruling is that the decision to forego

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marily of statements she made to a housemate approximately one year before the accident that left her in a coma. *Id.* at 2855. She remarked at the time that she would not want to live as a "vegetable." *Id.* The Court affirmed the interpretation of the Supreme Court of Missouri that such evidence fails to meet the "clear and convincing" standard. *Id.*

On December 14, 1990, Judge Teel of the Circuit Court of Jasper County, Missouri ruled that new evidence submitted by Nancy Cruzan's family was sufficient to satisfy the "clear and convincing" standard of proof. *See Summary of December 14, 1990 ruling, reprinted in* 6 ISSUES IN LAW & MED. 433 (1991) (reviewing the circuit court's decision subsequent to the Supreme Court's decision in *Cruzan*). Nancy died twelve days following the termination of the artificial feeding. *Id.* at 434.

The impact of the Supreme Court's decision in *Cruzan* has been apparent, at least in the state of Missouri. Christine Busalacchi is a young woman who has been in a persistent vegetative state since the day she suffered head trauma in an automobile accident in 1987. *See In re Busalacchi*, No. 59582, (Mo. Ct. App. Mar. 5, 1991) (LEXIS, States library, MO file). Her father, who was also her court-appointed guardian, wished to transfer her to a facility in Minnesota. *Id.* The state of Missouri alleged that the guardian intended to avoid the clear and convincing standard upheld by the Supreme Court in *Cruzan*. *Id.* The Court decided that because the specific issue was whether the guardian could move his daughter to another state, the case should be remanded to determine whether the patient's needs are being met in Missouri. *Id.* The burden of proof would then shift to the guardian to prove that better care could be provided in Minnesota. *Id.*

158. *Cruzan*, 110 S. Ct. at 2858 (O'Connor, J., concurring).

159. *See id.* at 2858 n.4 (listing states that have adopted living will statutes, thereby permitting an individual to appoint a health care proxy).

160. *See Zisser, supra* note 24, at 374 (discussing living wills).

161. *Cruzan*, 110 S. Ct. at 2857-58 n.2 (O'Connor, J., concurring) (listing states that have adopted durable power of attorney statutes authorizing the appointment of proxies to make health care decisions).

162. *Id.* at 2852 (holding that the state is not required to remain neutral and may affirmatively assert its interest in preserving life); *see* Susan R. Martyn & Henry J. Bourguignon, *Coming to Terms With Death: the Cruzan Case*, 42 HASTINGS L.J. 817, 851-52 (1991) (asserting that the state should be prevented from imposing a substantive standard in a decision concerning life and death).

life-sustaining treatment is an intimate one that properly rests within the scope of private family life.<sup>163</sup> Scholars supporting this argument assert that family members should be able to exercise an incompetent individual's right to refuse medical treatment.<sup>164</sup>

Justice William Brennan, dissenting in *Cruzan*, argued that all persons have a fundamental right to be free of unwanted medical care, stating that this right is not lost simply because one becomes incompetent.<sup>165</sup> He relied on earlier Court decisions that recognized fundamental rights within a family setting.<sup>166</sup> Moreover, he argued that Missouri's requirement of clear and convincing evidence placed an unconstitutional restraint on Nancy Cruzan's right to be free of unwanted medical care.<sup>167</sup>

Although the right to be free of unwanted medical care is not absolute, Justice Brennan contended that state interests should never outweigh it.<sup>168</sup> The state possesses an interest in preventing abuse by sur-

163. Martyn & Bourguignon, *supra* note 162, at 852.

164. See *id.* at 851-54 (arguing that an individual's family members should make the decision whether to terminate life-sustaining treatment).

165. *Cruzan*, 110 S. Ct. at 2867 (Brennan, J., dissenting). Justice Brennan argued that the right to refuse unwanted medical treatment is a fundamental one. *Id.* at 2864. If the right is considered to be fundamental, any countervailing state policy must be very closely tailored to fit the interest that the state seeks to fulfill. *Id.*

Justice Brennan reiterated that the majority opinion openly acknowledged that a competent person has a liberty interest, rooted in the due process clause of the fourteenth amendment, to be free of unwanted medical treatment. *Id.* at 2865. Therefore, Justice Brennan continued, if the right is to be properly considered a liberty interest, it must be fundamental. *Id.* Justice Brennan also observed that the right to refuse unwanted medical care is clearly among those principles "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Id.* (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

As previously noted, the fact that Nancy Cruzan was incompetent to make a decision did not destroy her fundamental right to refuse medical treatment. *Id.* at 2867. Justice Brennan argued that the state is not in a better position than a patient's family to decide what choice the patient would have made. *Id.* at 2877. He contended that "[i]n these unfortunate situations, the bodies and preferences and memories of the victims do not escheat to the State; nor does our Constitution permit the State or any other government to commandeer them." *Id.* at 2878. The State is a stranger to the patient, Justice Brennan continued, whereas "[f]amily members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. . . . It is . . . they who treat the patient as a person, rather than a symbol of a cause." *Id.* at 2877 (quoting *In re Jobes*, 529 A.2d 434, 445 (N.J. 1987)).

166. *Cruzan*, 110 S. Ct. at 2864 (Brennan, J., dissenting). Justice Brennan cites as examples of fundamental rights granted by the Constitution the holdings in *Zablocki v. Redhail*, 434 U.S. 374 (1978) (upholding the fundamental right to marry), and *Moore v. East Cleveland*, 431 U.S. 494 (1977) (upholding the fundamental right to select family living arrangements).

167. *Cruzan*, 110 S. Ct. at 2864 (Brennan, J., dissenting).

168. *Id.* at 2869.

rogate decisionmakers who may not properly consider the patient's interest, but may make a decision based on their own emotional strain.<sup>169</sup> Therefore, the state has a *parens patriae* interest in providing the incompetent patient with procedural safeguards to permit an accurate determination of what the patient would have wanted.<sup>170</sup> As Justice Brennan indicated, however, the imposition of a clear and convincing standard extends beyond the state's power in accomplishing this goal because the standard constitutes an asymmetrical evidentiary burden.<sup>171</sup> No proof is required to support a finding that the patient would wish to continue treatment, but clear and convincing evidence is required to terminate treatment.<sup>172</sup>

Further, two commentators recently asserted that requiring a high evidentiary standard to prevent abuse by a surrogate decisionmaker disregards the state's inability to make personalized decisions.<sup>173</sup> Although allowing family members to decide on behalf of a patient is not error-free, mistakes in judgment that may occur will be individual ones and not made by the state, which knows nothing about the particular patient's needs or desires.<sup>174</sup> Moreover, the state would be acting out of what it perceives to be society's best interests, which are not necessarily the patient's best interests.<sup>175</sup>

Although the particular issue in *Cruzan* pertains to passive euthanasia, while the controversy in the Netherlands focuses on active euthanasia, both involve the right to make the inherently private decision be-

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169. Martyn & Bourguignon, *supra* note 162, at 843-44 n.127 (citing A. Metsel, *THE RIGHT TO DIE* § 6.25, at 167 (1989)).

170. *Cruzan*, 110 S. Ct. at 2871 (Brennan, J., dissenting).

171. *Id.* at 2871-72.

172. *Id.*

173. Martyn & Bourguignon, *supra* note 162, at 845. Assigning decisionmaking to the state increases the risk of error in determining what the patient would have wanted because the state would be incapable of determining the patient's wishes. *Id.* at 846. See also *supra* note 165 (articulating Justice Brennan's argument that family members are better able than the state to ascertain a patient's wishes).

174. Martyn & Bourguignon, *supra* note 162, at 846.

175. *Id.* Justice Brennan also looked beyond the facts of the case, and offered a possible implication of the Court's holding. He reasoned that if the state were to prevail over family members acting on behalf of an individual, this would imply that the state could choose to perform other medical procedures on the patient as long as the patient didn't experience pain. *Cruzan*, 110 S. Ct. at 2869 n.13. Justice Brennan suggested that a kidney could be removed to benefit a third party in need, or other procedures could be performed to benefit others without the consent of the patient or a surrogate. *Id.* See also Martyn & Bourguignon, *supra* note 162, at 845 (arguing that if the state's interests are given priority and the state can mandate life-sustaining treatment, then it also possesses the power to stop such treatment if state interests would be served, thereby destroying groups of people who are sick or dying).



tween life and death.<sup>176</sup> The ultimate consequence of both issues is the impact on an individual's right of self-determination.<sup>177</sup> When a state imposes a high evidentiary standard to determine what an incompetent individual's wishes would be, the Supreme Court's decision in *Cruzan* may signify the potential curtailment of an individual's right of self-determination.<sup>178</sup> This contrasts with the policy in the Netherlands, which recognizes an individual's right of self-determination by allowing an individual to make the personal life and death decision within the boundaries of judicial guidelines.<sup>179</sup>

#### b. State Court Decisions

Cases decided by some state courts prior to the Supreme Court's decision in *Cruzan* recognized the authority of a surrogate to exercise a patient's right to terminate life-sustaining treatment.<sup>180</sup> The New Jersey Supreme Court was the first court to address the issue of euthanasia in *In re Quinlan*.<sup>181</sup> This case involved a woman in a permanent vegetative state, kept alive by a respirator and a feeding tube.<sup>182</sup> The New Jersey Supreme Court held that her father, as her guardian, could exercise her constitutional right to privacy,<sup>183</sup> and allowed him to make

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176. See *supra* notes 33-75, 144-75 and accompanying text (discussing euthanasia in the Netherlands and in the United States).

177. See *supra* notes 62, 72, 108-11 and accompanying text (describing the right of self-determination recognized by Dutch courts and by state court cases).

178. See *supra* notes 165-68 and accompanying text (discussing Justice Brennan's dissent in *Cruzan*).

179. See *supra* notes 33-75 and accompanying text (evaluating court cases in the Netherlands).

180. See *infra* notes 181-92 and accompanying text (discussing selected state court cases).

181. 355 A.2d 647 (N.J.), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976).

182. *Id.* at 654-56. Karen Quinlan had stopped breathing without medical explanation, and later slipped into a comatose state. *Id.* at 653-54. Her doctors diagnosed her as being in a persistent vegetative state, having no cognitive functions, but retaining primitive reflex abilities. *Id.* at 654. The medical experts reached the consensus that she could never be restored to cognitive life. *Id.* at 655.

183. *Id.* at 664. The New Jersey Supreme Court initially noted that the United States Supreme Court recognized a constitutional right to privacy in *Griswold v. Connecticut*, 381 U.S. 479 (1965), where the right to privacy was said to derive from the penumbra of specific guarantees in the Bill of Rights. *Quinlan*, 355 A.2d at 663. The court asserted that the privacy right is broad enough to include an individual's decision to refuse medical treatment under certain circumstances, just as the privacy right has been interpreted to encompass a woman's decision to terminate pregnancy under certain conditions. *Id.* at 663.

The court observed that the state's interest in preserving life could not outweigh Karen Quinlan's right to privacy. *Id.* at 664. Moreover, "[t]he only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she

the decision to withdraw life-sustaining treatment, if both her doctor and the hospital ethics committee concluded that she had no chance of recovery.<sup>184</sup> In so holding, the New Jersey Supreme Court determined that the patient's right to privacy outweighed the state's interest in preserving her life.<sup>185</sup>

The New Jersey Supreme Court in *In re Conroy*,<sup>186</sup> affirmed the *Quinlan* holding that an incompetent individual retains the right to refuse treatment.<sup>187</sup> In contrast to the basis for its decision in *Quinlan*, however, the court relied on the common law right of self-determination rather than on the constitutional right to privacy.<sup>188</sup> The court conducted a detailed analysis that would allow life-sustaining treatment to be withdrawn without requiring any evidence of the patient's wishes so long as the burden of continued treatment outweighed its benefits.<sup>189</sup>

The Supreme Judicial Court of Massachusetts similarly recognized the authority of a surrogate decisionmaker in *Superintendent of Belchertown State School v. Saikewicz*.<sup>190</sup> The court ruled that a probate court could exercise the right to refuse chemotherapy on behalf of a profoundly retarded elderly man with leukemia, provided that the probate court attempted to ascertain what the patient would have wanted under such circumstances.<sup>191</sup> The court based its decision both

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would exercise it in these circumstances." *Id.* The qualification alluded to was that the hospital ethics committee concur in the opinion of Karen's physicians that she had no chance of recovery from her comatose state. *Id.* at 672.

184. *Id.* at 671-72.

185. *Id.* at 663-64.

186. 486 A.2d 1209 (N.J. 1985).

187. *Id.* at 1236.

188. *Id.* at 1223.

189. *See id.* at 1229-37 (describing when the withdrawal of life-support treatment will be permitted). In reaching its decision, the court determined that an incompetent individual's right to refuse treatment could be exercised by a surrogate decisionmaker using one of three standards. The first standard is a subjective one, to be used when clear evidence of the individual's wishes exists. *Id.* at 1229-30. Under the subjective test, the surrogate decisionmaker attempts to determine whether the individual would have wanted life-sustaining treatment removed. *Id.* Clear evidence of the patient's wishes is required. *Id.* The second test is a limited objective test, which is used when some evidence of the individual's wishes exist, but not enough to satisfy the subjective test. *Id.* at 1232. Using this standard, treatment can be terminated when the surrogate decisionmaker takes into account the existing evidence and also ascertains that the burden of continuing life-sustaining treatment outweighs the benefits. *Id.* The third standard is purely objective, which the surrogate decisionmaker would apply when no evidence exists as to what the individual would have wanted. *Id.* at 1232. Using this test, if the burden of treatment outweighs the benefits of living, life-sustaining treatment may be removed. *Id.*

190. 370 N.E.2d 417 (Mass. 1977).

191. *Id.* at 430-32. In *Saikewicz*, the patient was a 67 year old profoundly mentally retarded man with a fatal form of leukemia. *Id.* at 419. The relevant issue was whether he should be given chemotherapy treatment. *Id.* at 420-21. If he were left untreated,

on the constitutional right to privacy and the common law doctrine of informed consent.<sup>192</sup>

c. Significance of State Court Decisions and Justice Brennan's Dissent in *Cruzan*

Justice Brennan's dissent in *Cruzan* and the holdings of state court cases recognize the importance of allowing a surrogate decisionmaker to exercise a patient's right to refuse medical treatment,<sup>193</sup> guaranteed by the constitutional right to privacy and by the common law doctrine of informed consent.<sup>194</sup> Although a state's interest in preserving life is an important one, as Justice Brennan articulated in his dissent, an individual's rights should not be dismissed merely because one has not clearly and convincingly expressed one's wishes with regard to maintaining or removing life-sustaining treatment.<sup>195</sup>

According to the reasoning of the New Jersey Supreme Court in *In re Quinlan*, the only way to safeguard an individual's right to refuse treatment is to permit family members or a guardian to decide on behalf of the patient.<sup>196</sup> The presumption that those who are incompetent to make a decision should not have life-support treatment removed if they fail to meet a clear and convincing evidentiary standard displays a

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the disease would run its natural course and would not inflict any pain on the patient, although he would die within weeks. *Id.* However, if he underwent chemotherapy, he would suffer severe and painful side effects. *Id.* In addition, the patient would be unable to comprehend the reasons for the medical treatment and he would be involuntarily placed in a state of great suffering. *Id.* at 432. Under such circumstances, the court ruled that no state interest prevailed over the patient's right to decline treatment. *Id.* at 435. Further, the probate court had properly considered what the patient's wishes would have been if he had been cognizant of his situation. *Id.* at 431-32.

Compare *Saikewicz*, 370 N.E.2d at 430-32 (allowing a probate court to ascertain the patient's wishes) with *In re Storar*, 420 N.E.2d 64 (N.Y.) (holding that a surrogate decisionmaker could not exercise the patient's right to refuse medical treatment when the patient was a mentally retarded man who had never been fully mentally cognizant, thereby making it impossible to ascertain what the patient's wishes would have been), cert. denied, 454 U.S. 858 (1981). In *In re Eichner*, decided simultaneously with *In re Storar*, the court did not reach the issue of whether a surrogate could exercise the right of a brain-damaged elderly man who was in a persistent vegetative state. *In re Eichner*, 420 N.E.2d 64, 72-73 (N.Y. 1981). The court found clear and convincing evidence that he would not have wanted to be kept alive under such conditions. *Id.*

192. *Saikewicz*, 370 N.E.2d at 431.

193. See *supra* notes 165-92 and accompanying text (discussing a surrogate's authority to exercise an individual's right to refuse medical treatment).

194. See *supra* notes 105-16 and accompanying text (examining the sources of the right to refuse medical treatment).

195. See *supra* notes 165-72 and accompanying text (disputing the Court's argument that a state may impose a clear and convincing evidentiary standard).

196. See *supra* note 183 (describing the New Jersey Supreme Court's view of how an individual's rights are best protected).

disrespect for their human worth.<sup>197</sup> Insofar as the position taken by Justice Brennan in *Cruzan* and by some state courts preserves an individual's right to make personal decisions,<sup>198</sup> the policy is similar in effect to the stance adopted by the judicial system in the Netherlands, which permits an individual to make the intimate decision between life and death.<sup>199</sup>

#### d. The Legislature

As Justice O'Connor discussed in her concurring opinion in *Cruzan*, state legislatures are free to enact living will statutes that allow individuals to appoint proxies to make health care decisions on their behalf in the event that they become unable to do so.<sup>200</sup> The Supreme Court's decision in *Cruzan* gave rise to a heightened concern regarding the legislature's role in recognizing the authority of surrogate decisionmakers.<sup>201</sup> In October 1990, Congress enacted the Patient Self-Determination Act<sup>202</sup> [hereinafter "the Act"], requiring hospitals, nursing homes, and hospices to advise patients of their right to implement an advance directive,<sup>203</sup> indicating their wishes regarding life-support treatment.<sup>204</sup> The Act also requires that health care providers advise patients of their right to accept or refuse medical care.<sup>205</sup> The Act recognizes the priority given to a patient's own preferences, thus reinforcing

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197. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 428 (Mass. 1977). A presumption that incompetent individuals should have life-sustaining treatment maintained in all situations when competent individuals may decide to decline treatment in such situations places a lesser value on the human worth of those who are incompetent. *Id.*

198. See *supra* notes 193-97 and accompanying text (discussing Justice Brennan's dissent and state court cases).

199. See *supra* notes 33-75 and accompanying text (evaluating court cases in the Netherlands).

200. See *supra* notes 158-61 and accompanying text (discussing living wills).

201. See generally Michael D. Cantor, *Learning From the Cruzan Decision: The Need For Advance Directives*, 265 JAMA 1751 (Apr. 3, 1991) (discussing the effects of *Cruzan*).

202. Patient Self-Determination Act, Pub. L. No. 101-508, § 4206, 104 Stat. 1388 (1990) (to be codified at 42 U.S.C. § 1395cc).

203. Margot L. White & John C. Fletcher, *The Patient Self-Determination Act: On Balance, More Help Than Hindrance*, 266 JAMA 410 (July 17, 1991). An advance directive may take the form of a living will or the appointment of a health care proxy. *Id.* at 410.

204. John LaPuma et al., *Advance Directives on Admission: Clinical Implications and Analysis of the Patient Self-Determination Act of 1990*, 266 JAMA 402, 402 (July 17, 1991).

205. White & Fletcher, *supra* note 203, at 410.

ing an individual's right of autonomy.<sup>206</sup> Therefore, while the Act pertains to the issue of passive euthanasia, it is a step toward recognizing individual autonomy, which the Netherlands has already recognized by permitting an individual to choose death by taking active measures.<sup>207</sup>

## B. ACTIVE EUTHANASIA IN THE UNITED STATES

### 1. General Overview

Although most United States case law focuses on passive euthanasia, active euthanasia is a separate issue that is also drawing attention.<sup>208</sup> A concurring opinion in a decision by the California Court of Appeals alluded to the practice of active euthanasia.<sup>209</sup> In the United States, most state statutes classify assisted suicide as murder, manslaughter, or the separate crime of "assisted suicide."<sup>210</sup> For example, in 1986, a jury found a man guilty of premeditated murder when he shot his wife to

206. LaPuma, *supra* note 204, at 403. The Act's provisions may also stimulate family discussions and thereby improve the surrogate decisionmaker's accuracy in representing the patient's wishes if the need arises. *Id.* at 403.

Despite the positive effects that the Act may have, possible drawbacks also exist. *Id.* at 403-04. Barriers to implementation may exist because individuals will not always complete the directives. *Id.* at 403. Further, physicians may feel uncomfortable discussing the options with patients, and instead, the physicians may wait for the patient to initiate the discussion. *Id.* An important negative effect is the tension between the physicians' incentive to contain costs and the need to make an objective decision. *Id.* at 404. The Act is part of the Omnibus Budget Reconciliation Act of 1990, which aims to decrease payments to Medicare-reimbursed providers. *Id.* The Act is expected to decrease provider costs on the assumption that elderly patients in particular will decide to limit expensive treatment. *Id.* Therefore, the possibility exists that health care providers will use the Act as a vehicle for meeting economic goals. *Id.* But cf. Rigger, *supra* note 95, at 32 (asserting that economic goals do not provide an incentive for doctors to advocate euthanasia in the Netherlands).

207. See *supra* notes 27, 62, 72 and accompanying text (discussing individual autonomy recognized by courts in the Netherlands).

208. See Nerland, *supra* note 13 (analyzing voluntary, active euthanasia).

209. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986). The California Court of Appeal permitted a mentally-competent quadriplegic to have a feeding tube removed, after having been confined to a bed and having experienced constant and severe pain. *Id.* at 306. The court asserted that the right to refuse medical treatment was a basic, fundamental right that should not be limited only to terminally-ill patients. *Id.* at 302.

In a concurring opinion, Judge Compton not only agreed with the majority opinion, but also observed that in instances where pain and suffering is very severe, a patient's choice to terminate life should be seen as a relieving process. *Id.* at 307 (Compton, J., concurring). He observed that the right to die is an important part of one's right to control one's destiny, provided that in exercising one's right to die, the rights of others are not harmed. *Id.* Further, he stated that the right to die encompasses one's right to make death painless and easy, and to request assistance in dying from others, including the medical profession. *Id.*

210. 2 WAYNE R. LAFAVE AND AUSTIN W. SCOTT, *SUBSTANTIVE CRIMINAL LAW* § 7.8, at 249-50 (1986).

death to relieve her suffering from Alzheimer's disease and related illnesses.<sup>211</sup> His wife had experienced chronic pain, and had repeatedly asked to die.<sup>212</sup>

Despite the classification of assisted suicide as a criminal act, courts have inconsistently decided cases involving euthanasia.<sup>213</sup> According to one study, forty-eight mercy killings were reported between 1930 and 1960.<sup>214</sup> In seventeen of these cases, the person who performed euthanasia later committed suicide, and in eleven others, the person performing euthanasia was convicted of manslaughter or second degree murder.<sup>215</sup> Five of the forty-eight individuals who performed euthanasia were convicted of first degree murder, while ten were found to be temporarily insane.<sup>216</sup> Only three cases led to acquittals, and just one case was dismissed.<sup>217</sup>

The illegal status of active euthanasia in the United States contrasts sharply with the approach taken in the Netherlands, which allows active euthanasia within the bounds of judicial guidelines.<sup>218</sup> While the Netherlands has recognized an individual's right to decide to end one's life using active measures,<sup>219</sup> the United States has not done so.<sup>220</sup> If one adheres to the position taken by those who argue that no meaningful distinction exists between active and passive euthanasia, since both lead to the same result,<sup>221</sup> then it follows that if passive euthanasia is allowed in recognition of an individual's right of self-determination, then active euthanasia should similarly be permitted. Allowing active euthanasia would acknowledge an individual's right of self-determination, which the Netherlands has recognized.<sup>222</sup>

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211. *Gilbert v. Florida*, 487 So. 2d 1185 (Fla. Dist. Ct. App.), *review denied*, 494 So. 2d 1150 (Fla. 1986). The court sentenced Mr. Gilbert to a term of life imprisonment with no possibility of release until his one-hundredth birthday. *Id.*

212. *Id.*

213. Hirsch, *supra* note 7, at 834.

214. Note, *The Right of the Terminally Ill to Die, With Assistance If Necessary*, 8 CRIM. JUST. J. 403, 414 n.74 (1986), *quoted in* Hirsch, *supra* note 7, at 834 n.79.

215. *Id.*

216. *Id.*

217. *Id.*

218. See *supra* notes 33-75 and accompanying text (discussing Dutch cases allowing active euthanasia).

219. *Id.*

220. See *supra* notes 210-12 and accompanying text (indicating that most states consider active euthanasia illegal).

221. See *supra* notes 13-14 and accompanying text (discussing the view that no distinction should be made between active and passive euthanasia).

222. See *supra* notes 27, 62, 72 and accompanying text (describing the right of self-determination recognized by Dutch courts).

## 2. Recent Developments

Although most state statutes condemn active euthanasia, recent developments suggest that many individuals are dissatisfied with this policy and wish to expand the right of self-determination to include active euthanasia. For example, on July 27, 1991, a grand jury in Rochester, New York declined to indict Dr. Timothy Quill, who had prescribed a barbiturate for a patient who expressed wishes to die after suffering painfully from an incurable blood cancer.<sup>223</sup> Dr. Quill wrote about his role in aiding the patient's death in the *New England Journal of Medicine*, hoping to test the bounds of the legal system and recognizing the need for the public and the legislature to acknowledge the existence of active euthanasia.<sup>224</sup> Many colleagues praised Dr. Quill for making public a largely hidden practice.<sup>225</sup>

In contrast to Dr. Quill's case is that of Dr. Jack Kervorkian, who in 1990 developed a "suicide machine" for patients who wished to relieve their intense suffering.<sup>226</sup> Although the court dismissed a charge of first degree murder against him in the death of a woman who used his machine, he was prohibited from using the suicide machine again.<sup>227</sup> More recently, police arrested Dr. Kervorkian for the deaths of two seriously ill women who also used his suicide machine to end their lives.<sup>228</sup>

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223. Lawrence K. Altman, *Jury Declines to Indict a Doctor Who said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1, col. 2 [hereinafter Altman]; *Her Physician Helped — A Message of Bravery in N.Y. Suicide Case*, SEATTLE TIMES, Mar. 12, 1991, at A8.

224. Altman, *supra* note 223, at A1, col. 2. Dr. Quill stated that he intended to provoke public discussion concerning the treatment of terminally-ill patients. *Id.* However, Dr. Cranford, a physician who opposes active euthanasia, expressed worry that some physicians might abuse the legalization of euthanasia. *Id.* More importantly, Dr. Cranford accurately assessed the importance of Dr. Quill's acquittal: "[I]t reflects a loss of confidence in medicine by the American public and a feeling that they will lose all control over their lives and that their lives will be unduly prolonged." *Id.*

Dr. Quill remarked that his case was "the tip of the iceberg," and that he has heard many stories of other doctors who have acted similarly with their long-suffering patients. *Id.* Speaking about the grand jury's failure to indict Dr. Quill, a spokesperson for the Hemlock Society, a right-to-die organization, stated: "Juries are seeing this conduct as a compassion, a help." *Id.*

225. Altman, *supra* note 223, at A1, col. 2.

226. *Jury Pool to be Quizzed in Assisted Suicide Trial*, Gannett News Service, May 6, 1991, available in LEXIS, Nexis library, Omni file.

227. *Id.*

228. William Douglas, *Murder Charge for MD*, NEWSDAY (Nassau and Suffolk Edition), Feb. 6, 1992, at 3. Other recent developments indicate that the public is becoming increasingly interested in debating the issue of active euthanasia. In another incident, a court acquitted an individual who had helped his terminally-ill wife end her life. *Jury Deliberates in Trial of Suicide Helper*, UPI, May 9, 1991, available in LEXIS, Nexis Library, Omni File; Peter Steinfelds, *Beliefs*, N.Y. TIMES, May 11, 1991, at A1, col. 4. The couple had traveled from California to Michigan, believing that

Euthanasia advocates interpret the heightened awareness of active euthanasia as an indication of the public's unhappiness with the health care system's treatment of terminally ill individuals, and growing sympathy for those who suffer chronic pain as a result of grave illness.<sup>229</sup> Opponents of euthanasia, however, argue that legalized active euthanasia will lead to abuses,<sup>230</sup> such as the Netherlands has experienced.<sup>231</sup> They argue that voluntary euthanasia will give rise to involuntary euthanasia, and lead to a disrespect for the sanctity of human life.<sup>232</sup> Some opponents also argue that the legalization of euthanasia will trump the development of modern medicine.<sup>233</sup> They reason that legalized euthanasia provides fewer incentives for the medical profession to

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assisted suicide was legal in that jurisdiction. *Innocent Verdict Returned: Assisted Suicide Case*, UPI, May 11, 1991, available in LEXIS, Nexis Library, Omni File [hereinafter *Innocent Verdict*]. Derek Humphrey, the national director of the Hemlock Society stated that "[t]he verdict sends a strong signal to legislators that the laws relating to assistance in suicide need urgent and serious reform." *Id.* He also observed, "[t]he public thinks this is an idea whose time has come. Hundreds of people every year illegally help loved ones to die and lawmakers should now take time to carefully modify the laws." *Id.*

The Hemlock Society, founded in 1980, advocates new laws permitting physicians to assist the suicide of dying persons pursuant to strict criteria. *Id.* Washington state, in its November 1991 election, defeated Initiative 119, a law that would have legalized physician-assisted suicide. Philip J. Boyle, *Vote Shows that Euthanasia Debate Will Go On*, LOS ANGELES TIMES, Nov. 9, 1991, at 17, col. 1. The law, however, was defeated by a narrow margin, suggesting that the issue is not a settled matter. *Id.* In California, euthanasia advocates are attempting to place a "Death With Dignity" statute on their state ballot in November 1992. Lynn Smith, *Right-to-Die Movement Gaining, 'Final Exit' Author Says; Suicide: Doctors' Opposition to Assisting in Deaths of the Terminally Ill is Diminishing, Leisure World Supporters Are Told*, LOS ANGELES TIMES (Orange County Edition), Jan. 13, 1992, at 1, col. 2 [hereinafter Smith, *Right-to-Die*].

Perhaps one of the clearest indications of public sentiment on the issue arises from the very high sales of a book entitled FINAL EXIT, written by Derek Humphrey, the executive national director of the Hemlock Society. *Good Morning America* (ABC television broadcast, Aug. 12, 1991). The book describes different ways in which one can commit suicide. *Id.* One medical ethicist who commented on its high sales volume suggested that the sales reflect several sources of discontent among the public: the public's dissatisfaction with the health care system, discontent by society's elderly with respect to how they are treated, and the inappropriateness of using high technology medical treatment. *Id.* The book has sold several hundred thousand copies and is being reprinted in several languages. Smith, *Right-to-Die*, at 1, col. 2.

229. See *Innocent Verdict*, May 11, 1991, *supra* note 228 (giving the opinion of euthanasia advocates).

230. See *supra* notes 86-102 and accompanying text (describing abuses of euthanasia).

231. See *supra* notes 86-102 and accompanying text (discussing euthanasia in the Netherlands).

232. See Fenigsen, *supra* note 31 and accompanying text (arguing that voluntary and involuntary euthanasia are intertwined).

233. Fenigsen, *supra* note 31, at 29.



find cures for diseases.<sup>234</sup> These concerns about legalized active euthanasia are valid ones. They are not, however, logically necessary consequences of legalized active euthanasia. Precautions may be taken to prevent widespread abuses.

### III. RECOMMENDATIONS

A comparison of the euthanasia laws in the Netherlands and in the United States indicates a difference in the particular focus between countries. In addition, the comparison points to disparities between the laws in each country and the actual practice of euthanasia. The underlying common factor is that in both countries, there exists a tension between the state's interest in preserving life and an individual's right of self-determination.<sup>235</sup> In the Netherlands, the recognition of an individual's right of self-determination has led to the acceptance of euthanasia.<sup>236</sup> Laxity in enforcing the guidelines under which euthanasia is permitted, however, has resulted in the denigration of the right of self-determination for those who have fallen victim to abuses.<sup>237</sup>

The tension between the state's interest in preserving life and individual self-determination is also manifested in euthanasia laws in the United States. While many states accept the role of a surrogate decisionmaker acting on behalf of an incompetent individual,<sup>238</sup> the Supreme Court has ruled that a high evidentiary burden may be imposed prior to allowing the authority of a surrogate decisionmaker.<sup>239</sup> The Supreme Court decision in *Cruzan* has tipped the scale in favor of the state's interest in preserving life.<sup>240</sup> Similarly, the illegal status of active euthanasia has placed a restriction on an individual's right of self-determination. This commentary proposes that an individual's right of self-determination can be maintained without resulting in abuses of legalized euthanasia.

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234. *Id.*

235. *See supra* notes 154-56, 168 (discussing the tension between the state's interest in preserving life and an individual's right to refuse treatment in *Cruzan*).

236. *See supra* notes 37-75 and accompanying text (discussing euthanasia in the Netherlands).

237. *See supra* note 90 and accompanying text (examining involuntary euthanasia in the Netherlands).

238. *See supra* notes 180-92 and accompanying text (discussing state court cases recognizing the authority of surrogate decisionmakers).

239. *See supra* note 157 and accompanying text (examining the *Cruzan* holding).

240. *See Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2854 (1990) (concluding that the state may impose a clear and convincing evidentiary standard before accepting the determination of a surrogate decisionmaker).

## A. PASSIVE EUTHANASIA

With respect to passive euthanasia, in cases involving incompetent patients with no prospect of recovery who are being kept alive only through medical technology, the courts should adhere to the substituted judgment of family members.<sup>241</sup> Allowing a state to require a high burden of proof to determine what an individual would have wanted jeopardizes the individual's privacy right and right of self-determination.<sup>242</sup> Just as the Netherlands has recognized an individual's right of self-determination in the analogous life and death decision pertaining to active euthanasia,<sup>243</sup> an individual's right of self-determination would be similarly acknowledged in passive euthanasia cases by allowing family members to exercise the right of an incompetent individual. Such a personal decision ought to be made by those who know the patient best and desire what is in the patient's best interest.<sup>244</sup> The state's interest in preserving life is not absolute and should not outweigh the choice of an individual or of a family member acting on the individual's behalf.<sup>245</sup> Although the state's interests are important,<sup>246</sup> the weight afforded them ought to be diminished in matters that are inherently private in nature.<sup>247</sup>

## B. ACTIVE EUTHANASIA

Legalizing active euthanasia would serve to recognize both an individual's right of privacy<sup>248</sup> and self-determination.<sup>249</sup> Active euthanasia must be strictly controlled, however, because of the possibility that its legalization will lead to the types of abuses that have occurred in the Netherlands. One possible abuse includes laxity in enforcing euthanasia guidelines. A result of this type of abuse could be widespread euthana-

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241. See *supra* notes 163-68, 173-75 and accompanying text (advocating the authority of decisionmakers acting on behalf of incompetent patients).

242. See *supra* note 183 (asserting that an incompetent person's right to privacy is destroyed by not recognizing the authority of surrogate decisionmakers).

243. See *supra* notes 27, 62, 72 and accompanying text (discussing the right of self-determination recognized by Dutch courts).

244. See *supra* notes 164-66 (discussing decisionmaking by family members).

245. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2869 (Brennan, J., dissenting).

246. See *supra* notes 119-41, 169-70 and accompanying text (discussing the nature of state interests).

247. See *supra* notes 162-66 (asserting that the family setting is the appropriate context for making private decisions).

248. See *supra* notes 112-18 and accompanying text (describing the constitutional right to privacy).

249. See *supra* notes 107-11 and accompanying text (describing the right of self-determination).

sia beyond what is legally permissible.<sup>250</sup> Insofar as the threat of involuntary euthanasia exists, legalized active euthanasia could result in an ironic reversal of the right of self-determination for some individuals.<sup>251</sup>

Active euthanasia should be legalized, but it should be performed only within comprehensive guidelines.<sup>252</sup> First, there must be an unequivocal, persistent, and well-considered consent from a patient who is in a chronic state of suffering.<sup>253</sup> Second, the request must be in writing.<sup>254</sup> Third, the physician must determine that there is no prospect for recovery.<sup>255</sup> Fourth, the individual must weigh alternative options.<sup>256</sup> Fifth, a physician must offer carefully monitored assistance.<sup>257</sup> Finally, the physician must obtain the opinion of at least one colleague.<sup>258</sup> The guidelines include objectively verifiable criteria,<sup>259</sup> including a written request and a medical determination that the patient has no hope for

250. See *supra* notes 86-100 and accompanying text (discussing abuses of euthanasia).

251. See *supra* note 90 and accompanying text (asserting that involuntary euthanasia has been a result of allowing voluntary euthanasia in the Netherlands).

252. See, e.g., *supra* notes 56-59 and accompanying text (describing guidelines proposed by the Dutch Medical Association and the Nurses' Union).

253. See *supra* notes 38-40 and accompanying text (describing the analogous requirements set forth by the *Leeuwarden* court). The first criterion, which requires chronic suffering and an incurable illness, ensures both that the individual has no possibility of improvement through medical treatment and that the suffering is severe. See also *Leeuwarden*, *supra* note 9, at 439; *supra* note 41 and accompanying text (describing *Leeuwarden* requirement that the doctor must have determined that the dying phase had set in). This requirement further safeguards against temporary wishes to die by providing that the individual's request to die be persistent.

254. See *Leeuwarden*, *supra* note 9, at 439. See also *supra* notes 40, 48 and accompanying text (noting that the *Leeuwarden* court decision required a written request). The second requirement provides an objective means of verifying the patient's request. See Bostrom, *supra* note 32, at 472 (asserting that a written request is objectively verifiable).

255. See *supra* notes 38, 41 and accompanying text (describing *Leeuwarden* criteria that the patient must have an incurable illness and the dying phase must have set in).

256. See *supra* note 55 (describing the requirement by the Dutch Medical Association and the Nurses' Union that alternatives must be considered).

257. See *Leeuwarden*, *supra* note 9, at 439; see also note 42 and accompanying text (describing the *Leeuwarden* requirement that a doctor must assist euthanasia). The fifth requirement reinforces the concept that euthanasia is a last resort to be undertaken only within a medically-supervised environment.

258. See *supra* notes 50-54 and accompanying text (discussing guidelines that the Dutch courts have adopted since 1984, requiring that a doctor consult a colleague). The final requirement serves to protect both the physician and the patient. See generally de Wachter, *supra* note 50, at 3317 (discussing the advantages of having a physician consult with a colleague). The patient obtains a second opinion regarding the chances of recovery, while the physician is protected against potential liability for giving an incorrect diagnosis. *Id.*

259. See Bostrom, *supra* note 32, at 472 (discussing criteria that are objectively verifiable); but see *supra* notes 56-57 and accompanying text (describing Dutch Medical Association guidelines, which do not include objectively verifiable criteria).

recovery. Since the guidelines are relatively detailed, a federal statute incorporating them, together with legislative history explaining the intent of the law, would likely be the most effective form of legalization.

The most important aspect of allowing active euthanasia is to enforce the guidelines strictly and consistently in order to reduce the possibility of abuse. This may be accomplished by establishing an agency through which all physicians, subject to approval, must register each case prior to assisting the patient's death. Both members of the medical profession and government representatives would have positions in the agency. The membership of government representatives would ensure that the legislation was properly executed. The appropriate punishment for a physician who is discovered violating the regulations could be a long prison sentence. In addition, a system of internal monitoring within the profession would constitute an additional safeguard against abuses.<sup>260</sup> A physician who reports a colleague who is later found to have violated the law would receive some type of benefit, such as a tax credit or a reduction in malpractice insurance.

Such a system could prevent the possible problems of widespread euthanasia being used in inappropriate circumstances, as the Netherlands has experienced. If the Netherlands strictly enforced its own judicial guidelines, the right of self-determination of all individuals would be better served because involuntary euthanasia would be more effectively prevented. Although the enforcement of any law is not without difficulties, if the guidelines are strictly enforced, problems will be minimal.

#### IV. CONCLUSION

Although the Netherlands and the United States focus on different aspects of euthanasia, both countries confront a dilemma concerning where to draw the boundary between honoring the state's interest in preserving life and an individual's right of self-determination. An analysis of the euthanasia experience in the Netherlands provides a helpful basis for determining what might be a useful agenda for legalized active euthanasia. To maintain an individual's rights of self-determination and privacy without engendering abuses, active euthanasia should be legalized and monitored through strictly enforced guidelines. With regard to passive euthanasia, an individual's privacy right and right of self-determination can best be maintained when family members are

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260. See generally de Wachter, *supra* note 50, at 3317 (suggesting that the legal requirements of euthanasia will be met if a colleague has knowledge of another physician's euthanasia case).

permitted to make life and death decisions on behalf of a family member who is unable to do so.