Netherlands

[Excerpted from: *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (CanLII)]

[455] Euthanasia and assisted suicide are governed in the Netherlands by the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, *2002, Stb.* 2001, 194 [the Dutch Act], which came into force in 2002. While both practices are offences under the *Penal Code* (Art. 293-294, Sr.), the Dutch Act creates an exception for physicians who comply with the due care and reporting requirements it prescribes. In describing the regime, I draw on the evidence of Dr. Kimsma, Professor Legemaate, Professor Lewis and Professor Shariff.

[456] The Dutch Act does not differentiate between euthanasia and assisted suicide. "Euthanasia" is used as a compendious term that encompasses both practices. Much of the research concerning the Dutch regime uses the word euthanasia in this way. In order to describe Dutch law and practice accurately, in this section the word "euthanasia" is used as it is in the Netherlands – as a term that includes both euthanasia and physician-assisted suicide.

[457] The Dutch Act is in part the codification of a permissive regime that had developed through a series of judicial decisions and professional guidelines issued over the preceding three decades.

[458] The *Postma* decision (District Court, Leeuwarden, 21 February 1973, N.J. 1973, No. 183), concerned the case of a physician who had administered a lethal dose of morphine to her 78-year old mother who was deaf and partially paralyzed, and had pleaded with her daughter repeatedly to end her life. The doctor was convicted of "death on request" but was sentenced to one week of probation instead of a possible 12-year term of imprisonment. The decision provoked legal discussion regarding the acceptability of active physician involvement in death. Subsequent court decisions confirmed that, under certain circumstances, euthanasia and assisted suicide could be justifiable even though they were offences under criminal law.

[459] The underlying legal reasoning for accepting active physician involvement in death remained unclear until 1984 when the first voluntary euthanasia decision reached the Dutch Supreme Court: *Schoonheim*, Supreme Court, 27 November 1984, N.J. 1985, No. 106. The Court reasoned that notwithstanding the prohibition of the practice in the *Penal Code*, a physician was able to invoke the defence of necessity when confronted with a conflict between his or her duties to preserve life on the one hand and to relieve suffering on the other. If, faced with such conflict, the physician chose a course of action that was objectively justifiable, he or she was not guilty of an offence. The Court held that the criteria for accepting the defence of necessity were to be derived from medical-ethical opinions formulated by the medical profession.

[460] This reasoning provided the foundation for voluntary euthanasia in the Netherlands until the Dutch Act was enacted in 2002. As earlier noted, the Act largely codified the due care criteria which had developed in the jurisprudence. Generally speaking, the criteria were that the patient's wish to die had to be informed and voluntary, and expressed clearly and repeatedly; the patient had to be suffering intolerably and with no hope of relief, though he or she did not have

to be terminally ill; the physician had to consult with at least one other physician; and, the physician had to report the death to the medical examiner.

[461] Unlike many jurisdictions which draw a moral or legal distinction between euthanasia and assisted suicide, the Netherlands treats both alike. "Euthanasia" refers to the termination of life upon request, thus encompassing both practices. Professor Legemaate explains that both the Dutch Act and the case law that preceded it treat euthanasia and assisted suicide the same way, and that the same requirements and procedures apply to each. A physician and patient may choose one or the other, depending on the circumstances at hand, the characteristics of the patient and his medical condition. In cases where a choice can be made, the Royal Dutch Medical Association advises physicians to favour assisted suicide for psychological reasons, but this is not a binding rule.

[462] Under Article 2 of the Dutch Act, a physician who carries out euthanasia is exempt from prosecution under the *Penal Code* if he or she complies with a number of due care criteria. Specifically, the physician must:

(a) be satisfied that the patient's request is voluntary and carefully considered;

(b) be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;

(c) have informed the patient about his or her situation and prospects;

(d) have come to the conclusion, together with the patient, that there is no reasonable alternative in light of the patient's condition;

(e) have consulted at least one other independent physician who must have seen the patient and provided a written opinion on the requirements of due care referred to in (a) to (d) above; and

(f) have terminated the patient's life or assisted with suicide with due medical care and attention.

[463] Regional Review Committees ("RRC"), which review all cases of euthanasia, have fleshed out some of these legislative requirements. For example, they have identified that there must be a sufficient physician-patient relationship to allow the physician to form a judgment concerning the requirements of due care. Similarly, criterion (f) has been interpreted to require the use of the appropriate method, substance and dosage as recommended by professional guidelines, and that the physician stay with the patient until death occurs, or, in the case of physician-assisted suicide, that the physician hand the medication to the patient and remain until the patient is pronounced dead (in case complications should arise).

[464] The requirement for an independent consultation increasingly is being satisfied by consultations with specialized physicians participating in the SCEN (Support and Consultation Regarding Euthanasia in the Netherlands) Project. These physicians are available to advise doctors who are faced with a request for physician-assisted death, and to act as the independent consultant required by the Act. A non-binding best practices protocol has been implemented among SCEN physicians.

[465] The Dutch Act establishes certain reporting requirements. A physician must report an assisted death to the medical examiner using a prescribed form indicating that he or she has complied with the due care criteria. The medical examiner, in turn, is required to conduct an examination of the deceased patient and ascertain the completeness and accuracy of the physician's report. He or she then notifies the relevant RRC.

[466] Five regional RRCs review and evaluate all cases of physician-assisted dying. Each RRC comprises an uneven number of members and must include a physician, a legal expert and an ethicist. The RRC must decide whether the reported instance of physician-assisted dying is within the limits of the Dutch Act or should be referred to the criminal authorities. It is only where the RRC has determined that the due care requirements have not been met that such a referral will be made. According to Dr. Kimsma, the conclusions of the RRCs are published online in the interests of transparency and public accountability.

[467] The RRCs are required to issue a joint annual report which includes information related to number and nature of reported cases, and the opinions and considerations involved.

[468] The Dutch Act is limited to the termination of life upon a patient's request. It does not extend to termination of life without request. A physician is not obligated to comply with a request for euthanasia.

[469] Jurisprudence from Dutch courts remains relevant in defining the permissible scope of euthanasia. Two Supreme Court decisions of note are *Chabot*, Supreme Court, 21 June 1994, N.J. 1994, No. 656, and *Brongersma*, 24 December 2002, Supreme Court, N.J. 2003, No. 167. In the former, the Court confirmed that mental, as well as physical, suffering can justify physician-assisted dying. It cautioned, however, that in such cases, the physician must be "extremely cautious". In *Brongersma*, the Court held that neither the previous rules nor the Dutch Act (the death occurred in 1998 but the case did not reach the Supreme Court until 2002) cover "tired of life" situations. Rather, physicians must limit themselves to requests for physician-assisted dying from patients suffering from a medically classifiable physical or psychiatric sickness or disorder.