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ARTICLE

Mutatis mutandis … On Euthanasia and Advanced Dementia in the Netherlands

Martin Buijsen

Erasmus School of Law and Erasmus School of Health Policy & Management, 3062 PA Rotterdam, The Netherlands
Corresponding author: Email. buijsen@eshpm.eur.nl

Abstract
Euthanasia and physician-assisted suicide are common practice in the Netherlands. In response to increasing requests from patients to end their lives, physicians are finding themselves placed in particularly precarious situations because of advance directives written by patients suffering from severe dementia. In April 2020, the Supreme Court of the Netherlands issued two judgments in the so-called *Dormicum* case: a case involving the deliberate termination of the life of a 74-year-old woman suffering from advanced dementia by a geriatrician in a nursing home in The Hague. The judgment of the lower criminal court was upheld, but the sanction imposed by the appellate disciplinary court was quashed. In this paper, the author reviews the two Supreme Court rulings, argues that both are fundamentally flawed and raises questions as to what they mean for Dutch criminal law, physicians, and patients going forward.

Keywords: euthanasia; physician-assisted suicide; The Netherlands; dementia; advance directive; criminal law

Introduction

On April 21, 2020, a legal battle that had been going on for 4 years finally came to an end. On that date, the Supreme Court of the Netherlands issued its judgments in what has become known as the *Dormicum* case: the deliberate termination of the life of a 74-year-old woman suffering from advanced dementia by a geriatrician in a nursing home in The Hague. Since April 22, 2016, no less than five adjudicating bodies have issued rulings in this case. Each ruling made headlines and boosted public debate. Now that the dust has somewhat settled, it is worthwhile to reflect on the outcomes of the judicial process. After the finding of the facts and the ruling by the Euthanasia Review Committee (hereinafter ERC), criminal as well as disciplinary proceedings were initiated. As the highest competent court in both criminal and disciplinary matters, the Supreme Court ruled twice.[1]

After first laying out the legal framework and presenting the facts of the case and the judicial process, I will examine the Court's reasoning and consider the significance of the two rulings. I will also argue that both are fundamentally flawed.

Legal Framework

The Netherlands is one of the very few countries that have legalized or decriminalized the voluntary termination of life.[2] Under the Dutch law, the termination of life on request (euthanasia) and assisted suicide are criminal offences.[3] Since the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (commonly referred to as the "Euthanasia Act") took effect in 2002, euthanasia and assisted suicide are no longer punishable if they are performed by a physician acting in compliance with

the due care criteria, as laid down in the Euthanasia Act, and who consequently notifies the municipal pathologist.[4] According to the Act the physician must:

1) be satisfied that the patient's request is voluntary and well considered;
2) be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
3) have informed the patient about her situation and her prognosis;
4) have come to the conclusion, together with the patient, that there is no reasonable alternative in her situation;
5) have consulted at least one other independent physician who must see the patient and give a written opinion on whether the due care criteria set out above have been fulfilled; and
6) have exercised due medical care and attention in terminating the patient's life or assisting in her suicide.[5]

These statutory due care criteria are based on the assumption that there is decisional competence on the part of the requesting patient at the moment of euthanasia or suicide. However, the Euthanasia Act does provide for situations in which no such competence exists. The Act also states: "If a patient aged 16 years or older is no longer capable of expressing her will, but prior to reaching this condition, was deemed to be capable of making a reasonable appraisal of her interests, and has drawn up a written advance directive containing a request for termination of life, the physician may carry out this request." And this in turn is followed by: "In such a case, the due care criteria apply *mutatis mutandis*."[6] Now, what does "mutatis mutandis" (roughly translated as "with the necessary changes") mean for a physician who is considering ending the life of a patient who is suffering from severe dementia but has drawn up an advance directive?

Facts and Judicial Process

Notification, Assessment, and Prosecution

The legal framework does not establish a right to euthanasia or assisted suicide. Physicians are not obligated to comply with requests for such. Euthanasia and assisted suicide are criminal offences, for which the Euthanasia Act provides a special ground for exemption from criminal liability. The Act only applies to medical practitioners: it provides the prospect of impunity for physicians treating patients who are suffering unbearably and who for that reason wish to die. Such physicians can find themselves facing conflicting obligations: the protection of life, on the one hand, and relief from suffering and compliance with the patient's wishes, on the other. Before the Euthanasia Act entered into force, Dutch criminal courts had already decided that a physician who opts for the latter can be discharged from prosecution under criminal law on the general grounds of force majeure.[7] The Euthanasia Act (basically the codification of national case law) stipulates that a physician who complies with a request for euthanasia or assisted suicide and who, in doing so, complies with the requirements of due care will be exempt from criminal prosecution. Nonphysicians are not entitled to invoke this special ground for exemption from prosecution.[8]

Whether the physician who performed euthanasia or assisted with suicide has acted in compliance with these requirements is assessed after the event. The physician is obligated to report the facts to the municipal pathologist, who—together with her findings—presents them to the competent ERC. If the ERC concludes that the physician did not act in compliance with the statutory due care criteria, the Public Prosecution Service (hereinafter the PPS) and the Health and Youth Care Inspectorate (hereinafter the Inspectorate) will be notified. These authorities will not be informed if it has reached the opposite conclusion.[9]

Whether or not the PPS decides to prosecute depends on the nature of the requirement that has not been met. Its policy rules differentiate between material and nonmaterial due care criteria. The material ones are the requirements that the request is voluntarily and well considered, and that the suffering is unbearable without prospect of improvement. The other criteria are nonmaterial. The PPS can decide not to prosecute, conditionally or otherwise, in the event of a contravention of a nonmaterial criterion. It will always prosecute when a material requirement of due care has not been met.[10] And that is what it did

in the *Dormicum* case. It was the first case to be criminally prosecuted since the Euthanasia Act came into effect on April 1, 2002. The ERCs have been reporting a handful of cases to the PPS every year since, but until the *Dormicum* case it had never actually proceeded with a criminal prosecution.

The Euthanasia Review Committee

The competent ERC ruled that the geriatrician had not complied with the requirements of due care.[11] To begin with, she could not have concluded unequivocally that the request was voluntary and well considered. Her patient, who suffered from Alzheimer's disease, had never made a verbal request for euthanasia, nor was there a clear written advance directive to that effect.[12]

In light of the patient's history and the oral testimony given by the geriatrician and the patient's general practitioner, the ERC established that the patient was no longer competent when her life was ended, at least not insofar as regards the subject of euthanasia. She had never discussed this subject, nor could she have discussed it, with the geriatrician. By her own admission, the geriatrician decided to terminate her patient's life solely on the basis of the patient's written advance directive.[13]

According to the policies of the ERCs, which set out the practical details of the statutory due care criteria, a written advance directive must make clear that it is unmistakably applicable to the situation that has arisen.[14] The physician then has to take into consideration the patient's entire medical history and all the other specific circumstances. She has to interpret the behavior and the statements of the patient, both during the course of the illness and immediately preceding the performance of the euthanasia. At that moment, it has to be abundantly clear that performing euthanasia is commensurate with the advance directive, and that there are no contraindications (i.e., clear signs that the patient did not want to have her life terminated). At that moment, it will also have to be clear that the patient experiences her suffering as unbearable.[15]

In this case, 4 years before her death and shortly after being diagnosed with Alzheimer's disease, the patient had drawn up a written advance directive with a dementia clause, which she had amended 2.5 years later (in January 2015). The reason why she wanted euthanasia was clear: she did not want to go into a nursing home for elderly people with dementia, and she wanted to say goodbye to her nearest and dearest in a dignified manner before it would be too late. Her own mother had developed dementia at a relatively young age and had spent many years in a nursing home before she died. This experience had seriously traumatized the patient and had caused her entire family tremendous distress. She absolutely did not want to go through this herself.[16]

In the first advance directive, the dementia clause started with the sentence: "I want to exercise my legal right to have voluntary euthanasia performed on me *when I am still somewhat competent and when I am no longer able to live at home with my husband.*"[17] However, it became apparent that the patient had changed her advance directive 1 year before she died. The clause now started as follows: "I want to exercise my legal right to have euthanasia performed on me *when I consider the time right for such.*"[18] And whereas in the earlier advance directive this clause had ended with "Trusting that by the time the quality of my life has reached the situation described above, I be euthanized voluntarily,"[19] in the second advance directive, the last sentence of this clause now read as follows: "Trusting that at such time as the quality of my life has become so poor *that euthanasia be performed at my request.*"[20] Apart from that, the second advance directive was identical to the first one.

In the year prior to her death, the patient had made it clear to her general practitioner on several occasions that she did not want to go into a nursing home and that, if this were to happen, she wanted euthanasia to be performed. According to her general practitioner, the patient had never expressed a desire for immediate euthanasia to be performed. And, although by the end of the year she had apparently frequently said at home that she wanted to die (but always with the addition of "but not now"), she had never actually asked the general practitioner to perform euthanasia. The ERC considered it plausible that the woman had lost her competence to decide on euthanasia during the course of that year. When she was eventually admitted to a nursing home, her husband asked the resident geriatrician to perform euthanasia on the basis of her written advance directive.[21]

The ERC found that there were two mutually exclusive dementia clauses, whereby there was doubt whether or not the patient wanted the written advance directive to replace a verbal request. Taking also into account the fact of the irreversibility of termination of life, the ERC consequently concluded that the physician should have erred on the side of caution. It therefore considered the provisions in the Euthanasia Act in relation to a written advance directive not to be applicable in this case. And, because a verbal request had also not been made, the ERC concluded that the geriatrician had not complied with the first requirement of due care.[22]

As regards the second statutory requirement, the ERC had no difficulty in determining the hopelessness of the patient's situation, since there is no cure for Alzheimer's disease. And, although there was evidence to show that the patient had better moments during her stay in the nursing home—one of the physicians who was called as a witness said that she seemed cheerful and happy when he saw her, and it is apparent from the medical record that, when asked by the geriatrician if she wanted to die, she answered on several occasions something to the effect of "not now, it has not gotten that bad yet!"—the committee nonetheless ruled that the physician could have reasonably held the conviction that the patient experienced her suffering as unbearable. According to the ERC, this requirement does not mean that patients have to suffer unbearably every minute of the day.[23] This is how it applied the second statutory criterion mutatis mutandis in this case.

Did the geriatrician inform her patient about the situation she was in and about her prognosis? No, but the ERC ruled that the patient had been sufficiently informed, by the general practitioner as well as by another geriatric clinician, although she was still decisionally competent and living at home. For all intents and purposes, the way it applied the third requirement mutatis mutandis meant that it was disregarded.[24]

The committee went on to rule that the geriatrician could have come to the conclusion that there was no other reasonable solution for the situation the patient was in. She was suffering because she missed her husband, but it was no longer possible for him to care for her at home, and he could not live with her in the nursing home. Furthermore, she had stated on numerous occasions in the past that she did not want to spend her final days in a nursing home. The geriatrician had also satisfied the requirement of prior consultation, according to the ERC. She had consulted not one, but two other independent physicians, one of whom was a psychiatrist.[25]

Finally, as regards the requirement of due medical care and attention in terminating the patient's life, the committee concluded as follows. First of all, prior to the euthanasia, the geriatrician had put Dormicum (midazolam) in her patient's coffee. This had been done surreptitiously, although it had been discussed with the patient's daughter and husband, in order to deprive the patient of the opportunity to resist the administration of the lethal drug. Furthermore, when the drip was inserted, the patient made a move backwards, and, when the thiopental was being administered, the patient woke up and tried to sit up, upon which her family helped to hold her down so the geriatrician could quickly administer the remainder of the dose. According to the ERC, the physician wrongfully failed to consider whether this could be interpreted as a relevant sign that the patient did not want to have the drip inserted or to be injected with a syringe. Indeed, she should have seriously considered this possibility. The physician should therefore have ceased the procedure in order to consider the situation that had arisen, and she should not have continued with the procedure once the patient had to be held down. The committee emphasized that coercion, or even the appearance of coercion, has to be avoided at all costs.[26]

The ERC's judgment was forwarded to the PPS and the Inspectorate. The latter took action first.

The Disciplinary Courts

The Inspectorate is responsible for the supervision of the quality and safety of the Dutch healthcare system. In the event of any shortcomings, it can take action in various ways. Physicians are subject to statutory disciplinary law, which authorizes the Inspectorate to submit complaints against physicians to a disciplinary board for healthcare.[27] The Regional Disciplinary Board (RDB) for healthcare ruled that

the complaint of the Inspectorate was well-founded and reprimanded the geriatrician.[28] On appeal, the Central Disciplinary Board (CDB) for healthcare reduced this to a warning.[29]

Disciplinary courts adjudicate on the basis of the professional standard.[30] According to the law, patients are entitled to be treated in accordance with this standard.[31] If the disciplinary court determines that a practitioner subject to statutory disciplinary law has not met the professional standard, it can impose a sanction.[32] The severity of the sanction imposed reflects both the importance of the quality standard that has been contravened as well as the extent to which the actions of the practitioner have contravened this standard: the greater the quality shortcoming, the more severe the sanction. A disciplinary sanction is not so much a punishment, although many will experience an imposed disciplinary sanction as retribution, but rather a judgment by the profession about the quality of the actions of one of its members. Statutory disciplinary law is a quality instrument—one should learn from one's mistakes.

In addition to statutory laws and regulations, the professional standard for healthcare professionals mainly consists of professional norms—guidelines, protocols, codes of conduct, and so forth—drawn up by the specific profession of which the healthcare professional is a member. If the caregiver is a physician, the professional standard will primarily consist of norms made by the medical profession itself. It is a typical feature of professional groups that they are granted considerable self-regulatory powers by society.

The guidelines applicable to euthanasia and assisted suicide are unique in one respect. Euthanasia and physician-assisted suicide are not normal medical procedures. If a medical procedure qualifies as normal, the individual professional will be subject to the applicable guidelines. She has no say in the matter. The guidelines for euthanasia and physician-assisted suicide, on the other hand, are only part of the professional standard if the physician wishes them to be a part of it; in other words, if she is willing to perform euthanasia or to provide suicide assistance. Again, at no time is a physician obligated to perform such procedures, since, after all, they are still considered to be criminal offences. But, if a physician does decide to comply with a request for such, she will have to abide by the applicable guidelines in order to fulfil the statutory due care criteria. Therefore, a failure to act in accordance with these guidelines would constitute a violation of her professional standard.

The Inspectorate's complaints were twofold: the requirement of a request by the patient had not been satisfied, and the euthanasia was not performed with due medical care and attention.[33] With respect to the first, the RDB determined that the written advance directive of the patient was not unequivocal and contained inconsistencies. Although the second advance directive made it unmistakably clear that the patient did not want to go into a nursing home, she had clearly incorporated elements of time and personal choice into the amendments that were made ("when I consider the time right for such," "at my request"). According to the RDB, in order for a written advance directive to be followed up, it has to be unambiguous. After all, termination of life is irreversible, and the deliberate ending of another human being's life is morally controversial.[34]

In addition, the disciplinary court objected to the way the various expressions of will of the patient were qualified during her stay in the nursing home. The geriatrician had explicitly stated that she would have gone ahead with euthanasia even if the patient had said that she did not want it. According to the physician, significance could no longer be accorded to any such statements by the patient because she was suffering from dementia. The RDB considered this to be an incorrect assumption from a general point of view, especially in the case of a patient who had not made an unequivocal advance directive.[35] Furthermore, according to the disciplinary board, the policy rules of the ERCs were very clear: any verbal statements made by a decisionally incompetent patient must not be inconsistent with the contents of an advance directive. Patients with dementia also have the right to refuse euthanasia later on.[36]

The disciplinary court did not attempt to qualify the response of the patient to the injection of the drugs, since it considered it no longer possible to determine the meaning of this response.[37] However, the RDB did find it reprehensible that the physician did not even try to discuss her concrete intention to terminate her patient's life with the patient and, instead, just put a sedative in her coffee. The statutory rules that apply for normal medical practice, and even the rules that apply in relation to compulsory

treatment and compulsory medication, stipulate that an attempt has to be made to obtain the permission of the patient first (appropriate to their mental capabilities). This could indeed lead to the euthanasia being postponed, but ultimately a patient still has the right to control her own life, a right that is not lost if she is affected by dementia.[38]

The CDB agreed with this judgment, but nonetheless found that the physician had only acted reprehensibly "to a limited extent."[39] It is apparent from its reasoning that its lowering of the sanction to a warning was primarily motivated by the thoroughness of the examinations carried out by the geriatrician prior to her patient's death and the degree to which other healthcare professionals were involved. She had also sought advice from a number of other professional care providers as well. In addition, the CDB did appear to sympathize with the way the Dormicum was administered.

The District Court

After the CDB had issued its ruling, the District Court of the Hague rendered its judgment in the criminal case.[40] The PPS had principally charged the physician with performing termination of life on request and, alternatively, with murder. But it also asked the District Court not to impose a sanction.[41]

The proceedings in the criminal case centered around the relationship between the way the request is phrased in the Criminal Code itself and the way it is phrased as a requirement of due care in the Euthanasia Act. The PPS was of the opinion that "express and serious desire" (Criminal Code) and "voluntary and well-considered request" (Euthanasia Act) had the same meaning.[42] And, if such a request had not been made, as was established by the ERC (and both disciplinary courts), then the euthanasia could not have taken place on the basis of an express and serious desire, and therefore this would probably constitute murder. After all, the life of the patient was deliberately ended, with or without premeditation, by administering a lethal drug.

The District Court did not agree with this argument. In its opinion, the legislator had deliberately used different phrases in order to make a distinction between different situations with different assessment criteria. The phrases are worded in such a way, according to the District Court, that first and foremost it had to be proven that the termination of life was carried out on the basis of an express and serious desire, and only then could an assessment be made about whether or not the physician had complied with the due care criteria and was entitled to invoke exemption from prosecution. After all, the requirements of due care are laid down in a specific law, the Euthanasia Act, and not in the Criminal Code.[43]

The District Court considered there to be sufficient proof for an express and serious desire on the part of the patient. According to the Court, it was apparent from the discussions in Parliament at the time that the legislator clearly intended that termination of life on the basis of an advance directive should fall within the scope of the Euthanasia Act. And there *was* an advance directive in this case. The dementia clause was perhaps not completely unambiguous, but, if it were to be interpreted such that the patient only wanted euthanasia as long as she could decide the exact moment herself, this would have deprived her advance directive of any meaning. It would reduce it merely to an announcement of a request at a later date, and, according to the District Court, all the evidence showed that this was not the patient's intention.[44]

Was the physician entitled to invoke exemption from prosecution? If the patient's desire for the termination of her life could be qualified as express and serious, was this request then also voluntary and well considered? According to the PPS, it was apparent from the parliamentary proceedings that the first requirement of due care entails that a written advance directive still has to be verified as long as a decisionally incompetent patient is able to make a concrete and coherent statement about whether she wants to live or die. The geriatrician had failed to comply with this.[45]

Initially, it seems as though in this respect the ruling of the District Court is not based on principles: "In light of the serious state of dementia the patient was in at the time, the defendant was not obligated to inquire about the wish of the patient to live or die at that particular time."[46] However, later it becomes clear that the District Court denies the existence of such an obligation altogether. According to the Court,

it is not possible to obtain verbal verification from a decisionally incompetent patient about her wishes or suffering. Such a requirement would obviate the advance directive. The District Court was well aware that guidelines had been drawn up by the medical profession which also oblige the physician to try to verify the current viewpoint of the patient concerning the ending of life even if she is incompetent; but, in the District Court's opinion this position is stricter than the requirements under the law. According to the Court, such a legal obligation does not exist.[47]

The Supreme Court

The Criminal Case

On April 21, 2020, the Supreme Court pronounced not one, but two judgments in the *Dormicum* case.[48] The parties involved in the criminal case, the PPS and the defendant, had decided to opt for a so-called "leap-frog appeal," meaning that no appeal was lodged with the Court of Appeal, and the case was brought immediately before the highest judicial body in the Netherlands. In addition, and simultaneously, the Supreme Court issued its judgment in the appeal in cassation lodged by the procurator general (PG) against the decision of the CDB. That had also never happened before.

In the criminal case, the Supreme Court upheld the judgment of the District Court of The Hague. In its opinion, the District Court had not erred; the geriatrician had acted with appropriate due care. It also ruled that a physician who is accused of not having complied with the Act's first requirement of due care cannot automatically be accused of performing termination of life without an "express and serious desire" on the part of the patient.[49]

According to the Supreme Court, the Euthanasia Act is unambiguous: a physician is allowed to act on the basis of a written request for termination of life once that has been made by a patient. In order for a physician to be allowed to carry out such a request, the law stipulates that the patient is no longer capable of expressing her will; but it does not make any distinction with respect to the possible causes of that incapacity. However, it is apparent from the parliamentary proceedings that the legislator explicitly included dementia as such a possible cause. A physician therefore has an obligation to interpret a written request in order to determine the intentions of the patient. In doing so, she has to take into account all the relevant circumstances and not just the literal wording of the request. At a minimum, the declaration has to be such that the patient requests termination of life in a situation whereby she is no longer able to form or express a will about such as a result of advanced dementia. Moreover, if the patient wants to see this request carried out in cases where there is no physically unbearable suffering, it will have to be clear from the request that the patient considers that her (future) state of advanced dementia itself would be unbearable. Furthermore, it is important that the physician carefully assesses the current situation the patient is in, so as to compare this situation with the circumstances described in the written request, whereby the physician has to pay special attention to contraindications conflicting with that request in the period following the drafting of the request by the patient, in particular oral statements by the patient that are inconsistent with that request. If these statements are made in the period after the point at which the patient is no longer able to form or express their own will due to advanced dementia, they can no longer be automatically construed as an expression of will explicitly aimed at the withdrawal or modification of the earlier written request.[50]

The Supreme Court concluded that the legislator had chosen to introduce a legal framework whereby the assessment of a request of a patient for termination of life by a physician should primarily be done by ERCs operating beyond the realm of criminal law. And, furthermore, the assessment of whether the physician acted in compliance with the due care criteria should be carried out on the basis of the guidelines and insights that apply to medical professionals. Even if termination of life does lead to criminal prosecution, which would not be the most appropriate reaction (considering the fact that physicians are also subject to disciplinary law), the criminal courts should adopt a cautious approach when answering the question of whether or not a medical act was acceptable in certain circumstances.[51]

The Disciplinary Case

The disciplinary law framework was dealt with in the second ruling of the Supreme Court.[52] The decision of the CDB was quashed. According to the Supreme Court, it demonstrated an incorrect interpretation of the law. The CDB had used the ERC judgment as the starting point for assessing whether the physician had acted with appropriate due care, and, in doing so, the Court continued, it failed to recognize the fact that it had the authority to make its own independent judgment. According to the Supreme Court, the assessment framework of the ERCs does not provide sufficient scope to answer the question that has to be answered in disciplinary proceedings: were the professional actions of the physician those of a reasonably skilled professional (i.e., in compliance with the professional standard)?[53]

The view held by both disciplinary boards, that in principle there is no room for interpretation of a written request, was therefore incorrect, according to the Supreme Court. The fact that determining the meaning of this patient's request required a certain amount of interpretation did not negate its legal validity, nor did the circumstance that the request contained some inconsistencies concerning the moment of euthanasia. The patient had clearly designated the moment of transfer to a nursing home as that moment. According to the Supreme Court, the fact that she did not make a request for termination of life in the consecutive period, when she was still able to express her will in relation to such circumstances, did not make that directive any less explicit.[54]

Some Critical Comments

The Need for Clarity

Since 2012, the ERCs have registered cases of termination of life involving dementia as a separate category. In that year, they received 42 notifications in this category (1% of the total number of notifications in that year),[55] and in 2019 (the year of the most recent annual report) the number had gone up to 162 (2.54% of the total number of notifications in that year).[56] It is not known whether any cases of termination of life involving dementia occurred before 2012 and, if so, how many. Since that year, however, the numbers have been increasing in both absolute and relative terms. From 2012 up to and including 2019, 947 cases of termination of life were reported in this category. In only 14 of these cases was the procedure performed on the basis of a written advance directive.

The need for clarity is apparent from the relatively large number of judgments in this category published on the website of the joint ERCs (98) and the relatively large number of notified cases that were judged to be inconsistent with the statutory due care criteria (4).[57] The PG and the Supreme Court presumably thought that the considerable disparity between the judgments of both disciplinary courts and that of the criminal court in the *Dormicum* case was not helpful for either physicians or patients. It is unfortunate that the Court of Appeal was never given the opportunity to review the facts. Consequently, it remains a mystery why the patient thought it necessary to subsequently incorporate elements of time and personal choice into her advance directive.

Nevertheless, there can be little doubt that, in particular, the Supreme Court's ruling in the criminal case brought about at least some legal certainty. Physicians considering whether or not to act in accordance with a written advance directive will be somewhat reassured. The Court unequivocally established that it is up to them to interpret the written advance directive, whereby in order to determine the intentions of the author all the circumstances of the case will have to be taken into account and not just the literal wording of the advance directive. And, for patients considering drawing up an advance directive, the Court's ruling in the criminal case does provide some guidance as regards the essential elements that have to be included.

Finally, by ruling that the question of whether the physician performing the euthanasia has acted in compliance with the due care criteria should be assessed on the basis of the insights and guidelines of the medical professional, the criminal courts have been given clarification that they should exercise caution, and the PPS too has been sent the clear message not to pursue a criminal prosecution too lightly.

On the Supreme Court's Ruling in the Criminal Case

Nevertheless, some critical comments are warranted. The *Dormicum* case hinges on interpretation: namely, on interpretation of the advance directive of the 74-year old patient, but also on that of the Euthanasia Act's provision on written advance directives. In the first sentence of that provision, two capabilities are mentioned: the capability to express one's will and the capability of making a reasonable appraisal of one's interests. The absence of the first capability is required when a physician is considering whether or not to comply with the written advance directive, whereas the second one needs to be present when that directive is being drafted. It is up to physicians to reconcile both parts of that sentence, since they have to act accordingly. A literal interpretation of that sentence would require a reticent attitude on their part. After all, only a deeply comatose patient is no longer able to express her will. In the *Dormicum* case, the PPS, the Inspectorate and both disciplinary courts took this position. The geriatrician, on the other hand, interpreted the sentence in such a way that she felt able to declare that she would have performed euthanasia even if her patient had indicated that she did not want to have her life ended. The criminal court clearly favored this interpretation. The practical implications of the different interpretations are enormous. But which interpretation is the correct one?

The Supreme Court based its judgment in the criminal case exclusively on legislative history. The reference list of its ruling consists of just a few references to 20-year-old parliamentary documents, dating from the time when the Bill was being discussed in Parliament.

Now, the Euthanasia Act is a text first and foremost, and legal texts have in common with many other "public" texts that the original intention of the empirical author is not particularly relevant for a proper understanding. Like literary works, legal texts are produced for a community of readers. The empirical author knows that the readers of the text will not necessarily interpret it in accordance with the author's original intent (*intentio auctoris*).[58] A published novel is not a secret diary, with author and reader being one and the same person. Nor is it a personal letter, with a recipient who can contact the sender. A law is no different, even when the author has left a multitude of notes about what was intended in the form of parliamentary papers and proceedings. Once released to the public, the text of the law is what we have to hold on to.[59]

A text is not a picnic, as Umberto Eco once said, to which the words are taken by its author and its meaning by its readers (*intentiones lectores*).[60] Likewise, a legal text cannot have every meaning attributed to it by its readers. The assertion that a text can have more than one meaning is true, but asserting that a text cannot have a correct meaning is most definitely false. A text does not allow for all interpretations. The text itself draws the line between those interpretations that are acceptable and those that are not. An assertion about the *intentio operis* of a text can only be proved by placing it alongside the text as a coherent whole. Any interpretation of one of its parts can be accepted if it is confirmed by other parts of that text, just as any interpretation given thereof must be rejected if it contradicts them. The more that part of the text is confirmed, the more acceptable its interpretation is.[61] In Ronald Dworkin's words, the interpretation with the best "fit" is the most acceptable or correct one.[62] Did the Supreme Court provide such an interpretation of the first sentence of the Act's provision on advance directives? Has it succeeded in finding its *intentio operis*?

Suppose that on these pages, I present the readers of *Cambridge Quarterly of Healthcare Ethics* with an interpretation of an enigmatic passage in *Foucault's Pendulum* by Umberto Eco, a passage to be found in chapter 107. And suppose, I then claim this interpretation to be the correct one. However, if I then subsequently add that I have only read chapter 107, my claim will hardly be taken seriously by those CQHE readers familiar with this famous 120-chapter novel. Such an interpretative strategy will startle many. An interpretation of a part of a text would surely have to be based on the entire text. In that sense, a critic must treat her texts respectfully. And what applies to literary criticism also applies in law. The lawyer will also have to read the entire "text," a text which—unlike Eco's bulky novel—is "written" by countless "authors."

The Dutch law on euthanasia and assisted suicide is not solely made up of the Euthanasia Act. The Burial and Cremation Act is also relevant, as are provisions of the Criminal Code on euthanasia and

assisted suicide, which are in turn embedded in fundamental rights, protected by the Dutch Constitution and numerous European and international human rights treaties to which the Netherlands is a party.

And here the shoe pinches. There is no reference whatsoever to fundamental rights in either of the judgments of the Supreme Court—not one—which is remarkable, incomprehensible even, since in his concluding observations in the criminal case the PG repeatedly refers to fundamental rights.[63] One can only speculate as to why the highest court in the Netherlands decided to limit applicable law in this way. Of course, judicial review of national legislation against fundamental rights as protected by the Dutch Constitution is not an issue, since this is prohibited by the latter,[64] but self-executing treaty provisions such as those of Article 2 (right to life) and Article 8 (right to respect for private life) of the Convention for protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, hereinafter the ECHR) are definitely justiciable. The fact that these provisions do not have a Dutch "author" does not mean that they are not part of the Dutch legal system.[65] According to the Constitution, national courts of law are required to declare that laws of national origin incompatible with such international treaty provisions are inapplicable.[66]

The Dutch Euthanasia Act is believed to be generally consistent with the relevant ECHR provisions, since the European Court of Human Rights (ECtHR) in Strasbourg has adopted a wide margin of appreciation in its rulings on assisted suicide.[67] However, the *Dormicum* case was obviously a hard case. On several occasions, the ECtHR ruled that decisions about one's death are within the scope of Article 8 ECHR. [68] In a Swiss case, it stated: "an individual's right to decide by what means and at what point her life will end, provided he or she is capable, or of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention."[69]

However, interferences with the exercise of this right are permitted. The ECtHR continued as follows: "In consequence, it is appropriate to refer, in the context of examining a possible violation of Article 8, to Article 2 of the Convention, which creates for the authorities a duty to protect vulnerable persons, even against actions by which they endanger their own lives. … For the Court, this latter Article obliges national authorities to prevent an individual from taking her own life if the decision has not been taken freely and with full understanding of what is involved."[70]

The Court in Strasbourg has acknowledged that states party to the ECHR have divergent views on voluntary termination of life; a positive state obligation to facilitate euthanasia or assisted suicide is therefore not implied in Article 8.[71] But, when a state does decide to allow euthanasia, it is obligated—as a consequence of Article 2—to prevent those who are unable to make such a decision freely and with full understanding of its implications from taking their own lives.[72] The ECtHR therefore considers interference in the exercise of the right to respect for private life permissible, but not to such an extent that the protected right ceases to be practical and effective. It adheres to this principle for all ECHR rights. And that means that everyone's right to choose the time and manner of death may not be "merely theoretical and illusory."[73]

Therefore, the ECHR—for the Court in Strasbourg a "living instrument" which is to be interpreted according to "present-day conditions"[74]—has created two important points of reference as regards voluntary termination of life. Admittedly, according to the ECtHR, it is primarily up to the states to weigh the relevant interests (life, i.e., that of vulnerable persons, versus respect for private life by respecting the decisions to end life of those who are able to do so), but it has clearly indicated a margin. The interference with the exercise of the right must not be so minor as to endanger the lives of the vulnerable, but also not so extensive that the right to a choice of time and manner of death turns out to be an empty shell in practice.

At the very least, the Supreme Court of the Netherlands should have spoken out clearly on the way the Act's provision concerning written advance directives relates to those points of reference. The other parts of Dutch euthanasia law (life, privacy, and physical integrity) are also protected by other treaties to which the Netherlands is a party, such as the International Covenant on Civil and Political Rights and the Convention on the Rights of Persons with Disabilities which I will not discuss here.

In the *Dormicum* case, the Supreme Court should have formed a coherent picture of the entirety of Dutch euthanasia law. It should have grasped its underlying principles; it should have produced a sound theory of all applicable rules; and it should have presented that interpretation of the provision that best fits that theory. Maybe the Court did come up with the most acceptable interpretation, but it has failed to demonstrate this convincingly.

On the Supreme Court's Ruling in the Disciplinary Case

The message to hold back was sent to the Inspectorate and the disciplinary boards as well. Again, Dutch disciplinary courts for healthcare do not intend to punish, but rather to simply render judgments about the quality of the actions of individual members of a healthcare profession. They rule on behalf of the profession on the basis of the group's own standard. Although legal experts also sit on these boards, their judgments are still those of fellow professionals.[75]

By reproaching the disciplinary courts for relying too heavily on the ERC judgment, the Supreme Court appears to have also overlooked the contribution of the medical profession in the development of the ERCs' policies. Not only do the review committees themselves include physicians,[76] but the medical profession also played a major part in the preparation of the ECRs' Code of Practice and its successor, the Euthanasia Code 2018, through extensive consultations within the associations representative of the profession.[77]

The RDB and the CDB chose to take the ERC judgment as a starting point. The disciplinary boards decided to rule on the basis of the ERC assessment framework. That is what they identified as the professional standard. That was the standard both disciplinary courts used to assess whether the professional actions of the geriatrician were those of a reasonably skilled professional, and they did so freely and independently. And now the Supreme Court, entirely made up of lawyers, has told them that the standard they chose as their own was the wrong one. Understandably, that message did not go down well at all with the disciplinary courts.[78]

The ruling by the CDB in the *Dormicum* case was the first one the Supreme Court has had to review, and the Court appears to have misunderstood the nature of disciplinary law. Hopefully, the message will not lead to loss of nuance. After all, it is perfectly conceivable that professional actions of physicians could fail to meet the professional standard without actually constituting a criminal offence. Euthanasia and assisted suicide are no exceptions. Would it really be acceptable for a physician not to have even tried to communicate with her demented patient about her concrete intention to perform euthanasia? Such behavior may not be considered criminal, but ought a reasonably skilled professional behave in that way?

Conclusion

The *Dormicum* case is a landmark in Dutch legal history. Both Supreme Court rulings will undoubtedly have provided comfort and reassurance to some physicians and patients. They did come at a cost, however. By not taking all applicable rules into consideration, the Court denied itself the opportunity to reflect properly on the relevant fundamental rights. Perhaps, in the words the Supreme Court itself used to reprimand the CDB: "it failed to recognize the fact that it had the authority to make its own, independent judgment."[79] And, on the other hand, in its desire for consistency it appears to have misunderstood the nature of disciplinary law.

And, finally, what about the ERC's judgment? No doubt both rulings of the Supreme Court were intended to serve the interests of certainty and consistency, but the judgment of the review committee has not been overturned. The Supreme Court does not have the authority to do that. Therefore, the ERC-judgment still stands. Again, the Supreme Court has made clear that ERCs assess the actions of physicians "beyond the realm of criminal law," and their framework was also said to be too narrow to assess whether a physician's professional actions meet her professional standard. The ERC judgment in the *Dormicum* case is not overturned, and the geriatrician is therefore not completely rehabilitated. But if

her actions were not wrong from a criminal law perspective nor from a disciplinary point of view, then what does that mean? Did the geriatrician in the *Dormicum* case act with appropriate due care or not?

Notes

1. HR 21 April 2020 (ECLI:NL:HR:2020:712) (criminal case) and HR 21 April 2020 (ECLI:NL:HR:2020:713) (disciplinary case).
2. With the passing of a bill on euthanasia in the Portuguese parliament on January 30, 2021, four European countries (and seven worldwide) have as yet legalized or decriminalized the voluntary ending of life.
3. Criminal Code, Section 293, paragraph 1, and Section 294, paragraph 2.
4. Criminal Code, Section 293, paragraph 2, and Section 294, paragraph 2.
5. Euthanasia Act, Section 2, paragraph 1.
6. Euthanasia Act, Section 2, paragraph 2.
7. Criminal Code, Section 40, and see HR 27 November 1984 (ECLI:NL:HR:AC8514).
8. Criminal Code, Section 293, paragraph 2, and Section 294, paragraph 2.
9. Euthanasia Act, Section 9, paragraph 2.
10. Instructions on Decisions to Prosecute in Cases of Termination of Life on Request (euthanasia and assisted suicide), Section 2.2.
11. Oordeel 2016-85; available at https://www.euthanasiecommissie.nl/uitspraken-en-uitleg/dementie/documenten/publicaties/oordelen/2016/niet-gehandeld-overeenkomstig-de-zorgvuldigheidseisen/oordeel-2016-85(last accessed 5 April 2021).
12. See note 11, Oordeel 2016-85, at 11–13.
13. See note 11, Oordeel 2016-85, at 11.
14. See note 11, Oordeel 2016-85, at 12.
15. Regionale toetsingscommissies euthanasie, EuthanasieCode 2018; available at https://www.euthanasiecommissie.nl/uitspraken/brochures/brochures/euthanasiecode/2018/euthanasiecode2018 (last accessed 5 April 2021).
16. See note 11, Oordeel 2016-85, at 12.
17. See note 11, Oordeel 2016-85, at 12.
18. See note 11, Oordeel 2016-85, at 12.
19. See note 11, Oordeel 2016-85, at 12.
20. See note 11, Oordeel 2016-85, at 12.
21. See note 11, Oordeel 2016-85, at 12.
22. See note 11, Oordeel 2016-85, at 12.
23. See note 11, Oordeel 2016-85, at 13.
24. See note 11, Oordeel 2016-85, at 13.
25. See note 11, Oordeel 2016-85, at 13.
26. See note 11, Oordeel 2016-85, at 13–14.
27. Individual Healthcare Professions Act, Section 47, paragraph 2, and Section 65, paragraph 1, under d.
28. RTG Den Haag 24 July 2018 (ECLI:NL:TGZRSGZ:2018:165).
29. CTG 19 March 2019 (ECLI:NL:TGZCTG:2019:68).
30. Individual Healthcare Professions Act, Section 47, paragraph 1.
31. Civil Code Book 7, Section 453.
32. Individual Healthcare Professions Act, Section 48.
33. See note 28, RTG 2018, at 9–10.
34. See note 28, RTG 2018, at 14.
35. See note 28, RTG 2018, at 15.
36. See note 28, RTG 2018, at 15.
37. See note 28, RTG 2018, at 16.

38. See note 28, RTG 2018, at 16.
39. See note 29, CTG 2019, at 17.
40. Rechtbank Den Haag 11 September 2019 (ECLI:NL:RBDHA:2019:9506).
41. See note 40, Rechtbank 2019, at section 4.2.
42. See note 40, Rechtbank 2019, at section 4.4.4.
43. See note 40, Rechtbank 2019, at section 5.3.2.
44. See note 40, Rechtbank 2019, at section 5.3.2.
45. See note 40, Rechtbank 2019, at section 5.3.2.
46. See note 40, Rechtbank 2019, at section 5.3.2.
47. See note 40, Rechtbank 2019, at section 5.3.2.
48. See note 1.
49. See note 1, HR 2020 (criminal case), at section 5.3.2.
50. See note 1, HR 2020 (criminal case), at section 5.5.2.
51. See note 1, HR 2020 (criminal case), at section 6.1.
52. See note 1, HR 2020 (disciplinary case).
53. See note 1, HR 2020 (disciplinary case), at section 5.3.
54. See note 1, HR 2020 (disciplinary case), at section 6.6.
55. Regionale toetsingscommissies euthanasie. *Annual Report 2012*, at 32; available at https://www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/jaarverslagen/2012/nl-en-du-fr/nl-en-du-fr/jaarverslag-2012 (last accessed 5 April 2021).
56. Regionale toetsingscommissies euthanasie. *Annual Report 2019*, at 12; available at https://www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/jaarverslagen/2019/april/17/index (last accessed 5 April 2021).
57. See Annual Reports by Regionale toetsingscommissies euthanasie; available at https://www.euthanasiecommissie.nl/de-toetsingscommissies/jaarverslagen (last accessed 5 April 2021).
58. Eco U, Rorty R, Culler J, and Brooke-Rose C (Stefan Collini ed.). *Interpretation and Overinterpretation*. Cambridge: Cambridge University Press; 1992, at 67.
59. See note 58, *Interpretation and Overinterpretation*, at 67.
60. See note 58, *Interpretation and Overinterpretation*, at 24.
61. See note 58, *Interpretation and Overinterpretation*, at 78.
62. Dworkin R. *Law's Empire*. Glasgow: Fontana Press; 1986, at 52.
63. Parket bij de Hoge Raad 17 December 2019 (ECLI:NL:PHR:2019:1338).
64. Constitution of the Netherlands, Section 120.
65. Constitution of the Netherlands, Section 93.
66. Constitution of the Netherlands, Section 94.
67. Adviescommissie Voltooid Leven. *Voltooid leven. Over hulp bij zelfdoding en mensen die hun leven voltooid achten*. Den Haag; 2016, at 4; available at https://www.rijksoverheid.nl/documenten/rapporten/2016/02/04/rapport-adviescommissie-voltooid-leven (last accessed 5 April 2021). See also Buijsen M. A life fulfilled: Should there be assisted suicide for those who are done with living?. *Cambridge Quarterly of Healthcare Ethics* 2018;**27**(3):366–75.
68. See ECtHR 29 April 2002, appl. no. 2346/02 (*Pretty v. United Kingdom*) and ECtHR 20 January 2011, appl. no. 31322/07 (*Haas v. Switzerland*).
69. See note 68, ECtHR 2011, at section 51.
70. See note 68, ECtHR 2011, at section 54.
71. See note 68, ECtHR 2011, at section 61.
72. See note 68, ECtHR 2011, at section 60, and also see ECtHR 9 June 1998, appl. no. 23413/94 (*LCB v. United Kingdom*).
73. See note 68, ECtHR 2011, at section 60, and see ECtHR 13 may 1980, appl. no. 6694/74 (*Artico v. Italy*)
74. See i.e., ECtHR 8 July 2004, appl. no. 53924/00 (*Vo v. France*).
75. Individual Healthcare Professions Act, Sections 55 and 56.

76. Euthanasia Act, Section 3, paragraph 2.
77. Regionale toetsingscommissies euthanasie. *Code of Practice*; available at https://www.euthanasiecommissie.nl/uitspraken/brochures/brochures/code-of-practice/1/code-of-practice-2015 (last accessed 5 April 2021), and see note 15, *EuthanasiaCode 2018*.
78. Nyst E. Centraal Tuchtcollege: "Waarschuwing specialist ouderengeneeskunde niet vervallen". *Medisch Contact* 2020;**75**(18):6.
79. See note 1, HR 2020 (disciplinary case), at section 5.3.

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