Dutch court decisions on nonvoluntary euthanasia critically reviewed

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Introduction

On June 1, 1994 a new law regulating voluntary and nonvoluntary euthanasia came into force in the Netherlands. By amending the law on the disposal of the dead a statutory basis is given to a procedure by which physicians report death in cases of euthanasia, assisted suicide and life-terminating actions without an explicit request.[2] This procedure requires a physician who has terminated a patient's life to inform the local medical examiner, who inspects the body externally and takes from the attending physician a statement which contains the relevant data (the patient's history, request, possible alternatives, consultation with a second physician, treatment etc.). This statement and the report of the local medical examiner, are checked by the Public Prosecutor who considers if the termination of the patient's life was contrary to the Penal Code as interpreted by the courts. Since 1984 the courts have allowed the defense of necessity to a physician who has performed euthanasia in certain circumstances (Penal Code art. 40). These circumstances are essentially: a free, well-considered request, unacceptable suffering, and consultation by the physician with a colleague.[3] The appeal to the defense of necessity (or *force majeure*) in these cases implies that in cases of an objectively established `conflict of duties' an infringement of a law can be justified by the judge. In cases of euthanasia this conflict concerns on one hand the duty to obey the law that forbids euthanasia and assisted suicide (Penal Code art. 293, 294), and on the other hand to alleviate suffering.

In Parliament the new regulation was criticized for including nonvoluntary euthanasia as well as voluntary euthanasia.[4] The Cabinet responded that a survey of Van der Maas et al. demonstrated that each year about 1000 patients had their lives terminated without an explicit request and that according to the Association of Paediatricians nonvoluntary euthanasia of severely handicapped babies is defensible in certain circumstances and occurs in practice.[5] According to the Cabinet, the obligation to report these cases of nonvoluntary euthanasia in a similar way as cases of voluntary euthanasia was the best way to develop an insight into that aspect of euthanasia practice. As there were no court decisions condoning nonvoluntary euthanasia,[6] each case reported would be prosecuted to

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[2] The new legal regulation (Bill no. 22 572) amends the law on the disposal of the dead (article 10); the law as amended provides the legal basis both for the form to certify natural death and the form to notify all cases of euthanasia, assisted suicide and a life-terminating action without request. The forms themselves are set out in an enactment ['Algemene Maatregel van Bestuur', AMvB]. This AMvB has been published in the Staatsblad [an official publication of the government] of 28 Dec 1993, as: Besluit van 17 Dec 1993, STAATSBLAD 688.

[3] H.J.J. Leenen, "Dying with dignity: developments in the field of euthanasia in the Netherlands," 8 MEDICINE AND LAW 520 (1989).

[4] Acts of Second Chamber of Parliament, TK44, p.3286, 3319, 3324, (2 February 1993).

[5] The results of the survey for the year 1990 have been published in: P.J. van der Maas, J.J.M. van Delden, L. Pijnenborg, *Euthanasia and other medical decisions concerning the end of life,* 22 HEALTH POLICY 1-262 (1992); see also L. Pijnenborg, END-OF-LIFE DECISIONS IN DUTCH MEDICAL PRACTICE. (*Thesis* Rotterdam 1995). For a discussion of these data and of the legal regulation, see: H. Jochemsen, *Euthanasia in Holland: An ethical critique of the new law*, 20 JOURNAL OF MEDICAL ETHICS 211-217 (1994); J. Keown, *Euthanasia in the Netherlands: Sliding down the slippery slope?* In: J. Keown (ed.), EUTHANASIA EXAMINED ch.16, (1995).
On neonatal euthanasia see: Nederlandse Vereniging voor Kindergeneeskunde, DOEN OF LATEN? GRENZEN VAN HET MEDISCH HANDELEN IN DE NEONATOLOGIE (Utrecht, 1992). [Dutch Association for Pediatrics, DOING OR LEAVING? LIMITS OF MEDICAL CARE IN NEONATOLOGY].

[6] Apart from decisions to stop treatment, including tube-feeding of PVS patients, which in some cases (viz., where the doctor's purpose is to shorten life) can be seen as nonvoluntary euthanasia. A well-known case in the Netherlands is the *Stinissen* case, concerning a woman who died after 16 years in coma because of the withdrawal

enable the courts to decide whether a physician who performed nonvoluntary euthanasia could successfully appeal to the defense of necessity.

In 1995 two physicians, who separately reported having terminated the lives of severely ill and handicapped babies were prosecuted brought before court. The importance of these decisions goes beyond these individual cases. Firstly, because it was made clear afterwards that these court decisions actually determine the circumstances in the Public Prosecutor will not prosecute a physician who has terminated a baby's life.[7] Secondly, because they demonstrate the courts' acceptance of nonvoluntary euthanasia as well as voluntary euthanasia. This could also have an impact on other groups of incompetent patients. Because of their importance these decisions merit a close examination and critical discussion. This will be done in this paper.

Since a correct interpretation of those decisions is only possible against the background of the developments of Dutch euthanasia practice and jurisprudence, these developments will be presented first.

Euthanasia practice

In 1996 the results were published of a second major survey on euthanasia practice in the year 1995.[8] Between 1990 and 1995 the total number of all deaths in the Netherlands had increased from 129,000 to 135,500; the number of requests for euthanasia had increased from 8,900 (7%) to 9,700 (7.1%) and the number of cases of (voluntary) euthanasia from 2,300 (1.8%) to 3,200 (2.4%). The number of cases of assisted suicide had remained constant at 400 (0.3%), whereas the number of cases of life-terminating actions without a specific request decreased slightly from 1000 to 900. By comparing results from different surveys the investigators conclude that the grey area between intensification of pain treatment and the intentional shortening of life remained constant at about 2% of deaths from all causes. In about 14,000 cases (10.5%) treatment was withdrawn or withheld with the explicit intention to shorten life; in 1990 this was done in about 2,670 cases (2.1%). Furthermore, a survey of paediatricians, which was not performed as part of the 1990 survey, revealed that in 15 cases the lives of babies had been terminated. However, in about 90 cases (including those 15) the physician acted with the explicit intention to shorten life.

The research also demonstrated that only 40% of the cases of voluntary euthanasia and assisted suicide were reported and that (in 1995) the cases of nonvoluntary euthanasia were not reported at all. (The cases of the two babies who had their lives ended were reported in 1993 and 1994 respectively).

These results indicate that the majority of cases of euthanasia and virtually all cases of nonvoluntary euthanasia that physicians report in anonymous surveys, are not reported to the legal authorities and, therefore, cannot be investigated. Consequently, it must be concluded that the legal

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of food and fluids. The Court of Appeal in Arnhem condoned this withdrawal; See: *Zaak Stinissen, Gerechtshof Arnhem d.d. 31 october 1989*, 14,1 TIJDSCHRIFT VOOR GEZONDHEIDSRECHT 79-83 (1990) and *Staking toediening van vocht and voeding onrechtmatig? Court of Appeal Arnhem d.d. 16 January 1990.* 14,2 TIJDSCHRIFT VOOR GEZONDHEIDSRECHT 167-171 (1990).

[7] *Geen vervolging euthanasie op wilsonbekwamen.* NRC-HANDELSBLAD 5 april 1996. [No prosecution for euthanasia with incompetent]. Before the District Court in Groningen, the public prosecutor even spoke of a pseudo-legislative process. SPEECH OF PROSECUTION IN THE CASE AGAINST K., District Court Groningen d.d. 30.10.1995, nr. 18. 070093/95, p.3.

[8] G. van der Wal, P.J. van der Maas. EUTHANASIE EN ANDERE MEDISCHE BESLISSINGEN ROND HET LEVENSEINDE. DE PRAKTIJK EN DE MELDINGSPROCEDURE. [Euthanasia and other medical decisions concerning the end of life. Practice and reporting procedure]. (Den Haag, 1996). For a summary see: P.J. van der Maas, *Euthanasia, physician-assisted suicide, and other medical decisions involving the end of life in the Netherlands, 1990-1995,* 335 NEW ENGLAND JOURNAL OF MEDICINE 1699 (1996); G. van der Wal, *Evaluation of the notification procedure for physician assisted death in the Netherlands*, IBID, 1706 (1996). For a discussion of these results see: H. Jochemsen, *Lessons from the Dutch: Does the regulation work?* In: R.M. Doerflinger (ed.), LIFE AT RISK: A CLOSER LOOK AT ASSISTED SUICIDE, in press.

authorities have neither a clear insight into the practice of life-termination by physicians, nor effective control of it. The data on the grey area between intensification of pain treatment and the intentional shortening of life and the data on the withholding of withdrawing of treatment with the ecplicit intention to shorten the life of the patient, also indicates that the line between life-terminating actions with or without an explicit request is very thin.[9] Furthermore, the survey confirms that clear-cut cases of nonvoluntary euthanasia regularly occur, not least involving severely ill and disabled newborn babies. Until the court decisions in 1995-1996 it was unclear whether the courts would accept this form of nonvoluntary euthanasia. We will now turn to these decisions.

Severely ill/disabled babies

Recent court decisions demonstrate that the courts now accept the appeal to `necessity' when the patient euthanised is a severely ill or handicapped baby. Two such cases have been prosecuted in the District Courts, the case of doctor P. in Alkmaar,[10] and the case of doctor K. in Groningen.[11] In both cases the Prosecutor appealed to the Courts of Appeal, in Amsterdam[12] and Leeuwarden,[13] respectively. In the Groningen case the Public Prosecutor had initially decided not to prosecute but was instructed to prosecute by the Minister of Justice who wanted the courts to lay down rules for physicians to follow in cases of life-termination without an explicit request.

Facts of the cases

In the Alkmaar case the baby had spina bifida, hydrocephalus, a spinal cord lesion and brain damage. The specialists decided not to operate on the spina bifida, because of the bad prognosis. From her behaviour it was concluded that the baby was suffering severe pain which was difficult to treat. The parents did not want the baby to suffer and asked for the termination of her life. Three days after the baby was born, she was killed by the attending gynecologist, P., after consultation with other specialists who had examined the baby. She died in the arms of her mother.

The Groningen case concerned a newborn baby with trisomy 13, a syndrome that manifested itself in a number of disorders (deformities of skull, face and hands, heart and kidney malfunction and brain damage). The baby was diagnosed to be non-viable; death was to be expected at most within a year, and probably within six months. After the situation had stabilized to a certain point, the baby was taken home and looked after by the parents, who had learned to supervise the tube-feeding. This caused no special problems for about a week, but then some tissue (meninges) came out through an opening in the skull. This appeared to be very sensitive and the baby appeared to be in pain. The family physician, K., gave some pain treatment, but that did not appear to be fully effective. After a number of days, with the explicit consent of the parents (though whether it was at their request remains unclear), the life of the baby was ended by lethal inyection. Before doing this, the family physician consulted a pediatrician, who had seen the baby, about how to terminate the baby's life. The pediatrician supported the proposed procedure and the choice of euthanatica.

Defense

The doctor's defense relied on three alternative lines of defense. First, it was argued that according to contemporary public and professional opinion, the expression `take a person's life' [`van het leven berooft'] used in the Penal Code (art. 289), does not apply to a carefully considered and performed

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[9] See literature mentioned in notes 4 and 7 for further proof of this conclusion.

[10] *Vonnis Arrondissementsrechtbank te Alkmaar d.d. 26 april 1995 in the case against P.* 19,5 TIJDSCHRIFT VOOR GEZONDHEIDSRECHT 292-301 (1995).

[11] *Vonnis Rechtbank te Groningen d.d. 13 november 1995 in the case against K.* 3,1 PRO VITA HUMANA 29-32 (1996).

[12] *Arrest Gerechtshof te Amsterdam d.d. 7 november 1995 in the case against P.* 3,1 PRO VITA HUMANA 25-28 (1996).

[13] *Arrest Gerechtshof te Leeuwarden, d.d. 4 april 1996 in the case against K.* 20,5 TIJDSCHRIFT VOOR GEZONDHEIDSRECHT 284-291 (1996).

life-terminating action by a physician in the context of careful medical practice. All the courts rejected this defense on the basis of the historical interpretation of article 289 and other articles of the Penal Code. Therefore, the courts concluded that in strictly juridical terms, murder was the appropiate charge.

Secondly, it was argued that the offence was not punishable because it was done as part of responsible medical practice and in agreement with medical-professional standards (invoking the so-called `medical exception'). This defense was also rejected by the courts. Life-terminating actions could not for the mere reason that they fall within the medical professional standard be regarded as medical actions a physician can perform with impunity.

The third argument was an appeal to the defense of necessity. All four courts accepted this and released the physicians without punishment.

The court decisions

In its judgement the Alkmaar District Court in the case of doctor P. formulated minimum requirements the physician must fulfil in such cases in order to appeal successfully to the defense of necessity[14]:
a) the baby suffers intolerably with no prospect of improvement; the suffering is incurable and cannot be alleviated, at least not in a medically meaningful way,
b) both the procedure leading to the decision to terminate the baby's life and the life-terminating action itself should meet the requirements of care and precision,
c) the physician's actions should comply with (scientifically) responsible medical opinion and with prevailing standards of medical ethics,
d) life-terminating actions should only be performed at the explicit, repeated, and consistent wish of the parent(s) as the legal representative(s) of the baby.

With the phrase "suffering that could not be alleviated in a medically meaningful way" (cf. a) supra) the Court hints at a situation in which the only way to alleviate the suffering is to render the patient (almost) comatose.

The decision of the Amsterdam Court of Appeal on the same case differed in some respects. With respect to (a) it argued that curative treatment (an operation) was not proportional and that pain and symptom treatment was medically meaningless because:
- such doses of medication would be needed that the baby would, as it were, "be floating between heaven and earth",[15]
- such pain treatment would in fact aim at hastening death, since the decision not to perform curative treatment can be interpreted as "a choice against the life of the baby",
- if the baby had survived for some time with pain treatment, the non-curative-treatment policy would have led to complications (especially expansion of the hydrocephalus) that would have caused doubts about that policy; this uncertainty would have been very burdensome for the parents, the nurses and the physicians,
- if the non-curative-treatment decision had been reversed later on, the chance for improvement would be less than if the baby had been treated immediately.

The court concluded that the life-termination in this case was the most appropiate course of action. However, physicians from another clinic published a different policy in such cases, ruling out the intentional killing of the baby.[16] Apparently they do not find curative and/or palliative treatment meaningless. This suggests that the opinion that life termination is the most appropiate course in such situations is open to question.

The Amsterdam Court did not mention the explicit request of the parents as a requirement

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[14] See reference 9, p.294.

[15] See reference 11, section 19.

[16] J.J. Rotteveel, R.A. Mullaart, F.J.M. Gabreëls, J.J. van Overbeeke, *Actieve levensbeindiging bij pasgeborenen met spina bifida?* [Active termination of life of newborn babies with spina bifida?] 140,6 NED TIJDSCHR GENEESKUNDE 323-324 (1996).

(cf. point (d) above), but concluded that the parents had consented to the killing of the baby. The requirement of the explicit request of the parents had been criticized because it suggests that the killing of an incompetent person can (partly) be justified by the request of somebody else.[17]

The Groningen District Court in the case of K, explicitly rejected the idea that the termination of a baby's life at the request of the parents could legally be seen as a case of euthanasia by proxy consent. Life and death are not matters in which a proxy could decide on behalf of the patient himself.[18] This rules out killing at, and because of, the request of third parties. The Court noted that it was not certain that the physician killed the baby because of the request of the parents. Its reason for the acceptance of such a life-terminating action, was apparently not the request but the conflict of duties that for courts may be the reason to accept a physician's appeal to the defense of necessity after having performed euthanasia (cf. Introduction). The court concluded from the evidence that the parents consented to the termination of their baby's life. However, it did not mention this consent explicitly as a necessary condition for accepting the appeal to the defense of necessity in such cases, whereas for euthanasia with competent patients the patient's request has always been considered a necessary requirement for a successful appeal to the defense of necessity.

The Leeuwarden Court of Appeal in the case of K, followed the same line as the Amsterdam Court in the case of P, mentioning the *consent* of the parents as essential for the defense of necessity. Other conditions considered important by the Leeuwarden court were[19]:
- no doubt must exist about diagnosis and prognosis,
- the doctor must consult colleagues,
- death must be brought about in a careful and correct way,
- the doctor must report the case.

The reasoning of the Courts

The reasoning the courts was broadly, but not exactly similar. In this section I will analyse the various arguments and make some brief comments. A more general, critical discussion will be given in the next paragraph.

In the first place the courts conclude, on the basis of the expert evidence, that the baby has disorders that will lead to a natural death unless treated. Secondly, they consider medical treatment aimed at saving the life of the baby as medically futile or disproportionate (in the Groningen case even with treatment the baby was nonviable). The courts differ in their interpretation of the situation and in the reasons to accept the physician's appeal to the defense of necessity. Before the Alkmaar court the physician argued that the decision to withhold treatment should be interpreted as a choice for the death of the baby. By this decision the baby was already yielded to death. It would be incorrect to consider the life-terminating action as the first and only expression of the decision to take the life of the baby. Therefore, acceptance of the withholding of treatment would logically require the acceptance of the life-terminating action. The court rejected this defense, concluding that the baby was killed precisely because death was not imminent.[20] However, considering whether this action is punishable this same court observes that "only the moment death would come was not certain".[21] The Amsterdam court goes further and agrees with the defense that the non-treatment decision can be seen as a choice against the life of the baby, concluding that, in the light of that decision, a decision

[17] H.J.J. Leenen, *Actieve levensbeëindiging bij een ernstig gehandicapte baby*, 23 NED JURISTENBLAD 851-852 (1995).

[18] See reference 10, p.30; by saying this the court does not mean to deny that physicians and relatives take decisions that effect the life and moment of death; it means to say that a decision to intentionally terminate the life of a patient can never been taken by a proxy.

[19] See reference 12, section 12.10

[20] See reference 9, p.293.

[21] IBID, p.300.

had then to be made about her death.[22] These considerations at least suggest that a short life expectancy (in this case between a few weeks and half a year) makes the killing (more) acceptable. It will be clear that this criterion can easily be extended to large groups of patients.

In the second place, the courts state that the physicians had two options: continue and intensify pain and symptom treatment, or kill the baby to finish its suffering. In the case of P the Amsterdam court put forward a number of reasons why pain treatment in this case would have been medically meaningless (see above). The physicians involved expected that it would be difficult to uphold the non-treatment decision when the baby would survive for a number of weeks. But operations would prevent a natural death, whereas the baby's quality of life was expected to be very low. Furthermore, survival was considered burdensome for the parents and the care-givers because then frequent medical decisions would have been necessary. This brings in the interests of third parties as a reason to end the life of an incompetent patient. Again, this reasoning in itself could be extended to other categories of patients.

With respect to the dilemma in which the physicians found themselves of treating the pain or killing the patient, the Courts of Appeal are more careful than the District Courts. The latter courts qualify the killing of the baby as "the only way to go"[23] and as a result of there being "no other choice".[24] In these formulations the real conflict of duties that justifies an appeal to the defense of necessity becomes apparent. This conflict has been described in the Court decisions as the conflict between, on the one hand, the duty to maintain life and obey the law prohibiting euthanasia and assisted suicide and, on the other hand, the duty to do everything possible to alleviate pain and suffering (cf. Introduction). But these two duties do not really conflict. Even the permission to kill does not provide a *duty* that could overrule the duty to maintain life. The logical opposite of the duty to maintain life is a duty to kill. So, the only duty that could really overrule the duty to respect life and not to kill is the duty to kill. If a court accepts an appeal to the defense of necessity on the basis of a conflict of duties, it logically would have to accept that in certain circumstances there is a duty to kill. Until recently the Courts had refrained from drawing this conclusion. However, the decisions of the Alkmaar and Groningen courts, when they speak of "the only choice" and "the one way to go", imply a duty to kill on the part of the physician involved. Therefore, it is all the more important that the Courts of Appeal used more careful formulations, though this implies a loss of logical consistency. They concluded that in the given circumstances the choice of the physician to end the life of the baby was justified because "according to scientifically sound medical opinion and (the) norms of medical ethics" he found himself in a situation of *force majeure* due to a conflict of duties.[25]

Another reason why in these cases the courts accepted the killing instead of pain treatment seems to be the opinion that the latter "as a side-effect could have had the death of the baby as a consequence"[26] or that it would also involve an intention to kill.[27]

On the moral equation of the shortening of life as a side-effect and intentional killing I will comment in the next paragraph. It should be pointed out here that particularly in the case of doctor K. one can argue that the courts should have rejected the killing as the better option. In this case the expert evidence consulted by the court diverged, both on the quality of medical care and on the ethics of killing the baby. Two medical experts saw at least possibilities for further pain treatment of the baby. One ethicist said killing was ethically defensible but that some people would think otherwise. The other ethicist said it was unethical, although some in Dutch society would accept it. The fact that two experts thought that pain treatment was possible is very important. In the light of the Supreme Court's

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[22] See reference 11, p.27, section 15.

[23] See reference 9, p.300.

[24] See reference 11, p.32.

[25] See reference 11, section 22 and reference 12, section 12.11. This is a more or less standard formulation that courts use in justifying the acceptance of the appeal to the defence of necessity by a physician who performed euthanasia.

[26] See reference 10, p.32.

[27] See reference 12, section 19.

decision in the case of Chabot and of the support of this decision by the Ministers of Justice and Public Health and by the KNMG, the termination of a patient's life cannot be accepted when there still are other possibilities of pain treatment.[28] In this context it is important to note that two experts consulted by the Leeuwarden Court of Appeal, but not by the Groningen Court, publicly stated that the life of the baby was not terminated because of untreatable pain. One of them said that the baby's life was intentionally ended because, given the circumstances, the parent wanted to be present when the child died.[29] According to the other expert the prevention of an undignified death was the main reason to end the baby's life.[30] For these experts these reasons should be seen in the context of the specific case, but the stated justifications could apply to larger groups of patients. It is also doubtful whether the courts would have accepted these reasons as valid. Once more this shows that the formulations used by physicians when reporting cases of euthanasia do not necessarily adequately represent reality.[31]

Discussion

In the above section two lines of reasoning can be traced, not uncommon in discourses that defend euthanasia. First, in cases of short life expectancy, stopping or not starting treatment while accepting that the patient will die is virtually morally equated with intentionally killing the patient. A decision not to treat is regarded as an intention to shorten the life of the patient. In my opinion this reasoning is flawed for two reasons. First, the prognosis that a patient will die soon cannot be a reason to accept his killing. The prognosis of each human life is death, sooner or later. What life-expectancy is short enough to allow such killing? Second, a nontreatment decision accepting death cannot be equated morally with intentionally killing.[32] Callahan has convincingly argued that such an equation misunderstands the causality between the nontreatment decision and death. Such an equation would only be valid if medicine could completely control the situation of the patient.[33] Such control does not exist, nor is it desirable.

A second false equation is that of pain and symptom treatment in which the doses are adjusted to the symptoms, which has as a side-effect a shortening of life, and intentional killing by the administration of lethal substances. This rejection of the principle of `double effect' is ethically unpersuasive. In fact the principle plays a role across medicine. Only if one looks at the final result do the two actions seem the same. A strict consequentialist approach could accept that those courses of action are morally equal. But such an approach is at odds with ordinary human experience and much non-consequentialist philosophy, which show that the moral evaluation of a person's actions takes into account the intention of the person. In fact, advocates of euthanasia and life-terminating

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[28] Chabot is a psychiatrist who assisted a mentally suffering patient in committing suicide. His case ultimately came before the Supreme Court. The Supreme Court decision of 21 June 1994 has been published in: 69 NED JURISTENBLAD 895 (1994); for an extensive presentation of this case, see: H. Hendin, *Seduced by death: doctors patients and the Dutch cure,* 10,2 ISSUES IN LAW & MEDICINE 123-168 (1994). For the position of the ministers of Justice and of Health care, see: W. Sorgdrager, E. Borst-Eilers, Euthanasie. De stand van zaken, [Euthanasia. The state of he art], 50 MEDISCH CONTACT 381-384 (1995). The position of the KNMG has been published in: W.R. Kastelein, STANDPUNT HOOFDBESTUUR KNMG INZAKE EUTHANASIE [position general committee KNMG on euthanasia], 1995.

[29] *Waar de wegen van twee kinderartsen scheiden,* [Where the paths of two pediatricians separate] REFORMATORISCH DAGBLAD, annex RD/Accent, Saturday 20 April 1996, p.8.

[30] Discussion with the pediatricians G. van Bruggen and H. A. A. Brouwers about the case of doctor K. EO-TIJDSEIN RADIO 18 April 1996.

[31] Cf. G. van der Wal, et al., Bij justitie gemelde euthanasie en hulp bij zelfdoding [to juridical authorities reported euthanasia and assisted suicide], 47 MEDISCH CONTACT 1023-1028 (1992). See also G. van der Wal, P.J. van der Maas, note 7, chapter 11.

[32] See also H. Jochemsen, *Life-prolonging and life-terminating treatment of severely handicapped babies: A discussion of the report of the Royal Dutch Society of Medicine of `Life-terminating actions with incompetent patients: Part I: Severely handicapped newborns',* 8,2 ISSUES IN LAW AND MEDICINE 167-181 (1992).

[33] D. Callahan, *When self-determination runs amok,* 22,2 HASTINGS CENTER REPORT 52-55 (1992); and D. Callahan, *Can we return death to disease?* 19,1 HASTING CENTER REPORT 4-6 (1989).

actions are very ambivalent, if not self-contradictory in rejecting this principle in these cases. For when they interpret the findings of Van der Maas et al. they distinguish (as does Van der Maas) euthanasia from other life-shortening acts and omissions, precisely on the grounds that euthanasia involves intentional, rather than foreseen, life-shortening.[34] If they did not make this distinction the number of cases of euthanasia would be dramatically higher than reported. It is, therefore, inconsistent for them to deny the distinction between, on the one hand, forgoing disproportional treatment, taking for granted an unavoidable shortening of life, and, on the other, intentional killing in the care for severely handicapped babies.

In conclusion

No doubt modern neonatology sometimes presents parents and caregivers with heart-rending situations. Very difficult decisions have to be made.[35] In cases of babies with multiple congenital disorders nontreatment decisions by parents together with caregivers are generally considered justifiable on the basis of the proportionality principle, the wish of the parents and the principle of not harming. In the nontreatment cases appropriate palliative care must be given to prevent avoidable suffering, even if this would shorten life as a side-effect.

However, medical practice and the court decisions in the Netherlands have clearly gone a radical step further, extending the practice of euthanasia to a class of incompetent patients. This disturbing extension has been based on reasoning which this paper has criticized as seriously flawed and as capable of further extension to other classes of vulnerable, incompetent patients.

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[34] See paragraph `Euthanasia practice' in this article and reference 7.

[35] See for example: T.H. Murray and A.L. Caplan (eds.), WHICH BABY SHALL LIVE? HUMANISTIC DIMENSIONS OF THE CARE OF IMPERILED NEWBORNS 1985 (Humana Press); *Special Issue on imperiled newborns*, 17,6 HASTINGS CENTER REPORT (1987).