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IDEAS

How Dutch Law Got a Little Too Comfortable With Euthanasia

The story of a 17-year-old's assisted death wasn't real—but it could have been.

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IMAGE SOURCE VIA GETTY

However alarmist some stories about Noa Pothoven's death might have been, one should remember that euthanasia of a minor as young as 16 for psychiatric suffering is indeed legal in the Netherlands.

Pothoven, a 17-year-old girl in that country, had struggled with depression, anorexia, and post-traumatic stress disorder, reportedly after being sexually abused at age 11 and raped at 14. She had sought permission for medical euthanasia and announced on Instagram that she

intended to die. Her passing on June 3 prompted news stories around the world, their dramatic headlines an implicit rebuke of Dutch assisted-death policies.

In most countries, the debate over physician-assisted suicide has centered on adults in the final stages of incurable physical illnesses. Pothoven's age and mental illness made her case quite different, which is why the initial English-language news stories on her death sparked such alarm. That uproar subsided when subsequent reports clarified that Pothoven's euthanasia request had been turned down, and that she had instead died by refusing to eat and drink.

This sad outcome does not, however, show that all is well with the Dutch approach to assisted death—or that fears of a slippery slope are merely alarmist.

I have researched the Netherlands' experience in detail and written a number of peer-reviewed papers about it. In Dutch usage, the term *euthanasia* legally covers cases in which medical professionals administer lethal injection and those in which doctors provide drugs that patients ingest to end their life. The Dutch system gives deference to doctors' expertise; it respects the relationship between an individual doctor and a patient; and it recognizes that mental illness can be painful and debilitating. Yet this system illustrates how priorities that appear logical on their own terms combine, in some cases, to produce disturbing results. A respected Dutch-language medical journal recently reported that an 18-year-old had died via medically assisted suicide for psychiatric problems.

In the United States, debates about physician-assisted suicide are typically couched in terms of patient autonomy. The rationale for the landmark 2002 euthanasia law in the Netherlands, though, was that it codified a legal option for doctors, whose primary duties—to preserve life and to relieve suffering—were thought to conflict in the case of certain anguished patients. In the decades before 2002, a series of court rulings

had offered legal protection for Dutch physicians who facilitated patients' deaths.

Unlike in most other jurisdictions where medically facilitated deaths are legal, the euthanasia law in the Netherlands has no requirement that a patient be close to death. The law's directives are few and broadly drawn. Aside from obtaining formal consent—a patient's request must be "informed" and "voluntary and well considered"—the doctor must be "satisfied" that two conditions are met: The patient has "unbearable suffering, without prospect of improvement," and there is "no reasonable alternative" to address it. The doctor must use the euthanasia medications properly, and she must consult an independent physician—though she is not bound by this outside consultant's opinion. Indeed, as long as the patient is at least 16, no other person's consent except the patient's is mandatory. (Parents of 16- and 17-year-olds are involved in the discussion, but their permission is not required. Patients as young as 12 can seek euthanasia with parental consent. In about 10 cases since 2002, children ages 12 to 17 have received euthanasia; as far as I know, all were for physical illnesses.)

After the patient's death, the doctors involved submit written reports, which are reviewed by one of five regional review committees consisting of a physician, a lawyer, and a bioethicist. These positions are not full-time jobs, but the five committees handle more than 6,500 cases a year. (In the United States, the per-capita equivalent would be 126,000.) Needless to say, the single physician on each committee cannot be a specialist on every disorder at issue. Over the years, only 0.18 percent of cases have been classified as "due care not met." The doctor is virtually always right when it comes to euthanasia. Only one doctor has ever been prosecuted for violating the 2002 law.

Until about 2010, the controversial practice of psychiatric euthanasia was rare, despite being permitted since the mid-1990s. Most Dutch psychiatrists—like most other doctors and the Dutch public—disapprove of psychiatric euthanasia. Still, there has been a steady increase, with 83

cases in 2017; the per-capita equivalent in the United States would be about 1,600 cases a year. Unlike euthanasia in general, psychiatric euthanasia is predominantly given to women. Most of these cases involve the End of Life Clinic, a network of facilities affiliated with the largest Dutch euthanasia-advocacy organization. These clinics routinely handle euthanasia requests refused by other doctors. (Noa Pothoven sought euthanasia there but was refused.)

An obvious question arises: How can any physician be sure that any patient with a serious psychiatric disorder, much less an 18-year-old, meets the legal criteria for euthanasia? The short answer is that the law gives considerable weight to their professional judgment.

Compared with cases involving cancer or other terminal illnesses, the application of the eligibility criteria in psychiatric euthanasia depends much more on doctors' opinions. Psychiatric diagnosis is not based on an objective laboratory or imaging test; generally, it is a more subjective assessment based on standard criteria agreed on by professionals in the field. Some doctors reach conclusions with which other doctors might reasonably disagree. Indeed, an otherwise healthy Dutch woman was euthanized 12 months after her husband's death for "prolonged grief disorder"—a diagnosis listed in the International Classification of Diseases but not in the Diagnostic and Statistical Manual of Mental Disorders used by psychiatrists and psychologists around the world.

Psychiatric disorders can indeed be chronic, but their prognosis is difficult to predict for a variety of reasons. There is a paucity of relevant, large longitudinal studies. Patients may get better or worse due to psychosocial factors beyond the control of mental-health providers. Also affecting prognoses is the varying quality and availability of mental-health care—which, even in wealthy countries, patients with significant symptoms may not receive. Noa Pothoven and her family had criticized the dearth of care options available in their country for patients like her. Indeed, more than one in five Dutch patients receiving psychiatric euthanasia have not previously been hospitalized; a significant minority

with personality disorders did not receive psychotherapy, the staple of treatment for such conditions. When treatments are available, doctors in the Netherlands have the discretion to judge that there are "no alternatives" if patients refuse treatment.

It is not easy to distinguish between a patient who is suicidal and a patient who qualifies for psychiatric euthanasia, because they share many key traits. In some cases, psychiatric euthanasia is simply a highly effective means of suicide, as in the case of a man who attempted suicide, was hospitalized, and then received psychiatric euthanasia.

In the end, one does not need to be a psychiatrist to appreciate how psychiatric disorders, especially when severe enough to lead to euthanasia requests, could interfere with a patient's ability to make "voluntary and well considered" decisions—especially when that patient is a minor. The basis for concluding that any teenager with a psychiatric disorder has "no prospect of improvement" and "no alternatives" is likely to be uncertain at best.

These concerns, perhaps, are what unsettled people who jumped to conclusions about Noa Pothoven's case this past week. Knowing how the rules are set up in the Netherlands, one can see how even a minor could be judged by some doctor as eligible for psychiatric euthanasia. But such a judgment, I believe, would be more a reflection of the priorities embedded in the Dutch law than the state of clinical science.

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