EXAMINING THE GRONINGEN PROTOCOL: COMPARING THE TREATMENT OF TERMINALLY-ILL INFANTS IN THE NETHERLANDS WITH TREATMENT GIVEN IN THE UNITED STATES AND ENGLAND

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In 2004, after two unsuccessful attempts to prosecute physicians who euthanized infants, physicians at the University Medical Centre in Groningen, with the help of the local prosecutor, produced the "Groningen protocol." This protocol set out a procedure for physicians to use if their intention is to end the life of a terminally-ill infant. The use of the protocol creates vast differences between the treatment of terminally-ill infants in the United States and England, on the one hand, and in the Netherlands on the other hand. The *Kadijk* and *Pearson* cases illustrate the application of the Groningen protocol while comparing the treatment of terminally-ill infants in the Netherlands, the United States, and England. While the Groningen protocol may appear to be extreme, the two case studies illustrate that the protocol has two advantages over the solutions provided in the United States and England. First, the Groningen protocol provides a quicker and more humane death for infants who are in pain and have a terminal diagnosis. Second, the Groningen protocol can be used as a regulatory device and can help to ensure transparency in the health care system.

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INTRODUCTION

There is a growing debate surrounding euthanasia and the right-to-die movement in both Europe and the United States.[1] Much of the controversy is centered in England, where euthanasia is illegal.[2] However, there is a growing movement to legalize euthanasia due to a significant number of Britons travelling to Switzerland to take advantage of their euthanasia laws.[3] The increase in foreigners travelling to Switzerland for the purpose of being euthanized has also caused concerns in Switzerland.[4] England and Switzerland are not the only countries to reconsider euthanasia. For example, the Luxembourgish Government recently took drastic measures to legalize some forms of euthanasia.[5] Many of the countries that are now legalizing euthanasia are modeling their laws on laws already existing in other countries.[6]

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1 *See* Sarah Lyall, *U.K. Arrests Filmmaker Admitting to Euthanasia; After Televised Moment Describing 'Terrible Pain' Long Ago, Police Move Fast*, INT'L HERALD TRIB., Feb. 19, 2010, at 4; Angela Willans, *Cleaning Up a Few Facts About Assisted Suicide*, N. DEVON J., May 7, 2009, at 57.

2 *See* Isabel Oakeshott, *Lord Falconer Backs Suicide Reform,* SUNDAY TIMES (London), May 31, 2009, http://www.timesonline.co.uk/tol/news/politics/article6395949.ece.

3 Denis Campbell, *800 Britons on Waiting List for Swiss Suicide Clinic*, OBSERVER (London), May 31, 2009, http://www.guardian.co.uk/society/2009/may/31/assisted-suicide-reform-uk-switzerland.

4 Deborah Ball & Julia Mengewein, *Assisted-Suicide Pioneer Stirs a Legal Backlash*, WALL ST. J., Feb. 6, 2010, at A1.

5 *Teri Schultz, Europe's Growing Euthanasia Debate,* GLOBALPOST (May 4, 2009, 8:09 ET), http://www.globalpost.com/dispatch/health/090501/euth. When Luxembourg's ruler, Grand Duke Henri, indicated he would not sign the bill passed by Parliament that legalized euthanasia, the Parliament changed the Luxembourg Constitution and stripped the Grand Duke of his power to reject laws. *Id*.

6 *See generally* Raphael Cohen-Almagor, *Dignity, Compassion, Care, and Safety Valves at the End-of-Life*, 41 ISR. L. REV. 358 (2008) (reviewing EUTHANASIA IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE (Mark Groenhuijsen & Floris Van Laanen eds., 2008)) (detailing euthanasia laws in four different countries).

The debate surrounding the right-to-die movement raises a number of controversial issues. These issues embody the continuing struggle between conflicting political, ethical, moral, social, religious, and philosophical beliefs within Western society.[7] One of the most controversial matters was introduced in 2004, when Dutch physicians at the University Medical Centre in Groningen, Netherlands proposed a set of guidelines for the active involuntary euthanasia of infants.[8] These guidelines, known as the Groningen protocol, set out a procedure for physicians to follow when terminating the life of a suffering infant for whom there is no pain relief.[9] The authors of the protocol assert that most Dutch physicians find it unacceptable to simply wait until death relieves the infant's suffering, and thus they would prefer to euthanize the baby under such circumstances.[10]

The use of the Groningen protocol sparked a heated debate centered on whether doctors or parents should bear the decision-making responsibilities for the involuntary euthanasia of children and infants.[11] The 1993 case of Tracy Latimer illustrates this point.[12] Tracy Latimer was a twelve-year-old girl who suffered from continuous pain due to a severe case of cerebral palsy.[13] She could not walk, talk, feed herself, or communicate with others.[14] Tracy had already undergone several operations and was soon to have another operation to remove part of her leg to relieve a dislocated hip.[15] To spare Tracy her continued pain, her father suffocated her using exhaust from his vehicle.[16] Tracy was unable to make the decision whether she should live or die for herself, and her

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[7] Lisa W. Bradbury, Note, *Euthanasia in the Netherlands: Recognizing Mature Minors in Euthanasia Legislation*, 9 NEW ENG. J. INT'L & COMP. L. 209, 209 (2003).

[8] JOHN GRIFFITHS, HELEEN WEYERS & MAURICE ADAMS, EUTHANASIA AND THE LAW IN EUROPE 231 (2008).

[9] *Id.*

[10] *Id.*

[11] *See* Matthew Schofield, *Baby Euthanasia Stirs Heated Debate; Dutch Hospital Plan Covers Terminally Ill, DETROIT FREE PRESS, Oct. 12, 2004, at 4A;* Hugh Hewitt, *Death By Committee; What the Groningen Protocol Says About Our World, and Where It Might Lead Next, WKLY. STANDARD, Dec. 1, 2004;* Lloyd Mack, *Op-Ed., Protecting the Vulnerable; Euthanasia Debate, DAILY MINER & NEWS (Kenora, Can.) Dec. 10, 2004, at A4.*

[12] The Latimer case is Canada's leading example of involuntary euthanasia of a minor. *See* Ian Robertson, *Group Hopes To Kill Controversial Bill; EUTHANASIA: MPs Preparing To Debate Legislation Next Week*, LONDON FREE PRESS (Ont.), Sept. 25, 2009, at B3.

[13] *Mack, supra note 11.*

[14] *Id.*

[15] *Id.*

[16] *Id.*

father made the decision for her.[17] He did so with no supervision and with no assistance from a physician.[18]

The Groningen protocol is designed to assist people who find themselves in Tracy's unfortunate situation as well as infants who cannot communicate with the decision makers. The purpose of the protocol is to restrain people like Tracy's father from committing these types of acts in secret and without supervision.[19] Rather, the Groningen protocol proposes that the decision to end an infant's life be made in conjunction with a physician who provides the guardian with all relevant medical information, and then the physician can end the child's life in a humane manner, if appropriate.[20]

The Groningen protocol is intended to make the decision-making process, as well as the decisions themselves, transparent.[21] Transparency is essential because life-and-death decisions are made in hospitals every day.[22] Experts acknowledge that doctors euthanize routinely in the United States and elsewhere, but the practice is not typically disclosed.[23] More than half of all deaths occur under medical supervision.[24] Under the supervision of a physician, decisions are made to discontinue measures that might marginally extend a child's life.[25] Rather than have these decisions made in relative secrecy—with varying amounts of information and little oversight—the goal of the Groningen protocol is to regulate these decisions.

This comment explores the Groningen protocol and argues that the protocol is needed to prevent the needless suffering of infants born with terminal conditions. While the Groningen protocol may appear to be extreme, its application presents a more humane solution than that currently used in the United States and England, and its use as a regulatory device is valuable for ensuring transparency in the health care system.

Part I defines some key terms and clarifies for the reader different kinds of euthanasia discussed in this article, both generally and

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[17] *Id*.
[18] *Id*.
[19] Toby Sterling, *Netherlands Studies Euthanasia of Babies; One Hospital Says It's Already Carrying Out Mercy Killings*, HERALD-SUN *(Durham, N.C.), Dec. 1, 2004, at A1*.
[20] GRIFFITHS, WEYERS & ADAMS, *supra* note 8, at 231.
[21] Sterling, *supra* note 19.
[22] *Id*.
[23] *Id*.
[24] *Id*.
[25] *Id*.

specifically relating to involuntary euthanasia of infants and children. Next, Part II examines the history of euthanasia in the United States, England, and the Netherlands, including the implementation of the Groningen protocol. Part III presents two case studies from England and the Netherlands, and applies the Groningen protocol to each case to show that application of the protocol leads to a more transparent and humane process in handling euthanasia. The comment concludes that the Groningen protocol is not an extreme solution, and that the solutions developed in the United States and England, while appearing to be less severe, are actually crueler and produce needless suffering.

I. BACKGROUND ON KEY TERMS AND DIFFERENT KINDS OF EUTHANASIA

The right-to-die debate is often confusing, in part because there are several categories of euthanasia. Thus, it is essential at the outset to define frequently used key terms.

"Suicide" is the act of taking one's own life voluntarily and intentionally,[26] whereas "physician-assisted suicide" involves the physician providing the means necessary for a patient to commit suicide but taking no additional action to complete the act.[27] Suicide and physician-assisted suicide differ from euthanasia because the patient is taking his or her own life.[28] "Euthanasia," simply defined, means "a good death" or "dying well,"[29] but the term typically refers to a physician's act that is primarily intended to cause the death of a patient.[30]

There is also a difference between active and passive euthanasia.[31] "Passive euthanasia" refers to a physician's inaction or omission, such as withholding life-sustaining hydration and nutrients or withholding potentially life-sustaining therapies.[32] The term "active euthanasia," in contrast, involves a conscious and intentional act, such as

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[26] MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 1249 (11th ed. 2003).

[27] Bradbury, *supra* note 7, at 210.

[28] Clarence Braddock III & Mark Tonelli, *Ethics in Medicine: Physician Aid-in-Dying*, UNIV. OF WASH. SCH. OF MED., http://depts.washington.edu/bioethx/topics/pad.html#ques3 (last modified Oct. 25, 2010).

[29] Bradbury, *supra* note 7, at 209.

[30] Mason L. Allen, Note, *Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia*, 31 BROOK. J. INT'L L. 535, 539 (2006).

[31] *See* Bradbury, *supra* note 7, at 209; Allen, *supra* note 30, at 540.

[32] Allen, *supra* note 30, at 540.

injecting a lethal dose of opiates into a patient, to terminate the life of a suffering individual.[33]

One conceptual dichotomy that has arisen is a distinction between active voluntary and active involuntary euthanasia.[34] "Active voluntary euthanasia" involves a mentally competent, suffering patient's request to ensure a quick, but premature, death.[35] In contrast, "active involuntary euthanasia" is the premature death of a patient due to physician intervention, without the individual's informed consent.[36]

The Groningen protocol contemplates a form of active involuntary euthanasia. Since the infant is not able to request euthanasia, the act is inherently involuntary. However, the line between voluntary and involuntary is somewhat blurred because, while the child cannot actively request euthanasia, the child's parent can make the request on behalf of the infant as the child's legal guardian.[37] Thus, there is an element of voluntary euthanasia as well. Additionally, since the physician is typically administering a drug to terminate the child's life, the act is one of active euthanasia.[38]

II. A BRIEF HISTORY OF EUTHANASIA

A. A BRIEF HISTORY OF EUTHANASIA THROUGH THE MID-TWENTIETH CENTURY

The Greeks were one of the first societies to consider certain forms of suicide acceptable.[39] In fact, the term "euthanasia" is derived from the Greek "eu," meaning "well," and "thanatos," meaning "death."[40] Euthanasia was a common practice because the Greeks considered suicide punishable only when the act was irrational.[41] Based upon the

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[33] Bradbury, *supra* note 7, at 209; Allen, *supra* note 30, at 540.

[34] *See* Bradbury, *supra* note 7, at 209

[35] *Id*.

[36] *Id*.

[37] *See* Eduard Verhagen & Pieter J.J. Sauer, *The Groningen Protocol —Euthanasia in Severely Ill Newborns,* 352 NEW ENG. J. MED. 959, 959–62 (2005); Douglas S. Diekema, *Ethics in Medicine: Parental Decision Making*, UNIV. OF WASH. SCH. OF MED., http://depts.washington.edu/bioethx/topics/parent.html#ques2 (last modified Apr. 11, 2008).

[38] *See* Bradbury, *supra* note 7, at 209.

[39] JENNIFER M. SCHERER & RITA J. SIMON, EUTHANASIA AND THE RIGHT TO DIE: A COMPARATIVE VIEW 1(1999).

[40] *Id*.

[41] *Id*. at 2. Sickness was considered a rational reason to commit suicide at this time. *Id*.

belief that human beings controlled their own bodies, both the Greeks and Romans would assist the elderly or ailing to commit suicide.[42]

In the third century, the arguments supporting suicide became less popular with the spread of Christianity.[43] It was at this point that views on euthanasia became entangled with religious beliefs.[44] Christian moralists argued that "a human's life was the sole property of God, and it was His and only His to give and take at His will."[45] Christian opposition to suicide peaked in the thirteenth century when Christian philosopher St. Thomas Aquinas published *Summa Theologica*.[46] Aquinas believed suicide was the most serious sin and "unlawful and contrary to the laws of nature."[47]

The Enlightenment was a time of rapid discoveries in medical knowledge, which created a new awareness of the struggles facing terminally ill patients.[48] This awareness led to a minor shift in attitudes toward accepting the practice of euthanasia. As a result, during the early twentieth century several pieces of legislation to legalize euthanasia were introduced in both the United States and England.[49] Although this legislation failed to pass, private euthanasia societies were created to carry on the mission.[50] This shift favoring euthanasia was temporary, as Adolph Hitler used the word "euthanasia" to describe his "mass extermination program," shattering any progress made toward the acceptance of euthanasia.[51] After Hitler was defeated, the General Assembly of the World Medical Association adopted a resolution stating

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[42] Margaret M. Funk, Note, *A Tale of Two Statutes: Development of Euthanasia Legislation in Australia's Northern Territory and the State of Oregon*, 14 TEMP. INT'L & COMP. L.J., 149, 149 (2000).

[43] Bradbury, *supra* note 7, at 216–17.

[44] *Id.* at 217.

[45] *Id.*

[46] *Id.*

[47] *Id.*

[48] *Id.* at 218.

[49] SCHERER & SIMON, *supra* note 41, at 4–5. In 1906, the Ohio legislature considered a bill to legalize the act of euthanasia. While there was some initial support of the bill in the legislature, the press fiercely criticized the bill and it was ultimately defeated. *Id.* at 4. Similarly, in 1935, England supported the "Voluntary Euthanasia Legislation Bill," which regulated the practice of euthanasia. The bill was defeated in 1936. *Id.*

[50] Bradbury, *supra* note 7, at 218–19.

[51] *Id.* at 219.

that all national medical associations should condemn euthanasia under all circumstances.[52]

B. EUTHANASIA IN ENGLAND

Following the General Assembly's declaration, Britain passed the Suicide Act 1961, which eliminated suicide as a crime but made "aid[ing], abet[ting], counsel[ing] or procur[ing] such an act by another" a statutory offense with a penalty of up to fourteen years imprisonment.[53]

The best-known case to challenge the Suicide Act was *Pretty v. United Kingdom*, in which a woman with motor neuron disease requested that her husband not be prosecuted for assisting in her death.[54] Diane Pretty knew that her disease would paralyze her and leave her unable to end her own life, so she asked her husband to assist her.[55] The House of Lords ruled that the Suicide Act did not create a right to die or a right to gain assistance in dying.[56] Instead, the House of Lords relied on principles from the European Convention of Human Rights, which emphasized the "sanctity of human life" and stated that no person should be "deprived of life by means of intentional human intervention."[57] The statement did not indicate whether an individual had a right to choose whether to live or die.[58]

However, there are many exceptions to the Suicide Act as a result of British medical procedure, which allows terminal sedation and refusal of treatment despite certain death.[59] Terminal sedation is an example of the "double effect" doctrine, under which reasonable measures may legally be taken to reduce a terminal patient's pain and suffering, even when such measures may accelerate death in the process.[60]

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[52] Thane Josef Messinger, *A Gentile and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 Denv. U.L. Rev. 175, 195 (1993).

[53] Suicide Act 1961, 1961, 9 & 10 Eliz. 2, c. 60, § 2 (Eng.).

[54] Pretty v. United Kingdom, 35 E.H.R.R. 1 (2002).

[55] Lindsay Pfeffer, Note, *A Final Plea for "Death with Dignity": A Proposal for the Modification and Approval of the Assisted Dying for the Terminally Ill Bill in the United Kingdom*, 15 CARDOZO J. INT'L & COMP. L. 497, 502 (2007).

[56] *Pretty*, 35 E.H.R.R. 1 ¶ 14.

[57] Pfeffer, *supra* note 55, at 502 (quoting SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL, VOL. I: REPORT, 2005, H.L. 86-I, at 25 (U.K.), *available at* http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86i.pdf).

[58] *Id*.

[59] *Id*. at 501.

[60] *Id*.

England is currently debating whether to legalize some forms of euthanasia.[61] Lord Charles Falconer is leading these efforts.[62] Part of the debate is centered on the growing number of Britons who are waiting to travel to other countries to take advantage of their euthanasia laws.[63] The result is a booming market for "death tourism," where Britons travel to countries allowing euthanasia, especially Switzerland, to end their lives.[64]

C. EUTHANASIA IN THE UNITED STATES

With the exception of Oregon and Washington State,[65] active voluntary and active involuntary euthanasia are illegal in the United States.[66] Like England, however, the United States allows passive euthanasia, in which patients refuse treatment, even if it leads to an earlier death.[67] In many states, third parties may exercise this right for incompetent patients when they believe, in good faith, that the patient's best interests require the action or inaction that will result in death.[68] Parents can make these decisions for their infants and children.[69] The decision to end the life of another person because of pain, discomfort, or incapacity is made frequently in hospitals and other care centers in the United States.[70]

Moreover, there is reason to believe that family members often take unlawful actions to end the lives of suffering individuals.[71] One such example is the previously discussed *Latimer* case, in which Tracy Latimer's father took affirmative steps to end his daughter's life.[72] Additionally, doctors are often willing to take unlawful steps to terminate

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61 Oakeshott, *supra* note 2.

62 *Id*.

63 Campbell, *supra* note 3.

64 *Assisted Suicide Prompts More Recommendations*, SWISSINFO.CH (Oct. 27, 2006, 12:31) http://www.swissinfo.ch/eng/Home/Archive/Assisted_suicide_prompts_more_recommendations.html?cid=5526380; *see also* Campbell, *supra* note 3.

65 In 1994, Oregon passed the Death With Dignity law, which allows physician-assisted suicide under certain conditions. Michael J. Miller, Commentary, *Death with Dignity in New York, DAILY REC. OF ROCHESTER (Rochester, NY), Nov. 10, 2009*. A similar statute was passed in Washington State in 2008. *Id*.

66 Richard S. Kay, *Causing Death for Compassionate Reasons in American Law* in EUTHANASIA IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE257, 277 (Marc Groenhuijsen and Floris van Laanen ed., 2006).

67 *Id*.

68 *Id*.

69 *See* NEIL M. GORSUCH, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 192 (2006).

70 Kay, *supra* note 66.

71 *Id*. at 258.

72 Mack, supra note *11*.

a patient's life.[73] A 1998 survey found that 11 percent of doctors surveyed were willing to prescribe lethal drugs and 7 percent were willing to administer lethal injections despite their illegality.[74] A 2000 study found that nearly 23 percent of oncologists surveyed supported physician-assisted suicide, and nearly 11 percent of those physicians had already participated in such acts.[75] Therefore, while the United States has only passed laws legalizing euthanasia in two states, there is evidence that active involuntary euthanasia is practiced regardless of what is technically legal, and passive involuntary euthanasia is a widespread practice throughout the country.[76]

D. EUTHANASIA IN THE NETHERLANDS

As opposed to England and most of the United States, which have not enacted legislation allowing euthanasia, the Netherlands enacted the Termination of Life Act in 2001 ("the Act"), which became effective the following year.[77] Under the Act, both active voluntary euthanasia and physician-assisted suicide are criminal offenses.[78] Although the Act does not specifically address involuntary euthanasia or terminal sedation, it is likely that both acts remain illegal.[79] There is, however, a statutory exception for physicians.[80] If a physician satisfies the requirement of due care and also subsequently notifies the municipal pathologist of the actions taken, then the physician is excluded from the Act's coverage.[81]

The requirement of due care has several components.[82] First, due care requires the physician to inform the patient of his or her condition as well as chances for recovery.[83] This procedural protection reaffirms the informed consent doctrine.[84]

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[73] Kay, *supra* note 66, at 258.

[74] Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1193 (1998).

[75] Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 ANNALS OF INTERNAL MED. 527, 529 (2000).

[76] *See id*.

[77] Allen, *supra* note 30, at 546–47.

[78] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, chs. 4-A, 4-B (Neth.) [hereinafter "The Act"].

[79] *See* Allen, *supra* note 30, at 554–56.

[80] The Act, *supra* note 78, ch. 4-A.

[81] *Id*.

[82] Allen, *supra* note 30, at 554–56.

[83] The Act, *supra* note 78, art. 2.

[84] Allen, *supra* note 30, at 555.

The second factor for due care requires the physician to believe that the patient's request to be euthanized was "voluntary" and "well-considered."[85] This standard is not very rigorous, as the physician must only "hold the conviction" that the patient's request was free and voluntary; the request is not required to actually be free and voluntary.[86]

The third factor of due care calls for the physician to "hold the conviction that the patient's suffering was lasting and unbearable."[87] Like the second requirement, it is not the patient's actual state of suffering that is considered; rather, it is the physician's subjective belief.[88] Moreover, the Act "does not define 'suffering' as either physical or emotional pain, nor does the Act provide objective criteria or clinical indicators that would assist physicians or prosecutors in determining whether a patient's actual suffering fits the statutory standard."[89]

According to the fourth due care factor, the patient must "hold the conviction that there was no other reasonable solution for the situation he was in."[90] This provision places the emphasis on the *patient's* subjective belief.[91] Such emphasis is ironic, considering physicians are usually in a better position than their patients to decide whether other reasonable solutions are available because of their training and expertise.[92]

Finally, the Act requires the physician to consult with another physician prior to performing the requested euthanasia.[93] This consultation includes a second examination by the consulting physician to determine if the due care requirement has been satisfied.[94] Requiring a second opinion also ensures that a single doctor does not make the decision to perform euthanasia alone.[95]

Once the requested euthanasia has been performed, the physician must notify the municipal pathologist and document the patient's death as termination from non-natural causes.[96] The pathologist must perform

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[85] The Act, *supra* note 78, art. 2.
[86] Allen, *supra* note 30, at 555.
[87] The Act, *supra* note 78, art. 2.
[88] Allen, *supra* note 30, at 555.
[89] *Id*.
[90] The Act, *supra* note 78, art. 2.
[91] Allen, *supra* note 30, at 555.
[92] *Id*.
[93] The Act, *supra* note 78, art. 2.
[94] Allen, *supra* note 30, at 556.
[95] *See* The Act, *supra* note 78, art. 2.
[96] Allen, *supra* note 30, at 556.

an autopsy to determine how the euthanasia was performed as well as to provide independent documentation of the procedure.[97] Finally, all euthanasia procedures must be reported to a regional euthanasia review committee that ensures physician compliance with the due care factors.[98]

Because of the stringency of these factors, the Act ensures that physicians are following a set protocol designed to help them determine whether euthanasia is the best course of action for a patient.[99] The decision to euthanize is not made alone; the physician must seek out a second opinion.[100] Because all euthanasia procedures must be reported to the proper authority,[101] there is governmental oversight to keep abuse of the law to a minimum. Thus, the Netherlands' Termination of Life Act tries to ensure that euthanasia will be performed in the most humane and beneficial manner for the patient.

E. EXPANSION OF THE DUTCH EUTHANASIA LAWS THROUGH THE GRONINGEN PROTOCOL

While the Termination of Life Act was successfully implemented, it did not apply to individuals under the age of twelve.[102] In 2004, after two unsuccessful attempts to prosecute physicians who euthanized infants,[103] physicians at the University Medical Centre in Groningen, with the help of the local prosecutor, produced the "Groningen protocol."[104] This protocol set out a procedure for physicians to use if their intention is to end the life of an infant.[105]

Like the Termination of Life Act, the Groningen protocol is designed to guarantee that euthanasia is the best course for the infant.[106] Five criteria are used to assess each case: 1) the certainty of the diagnosis and prognosis; 2) the presence of hopeless and unbearable suffering, and a very poor quality of life; 3) parental consent; 4) consultation with an independent physician and his or her agreement with the treating

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[97] *Id*.

[98] *Id*.

[99] *See* The Act, *supra* note 78.

[100] The Act, *supra* note 78, art. 2.

[101] Allen, *supra* note 30, at 556.

[102] *See* The Act, *supra* note 78.

[103] The two cases are the *Prins* and *Kadijk* cases. *See* JOHN GRIFFITHS, ALEX BOOD & HELEEN WEYERS, EUTHANASIA AND THE LAW IN THE NETHERLANDS 341 (1998). The Kadijk case is discussed at length in Part III.A *infra*.

[104] GRIFFITHS, WEYERS & ADAMS, *supra* note 8, at 231.

[105] *Id*.

[106] *See id*.

physicians; and 5) the execution of the procedure in accordance with the accepted medical standard.[107]

Even when the five criteria are met, the physician must collect information that is needed to support and clarify the decision to euthanize the child.[108] This includes information about the diagnosis and prognosis, making the decision to euthanize, the consultation with other physicians, implementing the procedure, and the steps taken after death.[109] In describing the diagnosis and prognosis, the physician must describe all relevant medical data and the results of diagnostic tests used to establish the diagnosis, describe how the degree of suffering and life expectancy was assessed, and describe how the prognosis regarding long-term health was assessed.[110] Further, the physician must document the availability of alternative treatments and if there were any alternative means of alleviating suffering.[111]

The physician must then document the process of making the decision to euthanize the infant.[112] This includes documenting who initiated the discussion about euthanasia and who participated in the decision-making process.[113] The doctor records all the opinions expressed and the final consensus of the decision-makers.[114]

Next, the physician must document the consultation process and the implementation of the procedure.[115] The physician must record the physician or physicians who gave a second opinion and describe their qualifications.[116] The results of the examination performed by the consulting physician are documented as well as any recommendations made by the consulting physician.[117] The physician also documents the procedure itself and the reasons for the chosen method of euthanasia.[118]

Finally, the physician documents the steps taken after the death of the infant.[119] This includes the findings of the coroner and how the

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[107] Verhagen & Sauer, *supra* note 37, at 961.
[108] *Id.*
[109] *Id.*
[110] *Id.*
[111] *Id.*
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] *Id.*

euthanasia was reported to the prosecuting authority.[120] Additionally, the physician must describe how the parents are being supported and counseled.[121] If there is any follow-up planned, including a case review, postmortem examination, or genetic counseling, then the physician documents this information as well.[122]

There has been confusion over exactly what circumstances the Groningen protocol covers.[123] Eduard Verhagen, the medical director of the Department of Pediatrics at the University Medical Centre in Groningen, gives an example of the type of case for which the protocol was intended:

> Shortly after the baby's birth it was diagnosed with a very serious case of the skin disorder *dystrophic epidermolysis bullosa*, in which every contact with the skin causes it to come loose. Daily nursing and changing of the dressing was extremely painful for the baby (even when coma was induced, the baby screamed with pain), and the baby's condition was complicated by associated eating and growth disorders and growing auto-amputation of the extremities. The prognosis was for a short life characterized by serious pain and practically no developmental possibilities. It was decided that life-prolonging treatment, which the baby would certainly need, would be "futile" and would be withheld. At that point, the parents asked the doctors to end the baby's life. There was at the time no treatment being given that could be withdrawn, since stopping the daily medical care of the baby's skin was considered irresponsible. The doctors considered the baby's suffering unbearable and hopeless; there was no effective way of treating it. It would have been possible to increase the pain relief drastically, thus causing the baby to stop breathing, but in effect this would have amounted to termination of life, and in any case the parents rejected the idea. Following the [p]rotocol, the doctors ended the baby's life when it was about [two] months old. They reported the death as "not natural."[124]

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[120] *Id*.
[121] *Id*.
[122] *Id*.
[123] GRIFFITHS, WEYERS & ADAMS, *supra* note 8, at 231.
[124] *Id*. at 233.

Active euthanasia was the only action the doctors could take that would eliminate the infant's pain. The infant's death was reported to the proper authorities, who determined that the termination of life was "carried out in a careful way and was justifiable."[125] Therefore, the doctor was not prosecuted in the case, and the euthanasia was deemed to be legal.[126]

The Groningen protocol received much attention in the foreign press.[127] The protocol was seen as a radical step down the "'slippery slope' from voluntary euthanasia to Nazi practices."[128] The Dutch Association of Pediatrics, however, adopted the protocol in July 2005, and the Dutch Parliament has since commented on its usefulness.[129]

On November 29, 2005, the Secretary of State for Health and the Minister of Justice notified the Second Chamber of Parliament that they intended to create a national committee to advise the prosecutorial authorities concerning cases of termination of life of newborn babies.[130] This body's role is to determine whether the doctor who reports a case has met the duty of due care.[131] The committee then forwards its ruling to the prosecutorial authorities, who ultimately decide whether to prosecute.[132]

The Dutch law can be summarized as follows: while the termination of life through drug administration is in principal considered murder, a doctor's participation in termination of life may be justified under certain circumstances.[133] These circumstances include a high level of certainty concerning diagnosis and prognosis; a legitimate decision to withhold treatment; both parents' informed consent; the unavailability of other medically responsible treatment options for the baby's suffering;

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[125] *Id*. at 233 n.67.

[126] *See id*. at 233.

[127] *See, e.g*. Ian Traynor, *Secret Killings of Newborn Babies Trap Dutch Doctors in Moral Maze: Call for New Rules to End Dilemma for Medical and Legal Professions*, GUARDIAN (London), Dec. 21, 2004, at 3; John Schwartz, *End-of-Life Decisions for Newborns; Dutch Doctors Defend Euthanasia Rules for Suffering Babies*, INT'L HERALD TRIB., Mar. 11, 2005, at 3; Sue Turton, '*In the Baby's Last Seconds You See the Pain Relax and Then They Fall Asleep . . .*,' TIMES (London), Apr. 26, 2005; Jim Holt, *Euthanasia for Babies?*, N.Y. TIMES MAG., Jul. 10, 2005 at 11.

[128] GRIFFITHS, WEYERS & ADAMS, *supra* note 8, at 233.

[129] *Id*.

[130] *Id*. at 234.

[131] *Id*.

[132] *Id*.

[133] *Id*. at 240.

the fulfillment of the due care requirement; and the reporting and reviewing of the baby's death as a result of "non-natural" causes.[134]

There are many parallels between euthanasia law and the law concerning termination of life of newborn babies,[135] and the Groningen protocol is an extension of the Termination of Life Act. Both require a high level of certainty that the diagnosis is accurate and that the patient's suffering is lasting and unbearable.[136] Both also require that there are no other reasonable solutions to cure the situation,[137] and both require the physician to report the death as "not natural."[138]

The main difference between the Termination of Life Act and the Groningen protocol is that while the Act requires the physician to inform the *patient* of his or her condition and chances of recovery, the Groningen protocol requires the physician to inform the *parents* of the infant, who must then voluntarily make a "well-considered" decision.[139] This modification is essential for the Groningen protocol to be effective, as the infant cannot be informed and cannot make a well-considered decision. Like other legal matters,[140] the burden is shifted to the parents to make such decisions.

III. TWO CASE STUDIES

Two case studies effectively illustrate the differences between the treatment of children in the United States and England, on the one hand, and in the Netherlands on the other hand. The case studies include one case where euthanasia is clearly a viable solution and one case where euthanasia is not appropriate.

A. THE *KADIJK* CASE

On April 1, 1994, a baby girl was born in the Netherlands with serious congenital defects, including a cleft palate, defects of the nose, a protruding forehead, and skin and skull defects on the top of her head.[141] Due to these defects, the baby was unable to breathe properly and

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[134] *Id*.
[135] *Id*.
[136] *See* The Act, *supra* note 78; Verhagen & Sauer, *supra* note 37, at 961.
[137] *See* The Act, *supra* note 78; Verhagen & Sauer, *supra* note 37, at 961.
[138] *See* The Act, *supra* note 78; Verhagen & Sauer, *supra* note 37, at 961.
[139] *See* The Act, *supra* note 78; Verhagen & Sauer, *supra* note 37 at 961.
[140] Diekema, *supra* note 37.
[141] GRIFFITHS, BOOD & WEYERS, *supra* note 104, at 342. This is an English translation of the opinion of the Court of Appeals decision.

frequently turned blue.[142] The infant was also diagnosed with the chromosomal defect trisomy 13.[143] More than 80 percent of children with trisomy 13 die in the first month of their life.[144] Additionally, the infant's kidneys were not functioning properly.[145] Artificial respiration was provided for the infant, without which the infant would have died immediately.[146]

After the requisite tests were performed and the baby's parents were informed that the infant would likely live between one week and several months, the parents decided to bring their infant home.[147] Approximately one week later, a protruding bulge of tissue, which was determined to be cerebral membrane, appeared at the site of one of the skull defects.[148] The bulge continued to grow, and physicians suggested surgically closing the defect.[149] The parents were opposed to the surgery because of the pain and risks involved for the infant and because of the infant's poor life expectancy.[150] Additionally, the child was clearly in pain and was having trouble breathing.[151] The parents approached Dr. Kadijk and requested euthanasia for their infant.[152]

The physician suggested that the parents give the decision some additional thought and confirmed that the infant's death was inevitable.[153] Kadijk also consulted another physician, who concurred that terminating the infant's life was a proper course of action.[154] After the infant's health further deteriorated, Kadijk administered lethal drugs, and the infant died peacefully in her mother's arms.[155]

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[142] *Id*.

[143] *Id*. Trisomy 13 is a genetic disorder associated with the presence of extra material from chromosome 13. Complications may include breathing difficulty or lack of breathing, deafness, feeding problems, heart failure, seizures, and vision problems. *Id*. Additionally, congenital heart disease is present in most infants with Trisomy 13. *Trisomy 13*, MEDLINEPLUS, http://www.nlm.nih.gov/medlineplus/ency/article/001660.htm (last updated Aug. 11, 2009).

[144] *Trisomy 13*, *supra* note 143.

[145] GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 342.

[146] *Id*.

[147] *Id*.

[148] *Id*. at 342–43.

[149] *Id*. at 343.

[150] *Id*.

[151] *Id*.

[152] *Id*.

[153] *Id*.

[154] *Id*.

[155] *Id*. at 343–44.

This case predates both the Groningen protocol and the legalization of euthanasia in the Netherlands.[156] The law in the Netherlands prior to the passage of the Termination of Life Act and the implementation of the Groningen protocol was substantially similar to the law in the United States and England: euthanasia was prohibited.[157] However, the use of euthanasia in this case is relatively uncontroversial.[158] If the Groningen protocol were applied to this case, all five criteria would be met.[159] First, the diagnosis and prognosis were certain.[160] Given that more than 80 percent of children with trisomy 13 die in the first month of their life,[161] and that the child was suffering severe effects from the disease,[162] it was virtually certain that the child would not survive and would suffer for its remaining life.[163] Second, the infant was likely suffering, as she was clearly in pain when she was picked up, when her diapers were changed, and when her wounds were being tended.[164] Additionally, she regularly turned blue because of difficulty breathing.[165] The third criterion was met because the parents of the child requested euthanasia.[166] This clearly meets the requirement of parental consent. Fourth, the treating physician consulted an independent physician who agreed with the treating physician that euthanasia was appropriate.[167] Lastly, the procedure was carried out in an acceptable manner.[168]

The infant in this case falls into a category of patients who potentially can survive but whose expected quality of life after the intensive care period is very grim.[169] Under these circumstances, the physician and parents must together decide if the treatment is in the best interest of the infant.[170] In this case, it was apparent to the parents as well

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[156] *See* Allen, *supra* note 30, at 546–47.
[157] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 18.
[158] *See* Verhagen & Sauer, *supra* note 37, at 960.
[159] *See id*. at 961.
[160] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343.
[161] *Trisomy 13*, *supra* note 143.
[162] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343.
[163] *Id*.
[164] *Id*. at 343.
[165] *Id*. at 342.
[166] *Id*. at 343.
[167] *Id*.
[168] *See id*. at 343–44.
[169] *See id*. at 342–44; Verhagen & Sauer, *supra* note 37, at 959.
[170] Verhagen & Sauer, *supra* note 37, at 960.

as the physicians that the infant would not survive, even with medical treatment.[171] In such a situation, where the infant will not survive despite treatment by the physician, neonatologists in both the United States and Europe are willing to withdraw treatment and allow the infant to die.[172]

The key difference between the treatment of the infant in the Netherlands and the treatment the infant would receive in England or the United States is the way in which the infant would die.[173] In the Netherlands, this infant received a sedative that caused a deep sleep, and then she received a lethal dose of alloferin.[174] The infant died within half an hour of the administration of the lethal drug.[175] However, in England and the United States, it is customary for doctors to starve the infant to death.[176] This method is not as quick and painless as the solution used in the Netherlands.[177] Starvation can take as long as ten days.[178] Moreover, while the infant may be sedated and suffer little pain, the parents still must observe the prolonged dying process of their child.[179] While both procedures inevitably reach the same conclusions, the process in the Netherlands provides the infant with a humane and dignified death.

B. THE *PEARSON* CASE

John Pearson was a child born in England with Down syndrome and no other apparent abnormalities. [180] Upon hearing of her son's condition, his mother told her husband that she did not want the infant.[181] Dr. Leonard Arthur examined the baby and decided that the infant should be sedated with painkillers and given water but not food.[182] John died within three days.[183]

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[171] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343.

[172] Verhagen & Sauer, *supra* note 37, at 960.

[173] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343–44; Barbara Smoker, *On Advocating Infant Euthanasia*, FREE INQUIRY MAG., Dec. 2003–Jan. 2004, at 17–18.

[174] GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343–44. Alloferin is a skeletal muscle relaxant used as an anesthesia adjuvant. *Alloferin*, MEDICAL DICTIONARY ONLINE: http://www.onlinemedicaldictionary.org/Alloferin.asp?q=Alloferin (last visited Apr. 23, 2011).

[175] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343–44.

[176] *See* Smoker, *supra* note 173.

[177] *Id*. at 18.

[178] *Id*.

[179] *Id*.

[180] GORSUCH, *supra* note 69, at 193–94.

[181] *Id*. at 194.

[182] *Id*.

[183] *Id*.

Dr. Arthur was charged with murder, but the court allowed an attempted murder charge to go to the jury.[184] Ultimately, the jury acquitted him on the attempted murder charge, but not without controversy.[185] The judge expressed several opinions during the trial, including doubts as to whether withholding care may be considered murder as well as the suggestion that life in an orphanage may not be worth living.[186] Thus, it is unclear what the jury's acquittal represented.[187] On the one hand, the jury could have concluded that the physician had not broken the law.[188] On the other hand, the jury's decision may have reflected the improper opinions offered by the judge.[189]

Applying the Groningen protocol, it is clear that the required criteria would not have been met.[190] First, while it was certain that the child had Down syndrome, no other ailments were diagnosed.[191] In fact, the infant's health was not fully investigated and other diagnostic tests were not performed,[192] as required by the Groningen protocol.[193] If further testing was done, then the heart defect that was found during the autopsy may have been discovered.[194] In this case, the Groningen protocol would have provided both the parents and the physician a more complete picture of the infant's health prior to euthanizing the child.[195] Information about an infant's health is essential to making an informed decision about whether to euthanize,[196] and in this instance, following the protocol would have provided vital information to aid the decision-making process.

Second, John was not suffering unbearably, and there was no indication of a very poor quality of life.[197] John was born with Down syndrome, but no other abnormalities were known at the time he was

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[184] *Id*. The autopsy revealed that John suffered from pneumonia and a heart defect and may have died from natural causes rather than from starvation. *Id*. Thus, Dr. Arthur could not be charged with murder. *Id*.

[185] *Id*.

[186] *Id*.

[187] *See id*.

[188] *See id*.

[189] *See id*.

[190] *See* Verhagen & Sauer, *supra* note 37, at 961.

[191] GORSUCH, *supra* note 69, at 193–94.

[192] *See id*.

[193] *See* Verhagen & Sauer, *supra* note 37, at 961.

[194] GORSUCH, *supra* note 69, at 194.

[195] *See* Verhagen & Sauer, *supra* note 37, at 961.

[196] *See id*.

[197] *See* GORSUCH, *supra* note 69, at 193–94.

born.[198] While Down syndrome may generally lead to a reduced quality of life, people who live with Down syndrome are often able to live creative, rewarding, fulfilling, and fairly independent lives.[199] Down syndrome also does not cause hopeless and unbearable suffering.[200] Thus, the second criterion of the Groningen protocol has not been met.

Third, Dr. Arthur did not consult an independent physician when deciding to euthanize John.[201] Rather, Dr. Arthur decided to euthanize him after his mother stated that she did not want the child.[202] While this may meet the third criterion of parental consent, it does not meet the requirement for consultation with an independent physician.[203] If an independent physician had been consulted, it is unlikely that this second physician would agree to withhold treatment if the child simply had Down syndrome.[204] A consultation with an independent physician is one way that the Groningen protocol provides oversight and regulation over euthanasia.[205] If the independent physician does not approve of the course of treatment, then euthanasia should not be allowed.

Last, it is unclear whether the procedure was carried out in accordance with the accepted medical standard, as required by the Groningen protocol.[206] As in the *Kadijk* case,[207] John was sedated with a painkiller and given water, but not food.[208] John was "going grey" the first day that food was withheld, but it took sixty-nine hours for the infant to die.[209] While the infant may not have been in any pain,[210] the

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[198] *Id*.

[199] Priscilla Alderson, *Down's Syndrome: Cost, Quality and Value of Life*, 53 SOC. SCI. & MED. 627–638 (2001).

[200] *See Facts About Down Syndrome*, NAT'L INSTS. OF HEALTH, http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm (last visited May 12, 2011).

[201] *See* GORSUCH, *supra* note 69, at 194.

[202] *Id*.

[203] *See* Verhagen & Sauer, *supra* note 37, at 961.

[204] Although people with Down syndrome have an increased risk for certain medical conditions such as congenital heart defects and respiratory problems, many of these conditions are now treatable, and most people with Down syndrome lead healthy lives. *Down Syndrome Fact Sheet*, NAT'L DOWN SYNDROME SOC., http://www.ndss.org/index.php?option=com_content&view=article&id=54:down-syndrome-fact-sheet&catid=35:about-down-syndrome&Itemid=74 (last visited Apr. 23, 2011).

[205] Verhagen & Sauer, *supra* note 37, at 961.

[206] *See id*.

[207] *See* GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 341–51.

[208] *See* GORSUCH, *supra* note 69, at 194.

[209] *Id*.

[210] Smoker, *supra* note 173.

administration of a lethal drug would provide a quicker and more humane death.[211]

The key difference in the treatment of the infant in England and the treatment the infant in the Netherlands is the way the infant's life was evaluated. The *Pearson* case suggests that in England, the physician might make the decision to euthanize the child after only a consultation with the parents.[212] Dr. Arthur did not consult an independent physician.[213] Rather, a single physician made the decision to euthanize the infant with the consent of the parents.[214] However, in the Netherlands a second, independent physician would have been consulted.[215] As mentioned above, given that the infant was diagnosed with Down syndrome and no other ailments, it is unlikely that a second, independent physician following the Groningen protocol would have agreed to perform euthanasia.[216] Thus, the consultation with a second physician would have likely provided the oversight necessary to prevent the abuses found in England.[217]

One potential solution to avoid the abuse found in the *Pearson* case is to provide information about adoption to birth parents.[218] Simply being ill-equipped to care for a baby born with a disease that requires greater care than normal does not mean that the child should not live.[219] The child may have a worthwhile life with a foster family or in an orphanage.[220] The Groningen protocol is a tool that is meant to provide transparency in making decisions about euthanasia,[221] but when euthanasia is not proper, information about foster care could be provided to the parents so that they can make an informed decision.[222]

The *Pearson* case also reveals a drawback of the Groningen protocol: the possibility of abuse. Abuse may be likely with the use of the Groningen protocol because regulating the system depends on the

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[211] *See id*.
[212] GORSUCH, *supra* note 69, at 194.
[213] *See id*.
[214] *See id*.
[215] *See* Verhagen & Sauer, *supra* note 37, at 961.
[216] *See id*.
[217] *See id*.
[218] GORSUCH, *supra* note 69, at 195.
[219] *Id*.
[220] *Id*.
[221] *See* Verhagen & Sauer, *supra* note 37, at 959.
[222] *See* GORSUCH, *supra* note 69, at 195.

physician's cooperation in performing euthanasia.[223] There are several ways the physician could abuse the system. First, the physician could forgo getting a second opinion from an independent physician, as the protocol requires.[224] Likewise, the physician could act without the consent of the parents.[225] This would mean the treating physician would act independently, without other physicians or the parents knowing about the euthanasia.

Second, even if the parents requested euthanasia and an independent physician approved the procedure, the physician could report the death as "natural."[226] By doing so, neither the coroner nor the district attorney would be notified of the procedure.[227] Without notification to the authorities, the physician would essentially be performing euthanasia without any oversight, which could lead to abuse.

Eduard Verhagen, one of the creators of the protocol, admits that abuse of euthanasia regulations has been a problem in the past.[228] Between 1997 and 2004, twenty-two cases of euthanasia in newborns were reported to the district attorneys' offices in the Netherlands.[229] A national survey indicates that euthanasia was performed on fifteen to twenty infants per year, but most cases of euthanasia were not reported to the authorities.[230] Verhagen hopes that the Groningen protocol will allow physicians to report all cases of euthanasia in newborns by removing the fear of prosecution.[231] When physicians feel free to report these cases, abuse of euthanasia regulations will likely decline.

CONCLUSION

While the Groningen protocol may appear to be extreme, the two case studies illustrate that the protocol has two advantages over the solutions provided in the United States and England. First, the Groningen protocol provides a quicker and more humane death for infants who are in pain and have a terminal diagnosis. Second, the Groningen protocol

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[223] *See* Verhagen & Sauer, *supra* note 37, at 960–61.
[224] *See id*.
[225] *See id*.
[226] *See id*.
[227] *See id*.
[228] *Id*. at 961.
[229] *Id*.
[230] *Id*.
[231] *Id*. at 961–62.

can be used as a regulatory device and can help to ensure transparency in the health care system.

The law in the Netherlands provides a more humane death than the laws in the United States and England for infants who are in pain and have a terminal diagnosis. The Netherlands' approach is illustrated by the *Kadijk* case.[232] The infant received a sedative that caused a deep sleep, and then the physician administered a lethal drug that caused the infant to die within half an hour.[233] In contrast, the approach used by the United States and England is exemplified by the *Pearson* case.[234] John was sedated with a painkiller and given water, but food was withheld.[235] It took sixty-nine hours for John to die.[236] This method is not as quick and painless as the solution used in the Netherlands.[237] Further, the parents must endure the prolonged dying process of the infant.[238] While both approaches have the same outcome, the process in the Netherlands provides both the infant and the parents with a more humane process.

The Groningen protocol can also be used as a regulatory device and help to ensure transparency in the health care system. This is demonstrated by the *Kadijk* case, where the physician consulted an independent physician who concurred that terminating the infant's life was a proper course of action.[239] In the *Pearson* case, however, the physician withdrew treatment without consulting an independent physician.[240] A consultation with an independent physician helps to provide oversight and regulation over euthanasia.[241] When two physicians agree that euthanasia is a viable option, as required in the Netherlands, it is more likely that infants will not be euthanized improperly.

As other countries consider passing laws legalizing euthanasia, they should view the Groningen protocol as the Dutch Parliament views the protocol: as a useful tool that can be used to alleviate the suffering of infants and to increase oversight in health care.[242] Further, the protocol more accurately reflects the actual practice of physicians, who regularly

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[232] GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343–44.
[233] *Id*.
[234] *See* GORSUCH, *supra* note 69, at 194.
[235] *Id*.
[236] *Id*.
[237] *See* Smoker, *supra* note 173.
[238] *Id*.
[239] GRIFFITHS, BOOD & WEYERS, *supra* note 103, at 343.
[240] *See* GORSUCH, *supra* note 69, at 194.
[241] *See* Verhagen & Sauer, *supra* note 37.
[242] See *id*. at 959.

use euthanasia despite its illegality.[243] Moreover, the protocol may accurately reflect the shifting moral beliefs of the general population of countries similar to England, where Dr. Arthur was acquitted in the *Pearson* case.[244] As society shifts toward a more rational approach to death, the aesthetics of the ancient Greeks and Romans may reemerge: it may become acceptable to provide the ailing, including infants, with a humane and dignified death.

[243] *See* Emanuel et al., *supra* note 75, at 529.
[244] *See* GORSUCH, *supra* note 69, at 194.