

Neonatal euthanasia: a comparative analysis of the UK and Netherlands approaches

In response to arguments that the Dutch and UK approaches are indistinguishable, the Doctrine of Double Effect (DODE) and the Acts and Omissions Doctrine (A/OD) are often cited in the UK context to justify decisions to hasten a neonate's death without being regarded as active euthanasia. Yet, the A/OD and the DODE fall short of justifying a distinction between active and passive euthanasia. Why is the UK reluctant to adopt active euthanasia as a therapeutic alternative?

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Note: In this article, UK law refers to the law as practised in England, Wales and Scotland. Consideration of the law within Northern Ireland is outside the scope of this article.

Keywords

euthanasia; withholding and withdrawal of treatment; doctrine of double effect; neonate; Groningen protocol

Key points

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1. Differences that exist between active euthanasia and the withholding and withdrawal of treatment are merely illusory.
2. Fears of affronts to autonomy and 'slippery slopes' are the primary reasons against an active approach to euthanasia being adopted.
3. Concerns are insufficient when balanced against counter arguments of autonomy and beneficence.
4. Criticisms of the Groningen protocol are insufficient and an active approach to euthanasia should be adopted.

Confusion within the debate on euthanasia, and on the extent to which there is a clear difference between active and passive euthanasia, is partly attributable to the existence of a variety of definitions. Active euthanasia is regarded as the active and intentional termination of life at a patient's request¹ and is typically brought about through lethal injection. Conversely, passive euthanasia is regarded as bringing about the death of a patient through omitting to prolong life, typically through withholding and withdrawal of treatment (WWOT), thus 'allowing' the patient to die as a result of their pre-existing condition². There is similarly a difference between voluntary, non-voluntary and involuntary euthanasia. Voluntary is at the request of a patient, non-voluntary is where the patient lacks the capacity to request euthanasia, but it is performed when in the patient's best interests. Finally, involuntary euthanasia is that performed against the patient's express wishes.

Law in the Netherlands

In the Netherlands, deliberately ending the life of a neonate is regarded as murder. However, in 2005 Dr Eduard Verhagen and his colleagues established the Groningen protocol³, which allows active euthanasia in exceptional circumstances. Simple adherence does not grant incontrovertible protection. However, provided certain requirements are met, a doctor can expect to avoid culpability.

Groningen protocol history

The protocol was enacted in 2002. Previously, the Dutch ministry and the Dutch Paediatric Association provided guidelines for reporting neonatal euthanasia as well as confirming the acceptability of decisions to abstain from treatment on the grounds of medical futility and stating that treatment should not be instigated where there is no chance of survival⁴.

Under these provisions, 22 cases of neonatal euthanasia were reported. These were analysed to determine whether additional requirements were relevant when reaching conclusions on culpability. No prosecutions arose and such decisions were based on the four Groningen protocol requirements being followed and the jurisprudence of the *Prins* and *Kadijk* cases in 1996⁵. These cases clarified that neonatal euthanasia is justifiable where the infant is in a hopeless and intolerable situation and traditional means of alleviating suffering have been exhausted. This information was amalgamated into the protocol, which was ratified by the Dutch Paediatric Association and is now the existing national regulation on neonatal euthanasia.

Groningen protocol provisions

Where euthanasia is appropriate, the infant's condition is divided into three categories³:

- **Group 1** infants with no chance of survival and where treatment is futile

according to current medical standards ('physiologic futility').

- **Group 2** infants with very poor prognoses but who may be kept alive with intensive care.
- **Group 3** infants who, while not being dependent on medical technology, will be subject to a life of continuous, untreatable suffering – the most controversial group.

Neonates cannot request euthanasia and parental requests are deemed insufficient, therefore physicians may initiate the process, with full parental consent, under very strict conditions. There must be:

1. Certainty over diagnosis and prognosis.
2. Hopeless and unbearable suffering.
3. Confirmation by an independent doctor.
4. Full parental consent.
5. A euthanasia procedure carried out in line with accepted medical practice.

Neonatal euthanasia must be adequately reported and the Minister of Justice will ultimately decide whether to prosecute. Provided the guidelines have been followed, the practitioner typically avoids prosecution and so far none have occurred³.

Criticism

Predominantly, the protocol's second criterion has been criticised for its terminology of 'hopeless' and 'unbearable suffering.' These are regarded as subjective feelings that are objectively unquantifiable. Moreover, as unbearable suffering is an unknowable entity it is argued that this causes considerable problems of quantification for those who lack the capacity to communicate⁶. In 2008, Kodish argued that: "The leap of faith required to assess this level of suffering in an infant with any certainty suggests a mirage of clinical accuracy that borders on hubris"⁶.

Verhagen appears to be in a double-bind situation. Exclusion of the terms unbearable and hopeless would cause criticisms of vagueness and arguments that suffering alone is an unjustifiably low standard to allow for neonatal euthanasia. Therefore it would appear that many of the criticisms are predicated on misunderstandings that give an ill-informed view of the protocol.

Law in the UK

Euthanasia, the active and intentional termination of life, is illegal in the UK. Yet a critically ill neonate's death can legally be

hastened through WWOT, whereby nutrition, hydration and resuscitation measures are withheld or withdrawn, and through administering sedatives and analgesics that, in large doses, hasten death. How is this possible if doctors may not perform acts designed to bring about death?

Acts and omissions

The Acts and Omissions Doctrine (A/OD) states that: "It makes a difference whether we actively intervene to bring about a result, or omit to act where it is foreseen that, as a result of the omission, the same result occurs"⁷. Therefore while doctors may perform no positive act with the intention to cause death⁸, criminal law differentiates between failing to provide treatment that causes death and actively bringing life to an end⁹. Similarly, when that patient has: "No further interests in being kept alive" and treatment confers: "No further benefit upon [them]"; the justification for providing it ceases and the doctor is no longer duty bound to treat. Accordingly: "The omission to perform what had previously been a duty would no longer be unlawful"¹⁰.

It could be argued that this judgment,

and subsequent law, is an example of linguistic and intellectual sophistry and not only were the Lords in the *Bland* case reluctant to uphold the A/OD, but such distinctions cause the law to be morally and intellectually misshapen. This distinction has been subject to extensive criticism on the grounds that the end result is the same regardless of whether the doctor acted or omitted to act. However, the law upholds it and allows for a neonate's life to be ended through categorising the WWOT as an omission and concluding that such omissions carry no culpability if the treatment is of no benefit to the neonate, particularly if it is futile or burdensome.

The Doctrine of Double Effect (DODE)

This is an additional way of ending a neonate's life. It has four conditions¹¹.

1. The action itself must not be morally wrong.
2. The intention must be to produce a good effect.
3. The good effect must not be achieved through the bad effect (causally).
4. Proportionally the good effect must outweigh the bad.

Case	Main outcomes
<i>R v Arthur</i> ¹⁵ and <i>Re B</i> ¹⁶	<ol style="list-style-type: none"> 1. Established that all neonatal end-of-life decisions must be reached by applying the best interests test which involves considering quality of life, futility and the respective burdens and benefits of giving or withholding treatment while being balanced against sanctity of life considerations. 2. Formulated the balancing act that would take place in all cases relating to the WWOT. 3. Upheld the sanctity of life principle, yet balanced it against best interests by considering the extent of the doctor's duty when prescribing treatment for a severely ill child suffering from a handicap of an irrevocable nature¹⁷ and deciding whether the life of the child was demonstrably going to be so awful that in effect the child must be condemned to die¹⁸.
<i>Re J</i> (a minor) (wardship: medical treatment)	<ol style="list-style-type: none"> 1. The law was confirmed and developed. 2. Held that account has to be taken of the pain, suffering and quality of life that the child will experience if life is prolonged. Emphasis was placed on the burdens of treatment when compared to the child's poor prognosis and its expected poor standard of life¹⁹.
<i>An NHS Trust v M</i>	<ol style="list-style-type: none"> 1. Law developed further. 2. Despite the child being unable to move or communicate and death being a certainty without artificial ventilation, it was held that the burdens of treatment did not outweigh the benefits as the child had discernable pleasures in his life²⁰.
<i>Winston-Jones</i> ²¹ and <i>Portsmouth NHS Trust v Wyatt</i> ²²	<ol style="list-style-type: none"> 1. A modern reflection on best interests. 2. In both instances, doctors agreed that artificial ventilation should be withheld if required. It was held that the treatment, considering the burdens it would entail, was not in the infant's best interests.

TABLE 1 Case law illustrating the legality of the WWOT in a court setting.

Therefore the DODE provides that foreseen acts that cause harm are, in law, permissible provided that the intention of the act was to do good. *Bland* clarified this by holding that: “A doctor may...lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient’s life”¹².

The doctrine’s legality was first confirmed in *R v Adams* where it was held that: “A doctor...is entitled to do all that is necessary to relieve pain and suffering, even if the measures...may incidentally shorten life” and that: “The cause of death was the illness or injury” rather than the medical treatment¹³. The doctrine’s applicability was reinforced following *R v Cox*¹⁴. It could be argued that the DODE is highly contentious as there is little difference between intended consequences and side-effects. However, despite concerns, the DODE is enshrined in law and as accepted medical practice.

Case law

TABLE 1 summarises case law illustrating the legality of the WWOT in a court setting. However, a professional framework also exists to allow decisions on the WWOT to be made appropriately and legally.

Professional guidance

The Royal College of Paediatrics and Child Health (RCPCH) Framework for Practice, illustrates five situations in which it is ethical and legal to withhold or withdraw treatment from a child: (i) where the child is brain dead or in a permanent vegetative state; (ii) where no curative treatment is available; and where the criteria of (iii) no chance, (iv) no purpose and (v) unbearable, apply²³. Similarly, the Nuffield Council on Bioethics provides guidance on quality, sanctity of life and best interests and sets out treatment recommendations based on the gestational age of the child²⁴.

Evidence shows that 43-72% of neonatal deaths occur as a result of WWOT²⁵. How is this any different to the situation in the Netherlands whereby the death of a terminally ill neonate is actively brought about? How can active euthanasia be rejected yet WWOT is accepted when the intention and the end result is the same?

The UK’s aversion to active euthanasia

Active euthanasia and the WWOT are highly controversial issues and it could be

Arguments for euthanasia	Arguments against euthanasia
<p>Autonomy Euthanasia is an enhancement to personal autonomy and self-fulfilment.</p> <p>Beneficence Death would be of most benefit to the patient.</p>	<p>Slippery slope Legitimises involuntary euthanasia.</p> <p>Sanctity of life Life is sacred and thus the taking of it is prohibited.</p> <p>Affront to autonomy Autonomy requires capacity and neonates cannot give consent therefore involuntary euthanasia is practiced.</p>

TABLE 2 Arguments for and against neonatal euthanasia.

argued that any differences are merely illusory. If this is the case, why is the UK so determined to hold on to the WWOT and reject active euthanasia as a therapeutic alternative?

Arguments for euthanasia – autonomy and beneficence

Two main assertions form the moral basis of arguments in favour of euthanasia (**TABLE 2**). The first is that allowing euthanasia is an enhancement to personal autonomy and self-fulfilment. Autonomy provides that everyone should have control over their bodies and be free to determine the course of their medical treatment without external influences. This means acknowledging a person’s views, and upholding the choices that they make.

Beneficence is the ethical principle that medical professionals must act for the benefit of their patients and is regarded as ascribing moral virtue to actions which aim to benefit another person²⁶. Euthanasia can be justified on this ground, as sometimes death would be of most benefit to the patient.

In response, some commentators have suggested that any life is better than none and that some are willing to endure suffering for one more day with a loved one. The persuasiveness of beneficence arguments increases with neonatal euthanasia, as infants do not have the luxury of such comforts. As Manninen argues: “Infants are locked in a perpetual state of present emotions and desires and the life of an infant in agony is nothing but perpetual existence in that agony”²⁷. Accordingly, if life is not in the baby’s best interests then surely it benefits the baby to end it?

These are only a few of the arguments in favour of euthanasia that are generally regarded as the most convincing. Surely if it is considered that euthanasia is

justified on these grounds it must similarly be argued that the Groningen protocol or a system of active neonatal euthanasia is justifiable?

Arguments against legalisation

However convincing arguments in favour of euthanasia are, no form is accepted in the UK. According to the Nuffield Council on Bioethics, active neonatal euthanasia should not be allowed, no matter how serious the baby’s condition. They express slippery slope concerns, that if neonatal euthanasia were acceptable it would be difficult to deny active euthanasia to incompetent adults and believe that allowing active neonatal euthanasia would have a detrimental impact on the doctor/patient relationship²⁴. The British Medical Association (BMA) are similarly concerned about: “A detrimental effect on societal attitudes and on the doctor-patient relationship, jeopardising ...vulnerable individuals”²⁸.

Many medical professionals also oppose legislation. For example, one anonymous consultant regarded adopting an approach like the protocol as: “Simply unnecessary as the infant is going to die anyway”. She did however, go on to give an example of one case that she considered borderline. It concerned a baby with severe muscular dystrophy who had to be given extra sedation, not enough to make this baby die, but enough to go to sleep.

Clearly there is strong opposition to active euthanasia, but the real question is why?

Slippery slope doctrine

Slippery slope reasoning takes a logical and an empirical form and provides that if A is accepted, which society concludes to be morally permissible, it should still be rejected as it would lead logically to accept B, which society regards as morally

unacceptable¹. The fear is that if euthanasia is accepted in neonates it will legitimise involuntary euthanasia for vulnerable members of society. Such a slope was recognised in *Bland* where it was stated that: “Once euthanasia is recognised as lawful in these circumstances it is difficult to see any logical basis for excluding it in others”²⁹.

Two points can be made in response. Firstly, according to Verhagen in interview: “There is no proof that the slippery slope exists and therefore nobody can truly say in favour or against”²⁹. Secondly, he stated that: “Following the protocol’s introduction the number of neonatal euthanasia cases has dropped considerably demonstrating that regulation of practice results in control of practice”²⁹. This may be regarded as evidence that society does not always slide down this slope and that such arguments could be described as counter-revolutionary fear mongering designed to preserve rigid societal trends³⁰.

It can be suggested that the evolution of euthanasia from adults to infants may simply be an acceptance that active euthanasia has necessary application in other areas. If it is acceptable to end the life of an adult who is suffering interminably and whose life may no longer be regarded as a benefit to them, surely it must be accepted that other individuals will be in a similar situation and therefore it is simply cruel to force them to endure their life and suffering simply because they cannot express a wish to end it.

Sanctity of life

Sanctity of life is the deeply ingrained principle that human life is sacred and the taking of it, even for honourable and merciful reasons, is prohibited. This doctrine has its roots in the Hippocratic oath swearing to: “Neither give a deadly drug to anyone if asked, nor make a suggestion to this effect”³¹. Therefore in upholding the sanctity of life some of the medical profession regard euthanasia as alien to the traditional ethos and moral focus of medicine²⁸.

It could be suggested that these arguments are little more than dodgy religious premise³⁰ that unconvincingly condemn euthanasia as the sanctity of life is by no means absolute. Life is not life at all costs and by concluding that: “In a conflict between sanctity of life, quality of life and self-determination, the sanctity of life must give way,” the Lords unequivocally confirmed this³².

Affront to autonomy

As previously argued, performing euthanasia on an adult who specifically requests it may be regarded as enhancing their autonomy. However, as autonomy requires capacity, can neonatal euthanasia be regarded as enhancing autonomy given that the child cannot give consent? For many people this would constitute involuntary euthanasia. Other concerns are that acting contrary to autonomy, even for honourable reasons, will result in a major medical-ethical paradigm shift and return to an age of paternalism, that is, acting for or in the best interests of another without their consent³³.

It could be argued that this is not too great a concern. Verhagen stated during interview that as persons can request euthanasia when they reach 18, it would be ridiculous to force someone to suffer simply because they are unable to request it. In his opinion: “If there is such extensive suffering, and you feel the parental vote is important, under strict circumstances and provided there is transparency [autonomy] doesn’t have to be a problem”.

Conclusion

The issues discussed in this article raise seemingly unanswerable questions and present a dilemma: legalise active euthanasia and risk that neonates will be euthanised when it is not in their best interests, or do not legalise and risk that neonates will be left to suffer interminably.

Accordingly the euthanasia debate will go on. However, such fervent debate and advocacy for active neonatal euthanasia has caused the law to open loopholes through which euthanasia can occur. Palliative measures are being enhanced and society is becoming increasingly accepting of the doctrines that permit a neonate’s life to be ended. While this could be seen as hypocritical in the face of blanket refusal of active euthanasia, arguably it is better than an all or nothing approach under which the life of a terminally ill neonate can never be ended.

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