

A MINOR'S RIGHT TO DIE WITH DIGNITY: THE ULTIMATE ACT OF LOVE, COMPASSION, MERCY, AND CIVIL LIBERTY

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TABLE OF CONTENTS

INTRODUCTION	220
I. UNITED STATES CASE LAW REGARDING PHYSICIAN- ASSISTED SUICIDE FOR ADULTS	222
II. RIGHT TO DIE IN OREGON, WASHINGTON, VERMONT, MONTANA, CALIFORNIA, AND COLORADO	225
III. COMPETENCY, COGNITIVE DEVELOPMENT, AND THE ACQUISITION OF DEATH	229
IV. EXCEPTIONS TO THE PRESUMPTION AGE OF MAJORITY	234
V. NETHERLANDS' AND BELGIUM'S RIGHT TO DIE LAWS.....	238
<i>A. Netherlands</i>	238
<i>B. Belgium</i>	240
VI. JUDICIAL DECISION MAKING TESTS AND AMENDMENTS TO PRESENT RIGHT TO DIE LEGISLATION IN THE UNITED STATES	244
CONCLUSION	246

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220 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

“They can see the children in the bed next to them suffocate They will say, ‘I know my life will end, but doctor, just don’t let it end like my friend’s did.’”¹

INTRODUCTION

Although advances in medical technologies have given some individuals a second chance at life, for others, such “progress” has merely prolonged their suffering. A number of these terminally ill patients turn to their doctors with a challenging request: to help them die with dignity through physician-assisted suicide.² Such requests permit a physician to prescribe a lethal dose of medication for the terminally ill patient to administer to himself or herself.³ Unlike adults, minors are not afforded the right to physician-assisted suicide.⁴ Children under the age of eighteen are presumed incapable of “understanding, deliberating about, and making decisions” regarding their health care.⁵ Instead, parents are afforded the right to make medical decisions for their children because parents are presumed to “act in the best interests of their child(ren).”⁶ However, children, like adults, have an interest in bodily integrity and the desire to possess and control their own person free from restraint.⁷ Over the last three

1. Charlotte McDonald-Gibson, *Belgium Extends Euthanasia Law to Kids*, TIME (Feb. 13, 2014), <http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/>. Recalling his inability to discuss the possibility of euthanasia with his minor patient suffering from Duchenne Muscular Dystrophy, Dr. Gerlant van Berlaer, a pediatrician at the University Hospital Brussels explained. *Id.*

2. Alison C. Hall, *To Die with Dignity: Comparing Physician Assisted Suicide in the United States, Japan and the Netherlands*, 74 WASH. U. L.Q. 803, 803 (1996).

3. Lara L. Manzione, *Is There a Right to Die? A Comparative Study of Three Societies (Australia, Netherlands, United States)*, 30 GA. J. INT’L & COMP. L. 443, 445 (2002).

4. *See generally id.*

5. Robert F. Weir & Charles Peters, *Affirming the Decisions Adolescents Make about Life and Death*, 27 HASTINGS CTR. REP. 29, 33 (1997).

6. *Parham v. J. R.*, 442 U.S. 584, 602–03 (1979). The United States Supreme Court addressed parental decision-making power in *Parham v. J.R.*, which stated, “The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children.” *Id.* at 602.

7. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

decades, the legal and medical professions have recognized that terminally ill children have the capacity to not only understand the fluctuations of treatment, but also grasp the realities of their illness and comprehend death and its finality.⁸ This Article argues that in light of the fundamental principle of individual autonomy, states should enact and/or amend their legislation to allow physician-assisted suicide for terminally ill minors.⁹

Part I discusses two landmark cases, *Washington v. Glucksberg*¹⁰ and *Vacco v. Quill*,¹¹ which led to the present right to die legislation in the United States. Part II reviews this country's right to die legislation regarding physician-assisted suicide. Part III defines competency,

8. Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 113 (2000); see *infra* Discussion Part.III.

9. Although beyond the scope of this Article, all states should amend their legislation to include the right to die by either euthanasia or physician-assisted suicide to terminally ill adults and minors with six months or less to live. Similar to physician-assisted suicide, euthanasia is the method of facilitating the passing of a patient suffering from a terminal illness or condition for reasons of mercy. *Euthanasia*, BLACK'S LAW DICTIONARY (9th ed.1999). The word euthanasia derives from the Greek word "eu," which means easy and "thanatos," which means death. Manzione, *supra* note 3, at 445. "For the Greeks and Romans, euthanasia signified a quiet and easy death, one without suffering." Deborah A. Waaney, *Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying*, 37 CLEV. ST. L. REV. 645, 647 (1989). Euthanasia occurs when a physician administers an injection that intentionally causes the patient's death. David Bryant, *The Need for Legalization and Regulation of Aid-in-Dying and End-of-Life Procedures in the United States*, 18. QUINNIPIAC HEALTH L.J. 287, 297 (2015). There are two types of euthanasia, active euthanasia and passive euthanasia. Kristina Ebbott, *A "Good Death" Defined By Law: Comparing the Legality of Aid-in-Dying Around the World*, 37 WM. MITCHELL L. REV. 170, 172 (2010). Active euthanasia is carried out by a facilitator (usually a physician) who provides the means of death, and carries out "the final death-causing act" by administering the lethal agent directly into the patient. *Active Euthanasia*, BLACK'S LAW DICTIONARY (9th ed.1999). Passive euthanasia enables a terminally ill person to die by withholding or withdrawing life-sustaining support such as a respirator or feeding tube. *Id.* This type of euthanasia occurred in *In re Quinlan*, 355 A.2d 647, 671-72 (N.J. 1976) (holding if the responsible physicians conclude "there is no reasonable possibility of [the patient] ever emerging from [a] present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefore on the part of any participant, whether guardian, physician, hospital or others").

10. *Washington v. Glucksberg*, 521 U.S. 702, 702 (1997).

11. *Vacco v. Quill*, 521 U.S. 793, 793 (1997).

222 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

examines theories of child cognitive development, and describes a child's concept of death. Part IV explains the exceptions to the presumptive age of majority and examines the applicability of the mature minor doctrine in relation to the right to die. Part V compares and contrasts the Netherlands and Belgium's right to die laws, the impact of the reduced age requirement for assisted death in the Netherlands, and the recent amendment to the 2002 Belgian Euthanasia Act, which removed all age restrictions for euthanasia. Incorporating aspects from right to die laws in the Netherlands and Belgium, Part VI proposes amendments to present right to die laws in the United States and offers guidelines that can be used to determine a minor's competence. This Article ultimately concludes all states should seek to implement assisted suicide legislation to include the right to die with dignity by physician-assisted suicide to everyone, regardless of age.

I. UNITED STATES CASE LAW REGARDING PHYSICIAN-ASSISTED SUICIDE FOR ADULTS

The first major challenge to physician-assisted suicide occurred in the United States Supreme Court case *Washington v. Glucksberg*.¹² In *Glucksberg*, three terminally ill patients, four physicians, and Compassion in Dying (a non-profit organization) argued a Washington statute criminalizing physician-assisted suicide was unconstitutional.¹³ The Court held an individual does not have an asserted right to assisted suicide because suicide "is not a fundamental liberty interest protected by the Due Process Clause" of the United States Constitution.¹⁴ As a result, as long as the law was rationally related to a legitimate government interest, physician-assisted suicide would remain a criminal act.¹⁵ The Court defined the following as legitimate

12. *Glucksberg*, 521 U.S. at 702.

13. Rena Patel, *Physician-Assisted Suicide: Is it Time?*, 35 CAL W.L. REV. 333, 341 (1999); see *Glucksberg*, 521 U.S. at 702. The Washington statute at issue provided, "A person is guilty of promoting a suicide attempt when he or she knowingly causes or aids another person to attempt suicide." WASH. REV. CODE § 9A.36.060(1) (1994).

14. *Glucksberg*, 521 U.S. at 728.

15. *Id.* at 728.

government interests:¹⁶ (1) the preservation of human life;¹⁷ (2) “protecting the integrity and ethics of the medical profession;”¹⁸ (3) the need to protect, not blur, the “time-honored line between healing and harming;”¹⁹ (4) “protecting vulnerable groups—including the poor, the elderly, and disabled persons from abuse, neglect, and mistakes;”²⁰ and (5) protecting individuals from involuntary euthanasia based on assisted suicide abuses in the Netherlands.²¹

The second challenge to state law prohibiting physician-assisted suicide occurred in *Vacco v. Quill*.²² In *Vacco*, three physicians and three patients challenged the “constitutionality of New York statutes making it a crime to aid a person in committing suicide.”²³ The plaintiffs argued banning physician-assisted suicide violated the Equal Protection Clause because a competent person refusing life-sustaining treatments (which is permitted) and physician-assisted suicide were “essentially the same thing.”²⁴ Instead, the Court held New York’s statute did not violate the Equal Protection Clause, because distinctions exist between physician-assisted suicide and refusing life-sustaining treatment based on the “fundamental legal principals of causation and intent.”²⁵

In terms of causation, a distinction was made “between refusal of medical treatment and physician-assisted suicide.”²⁶ For instance, “when a patient refuses life-sustaining treatment,” the patient’s death

16. *Id.*

17. *Id.*

18. *Id.* at 731.

19. *Id.*

20. *Id.*

21. *Id.* at 734.

22. *Vacco*, 521 U.S. at 793.

23. Patel, *supra* note 13, at 342–43. The New York statute at issue provided, “[A] person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide.” N.Y. PENAL LAW § 125.15 (McKinney 1967). “A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide.” *Vacco*, 521 U.S. at 796 n.1.

24. *Vacco*, 521 U.S. at 798.

25. *Id.* at 801.

26. Patel, *supra* note 13, at 343.

224 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

results from “an underlying fatal disease or pathology.”²⁷ In a physician-assisted suicide situation the patient ingests a lethal dose of medication prescribed by the attending physician, making the doctor and the prescribed medication the cause of death rather than the underlying disease.²⁸ In terms of intent, the Court concluded a physician who hastens death by honoring a patient’s refusal of life-sustaining treatment by withdrawing or administering “palliative treatment,” which intends only to “respect the patient’s wishes,” shows the physician’s purpose is to ease the patient’s suffering, and not to cause death.²⁹ The Supreme Court “declined to recognize a constitutional right to physician-assisted suicide,”³⁰ thereby leaving the decision of physician-assisted suicide to the states to legislate and regulate.³¹

The issues surrounding death and whether to legalize or prohibit certain forms of assisted suicide vary from country to country. In the United States, the American Medical Association’s (“AMA”) Council on Ethical and Judicial Affairs stated, the “sanctity of the physician/patient relationship” and a physician’s ethical obligations “grounded in the Hippocratic Oath” restrict physicians from participating in assisted suicide.³² The AMA argues, similar to the *Vacco* Court, assisted suicide is “simply an intentional taking of the patient’s life, even if it is with patient consent.”³³ Despite the AMA’s opinion, right to die legislation has been passed in both the United

27. *Vacco*, 521 U.S at 801.

28. *Id.*

29. *Id.* at 802.

30. Katherine A. Chamberlain, *Looking for a “Good Death”: The Elderly Terminally Ill’s Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61, 69 (2009).

31. *Id.* at 70.

32. Andrew Benton, *Personal Autonomy and Physician-Assisted Suicide: The Appropriate Response to a Modern Ethical Dilemma*, 20 OHIO N.U. L. REV. 767, 778 (1994). Furthermore, two duties in the Hippocratic Oath are incompatible: the promise to relieve suffering, and the promise to prolong and protect life. JOSEPH FLETCHER, *MORALS AND MEDICINE: THE MORAL PROBLEMS OF: THE PATIENT’S RIGHT TO KNOW THE TRUTH, CONTRACEPTION, ARTIFICIAL INSEMINATION, STERILIZATION, EUTHANASIA* 172 (1979).

33. Patel, *supra* note 13, at 335.

2018] A MINOR'S RIGHT TO DIE WITH DIGNITY 225

States and abroad.³⁴ Since the *Glucksberg* and *Vacco* decisions, five states have legalized physician-assisted suicide.³⁵ This evidence shows it is “morally preferable” for the patient to choose to die by physician-assisted suicide rather than “linger on in torment until death.”³⁶

II. RIGHT TO DIE IN OREGON, WASHINGTON, VERMONT, MONTANA, CALIFORNIA, AND COLORADO

Four months after the Supreme Court decided *Glucksberg* and *Vacco*, Oregon enacted its Death with Dignity Act. The Act allows terminally ill adult residents of Oregon to receive assistance in death from a physician by means of a lethal prescription.³⁷ To request physician-assisted suicide the patient must be:

[1] An adult³⁸ who is capable, [2] is a resident of Oregon,³⁹ and [3] has been determined by the attending physician and consulting physician to be suffering from a terminal disease,⁴⁰ and [4] who has voluntarily expressed his or her wish to die.⁴¹

Additionally, a patient's wish to die must be made voluntary and in writing.⁴² The written request must be “signed and dated by the patient, and witnessed by at least two individuals.”⁴³ At least one of the witnesses cannot be a relative, “entitled to any portion of the [patient's] estate,” or affiliated with the “health care facility where the qualified

34. See *infra* Discussion Part.III. The AMA's opinions have no impact on right to die legislation passed outside of the United States.

35. Christina White, *Physician Aid-in-Dying*, 53 HOUS. L. REV. 595, 597 (2015).

36. Antonios P. Tsarouhas, *The Case Against Legal Assisted Suicide*, 20 OHIO N.U.L. REV. 793, 801 (1994).

37. OR. REV. STAT. § 127.800–.995 (1997).

38. *Id.* § 127.800(1) (an adult is defined as someone who is eighteen years or older).

39. *Id.* § 127.800(11).

40. *Id.* § 127.800(12).

41. *Id.* § 127.800(3).

42. *Id.* § 127.805(1).

43. *Id.* § 127.810.

226 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

patient is receiving medical treatment or is a resident.”⁴⁴ Following a fifteen-day waiting period, the patient must reiterate his or her wish to no longer live in pain, at which point the attending physician may prescribe a lethal dose of medication to enable the patient to end his or her life.⁴⁵

The Death with Dignity Act incorporates a number of safeguards to “protect the interests of patients and health care providers.”⁴⁶ Under the Act the attending physician must:

- (1) Inform the patient regarding the patient’s medical diagnosis, prognosis, risks and probable results associated with taking the lethal medication, and feasible alternatives;⁴⁷
- (2) “[R]efer the patient to a consulting physician for medical confirmation of the diagnosis;”⁴⁸
- (3) Refer the patient to a counselor if either the attending physician or consulting physician is of the opinion that the “patient may be suffering from a psychiatric or physiological disorder;”⁴⁹
- (4) Request, but not require, the patient to notify his or her closest living relative of the prescription request;⁵⁰
- (5) Offer the patient an opportunity to rescind his or her request at any time;⁵¹ and
- (6) Prescribe that the lethal medication be taken by the patient without assistance from any third parties.⁵²

44. *Id.* A relative is defined as an individual related by “blood, marriage, or adoption.” *Id.* An individual is considered to be affiliated with the health care facility if they are “an owner, operator, or employee” of the facility. *Id.*

45. *Id.* § 127.840.

46. Patel, *supra* note 13, at 345.

47. OR. REV. STAT. § 127.815 (2014).

48. *Id.*

49. *Id.* § 127.825.

50. *Id.* § 127.835.

51. *Id.* § 127.845.

52. *Id.* § 127.815. Under component six of the Act, “oral medication may be difficult or impossible for many terminally ill patients to keep down due to nausea and other effects of their diseased states. In such circumstances, lethal injection may be the only alternative for these patients to exercise their rights under the Oregon Act.” Patel, *supra* note 13, at 347.

Additionally, the Act imposes “extensive documentation and reporting requirements on patients’ medical records.”⁵³ Since the law was adopted in 1997, data demonstrates the “implementation is safe, carried out with the appropriate compassionate intent, and protects its vulnerable citizens by preventing abuse of the law.”⁵⁴ On January 19, 2018, the Oregon Public Health Division reported 143 terminally ill adults (including 14 who had received the prescriptions in prior years) died in 2017 from ingesting medications prescribed by physicians under the Oregon Death with Dignity Act.⁵⁵

In 2008, eleven years after Oregon’s Death with Dignity Act was enacted, Washington State approved Ballot Initiative 1000—modeled after Oregon’s Act.⁵⁶ In 2009, Montana’s Supreme Court held, in *Baxter v. State*, although the state’s constitution did not guarantee the right to physician-assisted suicide, neither Montana case precedent nor legislative authority considers it against public policy.⁵⁷ Therefore, even though Montana does not have legislation legalizing physician-assisted suicide, the court concluded consent by the patient to be a valid defense for a physician participating in physician-assisted suicide.⁵⁸

53. Patel, *supra* note 13, at 346; *see also* § 127.855.

54. Anne Compton-Brown, *Examining Patient Integrity and Autonomy: Is Assisted Death a Viable Option for Adolescents in the United States?*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 86, 90 (2014).

55. PUB. HEALTH DIV., OR. HEALTH PLAN, OREGON DEATH WITH DIGNITY ACT: 2017 DATA SUMMARY OREGON HEALTH AUTHORITY 3 (2017), <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>.

56. *See* WASH. REV. CODE ANN. § 70.245.010–.904 (2008). The Act states, “An adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner in accordance with this chapter.”

Id.

57. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009). The case involved Robert Baxter, who was diagnosed with terminal cancer. *Id.* at 1214. “Baxter wanted the option of ingesting a lethal dose of medication prescribed by his physician and self-administered at the time of [his] own choosing.” *Id.*

58. *Id.* at 1211.

228 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

On May 20, 2013, Vermont passed the Vermont Death with Dignity Act.⁵⁹ Vermont's Act, also modeled after Oregon's Death With Dignity Act, allows a capable adult patient with fewer than six months to live to voluntarily submit a request to end "his or her life in a humane and dignified manner."⁶⁰ The request must be written and witnessed by two people.⁶¹ Unlike Oregon and Washington, there is no requirement that the physician and patient have a treating relationship.⁶² On June 9, 2015, California enacted the End of Life Option, also modeled after Oregon's Death with Dignity Act.⁶³ The Act was influenced by twenty-nine-year-old California resident, Brittany Maynard, who moved to Oregon to take advantage of Oregon's Death with Dignity Act.⁶⁴ Lastly, on November 8, 2016, Colorado passed Proposition 106, The End of Life Options Act (also modeled after Oregon's Death with Dignity Act), which went into effect on December 16, 2016.⁶⁵

A consequence of Washington, Vermont, California, and Colorado mirroring their right to die legislation after Oregon's Death with Dignity Act, is all five states fail to extend physician-assisted suicide to minors who otherwise meet the requirements. Furthermore, Montana's judicially created consent defense is limited to adult patients who

59. White, *supra* note 35, at 612.

60. *Id.* at 610; VT. STAT. ANN. tit. 18 § 5283 (2013).

61. *Id.*

62. White, *supra* note 35, at 612.

63. CAL. HEALTH & SAFETY 1.85 § 443-.22 (2015).

64. Mollie Reilly, *Right to Die Becomes Law In California*, HUFFINGTON POST (Oct. 6, 2015), http://www.huffingtonpost.com/entry/right-to-die-california_us_560c6037e4b076812700b6d8. Maynard's story "gained national attention," shedding light on the need for all states to enact right to die laws. *Id.* Maynard, a California resident, moved to Oregon to take advantage of the state's aid-in-dying law after being diagnosed with terminal brain cancer because at the time California had no end of life option in place. *Id.*

65. COLO. REV. STAT. ANN. § 25-48-103 (2016).

(1) An adult resident of Colorado may make a request, in accordance with sections 25-48-104 and 25-48-112, to receive a prescription for medical aid-in-dying medication if: (a) The individual's attending physician has diagnosed the individual with a terminal illness with a prognosis of six months or less; (b) The individual's attending physician has determined the individual has mental capacity; and (c) The individual has voluntarily expressed the wish to receive a prescription for medical aid-in-dying medication.

Id.

provide consent, thereby also limiting physician-assisted suicide to terminally ill adults. One reason states have denied terminally ill minors the right to die is because the “demarcation line at the age of majority (eighteen)” where those “above the line (adults)” are presumed competent and those “below the line (children)” are presumed incompetent and, therefore, incapable of making medical decisions.⁶⁶ A child's competence should not turn on the single fact of whether the child has turned eighteen. Rather, a treating physician should apply a contoured approach that considers whether a particular minor, regardless of age, has the capacity to decide to end his or her life.⁶⁷

III. COMPETENCY, COGNITIVE DEVELOPMENT, AND THE ACQUISITION OF DEATH

Although the terms capacity and competency are used interchangeably, they are not synonymous.⁶⁸ Capacity is an individual's mental or physical ability, evaluated and determined by physicians.⁶⁹ Competency is the ability to make a decision;⁷⁰ only a judge can declare an individual to be legally competent.⁷¹ Courts assess an individual's competency to make medical decisions by the presence or absence of the individual's ability to communicate choices; the individual's ability to understand his or her current situation, treatment options, and subsequent consequences; and the individual's ability to understand relevant information required to make an informed decision.⁷² Applying these factors, a court may find a child competent in some decisions and not in others.⁷³ For example, although some

66. Larry Cunningham, *A Question of Capacity: Towards a Comprehensive and Consistent Vision of Children and Their Status Under Law*, 10 U.C. DAVIS J. JUV. L. & POL'Y 275, 285 (2006).

67. *See infra* Discussion Part.III.

68. Derish, *supra* note 8, at 113.

69. Cunningham, *supra* note 66, at 281.

70. *Id.* at 280–81.

71. Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49-51 RUTGERS L. REV. 1, 11 (1996). For example, a physician's determination of a minor's competency is not presumed and can only be determined by a judge. *Id.*

72. Anthony W. Austin, *Medical Decisions and Children: How Much Voice Should Children Have in Their Medical Care?*, 49 ARIZ. L. REV. 143, 150 (2007).

73. *Id.* at 151.

230 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

states find that a child can competently decide to have an abortion without parental consent, that does not mean she is “per se competent” to make decisions regarding the right to die.⁷⁴

The assessment of minor competency has been expanded upon in the field of psychology because neither “statutes nor case law provide clear guidelines for judging competence.”⁷⁵ Experiments conducted during the twentieth century shed light on the cognitive development of children, their ability to make rational decisions, and their view of death.⁷⁶ For example, in 1978, psychologists Thomas Grisso and Linda Vierling sought to determine at what age a child is able to give meaningful consent.⁷⁷ Based on a “competence/informed consent model,” Grisso and Vierling concluded, “[A]dolescents over the age of fifteen are as competent as adults to make medical treatment decisions.”⁷⁸

In 1983, psychologist C.E. Lewis sought to determine a child’s perception of who was in control of decisions.⁷⁹ Lewis challenged the notion that only a parent knows when a child needs medical attention.⁸⁰ The study was conducted at the University Elementary School at the

74. *Id.*

75. Austin, *supra* note 72, at 152; *see also* Cunningham, *supra* note 66, at 279.

76. Cunningham, *supra* note 66, at 282. However, there is still no one theory of competence. Austin, *supra* note 72, at 150.

77. Austin, *supra* note 72, at 153; *see also* Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Development Perspective*, 9 PROF. PSYCHOL. 412, 416, 423 (1978).

78. Grisso & Vierling, *supra* note 77, at 216, 423. Grisso and Vierling defined meaningful consent as “‘sufficient intelligence’ to understand and appreciate the consequences of [his or her] decision.” *Id.* at 216. Under their theory, a child must be able to sustain his or her attention to the task at hand, have the “ability to delay response in process of reflecting on the issues,” and the ability to think in a “sufficiently differentiated manner” in order to prove that the child is capable of both inductive and deductive forms of reasoning. *Id.* at 418.

79. Charles E. Lewis, *Decisions Making Related to Health: When Could/Should Children Act Responsibly*, in CHILDREN’S COMPETENCE TO CONSENT 75, 78 (Gary B. Melton et al. eds., 1983).

80. *Id.* The study of “Child Initiated Care” addressed two questions: (1) “[g]iven the passivity of children in an adult-oriented health care system, what behaviors would children exhibit if they were free to initiate care on their own (without adult control);” and (2) “[w]ould participation in the decision-making process related to their own care have a positive impact on children’s health-related benefits and behaviors.” *Id.*

University of California, Los Angeles through a “care card system.”⁸¹ Cards were placed in boxes throughout the school from which the children could take cards, write their name on them, hand them to a teacher, and go directly to the school nurse.⁸² During their visit with the nurse the children were asked about their medical history, examined, and presented with the nurse’s diagnosis.⁸³ The children were then “asked to formulate options for the treatment” and choose which option they would like to proceed with.⁸⁴ By removing all parental figures from the decision of when to visit doctors, the children were forced to adopt internal control.⁸⁵ The study showed the number of visits to physicians (in this case, the school nurse) to ask questions by children five to twelve years old mirrored the rates of adults thirty-five to fifty-four.⁸⁶ Although the study was limited to non-life threatening conditions, Lewis concluded, “[C]hildren as young as five years old are capable of making medical decisions in a way that is similar to adults.”⁸⁷

Child cognitive development researcher, Jean Piaget, more specifically studied how and when children achieve the ability and maturity to make adult-like decisions.⁸⁸ Piaget found that children develop through four stages: (1) the sensorimotor stage,⁸⁹ (2) the

81. *Id.*

82. *Id.*

83. *Id.* It is important to note that the nurse followed the experiment procedures only “when there was no threat to the health or welfare of the child.” *Id.* at 79. If the child had a high fever of 102 or a serious injury that required immediate medical attention the child was no longer given decision-making power with regard to their treatment. *Id.*

84. *Id.* at 78.

85. Austin, *supra* note 72, at 153.

86. Lewis, *supra* note 79, at 79.

87. Austin, *supra* note 72, at 154.

88. Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 153 (2000).

89. Cunningham, *supra* note 66, at 282. In the sensorimotor stage, babies learn about the world through touch, sound, sight, and taste. *Id.*

232 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

preoperational stage,⁹⁰ (3) the concrete operation stage,⁹¹ and (4) the formal operation stage.⁹² Piaget concluded children between eleven and fifteen:

can engage in pure thought independent of actions they see or perform. They can hypothesize and draw deductions, understand theories, and combine them to solve problems In Piagetian theory, by the age of fifteen, a child's thinking has evolved into a mature state and adult thought exists within the child's repertoire of mental functions.⁹³

In addition to Piaget's theory, current psychological literature supports the premise that "a minor acquires a mature understanding of death before the age of majority (eighteen)."⁹⁴ Based on psychologist Maria Nagy's research, psychologists have identified three stages of maturation in a child's understanding of death.⁹⁵ During the first stage, a child of less than five years old perceives death as temporary or reversible.⁹⁶ In the second stage, a child between the age of five and nine begins to develop awareness of "death's finality" and the causes

90. *Id.* The preoperational stage occurs between the ages of two through seven. *Id.* During this time the child learns to communicate, however, they do not have the ability to understand the consequences of their actions. *Id.*

91. *Id.* During the concrete operational stage children between eleven and twelve begin to think logically and organize their worlds into hierarchies. *Id.*

92. Cunningham, *supra* note 66, at 282–83. The final stage, formal operational stage, runs from thirteen to fifteen. *Id.* During this time, the child learns to think hypothetically and reason through multiple options by analyzing possible outcomes. *Id.* at 283.

93. Schlam & Wood, *supra* note 88, at 153.

94. Rosato, *supra* note 71, at 55.

95. *Id.* Nagy examined 378 children between the ages of three to ten living in Budapest before WWII. CHARLES A. CORR & DONNA M. CORR, DEATH & DYING, LIFE & LIVING 363 (2009). Nagy's study involved the following: children seven to ten years old were asked to write down everything that comes to their mind about death; children six to ten years old were asked to make drawings about death (many of the older children also wrote explanations of their creations); and discussions were held with all of the children either about their compositions or drawings, or (in the case of 3 to 5 year olds) to get them to talk about their ideas and feelings about death. *Id.* Nagy's results were not published until 1948. *Id.*

96. *Id.* at 363–64; Rosato, *supra* note 71, at 56.

2018] A MINOR'S RIGHT TO DIE WITH DIGNITY 233

of death, but still views death as only a remote possibility.⁹⁷ In the final stage, a child nine years or older is aware that death is final and universal.⁹⁸ It is during this final stage that the child can name various causes of death and “recognizes death as a natural process.”⁹⁹ Although researchers agree the “death concept develops progressively” and “adolescents have a mature understanding of death,” they disagree as to the age each child acquires an understanding of death.¹⁰⁰

Based on the cognitive development and death recognition research of children, the American Academy of Pediatrics Committee on Bioethics supports the finding that minors achieve decisional making capacity at a much earlier age than is recognized legally.¹⁰¹ The Committee has also recommended children be more involved in health care decisions.¹⁰² Additionally, some experts believe children who suffer from a terminal illness develop a real maturity because “[w]hat the child experiences influences his or her maturity and thus also the way he [or she] thinks about death and thus the significance of the request he [or she] formulates.”¹⁰³ Society too must acknowledge minors’, suffering from terminal illnesses, ability to “combine their own decision-making abilities with the advice and consent of their parents and physicians, and conclude that that the harm of staying alive far outweighs the harm that would be done by requesting or receiving assistance in death.”¹⁰⁴

97. CORR & CORR, *supra* note 95, at 364. During the second stage, death is “imagined as a separate person” such as the grim reaper, ghost, or skeleton. *Id.*

98. *Id.* at 365.

99. Rosato, *supra* note 71, at 56.

100. *Id.* at 56–57.

101. Schlam & Wood, *supra* note 88, at 156.

102. *Id.*

103. Ludo M. Veny, *Law and Ethics. The Belgian Law on Euthanasia and Minors . . . A Bridge Too Far for the Current Decade?*, FIAT JUSTITIA 197, 204 (2015); *see infra* Discussion Part.VII.

104. Compton-Brown, *supra* note 54, at 97.

IV. EXCEPTIONS TO THE PRESUMPTION AGE OF MAJORITY

Under United States law, eighteen is the presumptive age of majority.¹⁰⁵ However, this is not a bright line age,¹⁰⁶ as several exceptions have emerged over the years: (1) emergency exception, (2) emancipation exception, (3) minor treatment statutes, and (4) the mature minor doctrine.¹⁰⁷ These exceptions were “not intended to protect the minors’ rights to self-determination,” but were designed to limit “negative consequences resulting from lack of medical care, such as significant harm to the child or to the community.”¹⁰⁸

The emergency doctrine is “one of the oldest exceptions” that permits medical treatment without requiring parental consent.¹⁰⁹ The doctrine enables physicians to treat minors in emergency situations without parental consent, because consent is presumed.¹¹⁰ However, minors do not have the ability to refuse emergency medical treatment

105. See *In re E.G.*, 549 N.E.2d 322, 326 (Ill. 1989).

106. *Id.*

107. Mary Irene Slonina, *State v. Physician et al.: Legal Standards Guiding the Mature Minor Doctrine and the Bioethical Judgment of Pediatricians in Life-Sustaining Medical Treatment*, 17 HEALTH MATRIX 181, 188 (2007). Additionally, the 1845 English case of *The Queen v. Smith* established the common law Rule of Sevens. Paul Arshagouni, “*But I’m an Adult Now. . .Sort of*,” 9 J. HEALTH CARE L. & POL’Y 315, 332 (2006). The rule of sevens established four presumptions: (1) “minors from birth to age seven had no capacity,” (2) “minors between the ages of seven and fourteen had a rebuttable presumption of no capacity,” (3) “minors from age fourteen to twenty-one had a rebuttable presumption of capacity,” and (4) “[t]hose over twenty-one were presumed to have full capacity.” Molly J. Walker Wilson, *Legal and Psychological Considerations in Adolescents’ End-Of-Life Choices*, 110 NW. U. L. REV. ONLINE 33, 40 (2015); see also *Bellotti v. Baird*, 443 U.S. 622, 622 (1979).

108. Rosato, *supra* note 71, at 26.

109. Carrie Ayn Smith, *A Case for Autonomy: An Examination into an Adolescent’s Right to Refuse Treatment*, 6 (May 1, 2014) (unpublished paper), http://scholarship.shu.edu/cgi/viewcontent.cgi?article=1578&context=student_scholarship.

110. *Id.*

A medical emergency exists where (1) the patient is incapacitated to the point that she cannot use her mental facilities to reach an informed choice; (2) the circumstances are life-threatening or serious enough that immediate treatment is required; and (3) it would be medically imprudent to attempt to solicit consent from some other authorized person on behalf of the patient. Schlam & Wood, *supra* note 88, at 164.

without parental consent.¹¹¹ In other words, the doctrine extinguishes a minor's autonomy to refuse treatment while shielding doctors from liability after providing medical care without parental consent.¹¹²

The second exception, emancipation, is based on the principal that minors who are independent from their parents should be treated as adults.¹¹³ Thus, emancipation is not based on principles of competence but of independence.¹¹⁴ Circumstances that define an emancipated minor vary by state.¹¹⁵ Most states grant minors the right to consent to or refuse treatment if the minor joins the military, marries, lives away from his or her parents and is self-supporting, or becomes a parent.¹¹⁶ Once granted this status, minors have "the same legal rights" and responsibilities as an adult, and can make their own medical decisions.¹¹⁷

The third exception, minor treatment statutes, addresses the "specific health needs of minors and society."¹¹⁸ Most of these statutory exceptions focus on "specific diseases, conditions, or treatments."¹¹⁹ For example, statutes permitting minors to consent to care for sexually transmitted diseases were drafted because states feared that "adolescents would not seek care, if they first were required to inform their parents and obtain their consent."¹²⁰ States have also

111. Ann Eileen Driggs, *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687, 691 (2001).

112. *Id.*

113. Slonina, *supra* note 107, at 189.

114. Rosato, *supra* note 71, at 28.

115. *Id.*

116. Schlam & Wood, *supra* note 88, at 165. Legislatures have determined that these circumstances amount to "an act of physical, psychological, or economic separation from one's parents." *Id.*

117. Slonina, *supra* note 107, at 189.

118. Jessica A. Penkower, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment—Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1177–78 (1996). "These statutes do not hinge on the maturity of the minor, nor were they created to further the rights of a minor who exhibits the maturity of an adult." *Id.* Society's interest in stopping the spread of sexually transmitted diseases was the motivating force in drafting these laws. *Id.*

119. *Id.* at 1178; *see also* FLA. STAT. § 743.06 (West 2016) (allowing any minor seventeen years or older to give consent to the donation, without compensation for, his or her blood).

120. Penkower, *supra* note 118, at 1178.

236 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

enacted statutes allowing minors to obtain treatment without parental consent for alcohol and substance abuse, psychiatric care, birth control, and abortions.¹²¹

The final exception, the mature minor doctrine, is a common law rule allowing minors to consent to or refuse a particular medical treatment without parental consent, if they can demonstrate they understand the risks, consequences, and nature of treatment.¹²² A minor has the capacity to understand the risks, consequences, and nature of treatment, if the minor has:

- (1) an intellectual appreciation of the causal connections between one's choices and the consequences that will likely follow, (2) a realistic affective and evaluative capacity to appreciate the weight and significance of the risks and benefits, proximate and distant, associated with one's choices, and (3) a self-determining capacity to choose or to decline to make a choice, while not being unduly swayed by impulse.¹²³

There is no case law on a minor's right to physician-assisted suicide or euthanasia. However, the mature minor doctrine case precedent should apply where a minor is seeking the right to die.

For example, in 1989, the Illinois Supreme Court, in *In re E.G.*, ruled a competent minor has the common law right (rather than a constitutional right) to refuse life-sustaining medical treatment.¹²⁴ E.G. (Ernestine Gregory) was diagnosed with acute non-lymphocytic leukemia six months before her eighteenth birthday.¹²⁵ E.G. refused blood transfusions, asserting that it violated her religious beliefs as a Jehovah's Witness.¹²⁶ The court ignored the age of E.G. when making their determination and held that eighteen "is not an impenetrable

121. *Id.*; see also FLA. STAT. § 394.56(1) (1985) (allowing minors twelve years and older to consent to outpatient mental health services); FLA. STAT. ANN § 390.025 (West 2016) (permitting a minor to get an abortion without consent of their parent or legal guardian as long as the treating physician gives actual or constructive notice to the parent or legal guardian).

122. Schlam & Wood, *supra* note 88, at 159–60.

123. Wilson, *supra* note 107, at 40. This criteria focuses on competence, not a presumptive based on age. *Id.*

124. *In re E.G.*, 549 N.E.2d at 328.

125. *Id.* at 323.

126. *Id.*

barrier” that precludes a minor from exercising and possessing rights associated with adulthood.¹²⁷ A minor’s right to consent or refuse medical treatment must be balanced against the state’s interests of preserving life, protecting the interests of parents and other related third parties, preventing suicide, and “maintaining the ethical integrity of the medical profession.”¹²⁸ Additionally, there must be “clear and convincing [evidence] that the minor is mature enough to appreciate the consequences of [his or] her actions, and that the minor is mature enough to exercise the judgment of an adult.”¹²⁹

In 1990, the mature minor doctrine was reaffirmed by the Maine Supreme Court in *In re Swan*.¹³⁰ *Swan* posed the question of whether Chad, a seventeen-year-old in a permanent vegetative state, could be taken off life support upon his parents’ request based on his previously articulated wishes, only a year earlier, to not receive life-sustaining medical treatment (“LSMT”).¹³¹ The court reiterated, “when an individual has clearly and convincingly in advance of treatment expressed his decision not to be maintained by life-sustaining procedures in a persistent vegetative state, health care professionals must respect that decision.”¹³² The court found Chad’s parents showed clear and convincing evidence that Chad “would not want to be kept alive by artificial means should [an] injury render him incapable of existing otherwise.”¹³³ Ultimately, Chad’s wishes to be taken off life support were upheld, and the parents were not held liable for his death.¹³⁴

127. *Id.* at 325. The court relied on the fact that E.G. was six months away from her eighteenth birthday and that a psychiatric evaluation found “she had a maturity level of an eighteen to twenty-one-year-old and the competency to reject the transfusion even if death would result.” Driggs, *supra* note 111, at 698.

128. *In re E.G.*, 549 N.E.2d at 328.

129. *Id.* at 327.

130. *In re Swan*, 569 A.2d 1202, 1206 (Me. 1990).

131. *Id.* His parents were petitioning the court to find they would not be held liable if they removed their son’s feeding tubes. Driggs, *supra* note 111, 699.

132. *In re Swan*, 569 A.2d at 1204 (citing *In re Joseph v. Gardner*, 534 A.2d 947, 947 (Me. 1987).).

133. *Id.* at 1204–05. Chad expressed his desire not to be kept alive on life support during a discussion with his mother about the *Gardner* case and at sixteen stated, “If I can’t be myself . . . no way . . . let me go to sleep.” *Id.* at 1205.

134. *Id.* at 1206.

238 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48

The mature minor doctrine and the reasoning in *E.G.* and *Swan*, are not the only authorities that can be used by states seeking to implement legislation to include the right to die by physician-assisted suicide to minors. For example, the legislative policies in the Netherlands and Belgium further the discussion regarding a minor's autonomy and his or her right to die.¹³⁵

V. NETHERLANDS' AND BELGIUM'S RIGHT TO DIE LAWS

A. Netherlands

The right to die in the Netherlands is regulated by the Termination of Life on Request and Assisted Suicide Act, ("Netherlands Act").¹³⁶ The Netherlands Act, which was passed April 1, 2002, defines assisted suicide as "intentionally assisting in a suicide of another person" or providing the person with the means to do so.¹³⁷ The Netherlands holds physicians to the same requirements and procedures for both physician-assisted suicide and euthanasia.¹³⁸ A physician and patient may choose one or the other, depending on the circumstances.¹³⁹ Under Article 2 of the Netherlands Act, a doctor involved in physician-assisted suicide or euthanasia will not be prosecuted if he or she complies with a number of due care criteria.¹⁴⁰ Specifically, the physician must: (a) be satisfied the patient's request is "voluntary and well-considered;" (b) be satisfied "the patient's suffering was lasting and unbearable;" (c) "inform[] the patient about the situation he was in and about his prospects;" (d) be satisfied "there was no other reasonable solution for the situation;" (e) "consult[] at least one other, independent physician who has seen the

135. See *infra* Discussion Part.VI.

136. Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, Stb. 2001, 194 (Neth.), <https://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda%20Ley%202002.pdf> [hereinafter Termination of Life on Request and Assisted Suicide Act].

137. *Id.* at ch. 4.

138. Manzione, *supra* note 3, at 454. Euthanasia occurs when a physician administers an injection that intentionally causes the patient's death. Bryant, *supra* note 9, at 297.

139. *Id.* For example, a severely physically handicapped person might require death by euthanasia rather than physician-assisted suicide. *Id.*

140. Termination of Life on Request and Assisted Suicide Act, *supra* note 136, at ch. 2.

patient and has given his written opinion on the requirements of due care[;]" and (f) "terminate[s] a life or assisted in a suicide with due care."¹⁴¹ Unlike the physician-assisted suicide statutes enacted in the United States, the Netherlands Act does not explicitly limit physician-assisted suicides to terminally ill *adult* patients.¹⁴²

- (1) The Netherlands Act further provides safeguards depending on the patient's age and capacity.¹⁴³ The attending physician may comply with a patient's request to terminate his or her life under the following circumstances:
- (2) The patient is *over the age of sixteen and no longer able to express his or her will, was deemed capable of making a reasonable appraisal of his or her own interests* before reaching this state, and has a written declaration requesting that his or her life be terminated.¹⁴⁴
- (3) The patient is *between the age of sixteen and eighteen and is deemed capable of making a reasonable appraisal of his or her own interests*, the attending physician may comply with the request to terminate his or her life or provide assistance with suicide, after the parent(s) and/or *guardian(s), have been consulted*.¹⁴⁵
- (4) The patient is *between the age of twelve and sixteen and deemed able to make a reasonable appraisal of his or her own interests, and the parent(s) and/or guardian(s) consent to the termination of life or to assisted suicide*.¹⁴⁶

141. *Id.*

142. Ebbot, *supra* note 9, at 187. If a patient suffers from psychological illness such as depression, then the attending physician must consult "at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care." Termination of Life on Request and Assisted Suicide Act, *supra* note 136, at ch. 2, art. 2. This Article does not take the position that minors suffering from psychological disorders should be extended the right to die because at the present time there are no guidelines or data which proves that a minor suffering from a psychological disorder such as depression is competent enough to make the decision to die.

143. *Id.* at ch. 2, art. 2.

144. *Id.* at ch. 2, art. 2(2).

145. *Id.* at ch. 2, art. 2(3). This means that although parents must be involved in the decision making process, their permission is not required. *Id.*

146. *Id.* at ch. 2, art. 2(4).

240 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48

The Netherlands Act also established a Regional Review Committee, which evaluates all assisted suicide cases to ensure that the physician's duty of due care to his or her patient was satisfied.¹⁴⁷

B. Belgium

On May 16, 2002, the lower house of Parliament passed the Belgian Act on Euthanasia ("Belgian Act") by 86 votes for, 51 against, and 10 abstentions.¹⁴⁸ Belgium's Advisory Committee on Bioethics proposed the Belgian Act to distinguish "'euthanasia' from other life-ending actions" (such as physician-assisted suicide).¹⁴⁹ Section 2 of the Belgian Act defines euthanasia "as intentionally terminating life by someone other than the person concerned, at the latter's request."¹⁵⁰ According to the Belgian Act, a physician who performs euthanasia commits no criminal offense if he or she ensures:

[1] the patient has attained the age of majority [eighteen] or is an emancipated minor, and is legally competent and conscious at the moment of making the request; [2] the request is voluntary, well-considered and repeated, and is not the result of any external pressure; and [3] the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.¹⁵¹

147. *Id.* at ch. 3, art. 3. "The Commission, composed of a lawyer, physician, and ethicist, examines each reported case to determine whether the physician complied with the strict requirements of the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act sufficiently to secure immunity from criminal prosecution." Compton-Brown, *supra* note 54, at 98.

148. Raphael Cohen-Almagor, *Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement*, 24 ISSUES IN L. & MED. 187, 192 (2009).

149. Veny, *supra* note 103, at 199.

150. The Belgian Act on Euthanasia of May 28th, 2002, 9 ETHICAL PERSP. 182, 182 (Dale Kidd trans., 2002) [hereinafter The Belgian Act on Euthanasia of May 2002].

151. *Id.*

The request to die by euthanasia must be made in writing, dated, and signed by the patient.¹⁵² If the patient is incapable of making a written request, he or she may designate a person to write the request.¹⁵³ This designated person must have attained the age of majority and not have any "material interest [i.e. financial benefit] in the death of the patient."¹⁵⁴

Before carrying out euthanasia, the physician must comply with a number of safeguards, which include the following:

The physician must inform the patient about the patient's "health condition and life expectancy, discuss with the patient his or her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences."¹⁵⁵

Both the patient and the physician must believe "there is no reasonable alternative to the patient's situation and that the patient's request is completely voluntary."¹⁵⁶

The physician must be certain of the "patient's constant physical or mental suffering" and have "several conversations with the patient spread out over a reasonable period of time."¹⁵⁷

The physician must confer with another physician regarding the "serious and incurable character of the disorder."¹⁵⁸ If the consulted physician believes the patient is not likely to die within "the near future," then he or she must consult a second professional in the field who is either a "psychiatrist or a specialist in the disorder in question."¹⁵⁹

Additionally, when a patient is not terminally ill, at least one month must have passed between the written request and the euthanasia.¹⁶⁰

152. *Id.* at 183.

153. *Id.*

154. *Id.*

155. *Id.* at 182.

156. *Id.*

157. *Id.*

158. *Id.* at 182–83.

159. *Id.* at 183.

160. *Id.*

242 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

On March 2, 2014, Belgium became the first nation to remove all formal age restrictions for euthanasia.¹⁶¹ The revised Act added safeguards regarding a minor's right to die.¹⁶² A physician who performs euthanasia does not commit a criminal offense if: (1) the patient is a "*minor with the capacity of discernment* and is conscious at the moment of making the request;" (2) "the request is voluntary, well-considered and repeated, and is not the result of any external pressure;" and (3) *the minor is in "constant and unbearable physical or mental suffering"* resulting from a serious and incurable disorder caused by illness or accident that cannot be alleviated.¹⁶³ Additionally, the attending physician must consult a child psychiatrist or a psychologist.¹⁶⁴ The consulted specialist must examine the minor patient and his or her medical records before certifying in writing that the child has the capacity of discernment.¹⁶⁵ The minor child or his or her legal representatives, regardless of whether the child is considered an emancipated or un-emancipated minor must make a written agreement for termination of his or her life.¹⁶⁶ If the patient is an un-emancipated minor, he or she must obtain unanimous *consent* from *both parent(s) and/or guardian(s) and the minor's medical team*.¹⁶⁷

161. Duncan Crawford, *Belgium's Parliament Votes through Child Euthanasia*, BBC NEWS EUR. (Feb. 13, 2014), <http://www.bbc.com/news/world-europe-26181615>. This means that a patient under the age of eighteen now has the ability to request the right to die by euthanasia. *Id.*

162. *Id.*

163. The Belgian Act on Euthanasia of May 28, 2002, ch. 2, § 3(1) (as amended Feb. 13, 2014) [hereinafter *The Belgian Act Amended*] (emphasis added), <http://eol.law.dal.ca/wp-content/uploads/2014/02/Law-of-28-May-2002-on-Euthanasia-as-amended-by-the-Law-of-13-February-2014.pdf>.

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.* at ch. 2, § 3(4).

TABLE 1 – COMPARING NETHERLANDS' AND BELGIUM'S RIGHT TO DIE ACTS

	Netherlands	Belgium
<i>Act</i>	<u>Termination of Life on Request Act</u>	<u>Belgian Euthanasia Act</u>
<i>Euthanasia</i>	Yes	Yes. Section 2
<i>Physician-assisted Suicide</i>	Yes	Yes
<i>Assisted Suicide Defined</i>	"[I]ntentionally assisting in a suicide of another person" or providing that person with the means to do so." ¹⁶⁸	"[I]ntentionally terminating life by someone other than the person concerned, at the latter's request." ¹⁶⁹
<i>Minimum Age</i>	12	None
<i>Illness</i>	Terminally ill with six months or fewer to live.	Terminally ill with six months or fewer to live.
<i>Require-ment for Minors</i>	(1) <u>Sixteen or older</u> and no longer able of expressing their will, but before reaching this state was deemed capable of making a reasonable appraisal of their own interests and has made a written declaration requesting their life be terminated, then the attending physician may comply with this request. ¹⁷⁰ (2) <u>Between sixteen and eighteen</u> and is deemed incapable of making a reasonable appraisal of their own interests, the attending physician may comply with a request made by the patient to terminate his or her life or provide assistance with suicide, after the parent(s) and/or guardian(s) have been consulted. ¹⁷¹ (3) <u>Between twelve and sixteen</u> and is deemed able to make a reasonable appraisal of his or her own interests, the attending physician may comply with the patient's request if the parent(s) and/or guardian(s) consent [verbally and in writing to the physician] to the termination of life or to assisted suicide. ¹⁷²	(1) The minor must have "the capacity of discernment" and be "conscious at the moment of making the request." ¹⁷³ (2) The minors request must be "voluntary, well-considered and repeated, and is not the result of any external pressure." ¹⁷⁴ (3) The minor must be in "constant and unbearable physical or mental suffering" resulting from "a serious and incurable disorder caused by illness or accident" that cannot be alleviated. ¹⁷⁵ A child psychiatrist or a psychologist must be consulted by the attending physician. If the patient is an unemancipated minor, the agreement of the legal representatives must be made in writing and <u>consent from both parent(s) and/or guardian(s) and the minor's medical team is required.</u> ¹⁷⁶

168. Termination of Life on Request and Assisted Suicide Act, *supra* note 136, at ch. 1.

169. The Belgian Act on Euthanasia of May 2002, *supra* note 150, at 150.

170. Termination of Life on Request and Assisted Suicide Act, *supra* note 136, at ch. 2, art. 2(2).

171. *Id.* at ch. 2, art. 2(3).

172. *Id.* at ch. 2, art. 2(4).

173. The Belgian Act Amended, *supra* note 163, at 183.

174. *Id.*

175. *Id.*

176. *Id.* at 182.

244 CALIFORNIA WESTERN INTERNATIONAL LAW JOURNAL [Vol. 48]

Since the Netherlands passed the Termination of Life on Request and Assisted Suicide Act, only five children have received assistance in dying.¹⁷⁷ Statistics show citizens in the Netherlands support the practice of assisted death and believe “assisted death should be available to those who want it.”¹⁷⁸ In Belgium, only one case of assisted suicide of a minor by euthanasia has been reported since lifting the age restriction in 2014.¹⁷⁹ Furthermore, Belgian poll results demonstrate seventy-five percent of Belgians support right to die laws permitting assistance in death to all minors who can demonstrate “a capacity for discernment through a series of requests and psychological evaluation.”¹⁸⁰

VI. JUDICIAL DECISION MAKING TESTS AND AMENDMENTS TO PRESENT RIGHT TO DIE LEGISLATION IN THE UNITED STATES

Opponents of right to die laws in the United States believe physician-assisted suicide is “incompatible with the role of a physician as a healer,” because a doctor’s “duty is to provide treatment, not cause death,” even if that is what his or her patient wants.¹⁸¹ Advocates of right to die laws believe when a physician has exhausted all reasonable means to reduce pain and suffering, only the terminally ill patient knows whether a life with “severe, unremitting suffering causes more harm than assisted death.”¹⁸² Further, this decision should not be reserved to individuals who have reached an arbitrary number, but rather to all individuals who have reached the “final stage” of development, regardless of age. The research offered by psychologists

177. Compton-Brown, *supra* note 54, at 97 (further information has not been published to respect the patient and family’s privacy).

178. *Id.* at 98.

179. Chandrika Narayan, *First Child Dies by Euthanasia in Belgium*, CNN (Sept. 17, 2016), <http://www.cnn.com/2016/09/17/health/belgium-minor-euthanasia/index.html>. On September 17, 2016, a terminally ill seventeen-year old’s request to die by euthanasia was granted with the consent of his parents. *Id.* No other information has been released on the patient’s medical condition to protect the privacy of his family. *Id.*

180. Compton-Brown, *supra* note 54, at 99.

181. Patel, *supra* note 13, at 334. This argument has been countered by the belief that “physicians are providers of comfort just as much as they are healers of illness.” *Id.* at 335.

182. Compton-Brown, *supra* note 54, at 89.

Grisso, Vierling, Lewis, Piaget, and Nagy should be used to create guidelines similar to those used in the Netherlands and Belgium, which allows terminally ill minors with six months or less left to live to request the right to die by physician-assisted suicide.¹⁸³

A minor's request for physician-assisted suicide must be made in writing by the minor or by a legally appointed guardian. Additionally, the minor must be a resident of the state in which he or she is requesting a physician-assisted suicide. Once a request has been made, the minor's treating physician will be required to make an initial determination of whether the minor-patient (1) has a terminal disease and (2) is in constant and unbearable physical suffering. If the treating physician determines the child is terminally ill, only has six months or less to live, and is constantly suffering from unbearable physical pain, the physician and consulting staff must assess the maturity or capacity of the child. The following considerations must be evaluated:

- (1) whether the minor understands that a choice is being made,
- (2) that the choice is one with a reasonable outcome, and
- (3) that the minor understands the implications (death) of the choice.¹⁸⁴

Moreover, the physician must refer the child to a psychiatrist or psychologist to determine if the child is capable of making a reasonable appraisal of his or her own interests. Following the child's psychological evaluation, the treating physician may comply with the minor's request to terminate his or her life by physician-assisted suicide. However, the minor's parent(s) and/or guardian(s) must receive notification (as practiced in the Netherlands and Belgium) of the minor's request to die, to ensure that all parties are aware of the final diagnosis and request.¹⁸⁵

183. See generally The Belgian Act on Euthanasia of May 2002, *supra* note 150; Termination of Life on Request and Assisted Suicide Act, *supra* note 136.

184. *Id.*

185. Termination of Life on Request and Assisted Suicide Act, *supra* note 136, at ch. 2, art. 2(3); The Belgian Act Amended, *supra* note 163, at 182.

CONCLUSION

*“[T]he ultimate self-determination [is] determin[ing] when and how you’re [going to] die when you’re suffering.”*¹⁸⁶

The idea of self-determination over one’s death is not “enshrined in the Constitution or the laws of the land.”¹⁸⁷ Nevertheless, the freedom to “choose the time and place of our own death” should be considered a right regardless of age.¹⁸⁸ It must be recognized that children also have an interest in the “possession and control” of their body when their happiness is replaced with endless suffering from a terminal disease.¹⁸⁹ The right of a child to end his or her own life “without interference from others, but with help if he [or she] chooses” from a physician is “the ultimate act of love, compassion, mercy” and civil liberty.¹⁹⁰

186. *People of the State of Michigan v. Jack Kevorkian*, 639 N.W.2d 291, 300 (Mich. 2001).

187. Robert L. Risley, *Ethical and Legal Issues in the Individual’s Right to Die*, 20 OHIO N.U. L. REV. 597, 609 (1993).

188. *Id.*

189. *See id.* at 600.

190. *See* Tsarouhas, *supra* note 36, at 800–01.