

Regional euthanasia review committees: 2006 annual report

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Foreword

This annual report deals with the work of the regional euthanasia review committees over the past calendar year.

In 2006, more than 1,900 cases of termination of life on request and assisted suicide were reported. There was one case in which the physician was found not to have acted in accordance with the due care criteria.

As in previous years, this annual report discusses a number of the notifications received, thus providing insight into the factors taken into consideration by the committees. These specific cases also illustrate the particular issues that arose in the year under review. In by far the majority of cases, no special problems arise when the committees make their assessments.

We believe that this publication will increase public awareness of the issues involved and will safeguard and improve the quality of these medical procedures. Other findings by the review committees (from which all identifying details have been removed) can be read on our website (www.toetsingscommissieseuthanasie.nl).

We trust that this will also increase understanding of the medical, legal and ethical questions that arise when cases are reviewed. The multidisciplinary nature of the committees means that notifications are read from three different viewpoints. This clearly makes for a more thorough discussion. In practice, however, we have observed that each discipline has its own particular jargon. It is therefore no simple matter to produce an annual report that is easily accessible to physicians, lawyers and ethicists alike.

One crucial issue continues to be physicians' willingness to report cases of euthanasia or assisted suicide. We are therefore very keen to see the results of the fourth national evaluation of the euthanasia review procedure.

A high rate of notification sheds light on how euthanasia is being dealt with in practice. This is an important goal of euthanasia policy here in the Netherlands.

R.P. de Valk-van Marwijk Kooy

Coordinating chair of the regional euthanasia review committees

Arnhem, May 2007

Introduction

The task of the review committees is to review cases of termination of life on request and assisted suicide. If the physician who performs the procedure and makes the notification has fulfilled the statutory due care criteria, the procedure is not deemed a criminal offence. This legislation, which has been in force since 2002, distinguishes the Netherlands from many other countries.

The year 2006 was not substantially different from previous years. The number of notifications remained practically the same (just over 1,900). To determine how physicians' willingness to report cases has evolved over the recent period, we need to know how many euthanasia procedures are actually performed each year. The fourth national review of life-terminating procedures has now been completed, in parallel with an evaluation of the legislation that has been in force since 2002. The results are expected later in 2007.

As in other years, this annual report deals with the statutory framework and the role of the committees, the figures and their interpretation. Also as in previous years, the due care criteria are clarified with reference to specific cases.

One current development is the website, which was updated in 2006. Many of the committees' findings, and in principle all of them from 2007 onwards, can be read on the website (with all identifying details removed). The purpose is to provide a clearer picture of how the committees make their assessments. The way in which identifying details are removed and findings are published has been discussed at length by the committees. The basic principle is that information should not be traceable to a particular individual. At the same time, the committees want to preserve the information value of the findings.

An important issue during the past year has been palliative sedation, whereby the patient's consciousness is deliberately reduced in the final stage of his life. The increased interest in palliative sedation does not mean that there is no longer so much demand for euthanasia. Unbearable suffering cannot always be alleviated by palliative sedation; moreover, there are patients who expressly refuse palliative sedation and indicate that they wish to remain conscious to the very end.

Another relevant and extremely important factor is the role of the independent physician. In recent years the SCEN project has significantly improved the standard of reporting by

independent physicians. It is important that the independent physician should keep to his role as a provider of support and independent advisor to the physician who performs the procedure. The latter is responsible for his own actions and for fulfilling the due care criteria.

One final issue is the relationship between euthanasia and dementia. In 2006, the committees received six notifications of euthanasia involving patients with a dementia syndrome.¹ Such cases remain exceptional.

In the Netherlands, more than 10,000 patients a year die in a final stage of dementia. Almost all of them die of natural causes at home, in a care home or in a nursing home, although at the end of their lives medical decisions are often made on such matters as restrictions on treatment, palliative care or withholding food and fluids. Only a very small number of cases involve the use of euthanasia as a means of helping the patient die. This continues to be highly exceptional, and is reserved for people with the unusual and painful combination of incipient dementia and very clear awareness of their disease. This enables them to consider themselves and their future while still capable of informed consent, and makes their present suffering unbearable. Termination of life is sometimes requested at this stage.

The cases presented in this report, as well as the information on the subject that you can read on the website, show how carefully physicians deal with these issues.

¹ Final conclusions on five of these notifications were reached in 2006, and one in 2007.

Chapter I

Committee activities

Statutory framework

There is still a good deal of misunderstanding in this country about the term 'euthanasia'.

Euthanasia means 'the termination of a person's life at his own express request.' Termination of life on request and assisted suicide are criminal offences in the Netherlands (Articles 293 and 294 of the Criminal Code). The only exception is when the procedure is performed by a physician who has fulfilled the statutory due care criteria and has notified the municipal pathologist. If the physician satisfies both conditions, the procedure he has performed is not treated as a criminal offence. The aforementioned articles of the Criminal Code identify them as specific grounds for exemption from criminal liability.

The due care criteria are set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'), and the physicians' duty to notify the municipal pathologist is dealt with in the Burial and Cremation Act.

Under the Act, notifications of termination of life on request and assisted suicide must be reviewed by regional euthanasia review committees ('committees'). The committees carry out their main task on the basis of the Act. They review notifications of termination of life on request and assisted suicide, and assess whether the physician has fulfilled the statutory due care criteria. Termination of life on request means that the physician administers the euthanatics to the patient. Assisted suicide means that he prescribes substances to be ingested by the patient himself.

One of the purposes of the legislation, which has been in force since 2002, is to safeguard and improve the quality of the procedures performed by physicians in terminating life. Essentially, the physician who performs the life-terminating procedure must account for his actions and submit to a review. The committees assess whether the physician has fulfilled the due care criteria. This ensures that sufficient light is shed on the practice of euthanasia.

In the decades before the aforementioned legislation came into force, the practice of euthanasia in the Netherlands had become more clearly defined. Decisions on whether or

not to prosecute were guided by 'due care criteria' which were formulated in ever-increasing detail in case law.²

In 1990 these criteria were formally laid down in the Notification Procedure, which acquired statutory status in 1994.

Physicians who reported cases of termination of life on request or assisted suicide and accounted for their actions were not normally prosecuted, since if they had fulfilled the aforementioned due care criteria they could successfully invoke *force majeure* under Article 40 of the Criminal Code (see footnote 2) and would be acquitted. Physicians became increasingly willing to report cases and, as a result, more and more light was shed on the practice of euthanasia in this country, as the surveys conducted every five years revealed. As physicians became more susceptible to review, the quality of the entire decision-making process in the terminal stages of patients' lives was also found to have improved. To further increase physicians' willingness to report cases, multidisciplinary regional euthanasia review committees were set up in 1998; their task was to review physicians' actions and advise the Public Prosecution Service accordingly. Nevertheless, physicians (who always find requests for euthanasia distressing) continued to have qualms about the criminal law framework within which their actions were assessed.

The purpose of the legislation that came into force in 2002 was therefore to decriminalise physicians who had fulfilled a patient's request for termination of life or assisted suicide, had fulfilled the due care criteria and had reported their actions, and to increase legal certainty. Now that specific grounds for exemption from criminal liability are laid down in the Criminal Code, termination of life on request and assisted suicide performed by a physician are no longer criminal offences, provided the physician has fulfilled the due care criteria (which are now also laid down in the Act) and has reported his actions. A further step towards the decriminalisation of euthanasia is the fact that the review committees, which previously had a purely advisory role, now assess whether the physician has fulfilled the due care criteria. They now refer notifications to the Public Prosecution Service and the Health Care Inspectorate only if the due care criteria have not been fulfilled.

² See in particular the 1984 Schoonheim judgment, in which the Supreme Court found that physicians who fulfilled a number of due care criteria were entitled to invoke *force majeure* (Article 40 of the Criminal Code) based on a conflict of duties: the duty to protect the patient's life, and the duty to curtail suffering. These criteria had been worked out in case law, with reference to Royal Dutch Medical Association guidelines, following the first major court ruling on euthanasia (the Postma judgment in 1973).

One of the purposes of this legislation was thus to increase physicians' willingness to report cases and hence to shed more light on the practice of euthanasia and enhance the quality of the decision-making process concerning the termination of life.

Role of the committees

When a physician has terminated the life of a patient on request, or assisted in his suicide, he notifies the municipal forensic pathologist. When doing so, he submits a detailed report showing that he has complied with the due care criteria.³ The pathologist performs an external examination and ascertains how the patient died and what substances were used to terminate his life. He then establishes whether the physician's report is complete. The report by the independent physician and, if applicable, the advance directive drawn up by the deceased are added to the file.

The pathologist notifies the committee, submitting all the required documents and any others that may be relevant, such as the patient's medical file and letters from specialists. Once the committee has received the documents, both the pathologist and the physician are sent an acknowledgement of receipt. The committees assess the physician's actions, examining whether he has acted in accordance with the statutory due care criteria. If a committee has any questions, the physician in question will be informed. Physicians are often asked to respond in writing to additional questions. The committees sometimes contact physicians by telephone if they need extra information.

If the information thus provided by the physician is insufficient, he may then be invited to provide further information in person. This gives him an opportunity to explain in more detail what took place in this particular case.

The physician is notified within six weeks of the committee's findings. This period may be extended once, for instance if the committee has further questions.

The multidisciplinary committees issue their findings on the notifications they assess. In almost every case they conclude that the physician has acted in accordance with the due care criteria. In such cases, only the notifying physician is informed. In 2006, one physician was found not to have acted in accordance with the criteria. In such cases, the findings are referred to the Board of Procurators General and the Health Care Inspectorate. The Board

³ A standard report form is available as an aid in drawing up the report. It can be filled in as it stands or used as a guide, and can be found at www.toetsingscommissieseuthanasie.nl

decides whether or not prosecution proceedings should be initiated. The Inspectorate decides in the light of its own tasks and responsibilities whether any further action should be taken. This may range from interviewing the physician to disciplinary action. The committees hold consultations with the Board of Procurators General and the Inspectorate every year.

There are five regional euthanasia review committees. The place of death determines which committee is competent to assess the case in question. Each committee comprises three members: a lawyer, who is also the chair, a physician and an ethicist. They each have an alternate. Each committee also has a secretary, who is also a lawyer, with an advisory vote at committee meetings. The secretaries and support staff form the secretariats, which are responsible for assisting the committees in their work. For organisational purposes the secretariats form part of an executive organisation of the Ministry of Health, Welfare and Sport. The secretariats have offices in Groningen, Arnhem and The Hague, and the committees meet there every month.

The committees are competent to assess cases in which a physician has terminated a patient's life on request or assisted in his suicide. They are not competent to do so if there has been no request to terminate the patients' life or to assist to his suicide.⁴ If a physician has terminated the life of a patient without the patient having explicitly requested it, the municipal pathologist must refer the case directly to the public prosecutor.

The committees are not competent to assess cases in which the life of a patient under 12 years of age has been terminated. Nor are they competent in cases involving normal medical procedure. The review procedure set out in the Act is not intended for such cases. Examples of normal medical procedure include ceasing or not commencing treatment that serves no medical purpose, ceasing or not commencing treatment at the patient's request, or administering treatment needed to alleviate the patient's suffering which leads to the patient's death. Normal medical procedure does not fall within the scope of criminal law and does not need to be reported.

In publishing their annual report and providing general information, the committees are helping to shed more light on the practice of termination of life on request and assisted suicide and to enable public scrutiny of these procedures.

⁴ See Article 1, paragraph 2 of the guidelines on the working procedures of the regional euthanasia review committees, adopted on 21 November 2006.

The committees help the Euthanasia in the Netherlands Support and Assessment Project (SCEN) train physicians to perform independent assessments. They also give presentations to municipal health services, associations of general practitioners, hospitals and foreign delegations, using examples from practice to provide information on applicable procedures and the due care criteria.

To ensure uniform assessments, the chairs of the committees and their alternates meet regularly. They also make agreements about working methods. If, for instance, a committee intends to find that a physician has not acted in accordance with the due care criteria, the draft findings are submitted to all its members and their alternates for comment, and to all the members of the other committees and their alternates for advice.

Developments in 2006

In the year under review there were a number of developments of relevance to the work of the committees.

Website

The committees' website was updated in 2006. It includes their findings, with all identifying details removed. The purpose is to provide a clearer picture of the cases dealt with by the committees and the factors that played a part in their assessments. The way in which identifying details are removed and findings are published has been discussed by the committees at length, and this has led to their being published in their present form. The basic principle is that information should not be traceable to a particular individual. At the same time, the committees want to preserve the information value of the findings. Dilemmas may arise when there is a rare combination of diseases and specific facts.

The committee concerned – and, if necessary, the meeting of committee chairs – determines whether findings can be published in such a way that the information cannot be traced to particular individuals. They sometimes decide to refrain from publication. Owing to technical teething troubles, the number of findings published in 2006 was relatively small.

Physicians' willingness to notify the municipal forensic pathologist and number of notifications in 2006

Although the practice of euthanasia in this country is transparent, physicians' willingness to

notify the municipal pathologist raises questions every year. It should therefore be emphasised that a rise or fall in the number of notifications says nothing about this. The extent to which physicians are willing to report to the municipal pathologist can only be determined by discovering how the number of notifications compares with the actual number of cases of euthanasia and assisted suicide in the Netherlands.

In 2006, the committees received 1,923 notifications of euthanasia and assisted suicide. In 2005, the number was 1,933.

In 2006, another five-yearly review of life-terminating procedures performed by physicians in the Netherlands was carried out. An additional purpose of this latest review was to evaluate the legislation that came into force in 2002. Committee files were used (confidentially, of course) in the review. The results of the review are due in May 2007. It should enable the actual numbers of cases of euthanasia in 2001 and 2006, and hence the notification rates in those years, to be compared.⁵

⁵ See also J. Griffiths, *Medisch Contact*, 16 March 2007, 62, No. 11, p. 466.

Chapter II

Overview of notifications

1 January 2006 to 31 December 2006

Notifications

The committees received 1,923 notifications in the year under review.

Euthanasia and assisted suicide

There were 1,765 cases of euthanasia, 132 cases of assisted suicide and 26 cases involving a combination of the two.

Physicians

In 1,692 cases the notifying physician was a general practitioner, in 151 cases a medical specialist working in a hospital and in 80 cases a physician working in a nursing home.

Conditions involved

The conditions involved were as follows:

Cancer	1,656
Cardiovascular disease	55
Neurological disorders	105
Pulmonary disorders, other than cancer	58
Other conditions	45
Combination of conditions	6

Location

In 1,528 cases patients died at home, in 145 cases in hospital, in 79 cases in a nursing home, in 79 cases in a care home and in 92 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committees deemed themselves competent to deal with the notification. In the year under review there was one case in which the physician was found not to have acted in accordance with the due care criteria.⁶

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 29 days.

⁶ The overview is of all notifications received in 2006. Notifications received at the end of a year are dealt with in the year that follows, because of the time needed to review them. The committees' findings on these notifications are therefore included in the following year's report.

Chapter III

Due care criteria

Due care criteria: general

In their findings the committees indicate whether or not, on the basis of their assessment, the physician has acted in accordance with the due care criteria. These criteria, as referred to in Article 293, paragraph 2 of the Criminal Code, are as follows.

Physicians must:

- (a) be satisfied that the patient's request is voluntary and well-considered;
- (b) be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
- (c) inform the patient about his situation and prognosis;
- (d) have come to the conclusion together with the patient that there is no reasonable alternative in the patient's situation;
- (e) consult at least one other independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;
- (f) exercise due medical care and attention in terminating the patient's life or assisting in his suicide.

In practically every case, the committees find that the physician has acted in accordance with the due care criteria. By far the majority of notifications give no grounds for further discussion by the committees. Examples of cases that did give grounds for discussion are set out in this chapter.

Case 1

The physician who terminates a patient's life on request or assists in his suicide must ascertain that the due care criteria set out in the Act have been fulfilled. The same applies to a physician who performs the procedure at another physician's request.

The patient, a woman between 50 and 60 years of age, had bone metastases from a carcinoma of unknown primary origin, possibly in the pancreas, and progressive paraplegia due to pathological fractures. She was suffering unbearably, with no prospect of improvement, and she had made a voluntary, well-considered request that her life be terminated. She had been informed about her situation and prognosis. The conclusion was that there was no reasonable alternative in her situation. An independent physician had been consulted, had seen the patient and had submitted a written report indicating why, in his opinion, the due care criteria had been fulfilled. The life-terminating procedure had been performed with due care and attention. When assessing the notification, the committee required further information from the physician concerning the point at which he had become involved in the case and the way in which the decision concerning the termination of the patient's life had been reached. After the physician's written reply had been discussed at a meeting of the committee, he was invited to appear in person.

In his written reply, the physician had stated that he was simply the person who had carried out the procedure. Further information provided by the physician in person indicated that the patient's general practitioner had gone through all the preliminary stages with the patient and that the patient, together with her family and the general practitioner, had decided that euthanasia was the only alternative in her situation. When the general practitioner had decided that the time had come to terminate the patient's life, he got in touch with the physician to ask how he should proceed. At this point the general practitioner had stated that, for emotional reasons, he was unable to perform the procedure, and requested the physician to do so instead.

After the patient had been seen by an independent physician, whose opinion was that the statutory due care criteria had been fulfilled, the physician visited the patient, made her acquaintance, spoke to her and briefly ascertained her condition. He had found her lying on the couch. She was conscious and lucid, and was not drowsy from morphine. It was perfectly possible to communicate with her. She begged for help. It was agreed that the life-terminating procedure would be performed within a few days. The physician received and studied the independent physician's written report on the morning of the day that the procedure was performed. As mentioned, he had seen and spoken to the patient and had studied her medical file, which he had received from her general practitioner. The physician was satisfied that further treatment would serve no medical purpose. The patient was suffering unbearably, with no prospect of improvement. The physician felt that her suffering was palpably unbearable. He had also asked her about her wish for euthanasia and had discussed it with her. He felt certain of her condition and her wish for euthanasia. He agreed

with the general practitioner and the independent physician that euthanasia was justified in this case.

The committee noted that, under the terms of Article 293, paragraph 2 of the Criminal Code, a physician who terminates a patient's life on request or assists in his suicide and wishes to invoke the specific grounds for exemption from criminal liability laid down in the Criminal Code must fulfil the due care criteria set out in Section 2 of the Act and then account for his actions by submitting a detailed report to the municipal pathologist in accordance with Section 7, subsection 2 of the Burial and Cremation Act. This also applies if the patient has been referred to him. The physician initially stated that he thought of himself simply as the person who had carried out the decisions reached by the general practitioner. If so, he would not, in the committee's view, have been able to invoke the specific grounds for exemption from criminal liability. Only when the physician was questioned in person was the committee satisfied that he had fulfilled the statutory due care criteria. His written report should have indicated how he had ascertained that the due care criteria had been fulfilled.

Given all the facts and circumstances of the case, the committee found that the physician had acted in accordance with the due care criteria.

Due care criteria: specific

This section indicates what factors the committees take into account when assessing notifications for fulfilment of each of the statutory due care criteria. This is illustrated with reference to cases that the committees assessed in 2006.

(a) Voluntary and well-considered request

Physicians must be satisfied that the patient's request is voluntary and well-considered.

The physician must be satisfied that the patient's request is voluntary and well-considered. Willingness to discuss the end of the patient's life, the patient's wishes and possible ways of fulfilling them are all part of the contact between the patient and the physician.

The request for euthanasia must have been made by the patient himself. It must also be voluntary. The physician must be certain that the patient has not made the request under pressure from those around him. In making their assessment, the committees consider when and how the patient made the request. In order to make a well-considered request, the

patient must have a full understanding of his disease, the situation he is in, the prognosis and any other ways of improving the situation.

If a patient is suffering from depression, this may adversely affect his ability to give informed consent. Where there is any doubt, a psychiatrist is often consulted in addition to the independent physician. The physician must be able to ascertain, or obtain confirmation, that the patient is capable of informed consent. If other medical practitioners have been consulted, it is important to make this known to the committees. In some cases, after weighing everything up, a physician may decide neither to consult an additional medical practitioner, nor to call in for a second time one who has been consulted earlier. Such information is also of relevance to the committees' assessment. If the physician gives a full account of the entire decision-making process in his initial notification, he may not be required to answer further questions later on. In Case 2, the physician listed the factors he had considered in reaching his decision.

Requests for euthanasia from patients suffering from dementia, should normally be treated with great caution, since there may be some doubt whether those patients are capable of informed consent or, given the nature of the condition, whether their request is voluntary and well-considered.

The physician must take the stage of the disease and the other specific circumstances of the case into account when reaching his decision. Patients at a more advanced stage of the disease will rarely be capable of informed consent. If a physician believes that a patient is in the initial stages of dementia, it is important to consult one or more experts in addition to the independent physician.

Apart from whether or not the request is voluntary and well-considered – see Case 3 – the question of whether the patient is suffering unbearably, with no prospect of improvement, is also of particular relevance in the case of dementia. This is discussed in more detail in the section on 'Unbearable suffering with no prospect of improvement' below.

Advance directive

On the standard report form the physician is asked whether there is an advance directive. This may suggest that such a directive is mandatory, but that is not so. The physician must be satisfied that the patient's request is voluntary and well-considered. Such a request is usually made orally.

A physician cannot be compelled by an advance directive to grant a request for euthanasia. He must always make his own judgement, since he will have to account for his actions in cases of termination of life or assisted suicide. There must be no uncertainty between the physician and the patient as to what the patient's wishes are; even if the patient is perfectly capable of expressing his wishes and of requesting euthanasia orally, a written directive can help eliminate any uncertainty and confirm the oral request.

An advance directive, which is specifically referred to in the Act, is intended for a patient who is no longer capable of expressing his wishes when the time comes to consider ending his life. It is advisable to draw up the directive in good time and update it at regular intervals and, where possible, describe the specific circumstances in which the patient wishes to have his life terminated. The clearer and more specific the directive is, the firmer the basis it provides for the physician's decision. A handwritten directive by the patient in which he describes the circumstances in his own words may sometimes make things clearer.

However, if the patient remains capable of informed consent until he dies, an advance directive is not mandatory for termination of life on request or assisted suicide. In almost all the reported cases that come before the committees, there is indeed a written directive. The committees consider this a useful practice, but wish to emphasise that it is not mandatory, if only to ensure that people are not put under unnecessary pressure to draw up such a directive, sometimes very shortly before they die. Evidence received by the committees reveals that patients and their relatives sometimes feel under unnecessarily great pressure to produce such a document.

Case 2 (voluntary and well-considered request)

Was the request voluntary or made under the influence of depression?

The patient, a man between 70 and 80 years of age, had multiple pathology: hypertension, heart failure and carcinoma of the prostate. He sustained frequent falls, which caused fractures. His mobility was limited, even with walking aids. His physical symptoms increased, and the moment at which he needed to be hoisted in and out of bed was a turning-point as far as he was concerned. It was clear that the due care criterion of unbearable suffering with no prospect of improvement was now fulfilled in his case. The patient had a full understanding of his illnesses and was aware of the prognosis. Treatment was no longer possible.

The patient had on several occasions expressed a wish that his life be terminated, but had changed his mind whenever he felt a bit better. In the end, however, he persisted with his request. The physician consulted an independent physician, who gave his written opinion on whether the due care criteria had been fulfilled. In his report, the independent physician stated that the patient was feeling increasingly lonely as a result of his illness. He sometimes had suicidal thoughts, and initially, feeling that his request for euthanasia had been turned down, he had tried to commit suicide. The independent physician found it hard to decide whether the patient was capable of informed consent, and advised the physician to consult a psychiatrist in order to determine this and, if appropriate, give the patient medication for depression and restlessness. If the psychiatrist found the patient sufficiently capable of informed consent, the independent physician said he would consider the due care criteria to have been fulfilled.

The patient was accordingly seen at home by a psychiatrist, who stated that he considered the patient capable of informed consent but believed that his request for termination of life was partly influenced by a depressive disorder. He suggested that the physician treat the patient with antidepressants. At first the patient was furious that things were dragging on so long, but eventually he agreed to the treatment. About three weeks later, the physician spoke to him once more. The antidepressant treatment had not made him change his mind about wanting his life to be terminated. The physician then phoned the psychiatrist, who said he should increase the dosage of antidepressants to see if that helped. He also suggested that the patient could subsequently be treated with another medicine. This meant that the physician would have to disregard the patient's explicit request for euthanasia for another three months. The physician did not feel he could justify this to the patient.

He did not consider it humane to subject the patient to several more months of treatment with antidepressants. He had known him since early 1980 and had talked to him a great deal in that time.

Over a period of many years he had seen the patient deteriorate further and further as a result of his severe degenerative neurological disease. In the end the patient could still accept the fact that it took him twenty minutes to get out of bed and into his mobility scooter, but when the bed hoist became part of his life he felt that was the end. The idea that he would henceforth be unable to move without help from others caused him unbearable suffering. He could no longer accept this. The physician could well understand this. He had always considered the patient's depressive symptoms to be part of his illness, and to him it made perfect sense that someone should feel miserable because his body had stopped

working properly. In the physician's opinion, the degree of the patient's suffering was not affected by his depression. He considered him capable of informed consent and believed his request was voluntary and well-considered. He told the psychiatrist so. The psychiatrist was unhappy at the physician's decision to stop the treatment and follow his own judgement. The physician then consulted the independent physician, who felt the crucial point was that the psychiatrist had found the patient capable of informed consent. The independent physician then saw the patient again, and after his visit he phoned the physician to tell him he considered the patient capable of informed consent.

The physician performed the life-terminating procedure with due care and attention.

Given all the facts and circumstances of the case, the committee concluded that the physician could be satisfied that the request was voluntary and well-considered and that he had acted in accordance with the due care criteria.

Case 3 (voluntary and well-considered request: dementia)

This description of a case involving termination of a dementia patient's life on request focuses on the request. For a discussion of unbearable suffering with no prospect of improvement, see Case 4, which deals with the same notification.

The patient, a woman between 70 and 80 years of age, had been diagnosed with Alzheimer's disease. Further examination at a later stage revealed incipient dementia. Treatment was no longer possible. The patient knew exactly what her prognosis was. She had a full understanding of the disease and was well aware that no treatment would slow down or halt its progress. She had always been very independent, enterprising and lively, even after retiring. She had had first-hand experience of close relatives suffering from the same disease. Her own deterioration had become more and more evident, and her wish to die at a moment of her own choosing had become increasingly urgent. The physician had consulted an independent physician, who had seen the patient twice and given his written opinion that the due care criteria had been fulfilled. The assisted suicide had been carried out with due medical care and attention.

In early 2006 the patient had asked the physician to terminate her life at an early stage. She had subsequently repeated the request whenever she saw him. Although she had recently lost control of things in her day-to-day life, in conversations she always proved capable of keeping to a line of argument and referring back to what had been said earlier. When talking about termination of life, she was still able to approach the issue from various angles. She

repeatedly stated that she was deteriorating rapidly, which the physician had also concluded. Years before, when Alzheimer's disease had been diagnosed in her family, she had expressed her concern about this and had indicated her wish for euthanasia if ever the same fate should overtake her. She had drawn up advance directives. She said she was very much afraid that at some point her request that her life be terminated would no longer be granted. At first the physician had been uncomfortable with the point at which the patient had said during one of their conversations, that she wanted her life to be terminated, for at that stage he felt she was mentally "too well". Gradually, however, he had become convinced that her time had come, given that her present situation and her prognosis were causing her unbearable suffering. The geriatric psychiatrist who had examined her and had diagnosed Alzheimer's disease could, from a professional point of view, understand her wish not to wait for the next stage of the disease, and respected her wish for euthanasia. The attending psychiatrist had stated that initially, in January 2005, she appeared to be suffering from depression because her partner had died. However, the psychiatrist concluded that her cognitive disorders, especially her forgetfulness and her increasingly unbearable sense of despair (she was still clearly aware of her disease), were the key factors.

Given all the facts and circumstances of the case, the committee found that the physician could be satisfied that the patient's request was voluntary and well-considered. When talking to her, he had always been alert to the degree of her suffering and the persistence of her wish. The physician stated that she had always been aware of the implications of her request, her situation and her prognosis. The geriatric psychiatrist, the attending psychiatrist and the independent physician considered that the patient was capable of informed consent and that she was very well aware of her situation and her prognosis.

The committee therefore found that the physician had acted in accordance with the due care criteria.

(b) Unbearable suffering with no prospect of improvement

Physicians must be satisfied that the patient's suffering is unbearable, with no prospect of improvement.

There is *no prospect of improvement* if there is no realistic means of treatment. The disease or condition that is causing the suffering is incurable and there is no realistic prospect of alleviating the symptoms. It is up to the physician to decide whether this is the case, in the light of the diagnosis and the prognosis. 'Realistic prospect' means that the improvement that

can be achieved by palliative care or other treatment must be in reasonable proportion to the burden such care or treatment places on the patient.

It is more difficult to determine how *unbearable* a patient's suffering is, since in principle this is more subjective. It is determined by the patient's point of view, his physical and mental stamina and his own personality. What is still bearable to one patient may be unbearable to another.

Notifications often describe unbearable suffering in terms of pain, nausea, shortness of breath, exhaustion, increasing humiliation and dependence, and loss of dignity.⁷ The degree to which such symptoms and circumstances are perceived as suffering will differ from patient to patient. In making their assessment, the committees therefore consider whether the physician found the patient's suffering to be palpably unbearable.

In the section on voluntary and well-considered requests, it has already been stated that a wish for euthanasia expressed by a patient suffering from dementia should be treated with great caution. The question of informed consent has already been discussed. Another key issue is whether dementia patients can be said to be suffering unbearably. Being aware of his disease and the prognosis may already cause the patient great suffering. Here again, the specific circumstances of the case will determine whether the physician feels the patient's suffering to be palpably unbearable. Case 4 describes what the patient's suffering entailed in that specific situation.

Physicians in general are of the opinion that deeply comatose patients do not suffer unbearably. If a patient is sedated to combat unbearable symptoms and loses consciousness as a result, he cannot normally be said to be suffering unbearably any longer.

Cases involving comatose patients usually lead the committees to ask further questions. The committees examine the specific facts and circumstances of each reported case. On this basis, a committee may find in a specific case that the physician has acted in accordance with the due care criteria. If a patient is in a shallow coma and displays outward symptoms of suffering, the physician may indeed be satisfied that the patient is suffering unbearably. Such a situation is described in Case 5.

⁷ See also SCEN/Royal Dutch Medical Association, June 2006, *Spiegelinformatie SCEN 2005*, p. 5.

Given the above, the committees feel that physicians should adopt an extremely cautious approach to patients who can no longer communicate.

A dilemma may arise if the physician has already promised the patient to cooperate in performing euthanasia. If a physician has made such a promise and is later confronted with what may be a sudden change in the situation whereby the patient is no longer suffering unbearably (for example, because the patient has gone into a spontaneous or induced coma), he may feel he is under moral or other pressure to proceed. It is therefore advisable for physicians to refrain from making unqualified promises to patients.

Not infrequently, the attending physician consults an independent physician who does not yet find that the patient is suffering unbearably. In many cases, the independent physician often indicates that he expects further deterioration to lead to unbearable suffering within a given period of time. In such cases, it is advisable for the physician to consult the independent physician again at a later stage. This is discussed in more detail in the section on independent assessment.

Case 4 (unbearable suffering with no prospect of improvement: dementia)

The facts of this case are the same as in Case 3, which concerns the same notification. The elements that mainly related to the patient's suffering are discussed below.

The patient had always been very independent, enterprising and lively, even after retiring. She had had first-hand experience of close relatives suffering from Alzheimer's disease. Her own deterioration had become increasingly evident. Mental stimulation had always been important to her. She had always been an extremely well-read person with a wide range of interests, but newspapers were now left unread and it took her months to get through a book. Her mind was growing dull. At first this made her feel that life had lost all its lustre, but as time passed she increasingly began to feel she was losing her identity. At the same time, she had less and less control over the organisation of her day-to-day life. She was losing her bearings, particularly her sense of time, and becoming dependent on help. She was aware that she had lost a large number of skills. She did not want to find herself unable to make her own decisions and totally dependent on others. She repeatedly expressed her despair at the idea of having to experience a slow, progressive intellectual decline. The idea that she would eventually be completely "useless" and would end up in a mental vacuum was unbearable to her. The realisation that she would no longer be able to make her own decisions was unacceptable to her.

Given all the facts and circumstances of the case, the committee found that the physician could be satisfied that the patient was suffering unbearably with no prospect of improvement. In making this assessment, the committee took account of the fact that the patient had been diagnosed with Alzheimer's disease, which is incurable and leads to progressive deterioration.

As regards the unbearable nature of her suffering, the committee noted that the reports by the physician and the independent physician had indicated that she had always been very independent, enterprising and lively. Mental stimulation had always been important to her. She lived by her intellect and based her identity on this. Her progressive mental decline, her increasing dependence, and the fact that she was totally aware of this and had a clear idea of how the disease would progress were causing her to suffer. Her only prospect was further deterioration. The idea that she would no longer be able to make her own decisions and would be totally dependent on others was already unacceptable to her. The physician, as well as the independent physician, other physicians who had been consulted and friends of the patient's, felt that under the circumstances her present suffering was palpably unbearable for a woman who had always been so mentally and physically active and enterprising.

Given all the facts and circumstances of the case, the committee found that the physician had acted in accordance with the due care criteria.

Case 5 (unbearable suffering with no prospect of improvement)

The patient was sedated and his life was then terminated on request.

The patient, a man between 60 and 70 years of age, was suffering from inoperable carcinoma of the stomach with extensive metastases and, at a later stage, liver metastases. The condition was incurable. The committee found that the physician could be satisfied that the patient had made a voluntary and well-considered request. The patient was well informed about his situation and prognosis. There was no longer any way to alleviate his suffering. An independent physician had written a report indicating the reasons why he believed that the due care criteria had been fulfilled.

Since the documents referred to a course of Dormicum, the committee asked the physician to provide further information, in writing and later in person, about the final days of the patient's life. The physician stated that the patient had indicated at the very onset of his disease that he wanted euthanasia if his suffering ever became unbearable. The physician

had frequently told the patient that he would be given help when dying, and had explained to him what palliative sedation and euthanasia involved.

On the Friday before he died, after being seen by the independent physician, the patient asked the physician to perform euthanasia on the following Tuesday. He was a man who wanted to remain in control of things. He hoped this extra time would give his wife and one of his children a chance to get used to the idea that he would be given euthanasia. During the weekend, however, he called for the physician, told him he could not take any more, and asked him to do something for him. At the same time, he said he still wanted to be given euthanasia on the Tuesday. The physician then explained to the patient that he could be sedated, but that he might die as a result.

On the Sunday the physician began to sedate the patient with a standard course of Dormicum (administered by pump). Fentanyl patches continued to be applied. It was agreed that euthanasia would still be performed if the patient's suffering persisted for several days despite this treatment. In the final days the physician continued to visit the patient daily, usually twice a day, and during that period he had extensive conversations with the patient's loved ones. The patient was not responding well to the sedation and was still restless. He continued to suffer from dyspnoea and restlessness despite the administration of additional ampoules of Nozinan. When the physician phoned the patient's home on the Tuesday morning, the night nurse told him he had again been restless. When the physician asked the patient's wife whether he should proceed with the course of sedation, she reminded him of his agreement with the patient. The physician then decided to perform euthanasia. The life-terminating procedure was performed with due medical care and attention.

It was clear to the committee that the patient had wanted to remain in full control of how his life ended. He had wanted to have euthanasia performed at a late stage in order to take account of his loved ones' feelings. When already suffering unbearably during the weekend, he had admittedly asked the physician to alleviate his suffering, but not to perform euthanasia at that point. He was willing to be sedated on condition that the physician would perform euthanasia on the agreed date if his suffering were still unbearable.

The committee found that the physician had convincingly shown that the applied palliative sedation had failed to alleviate the patient's suffering sufficiently. In the committee's view, the patient's suffering was unbearable at the point when euthanasia was performed. Given all the facts and circumstances of the case (including the further explanation provided), it found that the physician had acted in accordance with the due care criteria.

(c) Informing the patient

Physicians must inform the patient about his situation and prognosis.

In assessing fulfilment of this criterion, the committees determine whether, and in what way, the physician has informed the patient about his disease and prognosis. In order to make a well-considered request, the patient must have a full understanding of his disease, the diagnosis, the prognosis and the possible forms of treatment. It is the physician's responsibility to ensure that the patient is fully informed and to verify this. This criterion did not raise problems in any of the reported cases.

(d) No reasonable alternative

The physician and the patient have together come to the conclusion that there is no reasonable alternative in the patient's situation.

It must be clear that there is no realistic alternative available to the patient other than euthanasia. The focus is on treating and caring for the patient and on limiting and where possible eliminating the suffering, even if therapy is no longer possible or the patient no longer wants it. The emphasis must be on providing satisfactory palliative care at the end of the patient's life. However, this does not mean that the patient has to undergo every possible form of palliative care or other treatment. A patient who is suffering unbearably with no prospect of improvement can refuse palliative care or other treatment. Refusal of treatment is an important subject of discussion between physicians and patients.

One factor that can lead a patient to refuse palliative or other treatment is that it may have side effects which he finds hard to tolerate. In that case, the effect of the treatment does not outweigh its disadvantages.

There are also patients who refuse further palliative care (in the form of an increased dose of morphine) because of a fear of becoming drowsy or losing consciousness, which they definitely do not want. In such cases, the question of whether this fear is justified – in most cases it is not – must be discussed with the patient.

From this criterion, it can also be concluded that the decision must be reached jointly by the patient and the physician.

If treatment is refused, the committees will assess whether the physician and the patient were able to conclude together that, in this specific situation, there was no reasonable alternative.

Since this particular decision is reached jointly by the physician and the patient, the physician is expected to indicate in his report how he came to the conclusion that there was no reasonable alternative.

Case 6 (no reasonable alternative)

A patient suffering from Huntington's disease did not want to experience the final stage of the disease and her life, and therefore refused admission to a nursing home.

The patient, a woman between 40 and 50 years of age, had known since 1998 that she carried the Huntington gene. Shortly before, after a long illness, one of her parents had died in a nursing home from the sequelae of the disease. Another relative was in a nursing home with the same disease. In 1998 the patient was given antidepressant treatment for mood disorders. Her depression was probably the first symptom of Huntington's disease, which gradually became manifest from 2000 onwards. Her symptoms gradually worsened, with loss of voluntary motor function, deteriorating speech and dysphagia. From mid-2002 onwards she received outpatient care at the nursing home that specialises in the care of Huntington patients. She was given various forms of paramedical therapy and psychosocial counselling and support. In the last few years her mobility declined to the point where she became dependent on aids such as a mobility scooter and a wheelchair. She began to suffer from sluggish brain function, poor concentration and mild memory disorders. She became more and more ADL-dependent. She also suffered increasingly from intercurrent conditions such as bronchitis and urinary infections. She sustained more falls and bruises, and could only leave the house if physically supported by other people. By mid-June 2006 the burden of care was so great that admission to the nursing home was indicated. This meant she would become even more dependent and deteriorate further, and would have to experience the physical and mental decay she had witnessed in her close relatives. This caused her to suffer unbearably. There was no longer any treatment that could alleviate her suffering. She had made a voluntary and well-considered request that her life be terminated. When discussing her wish for euthanasia she was always capable of saying what she wanted to say, clearly and in detail. During her conversations in the final stage of her life, the physician did not find her to be suffering from depression or any other mental disorder.

The patient was seen twice by an independent physician, who gave his written opinion that the due care criteria had been fulfilled. It was clear to him that the patient's main reasons to want euthanasia were loss of independence and the fact that there was no prospect of improvement in her condition.

She made clear how much her independence mattered to her. The realisation that she was going to suffer just as her close relatives had done was unbearable to her. Her request was voluntary and well-considered. After seeing her the first time, he concluded that the due care criteria would be fulfilled once admission to the nursing home became unavoidable. He stated that his opinion would remain valid for two months and that he was prepared to make a new assessment after that period had elapsed.

When he saw the patient the second time, she had deteriorated further. It was clear to him that the situation had in fact already progressed beyond the limits of home care, and that admission to the nursing home was urgently indicated. He concluded that the due care criteria had been fulfilled. The life-terminating procedure was performed with due medical care and attention.

Given all the facts and circumstances of the case, the committee found that the physician had acted in accordance with the due care criteria.

(e) Independent assessment

Physicians must consult at least one other independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled.

A second, independent physician must see the patient and indicate in writing whether the due care criteria have been fulfilled. In this capacity, the second physician must make an independent assessment.

Failure to consult an independent physician will lead the committees to find that the physician did not act in accordance with the due care criteria.

The second physician must be independent of the attending physician and the patient.

In the case of the physician this means, for example, that there is no family or working relationship between the two physicians and that they are not members of the same group practice. In practice, the committees are confronted with a number of different arrangements in which general practitioners work under the same roof. They are not members of the same group practice, but they do share facilities; for example, they may rent the same premises, share computer systems or share electronic patient files. It is not easy to decide in advance which particular arrangements will jeopardise a physician's independence. In cases of doubt, the committees will therefore always ask further questions when such working arrangements are involved.

The physician's independence may also be jeopardised if the same two medical practitioners very often act as independent physicians on each other's behalf, thus effectively acting in tandem. This may create an undesirable situation. An attending physician and an independent physician may also know each other privately, or as members of a professional group that meets to discuss medical cases. Here again, the specific circumstances will determine whether this jeopardises a physician's ability to make an independent assessment. It is important for attending physicians and independent physicians to be aware of this and to make it clear to the committee how they reached an opinion on the matter.

In the case of the patient, there must, for example, be no family relationship or friendship, the physician must not be helping to treat him (and must not have done so in the past) and he must not have come into contact with him in the capacity of locum.

The independent physician's report is of great importance when assessing notifications.⁸ A report describing the patient's situation when seen by the physician and the way in which the patient talks about the situation and his wishes will give the committees a clearer picture. It is important for the independent physician to give his substantiated opinion on whether the due care criteria set out in (a) to (d) have been fulfilled. He should also specifically mention his relationship to the attending physician and the patient.

The independent physician is responsible for his own report. However, the attending physician bears final responsibility for fulfilling all the due care criteria. This means that he must also check that the independent physician has submitted a report and that the report is of a sufficiently high standard. In most cases he will take extensive account of the independent physician's findings; however, if there is a difference of opinion between the two

⁸ The checklist for reporting by independent physicians on euthanasia and assisted suicide can be used as a guide (see www.toetsingscommissies euthanasie.nl).

physicians, the attending physician must ultimately reach his own decision, for it is his own actions that the committees will be assessing.

The committees are pleased to note that more and more specialists are also SCEN physicians and that more and more SCEN physicians – usually general practitioners – are being called in as independent physicians by hospital specialists. The committees applaud SCEN's efforts to raise the standard of reporting still further.

Sometimes an independent physician concludes on seeing the patient that one of the due care criteria has not yet been fulfilled (see also 'Unbearable suffering with no prospect of improvement'). It is not always clear to the committees what exactly happened after that. In such cases they ask the notifying physician further questions. Examples are given in Cases 7 and 8.

If the independent physician is called in at an early stage and finds that the patient is not yet suffering unbearably or that a specific request for euthanasia has not yet been made, he will usually have to see the patient a second time. If he has indicated that the patient's suffering will very soon become unbearable and has specified what that suffering will entail, a second visit will not normally be necessary, but it may still be advisable for the two physicians to consult by telephone. If a longer period of time is involved or if the prognosis is less predictable, the independent physician will have to interview the patient a second time. If there has been further consultation between the attending physician and the independent physician, or if the independent physician has seen the patient a second time, it is important that this be mentioned in the notification.

The Euthanasia in the Netherlands Support and Assessment Project (SCEN) trains physicians to make independent assessments in such cases. In most cases it is SCEN physicians who are called in as independent physicians.

The committees emphasise that these SCEN physicians also have a part to play in providing support, for example by giving advice. If they are confronted with a request shortly before the weekend, the requesting physician is sometimes told that the patient cannot be seen until the Monday. In such cases it may be important to give the requesting physician advice, for example on possible medication or referral to a palliative care team. It is up to the attending physician to bear in mind that the patient's situation may deteriorate so quickly that his life may need to be terminated earlier than planned.

Case 7 (independent assessment)

Three months elapsed between the independent assessment and the life-terminating procedure. The particulars provided in the independent physician's report were inconsistent. The committee asked the attending physician and the independent physician to provide further information.

The patient, a man between 50 and 60 years of age, had urothelial carcinoma with metastases. He had been ill for more than two years and was suffering unbearably, with no prospect of improvement. The prognosis was negative, and there was no longer any treatment that could alleviate his suffering. His request that his life be terminated was voluntary and well-considered. He was well informed of his situation and prognosis.

The independent physician who had been called in by the attending physician saw the patient and concluded that he had made a voluntary and well-considered request. There was no prospect of improvement. However, at the time when the independent physician saw the patient, the situation was still bearable. The physician's report went on to state that in his opinion the due care criteria had been fulfilled. The life-terminating procedure was performed with due medical care and attention three months after he had seen the patient.

The committee wanted the attending physician to explain how the patient's disease had developed in the interval, and why the physician had not arranged for a second independent assessment shortly before the life-terminating procedure was performed. The committee also noted that the independent physician had concluded that the situation was not yet unbearable, but that the due care criteria had nonetheless been fulfilled. The committee wondered whether the attending physician had also noticed this inconsistency, and how he had dealt with it. In view of the number of questions, the committee decided to invite both the attending physician and the independent physician to appear in person.

When interviewed, the attending physician stated that the patient had been admitted to hospital with complications in mid-2006. When he was discharged, he was expected to live a few more weeks at most. He was very much afraid his condition would take a sudden turn for the worse, and therefore asked the physician to consult an independent physician in good time.

At the time he was seen by the independent physician, his suffering was not yet unbearable, but was expected to become so within three weeks. After he had been seen by the independent physician, the patient quite unexpectedly improved and he had a couple of good

months. However, multiple brain metastases were then diagnosed and his condition rapidly deteriorated. One morning his suffering suddenly became unbearable to him. His attitude had remained very positive throughout the progress of his disease. That morning, however, his request that his life be terminated was so acute that the physician did not feel justified in postponing the procedure any longer. He had therefore not considered getting in touch with the independent physician a second time. However, he had contacted a neurologist to find out whether there were any palliative alternatives left. On learning that there were none, the physician made preparations to perform the life-terminating procedure the same day.

The independent physician had seen the patient shortly after he was admitted to hospital. He was aware that the patient had been suffering unbearably for some time. When he saw the patient he assumed that he had no more than a few weeks left to live. During his visit it was very clear to him that the patient's fear that he would soon suffer severe shortness of breath, suffocation and pain was realistic. He was amazed to learn that the patient had survived three more months after his visit (since when he had not been touch again with the attending physician). The independent physician said he had taken the review committee's comment on the inconsistency between the content and the conclusion of his report very much to heart and would bear it in mind in future.

Given all the facts and circumstances of the case (including the further explanation provided), the committee found that the physician had acted in accordance with the due care criteria.

Case 8 (independent assessment)

The independent physician stated that the patient's request for euthanasia was not yet applicable, but would apply once his situation deteriorated (in the short or medium term). At that point, the due care criteria would be fulfilled. The committee asked the attending physician to provide further information on how the patient's suffering had developed in the period between the visit by the independent physician and the patient's death.

The patient, a man between 70 and 80 years of age, had been suffering from COPD for some time. In 2000 he developed endocarditis and aortic valve stenosis, for which he was subsequently fitted with an artificial valve and underwent partial pericardectomy. In the second half of the year his COPD progressed rapidly. He was given maximum therapy for his COPD, as well as heart medication. Treatment was no longer possible. The patient had made a voluntary and well-considered request that his life be terminated. An independent

physician was called in, saw the patient and gave his written opinion on whether the statutory due care criteria had been fulfilled. The patient had described his life and his suffering to him. He said that as long as he felt relatively well he wanted to continue living, but that he wanted euthanasia if the pain recurred. Among other things, the independent physician stated that the patient's request for euthanasia was not yet applicable, but that it would apply once his condition deteriorated (in the short or medium term). The independent physician could well understand this. At that point, the due care criteria would be fulfilled.

Since not all the due care criteria had been fulfilled at the point when the independent physician saw the patient (the request for euthanasia was not applicable at the time, but only once the patient's situation deteriorated), the committee asked the attending physician to provide further information on how the patient's suffering had developed in the period between the visit by the independent physician and the patient's death. The physician stated that, at the time the patient was seen by the independent physician, he had had a particularly good day because he had initially responded well to medication. However, this improvement had only been short-lived. The pain symptoms had recurred and the patient's shortness of breath had got worse, so that he was barely capable of washing and dressing himself any longer. Despite increased dosage of painkillers and maximum pulmonary medication, his situation did not improve. Just over a week after being seen by the independent physician, the patient had repeatedly asked the attending physician to perform euthanasia soon. During the last month the patient had convinced the physician that he found his symptoms unbearable.

Given all the facts and circumstances of the case (including the further explanation provided), the committee found that the physician had acted in accordance with the due care criteria.

(f) Due medical care

Physicians must exercise due medical care and attention in terminating the patient's life or assisting in his suicide.

Euthanasia or assisted suicide is normally carried out using the method, substances and dosage set out in the the Royal Dutch Pharmaceutical Society's advisory report.⁹

⁹ *Standaard Euthanatica: toepassing en bereiding* ('Standard euthanatics: application and preparation'), 2007.

The committees note the increasingly frequent use – contrary to the advice given in the report – of midazolam (sometimes in combination with opiates), particularly when inducing a coma. The committees consider this undesirable, and recommend the use of substances with proven effectiveness in inducing coma. This is not always the case with benzodiazepines.

In the case of euthanasia, the physician actively terminates the patient's life by administering the euthanatics, usually by intravenous injection. In the case of assisted suicide, the patient ingests the euthanatics himself. He does so by drinking a barbiturate potion.¹⁰ In principle, the physician must remain with the patient until the patient is dead. He must not leave the patient alone with the euthanatics. This is because the patient may vomit, in which case the physician may perform euthanasia. Furthermore, leaving such substances without medical supervision may pose a hazard to people other than the patient.

In exceptional cases different arrangements may be made in advance, but only for good reasons. The physician must always be on hand to intervene quickly if the euthanatics do not have the desired effect. Euthanasia must always be performed by the physician himself.

In practice, physicians are occasionally uncertain about their role in the euthanasia procedure. For example, if a case of euthanasia is reported by a physician who did not actually perform the procedure, the physician who performed the procedure must also sign the notification and will be deemed by the committees to be the notifying physician.¹¹

Information supplied to the committees

The notification documents must make clear to the committee whether the physician has acted in accordance with the statutory due care criteria. If the committee feels that the information supplied by the physician is insufficient to make this clear, it may ask him or the independent physician to provide additional information either orally or in writing, or invite them to appear in person, so that it can make a well-founded assessment.¹²

If the physician refuses, he forgoes an opportunity to explain his actions in more detail and runs the risk that the committee will be unable to find that he has acted in accordance with

¹⁰ Usually a 100-millilitre potion containing 9 grams of pentobarbital sodium or secobarbital sodium.

¹¹ See Article 3, paragraph 1 of the guidelines on the working procedures of the regional euthanasia review committees, adopted on 21 November 2006.

¹² See Article 9 of the guidelines on the working procedures of the regional euthanasia review committees, adopted on 21 November 2006.

the due care criteria and hence that the notification will be referred to the Public Prosecution Service and the Health Care Inspectorate. This happened in the following case.

Case 9 (information supplied to the committees)

If the physician does not avail himself of the opportunity to explain his actions to the committee in more detail, the committee may be unable to ascertain whether the due care criteria have been fulfilled. In the following case, this led the committee to find that the physician had not fulfilled the criteria.

The patient, a woman between 40 and 50 years of age who was gravely ill with mammary carcinoma and extensive metastases, had made a voluntary and well-considered request that her life be terminated. The physician had informed her of her situation and prognosis. They had together come to the conclusion that there was no reasonable alternative in her situation. An independent physician had submitted a written report stating that in his opinion all the due care criteria had been fulfilled.

When the committee asked the physician further questions in writing about how the patient's life had been terminated, the physician provided additional information.

The committee was satisfied that the patient had been suffering unbearably, with no prospect of improvement, until the day before her life was terminated. However, since it still had questions about the unbearable nature of her suffering at the point when the life-terminating procedure was performed, and wanted to ascertain how her condition had developed and what had ultimately made the physician decide to perform the procedure the next day, it invited him to provide further information in person. He did not respond to this invitation.

By answering the written questions in insufficient detail, and by failing to respond to the committee's twice-repeated invitation to provide further information in person, the physician made it impossible for the committee to obtain a clear picture of the unbearable nature of the patient's suffering. As a result, the committee was unable to determine whether the statutory due care criteria had been fulfilled in this case, and it therefore concluded that they had not been fulfilled. The matter was referred to the Board of Procurators General and the Health Care Inspectorate.

Annexe

Overview of notifications, region by region

A. Groningen, Friesland and Drenthe region

1 January 2006 to 31 December 2006

Notifications

The committee received 229 notifications in the year under review.

Euthanasia and assisted suicide

There were 201 cases of euthanasia, 23 cases of assisted suicide and 5 cases involving a combination of the two.

Physicians

In 210 cases the notifying physician was a general practitioner, in 11 cases a medical specialist working in a hospital and in 8 cases a physician working in a nursing home.

Conditions involved

The conditions involved were as follows:

Cancer	186
Cardiovascular disease	7
Neurological disorders	21
Pulmonary disorders, other than cancer	15
Other conditions	0

Location

In 177 cases patients died at home, in 11 cases in hospital, in 8 cases in a nursing home, in 11 cases in a care home and in 22 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. It met 12 times. In the year under review there were no cases in which the physician was found not to have acted in accordance with the due care criteria.

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 24 days.

B. Overijssel, Gelderland, Utrecht and Flevoland region

1 January 2006 to 31 December 2006

Notifications

The committee received 468 notifications in the year under review.

Euthanasia and assisted suicide

There were 440 cases of euthanasia, 24 cases of assisted suicide and 4 cases involving a combination of the two.

Physicians

In 409 cases the notifying physician was a general practitioner, in 41 cases a medical specialist working in a hospital and in 18 cases a physician working in a nursing home.

Conditions involved

The conditions involved were as follows:

Cancer	403
Cardiovascular disease	14
Neurological disorders	21
Pulmonary disorders, other than cancer	10
Other conditions	20

Location

In 371 cases patients died at home, in 40 cases in hospital, in 16 cases in a nursing home, in 22 cases in a care home and in 19 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. It met 12 times. In the year under review there were no cases in which the physician was found not to have acted in accordance with the due care criteria.

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 32 days.

C. North Holland region

1 January 2006 to 31 December 2006

Notifications

The committee received 485 notifications in the year under review.

Euthanasia and assisted suicide

There were 427 cases of euthanasia, 48 cases of assisted suicide and 10 cases involving a combination of the two.

Physicians

In 418 cases the notifying physician was a general practitioner, in 45 cases a medical specialist working in a hospital and in 22 cases a physician working in a nursing home.

Conditions involved

The conditions involved were as follows:

Cancer	419
Cardiovascular disease	15
Neurological disorders	23
Pulmonary disorders, other than cancer	20
Other conditions	8

Location

In 381 cases patients died at home, in 42 cases in hospital, in 24 cases in a nursing home, in 23 cases in a care home and in 15 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. It met 13 times. In the year under review there were no cases in which the physician was found not to have acted in accordance with the due care criteria.

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 27 days.

D. South Holland and Zeeland region

1 January 2006 to 31 December 2006

Notifications

The committee received 400 notifications in the year under review.

Euthanasia and assisted suicide

There were 372 cases of euthanasia, 24 cases of assisted suicide and 4 cases involving a combination of the two.

Physicians

In 349 cases the notifying physician was a general practitioner, in 32 cases a medical specialist working in a hospital and in 19 cases a physician working in a nursing home.

Conditions involved

The conditions involved were as follows:

Cancer	359
Cardiovascular disease	13
Neurological disorders	16
Pulmonary disorders, other than cancer	7
Other conditions	5

Location

In 320 cases patients died at home, in 30 cases in hospital, in 20 cases in a nursing home, in 12 cases in a care home and in 18 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. It met 11 times. In the year under review there was one case in which the physician was found not to have acted in accordance with the due care criteria.

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 30 days.

E. North Brabant and Limburg region

1 January 2006 to 31 December 2006

Notifications

The committee received 341 notifications in the year under review.

Euthanasia and assisted suicide

There were 325 cases of euthanasia, 13 cases of assisted suicide and 3 cases involving a combination of the two.

Physicians

In 306 cases the notifying physician was a general practitioner, in 22 cases a medical specialist working in a hospital and in 13 cases a physician working in a nursing home.

Conditions involved

The conditions involved were as follows:

Cancer	289
Cardiovascular disease	6
Neurological disorders	25
Pulmonary disorders, other than cancer	12
Other conditions	9

Location

In 279 cases patients died at home, in 22 cases in hospital, in 11 cases in a nursing home, in 11 cases in a care home and in 18 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. It met 12 times. In the year under review there were no cases in which the physician was found not to have acted in accordance with the due care criteria.

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 29 days.