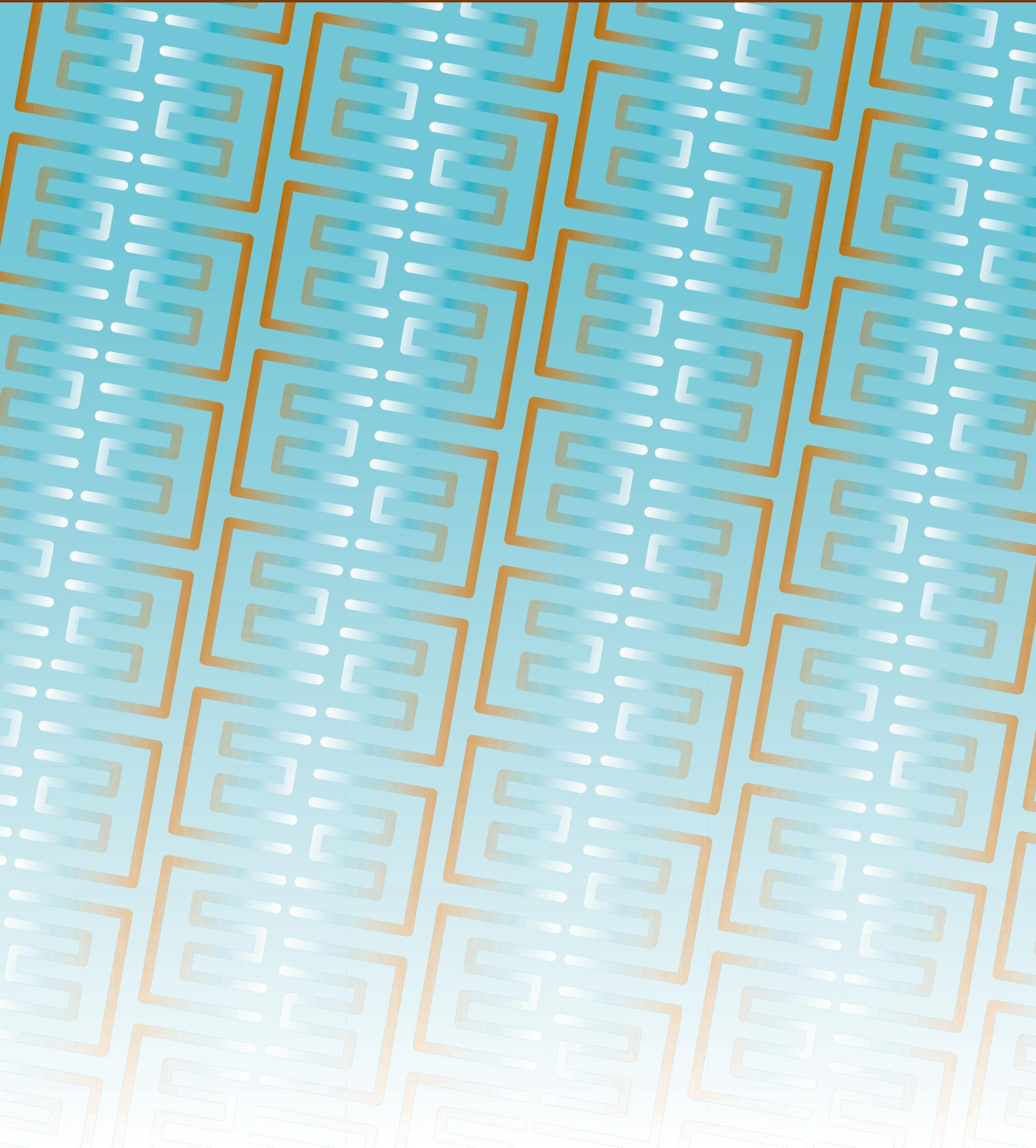


REGIONAL
EUTHANASIA
REVIEW COMMITTEES

RTE

CODE OF PRACTICE



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EUTHANASIA
REVIEW COMMITTEES



CODE OF PRACTICE

The Hague, April 2015

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PREFACE

It gives us great pleasure to present the Code of Practice of the Regional Euthanasia Review Committees (RTEs). We would like to say a few words about the purpose and history of the Code.

The joint annual reports of the RTEs and the findings published on their website give an impression of how the committees apply and interpret the statutory due care criteria for euthanasia as set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (*Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*). The second evaluation of the Act (2012) recommended that a Code of Practice be published to make this information more accessible. This recommendation was endorsed by several organisations closely concerned with the issue, including the Royal Dutch Medical Association (KNMG). The Minister of Health, Welfare and Sport and the Minister of Security and Justice also informed the House of Representatives that they concurred with the conclusion that a Code of Practice was desirable.

The Committees are very grateful to Professor J. Legemaate, professor of health law at AMC/ University of Amsterdam, for his work in drafting the code of practice. Professor Legemaate was assisted by a supervisory committee of RTE members, consisting of Professor J.K.M. Gevers (chair), Dr E.F.M. Veldhuis (physician) and Professor A.R. Mackor (ethicist), and general secretary Ms N.E.C. Visée.

The draft Code was presented to all members and secretaries of the RTEs for their comments, which resulted in useful input that was incorporated into this final version.

The Code outlines the issues that the committees regard as relevant in performing their statutory task, i.e. the review of notifications of termination of life on request and assisted suicide. The Code of Practice is important above all for physicians performing euthanasia and independent physicians, but it also contains useful information for patients and other interested parties. The RTEs hope that it will also make a positive contribution to an informed public debate on freedom of choice at the end of life.

The RTEs have ownership of the Code and bear sole responsibility for its content. They will regularly update it. The committees would be pleased to receive feedback via their general secretary (email: n.visee@toetscie.nl).

W.J.C. Swildens-Rozendaal, coordinating chair of RTEs
P.J.M. van Wersch, deputy coordinating chair of RTEs

The Hague, April 2015

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PURPOSE AND STRUCTURE OF THIS CODE OF PRACTICE

Since the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (hereafter: the Act) entered into force in 2002, five regional review committees have had the statutory task to review reported cases of termination of life on request and assisted suicide. In the intervening years, the committees have reviewed many thousands of cases on the basis of the due care criteria, in accordance with that task.¹ Each year, the committees give an account of these activities in a joint annual report. Many of their findings are also published on www.euthanasiecommissie.nl. The annual reports and the published findings of the committees give an impression of how they apply and interpret the statutory due care criteria for euthanasia. The committees have drawn up this Code of Practice to make this information more accessible, in accordance with a recommendation in the report on the second evaluation of the Act (2012).

The Act distinguishes between termination of life on request and assisted suicide. The Code uses the term ‘euthanasia’ to refer to both forms of termination of life. The distinction between termination of life on request and assisted suicide is made only where necessary.²

The Code outlines the issues and considerations that the committees regard as relevant in connection with the statutory due care criteria for euthanasia. The aim is not to describe every conceivable situation. Rather, the Code of Practice is intended as a summary of the considerations that the committees have published in their annual reports and findings. The Code focuses on these considerations; it does not examine specific cases.

The Code is important above all for physicians performing euthanasia and independent physicians, but it also contains useful information for patients intending to request euthanasia and other interested parties. It will give them an idea of the criteria that must be complied with, and of what they can expect. It is important that it is clear to everyone how the committees apply the Act.

The Code of Practice is structured as follows. Section 2 briefly outlines the legislation on euthanasia and the review committees’ procedures. It also considers the relevance of medical professional guidelines. Section 3 explains the statutory due care criteria in general terms. Section 4 then discusses some specific issues and situations, and section 5 lists a number of useful references.

¹ A translation of the Act is included in the annexe (page 35).

² This distinction is discussed in section 3.7, concerning due medical care in performing euthanasia and in section 4.1, on advance directives.

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OUTLINE OF THE ACT, COMMITTEE PROCEDURES AND RELEVANCE OF GUIDELINES

2.1 OUTLINE OF THE ACT: DUE CARE CRITERIA³

In the decades before the Termination of Life on Request and Assisted Suicide (Review Procedures) Act entered into force, a (legal) practice developed in the Netherlands in which a physician could under certain circumstances comply with a patient's request for euthanasia. The key consideration was the patient's request and the unbearable nature of his suffering, but there were other requirements too. These requirements were subsequently laid down in the Act, which has been in force since 2002.

It is often said that the Act legalised euthanasia. In formal terms, this is not the case. Under articles 293 and 294 of the Criminal Code, euthanasia is prohibited in the Netherlands, except in the event that it is performed by a physician who has complied with all the due care criteria set out in the Act (see below) and has notified the municipal pathologist in question (see section 2.2).⁴

Under section 2 (1) of the Act, the physician 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. have informed 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. have consulted 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. have exercised due medical care and attention in terminating the patient's life or assisting in his suicide.

³ For more detailed information please go to www.euthanasiecommissie.nl.

⁴ Articles 293 and 294 of the Criminal Code are included in the annexe (page 40).

The Act says nothing about the patient's life expectancy. In cases where the statutory due care criteria have been fulfilled, the patient's life expectancy plays no role. In practice, it will often be limited, but the Act does not rule out granting a request for euthanasia from a patient who might have many years to live. The key elements are the voluntary, well-considered nature of the patient's request, the unbearable nature of his suffering and the absence of any prospect of improvement. There is no provision in the Act that euthanasia may only be performed in the 'terminal stage'.

The Act applies to euthanasia for patients aged 12 and over. However, it sets certain requirements regarding parents' involvement when a minor requests euthanasia.

> See also section 4.2

Supplementary to the Act, a number of Supreme Court judgments are also of importance as they set requirements which remain relevant. They are discussed below where relevant.

> The Brongersma judgment (2002): section 3.3

> The Schoonheim judgment (1984): section 3.3

> The Chabot judgment (1994): section 4.3

The fact that the above due care criteria have been met does not mean that the physician is obliged to comply with a patient's request for euthanasia. Patients have no right to euthanasia, and physicians no duty to perform it. It is generally wise for a physician to inform the patient at an early stage if he⁵ does not want to perform euthanasia, so that the patient can, if desired, approach another physician.

2.2 OUTLINE OF THE ACT:

NOTIFICATION AND REVIEW

A physician who has performed euthanasia must notify this to the municipal pathologist, since euthanasia is not a natural cause of death.⁶ The municipal pathologist must report the case to the appropriate regional review committee. If the committee finds that the physician has satisfied all the requirements, and thus acted with due care, the review procedure ends. If the committee finds that the physician did not comply with one or more due care criteria, it is legally required to pass on the notification to the Public Prosecution Service (OM) and the Healthcare Inspectorate (IGZ).⁷ These bodies consider whether they are able to endorse the committee's findings and what steps they deem appropriate.

The committees examine whether the notifying physician has acted with due care in the context of the Act, the legislative history and relevant case law. They also take previous committee findings into account, and previous decisions of the OM and IGZ in cases where a committee found that the physician had not acted in accordance with the due care criteria. This means that it must be clear that the physician complied with due care criteria (c), (e) and (f) above, and that he can plausibly argue that, given the circumstances of the case, he was *reasonably* able to conclude that the due care criteria (a), (b) and (d) had been met.

5 Where this Code of Practice refers to 'he', please read 'he/she'.

6 See section 7 (2) of the Burial and Cremation Act included in the annexe (page 41).

7 Cases in which the committees find that the physician acted with due care are not forwarded to the OM and IGZ. It is however possible for these bodies to become aware of the case via another source (e.g. a third party). In that case, they have the authority to investigate the case.

2.3 COMMITTEE PROCEDURES⁸

There are five regional review committees: one for Groningen, Friesland, Drenthe and the islands of Bonaire, St Eustatius and Saba, one for Overijssel, Gelderland, Utrecht and Flevoland, one for North Holland, one for South Holland and Zeeland, and one for North Brabant and Limburg.⁹

The committees distinguish between two categories of notification: straightforward notifications (which account for some 75% of cases) and notifications that raise questions (around 25% of cases). Committee members review straightforward notifications digitally; they are not reviewed at the monthly committee meetings. Nevertheless, if any questions arise during the digital review process, the notification will be reviewed at the monthly committee meetings. Notifications that raise questions from the start (because, for instance, the case is particularly complex or the information in the report is incomplete) are always reviewed at the monthly meetings.

The committees assess the notifications they receive on the basis of the detailed report¹⁰ produced by the physician performing euthanasia,¹¹ the independent physician's report and other relevant documentation (such as patient records, letters from specialists and/or an advance directive). If the information provided is incomplete or raises questions, the committee can ask either physician to provide additional information in writing. The committee may also invite either physician to provide further information in person. A report is made of this meeting, which is sent to the physician concerned for comments. The physician may be accompanied by another person at the meeting. The committees are aware that such an interview with the committee may be burdensome for the physician. However, an oral account may be needed to clarify any uncertainties. In some cases, such an account can be useful or even vital for a proper assessment.

If the committee is considering finding that the physician did not act in accordance with the due care criteria, he will be invited for an interview before the decision is made, giving him the opportunity to explain his actions. If the committee remains of the same opinion after the interview, the provisional findings will be submitted to the members of all committees for their recommendations. Provisional findings may also be sent to the members of all committees in cases that are complex or that raise new legal or other issues, for instance. In this way, the committees try to harmonise their views and policy in the interests of legal certainty and legal uniformity.

8 For more detailed information, see www.euthanasiecommissie.nl, where Dutch versions of the 2006 guidelines on regional euthanasia review committee procedures can be downloaded; see also Chapter 3 of the 2013 annual report.

9 For the members and locations of the committees, see www.euthanasiecommissie.nl.

10 A 'detailed report' is obligatory under section 7 (2) of the Burial and Cremation Act. Failure to meet this requirement is an offence (section 81 of the Burial and Cremation Act).

11 Model reporting forms (in Dutch) can be downloaded from www.euthanasiecommissie.nl.

2.4 RELEVANCE OF MEDICAL PROFESSIONAL GUIDELINES

Various guidelines have been developed by the medical profession that can help a physician determine his views on a patient's request for euthanasia. These guidelines can provide help in interpreting the generally worded statutory due care criteria (more on which in section 3), but also cover issues which the physician has a professional responsibility to consider, but which do not have a bearing on the committee's review of a notification.¹² When reviewing notifications, the committees have their own responsibility which is based on statute. Elements of medical professional guidelines may be relevant for the committees if their content falls within the statutory framework. In particular, the committees always refer explicitly to the 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' produced in 2012 by the Royal Dutch Medical Association (KNMG) and the Royal Dutch Association for the Advancement of Pharmacy (KNMP) in order to assess compliance with the due care criterion on due medical care in performing euthanasia. This concerns, among other things, the choice of substance administered and the dose, and checks to establish the depth of the patient's coma. Given the reference in this due care criterion to due *medical* care, it is logical for the committee to focus on the standard that the medical professions themselves (physicians and pharmacists) have drawn up.

In any conflict between a guideline and the law, the law takes precedence in the committee's deliberations.¹³

¹² Examples include the due care which, under disciplinary rules, the physician must exercise towards the patient's family. See for example Zwolle Regional Disciplinary Board 18 May 2006, GJ 2006/135 and The Hague Regional Disciplinary Board 23 October 2012, GJ 2013/8.

¹³ See also the letter of 4 July 2014 from the Minister of Health, Welfare and Sport to the House of Representatives (Parliamentary Papers, House of Representatives, 2013-2014, 32 647, no. 30).

3

STATUTORY DUE CARE CRITERIA

3.1 THE PHYSICIAN PERFORMING EUTHANASIA

Under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act only a physician is authorised to perform euthanasia at a patient's request. The law focuses on the physician who actually performs euthanasia. This is generally the attending physician (usually the patient's general practitioner), though this is not a requirement in the Act. In all cases, the physician performing euthanasia must have informed himself thoroughly of the patient's situation and must have personally determined that all the due care criteria have been met. A physician who has known the patient for some time will be able to base this conclusion on his knowledge of his patient.

A physician other than the attending physician in non-acute situations

A physician other than the attending physician may also perform euthanasia at a patient's request. However, such a physician will generally have to make a convincing case that he took sufficient time to apprise himself of the patient's situation, in compliance with the statutory requirements. In cases where the physician performing euthanasia is not the attending physician, it is important that he indicate in his report to the committee how often and in how much detail the physician discussed the situation with the patient.

A physician other than the attending physician in acute situations

There may be circumstances (e.g. the attending physician is not available and the patient's condition has unexpectedly deteriorated) that lead to euthanasia being performed by another physician than was anticipated (e.g. a locum or a physician in the same practice). By law, the physician who actually performs the euthanasia must submit the notification. In such situations the physician performing the euthanasia may base his decision on the information supplied by the attending physicians, but he will also have to ascertain for himself, insofar as is reasonably possible in the specific situation, that the statutory due care criteria have been met.

Below, 'physician' refers to the physician performing euthanasia

3.2 VOLUNTARY AND WELL-CONSIDERED REQUEST

The Act states that the physician must be satisfied that the patient's request is voluntary and well considered. A written request is not required by law; an oral request is sufficient.

It follows from the Act that the patient must make the request himself. A request for euthanasia made by another person on behalf of the patient cannot be granted.¹⁴ The patient may make his request known well before euthanasia is performed, but if the patient's condition is deteriorating rapidly, there may be only a (very) short period of time between the request and the performing of euthanasia. In other words, a request need not necessarily have persisted for a long period of time in order to be granted. It must always be clear that the request has been made by the patient himself. It is normal for patients to be hesitant about euthanasia, but ultimately the physician must be satisfied that the request is unequivocal and consistent.

Most patients are capable of normal (i.e. oral) communication until the moment that euthanasia is performed. In some cases the patient's ability to communicate is severely impaired or hampered by their illness. This can give rise to a range of situations:

- the patient is unable to express his request in words, but can still communicate in other ways (e.g. hand gestures, by nodding or by squeezing the physician's hand in response to 'yes or no' questions);
- the patient can still express his request orally, but is unable to present supporting arguments. In such cases, it must be plausible, on the basis of his behaviour and what the patient is still able to communicate, that he is making a consistent request. The utterances the patient is still able to make at that point can be assessed in conjunction with earlier oral or written directives, and the patient's behaviour or signals.

In situations where the patient is completely incapable of communication, an advance directive may take the place of an oral request.

> For advance directives, see section 4.1

Voluntary request

The patient's request must be voluntary. There are two sides to this:

First, the request must have been made without any undue influence from others (external voluntariness). The physician must be satisfied that there has been no such influence. He should exercise particular caution when, for instance, a close relative of the patient becomes too overtly involved in the conversation between physician and patient, or repeatedly gives answers that the physician wishes to hear from the patient himself. It may then be necessary for the physician to speak with the patient privately. If a patient requests euthanasia partly because he feels he is a burden to others, the request may not necessarily be involuntary.¹⁵ However, the physician performing the euthanasia procedure and the independent physician both need to exercise particular caution in such situations.

¹⁴ A patient may not therefore authorise another person to make a request for euthanasia on his behalf. Others may however alert the physician to the fact that the patient has a wish for euthanasia, so that the physician can initiate discussion of the matter with the patient or, if the patient is no longer able to communicate, can assess any advance directive the patient might have made.

¹⁵ The feeling that one is a burden to others can be a factor contributing to the unbearable nature of suffering.

Second, the patient must be decisionally competent (internal voluntariness). Decisional competence means that the patient is able to understand relevant information about his situation and prognosis, consider any alternatives and assess the implications of his decision.¹⁶

Decisional competence is not an ‘all-or-nothing’ concept: a patient may be decisionally competent in one matter (e.g. a request for euthanasia) but not in another (e.g. financial matters). Competence must be assessed in relation to the decision in question. In many cases, there will be no doubt as to the patient’s decisional competence regarding his request for euthanasia. Sometimes, especially for specific groups of patients, the physician will have to consider the matter of the patient’s decisional competence more explicitly and in greater depth. If there are any doubts as to the patient’s decisional competence, it is wise for the physician to seek the advice of another physician with relevant expertise. This request for advice may be included in the specific questions put to the independent physician as referred to in section 2 (1) (e) of the Act, but the patient’s decisional competence can also be determined by a specialised physician prior to consultation with the independent physician.

> For specific groups of patients, see sections 4.3, 4.4 and 4.5

Well-considered request

The request must also be well-considered. This means that the patient has given the matter careful consideration on the basis of adequate information and a clear understanding of his illness. The request must not have been made on impulse. Caution is also required in cases where the patient expresses doubt by repeatedly making and withdrawing requests over a limited period of time. That a patient hesitates or has doubts regarding such a drastic step as euthanasia is understandable and not necessarily a contraindication. The important thing is that the request should be consistent, taking account of all the patient’s circumstances and utterances. A repeated request can be a sign that the patient is consistent in his desire for euthanasia.

In cases involving, for instance, psychiatric patients, patients with dementia, patients with intellectual disabilities, patients with aphasia, patients in a coma or a state of reduced consciousness, and minors, particular questions may arise in considering whether the patient’s request is voluntary and well considered.

> For further information on these situations, see Chapter 4

Key elements of ‘voluntary and well-considered request’

- Request made by patient himself
- ‘External voluntariness’: no undue influence from others
- ‘Internal voluntariness’ or decisional competence: insight into and understanding of the situation
- Well-considered request: well-informed, consistent view, not on impulse
- Consistence apparent from patient’s repeated request or other utterances
- Advance directive may take place of oral request (see section 4.1)
- Exercise particular caution in certain situations (see sections 4.2 to 4.5)

¹⁶ See the guidelines on assessing decisional competence (2007 version, in Dutch) at <http://www.rijksoverheid.nl/documenten-en-publicaties/brochures/2007/01/01/handreiking-voor-de-beoordeling-van-wilsbekwaamheid.html>.

3.3 UNBEARABLE SUFFERING WITH NO PROSPECT OF IMPROVEMENT

Medical dimension to suffering

The physician must be satisfied that the patient is suffering unbearably and that there is no prospect of improvement. In the 2002 Brongersma case, the Supreme Court ruled that the patient's suffering must have a medical dimension, either somatic or psychiatric.

There need not be a single, dominant medical problem. The patient's suffering may be the result of an accumulation of serious and minor health problems. The sum of these problems, in conjunction with the patient's medical history, life history, personality, values and stamina, may give rise to suffering that the patient experiences as unbearable.

General factors

Suffering is a broad concept. It can result from pain and shortness of breath, extreme exhaustion and fatigue, but also from growing dependence, feelings of humiliation, physical decline, loss of dignity or the fact that there is no prospect of improvement. In the 1984 Schoonheim case, the Supreme Court ruled that suffering can consist of (the fear of) increasing humiliation or the prospect of no longer being able to die a dignified death.

There is seldom only one dimension to the burden of suffering experienced by the patient. In practice, it is almost always a combination of aspects, including the absence of any prospect of improvement, which determines whether suffering is unbearable. The physician must therefore investigate all aspects that together make the patient's suffering unbearable.

A patient must be conscious of suffering. There are situations where this is not (or no longer) the case, as with coma, or where this is uncertain, as with reduced consciousness. Either of these situations can arise as a result of palliative sedation. In principle, if the patient is in a situation where he is no longer conscious of suffering, euthanasia may not be performed, irrespective of whether the patient's immediate family find his situation distressing or humiliating.

> For more on coma and reduced consciousness, see section 4.7

> For more on the relationship between euthanasia and palliative sedation, see section 4.8

The patient's consciousness of his suffering may be apparent from what he says, or from his other utterances or physical reactions. It is the overall picture that matters. In cases where a patient can no longer express his suffering in words, the physician must be alert to other signals that may reveal the patient's burden of suffering.

No prospect of improvement

A patient is regarded as suffering with *no prospect of improvement* if the disease or disorder causing the suffering is incurable and there are no means of alleviating the symptoms so that the suffering is no longer unbearable. This must be determined in the light of the diagnosis and prognosis, and of whether there are realistic options, other than euthanasia, that would end or alleviate the symptoms. In considering whether there is any realistic prospect of alleviating the symptoms, account must be taken both of the improvement that can be achieved by palliative care or other treatment and of the burden such care or treatment would place on the patient. 'No prospect of improvement' must be seen in relation to the patient's disease or disorder and its symptoms. There is no prospect of improvement if there are no

realistic curative or palliative treatment options that may – from the patient’s point of view – be considered reasonable. It is thus clear that the assessment of the prospect of improvement is closely linked to determining whether there is a reasonable alternative (section 2 (1) d of the Act).

> See also section 3.5

Patients also use equivalent terminology to indicate that the absence of any prospect of improvement is unacceptable to them, and that they want their suffering to end. In that sense, the patient’s perception that the situation is hopeless is part of what makes his suffering unbearable.

Unbearable nature of suffering

It is sometimes hard to decide whether suffering is *unbearable*, for this is a subjective notion. What is bearable for one patient may be unbearable for another. This depends on the individual patient’s perception of his situation, his life history and medical history, personality, values and physical and mental stamina. It is therefore important to consider the patient’s ‘biography’ when assessing his suffering. It must be palpable to the physician that this particular patient’s suffering is unbearable. The physician must therefore not only be able to empathise with the patient’s situation, but also see it from the patient’s point of view.

The fear of an imminent decline in health can be a major factor in the patient’s suffering. The patient may fear increasing pain, further humiliation, shortness of breath or nausea, or situations in which the patient’s core values (such as independence and dignity) are undermined. In such cases the patient’s current suffering is connected with the realisation that his situation will only deteriorate further and that values and circumstances that are important to him will come under increasing pressure. This is the case with diseases like cancer, but also with progressive ALS, multiple sclerosis, dementia and Huntington’s disease.

Key elements of ‘unbearable suffering with no prospect of improvement’

- There must be a medical dimension to the suffering
- Suffering can result from an accumulation of psychological and physical factors
- No prospect of improvement: there is no realistic alternative to euthanasia (see also section 3.5)
- Unbearable suffering: it is about the suffering of this specific patient (in relation to his life history, personality, stamina and values). The suffering must be palpable to the physician
- Suffering may also be caused by fear of future deterioration
- Patient must be aware of the suffering

3.4 INFORMING THE PATIENT

The physician must inform the patient about his situation and prognosis. A well-considered request as referred to in section 2 (1) (a) of the Act can be made only if the patient has a full understanding of his situation (disease, diagnosis, prognosis, treatment options). The committees assess whether the physician informed the patient adequately and how he did so. The physician must ascertain whether the patient is adequately informed and has understood the information provided. He may not simply assume this to be the case, even when other physicians were involved in the case prior to the request.

A patient suffering a long-term illness will generally have a good understanding of his situation and prognosis. He may even have discussed euthanasia on more than one occasion. In other cases, a request for euthanasia may come as something of a surprise to the physician. It is then particularly important that he establish satisfactorily that the patient has understood all the relevant information, in view of the irrevocability of euthanasia.

Key elements of 'informing the patient'

- Patient must be informed about his situation and prognosis
- Physician must ascertain that patient has understood the information

3.5 NO REASONABLE ALTERNATIVE

The physician and the patient must together come to the conclusion that there is no reasonable alternative in the patient's situation. This due care criterion, which must be seen in relation to suffering with no prospect of improvement, is necessary in view of the drastic and irrevocable nature of euthanasia. If there are less drastic ways of ending or considerably reducing the patient's unbearable suffering, these must be given preference.

The question of whether there is a reasonable alternative must be assessed in light of the current diagnosis. Where the physician lacks the expertise to assess whether reasonable alternatives exist, he should ascertain whether other physicians who do have that expertise have been involved in the patient's treatment, or he should consult a specialist in the medical field in question. He must also record such consultations in his report to the committee.

The physician and the patient must *together* arrive at the conclusion that no reasonable alternatives are available to the patient. The perception and wishes of the patient are important. There is an alternative to euthanasia if there is a realistic way of alleviating or ending the suffering which may – from the patient's point of view – be considered reasonable. The advantages of the alternative must outweigh the drawbacks, such as the burden on the patient: 'reasonable' from the patient's perspective means, among other things, that there is a favourable relationship between the outcome to be achieved through the alternative and the burden on the patient, while the positive effects must be achievable in the short term. The patient's life expectancy also plays a role in this regard. The burden must be assessed in light of the patient's individual circumstances, including the number of treatments he has already undergone, any side effects of the treatment, the stage of the disease and the patient's age, medical situation and physical and mental stamina. It is not necessary to try all possible alternatives. Sometimes, 'enough is enough'.

An invasive or lengthy intervention with limited results will not generally be regarded as a 'reasonable alternative'. Generally, 'a reasonable alternative' intervention or treatment can end or substantially alleviate the patient's suffering over a longer period. A patient who is decisionally competent may of course refuse such treatment, although as a consequence the physician may refuse to grant the patient's request for euthanasia at that moment.

Palliative care (which includes both pain relief and palliative sedation) plays an important role towards the end of life. In cases where the patient's suffering is largely due to pain, pain relief may be an alternative to euthanasia. However, a patient may have good reason to refuse palliative care, for example because he does not wish to become drowsy (due to higher doses

of morphine) or lose consciousness (through palliative sedation). It is important that the physician fully inform the patient about the benefits and disadvantages of palliative care, as the decision whether or not to use this option ultimately lies with the patient.

In summary, there is a reasonable alternative if:

- a. the proposed treatment/intervention significantly alleviates the patient's unbearable suffering
- b. the proposed treatment/intervention has positive effects within a reasonable period of time
- c. any drawbacks are outweighed by the benefits (effect versus burden)

The patient has a large say in determining whether an alternative is 'reasonable'.

In his report to the committee, the physician must indicate whether alternatives were available, how he discussed them with the patient and why the patient did not consider them reasonable.

Key elements of 'no reasonable alternative'

- Conclusion arrived at by physician and patient together
- Reasonable alternative has significant positive impact on suffering, takes effect fairly quickly, is long-lasting, has more benefits than disadvantages
- Burden on patient should be assessed in light of his specific circumstances
- Patient may refuse palliative care or treatment; this need not necessarily preclude granting a request for euthanasia

3.6 INDEPENDENT PHYSICIAN

Before performing euthanasia, the physician must consult at least one other, independent physician who must see the patient and give his assessment of the due care criteria discussed in sections 3.2 to 3.5. The independent physician forms an independent opinion of which he informs the physician in a written report. The purpose of the independent consultation is to ensure that the physician's decision is reached as carefully as possible. The independent physician's assessment helps the physician ascertain whether all the due care criteria have been met and reflect on matters before granting the request and performing euthanasia.

In the vast majority of cases the independent physician is a SCEN physician.¹⁷ SCEN physicians are trained to make independent assessments. They are organised into regional divisions. One of the aims of the SCEN organisation is to guarantee quality through peer supervision.

Information needs of the physician in the early stages

The independent physician as referred to in the Act is the person to whom the physician turns for a 'broad' assessment of the case: have the due care criteria referred to in section 2 (1) (a) to (d) of the Act been met (request, suffering, information, alternatives)? The physician will not generally consult an independent physician until he is seriously considering granting the patient's request for euthanasia.

¹⁷ The Euthanasia in the Netherlands Support and Assessment Programme (SCEN) trains physicians to make independent assessments. It falls under the Royal Dutch Medical Association (KNMG). The KNMG drew up a guideline for SCEN physicians in 2012, entitled *Goede steun en consultatie bij euthanasie* ['Good euthanasia support and independent assessment'].

The physician may also ask a SCEN physician or other physician for advice if he has questions before the euthanasia process actually commences. These questions may concern the process ('what steps do I need to take?'), for instance if the physician has little or no experience of euthanasia, or the patient ('is there reason to have the patient's decisional competence assessed?', 'are there any treatment alternatives?'). Asking support from a SCEN physician or other physician on such matters is not a consultation in the meaning of the Act. It is merely a request for advice prior to the 'statutory consultation'.

The physician's responsibility in relation to the independent physician

The physician performing the euthanasia procedure is expected to read the independent physician's written opinion and include it in his assessment of the patient's request. The physician must take the independent physician's opinion very seriously, but he does not need the independent physician's 'permission' to carry out euthanasia. If there is a difference of opinion between the two, the physician may nevertheless decide to grant the patient's request, but he will have to be able to explain his decision to the committee. Alternatively, he may consult another independent physician, though the idea is not that he should continue searching until he finds an independent physician who agrees with him.¹⁸ A physician who has consulted multiple independent physicians must submit all the independent physicians' written reports to the committee.

It is in the interests of the physician performing euthanasia that the independent physician write a comprehensive report.¹⁹ Sometimes the quality of the report is questionable because, for instance, the independent physician has not assessed all the due care criteria or has not presented enough arguments in support of his conclusion, or the report may contain internal inconsistencies. The physician performing euthanasia is answerable to the committee for the standard of the independent physician's report. It is he, after all, who is obliged to demonstrate convincingly that all the due care criteria have been met. If the independent physician's report is substandard, the physician may have to ask the independent physician for more information. If necessary, the physician can refer to the guidelines drawn up by the KNMG/SCEN on the independent physician's responsibilities and the reporting checklist.²⁰

The independent physician's independence and expertise

The Act requires consultation with at least one other, *independent* physician. This means the physician must be in a position to independently form his own opinion. It concerns independence in relation to both the physician and the patient.²¹ Any suggestion that he is not independent must be avoided. It is therefore important that the independent physician explain his relationship to the physician and the patient in his report.

It is possible that the physician and the independent physician know each other, perhaps as members of a peer supervision group. This need not present a problem. But there can in principle be no question of independence *in relation to the physician* if the independent physician is from the same medical practice or partnership, if there is a relationship of dependence with the physician (e.g. the independent physician is a registrar training with the physician), or if there is a family relationship between them. And if both physicians regularly act as independent physicians for each other, or know each other socially, the physician brought in for consultation may not in fact be independent, or appear not to be independent.

18 See section 23 of the KNMG guideline *Goede steun en consultatie bij euthanasie* (2012).

19 The SCEN has drawn up a checklist for the independent physician's report.

20 The KNMG guideline *Goede steun en consultatie bij euthanasie* (2012) and the checklist for the independent physician's report drawn up by the SCEN.

21 See also *Standpunt inzake euthanasie* ['Position paper on euthanasia']. KNMG, Utrecht, 2003, pp. 14-16.

In the situation where both physicians are members of the same locum group, whether or not this rules out independent assessment depends on the circumstances. What matters is that the physician and the independent physician should be aware of this and make their opinion on the matter clear in their reports to the committee.

The committees prefer an independent physician to be selected 'at random' wherever possible, using the SCEN duty roster. In cases where it is important that the advice of a physician with specific expertise be sought (psychiatrist, geriatrician etc.), a specialist in that field should be consulted as an independent physician, in addition to the normal SCEN physician called upon to make an assessment of all the due care criteria mentioned above.

> For more on such cases, see sections 4.3 to 4.5

If the SCEN physician has the specific expertise required, it will not as a rule be necessary to consult another physician. This also avoids unnecessarily burdening the patient.

The independence of the independent physician *in relation to the patient* implies among other things that there is no family relationship or friendship between the independent physician and the patient, and that the independent physician is not currently treating the patient, and has not done so in the recent past. Contact on a single occasion in the capacity of locum need not present any problem. This will depend on the nature of the contact and when it occurred.

The Act does not require the independent physician to give his opinion on the due medical care criterion (see section 3.7 below). However, there is no reason why the independent physician should not ask questions about this matter or advise the physician.²²

Generally speaking it is important that the independent physician have sufficient expertise to properly assess the case in question. If the independent physician has doubts about this, it is important that he discuss them with the physician.

In principle, the independent physician must see and speak with the patient

According to the Act, the independent physician must see the patient.²³ In the vast majority of cases, this will involve both seeing and speaking with the patient. It is possible that the patient is no longer capable of conversation by the time he is visited by the independent physician. If the physician sees such a situation developing, he would do well to ask the independent physician to come sooner. If necessary, the physician and independent physician can contact each other by telephone afterwards. If the independent physician is no longer able to communicate with the patient during his visit, he must provide an assessment based on all other available and relevant facts and circumstances. It can be useful to obtain further information from the physician and any family members of the patient. The Act therefore does not require that the independent physician is able at all times to communicate with the patient (either verbally or non-verbally). This also follows from the scope provided by the Act for performing euthanasia on the basis of the patient's advance directive when a patient is no longer able to communicate.

> For more on advance directives, see section 4.1

> For more on coma and reduced consciousness, see section 4.7

²² See also section 22 of the KNMG guideline mentioned in footnote 21.

²³ 'Seeing' the patient will normally mean 'visiting' the patient. This can lead to practical problems on Bonaire, St Eustatius and Saba, so the independent physician and patient may speak to each other via an online video link.

In some cases the independent physician visits the patient very shortly before euthanasia is to be performed, sometimes even on the day of the patient's death. The circumstances of the case, and particularly any unexpected and severe deterioration in the patient's situation, may make this unavoidable. The physician's report must then make it clear that he was aware of the independent physician's findings.

Consulting the independent physician for a second time

It is not unusual for some time to pass between the independent physician's visit to the patient and the performance of euthanasia. This is not usually a problem. The Act says nothing about the 'shelf life' of the independent physician's report. Generally speaking, the report will remain valid as long as there is no fundamental change in the patient's circumstances and in the progress of the disease. The time between the independent physician's visit and the performance of euthanasia is more likely to be a matter of days and weeks than of months. The more time elapses, the more logical it becomes for the physician to contact the independent physician again, and failure to do so will raise questions with the committee. It is not possible to give an absolute rule for such cases. It is up to the physician to decide, based on the independent physician's earlier findings and developments in the patient's circumstances. The physician will have to be able to explain his decision to the committee if necessary.

If further consultation between the physician and independent physician becomes likely, because a long time has elapsed and/or there have been new developments, it depends on circumstances whether the independent physician needs to see the patient a second time. Sometimes a telephone call between the physician and the independent physician, or between the independent physician and the patient, will suffice.

The independent physician will generally need to visit the patient a second time if he:

- visited the patient at an early stage and found that the patient was not yet suffering unbearably;
 - determined that all the criteria had been met, but a lot of time has elapsed since, or the patient's condition has changed in a way that was not foreseen when he drafted his report.
- In these cases, if the physician is unable to contact the original independent physician, another independent physician may be consulted. The latter will generally need to see the patient himself.

If the independent physician has indicated that the patient's suffering will very soon become unbearable and has specified what he believes that suffering will entail, a second visit by the independent physician will not normally be necessary if the patient's suffering does indeed become unbearable very soon.

The committees and the independent physician

The committees review the actions of the notifying physician, not those of the independent physician.²⁴ The independent physician may however be asked to answer questions from the committee, either in writing or in person. This does occasionally occur.

²⁴ The KNMG has set up a complaints committee on SCEN physicians, to which any of the parties involved in a euthanasia case may submit a complaint about the actions of a SCEN physician.

The committee can give the independent physician feedback if it has any comments concerning the standard of his reports. This will usually only be necessary if an independent physician repeatedly produces reports of questionable quality. The committees also provide general feedback to the SCEN organisation concerning the overall quality of reporting by SCEN physicians.

Key elements of 'independent physician'

- Consulting another physician for advice on a specific matter relating to the criteria is not formal consultation within the meaning of the Act
- Formal consultation: physician consulted must be independent, and any suggestion that he is not independent must be avoided
- In principle, independent physician must see and speak with patient; if communication is not possible, simply 'seeing' will suffice
- In certain circumstances, particularly if a long time has elapsed, independent physician may need to be consulted a second time (or, if he is unavailable, another independent physician)
- The physician performing euthanasia must read independent physician's report and consider it carefully

3.7 DUE MEDICAL CARE

The physician must exercise due medical care in performing euthanasia. Two aspects of this are the substances and doses administered, and appropriate checks to determine the depth of the induced coma. In assessing this due care criterion, the committees refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of 2012 (referred to below as the Guidelines). The Guidelines advise physicians and pharmacists on practical and effective methods of performing euthanasia and assisting suicide. They list preferred substances, and also explicitly advise against using certain other substances.

General

Below, a distinction is drawn between termination of life on request (when the physician administers the substances) and assisted suicide (when the patient himself takes the substances given to him by the physician). Certain standards must be observed in both cases. It is, for example, important that the physician's report describe the substances administered, the doses and method of administration, and how long the procedure took. Furthermore, in both cases the physician must have an emergency set of substances available in case something goes wrong with the first set. The physician may not leave the euthanatic with the patient prior to termination of life on request or assisted suicide, giving the patient or a third person the opportunity to take or administer the substance in the physician's absence.

Termination of life on request: order in which substances must be administered

In cases of termination of life on request, the Guidelines advise intravenous administration of a coma-inducing substance, followed by intravenous administration of a muscle relaxant. The Guidelines list substances that may be used and their recommended doses. If the physician deviates from the Guidelines, he will have to present convincing arguments in support of his actions. It is advisable for the physician to inform the patient and his family beforehand what effects the substances will have. He should also comply with the patient's individual wishes as far as possible, provided they fall within the scope provided by the Guidelines. A substance

such as midazolam may be used as premedication before a recommended coma-inducing substance is administered.

Termination of life on request: checking the depth of coma

The muscle relaxant must not be administered until the patient is in a deep coma, as he might otherwise perceive the effects of the muscle relaxant. To this end, it is vital that the physician establish that the coma is sufficiently deep before administering the muscle relaxant. If the committee has any doubts about this, it will ask the physician about the depth of the coma and how he established this.

Termination of life on request must be performed by physician

The physician may not allow a relative or other person to administer the euthanatics in his presence, using a PEG tube, for instance. The physician must perform every step of the procedure himself. This also means that the physician must remain present until death occurs.

Assisted suicide: substance and dose

In the case of assisted suicide, the physician dissolves the substance (a barbiturate) in a potion and hands this to the patient, who ingests it himself. The two steps described above (first inducing coma, then administering a muscle relaxant) are not applicable in assisted suicide. However, the physician must administer premedication to prevent vomiting and accelerate the passage of the substance through the stomach. The Guideline lists the type of substances, and their doses, to be used in assisted suicide.

Assisted suicide: physician must remain in immediate vicinity

If the patient wishes, the physician may leave the room after the patient has taken the euthanatic. He must however remain in the patient's immediate vicinity in order to intervene quickly if complications arise (e.g. if the patient vomits the potion back up). In that case the physician may have to terminate the patient's life after all. Sometimes, the patient does not die after drinking the barbiturate potion. The physician will then have to terminate the patient's life after a certain length of time. He must discuss this possibility beforehand with the patient and his family, and agree with the patient how long he will wait before terminating his life. The physician must prepare for this eventuality, by inserting an IV cannula prior to assisting with suicide, and by bringing along the substances needed to terminate the patient's life.

Relationship between physician and pharmacist

The physician bears final responsibility for exercising due medical care. His actions are assessed by the committees. If the pharmacist prepares the syringe or potion beforehand, he has an individual responsibility for its preparation and labelling. The physician must check whether he has received the correct substances in the correct doses.

It is important that the pharmacist have sufficient opportunity and time to carefully consider the pharmaceutical aspects of the case, such as the most appropriate substances and method to be used. It is therefore important that the physician contact the pharmacist in good time.

It is not the pharmacist's task to assess whether all the statutory due care criteria for euthanasia have been met. This is the responsibility of the physician. A pharmacist is therefore unlikely to refuse to supply substances because he holds a different opinion on the due care

criteria than the physician. However, like physicians, pharmacists are not obliged to assist with euthanasia. This is another reason why timely contact between the physician and the pharmacist is advisable, in order to prevent problems in the final stages.

Key elements of 'due medical care in termination of life on request'

- Sequence of events:
 - physician administers coma-inducing substance
 - checks depth of coma
 - physician administers muscle relaxant
- Recommended substances, doses, methods of administration and coma check method: KNMG/KNMP Guideline 2012
- Physician must have emergency set of intravenous substances to hand

Key elements of 'due medical care in assisted suicide'

- Sequence of events:
 - insert IV cannula and administer anti-nausea premedication
 - discuss with patient and family length of time to wait before terminating life, if necessary
 - physician hands barbiturate potion to patient
 - physician remains present or in immediate vicinity until death is confirmed
- Recommended substances, doses, methods of administration: KNMG/KNMP Guidelines 2012
- Physician must have emergency set of intravenous substances to hand

4

SPECIFIC ISSUES

4.1 ADVANCE DIRECTIVE

Section 2 (2) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act stipulates that a patient aged 16 or over who is decisionally competent in the matter may draw up an advance directive setting out a request for euthanasia.²⁵ If at some point the patient is no longer capable of expressing his will, the physician may accept the advance directive as a request pursuant to section 2 (1) (a) of the Act. The advance directive thus has the same status as an oral request for euthanasia.

Section 2 (2) of the Act states that, in the event of an advance directive, the due care criteria mentioned in the Act apply *mutatis mutandis*. This means, in accordance with the legislative history, that the due care criteria apply to the greatest extent possible in the given situation.²⁶ In other words, in assessing the due care criteria the physician must take account of the specific circumstances of the case; for instance, the patient may no longer be capable of communicating or responding to questions. The physician will generally have spoken with the patient when he was still capable of expressing his will. If a situation subsequently arises in which the patient's advance directive comes into play, information obtained in previous conversations with the patient will be particularly useful to the physician.

Other due care criteria apply 'mutatis mutandis'

When the advance directive replaces an oral request, the other due care criteria apply *mutatis mutandis*. The following general points should be noted.

- a. The patient's request must be voluntary and well-considered: the physician will be able to assess on the basis of his previous communication with the patient whether the request made in the advance directive is 'voluntary and well-considered'. The fact that the patient drew up an advance directive (and probably repeated and confirmed the wishes set out in it as long as he was able) can be considered a clear indication that the request is voluntary and well-considered. The physician can also base his conclusion on conversations with the patient's family or representative.
- b. The patient must be suffering unbearably, with no prospect of improvement: though the advance directive replaces an oral request, the physician must still establish or be satisfied that the patient is experiencing unbearable suffering immediately prior to the termination of life on request.
- c. The patient must be informed of his situation and prognosis: the physician must know that the patient was informed of his situation and prognosis when oral communication with the latter was still possible.

²⁵ The minimum age stated in section 2 (2) of the Act is 16. On the basis of the last sentence of section 2 (4), patients between the ages of 12 and 16 may also draw up a legally valid advance directive.

²⁶ This is set out in the explanatory memorandum to the amendment of the Act, concerning the addition of the second sentence to section 2 (2) (Parliamentary Papers, House of Representatives, 26 691, no. 35).

- d. There must be no reasonable alternative: as stated above (section 3.5) this is a conclusion that the physician and patient must arrive at together. It is therefore important that the physician carefully consider what the patient has written about this matter in his advance directive and what he said when he was still able to communicate, and assess whether the patient's views apply to the situation at hand.
- e. The independent physician: the Act stipulates that the independent physician must see the patient. This is also possible in this situation, even though there will be little or no possibility of communication between the independent physician and the patient. The independent physician will therefore have to base his report on his own observations and additional information from other sources (patient records, advance directive, conversations with physician and family).
 - > See also sections 3.6 and 4.7
- f. Due medical care: there are no specific issues with regard to this due care criterion in situations where termination of life is performed on the basis of an advance directive.

It is important that the physician keep meticulous records so that these points can be properly assessed.

The advance directive as provided for under section 2 (2) of the Act is deemed to reflect the will of the patient. In cases where the advance directive is consistent with statements made orally by the patient when he was still decisionally competent, no questions will generally arise. Even if the patient is no longer able to communicate normally, it may be possible to establish from his behaviour and utterances that his current wishes are consistent with wishes previously expressed, confirming the advance directive. The physician must be alert to any behaviour and utterances that may indicate resistance or objections to termination of life. If this is the case, euthanasia may not be performed.

Content of the advance directive

The advance directive can replace an oral request, but it can also help the physician determine when to carry out the patient's request. This depends on what the patient has specified in his advance directive. It is important that the patient indicate as clearly as possible the specific circumstances in which his request should be acted upon. These must be circumstances in which the patient can be said to be suffering unbearably.²⁷ The content of the advance directive plays an important role in assessing whether the suffering is unbearable for this particular patient, in addition to the patient's behaviour and prevailing medical opinion on the expected progress of the disease.

The Act does not limit the validity of an advance directive, nor does it require the directive to be regularly updated. However, the older the directive, the more doubt there may be as to whether it still reflects the patient's actual wishes. The directive will carry more weight if the patient has updated his advance directive, or orally reaffirmed its content. An advance directive should preferably be drawn up in good time and updated regularly, and describe as specifically as possible the circumstances in which the patient would wish his life to be terminated. It is the responsibility of the patient to discuss his advance directive with his physician when he drafts or updates it. The physician should include this information in his patient records. A personal directive drawn up by the patient in which he gives a description in his own words will generally be regarded as more significant than a pre-printed, standard form.

²⁷ An exception to the criterion requiring physicians to establish that the patient is suffering unbearably is described in section 4.7.

The following aspects are therefore important.

- a. To what degree or in what way did the patient reaffirm his written directive (either orally or otherwise) when he was still decisionally competent?
- b. If the patient is no longer capable of (effective) communication, has there been anything in his behaviour or utterances that contradicts his wishes as set out in the advance directive?
- c. Immediately prior to termination of life, is the patient's state one that he described in his advance directive as being a situation in which he would wish for his life to be terminated?

All things considered, the patient's wish for euthanasia must have been expressed so consistently over time that the advance directive can reasonably be regarded as expressing the will of the patient at the time of termination of life.

Advance directive: points to consider

- How clear is the advance directive?
- Did the patient reaffirm the advance directive when he was still decisionally competent?
- All things considered, can the advance directive be said to express the will of the patient?
- Can the patient be considered to be experiencing unbearable suffering at the moment euthanasia is performed?
- Do the patient's behaviour and utterances in any way contradict the content of the advance directive?
- Has the physician kept meticulous records?

4.2 MINORS

The Act applies to euthanasia for individuals aged 12 and over, but it does impose a number of additional requirements with regard to requests from minors:

- if the patient is a minor between the ages of 12 and 16, termination of life at the patient's request may only be carried out with the consent of the parent(s) or guardian (section 2 (4) of the Act);
- if the patient is a minor aged 16 or 17, the parent(s) or guardian must be consulted in the decision-making process, but their consent is not required (section 2 (3) of the Act).

The due care criteria described in section 3 of this Code are of course applicable in both cases. The statutory requirements concerning the involvement of the parent(s) or guardian in the decision-making process also apply if the minor's request is made in the form of an advance directive.²⁸

In the event of a request from a minor, particular attention will have to be paid to the patient's decisional competence. It is not considered impossible for a minor to be decisionally competent with regard to euthanasia, but the physician and the independent physician will both have to give this matter especially careful consideration.

Notifications of euthanasia involving minors aged between 12 and 18 are rare. Between 2002 and 2014 the RTEs received only five such notifications. In all cases, the patient's family understood and respected the patient's request for euthanasia.

²⁸ See footnote 25.

4.3 PATIENTS WITH A PSYCHIATRIC DISORDER

In line with the Supreme Court judgment in the 1994 Chabot case, physicians must exercise particular caution when a euthanasia request results (largely) from mental suffering.²⁹ Such cases often involve complex psychiatric problems, and require specific expertise.³⁰ Caution must particularly be exercised when assessing the voluntary and well-considered nature of the request, the absence of any prospect of improvement, and the lack of a reasonable alternative. It must be ruled out that the patient's psychiatric disorder has impaired his ability to form judgments. If the patient is not decisionally competent with regard to euthanasia, his request cannot be regarded as voluntary and well-considered. The physician must take particular note of whether the patient appears able to grasp relevant information, understands his disease and is consistent in his deliberations.

> See also section 3.2

As regards suffering with no prospect of improvement and the absence of a reasonable alternative, the possibility of other treatment options for the patient must be carefully explored. This is particularly so in cases where the patient is relatively young and might still have many years to live.³¹ If the physician does not have the expertise to assess whether alternatives are available, he will have to consult physicians who do have this specific expertise. If the patient refuses a reasonable alternative, he cannot in principle be said to be suffering with no prospect of improvement. At the same time, patients are not obliged to undergo every conceivable form of treatment. See also section 3.5.

Besides consulting a regular independent physician who assesses whether all the due care criteria mentioned in sections 3.2 to 3.5 have been met, the physician must also consult an independent psychiatrist, to assess the patient's decisional competence regarding the request, and whether he is suffering with no prospect of improvement. In order to avoid placing an unnecessary burden on the patient, it might be preferable to consult an independent physician (or SCEN physician) who is a qualified psychiatrist.

Combination of somatic and psychiatric disorders

The above refers to patients who request euthanasia because of suffering associated with a psychiatric disorder. Patients whose suffering is caused largely by a somatic disorder may also have mental problems which can aggravate the patient's suffering. In these cases, too, the physician and the independent physician must explicitly consider whether the patient's mental problems preclude a voluntary and well-considered request. If the independent physician is not a psychiatrist, it may also be necessary to seek the advice of a psychiatrist. It should be said, however, that it is normal for patients to be in low spirits in the circumstances in which they make a request for euthanasia, so that this in itself is not necessarily a sign of depression.

29 Specifically, the Supreme Court ordered physicians to exercise particular caution in all cases where patients' suffering is not demonstrably the result of a somatic disease or disorder and does not consist solely of the perception of pain and loss of physical function (Supreme Court 21 June 1994, NJ 1994/656).

30 See also the guidelines of the Dutch psychiatry association (*Nederlandse Vereniging voor Psychiatrie*) on 'Dealing with requests for assisted suicide from patients with a psychiatric disorder'. Utrecht, 2009.

31 See cases 11 and 12 in the 2013 Annual Report, which both involved a woman in her thirties. In both cases, the committee found that all the due care criteria had been complied with.

The number of notifications the committees receive concerning patients with psychiatric disorders has increased in recent years, particularly since 2011.

Patients with a psychiatric disorder: points to consider

- Can the patient's wish to die be considered a voluntary and well-considered request, or is it a symptom of his illness?
- Has it been established that there is no reasonable alternative for this particular patient?
- Has an independent psychiatrist been consulted in addition to the independent physician, or is the independent physician himself a psychiatrist?

4.4 PATIENTS WITH DEMENTIA

There is also reason to consider the statutory due care criteria with particular caution in cases involving patients with dementia. This is especially true of the criteria relating to decisional competence and unbearable suffering. As a patient's dementia progresses, his decisional competence will decline. After a time, the patient may become completely decisionally incompetent.

Early-stage dementia

In most cases so far notified to the committees, the patient was in the early stages of dementia. At this stage the patient generally has sufficient understanding of his disease and is decisionally competent in relation to his request for euthanasia. Besides the actual decline in cognition and functioning, the patient's suffering is often partly determined by their fear of further decline and the negative impact on their autonomy and dignity in particular (see also section 3.3). The key factor is the patient's perception of the progressive loss of personality, functions and skills, and the realisation that this process is unstoppable. This prospect can cause profound suffering in the present moment.

Late-stage dementia

It is still possible to grant a request for euthanasia at the stage where dementia has progressed to such an extent that the patient is no longer decisionally competent and is no longer able to communicate (or is able to communicate only by simple utterances or gestures), provided the patient drew up an advance directive when he was still decisionally competent. The directive must be clear, and evidently applicable to the current situation.

> For more on advance directives, see section 4.1

The physician and the independent physician must consider the entire disease process and any other specific circumstances when assessing the request. They must interpret the patient's behaviour and utterances, both during the disease process and shortly before euthanasia is performed. At that moment the physician must be satisfied that carrying out euthanasia is in line with the patient's advance directive, and that there are no contraindications (such as clear signs that the patient no longer wishes his life to be terminated). It must also be palpable to the physician that the patient is suffering unbearably at that point. As noted above, the assessment of the content of the advance directive will have a bearing on this matter.

In cases of euthanasia in patients with late-stage dementia, the physician and the independent physician have increased accountability. The independent physician (in his independent physician's report) and the physician (in the documents he submits to the committee) will

have to provide a meticulous account of their deliberations and the facts and circumstances on which they were based.

Consultation

The regular procedure of consulting an independent physician will generally suffice if a patient in the early stages of dementia wishes euthanasia. The patient does have to have been diagnosed with dementia according to prevailing medical practice .

When euthanasia is to be performed in the late stages of dementia, the physician must consult both a regular independent physician (SCEN physician), to assess the due care criteria described in sections 3.2 to 3.5, and a physician specialised in dementia (such as a geriatrician or an internal medicine physician specialising in geriatrics). In order to avoid placing an unnecessary burden on the patient, it may be preferable to consult an independent physician (SCEN physician) who also has such expertise. In the late stages of dementia the independent physician will not always be able to speak with the patient. The independent physician must then base his assessment on all other facts and circumstances. An advance directive drawn up by the patient and further information from the physician or the family can support this process.

Patients with dementia: points to consider

- Is the patient still capable of determining and expressing his will?
- If not, is there an advance directive?
- Is the patient still able to communicate at the point where euthanasia is to be performed?
If not:
 - is the situation obviously one referred to in the advance directive?
 - is the patient experiencing unbearable suffering?
 - are there clear signs that the patient does not wish his life to be terminated?
- Has the physician consulted another physician with expertise in the field or is the independent physician an expert himself?

4.5 PATIENTS WITH AN INTELLECTUAL DISABILITY

Notifications of cases of euthanasia involving patients with an intellectual disability are rare.³² There are cases where patients with a mild intellectual disability are capable of making a voluntary and well-considered request for euthanasia, and where all the other due care criteria are met.³³ In these cases, particular attention must be paid to the patient's decisional competence with regard to a request for euthanasia.

In addition to the regular independent physician, who assesses the due care criteria described in sections 3.2 to 3.5, the physician will also have to consult a physician with the expertise required to assess the patient's decisional competence (such as a physician specialising in the care of people with intellectual disabilities). In order to avoid placing an unnecessary burden on the patient, it may be preferable to consult an independent physician (SCEN physician) who also has such expertise.

³² See case 2 in the 2012 Annual Report.

³³ See also *Medische beslissingen rond het levenseinde bij mensen met een verstandelijke beperking* ['Medical decisions at end-of-life in people with intellectual disabilities'], by the Dutch association of physicians for people with intellectual disabilities (NVAVG), 2007.

4.6 PATIENTS WITH APHASIA

Aphasia is a language disorder. Patients with aphasia often have problems using and/or understanding language. A patient with aphasia may be able to make a voluntary and well-considered request, but he will generally have difficulty expressing his views and wishes orally. A patient with aphasia will often be able to express his will or answer questions in another way, for example by squeezing someone's hand or through facial expressions or gestures. Another option would be to ask only questions requiring a yes or no answer, which the patient could also answer using gestures or signs. In this way, despite the patient's language disorder, it is possible to form a good impression of his request for euthanasia and the decisional competence required. If the other due care criteria are satisfied, the request for euthanasia may be carried out.

An advance directive drawn up by the patient can be used in support of and in addition to the patient's limited oral utterances.

4.7 COMA/REDUCED CONSCIOUSNESS

The suffering experienced by the patient is of particular importance when considering whether euthanasia is permissible for a patient in a coma or state of reduced consciousness.

Coma

Suffering assumes a conscious state. If a patient is in a coma, i.e. a state of complete unconsciousness, he is unable to experience suffering.

Reduced consciousness

If a patient is in a state of reduced consciousness, the possibility that he is suffering (perhaps unbearably) cannot be ruled out.³⁴

When coma/reduced consciousness sets in just before euthanasia is to be performed

It is possible for a patient to fall into a coma or a state of reduced consciousness just before the agreed or intended time that euthanasia is to be performed. This is a difficult situation, as it raises the question of whether euthanasia can still be performed. In answering this question, it is necessary to distinguish between a number of different situations.

1. Coma is irreversible (caused by disease, patient cannot be aroused)

The patient may spontaneously fall into a coma in the final stages of his disease. Since he can no longer experience suffering in this state, the physician may not proceed with euthanasia, even if he had already agreed to perform it.

2. Reduced consciousness is irreversible (caused by disease, patient cannot be aroused), but there are signs the patient may be suffering

The patient may spontaneously fall into a state of reduced consciousness from which he cannot be aroused, and may show signs of possible suffering. In this situation, the physician may proceed with euthanasia. If there are no signs that the patient may be suffering, euthanasia cannot be performed.

³⁴ The Glasgow Coma Scale (GCS) provides guidance in determining the extent of a patient's reduced consciousness – and therefore also potential suffering. The GCS is included in KNMG Guideline 'Euthanasia for patients in a state of reduced consciousness', Utrecht, 2010.

3. Coma or reduced consciousness is reversible (medically induced, can be reversed by withdrawing medication)

If the patient is in a coma or state of reduced consciousness that has not occurred spontaneously but has been induced by medication, he could potentially be aroused in order to ascertain whether he is still suffering. However, the committees consider this to be inhumane. In such a situation, therefore, the physician may perform euthanasia if the patient had requested it previously, either orally or in an advance directive. The patient need not be aroused from the induced coma or state of reduced consciousness (with or without signs of possible suffering) simply to confirm to the physician and/or independent physician that he is still suffering unbearably.

4. Coma or reduced consciousness occurs after consultation has taken place

If the patient enters a state of reduced consciousness or reversible coma after the independent physician has visited the patient and communicated with him, in which case euthanasia may be performed, the independent physician need not be called in again. In this situation an advance directive is not necessarily required, even if the patient is no longer capable of expressing his will at the point when euthanasia is to be performed.³⁵

5. Coma or reduced consciousness occurs before consultation has taken place

The patient may also enter a state of reduced consciousness or reversible coma, where euthanasia is in principle permissible, before the independent physician has been able to see him. In this case, the independent physician can no longer communicate with the patient and must base his assessment of the patient's request on information provided by the physician, an advance directive, the patient records and information from others. He will have to assess the patient's suffering on the basis of his own observations, the patient records and information provided orally by the physician and others, such as the patient's family and carers.

> See also section 4.8 on euthanasia and palliative sedation

Coma/reduced consciousness occurs before euthanasia is planned

A patient may unexpectedly fall into a coma or state of reduced consciousness before the physician and the patient have completed, or even started, the euthanasia process. In order to proceed with euthanasia, there must at least be an advance directive drawn up by the patient. The independent physician will have to see the patient. If the state of reduced consciousness is irreversible, there must also be signs that the patient is or may be suffering.

> See also sections 3.6 and 4.1

Coma/reduced consciousness: points to consider

- Coma/reduced consciousness sets in shortly before planned euthanasia is to be performed:
 - has the physician established the depth of coma or reduced consciousness?
Has he used the GCS?
 - is the coma or state of reduced consciousness reversible?
 - if reduced consciousness is irreversible, is the patient showing signs that he is or may be suffering?
 - if the independent physician did not see the patient before the coma or state of reduced consciousness set in, does he have enough information to draw a conclusion?
- Coma/reduced consciousness before euthanasia is planned:
 - in addition to the above: did the patient draw up an advance directive?

³⁵ See also KNMG, 'Euthanasia for patients in a state of reduced consciousness'. Utrecht, 2010.

4.8 EUTHANASIA AND PALLIATIVE SEDATION

Euthanasia and palliative sedation are two different ways of ending or alleviating a patient's unbearable suffering. In the case of euthanasia, the patient's life is terminated. With palliative sedation, the patient is brought into a state of reduced consciousness until his death. Unlike euthanasia, palliative sedation is normal medical practice, though it is subject to specific criteria and conditions.³⁶

Patients who are suffering unbearably may make a request for euthanasia, but may sometimes opt for palliative sedation. Some patients do not want euthanasia, and palliative sedation may be a good alternative for them. Others refuse palliative sedation because they want to remain conscious until the very end. In this case, the patient may conclude that palliative sedation is not a 'reasonable alternative'. Refusing palliative sedation is not therefore an obstacle to euthanasia.

> See also section 3.5

There are cases in which the decision to grant a patient's request for euthanasia has been made, but sedation is administered prior to carrying out the procedure. This may lead to a situation where the patient is brought into a state of reduced consciousness just before euthanasia is to be performed and is therefore no longer capable of repeating or reaffirming his request for euthanasia. Euthanasia may then be performed if the patient previously described this situation – either orally or in an advance directive – as one in which he would want euthanasia to be performed. It is the committee's view that it would be inhumane in such cases to wake the patient solely for the purpose of having him confirm the unbearable nature of his suffering for the physician and/or independent physician.

Sometimes a patient may make a 'conditional' request for euthanasia. In this case, the patient is initially palliatively sedated, but the physician and the patient agree that euthanasia will be carried out should certain circumstances arise. For instance:

- it may take longer for the patient to die than he wished;³⁷
 - the patient still shows signs of suffering, despite being in a state of reduced consciousness.
- The committees emphasise that it is essential that the patient inform the physician of the specific situations in which his agreement to palliative sedation no longer applies and he wants his request for euthanasia to be carried out. In such situations, the physician will also have to determine the best time to consult the independent physician.

³⁶ See *Richtlijn palliatieve sedatie* ['Guideline on palliative sedation']. KNMG, Utrecht, 2009. One of the conditions is a life expectancy of two weeks or less.

³⁷ In this case, it can be concluded that the patient does not give consent for palliative sedation to continue. This concerns consent within the meaning of the Medical Treatment Contracts Act (article 450 (1) of Book 7 of the Civil Code).

4.9 'FINISHED WITH LIFE'

As the legislative history of the Act makes clear, the expression 'finished with life' refers to the situation of people who, often at an advanced age and without the medical profession having established that they have a disease or disorder that is accompanied by great suffering, have come to the conclusion that the value of their lives to them has decreased to the point where they would rather die than carry on living. The 'finished with life' issue has been the subject of public debate for some years. The question is whether euthanasia should be allowed in such cases.³⁸ This is not currently the case. As the case law and legislative history show, unbearable suffering must have a medical dimension (see also section 3.3). However there is no requirement that the medical condition should be serious or life-threatening. Multiple geriatric syndromes can also cause unbearable suffering with no prospect of improvement.³⁹

4.10 REQUIREMENTS NOT SET BY THE ACT

Some misconceptions exist regarding the criteria and conditions applying to euthanasia. The notifications received by the committees show that physicians and independent physicians sometimes set requirements that are not mentioned in the Act. The requirements laid down in the Act have been discussed and explained in this Code of Practice. Below is a list of conditions that are *not* laid down in the Act. A summary:

- The patient is not required to be in the terminal stage of his illness (see section 2.2).
- The physician and the patient do not need to be in a treatment relationship (see section 3.1).
- The patient is not required to provide a request for euthanasia in writing in addition to his oral request (section 3.2).
- The patient's request must be well-considered but it need not be persistent (section 3.2).
- The 'permission' of the independent physician is not required for euthanasia to be performed (section 3.6).
- A physician with expertise in assessing a patient's decisional competence does not have to be consulted as a matter of course, but only if there is reason to do so (i.e. there are reasonable doubts as to the patient's decisional competence, in the case of a patient as referred to in sections 4.2 to 4.5).
- Palliative sedation is not a 'reasonable alternative' within the meaning of section 2 (1) (d) of the Act (section 4.8).
- It is generally desirable, as well as self-evident, for the patient's family to be involved in a euthanasia request, but this is not a requirement; nor is the family's consent required for euthanasia.⁴⁰

³⁸ As this Code of Practice was being written, a committee chaired by Professor Paul Schnabel was working on an advisory report on the scope for complying with the wish of a growing group of people in the Netherlands for greater self-determination concerning the form of assistance they receive when they regard their life as finished. The advisory report is due to be published in 2015.

³⁹ See also *De rol van de arts bij het zelfgekozen levenseinde* ['The role of the doctor in termination of life at the patient's request'], KNMG, Utrecht, 2011, pp. 21-23, (in Dutch).

⁴⁰ The situation is different when the patient requesting euthanasia is a minor; see section 4.2.

5

USEFUL REFERENCES

5.1 THE COMMITTEES' WEBSITE

The committees' website can be found at www.euthanasiecommissie.nl. The site contains detailed information on the committees' procedures. A selection of the committees' findings and their joint annual reports can also be accessed via the site. The annual reports contain case descriptions. The website also has:

- a model form for physicians to use when notifying the municipal pathologist;
- a model reporting form for physicians, which must accompany the notification;
- a model form for municipal pathologists to use when notifying the committee.

5.2 THE SCEN ORGANISATION

The SCEN organisation, which falls under the KNMG, fulfils a key role in relation to the due care criterion on consultation with an independent physician (see section 3.6). In the vast majority of cases, physicians consult a trained SCEN physician. For more information (in Dutch), see <http://knmg.artsennet.nl/Diensten/SCEN.htm>.

5.3 EVALUATIONS OF THE ACT

The Termination of Life on Request and Assisted Suicide (Review Procedures) Act has been evaluated twice, in 2007 and 2012. The evaluation reports can be found (in Dutch) at www.zonmw.nl:

- Evaluation report, 2007: http://www.zonmw.nl/nl/publicaties/detail/evaluatie-wet-toetsing-levensbeeindiging-op-verzoek-en-hulp-bij-zelfdoding/?no_cache=1&cHash=864e5c92957c5f5d2746ec94897ee990
- Evaluation report, 2012: http://www.zonmw.nl/nl/publicaties/detail/tweede-evaluatie-wet-toetsing-levensbeeindiging-op-verzoek-en-hulp-bij-zelfdoding/?no_cache=1&cHash=048a18562816c15095a3b1b3a5f3b48d

5.4 PUBLIC PROSECUTION SERVICE POLICY RULES

Notifications of euthanasia where the committees have found the physician to have failed to comply with one or more of the due care criteria are passed on to the Public Prosecution Service and the Healthcare Inspectorate. The procedure followed by the Public Prosecution Service in such cases is set out in the *Aanwijzing vervolgingsbeslissing levensbeëindiging op verzoek (euthanasie en hulp bij zelfdoding)* ['Instructions on prosecution decisions in the matter of termination of life on request and assisted suicide'], which can be found (in Dutch) at <https://www.om.nl/vaste-onderdelen/zoeken/@86299/aanwijzing-5/>.

The decisions of the Public Prosecution Service and Healthcare Inspectorate are included in abridged form in the annual reports of the review committees, which are also published online.

ANNEXE

RELEVANT STATUTORY PROVISIONS



TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE (REVIEW PROCEDURES) ACT

CHAPTER I. DEFINITIONS

Section 1

For the purposes of this Act, the following definitions apply:

- a. Our Ministers: the Minister of Justice and the Minister of Health, Welfare and Sport;
- b. assisted suicide: intentionally helping another person to commit suicide or providing him with the means to do so as referred to in article 294, paragraph 2, second sentence, of the Criminal Code;
- c. the physician: the physician who, according to the notification, has terminated life on request or has provided assistance with suicide;
- d. the independent physician: the physician who has been consulted about the physician's intention to terminate life on request or to provide assistance with suicide;
- e. the care providers: the persons referred to in article 446, paragraph 1, of Book 7 of the Civil Code;
- f. the committee: a regional review committee as referred to in section 3;
- g. regional inspector: a regional inspector employed by the Health Care Inspectorate of the Public Health Supervisory Service.

¹ See for proceedings in the States General: Parliamentary Papers, House of Representatives, 1998/1999, 1999/2000, 2000/2001, 26 691; Proceedings of the House of Representatives, 2000/2001, pp. 2001-2072, 2107-2139, 2202-2223, 2233-2260, 2372-2375; Parliamentary Papers, Senate, 2000/2001, 26 691 (137, 137a, 137b, 137c (reprint), 137d, 137e, 137f, 137g, 137h); Proceedings of the Senate, 2000/2001, see session of 10 April 2001.

CHAPTER II. DUE CARE CRITERIA

Section 2

1. In order to comply with the due care criteria referred to in article 293, paragraph 2, of the Criminal Code, the physician 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. have informed 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. have consulted 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. have exercised due medical care and attention in terminating the patient's life or assisting in his suicide.
2. If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests, has made a written declaration requesting that his life be terminated, the physician may comply with this request unless he has well-founded reasons for declining to do so. The provisions of subsection 1 apply *mutatis mutandis*.
3. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or parents who have responsibility for him, or else his guardian, has or have been consulted.
4. If the patient is a minor aged between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the physician may, if a parent or the parents who have responsibility for him, or else his guardian, can agree to the termination of life or to assisted suicide, comply with the patient's request. Subsection 2 applies *mutatis mutandis*.

CHAPTER III. REGIONAL REVIEW COMMITTEES FOR THE TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE

Division 1: Establishment, composition and appointment

Section 3

1. There are regional committees to review reported cases of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2, and article 294, paragraph 2, second sentence, of the Criminal Code.
2. A committee consists of an odd number of members, including in any event one legal expert who also chairs the committee, one physician and one expert on ethical or moral issues. A committee also comprises alternate members from each of the categories mentioned in the first sentence.

Section 4

1. The chair, the members and the alternate members are appointed by Our Ministers for a period of six years. They may be reappointed once for a period of six years.
2. A committee has a secretary and one or more deputy secretaries, all of whom must be legal experts appointed by Our Ministers. The secretary attends the committee's meetings in an advisory capacity.
3. The secretary is accountable to the committee alone in respect of his work for the committee.

Division 2: Resignation and dismissal

Section 5

The chair, the members and the alternate members may tender their resignation to Our Ministers at any time.

Section 6

The chair, the members, and the alternate members may be dismissed by Our Ministers on the grounds of unsuitability or incompetence or for other compelling reasons.

Division 3: Remuneration

Section 7

The chair, the members and the alternate members are paid an attendance fee and a travel and subsistence allowance in accordance with current government regulations, in so far as these expenses are not covered in any other way from the public purse.

Division 4: Duties and responsibilities

Section 8

1. The committee assesses, on the basis of the report referred to in section 7, subsection 2 of the Burial and Cremation Act, whether a physician, in terminating life on request or in assisting with suicide, acted in accordance with the due care criteria set out in section 2.
2. The committee may request the physician to supplement his report either orally or in writing, if this is necessary for a proper assessment of the physician's conduct.
3. The committee may obtain information from the municipal pathologist, the independent physician or the relevant care providers, if this is necessary for a proper assessment of the physician's conduct.

Section 9

1. The committee notifies the physician within six weeks of receiving the report referred to in section 8, subsection 1, of its findings, giving reasons.
2. The committee notifies the Board of Procurators General and the regional health care inspector of its findings:
 - a. if the physician, in the committee's opinion, did not act in accordance with the due care criteria set out in section 2; or
 - b. if a situation occurs as referred to in section 12, last sentence, of the Burial and Cremation Act. The committee notifies the physician accordingly.
3. The time limit defined in the first subsection may be extended once for a maximum of six weeks. The committee notifies the physician accordingly.
4. The committee is empowered to explain its findings to the physician orally. This oral explanation may be provided at the request of the committee or the physician.

Section 10

The committee is obliged to provide the public prosecutor with all the information that he may request:

- 1° for the purpose of assessing the physician's conduct in a case as referred to in section 9, subsection 2; or
- 2° for the purposes of a criminal investigation.

Division 6: Procedures

Section 11

The committee is responsible for making a record of all reported cases of termination of life on request or assisted suicide. Our Ministers may lay down further rules on this point by ministerial order.

Section 12

The committee adopts its findings by a simple majority of votes.

The committee may adopt findings only if all its members have taken part in the vote.

Section 13

The chairs of the regional review committees meet at least twice a year in order to discuss the methods and operations of the committees. A representative of the Board of Procurators General and a representative of the Health Care Inspectorate of the Public Health Supervisory Service will be invited to attend these meetings.

Division 7: Confidentiality and disqualification

Section 14

The members and alternate members of the committee are obliged to maintain confidentiality with regard to all the information that comes to their attention in the course of their duties, unless they are required by a statutory regulation to disclose the information in question or unless the need to disclose the information in question is a logical consequence of their responsibilities.

Section 15

A member of the committee sitting to review a particular case must disqualify himself and may be challenged if there are any facts or circumstances which could jeopardise the impartiality of his judgment.

Section 16

Any member or alternate member or the secretary of the committee must refrain from giving any opinion on an intention expressed by a physician to terminate life on request or to provide assistance with suicide.

Division 8: Reporting requirements

Section 17

By 1 April of each year, the committee must submit to Our Ministers a report on its activities during the preceding calendar year. Our Ministers may lay down the format of such a report by ministerial order.

The report referred to in subsection 1 must state in any event:

- a. the number of cases of termination of life on request and assisted suicide of which the committee has been notified and which the committee has assessed;
- b. the nature of these cases;
- c. the committee's findings and its reasons.

Section 18

Each year, when they present their budgets to the States General, Our Ministers must report on the operation of the committees on the basis of the report referred to in section 17, subsection 1.

Section 19

1. On the recommendation of Our Ministers, rules will be laid down by order in council on:
 - a. the number of committees and their powers;
 - b. their locations.
2. Further rules may be laid down by Our Ministers by or pursuant to order in council with regard to:
 - a. the size and composition of the committees;
 - b. their working methods and reporting procedures.

CHAPTER IIIA. BONAIRE, ST EUSTATIUS AND SABA

Section 19a

This act also applies in the territories of the public bodies Bonaire, St Eustatius and Saba, in accordance with the provisions of this chapter.

Section 19b

1. For the purposes of:
 - section 1 (b), ‘article 294, paragraph 2, second sentence, of the Criminal Code’ is replaced by: ‘article 307, paragraph 2, second sentence, of the Criminal Code of Bonaire, St Eustatius and Saba’;
 - section 1 (f), ‘a regional review committee as referred to in section 3’ is replaced by: ‘a committee as referred to in section 19c’;
 - section 2, subsection 1, opening words, ‘article 293, paragraph 2, second sentence, of the Criminal Code’ is replaced by: ‘article 306, paragraph 2, second sentence, of the Criminal Code of Bonaire, St Eustatius and Saba’;
 - section 8, subsection 1, ‘section 7, subsection 2 of the Burial and Cremation Act’ is replaced by: ‘section 1, subsection 3 of the Death Certificates (Bonaire, St Eustatius and Saba) Act’;
 - section 8, subsection 3, ‘or the relevant care providers’ lapses’;
 - section 9, subsection 2, opening words, ‘the Board of Procurators General’ is replaced by ‘the Procurator General’.
2. Section 1 (e) does not apply.

Section 19c

Notwithstanding section 3, subsection 1, a committee will be appointed by Our Ministers that is competent to review reported cases of termination of life on request or assisted suicide as referred to in article 306, paragraph 2, and article 307, paragraph 2, second sentence, of the Criminal Code of Bonaire, St Eustatius and Saba.

Section 19d

The chair of the committee referred to in section 19c takes part in the meetings referred to in section 13. The Procurator General or a representative appointed by him and a representative of the Health Care Inspectorate also take part.

CRIMINAL CODE

Article 293

1. Anyone who terminates another person's life at that person's express and earnest request is liable to a term of imprisonment not exceeding twelve years or a fifth- category fine.
2. The act referred to in the first paragraph is not an offence if it is committed by a physician who fulfils the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies the municipal pathologist of this act in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act.

Article 294

1. Anyone who intentionally incites another to commit suicide is, if suicide follows, liable to a term of imprisonment not exceeding three years or to a fourth-category fine.
2. Anyone who intentionally assists another to commit suicide or provides him with the means to do so is, if suicide follows, liable to a term of imprisonment not exceeding three years or a fourth-category fine. Article 293, paragraph 2 applies *mutatis mutandis*.

BURIAL AND CREMATION ACT

Section 7

1. The person who conducted the post-mortem examination must issue a death certificate if he is satisfied that the death was due to natural causes.
2. If death was the result of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2, or article 294, paragraph 2, second sentence, of the Criminal Code respectively, the physician must not issue a death certificate and must immediately notify the municipal pathologist or one of the municipal pathologists of the cause of death by completing a report form. the physician must enclose with the form a detailed report on compliance with the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.
3. If the physician decides, in cases other than those referred to in subsection 2, that he is unable to issue a death certificate, he must immediately notify the municipal pathologist or one of the municipal pathologists accordingly by completing a report form.

