

Regional euthanasia review committees: 2008 annual report

Contents

Foreword

Chapter I Developments in 2008

 Notifications

 Due medical care

 Psychiatric problems

Chapter II Due care criteria: general

 Due care criteria: specific

 (a) Voluntary and well-considered request

 Advance directive

 (b) Unbearable suffering with no prospect of improvement

 Unbearable suffering in special cases

 Palliative sedation

 (c) Informing the patient

 (d) No reasonable alternative

 (e) Independent assessment

 (f) Due medical care

Chapter III Committee activities

 Statutory framework

 Role of the committees

Annexes

I Overview of notifications

 Overview of notifications: total

 Overview of notifications: region by region

 A. Groningen, Friesland and Drenthe region

 B. Overijssel, Gelderland, Utrecht and Flevoland region

- C. North Holland region
- D. South Holland and Zeeland region
- E. North Brabant and Limburg region

II The Termination of Life on Request and Assisted Suicide (Review Procedures) Act

Foreword

This is the 2008 annual report of the five regional euthanasia review committees, in which they account for their review of cases under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). In addition the committees normally publish all their findings (with identifying details removed) on www.euthanasiecommissie.nl. With due respect for privacy, these publications thus provide as clear a picture as possible of the requirements laid down in the Act regarding annual reports (details of the number of notifications, the nature of the notified cases, the findings and the considerations on which these are based).

In 2008, a total of 2,331 cases were notified. In ten cases the committees found that the physician had not acted in accordance with the due care criteria laid down in the Act. In all other cases they found that the criteria had been fulfilled. You will find further details in this report.

The number of notified cases was 10% higher than in 2007. There had been a similar increase between 2006 and 2007. The committees asked Dr Agnes van der Heide of the Social Health Care Department at the Erasmus University Medical Centre Rotterdam to investigate possible reasons for this trend, which has been apparent since 2003.

Dr van der Heide concluded that the increase has only involved termination of life on request, performed by general practitioners, mainly on cancer patients. This is the 'classic' category of cases in which most such procedures have always been performed. The researcher found two main likely reasons for the increase (separately and in combination):

- The Royal Dutch Medical Association's guidelines on palliative sedation have made the boundary between euthanasia and palliative sedation clearer. It now seems likely that palliative sedation is used as an alternative to euthanasia to a lesser extent than was previously assumed.
- The most recent national evaluation of the Act (conducted in 2005) estimated willingness to notify at 80%. The other 20% of cases mainly involved termination of life with the help of morphine. It seems likely that regular euthanatics are being used more and more often, and that these cases are also being notified. The rate of notification has increased as a result.

Although the committees agree with these findings, they are not entirely certain about them. The national evaluation should therefore be repeated, not only to explain the considerable increases in the number of notifications but also, more generally, to monitor closely how medical decisions at the end of life are reached in practice.

The committees greatly welcome any feedback you may wish to provide. On their behalf I invite you to send this to the email address below.

The Hague, April 2009

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Chapter I Developments in 2008

The following developments took place in 2008.

Notifications

In 2008, the regional euthanasia review committees ('the committees') received 2,331 notifications of termination of life on request or assisted suicide.¹ The 2007 figure had been 2,120; there was thus a 10% increase. In each case the committees examined whether the physician who had performed the procedure had acted in accordance with the due care criteria set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). In ten cases the committees found that the physician had not acted in accordance with the criteria. The most relevant elements of these findings are described in Chapter II (Due care criteria: specific) as cases under the criterion concerned. The actual findings (as well as all the findings in which the committees concluded that the physician had acted in accordance with the due care criteria) are published in full on the committees' website www.euthanasiecommissie.nl. Only those findings whose publication could jeopardise the patient's anonymity are not published.

Due medical care

In everyday practice the committees are confronted with the use of substances that are not listed as first-choice substances in the guidelines of the Royal Dutch Association for the Advancement of Pharmacy (KNMP) *Standaard Euthanatica* (Standard for euthanatics),² and with notifications in which the dosage of euthanatics used is not specified or is not in accordance with the Association's recommendations.

In assessing whether the due medical care criterion has been fulfilled, the committees carefully consider what is the current standard in medical and pharmaceutical research and practice. They normally take the method, use of substances and dosage recommended by the Association as their guide. *Standaard Euthanatica* also states which substances the KNMP does or does not recommend for use in cases of termination of life on request or assisted suicide.

The Pharmacy Research Institute, which is linked to the KNMP, confirms that the Association makes a distinction between first-choice and second-choice coma-inducing substances. The

¹ The figures – total and region by region – are given in an annexe to the full report.

² *Standaard Euthanatica: toepassing en bereiding* (Standard for euthanatics: application and preparation), 2007, KNMP/Pharmacy Research Institute (WINAP).

second-choice substances are listed in the advisory report under 'Emergency solutions'. These are substances with which physicians have less experience, but which can be used as alternatives to first-choice substances if necessary. The guidelines also list substances that are not alternatives to first-choice substances and substances that the Association specifically advises against.

If a physician does not use a first-choice substance, the committees will ask further questions. When assessing whether the due medical care criterion has been fulfilled, the basic principle is that emergency solutions (second-choice substances) are permitted if the physician provides sufficient grounds for having used them. The committees will therefore ask further questions if the physician fails to provide such grounds or uses substances that are not listed as alternatives or should not be used at all. If the dosage is not specified, the committees will also ask about it. If the dosage is not in accordance with the recommendations, the physician will be asked to explain why. If the method of administration is not indicated, the committees will also enquire about this.

Psychiatric problems

The committees received two notifications of assisted suicide involving patients with psychiatric problems. In both cases the committee found that the physician had acted in accordance with the due care criteria. In general, requests for termination of life or assisted suicide made by patients who are suffering because of a psychiatric illness or disorder should be treated with great caution. If there is a psychiatric background to the patient's condition, it is more difficult to decide whether the patient is suffering unbearably with no prospect of improvement and has made a voluntary and well-considered request. In all such cases the physician must be even more alert than usual.

Both notifications were well documented, and both cases had a long previous history which the physician clearly explained to the committee. A number of independent physicians and other experts, including several psychiatrists, were involved in the cases. After seeing and interviewing the patients, they gave their substantiated opinion on whether the due care criteria had been fulfilled. Both cases are included in this report.

Chapter II

Due care criteria

Due care criteria: general

The committees assess whether the notifying physician has acted in accordance with all the statutory due care criteria. These criteria, as laid down in the Act, are as follows.

Physicians must:

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

The information provided by notifying physicians is of crucial importance to the committees' assessments. If the physician gives an account of the entire decision-making process in his notification, he may not be required to answer further questions later on.

In 2008, most notifications again gave no grounds for further discussion or questions when they came before the committees. In almost every case the committees concluded that the physician had acted in accordance with the due care criteria. In some cases a notification led to discussion within the committee. Where necessary, the physician was asked to provide further information in writing or in person. This chapter includes examples of cases that led to further discussion and questions.

Due care criteria: specific

(a) Voluntary and well-considered request

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

The physician must be satisfied that the patient's request is voluntary and well-considered. Key elements in the contact between the physician and the patient include willingness to discuss the (possibly imminent) end of the patient's life, the patient's wishes, and ways in which they can or cannot be fulfilled. The patient's request must be specifically made to the physician.

A number of elements are crucial here. First, the request for termination of life or assisted suicide must have been made by the patient himself. Second, it must be voluntary. There are two aspects to this. The request must be *internally* voluntary, i.e. the patient must have the mental capacity to determine his own wishes freely, and *externally* voluntary, i.e. he must not have made his request under pressure or unacceptable influence from those around him. Third, in order to make a well-considered request, the patient must be fully informed and have a clear understanding of his disease. The patient is considered decisionally competent if he is capable of making an internally voluntary, well-considered request.

Psychiatric illness or disorders

In general, requests for termination of life or assisted suicide based on suffering arising from a psychiatric illness or disorder should be treated with great caution. If such a request is made by a psychiatric patient, even greater consideration must be given to the question of whether the request is voluntary and well-considered. A psychiatric illness or disorder may make it impossible for the patient to determine his own wishes freely. The physician must then determine whether the patient is decisionally competent. Among other things, he must look at whether the patient appears capable of grasping relevant information, understanding his condition and advancing consistent arguments. In such cases it is important to consult not only the independent physician but also one or more experts, including a psychiatrist, who can give an expert opinion on the matter. If other medical practitioners have been consulted, it is important to make this known to the committee.

Depression

If a patient is suffering from depression, it cannot be ruled out that this will adversely affect his decisional competence. Where there is any doubt, a psychiatrist is often consulted in

addition to the independent physician. The attending physician must thus ascertain, or obtain confirmation, that the patient is capable of making an informed decision. If other medical practitioners have been consulted, it is important to make this known to the committee. In some cases, after weighing everything up, a physician may decide neither to consult an additional medical practitioner, nor to call in for a second time one who has been consulted earlier. Such information is also of relevance to the committees' assessment.

Dementia

Some notifications concern termination of life on request or assisted suicide involving patients suffering from dementia. The cases notified in 2008 were found by the committees to have been handled with due care. The patients were in the initial stages of the disease and still had insight into the condition and its symptoms (loss of bearings and personality changes). They were deemed capable of making an informed decision because they could fully grasp the implications of their request.

The committees act on the principle that physicians should normally treat requests for termination of life from patients suffering from dementia with additional caution. They must take the stage of the disease and the other specific circumstances of the case into account when reaching a decision. Patients at a more advanced stage of the disease will rarely be decisionally competent. If a physician believes that a patient is in the initial stages of dementia, it is important to consult one or more experts in addition to the independent physician.

Apart from whether or not the request is voluntary and well-considered, the question of whether there is no prospect of improvement in the patient's suffering, and above all whether his suffering is unbearable (this is discussed in more detail on page), must be assessed by the physician with extreme care in all such cases. The committees' advice is that in such cases the physician must take additional care in reaching his decision and must make clear to the committee how it was reached.

Advance directive

The following needs to be said about advance directives. The Act requires the physician to be satisfied that the patient has made a voluntary and well-considered request. The request is almost always made during a conversation between the physician and the patient, and hence is made orally. What matters most is that the physician and the patient should be in no doubt about the patient's request.

The Act makes specific provision for a written directive. This replaces an oral request in cases where a patient who used to be decisionally competent is no longer capable of expressing his wishes when the time comes to consider ending his life.

The due care criteria likewise apply here, which is why it is so important that the physician to whom the request is made in a specific situation should be in no doubt regarding the advance directive. It is therefore advisable to draw up the directive in good time and update it at regular intervals and as far as possible describe the specific circumstances in which the patient wishes to have his life terminated. The clearer and more specific the directive is, the firmer the basis it provides for the physician's decision. The latter, as well as the independent physician, will have to decide in the light of both the described and the current situation whether the patient has made a voluntary and well-considered request, whether he is suffering unbearably with no prospect of improvement and whether he has no reasonable alternative. A handwritten directive drawn up by the patient in which he describes the circumstances in his own words often provides additional personal confirmation. In Case 11 the advance directive played a part in determining whether a patient who could no longer communicate had made a voluntary and well-considered request.

If, on the other hand, the patient is capable of expressing his wishes and can request that his life be terminated, an advance directive can help eliminate any uncertainty and confirm the oral request.

Contrary to popular belief, the Act does not require an advance directive to be drawn up. In practice, the existence of such a directive does make it easier to assess the case, but the committees wish to emphasise that it is not the intention that people be put under unnecessary pressure to draw up such a directive, sometimes very shortly before they die.

By recording details of any general discussion of a patient's wish for termination of life and the decision-making process concerning the end of his life in the patient's records, the physician can also help eliminate any uncertainty. This may, for example, be of help to locums and others involved in reaching a decision.

Case 1 (not included here)

Case 2 (not included here)

Case 3 (voluntary and well-considered request)

The patient was suffering from a psychiatric illness. In the interests of clarity the entire case is described below, including a discussion of whether the patient was suffering unbearably, with no prospect of improvement.

After a period of hospital admissions and outpatient treatment, the patient, a woman between 60 and 70 years of age, was admitted to an institution for psychiatric patients. She was suffering from a serious, chronic, therapy-resistant depressive disorder, and for many years had had recurrent, serious depressive episodes with suicidal tendencies. She had been extensively treated with electroconvulsive therapy (ECT) and a range of medicines. Light therapy and sleep deprivation had also been tried, as well as a number of psychotherapy sessions. According to current professional views on the treatment of depression, there were no alternative treatments left.

Besides regularly indicating her wish to commit suicide, from the end of 2007 onwards the patient repeatedly and specifically asked the physician to terminate her life. On several occasions the physician examined whether the patient realised what assisted suicide entailed and what the consequences would be for her and others, and was particularly alert to possible hesitation when certain issues were mentioned. When explicitly questioned, the patient always indicated that she had understood what had been discussed. She proved capable of discussing things in a differentiated manner. In early 2008, a neuropsychological examination was also carried out. Like the clinical impression, the examination revealed no evidence that the patient was incapable of understanding the implications of her request.

Her suffering entailed feelings of anxiety and gloom, as a result of which she had ceased to engage in social activities. She was no longer able to enjoy anything. She repeatedly stated that she did not want to continue living like this, and said several times that she was planning to commit suicide (she had already made one attempt) unless she could be 'helped'.

The physician was satisfied that there was no prospect of improvement in the patient's suffering. All the stages of the depression treatment protocol had been completed without there being any improvement in her condition. Her depressive mood was so prolonged and persistent that spontaneous recovery was unlikely. Even if this did occur there was a risk of relapse, just as there had been after her first ECT treatment: within six months she had been readmitted to hospital with new depressive symptoms that had started two months after the treatment.

The available medication could not be used effectively, either as a direct cure or as maintenance treatment, because of side effects which the patient found unbearable, including hypotension, hair loss and increased anxiety. She found these side effects very distressing, and this contributed to her sense of despair and hopelessness. Despite medication she continued to complain of unremitting anxiety and gloom.

The physician was satisfied that her suffering was unbearable. The patient was always consistent and specific in describing her symptoms, and he therefore took them seriously.

The physician called in a psychiatrist to obtain an expert second opinion. The psychiatrist knew the patient from previous outpatient and hospital treatments over a four-year period. He described her as someone whose suffering was visibly immense. Her ability to verbalise was normally developed. She was aware of her disease. Her mind was lucid, and it was possible to attract and maintain her attention.

Her mental orientation and powers of observation were normal. Her memory was in all respects more or less intact. Her concentration was slightly reduced. Her thought processes were sluggish, but formally coherent. Her specific thoughts were affected by her dejected mood, and there was an anxious, gloomy preoccupation with her illness and the associated suffering. She was not suffering from delusions.

The psychiatrist concluded that, although the patient was suffering from serious, therapy-resistant depression, she was decisionally competent and her request for assisted suicide had been voluntary and well-considered. Her wish to die had gradually become persistent, consistent and well-considered.

Although unbearable suffering in psychiatric patients is hard to determine objectively, the expert concluded that the patient's suffering was palpably unbearable. Part of what made it unbearable was that there was very little or no prospect of improvement. All attempts to resocialise the patient had failed. Despite her good relations with various members of her family and years of supportive therapy, she had proved quite unable to improve her poor quality of life. The expert concluded that she no longer had any alternatives left.

The physician consulted another expert, also a psychiatrist, on whether a third ECT treatment – something the patient was opposed to – would serve any purpose. The expert stated that little could be expected of this form of therapy.

The physician then consulted two independent physicians. The first, an independent psychiatrist, came to the same conclusions as the first psychiatrist regarding the patient's mind, orientation, memory, powers of observation and thinking, and agreed that she was decisionally competent and that her request for assisted suicide had been voluntary and well-considered. There were no delusions as a result of her mood disorder. Her wish to die was no longer primarily a symptom of vital depression, but a corollary of her decision that she did not want to continue living with this serious disorder. Her persistent requests for assisted suicide had begun in mid-2006. By that stage she was effectively no longer treatable, for the second ECT treatment, additional medication and supportive therapy had not had the desired effect. It was found that the patient had first made her voluntary, well-considered request for assisted suicide when it had become clear that her disorder was becoming chronic. The independent physician felt that she could sufficiently grasp the implications of her wishes and decisions. Despite her serious depression, she was still able to make a reasonable assessment of her situation. The independent physician considered her decisionally competent.

He found that there was no prospect of improvement in her suffering, owing to a serious, chronic, therapy-resistant depressive disorder from which she was unlikely to recover. There was no longer any alternative therapy available, for all the stages of the depression treatment protocol had been completed without there being any improvement in her condition. Improvement could no longer reasonably be expected. The patient could not see any future, since all attempts to improve her mood had failed. As a result of her total inability to adapt, she felt she no longer had any quality of life. The independent physician felt that her suffering was palpably unbearable. He concluded that the due care criteria had been fulfilled.

It was clear to the second of the independent physicians, who was a general practitioner and a SCEN physician, that the patient's request to be allowed to end her life was not something temporary. She felt she no longer had any quality of life. Her depression had persisted for many years, and her inability to enjoy life was palpable. The protracted nature of her illness and the severity of her suffering were an unbearable burden. The independent physician had found that the attending physicians, the independent experts and the patient herself no longer expected her to recover. There was no prospect of improvement in her suffering. An independent psychiatrist had found her decisionally competent. Of her own accord she had made a well-considered request for assisted suicide in order to end her unbearable suffering with no prospect of improvement. The second independent physician also concluded that the due care criteria had been fulfilled.

The committee concluded from the physician's excellent and very detailed report that the entire procedure had been very meticulous. There had been many preliminary stages before the assisted suicide took place. Two independent physicians, as well as other experts including several psychiatrists, had been involved in the case, and had given their substantiated opinion on whether the due care criteria had been fulfilled.

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

Case 4 (not included here)

(b) Unbearable suffering with no prospect of improvement

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

There is *no prospect of improvement* if the disease or condition that is causing the patient's suffering is incurable and even partial recovery, in which the symptoms are alleviated to such an extent that the suffering is no longer unbearable, is also impossible.

It is up to the physician to decide whether this is the case, in the light of the diagnosis and the prognosis. In answering the question of 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 places on the patient. In this sense, 'no prospect of improvement' refers to the disease or condition and its symptoms. Patients use equivalent terminology to indicate that the fact that there is no longer any prospect of improvement is unacceptable to them, and that they want their suffering to end. In that sense, this perception of the situation by the patient is part of what makes suffering unbearable.

It is harder to decide whether suffering is *unbearable*, for this is essentially an individual notion. Whether suffering is unbearable is determined by the patient's perception of the future, his physical and mental stamina, and his own personality. What is still bearable to one patient may be unbearable to another.

Notifications often describe unbearable suffering in terms of physical symptoms such as pain, nausea and shortness of breath – all based on the patient's own statements – and

feelings of exhaustion, increasing humiliation and dependence, and loss of dignity. As already indicated, perceptions of such symptoms and circumstances will differ, because they are linked to particular individuals.

The physician must find the patient's suffering to be palpably unbearable. The question here is not whether people in general or the physician himself would find suffering such as the patient's unbearable, but whether it is unbearable to the patient. The physician must therefore be able to empathise not only with the patient's situation, but also with the patient's point of view.

A crucial factor when the committees make their assessments is whether the physician is able to make clear that he found the patient's suffering to be palpably unbearable.

Unbearable suffering in special cases

Dementia

As already indicated in the section on voluntary and well-considered requests, requests for euthanasia made by patients suffering from dementia should normally be treated with great caution. The question of decisional competence has already been discussed.

Another key issue is whether dementia patients can be said to be suffering unbearably. What makes their suffering unbearable is often their awareness of the deterioration in their personality, functions and skills that is already taking place, coupled with the realisation that this will get worse and worse and will eventually lead to utter dependence and total loss of self. Already being aware of their disease and the prognosis may cause patients great and immediate suffering. In that sense, 'fear of future suffering' is a realistic assessment of the prospect of further deterioration. Here again, the specific circumstances of the case will determine whether the physician feels the patient's suffering to be palpably unbearable.

Psychiatric illness or disorder

The section on voluntary and well-considered requests describes the two notifications of assisted suicide involving patients with a history of psychiatric illness that were received by the committees. The committees were satisfied that these patients' suffering could not have been alleviated. Years of intensive treatment had made no difference. The likely results (which would probably have been minimal) would not have been in reasonable proportion to the burden that yet more treatment would have placed on them. The physicians had discussed things with the patients at length, and together they had concluded that there was

no reasonable alternative treatment left. There was no prospect of improvement in the patients' suffering. It was clear to the committees that the patients had found their suffering unbearable for some considerable time. In both cases the committees felt that, on the basis of the physician's professional medical and ethical insight and experience, after intensive, repeated interviews with the patient, he could reasonably conclude that the patient's suffering was unbearable.

Coma

Another key issue is whether comatose patients can be said to be suffering unbearably. The general medical opinion is that deeply comatose patients do not suffer and hence do not suffer unbearably. By way of comparison, if a patient is given palliative sedation during the terminal phase to relieve unbearable symptoms, the purpose of the treatment is to induce loss of consciousness so that the patient is no longer aware of suffering.

If a patient is in a shallow rather than a deep coma and still displays outward symptoms of suffering, the physician may indeed be satisfied that the patient is suffering unbearably. Despite this latitude for distinguishing between shallow and deep coma, the committees feel that physicians should adopt a cautious approach to termination of life in patients who can no longer communicate.

Cases involving comatose patients usually lead the committees to ask further questions. The committees then examine the specific facts and circumstances. In the light of these, a committee may still find in such cases that the physician has acted in accordance with the due care criteria.

Termination of life involving patients who can no longer communicate is sometimes complicated by the fact that the physician has already made promises to the patient without allowing for the possibility that the patient may go into a coma. If a physician has made such a promise and is later confronted with a sudden change in the situation whereby the patient is no longer suffering unbearably (for example, because the patient has gone into a spontaneous coma), the physician faces a dilemma, owing to the conflict between his promise to the patient and the fact that the unbearable suffering criterion is no longer fulfilled. In such cases, the patient's relatives may also remind the physician of his promise and insist that the procedure be carried out, making him feel he is under moral pressure to proceed. It is therefore advisable for physicians to refrain from making unqualified promises to patients and to point out the possibility that they may go into a coma, at which point the life-terminating procedure cannot normally be continued.

Palliative sedation

Palliative sedation means deliberate reduction of the patient's consciousness in order to eliminate untreatable suffering in the final stage of his life. Palliative sedation can only be considered if the patient is expected to die soon.³

The possibility of palliative sedation does not always rule out euthanasia. There are patients who expressly refuse palliative sedation and indicate that they wish to remain conscious to the very end.

(c) Informing the patient

Physicians must inform the patient about his situation and prognosis.

In assessing fulfilment of this criterion, the committees determine whether, and in what way, the physician has informed the patient about his disease and prognosis. In order to make a well-considered request, the patient must have a full understanding of his disease, the diagnosis, the prognosis and the possible forms of treatment.

It is the physician's responsibility to ensure that the patient is fully informed and to verify this. This criterion did not lead the committees to comment on any of the reported cases.

(d) No reasonable alternative

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

It must be clear that there is no realistic alternative way of alleviating the patient's suffering, and that termination of life on request or assisted suicide is the only way left to end that suffering. The focus is on treating and caring for the patient and on limiting and where possible eliminating the suffering, even if curative therapy is no longer possible or the patient no longer wants it. The emphasis in medical decisions at the end of life must be on providing satisfactory palliative care. However, this does not mean that the patient has to undergo every possible form of palliative care or other treatment. Even a patient who is suffering

³ See the Royal Dutch Medical Association's guidelines on palliative sedation (revised in 2009).

unbearably with no prospect of improvement can refuse palliative care or other treatment. Refusal of treatment is an important subject of discussion between physicians and patients.

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

There are also patients who refuse an increased dose of morphine because of a fear of becoming drowsy or losing consciousness. The physician must then ensure that the patient is properly informed and discuss with him whether this fear is justified, for such feelings of drowsiness and confusion often pass quickly.

If the physician and the patient then reach a joint decision, the physician will be expected to indicate in his report to the committee why other alternatives were not deemed reasonable or acceptable in this specific case.

In practice, this due care criterion did not raise any problems.

(e) Independent assessment

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

The physician is legally required to consult a second, independent physician who will give an independent expert opinion on whether the due care criteria (a) to (d) have been fulfilled before the termination of life on request or the assisted suicide takes place, and draw up a written report. The purpose of this is to ensure that the decision is reached as carefully as possible. The independent physician sees the patient to determine whether the physician who intends to perform the procedure has not overlooked anything regarding the due care criteria. This consultation must be formal, and specific questions must be answered. The committees interpret the term 'consult' to mean considering the independent physician's findings and taking coherent account of them when deciding whether to grant the patient's request for termination of life.

In Case 7 no such consultation took place, as the physician terminated the patient's life before considering the independent physician's findings. The same happened in Case 10.

In Case 9 an attending locum had stated that he believed the due care criteria had been fulfilled. He did so during a conversation about the patient's condition and possible treatment, so this could not be considered as consultation with a second, independent physician. In this case, as in Cases 7 and 10 above, the committee found that the physician had not acted in accordance with the due care criteria.

The second physician must be independent of the attending physician and the patient. In the case of the physician this means, for example, that there is no family or working relationship between the two physicians. Nor may they be members of the same group practice.

In reality, the committees are confronted with a number of different arrangements in which general practitioners work under the same roof. They are not members of a group practice who care for patients jointly, but they do share facilities; for example, they may rent the same premises, share computer systems or share electronic patient files. It is not easy to decide beforehand which particular arrangements will jeopardise a physician's independence, for such information is not usually available in advance. In cases of doubt, the committees will therefore always ask further questions when the attending physician and the independent physician are involved in the same such working arrangement.

The physician's independence may also appear open to question if the same two medical practitioners very often act as independent physicians on each other's behalf, thus effectively acting in tandem. This may create an undesirable situation, for their independence may then – rightly – be called into question. The committees feel that, if a physician always consults the same independent physician, the latter's independence can easily be jeopardised. It is vital to avoid anything that may suggest the physician is not independent.

A notifying physician and an independent physician may also know each other privately, or as members of a peer supervision group. The fact that they know each other privately does not automatically rule out an independent assessment, but it does call the physician's independence into question. The fact that they know each other as members of a peer supervision group – a professional activity – need not call the physician's independence into question; whether it rules out an independent assessment will depend on how the group is organised. What matters is that the notifying physician and independent physician should be aware of this and make it clear to the committee how they reached an opinion on the matter.

In the case of the patient there must, among other things, be no family relationship or friendship between them, the physician must not be helping to treat him (and must not have done so in the past) and he must not have come into contact with him in the capacity of locum. In Case 5 the physician's independence was jeopardised because he was the patient's general practitioner. In this case the committee found that he did not qualify as an independent physician. In Cases 9 and 11 an attending physician was likewise consulted as an independent physician. In Case 8 the 'independent' physician did not qualify as such in relation to the patient, for she was involved in the patient's treatment as an advisor on palliative care and had already formed an opinion on the situation as if she were being consulted as an independent physician in connection with a request for termination of life prior to the actual request for an independent opinion.

Not only is the independence requirement set out in so many words in section 2, subsection 1 (e) of the Act, but at various points during the preparatory work on the Act it was explicitly stated that a physician who is thinking about terminating a patient's life must consult an independent physician.

The Royal Dutch Medical Association's 2003 Position Paper on Euthanasia also explicitly stated (p. 15) that the physician's independence must be guaranteed. According to the KNMG, this implied that a member of the same group practice, a registrar, a relative or a physician who was otherwise in a position of dependence in relation to the physician who called him in could not normally be deemed independent. The need to avoid anything that might suggest the physician was not independent was once again emphasised.

The independent physician's report is of great importance when assessing notifications.⁴ A report describing the patient's situation when seen by the physician and the way in which the patient talks about his situation and his wishes will give the committees a clearer picture.

The independent physician must give his opinion on whether the due care criteria set out in (a) to (d) have been fulfilled. He should also specifically mention his relationship to the attending physician and the patient.

The independent physician is responsible for his own report. However, the attending physician bears final responsibility for performing the life-terminating procedure and for fulfilling all the due care criteria. He must therefore determine whether the independent

⁴ The checklist for reporting by independent physicians on euthanasia and assisted suicide can be used as a guide (see www.euthanasiecommissie.nl).

physician's report is of sufficient quality and whether the independent physician has given his opinion as to whether the due care criteria set out in (a) to (d) have been fulfilled. If necessary, he must ask the independent physician further questions.

Sometimes an independent physician concludes on seeing the patient that one of the due care criteria has not yet been fulfilled. In such cases, it was not always clear to the committees what exactly happened after that, so that further questions had to be put to the notifying physician. If the independent physician is called in at an early stage and finds that the patient is not yet suffering unbearably or that a specific request for euthanasia has not yet been made, he will usually have to see the patient a second time.

If he has indicated that the patient's suffering will very soon become unbearable and has specified what he believes that suffering will entail, a second visit will not normally be necessary, but it may still be advisable for the two physicians to consult by telephone or in some other manner. If a longer period of time is involved or if the prognosis is less predictable, the independent physician will normally have to visit the patient a second time. This was the situation in Case 6. The committee found that consultation with a second independent physician could not be deemed to have taken place, since the consultation had taken place five months before the life-terminating procedure was performed. The patient's situation had stabilised after the consultation and then remained bearable for some time, creating a new situation that called for additional consultation after the patient had expressly requested euthanasia. The attending physician should therefore have been aware of the need to consult an independent physician once again when preparing to perform the life-terminating procedure five months later. The committee took account of the general assumption, in connection with euthanasia, that reports by independent physicians remain valid only for a limited period of time, and certainly not for five months. The committee found that the physician had not acted in accordance with the due care criteria.

If there has been further consultation between the attending physician and the independent physician, or if the independent physician has seen the patient a second time, it is important that this be mentioned in the notification.

If there is a difference of opinion between the two physicians, the attending physician must ultimately reach his own decision (even if he takes extensive account of the independent physician's findings), for it is his own actions that the committees will be assessing.

The Euthanasia in the Netherlands Support and Assessment Project (SCEN) trains physicians to make independent assessments in such cases. In most cases it is such 'SCEN physicians' who are called in as independent physicians. SCEN physicians also have a part to play in providing support, for example by giving advice.

Case 5 (independent assessment)

Findings: due care criteria not fulfilled

The 'independent physician' was the patient's own general practitioner. As her attending physician, he could not be deemed independent of her. The claim by the physician who performed the procedure that he should be considered as the independent physician was rejected by the committee, for the physician who performs the procedure cannot also act as the independent physician. The committee found that the physician had not acted in accordance with the due care criteria.

A woman between 70 and 80 years of age presented with abdominal symptoms and was diagnosed with sigmoid carcinoma, with secondaries in the liver. She was given chemotherapy. After a few months her disease had progressed and secondaries were found in the bones. She was suffering unbearably, with no prospect of improvement. On several occasions she discussed euthanasia with her general practitioner. Five days before the life-terminating procedure was performed, she made her first specific request for euthanasia to the general practitioner. He had religious or other objections to performing euthanasia. Since he was satisfied that all the due care criteria had been fulfilled, he had asked a physician in the same group of general practitioners to perform the procedure. The latter physician had contacted the patient by telephone two days before the procedure was performed, had visited her at home a day later and had discussed in detail her wish to have her life terminated with her and her husband. The physician concluded that the due care criteria had been fulfilled.

He then asked the general practitioner to act as the independent physician. They both believed they were thus acting in the spirit of the Act, for they both believed that the physician who performed the procedure could be deemed independent and that the general practitioner could be seen as the one who had a long-term therapeutic relationship with the patient. Five days before the patient's life was terminated, the general practitioner had talked to her and her husband at length, and had drawn up a report on this conversation. He concluded that the due care criteria had been fulfilled.

The committee found that consultation with a second independent physician within the meaning of the Act could not be deemed to have taken place, for the physician who performed the assisted suicide procedure could not also act as the independent physician. The committee rejected the physician's claim that the due care criteria set out in the Act had effectively been fulfilled in the sense that he should be seen as the independent physician. In the committee's view, Section 2, subsection 1 (e) of the Act could only be interpreted to mean that a physician who is considering granting a request for assisted suicide must consult at least one other, independent physician. That had not been done in this case. The committee found that the physician had not acted in accordance with the due care criteria.

The case was referred to the Board of Procurators General and the Healthcare Inspectorate. The Board decided not to prosecute. After an interview with both physicians, the Healthcare Inspectorate closed the case.

Case 6 (independent assessment)

Findings: due care criteria not fulfilled

The procedure was performed five months after the independent assessment. The patient's situation had stabilised after the consultation and then remained bearable for some time, creating a new situation that called for additional consultation after the patient had expressly requested euthanasia. The attending physician should therefore have consulted an independent physician once again.

A woman between 60 and 70 years of age was diagnosed with metastasised breast cancer. There was no prospect of cure, and her condition gradually deteriorated. She was suffering unbearably, with no prospect of improvement, and had requested her physician to terminate her life. The physician called in a fellow general practitioner, who was also a SCEN physician, as an independent physician. The independent physician visited the patient five months before the life-terminating procedure was performed. He found that the patient's suffering would soon become palpably unbearable. In his report, he concluded that the due care criteria had been fulfilled.

The committee noted that the independent physician's report was five months old, whereas it is generally assumed, in connection with euthanasia, that reports by independent physicians remain valid only for a limited period of time, and certainly not for five months. Furthermore,

the independent physician had not found that the patient was suffering unbearably, but only that her suffering would soon become unbearable; yet he had concluded that the due care criteria had been fulfilled. The committee felt that this had misled the attending physician. The committee therefore invited both physicians for a personal interview.

The committee found that consultation with a second independent physician could not be deemed to have taken place in this case, since the consultation had taken place five months before the life-terminating procedure was performed and, although the independent physician's report had stated that the due care criteria had been fulfilled, it had only indicated that the patient's suffering would *soon* be palpably unbearable. In the committee's view, the physician should have realised, given the progress of the disease after the consultation, that the independent physician's statement that the patient's suffering would soon become bearable was simply an educated guess and was not borne out by the actual progress of the disease. The patient's situation had stabilised after the consultation and then remained bearable for some time, creating a new situation that called for additional consultation after the patient had expressly requested euthanasia. The attending physician should therefore have been aware of the need to consult an independent physician once again when preparing to perform the life-terminating procedure five months later. In failing to do so, he had not, in the committee's opinion, fulfilled the due care criteria.

The case was referred to the Board of Procurators General and the Healthcare Inspectorate. The Board decided not to prosecute. After an interview with the physician, the Healthcare Inspectorate closed the case.

Case 7 (independent assessment)

Findings: due care criteria not fulfilled

The physician had terminated the patient's life on request before being able to consider the findings of the independent physician he had called in. The committee found that consultation with a second, independent physician had not taken place, and concluded that the due care criteria had not been fulfilled.

A man over 90 years of age had a growing, incurable eye tumour. The attending physician consulted an independent specialist who was also a SCEN physician. The latter found that the due care criteria had been fulfilled. The notification had caused the committee to ask a number of questions. The committee gathered from the notification that the attending

physician had been unable to wait for the results of the consultation, and wondered when exactly the independent physician had made her report to the attending physician about her findings and conclusion. The committee also noted that the independent physician had dated her report on the same day as the procedure but had not faxed it to the attending physician until two days later. This caused the committee to wonder just how independent she had felt when writing her report. Both physicians were invited for a personal interview.

In the light of the facts and circumstances of the case, the committee considered the following issues. As far as the committee is concerned, 'consulting' a second, independent physician means *considering the independent physician's findings* and taking coherent account of them in assessing the patient's request that his life be terminated.

In the committee's view, consultation with a second, independent physician had not taken place in the sense just referred to, since the attending physician had terminated the patient's life before considering the independent physician's findings.

The attending physician had not communicated personally with the independent physician. He had let his successor make all the necessary contacts and had not been in touch with the independent physician, orally or otherwise, to discuss her findings.

In the committee's opinion, the attending physician had thus relied on his own assessments, and, in choosing not to consider the second opinion, had ruled out any possibility of reflecting (through consultation) on his actions. In performing the life-terminating procedure on the basis of his own assessments, without considering the independent physician's findings, the attending physician had not, in the committee's opinion, fulfilled the due care criteria.

The case was referred to the Board of Procurators General and the Healthcare Inspectorate. The Board decided not to prosecute. After an interview with the physician, the Healthcare Inspectorate closed the case.

Case 8 (not included here)

Case 9 (not included here)

Case 10 (not included here)

Case 11 (independent assessment)

Findings: due care criteria not fulfilled

The independent physician was a specialist who was treating the patient. The attending physician had not been sufficiently aware that the Act required the independent physician to be truly independent, and she had felt that an independent consultation would not be sufficiently helpful and would not be necessary, as the patient's situation clearly matched the description of unbearable suffering as set out in his advance directive.

At the end of June 2008, a man between 80 and 90 years of age suffered a serious ischaemic CVA in the left hemisphere as a complication during by-pass surgery (CABG) after a previous heart attack. This led to acute hemiparesis on the right-hand side of the body, as well as severe aphasia. The patient's clinical situation did not improve in the weeks that followed. He developed Cheyne-Stokes respiration. A CT scan revealed a major haemorrhagic infarct in the area of the middle cerebral artery, with no prospect of cure. The patient was suffering unbearably because of his total dependence on others for activities of daily living (ADL) and his inability to speak.

In late May 2008 the patient had a number of lengthy conversations with the attending physician about his wish for euthanasia if his suffering became unbearable. The physician had advised him to draw up an advance directive, so that the physician could use it as a basis for action if the patient himself were no longer able to make his own request. Among other things, the patient's directive indicated that he wanted euthanasia if invalidity were to leave him in a state of total dependence. Four days before he died, in the presence of his wife and daughter, the patient had specifically asked the physician, by nodding or shaking his head, to terminate his life. Two days before the patient died, he could no longer respond to questions from the physician and the attending specialist who had been consulted.

Two days before the weekend, after examining the advance directive, the physician had telephoned SCEN. She was told she would not be phoned back until after the weekend. She then decided to consult a specialist who was also attending the patient. In response to a question from the committee, she replied that she had not been sufficiently aware that the Act required the independent physician to be truly independent. She had felt that an independent consultation would not be sufficiently helpful and would not be necessary, as the patient's situation clearly matched the description of unbearable suffering as set out in his advance directive, which stated that he did not wish to continue living if he became totally

ADL-dependent. Furthermore, the patient was by then largely incapable of communicating, and would therefore be unable to confirm his wish for euthanasia to a SCEN physician.

The specialist consulted by the physician visited the patient two days before his life was terminated. The specialist found that the patient was suffering unbearably, with no prospect of improvement, because of his total dependence and his inability to speak. He did not observe the patient repeating his wish for euthanasia. The specialist arranged for an MRI scan, which confirmed that there was no prospect of improvement in the patient's situation.

After extensive consultation with the physician, the patient's family and the nursing staff, it was agreed that, in view of the patient's negative prognosis, the physician would perform the euthanasia procedure.

The committee found that the physician could be satisfied that the patient had made a voluntary, well-considered request. It bore in mind that his advance directive had clearly indicated that he wanted euthanasia if invalidity were to leave him in a state of total dependence. Four days before he had died, he had also made his wish for euthanasia clear to the physician. The committee also found that the physician could be satisfied that the patient was suffering unbearably, with no prospect of improvement. In an extensive conversation with the physician, and in his advance directive, he had made clear what unbearable suffering would entail as far as he was concerned. Although shortly before his death he could no longer express the unbearable nature of his suffering, it was clear to the physician that the patient was in a situation that he had described as unbearable suffering and now perceived as such.

The committee found that the independent assessment criterion had not been fulfilled. It noted that the physician had deliberately consulted a specialist who was attending the patient. She had not wanted to call in a SCEN physician, as this would take more time. Nor had she considered any other form of independent assessment. She stated that she had not been sufficiently aware that the Act required the independent physician to be truly independent. The committee took the view that she should have been aware of the importance of independent assessment in cases of euthanasia. It noted that the specialist consulted in connection with termination of life on request could not be deemed independent, as he was attending the patient.

The committee found that the physician had not acted in accordance with the due care criteria.

The case was referred to the Board of Procurators General and the Healthcare Inspectorate. Neither body has so far responded.

(f) Due medical care

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

Termination of life on request or assisted suicide is normally carried out using the method, substances and dosage recommended in the *Standaard Euthanatica* (2007), the guidelines drawn up by the KNMP.⁵ In cases of termination of life on request, the report recommends intravenous administration of a coma-inducing substance, followed by intravenous administration of a muscle relaxant. In the guidelines, the KNMP indicates which substances should be used to terminate life on request, and also which ones should not be used. It makes a distinction here between 'first-choice'⁶ and 'second-choice'⁷ substances. Physicians have less experience with the latter category of substances, which are also less discriminating. The KNMP also lists substances that are not alternatives to first-choice substances and substances that should not be used at all.

If a physician does not use a first-choice substance, the committees will ask him further questions. When assessing whether the due medical care criterion has been fulfilled, the committees act on the principle that emergency solutions (second-choice substances) are permitted, provided that the physician gives sufficient grounds for having used them. The committees will therefore ask further questions if the physician fails to give sufficient grounds for using emergency solutions, or uses substances that are not listed as alternatives or should not be used at all.

The use of non-recommended substances may have negative consequences for both the patient and any relatives who are present. This can be avoided by using the appropriate substances.

⁵ *Standaard Euthanatica: toepassing en bereiding* ('Standard for euthanatics: application and preparation'), 2007.

⁶ As listed in the table on page 22 of *Standaard Euthanatica*.

⁷ As listed on page 26 of *Standaard Euthanatica*.

The committees note that Dormicum is sometimes used as pre-medication before euthanasia is performed. The prescribed coma-inducing substances are also administered in such cases. There is then no objection to the use of Dormicum or similar substances as pre-medication. Before performing euthanasia, physicians are advised to discuss with the patient and his relatives what effect the substances will have. Subject to the constraints imposed by the KNMP's recommendations in *Standaard Euthanatica*, it is important to fulfil patients' personal wishes.

Standaard Euthanatica also states which dosages the KNMP recommends for termination of life on request and assisted suicide. The committees will ask the physician further questions if the dosage is not mentioned or differs from the dosage indicated in *Standaard Euthanatica*. If the method of administration is not mentioned, the committees will also enquire about this.

There must be a guarantee that a patient is in a deep coma when the muscle relaxant is administered. The dosage of the coma-inducing substance is crucial in order to ensure that the patient cannot perceive the effects of the muscle relaxant. In cases 12 and 13 the physicians used a lower dosage than recommended in *Standaard Euthanatica*. In both cases they had taken advice from a pharmacist. The committee noted that it is the physician who bears responsibility for performing the life-terminating procedure with due care. In both cases it was found that the physician had not acted in accordance with the due care criteria, for owing to the low dosage used there was no guarantee that the patients were in a deep coma when the muscle relaxant was administered.

In the case of euthanasia, i.e. termination of life on request, the physician actively terminates the patient's life by administering the euthanatics to the patient intravenously. In the case of assisted suicide, the physician gives the euthanatic to the patient, who ingests it himself. The physician must remain with the patient until the patient is dead. This is because there may be complications; for example, the patient may vomit the potion back up. In that case the physician may perform euthanasia.

Nor may the physician leave the patient alone with the euthanatics. This may be hazardous, including to people other than the patient.

In practice, physicians are occasionally uncertain about their role in performing the euthanasia procedure. For example, if a case of euthanasia is reported by a physician who

did not actually perform the procedure, the physician who performed the procedure must also sign the notification and will be deemed by the committees to be the notifying physician.⁸

Case 12 (Due medical care)

Findings: due care criteria not fulfilled

The physician had used a coma-inducing substance that was not one of those recommended by the KNMP. Since there was no guarantee that the patient was in a deep coma from the moment when the muscle relaxant was administered until she died, the committee concluded that the due medical care criterion had not been fulfilled.

In this case the physician had terminated the patient's life by intravenous administration of 500 mg of Nesdonal in 20 ml of 0.9% NaCl and 75 mg of Tracrium. In response to further questions asked by the committee, the physician stated that he had opted for this dosage in consultation with an anaesthetist. They did not consider it advisable to administer the coma-inducing substance in a single 2000 mg dose, as recommended by the KNMP. According to the anaesthetist, a quadruple dose of thiopental was excessive. The physician felt that he could rely on the anaesthetist's extensive experience.

The intravenous drip was turned on at a high flow rate. After three minutes the patient lost consciousness, and after eight minutes she was in a deep coma. The Tracrium drip was turned on immediately afterwards. The patient died five minutes later. The physician stated that he had checked whether the patient was in a coma by administering a pain stimulus. He stated that he had not observed the patient to be no longer comatose when the Tracrium was administered, but that he could not prove that she really had remained in a coma.

The committee noted the fact that the patient's muscles were paralysed after the administration of Tracrium, so that she was incapable of any response. Because of that, there was no way of knowing whether she was in a coma or not. Given the low dose of thiopental, there was no guarantee that she had remained in a coma from the moment when the muscle relaxant was administered until she died.

⁸ See Article 3, paragraph 1 of the guidelines on the working procedures of the regional euthanasia review committees, adopted on 21 November 2006.

The committee found that, in administering a dose of 500 mg of Nesdonal to induce the coma, the physician had taken the risk that the patient might not be comatose at some point between the administration of the muscle relaxant and her death. Even if the physician had felt he could rely on the anaesthetist's advice, he himself was responsible for performing the life-terminating and assisted suicide procedure with due care.

Standaard Euthanatica recommends the use of a 2000 mg dose of thiopental as a coma-inducing substance. This dosage has been changed since the previous (1998) version of the Society's report, as the 1500 mg dose recommended in that report has proved too low in some cases.

The committee endorses the need for a guarantee that a patient cannot awake from his coma and perceive the effects of the subsequently administered muscle relaxant, and therefore considers the dosage of the coma-inducing substance crucial.

The committee found that the physician had not acted in accordance with the due care criteria.

The case was referred to the Board of Procurators General and the Healthcare Inspectorate. Neither body has so far responded.

Case 13 (not included here)

Case 14 (not included here)

Chapter III

Committee activities

Statutory framework

Termination of life on request and assisted suicide are criminal offences in the Netherlands (Articles 293 and 294 of the Criminal Code). The only exception is when the procedure is performed by a physician who has fulfilled the statutory due care criteria and has notified the municipal pathologist. If the physician satisfies both conditions, the procedure he has performed is not treated as a criminal offence. The aforementioned articles of the Criminal Code identify them as specific grounds for exemption from criminal liability. The due care criteria are set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'), and the physician's duty to notify the municipal pathologist is dealt with in the Burial and Cremation Act.

The Act also states that it is the task of the regional euthanasia review committees to determine, in the light of the physician's report and other documents accompanying the notification, whether a physician who has terminated a patient's life on request or assisted in his suicide has fulfilled the due care criteria referred to in Section 2 of the Act.

Termination of life on request means that the physician administers the euthanatics to the patient. Assisted suicide means that the physician supplies the euthanatics to the patient, who ingests them himself.

Role of the committees

When a physician has terminated the life of a patient on request, or assisted in his suicide, he notifies the municipal pathologist. When doing so, he submits a detailed report showing that he has complied with the due care criteria.⁹ The pathologist performs an external examination and ascertains how the patient died and what substances were used to terminate his life. He then establishes whether the physician's report is complete. The report by the independent physician and, if applicable, an advance directive drawn up by the deceased are added to the file.

The pathologist notifies the committee, submitting all the required documents and any other relevant documents provided by the physician, such as the patient's medical file and letters

⁹ A standard report form is available as an aid in drawing up the report. It can be filled in as it stands or used as a guide, and can be found at www.euthanasiecommissie.nl

from specialists. Once the committee has received the documents, both the pathologist and the physician are sent an acknowledgement of receipt.

The committees assess whether the physician has acted in accordance with the statutory due care criteria. If a committee has any questions following a notification, the physician in question will be informed. Physicians are often asked to respond in writing to additional questions.¹⁰ The committees sometimes contact physicians by telephone if they need extra information. If the information thus provided by the physician is insufficient, he may then be invited to provide further information in person. This gives him an opportunity to explain in more detail what took place in this particular case.

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

The committees issue their findings on the notifications they assess. In almost every case they conclude that the physician has acted in accordance with the statutory due care criteria. In such cases, only the notifying physician is informed.

In 2008, ten physicians were found not to have acted in accordance with the criteria. In such cases, the findings are not only sent to the notifying physician, but are also referred to the Board of Procurators General and the Healthcare Inspectorate. The Board decides whether or not the physician in question should be prosecuted. The Inspectorate decides in the light of its own tasks and responsibilities whether any further action should be taken. This may range from interviewing the physician to disciplinary action. The committees hold consultations with the Board and the Inspectorate every year.

There are five regional euthanasia review committees. The place of death determines which committee is competent to assess the case in question. Each committee comprises three members: a lawyer, who is also the chair, a physician and an ethicist. They each have an alternate. Each committee also has a secretary, who is also a lawyer, with an advisory vote at committee meetings. The committees act as committees of experts. The secretariats are responsible for assisting the committees in their work. For organisational purposes the secretariats form part of the Central Information Unit on Healthcare Professions (CIBG) in The Hague, which is an executive organisation of the Ministry of Health, Welfare and Sport.

¹⁰ In 2005, according to the evaluation of the Act, this happened in some 6% of notified cases.

The secretariats have offices in Groningen, Arnhem and The Hague, and the committees meet there every month.

The committees help the Euthanasia in the Netherlands Support and Assessment Project (SCEN) train physicians to perform independent assessments.

The committees see all the reports by the independent physicians consulted by the notifying physicians, and they alone have an overall picture of the quality of these reports. The quality of reporting needs to be constantly monitored. The committees' general findings are forwarded to SCEN each year.

Committee members also give presentations to municipal health services, associations of general practitioners, hospitals, foreign delegations and so on, using examples from practice to provide information on applicable procedures and the due care criteria.

Annexe I

Overview of notifications: total

1 January 2008 to 31 December 2008

Notifications

The committee received 2,331 notifications in the year under review.

Euthanasia and assisted suicide

There were 2,146 cases of euthanasia, 152 cases of assisted suicide and 33 cases involving a combination of the two.

Physicians

In 2,083 cases the notifying physician was a general practitioner, in 152 cases a medical specialist working in a hospital, in 91 cases a physician working in a nursing home and in 5 cases a physician being trained as a specialist.

Conditions involved

The conditions involved were as follows:

Cancer	1,893
Cardiovascular disease	62
Neurological disorders	117
Other conditions	145
Combination of conditions	114

Location

In 1,851 cases patients died at home, in 145 cases in hospital, in 87 cases in a nursing home, in 111 cases in a care home and in 137 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. In the year under review there were ten cases in which the physician was found not to have acted in accordance with the due care criteria.

Length of assessment period

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