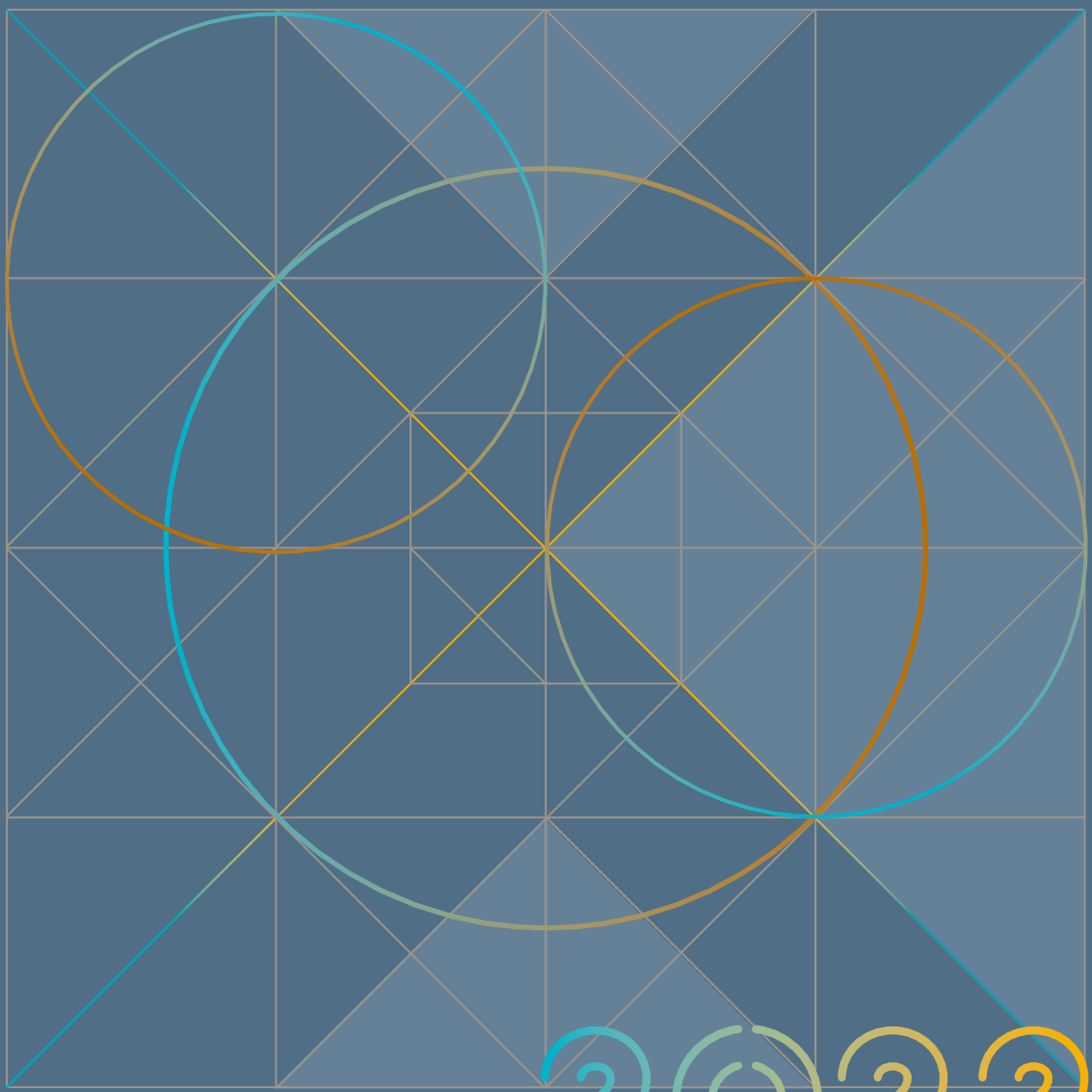
RTE

REGIONAL EUTHANASIA REVIEW COMMITTEES



ANNUAL REPORT 2022

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CHAPTER 2 CASES

FOREWORD

The increase in the number of notifications of euthanasia[1] is the most striking aspect of the figures in this annual report. In 2022 the Regional Euthanasia Review Committees (RTEs) received 8,720 notifications, an increase of 13.7% compared to the previous year. This is 5.1% of the total number of deaths in 2022, compared to 4.6% in 2021. This upward trend, in both the absolute and relative numbers, has been visible for a number of years.

Since no academic research has been conducted into the causes of this increase, it is impossible to make any substantiated predictions about how the number of euthanasia cases will develop in the Netherlands. However, there are no indications that this trend will change in the coming years.

The steady rise in the number of notifications is reflected in the RTEs' gradually increasing workload, which was very heavy in 2022. As a result the average amount of time taken to deal with a notification rose by 6% to 34 days. No further, meaningful efficiency gains are possible within the parameters of the review methods as laid down by law. In 2023, the RTEs therefore intend to expand the number of committee members.

In 2022, the RTEs found in 13 cases that the physician did not act in accordance with the due care criteria. While that is more than the seven cases in 2021 in which the RTEs came to the same conclusion, as a percentage of the total number of notifications (0.15%), it remains so low that it can be concluded once again without any doubt that in the Netherlands the procedures relating to euthanasia are carried out with great care. This annual report describes 10 cases in which the RTEs concluded that the due care criteria had not been fulfilled. The RTEs will also actively draw attention to these cases among the physicians who are most often involved in performing euthanasia, in the hope that the number of such cases will decline again in 2023.

It is worth noting that in nearly all of these cases, the finding that the due care criteria had not been fulfilled could probably have been avoided if the physicians – and the independent physicians – had been more familiar with the relevant sections of the Euthanasia Code. The RTEs developed the Euthanasia Code as a practical guide for physicians, to give

1 *In this annual report, termination of life on request and assisted suicide are jointly referred to as euthanasia.*

them prior insight into the way in which the RTEs interpret the statutory due care criteria.

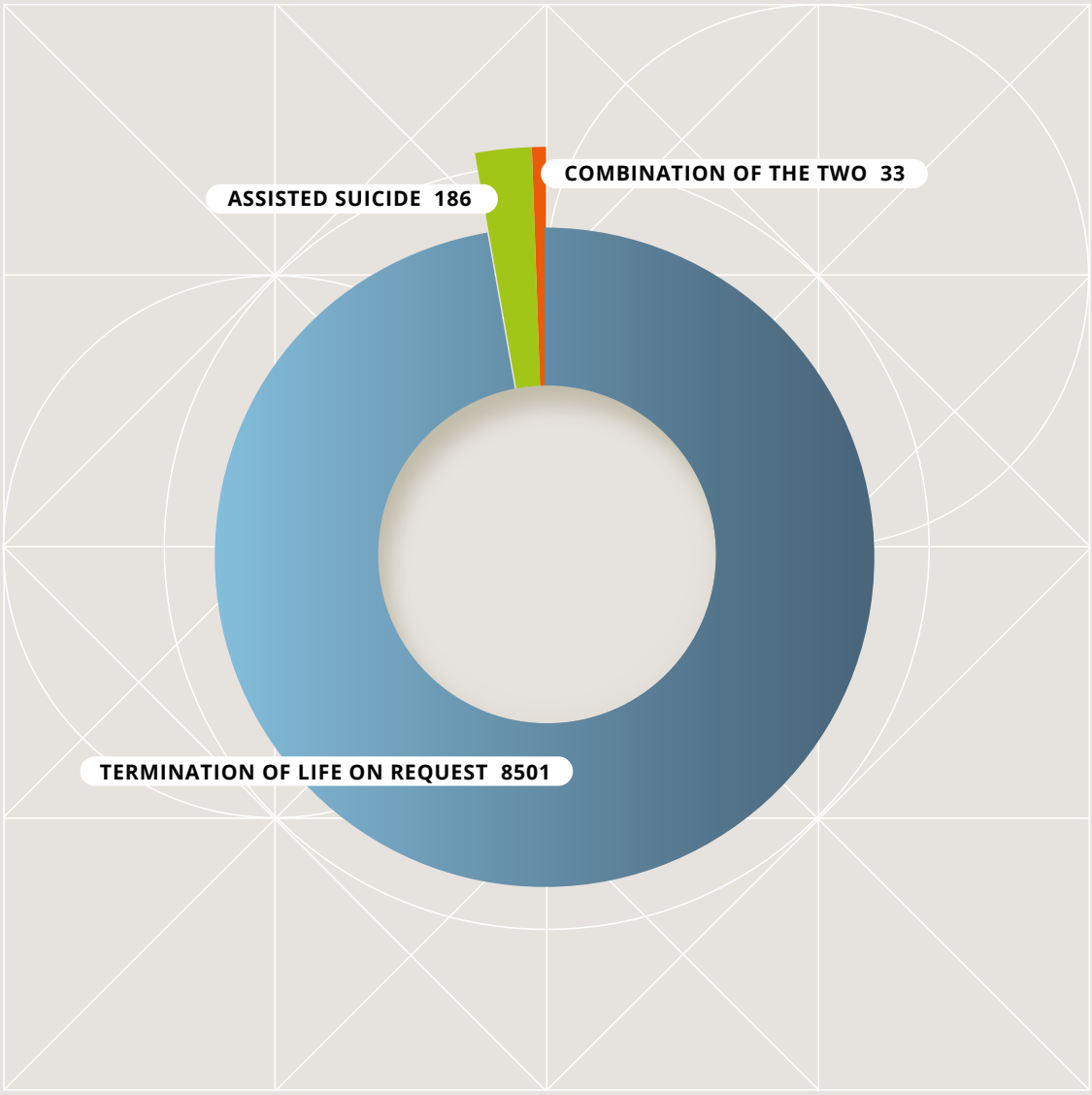
The way in which the norms laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act') are implemented may change as a result of shifting social attitudes. And even after 20 years, new and unexpected situations arise in the cases under review. That means the Euthanasia Code must be updated regularly. The most recent update was completed in July 2022 and the Euthanasia Code 2022 has been distributed widely.

This year the RTEs again received effective support from the Ministry of Health, Welfare and Sport – in particular the Disciplinary Boards and Review Committees (Secretariats) Unit. We are particularly proud of the introduction of a new digital system for review and registration. Thanks to concerted efforts, a reliable system was developed and implemented smoothly – on schedule and within budget.

The year 2022 marked the 20th anniversary of the entry into force of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, legalising and regulating euthanasia in the Netherlands. The RTEs review each euthanasia notification on the basis of the criteria laid down in the Act. In these 20 years, the RTEs have reviewed 91,565 notifications of euthanasia. In 133 cases, the statutory due care criteria had not been fulfilled. One case led to criminal proceedings. I believe these figures allow me to tentatively conclude that the Act and in its wake the RTEs have achieved the intended goal: euthanasia procedures are carried out in the Netherlands with great care and transparency. It is also likely that the Act has a much wider effect. How many people who died naturally will have found comfort in the knowledge that if their condition truly became unbearable, euthanasia would be a possibility? To me that is a reassuring thought.

JEROEN RECOURT
Coordinating chair

RATIO BETWEEN TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE



CHAPTER 1
FIGURES AND DEVELOPMENTS IN 2022

1 ANNUAL REPORT

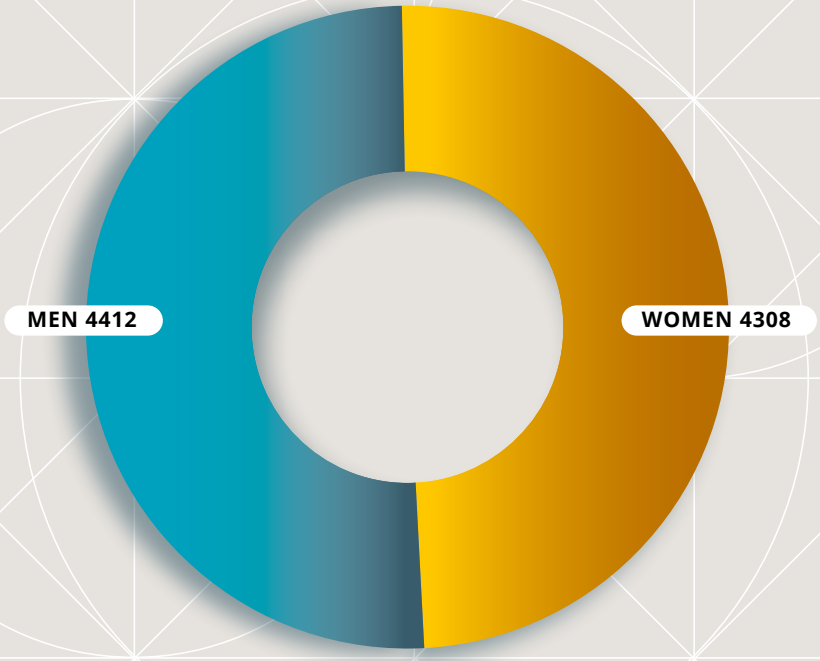
In this annual report the Regional Euthanasia Review Committees ('RTEs') report on their work over the past calendar year. They thus account – to society, government and parliament – for the way in which they fulfil their statutory task of reviewing notified cases of termination of life on request and assisted suicide on the basis of the due care criteria laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). This report 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.

Another aim of the annual report is to give physicians and other interested parties insight into the way in which the committees have reviewed and assessed specific notifications. Chapter 2 therefore gives an extensive account of common and less common review findings.

We have aimed to make the annual report accessible to a wide readership by avoiding the use of legal and medical terms as much as possible, or by explaining them where necessary.

For more information on the outlines of the Act, the committees' procedures, etc., see the Euthanasia Code 2022 and the website of the RTEs: https://english.euthanasiecommissie.nl.

MALE/FEMALE RATIO



2 NOTIFICATIONS

NUMBER OF NOTIFICATIONS

In 2022 the RTEs received 8,720 notifications of euthanasia. This is 5.1% of the total number of people who died in the Netherlands in that year (169,938).[2] The number of notifications increased by 13.7% compared to 2021 (7,666). The number of notifications relative to the total number of deaths increased by 0.5% (rounded off) compared to 2021.

The breakdown of the number of notifications of euthanasia in the five separate regions can be found on the website (www.euthanasiecommissie.nl/uitspraken-en-uitleg (in Dutch)).

MALE/FEMALE RATIO

As in previous years, the number of notifications concerning men and women were almost the same: 4,412 men (50.6%) and 4,308 women (49.4%).

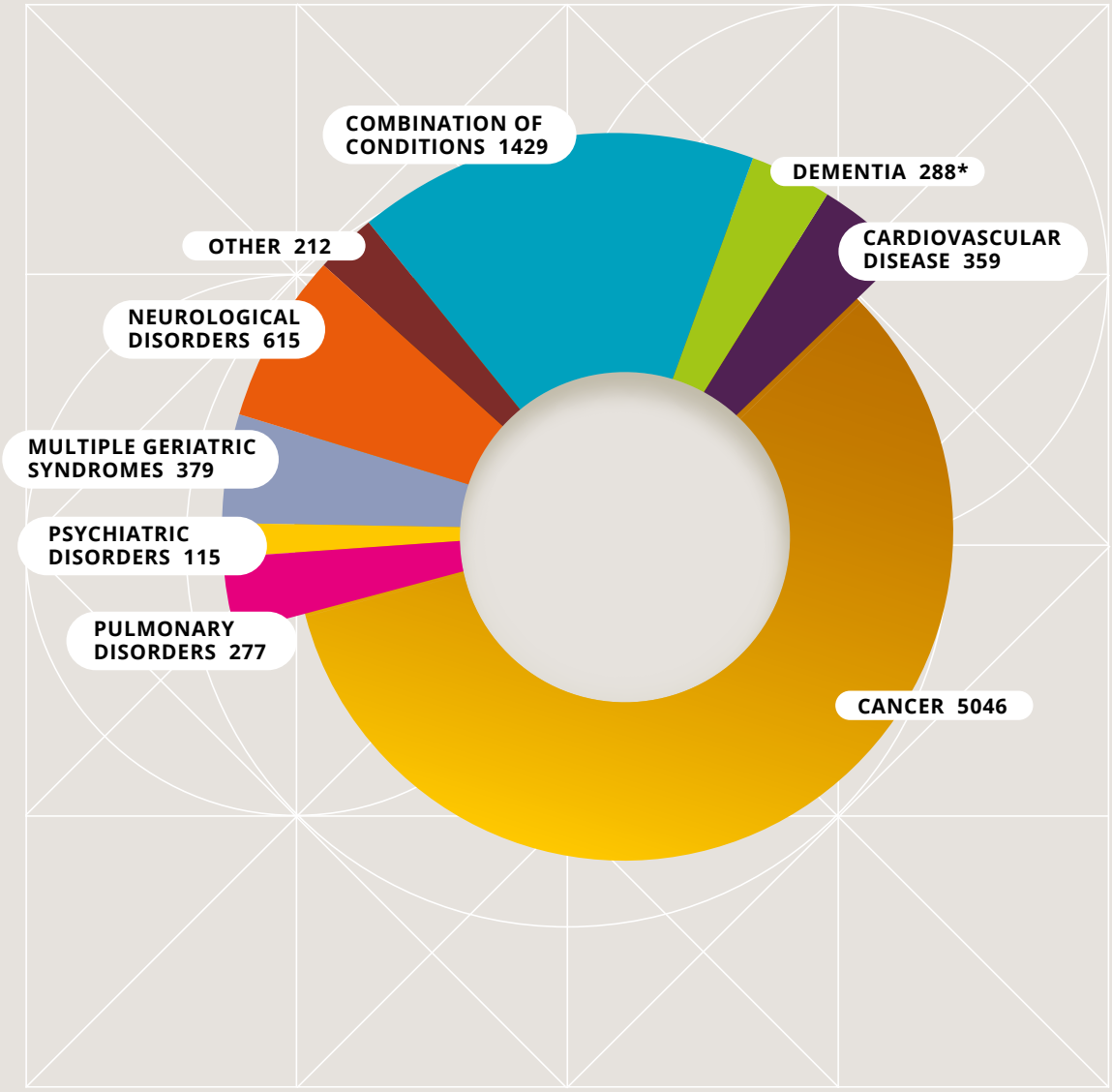
RATIO BETWEEN CASES OF TERMINATION OF LIFE ON REQUEST AND CASES OF ASSISTED SUICIDE

For points to consider regarding due medical care, see pages 34 ff of the Euthanasia Code 2022.

There were 8,501 notifications of termination of life on request (97.4% of the total), 186 notifications of assisted suicide (2.1%) and 33 notifications involving a combination of the two (0.38%). A combination of the two occurs if, in a case of assisted suicide, the patient ingests the potion handed to them by the physician, but does not die within the time they have agreed on. The physician then performs the termination of life on request by intravenously administering a coma-inducing substance, followed by a muscle relaxant.

2 *Source: CBS Statistics Netherlands, 14 February 2023.*

CONDITIONS



* *patient decisionally competent: 282*
patient not decisionally competent: 6

MOST COMMON CONDITIONS

In 2022, 7,726 (88.6%) notifications received by the RTEs involved patients with:

- incurable cancer (5,046; 57.8%);
- neurological disorders such as Parkinson's disease, multiple sclerosis and motor neurone disease (615; 7.0%);
- cardiovascular disease (359; 4.1%);
- pulmonary disorders (277; 3.2%);

or a combination of conditions, usually somatic (1,429; 16.4%).

DEMENTIA

For points to consider regarding patients with dementia, see pages 47 ff of the Euthanasia Code 2022.

There were 282 cases of euthanasia involving patients with dementia who were still decisionally competent with regard to their request for euthanasia. These patients still had insight into their condition and its symptoms, such as spatial and temporal disorientation, and personality changes. Case 2022-115, described in Chapter 2, is an example.

Six notifications in 2022 (the same number as the previous year) involved patients in an advanced or very advanced stage of dementia who were no longer decisionally competent with regard to their request for euthanasia and no longer able to communicate regarding their request. In their cases the advance directive was considered to be their request for euthanasia. One of these cases (2022-043) is described in Chapter 2 of this report. All of these notifications have been published on the website of the RTEs.

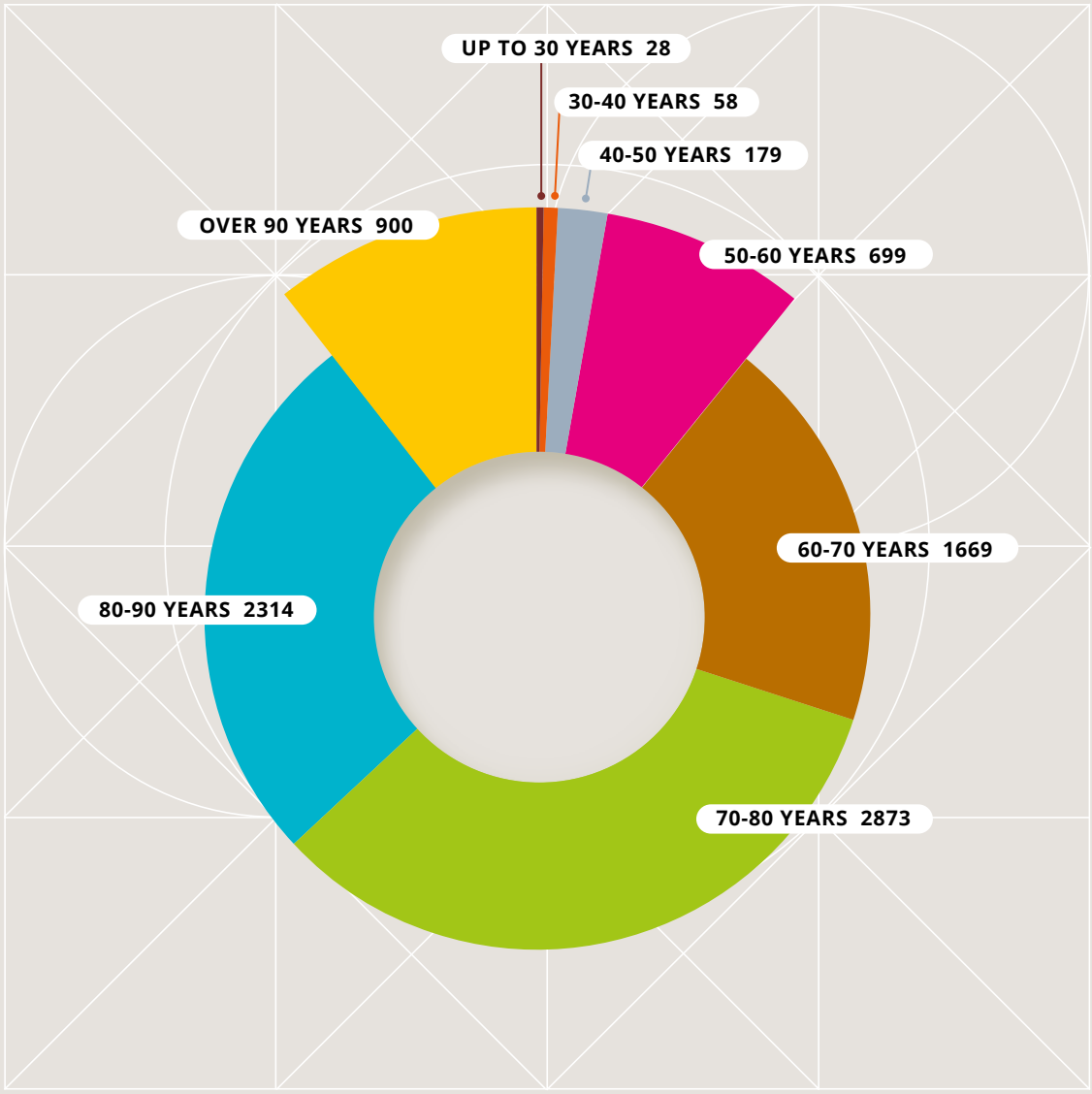
PSYCHIATRIC DISORDERS

For points to consider regarding patients with a psychiatric disorder, see pages 45 ff of the Euthanasia Code 2022.

In 115 notified cases of euthanasia (1.3%) the patient's suffering was largely caused by one or more psychiatric disorders, the same number as in 2021. In 32 of these cases the notifying physician was a psychiatrist, in 29 cases a general practitioner, in 3 cases an elderly-care specialist and in 51 cases another physician. In 65 cases of euthanasia involving patients with psychiatric disorders, the physician performing euthanasia was affiliated with the Euthanasia Expertise Centre (EE). The physician must exercise particular caution in cases where the suffering that gives rise to the patient's request for euthanasia is caused by a psychiatric disorder, as was done in case 2022-085 (described in Chapter 2).[3]

3 *Euthanasia Code 2022, pp. 45 ff.*

AGE


UP TO 30 YEARS 28
30-40 YEARS 58
40-50 YEARS 179
OVER 90 YEARS 900
50-60 YEARS 699
60-70 YEARS 1669
80-90 YEARS 2314
70-80 YEARS 2873

MULTIPLE GERIATRIC SYNDROMES

For points to consider regarding multiple geriatric syndromes, see page 22 of the Euthanasia Code 2022.

Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis and its effects, osteoarthritis, balance problems or cognitive decline – may cause unbearable suffering without prospect of improvement. These syndromes, which are often degenerative in nature, generally occur in elderly patients, and can be the sum of several related symptoms. In conjunction with the patient's medical history, life history, personality, values and stamina, they may give rise to suffering that that patient may experience as unbearable and without prospect of improvement. In 2022 the RTEs received 379 notifications of euthanasia (4.3%) that fell into this category. A notification reviewed by the RTEs relating to multiple geriatric syndromes is included in Chapter 2 and has been published on the website (2022-079).

OTHER CONDITIONS

Lastly, the RTEs register cases involving conditions that do not fall into any of the above categories, such as chronic pain syndrome, rare genetic disorders, kidney failure or blindness, as 'other conditions'. There were 212 such cases in 2022.

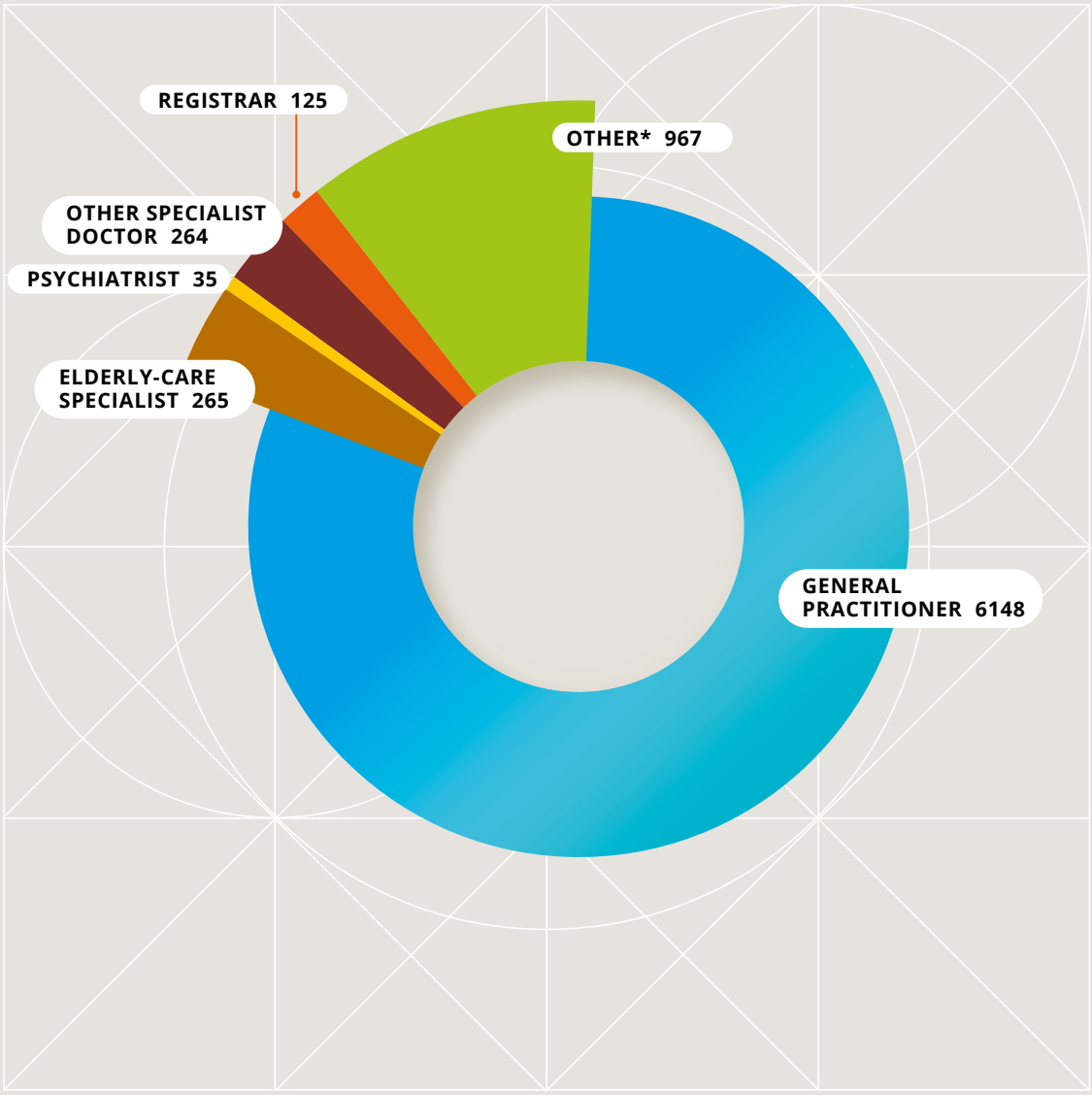
AGE

The highest number of notifications of euthanasia involved people in their seventies (2,873 cases, 32.9%), followed by people in their eighties (2,314 cases, 26.5%) and people in their sixties (1,669 cases, 19.1%). In 2022 the RTEs reviewed one notification of euthanasia involving a minor between the ages of 12 and 16. The committee found in this case that the physician had fulfilled the due care criteria set out in the Act. Separate additional requirements apply in cases involving minors between the ages of 12 and 16 and minors aged 16 or 17.[4] In 27 cases the patient was over 100 years of age. The oldest patient was 104. There were 86 notifications concerning people aged between 18 and 40. In 44 of these cases, the patient's suffering was caused by cancer and in 24 cases it was caused by a psychiatric disorder.

In the category 'dementia', the highest number of notifications involved people in their eighties (113 cases), followed by people in their seventies (110 cases). In the category 'psychiatric disorders', there were 24 notifications involving people in their fifties and 20 involving people in their sixties. In the category 'multiple geriatric syndromes' most of the notifications concerned people aged 90 or older (252 cases).

4 *For points to consider regarding minors, see pages 44 and 45 of the Euthanasia Code 2022.*

NOTIFYING PHYSICIANS



* *For example, physicians affiliated with the Euthanasia Expertise Centre or a junior doctor.*

LOCATIONS

In 2022 as in previous years, in the vast majority of cases the patient died at home (6,939 cases, 79.6%). Other locations were a nursing home or care home (829 cases, 9.5%), a hospice (667 cases, 7.7%), a hospital (157 cases, 1.8%) or elsewhere, for instance at the home of a family member, in an assisted-living facility or in a convalescent home (128 cases, 1.5%).

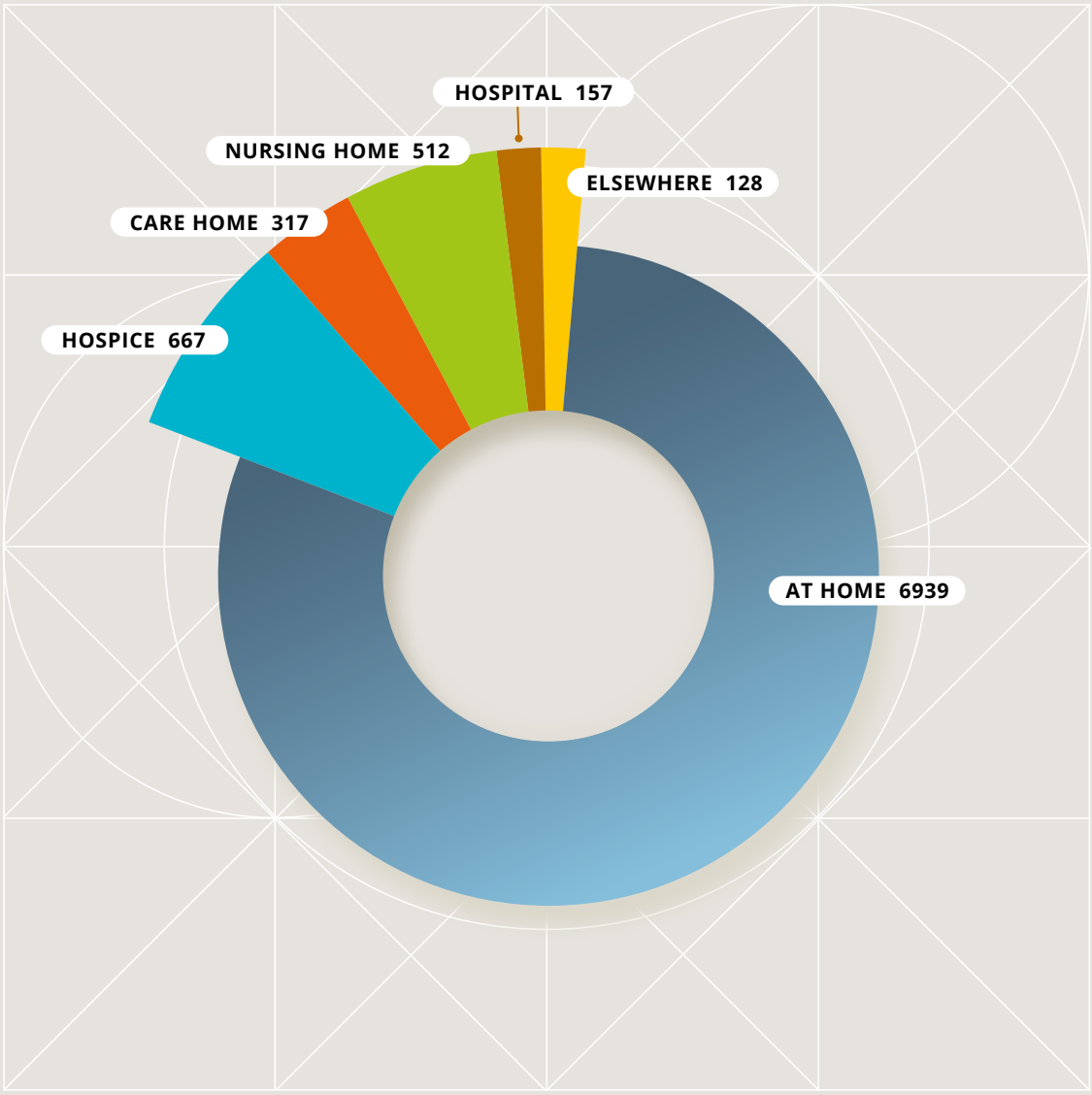
NOTIFYING PHYSICIANS

The vast majority of cases were notified by a general practitioner (7,013, or 80.4% of the total number). The other notifying physicians were elderly-care specialists (316), other specialist doctors (264) and registrars (125). There was also a group of notifying physicians with other backgrounds (967), most of them affiliated with the EE.

The number of notifications by physicians affiliated with the EE (1,241; 14.2%) increased by 118 compared to 2021, when there were 1,123 notifications by this group. EE physicians are often called upon if the attending physician considers a request for euthanasia to be too complex. Physicians who do not perform euthanasia for reasons of principle or who will only perform euthanasia if the patient has a terminal condition also often refer patients to the EE. In some cases, rather than being referred by an attending physician, the patients themselves contact the EE or ask their families to do so. More than half of the notifications involving patients with a psychiatric disorder came from EE physicians: 65 out of 115 notifications (over 56.5%). That is a lower percentage than in 2021 (83 out of 115 notifications; 72%). Of the 288 notifications of cases in which the patient's suffering was caused by a form of dementia, 123 (42.7%) came from EE physicians. Of the 379 notifications involving patients with multiple geriatric syndromes, 157 (41.4%) came from EE physicians.

5 *The guidelines, their background and underlying arguments can be found (in Dutch) at https://www.transplantatiestichting.nl/medisch-professionals/donatie-na-euthanasie.*

LOCATIONS


HOSPITAL 157
NURSING HOME 512
ELSEWHERE 128
CARE HOME 317
HOSPICE 667
AT HOME 6939

EUTHANASIA AND ORGAN AND TISSUE DONATION

Termination of life by means of euthanasia does not preclude organ and tissue donation. The Richtlijn Orgaandonatie na euthanasie (Guidelines on organ donation after euthanasia) published by the Dutch Foundation for Transplants provides a step-by-step procedure for such cases.[6] In 2022, the RTEs received six notifications that mentioned specifically that organ and/or tissue donation had taken place after euthanasia.

COUPLES

In 58 cases, euthanasia was performed simultaneously on both members of a couple (29 couples). Of course, the due care criteria set out in the Act must be satisfied in each case separately. Each partner must be visited by a different independent physician in order to safeguard the independence of the assessment.[7]

DUE CARE CRITERIA NOT COMPLIED WITH

In 13 of the notified cases in 2022, the RTEs found that the physician who performed euthanasia did not comply with all the due care criteria set out in section 2 (1) of the Act. Ten of these cases are described in Chapter 2. Two cases involved a couple; in these cases the physician consulted only one independent physician for both members of the couple. For that reason the committee found in both cases that the physician had not acted in accordance with the due care criteria. Only one of these cases has been included in this report, due to the similarity between them. In three cases, the independent physician was registered as a patient in the practice of the GP who performed euthanasia, and the committee found that this jeopardised the independent physician's independence.[8] One of these cases is included in Chapter 2.

6 *The guidelines, their background and underlying arguments can be found (in Dutch) at https://www.transplantatiestichting.nl/medisch-professionals/donatie-na-euthanasie.*

7 *Euthanasia Code 2022, p. 30.*

8 *Euthanasia Code 2022, pp. 29-30.*

STRAIGHTFORWARD AND NON-STRAIGHTFORWARD CASES

Since 2012, notifications received by the RTEs have been processed as follows. Upon receipt of a notification, the secretary of the committee, who is a lawyer, provisionally categorises the case as a non-straightforward case (VO) or a straightforward case (NVO). Notifications are categorised as straightforward if the secretary of the committee considers that the information provided is complete and the physician has complied with the statutory due care criteria, unless the notification falls into a category that is considered non-straightforward. That category includes, for instance, cases in which the patient's suffering is caused by one or more psychiatric disorders, in which euthanasia is performed on the basis of an advance directive or in which the patient is a minor. After the initial selection by the secretary of the committee, the committee reviews the notification. This is done digitally for the straightforward cases. The committee then decides whether it agrees with the secretary's provisional view that the notification is straightforward or whether on the contrary it considers it to be non-straightforward. In the latter case the committee categorises the notification as non-straightforward and discusses it at a meeting. In 2022 it did so in 40 cases (just under 0.5% of notifications).

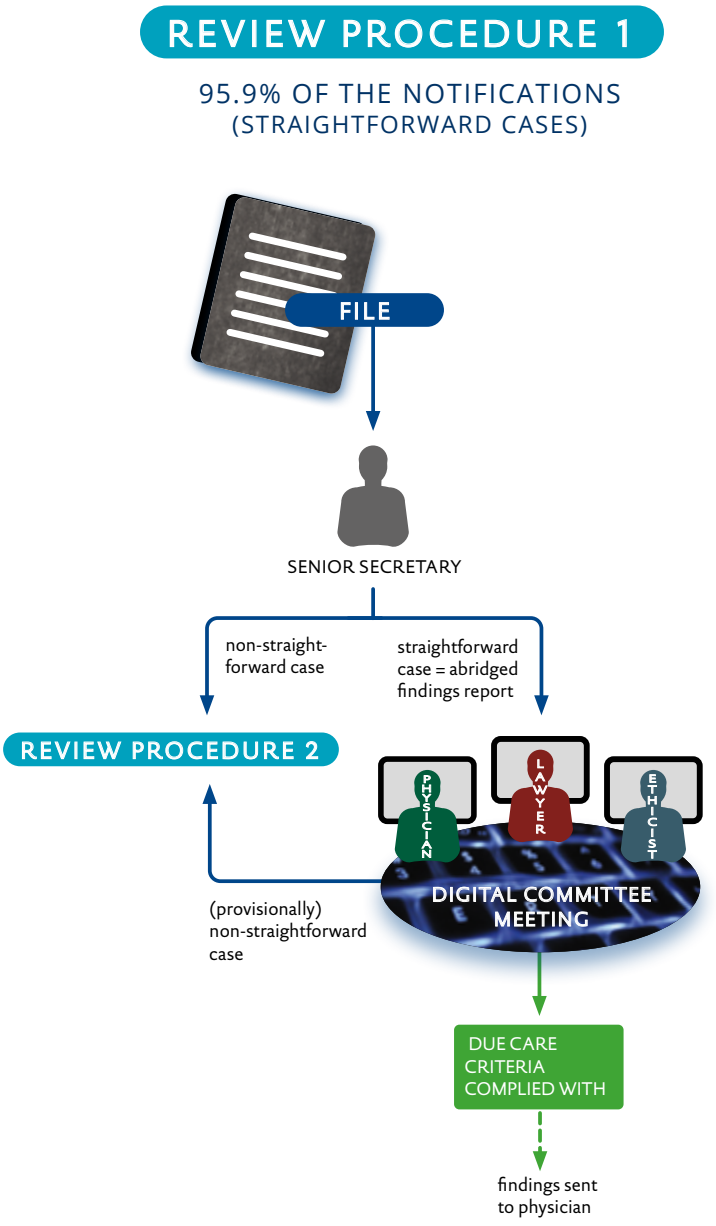
If a notification is completely straightforward, the physician always receives an abridged findings report, informing the physician of the committee's finding, based on the notification, that the physician has complied with all the due care criteria. In 2022, 95.9% of the notifications received were categorised as straightforward by the secretary of the committees.

Cases 2022-067, 2022-029, 2022-094, 2022-031 and 2022-006 are included in Chapter 2 as examples of straightforward notifications, as a result of which the physician received an abridged findings report. It should be noted that Chapter 2 gives a summary of the cases in question. Similar descriptions of some of the straightforward cases are published (in Dutch) on the website of the RTEs (www.euthanasiecommissie.nl). The abridged findings reports sent to the physicians are not included in these summaries.

Non-straightforward cases are discussed by the committee at a meeting, and the findings are written out in full. In such findings the committee sets out which aspects of a notification were not straightforward and what its reasons were for deciding that the due care criteria were, or were not, complied with. The committee limits its explanation to the

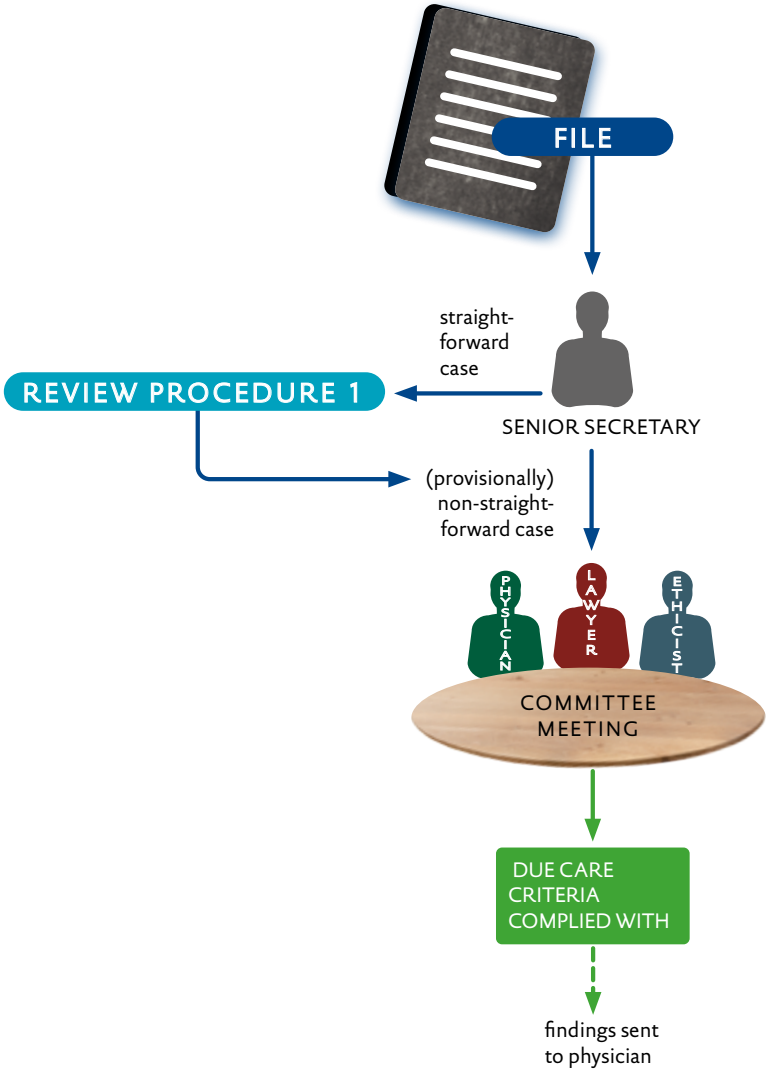
aspect of the case that raised questions. In this way the RTEs expect to give physicians and other stakeholders a clearer picture of the way they reach their findings and the decisive arguments underlying them.

Of all the notifications received, 4.1% were immediately categorised as non-straightforward because, for example, they involved patients with a psychiatric disorder, there were questions about how euthanasia had been performed, or because the case file submitted by the notifying physician was not detailed enough for the committee to reach a conclusion.



REVIEW PROCEDURE 2

4.1% OF THE NOTIFICATIONS
(NON-STRAIGHTFORWARD CASES)



In 2022 the average time between the notification being received and the findings being sent to the physician was 34 days. This is within the maximum time limit of two times six weeks laid down in section 9 of the Act, however it is two days longer than in 2021. The longer processing time is explained partly by the increase in the number of notifications and partly by staff changes.

WRITTEN AND ORAL QUESTIONS PUT BY THE COMMITTEES

In some cases the reports completed by the physician and the independent physician and the accompanying documents do not provide enough information for the committee to be able to assess the notification. The committee can then decide to ask the physician or the independent physician for further clarification. In 18 cases, the committee asked the notifying physician after its meeting for a further written explanation. In one case it asked the independent physician for such an explanation.

In 28 cases the committee invited the notifying physician (and in one case the independent physician) to answer the committee's questions in person at the next committee meeting, sometimes after having first put written questions to the physician. These included the 13 cases in which the committee ultimately found that the due care criteria had not been complied with.

If the committee has a question about a simple, factual matter, it may also be asked by phone.

COMPLEX NOTIFICATIONS

Some cases are considered to be so complex that all the RTE members and secretaries should be able to have a say in the matter. This leads to intensive discussions between the committees. The standard practice is that when a committee believes a particular notification does not meet the due care criteria, it makes the case file and its draft findings available to all the committee members and secretaries on the RTE intranet site. Notifications of cases in which a physician granted a request for euthanasia by a decisionally incompetent patient on the basis of their advance directive are always handled this way. The committee reaches a final conclusion after studying the comments from other committee members.

The same is done in other cases where the committee feels it would benefit from an RTE-wide consultation. The aim is to ensure the quality of the review is as high as possible and to achieve maximum uniformity in the findings.

Thirty-four cases were discussed in this way in 2022. They include the cases in which it was found that the due care criteria had not been complied with. In a handful of cases the findings are also discussed in the periodic meetings of, respectively, chairpersons, physicians and/or ethicists.

REFLECTION CHAMBER

At the request of the national consultative committee of chairpersons, the RTEs' reflection chamber updated the Euthanasia Code. The updated version was published in July 2022. The Royal Dutch Medical Association (KNMG), the Royal Dutch Association for the Advancement of Pharmacy (KNMP), the Public Prosecution Service, the Health and Youth Care Inspectorate (IGJ), the Euthanasia Expertise Centre (EE) and the Netherlands Psychiatric Association (NVVP) were all consulted about the content. The Euthanasia Code 2022 was sent to all GPs, psychiatrists and elderly-care specialists.

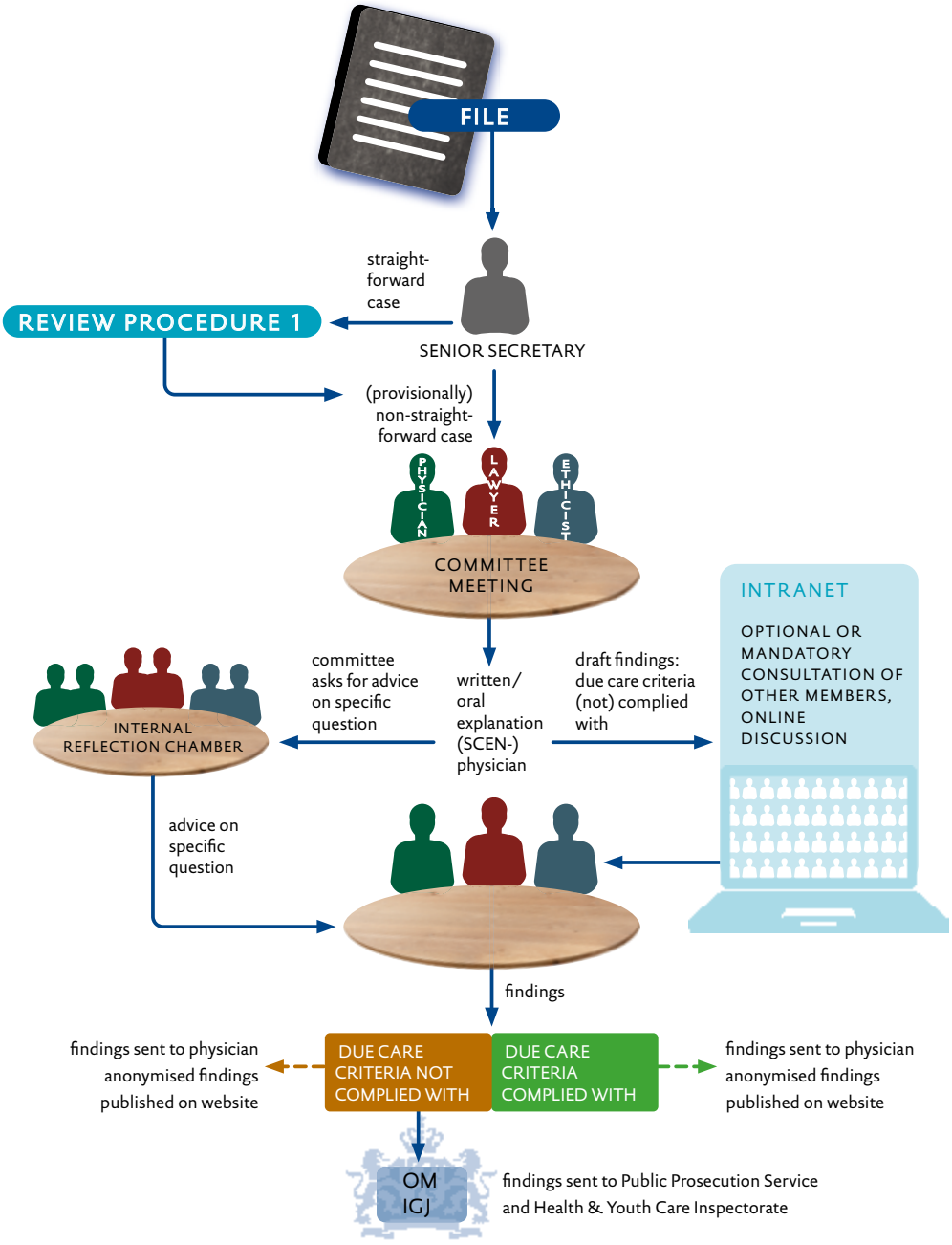
MISCELLANEOUS

The RTEs' new digital system was introduced in May 2022. Once a notification has been entered into the system by a staff member, the physician is automatically sent an email with confirmation of receipt of the notification. The RTEs now receive the vast majority of notifications digitally from the municipal pathologist.

The report of the fourth evaluation of the Act, which will include an evaluation of the RTEs' functioning, will be published in 2023.

REVIEW PROCEDURE 3

<0.5% OF THE NOTIFICATIONS (NON-STRAIGHTFORWARD CASES)



ORGANISATION

There is one RTE for each of five regions. Each region has three lawyers (one regional chair and two chairs), three physicians and three ethicists. This brings the total number of committee members to 45. In view of the increasing number of notifications, the RTEs are consulting with the Ministry of Health, Welfare and Sport and the Ministry of Justice about expanding the number of committee members.

The committee members are publicly recruited and appointed for a term of four years by the Minister of Health, Welfare and Sport and the Minister of Justice and Security, on the recommendation of the committees. They may be reappointed once.

The committees are independent: they review the euthanasia notifications for compliance with the statutory due care criteria and reach their conclusions without any interference from ministers, politicians or other parties. In other words, although the members and the coordinating chair are appointed by the ministers, the latter are not empowered to give 'instructions' regarding the substance of the findings.

The coordinating chair of the RTEs presides over the policy meetings of the committee chairs, at which the physicians and ethicists are also represented. The RTEs are assisted by a secretariat consisting of approximately 25 staff members: the general secretary, secretaries (who are also lawyers) and administrative assistants (who provide process support). The secretaries attend committee meetings in an advisory capacity and are coordinated by the general secretary.

CHAPTER 2
CASES

1 INTRODUCTION

This chapter describes various findings by the RTEs. The essence of the RTEs' work consists of reviewing physicians' notifications concerning euthanasia.

A physician who has performed euthanasia has a statutory duty to report this to the municipal pathologist. The municipal pathologist then sends the notification and the various accompanying documents to the RTE. The main documents in the notification file submitted by physicians are the notifying physician's report, the independent physician's report, excerpts from the patient's medical records such as letters from specialist doctors, the patient's advance directive if there is one and a declaration by the municipal pathologist. The independent physician is almost always contacted through the Euthanasia in the Netherlands Support and Assessment Programme (SCEN), which falls under the Royal Dutch Medical Association (KNMG).

The committees examine whether the notifying physician has acted in accordance with the six due care criteria set out in section 2 (1) of the Act.

The due care criteria say that 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 his 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 the patient's suicide.

The RTEs review notifications in the context of the Act, its legislative history, the relevant case law and the Euthanasia Code 2022,[8] which was drawn up on the basis of earlier findings of the RTEs. They also take the decisions of the Public Prosecution Service and the Health and Youth Care Inspectorate into account.

The RTEs decide whether it has been established that the criteria of (c) informing the patient, (e) consulting an independent physician, and (f) due medical care have been fulfilled. These are matters that can be established on the basis of the facts. The other three due care criteria prescribe that the physician must be satisfied that (a) the patient's request was voluntary and well considered and (b) the patient's suffering was unbearable, with no prospect of improvement, and have come to the conclusion that (d) there was no reasonable alternative. Given the phrasing of these due care criteria, the physician has a certain amount of discretion in making the assessment. When reviewing the physician's actions with regard to these three criteria, the RTEs therefore look at the way in which the physician assessed the facts and at the explanation the physician gives for his or her decisions. The RTEs thus review whether, within the room for discretion allowed by the Act, the physician could reasonably conclude that these three due care criteria had been met. In so doing they also look at the way in which the physician substantiates this conclusion. The independent physician's report often contributes to that substantiation.

The cases described in this chapter fall into two categories: cases in which the RTE found that the due care criteria had been complied with (section 2) and cases in which the RTE found that the due care criteria had not been complied with (section 3). The latter means that in the view of the committee in question, the physician failed to comply fully with one or more of the due care criteria.

Section 2 is divided into three subsections. In subsection 2.1 we present five cases that are representative of the vast majority of notifications received by the RTEs. These are cases involving incurable conditions, such as cancer, neurological disorders, cardiovascular disease, pulmonary disease or a combination of conditions. In these cases, the findings are not written out in detail; instead the physician receives an abridged findings report. This is a letter that simply states that the physician has acted in accordance with the due care criteria.

8 *The Euthanasia Code 2022 can be downloaded from the website of the RTEs (https://english.euthanasiecommissie.nl).*

In subsection 2.2 we examine the various due care criteria, focusing in turn on (a) a voluntary and well-considered request, (b) unbearable suffering without prospect of improvement, (d) the joint conclusion that there is no reasonable alternative, (e) consultation of an independent physician and (f) due medical care. There is no explicit reference here to due care criterion (c): informing the patient about their prognosis. This criterion is generally closely connected with other due care criteria, particularly the criterion that the physician must be satisfied that the request is voluntary and well considered. This can only be the case if the patient is well aware of their health situation and of their prognosis.

In subsection 2.3 we describe four cases of euthanasia involving patients who fall into specific, complex categories: patients with a psychiatric disorder, patients with multiple geriatric syndromes and patients with dementia.

Section 3 deals with cases in which the RTEs found this year that the due care criteria had not been met. The full findings of 10 of these cases have been included in this report.

Each case in this report has a number which corresponds to the case number on the website of the RTEs (www.euthanasiecommissie.nl). Extra information is usually given on the website about cases in which the physician received the full findings. If the physician received only abridged findings, a short summary of the facts of the case is given on the website or in the annual report.

2 PHYSICIAN ACTED IN ACCORDANCE WITH THE DUE CARE CRITERIA

2.1 FIVE EXAMPLES OF THE MOST COMMON NOTIFICATIONS

As stated in Chapter 1, the vast majority of euthanasia cases involve patients with cancer, neurological disorders, cardiovascular disease, pulmonary disease or a combination of conditions. The following five cases, all straightforward notifications, are examples. They give an impression of the types of notification that the RTEs receive most frequently.

The findings are set out in most detail for the first case, to show that the committees examine all the due care criteria. In the other cases, the focus is mainly on the suffering of the patients.

CANCER

Lung cancer, refusal of further tests

The patient, a man in his eighties, was given a tentative diagnosis of lung cancer three months before his death. Given his age and poor physical condition, he did not want any further tests to be done. His condition was incurable.

The patient was very short of breath and had severe coughing fits and backache. He had also lost a lot of weight in a short period of time. The patient was increasingly unable to do things and was unable to leave the house. He suffered from his general debilitation and the lack of any future prospects.

One month before his death, the patient asked the physician to perform euthanasia. According to the physician, the request for euthanasia was voluntary and well considered. She established that the patient was not depressed, despite the many setbacks he had experienced. The physician considered him to be decisionally competent regarding his request for euthanasia.

The physician was satisfied that the patient's suffering was unbearable to him and with no prospect of improvement according to prevailing medical opinion. There were no longer any acceptable ways to alleviate his suffering. It was also clear from the case file that the physician and the specialist doctors had informed the patient about his situation and the treatment options.

The physician consulted an independent SCEN physician. The SCEN physician saw the patient one week before his death and came to the conclusion that the due care criteria had been fulfilled.

The physician performed the euthanasia using the method, substances and dosage recommended in the KNMG/KNMP's 'Guidelines for the Practice of Euthanasia and Physician-assisted Suicide' of September 2021.

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

Number 2022-067 on the website.

NEUROLOGICAL DISORDER

MS, euthanasia process taken over by another physician

The patient, a man in his sixties, was diagnosed with multiple sclerosis (MS) seven years before his death. MS is a disease of the central nervous system that damages the nerves so that they cannot properly transmit signals to and from the brain. The patient's condition was incurable.

The patient was experiencing increasing functional decline, which made him largely dependent on care and the use of a wheelchair. He had to be helped into and out of his wheelchair using a patient lift and this often caused faecal incontinence. The patient's suffering consisted of physical deterioration and painful muscle spasms. The lack of any prospect of improvement and his fear of further deterioration also took an emotional toll on the patient.

As the patient's GP did not want to perform euthanasia, another GP in the same practice took over the euthanasia process. During his first conversation with this physician, six weeks before his death, the patient asked the physician to perform euthanasia. Several more conversations followed, during which the patient kept repeating his request.

The physician was satisfied that the patient's suffering was unbearable to him and with no prospect of improvement according to prevailing medical opinion. There were no longer any acceptable ways to alleviate the patient's suffering.

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

Number 2022-029 on the website.

PULMONARY DISEASE

COPD, deterioration due to COVID infection

The patient, a woman in her seventies, was diagnosed with COPD (a lung disease) many years before her death. She eventually reached the end stage of COPD. Around a year before her death, the patient contracted COVID-19, after which her lung function had decreased further. The extra oxygen she received did not alleviate her breathing difficulties sufficiently. There were no more treatment options for the patient.

The patient's suffering consisted of extreme breathing difficulties, fatigue and loss of strength. She could do very little and spent her days sitting or lying in bed. Even eating and drinking took a great effort. The patient was afraid of choking. She had seen this happen to someone close to her who had the same condition, and she wanted to prevent it from happening to her.

The physician was satisfied that the patient's suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate her suffering that were acceptable to her.

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

Number 2022-031 on the website.

CARDIOVASCULAR DISEASE

Cardiovascular disease with amputation, loss of autonomy

The patient, a man in his seventies, had been suffering from vascular disease for a year before his death. As a result, part of his right foot and then later his right lower leg had to be amputated. During a hospital admission one month before his death, the patient was diagnosed with severe heart failure. Treatments were not effective, and the condition proved incurable.

The patient's amputation wound did not heal properly and further amputation, this time above the knee, became necessary. He did not want to undergo this major operation, partly in view of his very poor physical condition caused by his heart failure. The patient was severely fatigued and could do very little. He suffered from his dependence on others, the loss of self-sufficiency and the lack of any prospect.

The physician was satisfied that this suffering was unbearable to the patient and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate his suffering that were acceptable to him.

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

Number 2022-094 on the website.

COMBINATION OF CONDITIONS

CVA (ischaemic stroke), metastasised melanoma, communication difficulties

The patient, a woman in her sixties, suffered a cerebrovascular accident (CVA) around six months before her death. As a result one side of her body was paralysed. She also had difficulty speaking and with performing everyday tasks. Around two months before her death, the patient was diagnosed with metastasised melanoma (a type of skin cancer). Her condition was incurable.

The patient's suffering consisted of the disabilities caused by the CVA. She was only able to express herself by means of head movements, which she found very frustrating. The patient could do very little and became dependent on other people. The loss of speech and autonomy was at odds with the active and language-oriented person she had always been. The situation took a very heavy emotional toll and the patient suffered from the lack of any prospect due to the metastasised melanoma.

The physician asked the patient if she wanted euthanasia. The patient was able to answer 'yes or no' questions by moving her head. During the conversations, she remained consistent in her request.

The physician was satisfied that the patient's suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate her suffering that were acceptable to her.

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

Number 2022-006 on the website.

2.2 FIVE CASES ILLUSTRATING THE DUE CARE CRITERIA IN THE ACT

In this subsection five cases are described with a focus on one of the following five due care criteria: the physician must be able to conclude that (a) the patient's request is voluntary and well considered, that (b) the patient's suffering is unbearable, with no prospect of improvement, and that (d) the physician and the patient together are satisfied that there is no reasonable alternative; the physician must also (e) consult an independent physician and (f) exercise due medical care and attention in terminating the patient's life. All but one of the cases described below were non-straightforward notifications. This means that these notifications were discussed at a committee meeting and that the physician received a full report of findings regarding the due care criteria.

VOLUNTARY AND WELL-CONSIDERED REQUEST

The Act states that the physician must be satisfied that the patient's request is voluntary and well considered. The patient must make the request personally.

In assessing this due care criterion, questions may in certain situations arise concerning the voluntary and well-considered nature of the request for euthanasia, for instance in cases involving minors (see the Euthanasia Code 2022, pp. 20-21).

VOLUNTARY AND WELL-CONSIDERED REQUEST

Minors

The patient, a boy aged between 12 and 16, was diagnosed with a malignant tumour more than three years before his death. Around a year before his death it was established that the tumour had metastasised. His condition was incurable. The patient was in a great deal of pain and had hardly any energy; he had become bedridden as a result.

The Act applies to euthanasia for people aged 12 and over. It sets a number of additional requirements for cases involving patients aged between 12 and 16. The committee reviewing this case therefore reflected on these requirements: the patient's ability to make a reasonable assessment of his interests ('internal voluntariness' or decisional competence) and his parents' concurrence with his request for euthanasia.

The physician explained in his report that he had spoken regularly with the patient over a long period of time. As a result, the physician was satisfied that the patient had thought carefully about his choices and was able to fully grasp the consequences. The physician considered him to be decisionally competent regarding his request for euthanasia. The patient discussed everything with his parents and they supported him in his request for euthanasia. By way of support, the physician asked another physician in his practice to assess whether the patient was decisionally competent. The other physician had no doubt about this either. The independent physician also considered the patient decisionally competent and that his parents supported him.

The committee found that the physician could be satisfied that the patient's request was voluntary and well considered and that his parents concurred with his request. The other due care criteria had also been fulfilled.

Number 2022-072 on the website.

UNBEARABLE SUFFERING WITHOUT PROSPECT OF IMPROVEMENT AND ABSENCE OF A REASONABLE ALTERNATIVE

'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. [...] There is no prospect of improvement if there are no curative or palliative treatment options that could end the patient's suffering. It is thus clear that the assessment of the prospect of improvement is closely linked to determining whether there is a reasonable alternative that would alleviate or end the suffering. [...] It is sometimes hard to establish 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 must be palpable to the physician, also in light of what has happened so far, that this particular patient's suffering is unbearable.' (Euthanasia Code 2022, p. 23.)

Although due care criteria (b) 'unbearable suffering without prospect of improvement' and (d) 'no reasonable alternative' are often viewed and assessed together because there is a degree of overlap between the two, they will be discussed in separate cases below. The first case focuses on unbearable suffering without prospect of improvement and the second case on the joint conclusion of the physician and patient that there was no reasonable alternative. It must, however, be taken into consideration that these two criteria can never be viewed entirely separately.

UNBEARABLE SUFFERING WITHOUT PROSPECT OF IMPROVEMENT

Multiple geriatric syndromes, doubt concerning the medical dimension, oral explanation by physician

The patient, a woman in her eighties, was hearing impaired, visually impaired, had high blood pressure and suffered from vertigo. She also had several suspicious spots on her skin, having previously suffered from melanoma.

On the basis of the case file, it was insufficiently clear to the committee what constituted the patient's unbearable suffering and what the relationship was between this suffering and her diagnosed medical conditions.

The physician was invited to give an oral explanation. During that meeting he told the committee that the patient had experienced increasing disabilities and suffered from her functional decline. The patient had consistently said this in several conversations with the physician, starting 10 months before her death. As a result of the increasing severity and extent of her symptoms, the patient eventually could no longer do anything that she used to derive pleasure from. She could no longer drive, work in the garden or follow current affairs on television. She also had increasing difficulty walking without assistance. The patient became lonely, sombre and anxious.

The physician stated that the patient had always been very persevering and strict with herself. She was also very attached to her independence, so she absolutely did not want to go into a care facility. The physician was satisfied that, in light of her character and life history, the patient was suffering unbearably and without prospect of improvement.

The independent physician consulted by the physician considered that the patient's wish to die comprised aspects of what he referred to as 'completed life', but he also believed medical conditions formed the basis of the patient's unbearable suffering without prospect of improvement. At the meeting the physician said that he felt very much supported by this conclusion, since the independent physician had asked the patient detailed questions about her suffering.

The committee noted that the patient had always lived an independent life. Over the years, her disabilities had increased, and as a result she spent her days mainly sitting on a chair. The patient suffered from this deterioration and her increasing dependence on others. The committee

came to the conclusion that due to her cumulative disabilities the patient was no longer able to give purpose to her life.

The committee therefore found that the physician could be satisfied that the patient was suffering unbearably without prospect of improvement. The other due care criteria had also been fulfilled, in the committee's view.

Number 2022-056 on the website.

NO REASONABLE ALTERNATIVE

Neurological problems due to a fall, written explanation by physician, patient's refusal to undergo further tests and treatment

The patient, a woman in her sixties, had fallen and hit her head hard several decades before her death. She subsequently developed neurological problems, including headaches, facial pain, dizziness, double vision, sleeping problems and lack of concentration. One year before her death, she shattered her heel in a fall. Around a month before her death she broke her wrist in another fall.

The physician had stated in his report that he was not completely satisfied that the patient's suffering was without prospect of improvement according to prevailing medical opinion. In addition, the independent physician had mentioned possible treatment options for the patient. The committee therefore decided to ask the physician for a further explanation.

In that explanation, the physician stated that in writing the report he had been led by the words 'according to prevailing medical opinion'. As some of the tests that the patient had undergone were outdated, he was not sure whether there had been any new medical developments that could have alleviated her symptoms somewhat. The physician had discussed treatment options with the patient, but she did not want to undergo any new tests or treatment. The patient had been discouraged by the limited results of previous treatments. She did not want any psychological support either; she found sufficient support in her faith.

It became clear to the committee that in the 30 years prior to her death the patient had been treated by several different specialist doctors, to no effect. Although the independent physician had given some treatment recommendations, in its considerations the committee took account of the fact that the independent physician was able to empathise with the patient for not wanting to undergo any more treatment.

The committee noted that the patient did not have the strength to undergo any more treatment. Given the patient's age, combined with her physical condition and her extensive treatment history, all the physicians involved in the case were able to empathise with her.

The committee therefore found that the physician could come to the conclusion, together with the patient, that there was no reasonable alternative in her situation. The other due care criteria had also been fulfilled, in the committee's view.

Number 2022-114 on the website.

CONSULTATION

Before performing euthanasia, the physician must consult at least one other, independent physician who must see the patient and assess whether the statutory due care criteria concerning the request, the suffering, the absence of a reasonable alternative and informing the patient have been complied with.

The independent physician consulted is preferably a SCEN physician. SCEN is the abbreviated Dutch name of the Euthanasia in the Netherlands Support and Assessment Programme of the KNMG. SCEN physicians are trained by the KNMG and are available to make an independent, expert assessment in the context of a request for euthanasia (Euthanasia Code 2022, pp. 27-28).

CONSULTATION

Straightforward notification, cancer, patient living in the Caribbean part of the Netherlands

The patient, a woman in her sixties, was diagnosed with extensively metastasised lung cancer two weeks before her death. Her condition was incurable. The patient was in a lot of pain that could not be treated with medication. In a short period of time she had become very weak and bedridden. Being dependent on others was terrible for her.

Around one week before her death, the patient asked the physician to perform euthanasia. The physician consulted an independent physician who was not a SCEN physician. The reason for this was that there was no SCEN physician available on the island where the patient lived. The independent physician was satisfied that the due care criteria had been complied with.

Although it is preferable for the physician to consult a SCEN physician, this is not a statutory requirement, as is noted in the Euthanasia Code. The committee found that the physician had acted in accordance with all the due care criteria.

Number 2022-054 on the website.

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 coma. In assessing compliance with this due care criterion, the committees refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of 2021 (referred to below as the Guidelines). According to the Guidelines, the physician must have an emergency set of substances available in case something goes wrong with the first set (Euthanasia Code 2022, pp. 34-36).

DUE MEDICAL CARE

Cancer, second dose of muscle relaxant administered, written explanation by physician

In the case of this patient, a woman in her fifties, difficulties occurred during the euthanasia procedure. The physician gave the following clarification to the committee.

The day before euthanasia was performed, a specialised nurse had inserted an IV cannula in a vein in the crook of the patient's elbow. The next day, the physician administered 2000mg of thiopental, a coma-inducing substance. The patient continued to breathe normally. While the physician was administering the substance, she felt no resistance in the syringe and there was no swelling on the skin. Half an hour after the thiopental was administered, the physician established that the patient was in a sufficiently deep coma, by applying a pain stimulus and checking the eyelash reflex. The physician then administered 150mg of rocuronium, a muscle relaxant. The explanation she gave for waiting so long between administering the two substances was that she did not want the euthanasia procedure to be too abrupt. This had been the family's wish. However, after the rocuronium had been administered, the patient did not die. The physician was under the impression that there was nothing wrong with the cannula; she had checked this. She therefore decided after 25 minutes to administer the rocuronium dose from the emergency set. As the patient still did not die, even after the second dose, the physician contacted an anaesthesiologist who was part of the palliative team. It was agreed that if the situation remained unchanged, the ambulance service would come and insert a new cannula and the pharmacist would supply a third set of euthanatics. In the following few minutes, the patient's breathing became increasingly shallow, and she died peacefully.

The committee noted that, contrary to the advice in the Guidelines, the physician did not insert a new cannula after the patient did not respond sufficiently to the thiopental. She also waited a long time between administering the thiopental and the first dose of rocuronium, whereas the Guidelines recommend administering these doses in quick succession, if a sufficiently deep coma has been established.

The committee also noted that the physician sought the advice of an anaesthesiologist when the patient did not die. The patient did not awaken from her coma during the procedure. The physician checked this too. During the procedure, the physician remained calm and at no point did she leave the patient and her family.

The committee therefore found that, although the Guidelines had not been followed completely, the physician had, in this specific situation, exercised due medical care in carrying out the termination of life on request. In the committee's view, the other due care criteria had also been fulfilled.

Number 2022-116 on the website.

2.3 FOUR EXAMPLES OF CASES INVOLVING PATIENTS IN A SPECIAL CATEGORY

This subsection describes four cases involving patients in a special category. The first two cases involve patients with a psychiatric disorder and multiple geriatric syndromes, respectively. The other two cases involve patients with dementia. Three out of the four cases were non-straightforward notifications.

PSYCHIATRIC DISORDER

'If a request for euthanasia is based (mainly) on suffering caused by a psychiatric disorder, physicians are expected to exercise particular caution. [...] In line with this principle, the RTEs review whether the physician consulted an independent psychiatrist and whether the latter assessed the patient's decisional competence with regard to their request for euthanasia, whether the patient was suffering unbearably and whether there were no reasonable alternatives. The independent psychiatrist may give advice on treatment if necessary.' (Euthanasia Code 2022, pp. 45-46.)

Various psychiatric disorders

The patient, a woman in her twenties, suffered from obsessive-compulsive disorder (OCD), an autism spectrum disorder (ASD), post-traumatic stress disorder (PTSD) and recurrent periods of depression. She also had a mild intellectual disability and suffered from anorexia. Due to her conditions, the patient was no longer able to give purpose to her life or enjoy activities. There was a constant suicide risk. The patient felt worn out and did not want to suffer any longer.

The physician established that the patient had a realistic perception and understanding of her illness, her situation and her prospects, and was aware of the implications of her wish for euthanasia. The independent psychiatrist was of the opinion that the patient was able to explain clearly, and in a way that was palpable, why she wanted euthanasia. The independent physician, who was also a psychiatrist, established that the patient's wish for euthanasia was not a symptom of her psychiatric disorders. All the physicians involved in the case found that the patient was decisionally competent regarding her request for euthanasia.

It was clear from the case file that, in the six years before her death, the patient had undergone an extensive process of treatment and counselling, including various types of medication, hospitalisation, outpatient counselling and specialist treatment. She had been treated in accordance with the applicable guidelines, but this had not had sufficient effect. On the contrary, her situation had deteriorated. The compulsive rituals that were part of her OCD took up almost her entire day. She also had nightmares and relived traumatic experiences.

Despite the patient's young age, the independent psychiatrist concluded that her situation could not be improved by treatment. All the physicians involved in the case were of the opinion that she was suffering unbearably without prospect of improvement and that there was no reasonable alternative for her.

The committee was of the opinion that the physician had exercised particular caution. In the committee's opinion, the physician could be satisfied that the patient's request for euthanasia was voluntary and well considered, that her suffering was unbearable and without prospect of improvement, and that the physician and the patient together could be satisfied that there was no reasonable alternative in the patient's situation. The other due care criteria had also been fulfilled, in the committee's view.

Number 2022-085 on the website.

MULTIPLE GERIATIC SYNDROMES

The patient's suffering must have a medical dimension, which can be 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 (see Euthanasia Code 2022, p. 22).

MULTIPLE GERIATIC SYNDROMES

Straightforward notification, various conditions, elderly-care specialist consulted, GP performed euthanasia

The patient, a woman in her eighties, had been suffering from several geriatric syndromes for some time before her death. She was almost completely blind, suffered from osteoporosis with vertebral compression fractures, severe spinal deformity and vascular disease. Several months before her death she was also diagnosed with dementia. Around a month before her death, the patient contracted COVID-19. She was admitted to hospital, and it was then suspected that she was also suffering from heart failure. She did not want any further tests to be carried out.

The patient was experiencing a lot of pain in her back and legs, as a result of which she eventually spent her days just sitting on a chair. She was severely fatigued, short of breath, could see very little and kept losing her grip on the situation. She could no longer do the things that used to provide her with some distraction, such as watching television and knitting. The patient was hardly able to take care of herself any more. It became necessary for her to go into a nursing home, but she absolutely did not want to. She was suffering from the loss of autonomy and the ensuing dependence on other people.

Around two weeks before her death the patient asked the physician to perform euthanasia. The physician concluded that the request was voluntary and well considered. However, to be on the safe side, the physician consulted an elderly-care specialist, who also concluded that the patient was decisionally competent regarding her request for euthanasia. The physician was satisfied that her suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate the patient's suffering. The committee found that the physician had acted in accordance with the due care criteria.

Number 2022-079 on the website.

DEMENTIA

In cases involving patients with dementia, the physician is required to exercise particular caution when considering whether the statutory due care criteria have been met. This is especially true of the criteria relating to the voluntary and well-considered nature of the request, and unbearable suffering. In the early stages of dementia, the normal consultation procedure is generally sufficient. 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 (see Euthanasia Code 2022, pp. 47-48).

In nearly all the cases notified to the committees, the patient still has sufficient understanding of their situation and is decisionally competent in relation to their request for euthanasia. Besides the current decline in cognitive ability 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 Euthanasia Code 2022, p. 48).

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, provided the patient drew up an advance directive containing a request for euthanasia when still decisionally competent. Section 2 (2) of the Act states that an advance directive can replace an oral request and that the due care criteria mentioned in section 2 (1) of the Act apply mutatis mutandis (see Euthanasia Code 2022, pp. 48-49).

The following case involved a patient with dementia who was decisionally competent regarding her request for euthanasia. It is followed by a case in which euthanasia was performed on the basis of an advance directive.

DECISIONALLY COMPETENT PATIENT WITH DEMENTIA

Advancing dementia, elderly-care specialist consulted, patient decisionally competent

The patient, a woman in her eighties, was diagnosed with dementia several months before her death. It was likely that she had Alzheimer's disease. The patient was living in an assisted-living facility, but due to the rapid deterioration in her situation she would have to go into a nursing home. She had seen this at first hand with her late husband, and she did not want this to happen to her. She considered it to be degrading.

The physician, who had been the patient's GP for many years, had regularly discussed euthanasia with her. During these discussions, the patient always said she did not want to go into a nursing home and that if her dementia progressed she wanted euthanasia. The physician consulted an elderly-care specialist. The specialist was of the opinion that the patient was capable of fully grasping the implications of her choice. The independent physician also concluded that, despite her increasing loss of insight into her disease, the patient was capable of explaining clearly why she wanted euthanasia. All the physicians involved in the case found that the patient was decisionally competent regarding her request for euthanasia.

According to the physician, the patient was suffering unbearably. She had previously always been in full control of her life, but this was no longer possible due to her dementia. She could also no longer enjoy music. She dreaded the prospect of moving into a nursing home. She also became anxious and suspicious and suffered pain due to neuropathy (damaged nerves). This pain could not be treated properly, as the patient was afraid of taking new medication. The independent physician also concluded that the patient was suffering unbearably due to the prospect of further cognitive deterioration and having to go into a nursing home. The elderly-care specialist established that the patient was currently suffering unbearably. She suffered from the lack of purpose, from loneliness and from her dependence on other people.

The committee was of the opinion that the physician had exercised the particular caution expected of her in this situation. The committee found that the physician could be satisfied that the patient's request was voluntary and well considered and that she was suffering unbearably. The other due care criteria had also been fulfilled, in the committee's view.

Number 2022-115 on the website.

PATIENT WITH DEMENTIA WHO IS NO LONGER DECISIONALLY COMPETENT

Alzheimer's disease, advance directive, Euthanasia Expertise Centre

The patient, a woman in her seventies, was diagnosed around two-and-a-half years before her death with Alzheimer's disease on the basis of symptoms she had been suffering from for some time. More than two years before her death, she had drawn up a living will, including a dementia directive, with a notary. More than a year before her death she wrote an additional advance directive.

The patient's husband contacted the Euthanasia Expertise Centre (EE), because her GP would not perform euthanasia in cases involving dementia. The physician first visited the patient nine months before her death and again one month later. During these two visits, the patient said things that indicated she wanted to stay with her husband.

Two-and-a-half months before her death, the patient's husband again contacted the physician. He asked the physician to grant his wife's wish for euthanasia. The patient was no longer able to express her request herself. The physician visited the patient another four times.

VOLUNTARY AND WELL-CONSIDERED REQUEST

The committee concluded on the basis of the case file that the patient had been decisionally competent when she drew up her advance directives. In her living will with dementia directive, the patient had indicated that she wanted to die if she was in a terminal stage of decline for which no effective treatment was possible. The patient had also drawn up an additional advance directive, entitled 'fear of things to come'. In it, she had written that she feared loss of dignity since she could no longer think properly and could not take care of herself. The patient did not want to be dependent on other people; she wanted a dignified end to her life.

During the visit two months before her death, the physician concluded that the patient was decisionally incompetent with regard to her request for euthanasia. Her situation had deteriorated badly. In the physician's view, the current situation corresponded with the circumstances the patient had described in her advance directive. The physician also spoke with the patient's immediate family. They all confirmed that the patient would not have wanted to be in a situation like this. The patient's attending physicians also confirmed this.

The committee noted that, although the patient's living will was worded in rather general terms, her additional advance directive clarified matters. The committee was satisfied that when the termination of life on request was carried out, the circumstances referred to by the patient in her living will and described in her advance directive indeed existed. The patient was completely dependent on other people and no longer had any control over her thinking and actions. It was these aspects in particular that the patient had mentioned in her advance directive. The committee concluded that the patient's advance directive met two essential requirements: first that the patient wanted euthanasia if she became decisionally incompetent due to her dementia, and second that the suffering caused by her dementia was the basis for her request for euthanasia.

The committee also noted that the physician had made several attempts to communicate with the patient. She had tried to ascertain whether the patient could indicate verbally or non-verbally that she no longer wanted euthanasia. During the final conversations between the physician and the patient, communication was very difficult. It was often impossible to understand what the patient was saying. But in the moments when she appeared lucid, she made comments such as 'I'm lost, I don't want this anymore, I can't do anything anymore.'

UNBEARABLE SUFFERING WITHOUT PROSPECT OF IMPROVEMENT AND ABSENCE OF A REASONABLE ALTERNATIVE

As regards the unbearable nature of the patient's suffering, in the committee's view the physician had assessed this carefully. At an earlier stage, the patient had been frustrated about things other people could do and she could not. Later she often cried for long periods of time. According to the physician she was distressed and appeared frightened, and there was fear in her eyes. The patient became increasingly restless. She would walk around endlessly with her back hunched and would sometimes crouch on her hands and knees, drooling and calling for help. She could hardly speak and had trouble swallowing, so she could only eat liquid food. As a result, she had lost a lot of weight.

The patient's attending physicians confirmed this picture. They saw the suffering in the patient's eyes. Sometimes the patient had lucid moments, when she would walk away, angry and sad. In those moments in particular, the unbearable suffering was plain to see. The physician concluded that the patient was suffering both mentally and physically. She suffered from her dementia.

The independent elderly-care specialist and the independent physician also confirmed that the patient was suffering unbearably, even in her

lucid moments. During the conversation with the independent physician, the patient constantly looked frightened and muttered that she was scared and didn't want to go on. The physician was also satisfied that there was no reasonable alternative that would alleviate the patient's suffering. She was completely dependent on others and her cognitive deterioration was irreversible. Support and medication had not provided the patient sufficient relief. She also did not want to be admitted to a care facility. In addition, her suffering was without prospect of improvement. The independent elderly-care specialist and the independent physician concurred with the physician's conclusion.

INFORMED ABOUT THE SITUATION AND PROGNOSIS

It was clear from the case file that, since her diagnosis, the patient had spoken regularly with her GP about euthanasia and her advance directives. She had also discussed her disease and the prognosis with her immediate family. The patient had also written a number of letters, from which it was apparent that she was aware of her disease and its progression. In addition, during their first two conversations the physician had been able to discuss the patient's wish for euthanasia normally with her. The committee therefore found that at the time she drew up her advance directive the patient had been aware of her disease and its progression.

CONSULTING AN INDEPENDENT PHYSICIAN

The independent physician consulted by the physician had seen and spoken with the patient and studied all the relevant information, including the advance directive. He also spoke with the patient's husband. The independent physician concluded that the due care criteria for performing euthanasia had been complied with. The committee noted that the physician had also consulted an independent elderly-care specialist. The elderly-care specialist read the case file and spoke with various persons involved. She also listened to audio recordings of the patient. The elderly-care specialist had tried to have a conversation with the patient. She came to the conclusion that the patient was decisionally incompetent and agreed with the physician that the due care criteria had been fulfilled.

PROCEDURE

The committee noted that the physician had discussed the procedure, in the patient's presence, with the patient's family during her last visit. Having consulted a pharmacist, the physician thought that it would wise to administer a sedative before the euthanasia procedure on account of the patient's restless behaviour. This premedication was given to the patient in her apple sauce. She ate the apple sauce and went to bed. At this point, the physician was not yet present. After 45 minutes the

premedication started to take effect and the patient fell asleep. The physician, who had just arrived at that point, carried out the termination of life in accordance with the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of September 2021.

The committee found that the physician could be satisfied that the patient's request was voluntary and well considered, and that the written request for euthanasia could take the place of an oral request. The physician had also fulfilled the other due care criteria, in the committee's view.

Number 2022-043 on the website.

3 PHYSICIAN DID NOT ACT IN ACCORDANCE WITH THE DUE CARE CRITERIA

In the year under review, the RTEs found in 13 cases that the physician had not fulfilled the due care criteria in performing euthanasia. In one case, several due care criteria had not been met. Six cases concerned the due care criterion of consulting an independent physician, five cases concerned the particular caution that must be exercised in cases in involving a patient with a psychiatric disorder and in one case due medical care was not exercised when the euthanasia procedure was carried out. The findings in all these cases can be found on the website.

SEVERAL DUE CARE CRITERIA NOT FULFILLED

The Act states that the physician who performs euthanasia must comply with the due care criteria. This includes the physician being satisfied that the patient's request for euthanasia is voluntary and well considered, that their suffering is unbearable and without prospect of improvement, and that there is no reasonable alternative in the patient's situation. In the following case, the physician himself was not convinced that these due care criteria had been fulfilled.

CASE 2022-007

In this case, the physician wrote in his report that he had a number of doubts during the euthanasia process. He also wrote that he had made a compromise with his patient: he would not perform termination of life, but would assist in her suicide. The committee therefore decided to invite the physician to give an oral explanation.

At the meeting with the committee, the physician stated that he had thought it strange that the patient had made a request for euthanasia. Her husband had recently gone into a nursing home. As the physician had the impression that the patient was mentally unstable, he decided to consult an independent psychiatrist. The psychiatrist established that the patient was not suffering from a depressive or psychiatric disorder; he considered the patient to be decisionally competent. The physician consulted an independent physician who also considered the patient to be decisionally competent. The physician himself, however, stated that he thought the patient's request for euthanasia had been prompted by loneliness and possible depression.

The physician was also not convinced that the patient was suffering without prospect of improvement. He saw moving into a care home as a reasonable solution for her. She would be able to socialise there, which might help her to gain more enjoyment from her life. However, the patient was not prepared to discuss moving house. The physician could not empathise with this. Even the fact that the independent psychiatrist and the independent physician were of the opinion that the patient was suffering unbearably without prospect of improvement and that there was no alternative that would be reasonable to her did nothing to remove the physician's doubts. As the physician did want to go some way towards granting the patient's wish, he decided on a compromise: no euthanasia by means of an IV cannula, but assisted suicide, whereby the patient would herself ingest a potion that would end her life.

During the meeting the committee pointed out to the physician that the Act does not offer scope for such a compromise. The same due care criteria apply to both termination of life on request and assisted suicide. The physician should have discussed his doubts with the patient. The committee understood the physician's comment that if the patient ingested the euthanatics herself, that would indicate an intrinsic wish on the part of the patient. However this makes no difference for the assessment of the due care criteria.

As the physician was not satisfied that the patient's request for euthanasia was voluntary and well considered, that her suffering was

unbearable and without prospect of improvement, and that there was no reasonable alternative in the patient's situation, he should not have performed euthanasia. The committee therefore found that the physician had not acted in accordance with these due care criteria. The physician had fulfilled the other due care criteria.

CONSULTING AN INDEPENDENT PHYSICIAN

The Act states that physicians must consult at least one other, independent physician, who must see the patient and give a written opinion on whether due care criteria (a) to (d) have been fulfilled. The Euthanasia Code also refers to the fact that the Act states that this physician must be independent. The independent physician must be in a position to form their own opinion. The concept of independence refers to their relationship with both the physician and the patient. The requirement of independence on the part of the independent physician in relation to the physician means that there must be no personal, organisational, hierarchical or financial relationship between the two. For instance, if a certain physician is from the same medical practice or partnership, if there is a financial or other relationship of dependence with the physician requesting an opinion (for instance, if the independent physician is a registrar), or if there is a family relationship between them, that person cannot act as the independent physician. Nor can the independent physician be the physician's patient (see Euthanasia Code 2022, pp. 27 ff).

With regard to three notifications, the committee found that there was a relationship of dependence because the independent physician was registered as a patient with the physician performing euthanasia. One of these cases is described below, the other two can be found on the website.

CASE 2022-052

(see also cases 2022-070 and 2022-109)

In this case, the physician wrote the following in her report with regard to the independent physician's independence in relation to her: 'By coincidence he is a patient [of mine]. I found this out, but I've never seen him at the surgery. We have no other relationship.' In his report, the independent physician wrote: 'I feel free to do the consultation. I know the GP as a colleague, but we have no further relationship.'

It became apparent from the oral explanation to the committee that the physician and the independent physician had come into contact through the roster of SCEN physicians. The physician recognised the independent physician's name. In her oral explanation, the physician stated that they had discussed whether it was a problem that the independent physician was registered as a patient in her practice. The independent physician said it was not. The physician therefore did not consider consulting a different SCEN physician.

The physician also stated that she had taken over the practice, with a large number of patients, from her predecessor. At that time the independent physician was already registered as a patient. She never had an introductory appointment with him, nor did the independent physician ever visit her surgery. He was never referred to specialist doctors by her, nor had there been any contact by phone. According to the physician, there was therefore no active doctor-patient relationship. It did not 'feel' like the independent physician was her patient. The independent physician also stated that he had never visited the physician or spoken to her before. He had visited the practice, but not the physician herself.

In the committee's view it is not appropriate for a physician who is registered as a patient of the physician performing euthanasia to be consulted as the independent physician, because the suggestion of non-independence must be avoided.[9] In this case there was a suggestion of non-independence due to the existing doctor-patient relationship between the physician and the independent physician.

9 *At the time of these findings, the Euthanasia Code 2018 (revised version published in 2020) was still in effect. This is why reference is still made to 'the suggestion of non-independence'. This term is no longer used in the new Euthanasia Code 2022. The rules regarding the relationship between the independent physician's independence in relation to the physician performing euthanasia have not changed, however.*

The physician knew that the independent physician was registered as a patient in her practice. She should have consulted a different independent physician in order to avoid any suggestion of non-independence. The committee therefore found that no independent physician had been consulted.

The physician had fulfilled the other due care criteria.

THE INDEPENDENT PHYSICIAN'S INDEPENDENCE IN RELATION TO THE PATIENT (DOUBLE EUTHANASIA)

Sometimes, both members of a couple may make simultaneous requests for euthanasia. If both requests are granted, this is sometimes referred to as 'double euthanasia'. In such cases, the committees expect the physician or physicians to consult a different independent physician for each of the partners. This is necessary to ensure that the two cases are assessed separately. Both independent physicians must be satisfied that neither partner is exerting undue pressure on the other in relation to their request for euthanasia (Euthanasia Code 2022, p. 30).

The following (combined) cases are an example of this.

CASE 2022-098 (AND 2022-099)

In this case, a patient and his wife requested euthanasia simultaneously. The couple were living together in a nursing home.

The committee noted that the same independent physician had been consulted for both the man and the woman. The committee therefore decided to invite the physician and the independent physician to give an oral explanation.

At the meeting with the committee it became apparent that the physician had already told the independent physician on the phone that the case concerned a SCEN consultation for a couple. The independent physician said that he did not consider the consultation request as one for double euthanasia, but as two separate consultations. The independent physician visited the two patients one after the other on the same day; first the woman and then the man. Part of the conversation with each of the two patients was in private. The independent physician was satisfied in both cases that the due care criteria had been complied with.

Both the physician and the independent physician stated that they were not familiar with the section of the Euthanasia Code from which it follows that a separate independent physician must be consulted for each of the patients in cases involving double euthanasia.

As the independent physician had spoken with both the man and the woman, the suggestion of non-independence in relation to the two patients could not be avoided.[10] Moreover, the independent physician stated that it would have been possible to have two different independent physicians visit the man and the woman, if the physician had requested it. The committee therefore found that the physician had not fulfilled the due care criterion concerning consultation of at least one other, independent, physician.

The physician had fulfilled the other due care criteria.

10 *At the time of these findings, the Euthanasia Code 2018 (revised version published in 2020) was still in effect. This is why reference is still made to 'the suggestion of non-independence'. This term is no longer used in the new Euthanasia Code 2022. The rules regarding the relationship between the independent physician's independence in relation to the physician performing euthanasia have not changed, however.*

THE INDEPENDENT PHYSICIAN MUST SEE THE PATIENT

Both the Explanatory Memorandum to the Act and the Euthanasia Code state that the independent physician must see the patient. 'Seeing' the patient will normally mean 'visiting' the patient (see Euthanasia Code 2022, p. 31, footnote 24). In the following case, the physician did not fulfil that requirement.

In this case the independent physician did not visit or see the patient, but instead did the consultation by phone, due to coronavirus symptoms. The physician and the independent physician were invited by the committee to give an explanation.

At the meeting with the committee, the physician stated that she only noticed that the SCEN consultation had taken place by phone when she received the SCEN report. The physician was aware of the requirement for the independent physician to see the patient. She therefore asked the independent physician whether his not having paid a visit in person was permissible. The independent physician consulted with a fellow SCEN physician and was satisfied that a consultation by phone was in accordance with the due care criteria. He conveyed this to the physician, who acted on this information.

The independent physician informed the committee in writing that a video conference had not been an option for the patient. The physician had not verified this, but at the meeting with the committee she said that in fact she did not see why the patient could not have taken part in a video conference.

The committee noted that the independent physician's assessment had not been done in the correct manner. The physician bears ultimate responsibility for the euthanasia process and thus also for correctly fulfilling the requirement of consulting an independent physician. Although the physician had conveyed her doubts about a consultation by phone to the independent physician, she had still consented to his method. The physician should have checked whether the independent physician's information was sufficient.

In addition, there were ways in which the consultation could have been done correctly in this situation. The physician could have contacted a different SCEN physician; according to her there would have been enough time. The video conferencing option could also have been explored. That would at least have allowed the independent physician to see the patient.[11]

The committee found that the due care criterion concerning consultation of at least one other, independent, physician had not been fulfilled. The physician had fulfilled the other due care criteria.

11 *In the exceptional situation caused by the coronavirus pandemic, SCEN physicians were allowed to use digital means (video conferencing) for their SCEN consultations instead of visiting the patient in person. The arrangement that made this possible is now no longer in effect.*

DUE MEDICAL CARE

In assessing whether the physician has exercised due medical care, the RTEs refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide'. 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 (see Euthanasia Code 2022, p. 34). The Guidelines also state that the physician must not administer the muscle relaxant until the patient's consciousness is sufficiently reduced by the coma-inducing substance and the physician has adequately established this. This requirement was not fulfilled in the following case.

CASE 2022-040

During the euthanasia procedure in this case, the physician first wanted to use sodium chloride to flush the cannula that had already been inserted, before administering the coma-inducing substance and the muscle relaxant. However, he picked up the wrong syringe, namely the one with the muscle relaxant. He injected one-third of its contents into the cannula, assuming that it was the syringe with sodium chloride.

After three to five minutes, the physician saw that the patient had lost consciousness. The physician checked his breathing, heart activity and reflexes, and established that the patient had died. The physician checked the cannula and then saw the partially used syringe with the muscle relaxant. At that point he realised he had made a mistake.

The physician informed the forensic physician about what had happened. They discussed the fact that it was unclear what the ultimate cause of death was. It could have been the administration of the muscle relaxant, but it could also have been a cardiac arrest. The latter was conceivable in view of the patient's weakened state and the fact that his implantable cardioverter defibrillator (ICD) had been switched off. As the muscle relaxant had been administered, it was decided that a notification would be sent to the RTE.

The physician was invited to a meeting with the committee. He said that he was aware of the lack of due medical care and that the mix-up with the syringes should never have happened. He had discussed the faulty procedure at a multidisciplinary consultation and submitted a report under the Safe Reporting of Incidents Procedure (VIM). In that report, the physician listed a number of points for improvement for himself, so as to avoid a repetition in the future.

The committee pointed out that the Guidelines state that the physician must not administer the muscle relaxant until the patient's consciousness is sufficiently reduced and the physician has adequately established this. The physician had not administered a coma-inducing substance, so the patient's consciousness had not been sufficiently reduced when the physician administered the muscle relaxant. The committee found that the physician had not fulfilled the criterion of due medical care.

The physician had fulfilled the other due care criteria.

EXERCISING PARTICULAR CAUTION IN CASES INVOLVING PATIENTS WITH PSYCHIATRIC DISORDERS

If a request for euthanasia is based (mainly) on suffering caused by a psychiatric disorder, physicians are expected to exercise particular caution. Such caution must be exercised especially 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. The RTEs' basic principle is that for this category of patients the physician must always seek psychiatric expertise. The purpose of seeking psychiatric expertise is for the physician to ensure they are well informed and can reflect critically on their own convictions (see Euthanasia Code 2022, pp. 45-47).

In the following three cases, the requirement to consult an independent psychiatrist was not fulfilled. As a result, the physician did not exercise the required particular caution.

CASE 2022-039

This case involved a patient with chronic depressive disorder. She had undergone various types of treatment, to no effect. The patient also had various physical problems, particularly abdominal complaints and symptoms similar to those of Parkinson's disease. No somatic causes could be found for this. In addition, the patient had become blind in one eye due to a stroke and had possibly developed neurocognitive disorders.

In his report, the physician specifically mentioned the central role that the patient's depressive disorder had played in her request for euthanasia, but he had not consulted an independent psychiatrist.

The committee therefore decided to invite the physician to a meeting. The physician said that he had based his decisions fully on the independent physician's conclusion. The independent physician had established that the essence of the patient's suffering consisted of her depressive disorder. The independent physician then concluded that all the due care criteria for the performance of euthanasia had been fulfilled.

In the committee's view, the advice of the independent physician, who was not a psychiatrist, was insufficient. Once the independent physician had established that the essence of the patient's suffering consisted of a depressive disorder, he should have pointed out to the physician that the Euthanasia Code requires the physician to consult an independent psychiatrist in such cases. However, even though the independent physician should have informed the physician better in this case, it is always the physician who bears ultimate responsibility.

As the physician had not consulted an independent psychiatrist, the committee found that the physician could not be sufficiently satisfied that the patient's request was voluntary and well considered, that she was suffering without prospect of improvement and that there was no reasonable alternative in her situation.

The physician had fulfilled the other due care criteria.

CASE 2022-059

This case concerned a patient who had from a young age suffered from depression, an anxiety disorder, borderline personality disorder and post-traumatic stress disorder (PTSD). She had undergone extensive treatment for this. In addition, the patient suffered from a debilitating pain syndrome and she was visually impaired and hearing impaired. She was dependent on other people and had become socially isolated.

Four years earlier, she had started a euthanasia process, with the help of her GP. The independent physician consulted at the time concluded that a psychiatric expert should be consulted. The patient had refused this because of her traumatic experiences with regard to psychiatric treatment. The euthanasia process was halted for that reason. When the patient wanted to begin a new euthanasia process, she approached a GP (the physician in this case) whom she knew from participation in a scientific study.

The physician consulted an independent geriatrician. The views expressed by the geriatrician on the patient's suffering were insufficient to draw any conclusions. The independent physician consulted by the physician concluded that the patient's chronic psychiatric problems did not affect her decisional competence with regard to her request for euthanasia. This independent physician (the same one who had visited the patient four years previously) thus disregarded his own earlier conclusion that the patient's request for euthanasia required a psychiatric assessment. The independent physician agreed with the physician that a psychiatric assessment would be 'unrealistic, ineffective and disproportionate'. However he did not substantiate this assertion.

After studying the case file, the committee wanted to gain more insight into the euthanasia process, given its exceptional nature. The committee therefore invited the physician to give an oral explanation.

At the meeting with the committee, the physician said that the patient's PTSD had become less severe. According to her, the patient was also no longer suffering from depression or an anxiety disorder. In addition, the borderline personality disorder had not affected the patient's decisional competence. The physician could understand that the patient had not wanted to cooperate with a psychiatric assessment, for fear of her PTSD flaring up. The physician had no doubts about the patient's decisional competence with regard to her request for euthanasia and had therefore seen no reason to consult an independent psychiatrist.

As regards the unbearable nature of the patient's suffering and the absence of a reasonable alternative, the physician said at the meeting that the patient did not want to undergo any more treatment for her pain syndrome. Nothing could be done about her visual impairment or her hearing impairment. Her mental suffering was also irreversible according to the physician. The physician believed that bringing in an independent psychiatrist to assess the unbearable nature of the suffering would place an unnecessary burden on the patient.

In the committee's view, although the physician and the independent physician had no doubts about the patient's decisional competence, the physician should nonetheless have exercised particular caution, given the patient's mental health problems and the complexity of the case. The physician was of the opinion that the patient's mental health problems had diminished. In the committee's view however, this should have been established by an independent psychiatrist. The committee also considered that a psychiatric assessment had been deemed necessary in the previous euthanasia process and that the physician had not had a sustained treatment relationship with the patient. They had met in person only once; other contact had mainly taken place digitally.

As the physician had not consulted an independent psychiatrist, the committee found that the physician could not be sufficiently satisfied that the patient's request was voluntary and well considered, that she was suffering without prospect of improvement and that there was no reasonable alternative in her situation.

The physician had fulfilled the other due care criteria.

CASE 2022-068

This case concerned a patient with obsessive compulsive disorder. She also suffered from borderline personality disorder and chronic depression. The patient was suicidal. Her extreme compulsions limited her daily life: she could no longer go outside and had hardly any social contacts left. The patient was sombre, anxious and lonely.

The patient's former GP had referred her to a psychiatrist, to see whether there were any treatment options left. The psychiatrist assessed the patient two years before her death. He concluded that the patient's depression was largely in remission and that she had found a balance in dealing with the obsessive compulsive disorder. In addition, he considered the patient to be decisionally competent with regard to refusing treatment. In his report, the psychiatrist mentioned specifically that he had seen the patient, not in the context of a request for euthanasia, but with a view to possible treatment.

The physician was invited to provide an oral explanation. At the meeting with the committee, the physician confirmed that she had considered the psychiatrist's report as the report of an independent psychiatrist in the context of the required 'particular caution'. In the physician's view, the report sufficiently answered the questions she would have asked in the context of a request for euthanasia. She did not consider the fact that the report was two years old reason enough to contact the psychiatrist again, as the patient's situation had not changed in the meantime. As regards the psychiatrist's specific remark that the assessment had not taken place in the context of a request for euthanasia, the physician stated that this had been included in the report due to disagreement between the patient and the clinic with which the psychiatrist was affiliated. According to the physician, at the time of the assessment the patient already had a wish to die.

The committee found that the psychiatrist's report could not be considered as the consultation of an independent expert within the meaning of the Euthanasia Code. The psychiatrist had stated that his assessment had not been conducted in the context of a request for euthanasia. Moreover, two years had passed between the report and the performance of euthanasia. In such a situation the physician must establish whether the circumstances have changed, and it therefore makes sense for the physician to again contact the independent psychiatrist in question. As there was no further contact between the physician and psychiatrist, the physician was insufficiently able to reflect critically on her own convictions. The report by the independent

physician consulted by the physician could not suffice either, as the independent physician did not have enough expertise in the field of psychiatry.

As the physician had not consulted an independent psychiatrist, the committee found that the physician could not be sufficiently satisfied that the patient's request was voluntary and well considered, that she was suffering without prospect of improvement and that there was no reasonable alternative in her situation.

The physician had fulfilled the other due care criteria.

In the fourth case the physician consulted an independent psychiatrist. However, the psychiatrist did not give his views on whether there was any prospect of improvement or on the absence of a reasonable alternative.

CASE 2022-075

This case concerned a patient who had been suffering from chronic pain in different parts of her body for nine years. She could no longer stand the pain. The cause of the pain was unknown and although the patient underwent various courses of treatment, none of them helped. She also suffered from borderline personality disorder and recurring depression.

The physician consulted an independent psychiatrist. However, the physician only asked him to assess the patient's mental state in the context of her request for euthanasia (the physician was unaware of the fact that the independent psychiatrist must also assess other matters). The independent psychiatrist considered the patient to be decisionally competent with regard to her request for euthanasia. The other physicians involved had no doubts about the patient's decisional competence with regard to her request for euthanasia either.

In his report, the independent psychiatrist also noted that he had insufficient insight into the treatment undergone by the patient throughout the years. As a result, he had doubts as to the effect of her lifestyle on her mood and the ensuing wish for euthanasia. In the independent psychiatrist's opinion, it might be possible to influence the patient's wish for euthanasia.

The committee decided to invite the physician to a meeting to discuss matters, including the lack of prospect of improvement in the patient's suffering. At the meeting, the physician stated that he believed the patient's suffering was without prospect of improvement. No explanation had ever been found for her pain symptoms. The mental healthcare facility where the patient had been treated indicated that, after all the patient's visits over the years, there was nothing more they could do for her. The patient did not want to undergo any further assessments or treatment.

The physician stated that after the independent psychiatrist had confirmed that the patient was decisionally competent with regard to her request for euthanasia, he had disregarded the independent psychiatrist's further remarks about possible treatment options. The

physician did, however, ask the independent physician to assess possible treatment options for the patient. To that end, the independent physician asked for an overview of the patient's treatment history. The physician requested this information from the psychiatric clinic and shared it with the independent physician. On the basis of this information, the independent physician was satisfied that the patient's suffering was without prospect of improvement. The independent physician then shared this information with the independent psychiatrist, who, on the basis of that information, was able to understand why the independent physician had come to this conclusion.

The committee considered this course of events strange, particularly because the independent psychiatrist told the independent physician that he understood the latter's view, whereas this should really have been discussed with the physician. It is the physician, not the independent physician, who is responsible for the euthanasia process. The physician must therefore be in possession of all the relevant information, and he should have discussed his considerations and conclusions with the independent psychiatrist, particularly in view of the fact that the independent psychiatrist had previously expressed doubt as to whether the patient was suffering without prospect of improvement. While it is true that the physician did not ask the independent psychiatrist about this, when the latter said he had doubts, the physician should have taken this into account in his decision.

The committee found that the physician had failed to sufficiently demonstrate that he could be satisfied that the patient was suffering without prospect of improvement and that there were no reasonable treatment options left.

The physician had fulfilled the other due care criteria.

In the final case in this report, the independent psychiatrist found that the patient was not decisionally competent. The physician disregarded this finding.

CASE 2022-017

This case concerned a patient who was diagnosed with delusional disorder (a psychotic disorder) 10 years before his death. Around that time, the patient was taken into custody at a remand centre, in connection with a criminal offence. He was experiencing a psychotic episode at the time and became chronically depressed. Later, the patient was admitted under an involuntary admission measure to a clinical residential facility. By his own account, the patient had always functioned normally before his psychotic episode, and he believed that the diagnosis of his psychotic disorder was incorrect.

The committee first considered the fact that the patient had been admitted involuntarily to a mental healthcare facility. It was clear from the case file that being in an involuntary setting was the only way for this patient to be able to function. In the committee's view this admission did not affect the voluntary nature of this request.

Just under two years before the patient's death, the physician consulted an independent psychiatrist, who concluded that the patient was not decisionally competent with regard to his request for euthanasia. In her view, the patient's wish to die stemmed from psychotic episodes.

The committee therefore decided to invite the physician to give an oral explanation. At the meeting with the committee, the physician, who was a psychiatrist herself, stressed that she was convinced that the patient was decisionally competent with regard to his request. Although several psychiatrists had doubts about the patient's decisional competence, according to the physician this did not concern his decisional competence with regard to his wish for euthanasia. The physician countered the assertion that the patient's reasoning was based on psychotic episodes by asserting that the patient was able to recount his experiences of loss in a way that made them palpable. In her view, therefore, there really was 'partial decisional competence in this area'. The physician stated that the patient's delusional disorder and his wish to die were two separate things. In her view there was a difference in interpretation between her and the other psychiatrists who had been involved in the patient's case.

In its deliberations, the committee took into account the norm in the Euthanasia Code that states that if there is a difference of opinion between the physician and the independent physician, the physician can nevertheless decide to grant the patient's request for euthanasia, but will have to be able to provide adequate grounds for this decision (Euthanasia Code, pp. 28-29). The committee believes the same applies in the event of a difference of opinion between the physician and the independent expert. However, the committee concluded that, during the meeting, the physician had insufficiently substantiated her own views. The committee also questioned whether the physician had been sufficiently open to the independent psychiatrist's assessment of the patient's decisional competence. In this respect, the committee took into account an email from the independent psychiatrist to the physician, sent two weeks before the patient's death. The independent psychiatrist wrote that in the two years since she had been consulted, her opinion regarding the patient's decisional competence had not changed. She also wrote that she did not understand the physician's reasoning regarding the patient's decisional competence and noted that the physician had not systematically considered each of the criteria for assessing decisional competence.

After studying the documentation and meeting with the physician, the committee could not help but think that the physician had been convinced right from the start of the euthanasia process that euthanasia should be performed. As a result, the committee found, she had been insufficiently receptive to the independent psychiatrist's views. The committee therefore had no other option than to conclude that the physician had not exercised the required particular caution with regard to the due care criterion concerning the voluntary and well-considered request.

The physician had fulfilled the other due care criteria.

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