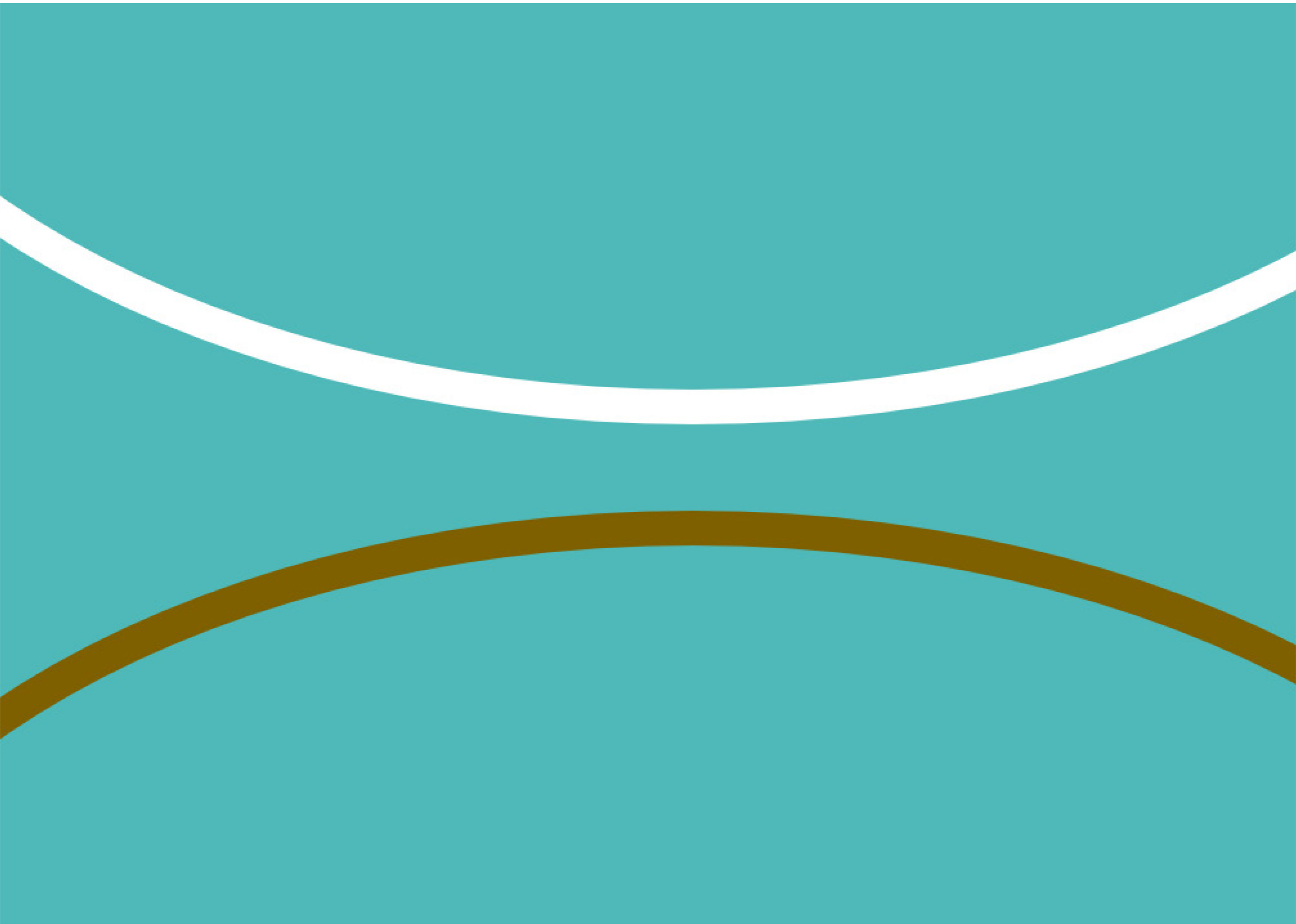
RTE REGIONAL EUTHANASIA REVIEW COMMITTEES

EuthanasiaCode

Review Procedures in Practice

This version is applicable from January 2026



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Foreword

It is my pleasure to present to you the latest version of the Euthanasia Code of the Regional Euthanasia Review Committees (RTEs). Previous versions of the Euthanasia Code had the year of publication in the title. This is no longer the case, as it is the RTEs' intention to update the Euthanasia Code every six months from now on.

The current update concerns a limited number of points, which you can find on page 4. Another important change is in the format: from now on the Code will only be published digitally.

In the Euthanasia Code, the RTEs explain how they review notifications of euthanasia for compliance with the statutory due care criteria. This is important for physicians who are involved in the performance of euthanasia. The Code provides practical guidance for both physicians and independent physicians on preparing and performing euthanasia.

It is also important for society at large to know how the RTEs translate the legal requirements for due care in relation to euthanasia into practical review criteria. By providing transparency regarding the way in which they review cases, the RTEs wish to foster confidence in the review procedure and thus confidence in the due care that characterises the euthanasia process.

The Euthanasia Code is also vital for the members and staff of the RTEs. The various committees are all expected to adhere to the Code when they review euthanasia notifications. In this way the Code promotes legal uniformity among the committees.

I am grateful to the members and secretaries of the RTE reflection chamber for all the hard work they have put into updating the Code.

If there is anything you think should be added to the Euthanasia Code, please use the contact form on the website (english.euthanasiecommissie.nl) to send us your comments.

Mariëtte Moussault,
Coordinating chair of the regional euthanasia review committees

Main changes compared with the 2022 version

- A passage was removed from section 3.6. (Independent physician) which stated that the RTEs can contact a SCEN physician if the quality of their report is insufficient. The RTEs do not review the actions of the SCEN physician, but of the physician who performed euthanasia. In the event that the quality of the SCEN physician's report is insufficient, the RTEs will inform the physician who performed euthanasia accordingly.

- A separate section (section 4.3.) has been included on the topic of 'double euthanasia', under the heading of 'Specific issues'. Section 3.6. (Independent physician) now includes a reference to that section in the passage about 'double euthanasia'. The term 'couple' has been replaced by 'two persons in a close relationship with each other'.

- Section 3.7. (Due medical care) includes a new section on what a physician should do if the procedure for termination of life on request does not proceed according to plan, and in what circumstances the RTEs will reach the conclusion that due medical care was not exercised when carrying out the termination of life on request.

- In section 4.4. changes have been made to the specific issue of 'patients with a psychiatric disorder or a combination of somatic and psychiatric disorders'. The review framework has been made clearer. A number of distinct possible situations have been described, including what is expected from the physician in those situations. A flowchart has also been included.

1. Purpose and structure of the Euthanasia Code

Since the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act') entered into force in 2002, five regional review committees have had the statutory task to review notifications by physicians of cases in which they have carried out termination of life on request or assisted with suicide. In the intervening years, the committees have reviewed many thousands of cases on the basis of the due care criteria set out in the Act.[1]

Each year, the RTEs give an account of these activities in a joint annual report. They also publish a considerable number of their findings on euthanasiecommissie.nl. The annual reports and the published findings of the committees give an impression of how the committees apply and interpret the statutory due care criteria for euthanasia. In order to make this information more accessible, the committees have drawn up a Euthanasia Code. As of 2026, the Euthanasia Code will be updated twice a year.

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

In the Euthanasia Code, the RTEs give a practical overview of how they interpret the due care criteria. The aim of the Code is not to describe every conceivable situation, but to provide a summary of the committees' deliberations.

The Code is of particular relevance to physicians performing euthanasia and independent physicians, but it also contains useful information for patients intending to request euthanasia and for other interested parties. It gives them an idea of the due care criteria that must be complied with. It is important that it is clear to everyone how the committees apply the Act.

The Euthanasia Code is structured as follows. Chapter 2 briefly outlines the legislation on euthanasia and the review committees' procedures. It also considers the relevance of medical professional guidelines. Chapter 3 contains a general explanation of the statutory due care criteria and of the way in which the RTEs interpret them. Chapter 4 discusses a number of specific issues and situations. Chapter 5 lists several useful references.

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[1] A translation of the Act is included in the annexe containing relevant statutory provisions.

[2] This distinction is discussed in, for instance, section 3.7., concerning due medical care in performing euthanasia.

2. Outline of the Act, committee procedures and relevance of guidelines

2.1. Outline of the Act

Due care criteria[3]
In the decades before the Act entered into force, a (legal) practice developed in the Netherlands in which a physician could under certain circumstances comply with a patient's request for euthanasia if the patient was suffering unbearably. There were other requirements besides the patient's request and the unbearable nature of their suffering. These were subsequently laid down in the Act, which has been in force since 2002.

Under articles 293 and 294 of the Criminal Code, euthanasia is prohibited in the Netherlands. The entry into force of the Act did not change that. An exception has been made for physicians only. Euthanasia performed by a physician who has complied with all the due care criteria set out in the Act and has notified the municipal pathologist is not a criminal offence (see section 2.2. of this Code).[4]

Under section 2 (1) of the Act, the physician must:
a. be satisfied that the patient's request is voluntary and well considered;
b. be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
c. have informed the patient about their situation and prognosis;
d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;
e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled; and
f. have exercised due medical care and attention in terminating the patient's life or assisting in the patient's suicide.

The patient's suffering must have a medical dimension (see section 3.3.). However, there is no requirement that the medical condition should be a somatic (physical) disease or disorder. Nor does it have to be life-threatening. There is no provision in the Act that euthanasia may only be performed in the terminal stage.

In cases where the statutory due care criteria have been fulfilled, the patient's life expectancy plays no role. In practice, it will often be limited, but the Act does not rule out granting a request for euthanasia from a patient who might have many years to live.

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

> See also section 4.2.

A number of Supreme Court judgments are of importance to the interpretation of the Act. They set requirements, supplementary to the Act, which remain relevant. These judgments are discussed below where appropriate.

> Schoonheim judgment (1984): section 3.3.

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[3] For more detailed information please go to english.euthanasiecommissie.nl.
[4] Articles 293 and 294 of the Criminal Code are included in the annexe containing relevant statutory provisions.

> *Chabot judgment (1994): section 3.3.*

> *Brongersma judgment (2002): section 3.3.*

> *The judgment in the criminal case concerning euthanasia for a patient with advanced dementia (2020): section 4.1.*

Physicians are not obliged to grant a request for euthanasia, even if the due care criteria set out in the Act have been fulfilled. Patients do not have a right to euthanasia, and physicians are entitled to refuse to carry out euthanasia. If a physician is unwilling to perform euthanasia, it is prudent from a medical professional point of view to inform the patient accordingly as early as possible.[5] The patient can then, if they so wish, contact another physician. Physicians may also refer the patient to a colleague, or to the Euthanasia Expertise Centre.[6]

Notification and review

A physician who has performed euthanasia must notify this to the municipal pathologist, completing the appropriate model notification form and handing it over at the post-mortem examination. The physician also provides the pathologist with a detailed report[7] (using the model reporting form as provided for in the Model Forms (section 9, subsection 2 of the Burial and Cremation Act) Decree, which can be downloaded (in Dutch) from euthanasiecommissie.nl or knmg.nl), together with the independent physician's report.[8] In most cases, the physician also submits other information, such as all or parts of the patient's medical records, letters from specialists and, if there is one, the patient's advance directive. The municipal pathologist must send the notification, including the various documents, to the appropriate regional review committee, which then reviews the reports and the euthanasia procedure.[9] If the committee finds that the physician has satisfied all the requirements, it informs the physician in writing, and the review procedure ends.

If the committee finds that the physician did not fulfil one or more due care criteria, it will also inform the physician in writing. But it is then also legally required to report its findings to the Public Prosecution Service (OM) and the Health and Youth Care Inspectorate (IGJ).[10] These bodies then consider what steps they think are appropriate.

The committee examines whether the physician who performed euthanasia acted with due care in the context of the Act, the legislative history and relevant case law. It also takes into account previous findings of the RTEs, medical and other professional standards, and decisions made by the Public Prosecution Service regarding euthanasia cases.

The committee establishes whether all the aforementioned due care criteria have been fulfilled. When considering due care criteria (a), (b) and (d), the committee establishes whether the physician was reasonably able to conclude that the patient's request was voluntary and well considered, that the patient's suffering was unbearable, with no prospect of improvement, and that there was indeed

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[5] See The Hague Regional Disciplinary Board, 19 June 2012.

[6] expertisecentrumeuthanasie.nl/en

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

[8] See section 7 (2) of the Burial and Cremation Act. A translation of this provision is included in the annexe containing relevant statutory provisions.

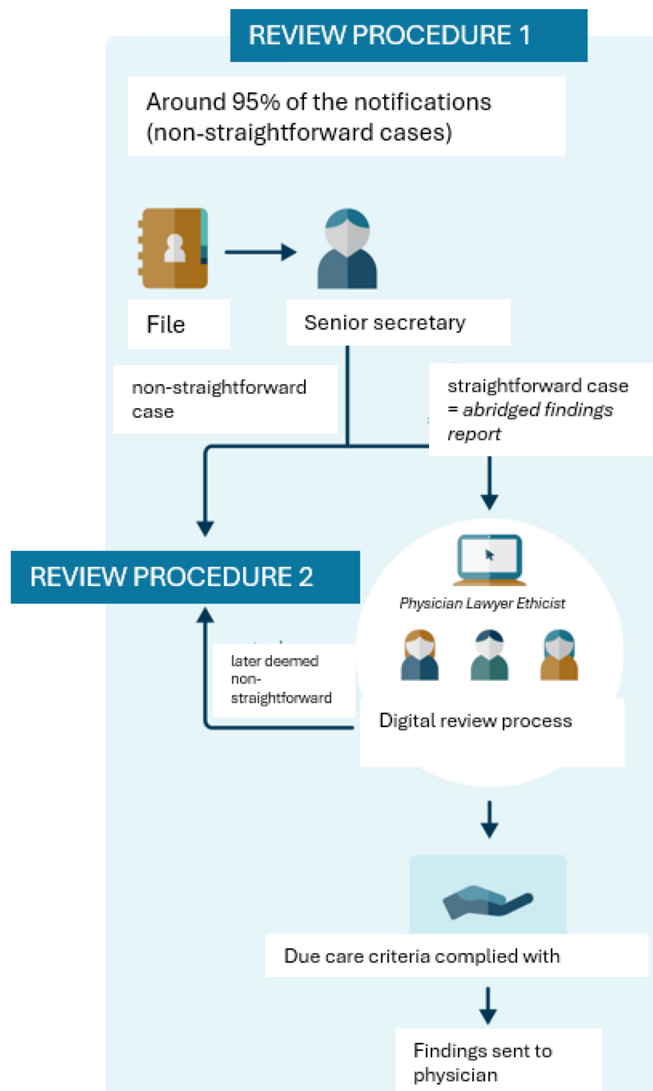
[9] If necessary the committee can ask the municipal pathologist for further information.

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

no reasonable alternative. As regards due care criteria (c), (e) and (f), the committee establishes whether the physician informed the patient, whether the physician consulted at least one independent physician and whether the physician exercised due medical care in carrying out the procedure.

2.2. Committee procedures[11]

There are five regional review committees: one for Groningen, Friesland, Drenthe and the BES islands,[12] one for Overijssel, Gelderland, Utrecht and Flevoland, one for North Holland, one for South Holland and Zeeland, and one for North Brabant and Limburg.[13]



[11] For more detailed information, see www.euthanasiecommissie.nl, where the Dutch version of the guidelines on regional euthanasia review committee procedures (2019) can be downloaded.
[12] Bonaire, Saba and St Eustatius.
[13] For the composition of the committees, see www.euthanasiecommissie.nl.

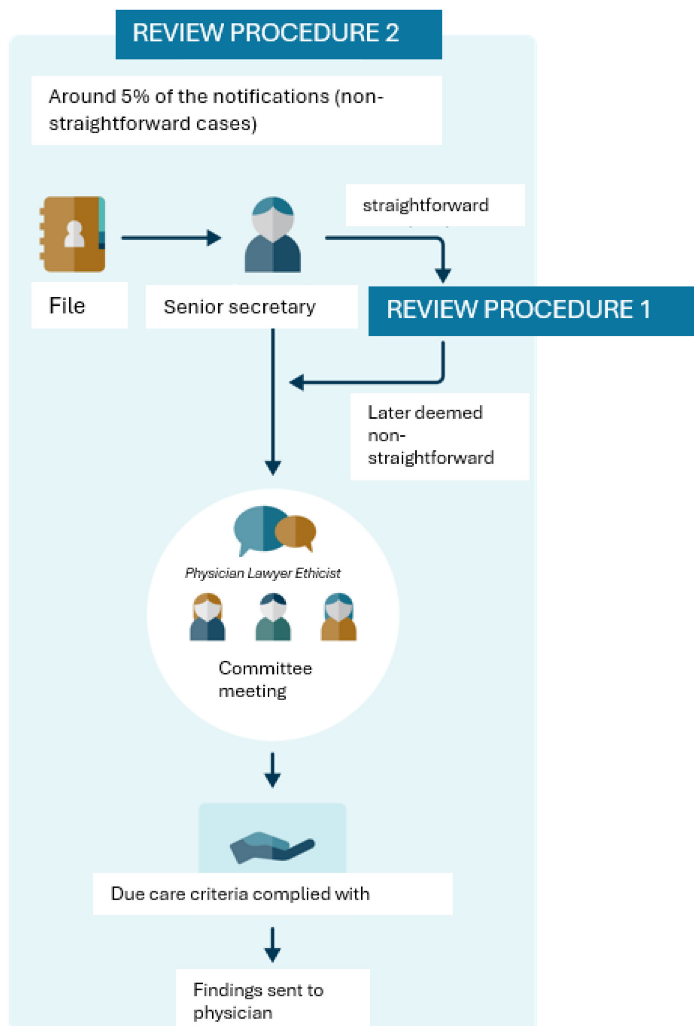
The committees assess the notifications they receive on the basis of the detailed report produced by the physician who performed euthanasia (i.e. the completed model reporting form), the independent physician's report and other relevant documentation (such as medical records, letters from specialists and/or an advance directive).

Review procedure 1

The committees distinguish between two categories of notification: straightforward notifications (which account for some 95% of cases) and notifications that raise questions (around 5% of cases). Committee members review straightforward notifications digitally, and can consult with one another via a secure digital network. Straightforward notifications are not reviewed at committee meetings.

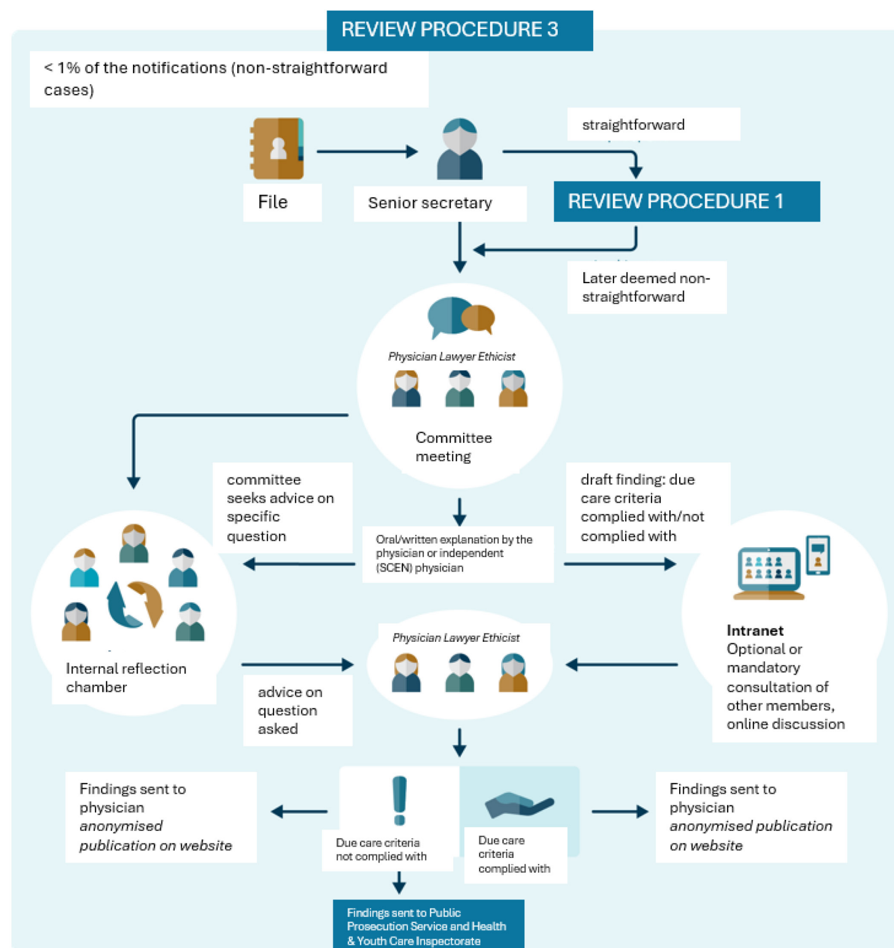
Review procedure 2

If any questions arise during the digital review process, the committee members may agree to change the status of the notification to non-straightforward. Non-straightforward notifications are always reviewed at a committee meeting. Whether a particular notification is straightforward or not depends on the questions it raises. For instance, the case may be particularly complex, or the information provided by the physician is insufficiently clear.



Review procedure 3
The physician must answer the questions on the model reporting form. If the information provided is incomplete or raises questions, the committee can phone the physician who performed euthanasia or the independent physician to ask for additional information. The committee may also ask either physician to provide further information in writing or may invite either physician to provide further information in person. A report is made of the interview, which is sent to the physician concerned for comments. The physician can be accompanied by another person at the meeting. The committees are aware that such an interview with a committee is burdensome for the physician. However, an oral account may be needed to clarify any uncertainties. In some cases, such an account can be essential for a proper assessment. Besides the physician and the independent physician, the committee can also ask the pathologist or the healthcare professionals involved for additional information.

If the committee is considering finding that the physician did not act in accordance with the due care criteria, the physician will always be invited for an interview before the decision is made, giving them the opportunity to explain their actions. Once again, a report is made of this meeting, which is sent to the physician concerned for comments. If the committee's opinion is unchanged after the interview, it will submit its provisional findings electronically to the members and secretaries of all RTEs for their recommendations. The committee will then reach a final decision.



A committee can also decide to send provisional findings to the members and secretaries of all RTEs, for instance, in cases that are complex or that raise new legal or other issues. In this way, the committees try to harmonise their findings in the interests of legal certainty and legal uniformity.

In 2017 the RTEs established an internal reflection chamber, which advises on points of law to further a number of aims, including enhanced coordination and greater consistency in the committees' findings. A committee or the national consultative council of chairpersons can ask the reflection chamber for advice on a particular issue. It is then up to the committee or the council to decide what should be done with the chamber's advice.

In principle, the committee informs the physician of its findings within six weeks of receiving the notification. That period can be extended by another six weeks if circumstances require it. The committee informs the physician of any such delay.

2.3. Relevance of medical professional position papers and guidelines

When reviewing notifications of euthanasia the committees have their own responsibility, which is based on statute. That means that medical professional position papers and guidelines apply insofar as they fall within the statutory framework. There may be differences between a position paper or guideline and the Act or case law, particularly where the position paper or guideline sets stricter requirements than the Act or case law. In such cases the committees consider the Act, case law and the existing review procedures to be decisive.[14] Medical professional position papers or guidelines may also cover issues which the physician has a professional responsibility to consider, but which do not have a bearing on the committee's review of a notification.[15] The committee may then find that a physician has complied with the due care criteria, even though the physician did not act entirely in accordance with the standards of their professional group.

Various position papers and guidelines have been drawn up by the medical profession that can be important to a physician in making a decision on a patient's request for euthanasia. Examples are KNMG's position paper on end-of-life decisions (2021), the KNMG guidelines on 'Euthanasia for patients in a state of reduced consciousness' (2010) and the NVVP's guidelines on 'Dealing with requests for termination of life on request from patients with a psychiatric disorder' (2018). These position papers and guidelines can provide help in interpreting the generally worded statutory due care criteria (more on which in chapter 3). There is one set of guidelines to which the committees refer explicitly in their findings: the KNMG/KNMP guidelines on 'Performing euthanasia and assisted suicide procedures' (2021). These guidelines are important in assessing compliance with the due care criterion of due medical care in performing euthanasia. They concern, among other things, the choice of substance and the dose, and adequate checks to establish whether the patient's consciousness is sufficiently reduced. Given the reference in this due care criterion to due medical care, it is logical for the committee to focus on the guidelines that the medical professions themselves (physicians and pharmacists) have drawn up.

[14] See also the letter of 4 July 2014 from the Minister of Health, Welfare and Sport to the House of Representatives (Parliamentary Papers, House of Representatives 2013-2014, 32 647, no. 30).
[15] Examples include the due care which, under disciplinary rules, the physician must exercise towards the patient's family. See for example Zwolle Regional Disciplinary Board 18 May 2006, GJ 2006/135 and The Hague Regional Disciplinary Board 23 October 2012, GJ 2013/8.

3. Statutory due care criteria

3.1. The physician performing euthanasia

Under the Act only a physician is authorised to perform euthanasia at a patient's request. The Act focuses on the physician who actually performs euthanasia. This is generally the attending physician, though this is not a requirement in the Act. In all cases, before terminating a patient's life on request or providing assistance with suicide, the physician must be fully informed about the patient's situation and must have personally determined that all the due care criteria have been met. An attending physician who has known the patient for some time will be able to base this conclusion on their knowledge of the patient.

A physician other than the attending physician in non-acute situations
A physician other than the attending physician can also grant a patient's request for euthanasia. However, such a physician will generally have to make a convincing case that they took sufficient time to obtain a clear picture of the patient's situation in relation to the statutory requirements. In cases where the physician performing euthanasia is not the attending physician, it is important that the physician who performed euthanasia indicate in their report to the committee how often and in how much detail they discussed the situation with the patient.

A physician other than the attending physician in acute situations
There may be circumstances (e.g. the attending physician is not available and the patient's condition has unexpectedly deteriorated) that lead to the euthanasia procedure being performed at short notice by a physician other than the attending physician (e.g. a locum or a physician in the same practice). By law, the physician who actually performs the euthanasia must submit the notification. In these circumstances, the physician can base their decision on the information supplied by colleagues also involved in the case, but they will also have to ascertain personally that the statutory due care criteria have been met.

Below, 'physician' refers to the physician performing euthanasia.

3.2. Voluntary and well-considered request

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

It follows from the Act that the patient must make the request personally. A request for euthanasia made by another person on behalf of the patient cannot be granted.[16] It must always be clear that the request has been made by the patient personally.[17]

[16] A patient cannot therefore authorise another person to make a request for euthanasia on their behalf. The basic principle is that the patient must make the request for euthanasia personally. See Parliamentary Papers, House of Representatives 1998-1999, 26 691, no. 3, p. 9. Others may however alert the physician to the fact that the patient has a wish for euthanasia, so that the physician can initiate discussion of the matter with the patient or, if the patient is no longer able to communicate, can assess any advance directive the patient might have made.
[17] See case 2022-035 on the RTEs' website. This concerned a woman who spoke no Dutch or English. A family member acted as interpreter. In its findings the committee explicitly discussed the question as to whether, in these circumstances, the physician could be satisfied that the patient's request was voluntary and well considered. After all, it must always be clear that the request has been made by the patient personally. In this instance the committee found that this was indeed the case.

The patient can make a request for euthanasia well before euthanasia is performed, but if the patient's condition is deteriorating rapidly, there may be only a (very) short period of time between the request and the performing of euthanasia. In other words, a request need not necessarily have persisted for a long period of time in order to be granted. It is also not unusual for patients to be hesitant about euthanasia, and this is understandable, but ultimately the physician must be satisfied that the request is unequivocal and consistent.

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

- the patient is unable to express the request in words, but can still communicate in other ways (e.g. hand gestures, by nodding or by squeezing the physician's hand in response to 'yes or no' questions, or using a speech-generating device);
- the patient can still express the request orally, but is unable to present supporting arguments.

In such cases, the physician must be satisfied, on the basis of the patient's behaviour and what they are still able to communicate, that the patient is making a consistent request. The utterances the patient is still able to make at that point can be assessed in conjunction with earlier oral or written directives, and earlier behaviour or signals.

In situations where the patient is no longer capable of expressing their wishes with regard to euthanasia, an advance directive may take the place of an oral request.

> For more on advance directives, see section 4.1.

Voluntary request

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

First, the request must have been made without any undue influence from others (external voluntariness). The physician must be satisfied that there has been no such influence. The physician should exercise particular caution when, for instance, a close relative of the patient becomes too overtly involved in the conversation between the physician and the patient, or repeatedly gives answers that the physician wishes to hear from the patient personally. It may then be necessary for the physician to speak with the patient privately. If a patient requests euthanasia partly because they feel they are a burden to others, the request may not necessarily be involuntary.[18]

Second, the patient must be decisionally competent with regard to their request for euthanasia (internal voluntariness).[19] This means that the patient must fulfil four criteria.[20] They must be able to communicate intelligibly about their request for euthanasia. They are able to understand the relevant medical and other information about their situation and prognosis. They must have insight into their condition: in other words they can assess their situation, the implications of euthanasia and any alternative treatment. Finally, they must be able to make it clear why they want euthanasia to be performed.

Decisional competence may fluctuate over time. A patient may also be decisionally competent in one matter (e.g. a request for euthanasia) but not in another (e.g. financial matters). This is also

[18] The feeling that one is a burden to others can contribute to the suffering experienced by the patient.

[19] The parliamentary documents concerning the Act repeatedly state that the patient must be decisionally competent in order to request euthanasia. See, for instance, Parliamentary Papers, House of Representatives 1999-2000, 26 691, no. 6, pp. 5-7.

[20] P.S. Appelbaum and T. Grisso, 'Assessing patients' capacities to consent to treatment', New England Journal of Medicine 1988: 1635-1638.

stated in the description of decisional competence given in the Medical Treatment Contracts Act (article 7:465 of the Civil Code): the patient is deemed capable of making a reasonable assessment of their interests with regard to the decision in question.[21]

If a patient is decisionally incompetent in this regard, the Medical Treatment Contracts Act allows their representative to give informed consent on their behalf for a specific medical procedure. Such representation is not possible with regard to a request for euthanasia: the patient must be personally capable of assessing the scope of such a request, of understanding the information on the prognosis and the alternatives, and of coming to an independent decision on the matter. If a patient is no longer decisionally competent with regard to a request for euthanasia, an advance directive drawn up when they were still decisionally competent with regard to their request can take the place of an oral request.

In many cases, there will be no doubt as to the patient's decisional competence regarding their request for euthanasia. Sometimes, especially for specific categories of patients, the physician will have to consider the matter of the patient's decisional competence in this regard more explicitly and in greater depth. If there are any doubts as to the patient's decisional competence with regard to their request for euthanasia, it is wise for the physician to seek the advice of another physician with relevant expertise. This request for advice may be included in the specific questions put to the independent physician as referred to in section 2 (1) (e) of the Act. The patient's decisional competence can also be determined by a specialised physician prior to consultation with the independent physician.

> For specific groups of patients, see sections 4.4, 4.5 and 4.6

The requirement that the patient be decisionally competent with regard to their request for euthanasia is closely related to the requirement that the request for euthanasia be well considered. See below.

Well-considered request

The request must also be well considered. This means that the patient has given the matter careful consideration on the basis of adequate information and a clear understanding of their condition. The request must not have been made on impulse. Caution is also required in cases where the patient expresses doubt by repeatedly making and withdrawing requests over a given period of time. That a patient hesitates or has doubts regarding such a profound step as euthanasia is understandable and not necessarily a contraindication. The important thing is that the request should be unequivocal, in light of all the patient's circumstances and utterances.

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

> For further information on these situations, see Chapter 4.

[21] See the guidelines on assessing decisional competence (2007 version, in Dutch).

KEY ELEMENTS OF ‘VOLUNTARY AND WELL-CONSIDERED REQUEST’

- Request made by patient personally
- ‘External voluntariness’: no undue influence from others
- ‘Internal voluntariness’ or decisional competence regarding the request for euthanasia: insight into and understanding of the situation
- Well-considered request: well-informed, unequivocal, not on impulse
- An advance directive can replace an oral request (see section 4.1.)
- Particular caution to be exercised in certain situations (see chapter 4)

3.3. Unbearable suffering without prospect of improvement

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

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

The patient must be conscious of suffering. There are situations where this is not (or no longer) the case, as with coma, or where this is uncertain, as with reduced consciousness. In principle, if the patient is in a situation where they are no longer conscious of suffering, euthanasia cannot be performed, irrespective of whether the patient’s immediate family find the patient’s situation distressing or humiliating.

> For more on coma and reduced consciousness, see section 4.8.

> For more on the relationship between euthanasia and palliative sedation, see section 4.9.

The patient’s consciousness of their suffering may be apparent from what they say, or from their other utterances or physical reactions. In cases where a patient can no longer express their suffering in words, the physician must be alert to other signals that may reveal the patient’s burden of suffering.

Medical dimension to suffering
The guiding principle for the RTEs is that the physician must be satisfied that the patient is suffering unbearably without prospect of improvement and that the suffering has a medical dimension (Brongersma judgment, 2002). The condition may be either somatic or psychiatric in nature (Chabot judgment, 1994). There need not be a single, dominant medical condition. The patient’s suffering may also be the result of an accumulation of serious and minor conditions, and that accumulation may cause the patient to suffer unbearably. What constitutes unbearable suffering differs from one patient to another, and depends on the patient’s medical history, life history, personality, values and stamina.

Multiple geriatric syndromes
As we have seen, for a patient's request for euthanasia to be considered, their suffering must have a medical dimension. However, it is not a requirement that there be a *life-threatening* medical condition. Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis, osteoarthritis, balance problems or cognitive deterioration – may cause unbearable suffering without prospect of improvement.

These syndromes, which are often degenerative in nature, generally occur in elderly patients, and a combination of these syndromes and the related symptoms can cause suffering. For these patients, too, the suffering and its unbearable nature are connected to matters such as life history, personality and stamina.

This is where the distinction lies between multiple, largely degenerative syndromes and the issue of 'completed life', insofar as the latter refers to suffering that has no medical dimension. Multiple geriatric syndromes, conversely, do have a medical dimension.

> For 'completed life', see section 4.10.

No prospect of improvement
A patient is regarded as suffering with no prospect of improvement if the disease or disorder causing the suffering is incurable and there are no means of alleviating the symptoms so that the suffering is no longer unbearable. The diagnosis and the prognosis are central to the assessment of whether there is no prospect of improvement. This must be determined in the light of whether there are realistic options, other than euthanasia, that would end or alleviate the symptoms. In considering whether there is any such prospect, the physician must take account both of the improvement that can be achieved by treatment and of the burden such treatment would place on the patient. 'No prospect of improvement' must be seen in relation to the patient's disease or disorder and its symptoms. There is no prospect of improvement if there are no 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 (section 2 (1) (d) of the Act).

> See also section 3.5.

Patients sometimes also use equivalent terminology to indicate that the fact that there is no longer any prospect of improvement makes their suffering unbearable to them, and that they therefore want their suffering to end. In that sense, the patient's perception that the situation is hopeless is part of what makes their suffering unbearable.

Unbearable nature of 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 their situation, their 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. The physician must therefore not only be able to empathise with the patient's situation, but also see it from the patient's point of view.

The fear of an imminent decline in health can be a major factor in the patient's suffering. The patient may fear increasing pain, further humiliation, shortness of breath or nausea, or situations in which their core values (such as independence and dignity) are undermined. In such cases the patient's current suffering is connected with the realisation that their situation will only deteriorate further

and that values and circumstances that are important to them will come under increasing pressure. This can be the case with cancer, but also with progressive diseases like ALS, multiple sclerosis, dementia and Parkinson's disease.

KEY ELEMENTS OF 'UNBEARABLE SUFFERING WITH NO PROSPECT OF IMPROVEMENT'

- There must be a medical dimension to the suffering
- The suffering can result from an accumulation of mental and physical factors
- The suffering can result from symptoms caused by a combination of disorders
- The suffering can result from symptoms caused by multiple geriatric syndromes
- No prospect of improvement: there are no curative or palliative treatment options that could end the patient's suffering (see also section 3.5.)
- Unbearable suffering: it is about the suffering of this specific patient (in relation to their life history, medical history, personality, values and stamina). The suffering must be palpable and understandable to the physician
- Unbearable suffering may also be caused by fear of future deterioration
- The patient must be conscious of suffering

3.4. Informing the patient

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

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

KEY ELEMENTS OF 'INFORMING THE PATIENT'

- The patient must be informed about their situation and prognosis
- The physician must ascertain that patient has understood the information

3.5. No reasonable alternative

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

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

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

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

Palliative care plays an important role towards the end of life. A patient may have good reason to refuse palliative treatment, for example because they do not wish to become drowsy or lose consciousness. It is important that the physician fully inform the patient about the benefits and disadvantages of palliative treatment, as the decision whether or not to use this option ultimately lies with the patient.

In summary, there is a reasonable alternative if:
a. the proposed treatment/intervention significantly alleviates the patient's unbearable suffering
b. the proposed treatment/intervention has positive effects within a reasonable period of time
c. any drawbacks are outweighed by the benefits (effect versus burden).

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

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

KEY ELEMENTS OF 'NO REASONABLE ALTERNATIVE'

- Conclusion arrived at by the physician and the patient together
- Reasonable alternative has significant positive impact on suffering, takes effect fairly quickly, is long-lasting, has more benefits than disadvantages
- Burden on patient should be assessed in light of patient's specific circumstances
- If the patient refuses a reasonable alternative, this may be an obstacle to performing euthanasia
- If the patient refuses palliative sedation, this will generally not preclude granting a request for euthanasia

3.6. Independent physician

Before performing euthanasia, the physician must consult at least one other, independent physician who must see the patient and assess whether statutory due care criteria (a) to (d), discussed in sections 3.2. to 3.5., have been complied with. The Act does not require the independent physician to give their opinion on the exercise of due medical care in performing euthanasia, in relation to due care criterion (f) (see section 3.7. below). However, there is no reason why the independent physician should not advise the physician about this matter.

The independent physician forms an independent opinion on whether the first four due care criteria – (a) to (d) – have been complied with, and informs the physician in a written report. The purpose of this consultation is to ensure that the physician's decision is reached as carefully as possible. The independent physician's assessment helps the physician ascertain whether all the due care criteria have been met and reflect on the request for euthanasia before making a final decision. The physician must read the independent physician's report and take it into account in deciding whether to grant the request for euthanasia. The independent physician's report is also essential for the committee in reaching its decision on whether all due care criteria have been complied with. The committees believe it is important for the physician performing euthanasia to request a consultation. If the physician does not do so, the committee will expect them to explain the reasons for this in their report.

For instance, the patient may be being treated by a team of physicians and it may be the case that one physician requests the consultation and another actually performs euthanasia. If the physician performing euthanasia is not the physician who requests the consultation, the physician performing euthanasia must contact the independent physician beforehand to inform them of their intention to perform euthanasia. In such cases the independent physician and the physician performing euthanasia will have to affirm their independence in relation to one another. The physician performing euthanasia must read the independent physician's report and take it into account in deciding whether to grant the request for euthanasia.

The independent physician should not assess the physician, nor is it their task to give the physician 'permission'. The independent physician must make their own assessment of whether the due care criteria have been met and inform the physician accordingly, stating reasons.

The independent physician consulted is preferably a SCEN physician. SCEN refers to the Euthanasia in the Netherlands Support and Assessment Programme, which falls under 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. SCEN physicians also offer support and provide information. Only physicians may consult a SCEN physician. The KNMG has drawn up guidelines for SCEN physicians, entitled 'Steun en consultatie bij euthanasie' ['Euthanasia support and independent assessment'] (2023). It is in the interests of the physician performing euthanasia that the independent physician write a comprehensive report. To help with this, the SCEN organisation has drawn up a checklist for the independent physician's report, and the KNMG provides a model reporting form for SCEN physicians: 'Modelverslag voor SCEN-artsen' (2023). These documents can be found via scen.nl. SCEN physicians are organised into regional divisions. One of the aims of the SCEN organisation is to guarantee quality through peer supervision.

Information needs of the physician in the early stages

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

The physician can also ask a SCEN physician, another physician or a euthanasia counsellor of the Euthanasia Expertise Centre (EE) for advice if they have questions before the euthanasia process actually commences. These questions may concern the process ('What steps do I need to take?'), for instance if the physician has little or no experience of euthanasia, or the patient ('Is there reason to have the patient's decisional competence with regard to their request for euthanasia assessed?', 'Are there any treatment alternatives?'). Asking advice from a SCEN physician, another physician or an EE euthanasia counsellor on such matters is not a consultation within the meaning of and as required by the Act. It is merely a request for advice prior to the statutory consultation.

The physician's responsibility in relation to the independent physician

The physician is expected to take note of the independent physician's report before making a final decision on the request for euthanasia. The physician must take the independent physician's opinion very seriously. If there is a difference of opinion between the two, the physician can nevertheless decide to grant the patient's request, but will have to be able to provide adequate grounds for this decision, reflecting explicitly on the views expressed by the independent physician. Alternatively, the physician may consult another independent physician, though the idea is not that the physician should continue searching until they find an independent physician who agrees with them.[22] A physician who has consulted multiple independent physicians must submit all the independent physicians' written reports to the committee, via the pathologist.

It is in the interests of the physician performing euthanasia that the independent physician write a comprehensive report. Sometimes the quality of the report is questionable because, for instance, the independent physician has not assessed compliance with all the due care criteria or has not presented enough arguments in support of their conclusion, or because the report contains internal inconsistencies. One example of internal inconsistency, for instance, is if the independent physician writes that the patient's suffering is not yet unbearable, or that the patient has not yet made a specific request, but still concludes that all the due care criteria have been met. If the independent physician's report is substandard, the physician must ask the independent physician to modify it. If necessary, the physician can refer to the guidelines drawn up by the KNMG/SCEN on the independent physician's responsibilities and the reporting checklist. If the amended report is still below par, the physician will have to consult a second independent physician.

[22] See section 4.3 of the KNMG guidelines 'Steun en consultatie bij euthanasie' (2023).

The independent physician's independence
The Act requires consultation with at least one other, independent physician. 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. It is therefore important that the independent physician and the physician explain their relationship with each other and with the patient in their reports.

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 the independent physician is from the same medical practice or partnership, if there is a financial or other relationship of dependence with the physician (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 or physician.[23]

In addition, if both physicians regularly act as independent physicians for each other, the physician brought in for consultation may not in fact be independent. This also applies to a SCEN physician who has provided support that goes beyond mere advice or information in the period before the euthanasia process. If the physician and the independent physician know each other socially, this may also call into question their independence in relation to one another. It is possible that the physician and the independent physician know each other, perhaps as members of a peer supervision group. This need not present a problem as such. Whether or not independent assessment is possible where both physicians are members of the same locum group depends on the circumstances. What matters is that the physician and the independent physician should be aware of this and make their opinion on the matter clear to the committee, stating reasons.

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

'Double euthanasia'
'Double euthanasia' require special attention to be paid to both the physician and independent physician in this respect. Section 4.3. deals with this topic.

The independent physician's expertise
The committees prefer an independent physician to be assigned 'at random', on the basis of the SCEN physicians' duty roster. Generally speaking the independent physician will have sufficient expertise to properly assess the case in question. If the independent physician has doubts about this, it is important that they discuss them with the physician.

In some cases, it may be necessary for the physician performing euthanasia to seek the advice of a physician with specific expertise (psychiatrist, geriatrician etc.) in addition to the normal SCEN physician in order to make a good assessment of compliance with the due care criteria, particularly with regard to decisional competence regarding the request for euthanasia, the lack of prospect of improvement and/or a reasonable alternative. This will mainly be the case if the patient has a psychiatric disorder, dementia or an intellectual disability, but there may also be other reasons (for

[23] See cases 2020-151 and 2021-71 (independent physician registered as a patient in the physician's practice) on the RTEs' website.

instance, if the physician has reasonable doubts about the patient's decisional competence with regard to their request for euthanasia).

> For more on consulting an expert with regard to patients with a psychiatric disorder, dementia or an intellectual disability, see sections 4.1. and 4.4. to 4.6.

In principle, the independent physician must see and speak with the patient
The Act stipulates that the independent physician must see the patient.[24] In the vast majority of cases, this will involve both seeing and speaking with the patient. In principle, the independent physician should also see the patient alone. It is possible that the patient is no longer capable of conversation by the time they are visited by the independent physician, If the physician sees such a situation developing, they would do well to ask the independent physician to come sooner. If necessary, the physician and independent physician can contact each other by telephone afterwards. If the independent physician is no longer able to communicate with the patient during their visit, they must provide an assessment based on all other available and relevant facts and circumstances. It can be useful to obtain further information from the physician and any family members of the patient or other healthcare professionals involved in the patient's care. The Act therefore does not require that the independent physician is always able to communicate with the patient (either verbally or non-verbally). This also follows from the scope provided by the Act for performing euthanasia on the basis of the patient's advance directive when a patient is no longer able to communicate.

> For more on advance directives, see section 4.1.

> For more on coma and reduced consciousness, see section 4.8.

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

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

Quite often the independent physician will visit the patient at a time when the patient's request is not immediately relevant and their suffering is not yet unbearable. In such cases the independent

[24] 'Seeing' the patient will normally mean 'visiting' the patient. This can lead to practical problems on the BES islands, so the independent physician and the patient may speak to each other by video call.

physician must conclude that not all the due care criteria have yet been met. In certain cases the independent physician will be able to say with a high degree of certainty how the situation will progress and when all the due care criteria will have been met. It is then generally sufficient for the physician and the independent physician to speak on the phone when the request has become immediately relevant and the patient's suffering unbearable. If the situation is less clear-cut, it makes sense for the independent physician to visit the patient again. In some cases, contact by phone between the independent physician and the patient may suffice.

The independent physician will generally need to visit the patient a second time if they:
- visited the patient at an early stage and found that the patient was not yet suffering unbearably;
- determined that all the criteria had been met, but a lot of time has elapsed since, or the patient's condition has changed in a way that was not foreseen when the independent physician drafted their report.

If the physician is unable to contact the original independent physician, another independent physician may be consulted. In principle, the latter will need to see the patient personally and if possible speak with the patient. The independent physician must also draw up a report of this second contact, possibly as an addendum to the first report.

The committees and the independent physician
The committees review the actions of the physician performing euthanasia, not those of the independent physician.[25] Occasionally, the independent physician may however be asked to answer questions from the committee, either in writing or in person.

Once a year the committees and the KNMG/SCEN discuss the quality of the consultations and the independent physicians' reports in general.

KEY ELEMENTS OF 'INDEPENDENT PHYSICIAN'

- Asking another physician for advice on a specific matter relating to the criteria is not formal consultation within the meaning of the Act
- Formal consultation: physician consulted must be independent
- In principle, independent physician must see and speak with patient; if communication is not possible, simply 'seeing' may suffice
- In certain circumstances, particularly if a long time has elapsed after the independent physician was consulted, they may need to be consulted a second time (or, if they are unavailable, another independent physician)
- The independent physician must make specific reference in their report to the due care criteria set out in section 2 (1) (a) to (d) of the Act
- The physician performing euthanasia must read the independent physician's report and consider it carefully before performing euthanasia

[25] The KNMG has set up a complaints committee, to which any of the parties involved in a euthanasia case can submit a complaint about the actions of a SCEN physician.

3.7. Due medical care

The physician must exercise due medical care in performing euthanasia. Two aspects of this are the substances and doses administered, and appropriate checks to determine the depth of sedation of the patient. 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 ('the Guidelines'). These Guidelines advise physicians and pharmacists on practical and effective methods of performing euthanasia and assisting suicide. They list preferred substances, and also explicitly advise against using certain other substances.

General
Below, a distinction is drawn between termination of life on request (when the physician administers the substances) and assisted suicide (when the patient takes the substances given to them by the physician). Certain standards must be observed in both cases. It is, for example, important that the physician's report describe the substances administered, the doses and method of administration, and how long the procedure took. According to the Guidelines, the physician must have an emergency set of substances and items with which to administer them in case something goes wrong with the first set. The physician may not leave the euthanatic with the patient prior to termination of life on request or assisted suicide, so as to avoid giving the patient or a third person the opportunity to take or administer the substance in the physician's absence. In order to ensure the physician's actions can be reviewed properly, the same physician must administer all the substances to the patient.

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

In cases of termination of life on request, the Guidelines advise intravenous administration of a coma-inducing substance, followed by intravenous administration of a muscle relaxant. The Guidelines list the substances that can be used and their recommended doses. If the physician deviates from the Guidelines, they will have to present convincing arguments in support of their actions. Before performing euthanasia, physicians are advised to discuss with the patient and the patient's relatives what effect the substances will have. The physician should also comply with the patient's individual wishes as far as possible, provided they fall within the scope provided by the Guidelines.

Termination of life on request: establishing whether consciousness is sufficiently reduced

The physician must not administer the muscle relaxant until the patient's consciousness is sufficiently reduced, as the patient might otherwise perceive the negative effects of the muscle relaxant. To this end, it is vital that the physician establish that the patient's consciousness is sufficiently reduced before administering the muscle relaxant. There is a question about this on the model reporting form, which the physician must answer.

In the RTEs' view, the physician has adequately established that the patient's consciousness is sufficiently reduced if the patient shows no protective reflexes (such as the eyelash reflex and the corneal reflex) or no response to a pain stimulus[26] (heavy pressure on the fingernail bed or pinching the trapezius muscle).

If the committee has any doubts about this, it will ask the physician about the patient's depth of sedation and how the physician established this.

[26] When the physician applies a pain stimulus to the patient this may be upsetting to the patient's family.

Termination of life on request: if the procedure does not go as planned, start again from the beginning

If the euthanasia procedure does not go according to plan, the physician must go through the entire procedure again from the beginning. This means that the physician must insert a new IV cannula and re-administer all the substances. This is set out in the Guidelines.

Administering the coma-inducing substance must not take longer than five minutes, in order to achieve the correct peak concentration in the brain and prevent redistribution throughout the body. In principle immediately after the coma-inducing substance has been administered and it has been established that the patient's consciousness is sufficiently reduced, the muscle relaxant must be administered. If the IV cannula is working properly the required level of reduced consciousness will be achieved quickly, and after the subsequent administering of the muscle relaxant the patient will soon stop breathing. If the required level of reduced consciousness is not achieved within 10 minutes of the coma-inducing substance having been administered, or if the patient does not stop breathing within 10 minutes of the muscle relaxant having been administered, it is likely that either the substance has missed the vein (which is not always visible as a lump or swelling) or that the IV cannula has ceased to function during or as a result of the injection of the coma-inducing substance. In both cases the physician must start the entire procedure again from the beginning in order to prevent a situation in which the patient is conscious when the muscle relaxant takes effect (and experiences the feeling of not being able to breathe).

Starting the procedure over always means: inserting a new IV cannula, administering the coma-inducing substance and, after establishing that the patient's consciousness is sufficiently reduced, administering the muscle relaxant. This is why a physician performing euthanasia must always carry an emergency set containing everything needed for the procedure. If the emergency set must be used due to a problematic situation arising during the euthanasia procedure, a new IV cannula must always be inserted. Please note: even if it is only the muscle relaxant that appears not to be taking effect, it is not sufficient to simply check (or check again) whether the patient's consciousness is sufficiently reduced and administer a new dose of muscle relaxant. In such a case there is a risk that the muscle relaxant has made the patient incapable of responding to checks for reduced consciousness, while in fact there is awareness.

Whether or not the physician has exercised due medical care in the event of complications during the procedure is not something that can be captured in precise rules. For procedures during which complications have occurred and in which the above-mentioned Guidelines were not followed, the RTEs take as a rule of thumb that, when no coma-inducing substance was administered via a new, working IV cannula, there must have been no more than 30 minutes[27] between the – first – coma-inducing substance having been administered and the administering of the muscle relaxant that led to the patient's death.[28] This also applies if the physician has adequately checked the patient's level of consciousness, as in that case there is a risk that the patient could be aware when the muscle relaxant takes effect, even though this is not apparent to the physician performing euthanasia.

Termination of life on request: procedure must be performed by physician

The physician may not allow a relative or any other person to administer the euthanatics in the physician's presence, not even using a PEG tube. The physician must perform every step of the

[27] Based on an expert opinion.

[28] See news item 'RTE en KNMG/KNMP aan artsen: als uitvoering euthanasie niet verloopt zoals beoogd, begin opnieuw' ('RTEs and KNMG/KNMP tell physicians: if euthanasia procedure does not go as planned, start again from the beginning') | KNMG

procedure personally, and may not delegate anything to anyone else, such as a nurse of another physician. This also means that the physician must remain present until death occurs and the consultation with the pathologist has ended.[29]

Assisted suicide: substance and dose

In the case of assisted suicide, the physician hands the substance (a barbiturate) to the patient, who ingests it. The two steps described above (first sufficiently reducing the patient's consciousness, then administering a muscle relaxant) are not applicable in assisted suicide. However, the physician must administer premedication to prevent nausea and vomiting. The Guidelines list the type of substances, and their doses, to be used in assisted suicide.

Assisted suicide: physician must remain in immediate vicinity

If the patient wishes, the physician may leave the room after the patient has taken the euthanatic. The physician must however remain in the patient's immediate vicinity in order to intervene quickly if complications arise (e.g. if the patient vomits the potion back up). In that case the physician may have to terminate the patient's life after all. Sometimes, the patient does not die after drinking the barbiturate potion. In these cases too, the physician will then have to terminate the patient's life after a certain length of time. The physician must discuss this possibility beforehand with the patient and the patient's family, and agree with the patient how long to wait before terminating the patient's life. The physician must prepare for this eventuality, and insert an IV cannula prior to assisting with suicide and bring along the substances needed to terminate the patient's life. Again, the physician must remain present until death occurs and the consultation with the pathologist has ended.[30]

Relationship between physician and pharmacist The physician bears final responsibility for exercising due medical care. The physician's actions are assessed by the committees. If the pharmacist prepares the syringes or potion beforehand, that person has an individual responsibility for its preparation and labelling. The physician must check whether the correct substances in the correct doses have been received.

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

Like physicians, pharmacists are not obliged to assist with euthanasia.

[29] See case 2021-81 on the RTEs' website, in which, after administering some of the euthanatics, the physician left the patient in order to fetch an extra needle, leaving the muscle relaxant with the patient and the patient's family.
[30] See case 2019-57 on the RTEs' website, in which the physician had left the patient after the potion had been ingested by the patient, but before the patient had died.

KEY ELEMENTS OF 'DUE MEDICAL CARE IN TERMINATION OF LIFE ON REQUEST'

- Sequence of events:
  - physician administers coma-inducing substance
  - physician checks that the patient's consciousness is sufficiently reduced
  - physician administers muscle relaxant.
- Physician remains present until the physician has confirmed the patient's death, the pathologist has attended, and the consultation with the latter has ended. Recommended substances, doses, methods of administration and ways of checking whether patient's consciousness is sufficiently reduced:
- KNMG/KNMP Guidelines 2021.
- Physician must have emergency set of intravenous substances and the items needed to administer them to hand.
- If the procedure does not go as planned, start again from the beginning. That means: inserting a new IV cannula, administering the coma-inducing substance and, after establishing that the patient's consciousness is sufficiently reduced, administering the muscle relaxant.

KEY ELEMENTS OF 'DUE MEDICAL CARE IN ASSISTED SUICIDE'

- Sequence of events:
  - discuss with patient and patient's family length of time to wait before terminating life, if necessary
  - insert IV cannula and administer anti-nausea premedication beforehand
  - physician hands barbiturate potion to patient
- Physician remains present or in immediate vicinity until the physician has confirmed the patient's death, the pathologist has attended, and the consultation with the latter has ended.
- Recommended substances, doses, methods of administration: KNMG/KNMP Guidelines 2021.
- Physician must have emergency set of intravenous substances and the items needed to administer them to hand.

4. Specific issues

4.1. Advance directive

Section 2 (2) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act stipulates that a patient who is decisionally competent in the matter can draw up a written directive setting out a request for euthanasia ('advance directive'). If at a later point the patient is no longer capable of expressing their will with regard to euthanasia (due to, for instance, advanced dementia or reduced consciousness), the physician can accept the advance directive as a request as referred to in section 2 (1) (a) of the Act. The advance directive thus has the same status as an oral request for euthanasia.[31]

The Act does not limit the validity of an advance directive, nor does it require the directive to be regularly updated. However, the older the directive, the more doubt there may be as to whether it still reflects the patient's actual wishes. The directive will carry more weight if the patient has updated their advance directive, or orally reaffirmed its content. It is important that the patient describe as specifically as possible the circumstances in which they would wish their life to be terminated. It is the responsibility of the patient to discuss their advance directive with the physician when drafting or updating the document. The physician should include this information in the medical records. It is also advisable for the patient to give the advance directive to the physician so that it can be added to the medical records. There is no prescribed format for an advance directive, and the patient can write in their own words. A personal directive drawn up by the patient in which they describe their wishes in their own words will generally be regarded as more significant than a pre-printed, standard form. It is not necessary for the patient to go to a notary to register the advance directive in a living will.

Due care criteria apply *mutatis mutandis*
Section 2 (2) of the Act states that, in the event of an advance directive, the due care criteria mentioned in section 2 (1) of the Act apply *mutatis mutandis*. This means, in accordance with the legislative history, that the due care criteria 'apply to the greatest extent possible in the given situation'.[32] In other words: the physician must apply the due care criteria in a way that does justice to the exceptional nature of such cases. The physician must take account of the specific circumstances of the case; for instance, the patient might no longer be capable of communicating or responding to questions. The physician will generally have spoken with the patient when the latter was still capable of expressing their will with regard to euthanasia. If a situation subsequently arises in which the patient's advance directive comes into play, information obtained in previous conversations with the patient will be particularly useful to the physician.

If euthanasia is performed on the basis of an advance directive, the due care criteria apply *mutatis mutandis*. The following observations can be made in this respect.

a. The physician must be satisfied that the patient's request is voluntary and well considered
The physician must be satisfied that the patient's advance directive was drawn up voluntarily and after thorough consideration. The physician must base their conclusion on their own assessment of the medical records and the patient's specific situation. In addition, consultations with other health professionals who are or have been in a treatment relationship with the patient, as well as

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[31] See the letter from the Minister of Health, Welfare and Sport of 4 July 2014 on the advance directive with regard to euthanasia.
[32] This is set out in the explanatory memorandum to the amendment of the Act that led to the addition of the second sentence to section 2 (2) (Parliamentary Papers, House of Representatives, 26 691, no. 35).

consultations with family members, are important sources of information in this situation, as oral verification of the patient's wishes is no longer possible.

The physician must also establish that the patient's current situation corresponds to the situation described by the patient in their advance directive. The first step is to establish the content of the advance directive. In doing so, the physician must study the advance directive with a view to determining the patient's intentions. The physician must take note of all circumstances of the case, not just the literal wording of the request. In other words, there is some room for interpretation of the advance directive. However, if the advance directive contains any unclear or contradictory passages of an essential nature this can lead to the request for euthanasia not being granted.

At the very least, the advance directive must always describe that the patient requests euthanasia in those situations in which they are no longer capable of expressing their will with regard to euthanasia. If the patient also wants their request to be granted in the event that their unbearable suffering is not of a physical nature, it must also be apparent from the advance directive that the patient considers their expected mental suffering in this situation to be unbearable for them and that this is the basis for their request.

The physician will have to assess whether any contraindications preclude the performance of euthanasia. Contraindications from the period when the patient was still capable of expressing their wishes with regard to euthanasia can be interpreted by the physician as a revocation or amendment of the previously drawn up advance directive. In that case euthanasia cannot be performed. Contraindications arising when the patient is no longer capable of expressing their wishes with regard to euthanasia (for instance, due to advanced dementia) cannot be interpreted as a revocation or amendment of the previously drawn up advance directive. The physician can, however, interpret them as an indication which, in combination with the patient's condition and behaviour as a whole, is relevant for the assessment of the patient's current physical and mental state. That physical and mental state may compel the physician to conclude that the situation foreseen by the patient when they drew up the advance directive – the situation in which the patient would want their life terminated – is not in fact the current situation. This may be the case, for instance, when clear verbal utterances or consistent behaviour on the part of the patient do not match the essence of the request. The physician's assessment of whether there are circumstances that might point to contraindications is also important to the assessment of the unbearable nature of the patient's suffering.

The physician must also endeavour to communicate meaningfully with the patient about matters including the intention to perform euthanasia. The physician is not required to inquire about the patient's current wish to live or die if the patient is no longer capable of expressing their wishes on the matter. No such requirement is laid down by the Act. The specific situation of a patient who is no longer capable of expressing their wishes with regard to euthanasia means that oral verification of the patient's wishes and their suffering is not possible. A verification requirement is incompatible with the advance directive, which is specifically intended for situations in which the person who drew it up is no longer capable of expressing their wishes with regard to euthanasia.

b. The physician must be satisfied that the patient is suffering unbearably and that there is no prospect of improvement

When euthanasia is performed, the physician must be satisfied that the patient is experiencing unbearable suffering.[33] There may be current unbearable suffering caused by physical illness or injuries, but there may also be current unbearable suffering if the patient is in the situation they

[33] An exception to the criterion requiring physicians to establish that the patient is suffering unbearably is described in section 4.8.

described in their advance directive as (expected) unbearable suffering and it can be deduced from the patient's consistent behaviour that they are suffering unbearably. However, the mere circumstance that the patient is in the situation described in the advance directive is not a sufficient basis to conclude that the patient is indeed currently suffering unbearably. The physician must always determine in a careful and transparent manner whether the patient is indeed currently suffering unbearably. This requires a careful assessment of the patient's current situation, based on all the circumstances of the specific case. The physician will have to answer the question as to how severely the patient is suffering on the basis of their conclusions regarding the patient's current state. The physician can base their conclusions on their own assessment of the patient's medical records and specific situation. All of the patient's verbal or non-verbal utterances may play a role. Consultations with other health professionals who are or have been in a treatment relationship with the patient are also important, as are consultations with family members. If the physician is not satisfied that the patient is currently suffering unbearably, euthanasia cannot be performed.

Establishing whether a patient is actually suffering unbearably and without prospect of improvement is a professional medical assessment, and is therefore the prerogative of the physician. The retrospective review by the committee of whether the physician could be satisfied that the patient was suffering unbearably amounts to a review of whether the physician could reasonably conclude that the patient was suffering unbearably.

c. The physician informed the patient sufficiently about the latter's situation and prognosis

The physician must be satisfied that the patient has been informed sufficiently about their situation and prognosis and about the significance and consequences of their advance directive. Within the unavoidable limitations imposed by the patient's condition, the physician must also endeavour to communicate meaningfully about these issues with the patient.

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

The physician must be satisfied that there is no reasonable alternative in the patient's current situation, both according to prevailing medical opinion and in light of the patient's advance directive. The physician will have to base their conclusion on their own assessment of the medical records and the patient's specific situation, consultations with other health professionals who are or have been in a treatment relationship with the patient, and consultations with the patient's family members. As the patient is no longer capable of expressing their wishes with regard to euthanasia, it is important that the physician carefully consider what the patient has written about this matter in their advance directive and what they said when they were still able to communicate.

e. The physician must 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

This requirement applies in full to euthanasia for patients who are no longer capable of expressing their wishes with regard to euthanasia. The Act stipulates that the independent physician must see the patient. This remains necessary even in a situation in which there will probably be little if any meaningful communication between the independent physician and the patient. This means that in forming their opinion, the independent physician will have to supplement their own observations with information from the physician and other sources. This may include the patient's medical records, oral information from the physician, letters from specialists, the content of the advance directive, and conversations with family members and/or healthcare professional.

The fact that the patient is no longer capable of expressing their wishes with regard to euthanasia is generally reason for consulting a second independent physician with specific expertise relevant to

the patient's condition (such as a geriatrician, elderly-care specialist, an internist specialising in geriatrics, a geriatric psychiatrist or a neurologist). That expert must give an opinion, based on their own examination of the patient, on the patient's decisional competence with regard to their request for euthanasia, whether the patient is suffering unbearably with no prospect of improvement, and possible reasonable alternatives. As regards the position of the independent expert, it should be noted that the conditions and requirements listed in section 3.6. regarding the independent physician's independence apply *mutatis mutandis*.

In addition, it would be appropriate for the physician to give the independent physician and the independent expert the opportunity to comment on the specific procedure the physician intends to follow when performing euthanasia.

If either the independent (SCEN) physician and/or the independent expert produces a report that is substandard, the physician must ask them to modify their report. If the amended report is still below par, the physician will have to consult a second independent (SCEN) physician and/or a second independent expert.

If the independent (SCEN) physician and/or the independent expert present divergent views, the physician must specifically reflect on their views. It would also be appropriate in that case to consult a second independent (SCEN) physician and/or independent expert, so as to exercise the required particular caution.

> See also sections 3.6. and 4.5.

f. Due medical care

One element of due medical care is that, when preparing for and carrying out the euthanasia procedure, the physician takes into account possible irrational or unpredictable behaviour on the part of the patient as a result of their condition. The euthanasia procedure should be as comfortable as possible for the patient. If the patient is decisionally incompetent with regard to euthanasia and there are signs that they may become upset, agitated or aggressive during the euthanasia procedure, the medical standards that the physician must observe may lead them to conclude that premedication is necessary.

In principle the physician must endeavour to communicate meaningfully with the patient about the moment when the euthanasia procedure will be carried out and the method that will be used, including the possible administering of premedication, unless this would be detrimental to the patient, for instance because a conversation on this subject would cause the patient to become very upset or agitated. If, however, it transpires that the patient cannot comprehend these issues and that meaningful communication with the patient is therefore not possible on this matter, it is not necessary for the physician to consult with the patient on this. Such a conversation would be pointless and could cause the patient to become agitated and upset. Whenever the physician sees or speaks with the patient, the physician must always be alert to contraindications that would preclude the performance of euthanasia.

> See also section 4.5. Patients with dementia

> See also section 4.8. Coma and reduced consciousness

ADVANCE DIRECTIVE: POINTS TO CONSIDER

- Is the patient no longer capable of expressing their wishes with regard to euthanasia?
- Was the patient decisionally competent with regard to euthanasia when they set out their request in their advance directive?
- Have the due care criteria been met to the greatest extent possible in the given situation? The physician must apply the due care criteria in a way that does justice to the exceptional nature of the case.
- Does the patient's current situation correspond to the situation described by the patient in their advance directive? The physician can interpret the advance directive with a view to determining the patient's intentions.
- Are there any contraindications that preclude the performance of euthanasia?
- Is the patient suffering unbearably?
- In addition to the independent physician, has the physician consulted an expert on the patient's conditions?
- Is premedication required? If no meaningful communication is possible with the patient, it is not necessary for the physician to consult with the patient about what method will be used (including the administration of premedication).

4.2. Minors

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

- the minor must be deemed to be capable of making a reasonable appraisal of their interests in this matter;
- if the patient is a minor between the ages of 12 and 16, termination of life at the patient's request can only be carried out with the consent of a parent or the parents who have responsibility for the patient, or else the patient's guardian (section 2 (4) of the Act);
- if the patient is a minor aged 16 or 17, a parent or the parents who have responsibility for the patient, or else the patient's guardian, must be consulted in the decision-making process, but their consent is not required (section 2 (3) of the Act).

The due care criteria described in Chapter 3 of this Code are of course applicable in both cases. The statutory requirements concerning the involvement of the parent(s) or guardian in the decision-making process also apply if the minor's request is made in the form of an advance directive.[34]

Notifications of euthanasia involving minors aged between 12 and 18 are rare.

4.3. 'Double euthanasia'

Sometimes, two persons in a close relationship with each other may make simultaneous requests for euthanasia, and request that the two euthanasia procedures be carried out simultaneously. Examples are life partners, a parent and child, or two siblings. If both requests are granted, this is sometimes referred to as 'double euthanasia'. In such cases, the physician must consult a different independent physician for each of the two persons. This is necessary to ensure that the two cases

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

are assessed separately. Both independent physicians must also be satisfied that neither person is exerting undue pressure on the other in relation to their request for euthanasia.

4.4. Patients with a psychiatric disorder or a combination of somatic and psychiatric disorders

General

If the patient has a psychiatric disorder, or such a disorder occurs in their recent medical history, the physician and the independent physician must explicitly consider:

- whether the patient's psychiatric disorder precludes a voluntary and well-considered request;
- whether the psychiatric disorder contributes to the patient's suffering and, if this is the case;
- whether the physician is satisfied that the patient is suffering unbearably and that there is no reasonable alternative.

The above applies in the following three situations:

A. the suffering is caused entirely by the psychiatric disorder;
B. the suffering is caused by a combination of a somatic condition and a psychiatric disorder;
C. the suffering is caused by a somatic disorder and in addition the patient has a psychiatric disorder or such a disorder occurs in their recent medical history.

In assessing whether the patient's request for euthanasia is voluntary and well considered, the physician must rule out that the patient's powers of judgment have been impaired by their psychiatric disorder. If the patient is not decisionally competent with regard to their request for euthanasia, that request cannot be regarded as voluntary and well considered. The physician must take particular note of whether the patient is able to grasp relevant information, understands their disease and is unequivocal in their deliberations.

> See also section 3.2.

As regards suffering with no prospect of improvement and the absence of a reasonable alternative, the physician must carefully explore the possibility of other options that could end or reduce the patient's suffering. This is particularly so in cases where the patient is relatively young and might still have many years to live.[35] If the patient refuses a reasonable alternative, they cannot be said to be suffering with no prospect of improvement. At the same time, patients are not obliged to undergo every conceivable form of treatment or intervention.

> See also section 3.5.

Situations A and B: Suffering caused by a psychiatric disorder and suffering caused by a combination of somatic and psychiatric disorders: in principle an independent psychiatrist must be consulted

If the request for euthanasia is prompted by suffering caused by a psychiatric disorder or by a combination of somatic and psychiatric disorders (situations A and B, referred to above), physicians are expected to exercise particular caution. Such cases are often complex and require specific expertise. The RTEs consider that, in principle, for this category of patients the physician must always seek psychiatric expertise in order to exercise the particular caution that is expected of physicians in such situations. The purpose of seeking psychiatric expertise is for the physician to ensure they are

[35] See cases 2016-41 and 2016-78 in the RTEs' 2016 annual report. Both cases have been published on the RTEs' website: www.euthanasiecommissie.nl. One involved a woman in her forties; the other, a man in his thirties. In both cases, the committee found that all the due care criteria had been complied with.

well informed and can reflect critically on their own convictions. This ensures a careful process of consideration.

In line with this principle, the RTEs review whether the physician consulted an independent psychiatrist and whether the latter, in addition to forming an opinion on the diagnosis, assessed:

- whether the request was voluntary and well considered (section 2 (1) (a) of the Act);
- whether the patient was suffering unbearably (section 2 (1) (b) of the Act);
- whether there were no reasonable alternatives (section 2 (1) (d) of the Act).

The independent psychiatrist may give advice on treatment if necessary.

The physician can decide:

- to consult an independent psychiatrist in addition to an independent (SCEN) physician or
- to consult an independent (SCEN) physician who is also a psychiatrist (a 'SCEN psychiatrist').

If the physician decides to consult a SCEN psychiatrist, they are not required to subsequently also consult a regular independent (SCEN) physician. As is the case with the independent psychiatrist, the SCEN psychiatrist must give an opinion, based on their own examination of the patient, on the psychiatric diagnosis or diagnoses and whether the treatment so far has been adequate. In addition, in their role as the independent (SCEN) physician, they must also assess the euthanasia request on the basis of the due care criteria. The SCEN psychiatrist may also give advice on treatment.

From the point of view of the RTEs, it is of no importance whether the physician performing euthanasia is a psychiatrist or another type of physician, for instance a general practitioner. In both situations an independent psychiatrist must be consulted, although that independent psychiatrist may also be the independent (SCEN) physician. Here the RTEs deviate somewhat from the NVVP's 2018 guidelines on 'Dealing with requests for termination of life on request from patients with a psychiatric disorder' (which can be found, in Dutch, on https://www.nvvp.net/home and richtlijnendatabase.nl), and the 2025 addendum concerning the consultation phase.

The subsections 'The independent physician's independence', 'In principle, the independent physician must see and speak with the patient' and 'Consulting the independent physician for a second time' in section 3.6. apply *mutatis mutandis* to the independent psychiatrist. Among other things this means that the independent psychiatrist must affirm their independence in relation to the physician and the patient, that they must see and speak with the patient, and that if a considerable amount of time has lapsed between the independent psychiatrist's report being issued and the intended date on which euthanasia is to be performed, it is appropriate for the physician and the independent psychiatrist to contact each other again to discuss, *inter alia*, whether a new report is necessary.

If the (SCEN) psychiatrist's report is substandard, the physician must ask the (SCEN) psychiatrist to modify it. If the amended report is still below par, the physician will have to consult a second (SCEN) psychiatrist. If the (SCEN) psychiatrist's views differ from those of the physician, it is all the more important for the physician to specifically reflect on the (SCEN) psychiatrist's views. It would also be appropriate in that case to consult a second (SCEN) psychiatrist, so as to exercise the required particular caution.

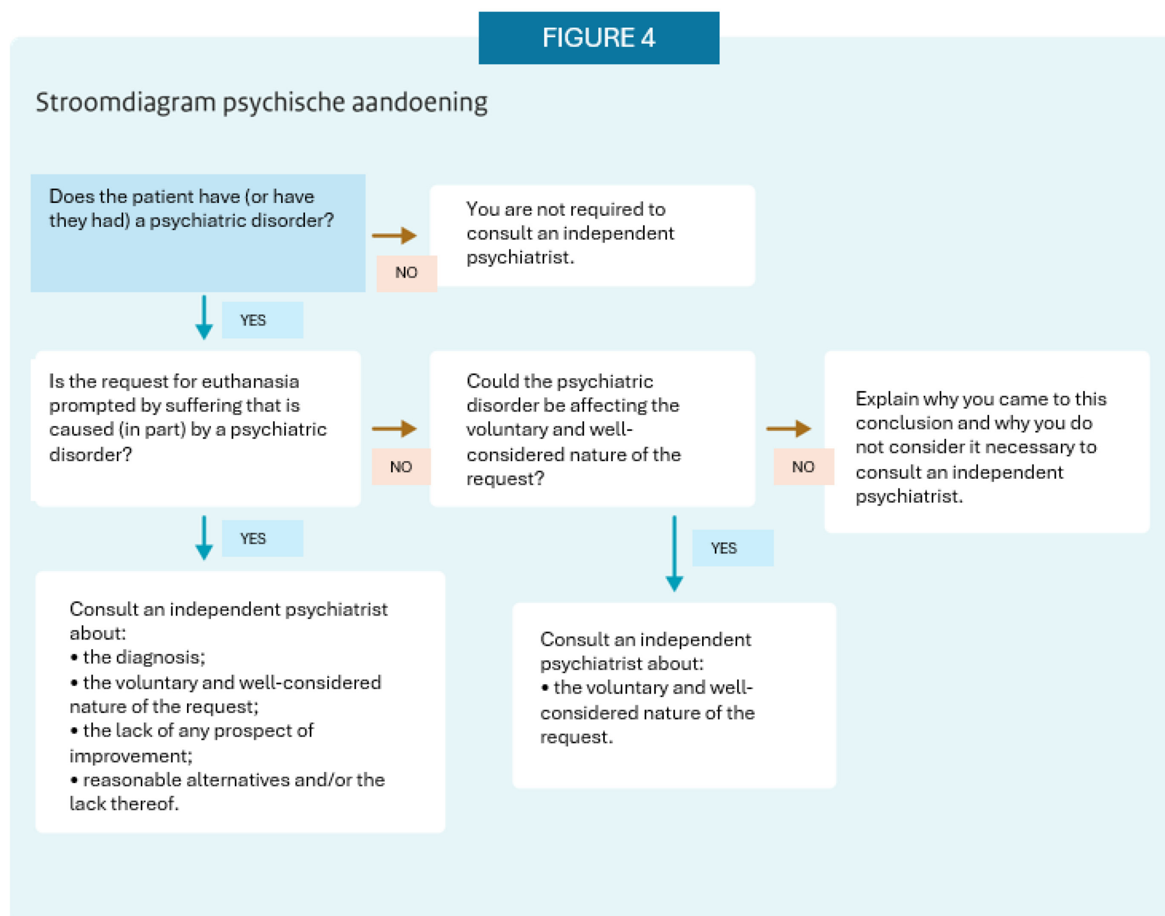
If a case involves an unusual combination of somatic and psychiatric disorders (situation B), it is not always sufficient to consult only an independent psychiatrist. An example is a patient with both dementia and a psychiatric disorder. These disorders can interact with each other and may both affect the patient's decisional competence. The physician must assess whether this is the case. It

may be necessary to consult not only an independent psychiatrist but also one or more other physicians with specific expertise or an independent (SCEN) physician with specific expertise.

Situation C: Suffering caused by a somatic disorder and additionally the patient has or has had a psychiatric disorder
If the patient's suffering is caused by a somatic disorder and additionally the patient has a psychiatric disorder, or such a disorder occurs in their recent medical history (situation C, referred to above), the physician and the independent physician must consider whether the psychiatric disorder affects the voluntary and well-considered nature of the request. In such cases it may be necessary to ask an independent psychiatrist or a SCEN psychiatrist for advice on the voluntary and well-considered nature of the request.[36] In this case the criteria concerning the lack of prospect of improvement and the absence of readable alternatives apply to the somatic disorder, as it is that disorder that causes the suffering.

If the physician is convinced that the psychiatric disorder is not affecting the voluntary and well-considered nature of the request, the physician need not consult an independent psychiatrist. This gives the physician scope to make their own assessment. The physician must, however, explain clearly why they did not consider such consultation necessary, and how they came to the conclusion the patient's request was voluntary and well considered.

The following figure shows a schematic overview of situations A, B and C as described above.



[36] See case 2022-039 on the RTEs' website.

PATIENTS WITH A PSYCHIATRIC DISORDER OR A COMBINATION OF SOMATIC AND PSYCHIATRIC DISORDERS: POINTS TO CONSIDER

- Have the physician and the independent physician considered whether the psychiatric disorder may be affecting the voluntary and well-considered nature of the request, the lack of any prospect of improvement, and the absence of a reasonable alternative?
- Has the physician consulted either an independent psychiatrist or an independent (SCEN) physician who is also a psychiatrist? This is necessary if:
  - the suffering is caused by a psychiatric disorder; or
  - the suffering is caused by a combination of somatic and psychiatric disorders; or
  - the psychiatric disorder may be affecting the patient's decisional competence.

4.5. Patients with dementia

In cases involving patients with dementia, there is also reason to exercise great 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. As a patient's dementia progresses, their decisional competence will decline.

Still decisionally competent with regard to a request for euthanasia
In the vast majority of the cases so far notified to the committees, the patient still had sufficient understanding of their disease and was 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 also section 3.3.). The key factor is the patient's perception of the progressive loss of personality, functions and skills, and the realisation that this process is unstoppable. This prospect can cause profound suffering in the present moment.

The regular procedure of consulting an independent physician will generally suffice if a patient with dementia is still decisionally competent with regard to their request for euthanasia. However, the patient must have been diagnosed with dementia according to prevailing medical practice. If there are any doubts as to the patient's decisional competence with regard to the request for euthanasia, it is wise for the physician to seek the advice of an independent expert on that specific matter. As regards the position of the independent expert, the conditions and requirements listed in section 3.6. regarding the independent physician's independence apply *mutatis mutandis*. If a considerable amount of time has lapsed between the independent expert's report being issued and the intended date on which euthanasia is to be performed, it is appropriate for the physician and the independent expert to contact each other again to discuss, *inter alia*, whether a new opinion is necessary.

If the independent expert's report is substandard, the physician must ask the independent expert to modify it. If the amended report is still below par, the physician will, in principle, have to consult a second independent expert.

If the independent expert presents a divergent view, the physician must specifically reflect on that view. It would also be appropriate in that case to consult a second independent expert, so as to exercise the required particular caution.

No longer decisionally competent with regard to a request for euthanasia

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 with regard to their request for euthanasia, provided the patient drew up an advance directive containing such a request when still decisionally competent in that respect.

> For more on euthanasia on the basis of an advance directive, see section 4.1.

PATIENTS WITH DEMENTIA: POINTS TO CONSIDER

- Is the patient still decisionally competent with regard to their request for euthanasia?
- If not, is there an advance directive? For more on euthanasia on the basis of an advance directive, see section 4.1.

4.6. Patients with an intellectual disability

Notifications of cases of euthanasia involving patients with an intellectual disability are rare.[37] There are patients with a mild intellectual disability who are capable of making a voluntary and well-considered request for euthanasia, and where all the other due care criteria have been met.[38] In these cases, particular attention must be paid to the patient's decisional competence with regard to their request for euthanasia.

Consulting an independent expert
If there are doubts about a patient's decisional competence with regard to their request, the physician must also consult – in addition to the regular independent physician who gives their opinion on all the due care criteria referred to in sections 3.2. to 3.5. – a physician with the expertise necessary to assess the patient's decisional competence (for instance a physician specialised in intellectual disabilities). Here too, it may suffice to consult one independent (SCEN) physician who is also an expert in the relevant field. As regards the position of the independent expert, it should be noted that the conditions and requirements listed in section 3.6. regarding the independent physician's independence apply *mutatis mutandis*.

If the independent expert's report is substandard, the physician must ask the independent expert to modify it. If the amended report is still below par, the physician will have to consult a second independent expert.

If the independent expert presents a divergent view, the physician must specifically reflect on that view. It would also be appropriate in that case to consult a second independent expert, so as to exercise the required particular caution.

[37] See case 2016-03 on www.euthanasiecommissie.nl.
[38] See 'Medische beslissingen rond het levenseinde bij mensen met een verstandelijke beperking' ['Medical decisions at end-of-life in people with intellectual disabilities'] (2007), by the Dutch association of physicians for people with intellectual disabilities (NVAVG), and 'Handreiking Omgaan met vragen om levensbeëindiging bij wilsonbekwame mensen met een verstandelijke beperking' ['Guidelines on dealing with requests for euthanasia from decisionally incompetent patients with intellectual disabilities'] (2013), also by the NVAVG.

4.7. Patients with a verbal communication disorder

A patient with a verbal communication disorder (such as aphasia) may be able to make a voluntary and well-considered request, but they will generally have difficulty expressing their views and wishes verbally. However, a patient with such a disorder will often be capable of answering questions or expressing their wishes regarding the request for euthanasia in another manner, for instance by squeezing someone's hand or using facial expressions or gestures. One option would be to ask only questions requiring a yes or no answer, which the patient could answer using gestures or signs. In this way, despite the patient's language disorder, the physician and the independent physician can form a good impression of the patient's request for euthanasia and the decisional competence required. If the other due care criteria are satisfied, euthanasia may be carried out.

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

4.8. Coma and reduced consciousness

The RTEs' framework for reviewing cases of euthanasia concerning patients in a state of reduced consciousness largely matches the KNMG's 'Guidelines on euthanasia for patients in a state of reduced consciousness' ['Richtlijn Euthanasie bij een verlaagd bewustzijn'] (2010).

The physician must ascertain that the patient is in a state of reduced consciousness or in a coma, for instance using the Glasgow Coma Scale (GCS).[39] The suffering experienced by the patient is of particular importance when considering whether euthanasia is permissible for a patient in a coma or state of reduced consciousness not resulting from palliative sedation.

> *For more on euthanasia and palliative sedation, see section 4.9.*

Coma:
Suffering assumes the patient is in a conscious state. Since a patient in a coma is in a state of complete unconsciousness, they cannot be said to be suffering.

Reduced consciousness:
If a patient is in a state of reduced consciousness, the possibility that they are suffering (perhaps unbearably) cannot be ruled out.

Situation 1.
Coma or reduced consciousness sets in after the patient has asked the physician to perform euthanasia but before euthanasia is due to be performed
It is possible for a patient to fall into a coma or a state of reduced consciousness after they have asked the physician to perform euthanasia but before euthanasia is due to be performed. This is a difficult situation, as it raises the question of whether euthanasia can still be performed.

In answering this question, it is necessary to distinguish between a number of different situations.

Distinction between irreversible and reversible coma or state of reduced consciousness
- Situation 1a. *irreversible coma* (caused by disease, patient cannot be aroused).

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

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

- Situation 1b. *irreversible state of reduced consciousness* (caused by disease, patient cannot be aroused):
  1. There are signs of suffering. The patient may spontaneously fall into a state of reduced consciousness from which they cannot be aroused, and may show signs of suffering. Such signs include, in particular, moaning, shortness of breath with or without abnormal respiration, and grimacing. Additional symptoms may include restlessness, confusion and (faecal) vomiting. In this situation, the physician can proceed with euthanasia.
  2. There are no signs of suffering. Euthanasia cannot be performed.

- Situation 1c. *reversible coma or reversible state of reduced consciousness* (medically induced, can be reversed by withdrawing medication).
  If the patient is in a medically induced coma or state of reduced consciousness that has not occurred spontaneously and shows no signs of suffering, the patient could potentially be aroused in order to ascertain whether they are indeed still suffering. However, if it is likely that suffering will occur if the patient is brought back to full consciousness, the committees consider it inhumane to do this. In such a situation, therefore, the physician can perform euthanasia if the patient had requested euthanasia previously, either orally or in an advance directive. The patient therefore need not be aroused from the reversible coma or state of reduced consciousness (even without signs of suffering) simply to confirm to the physician and/or independent physician that they are still suffering unbearably.

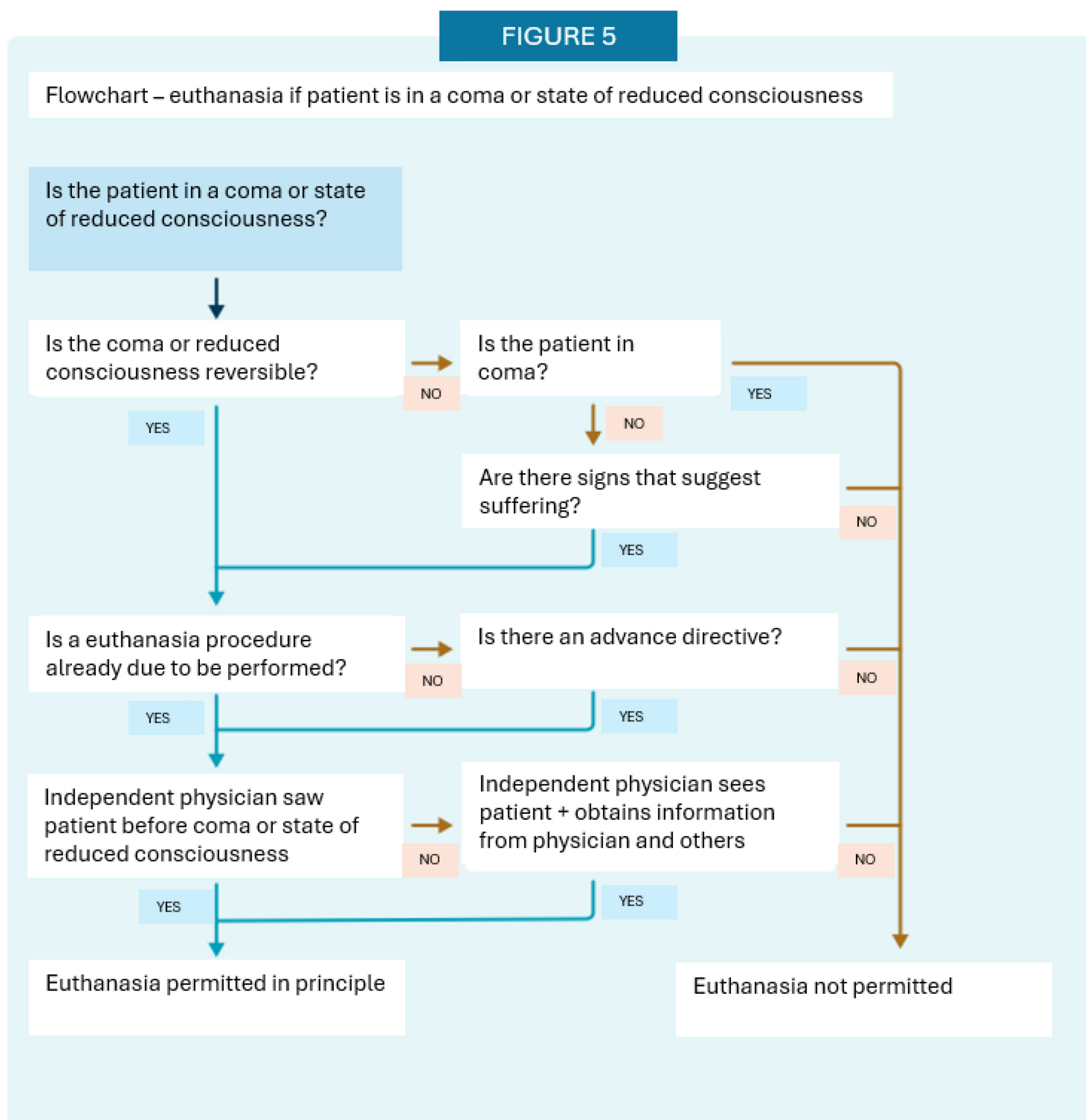
In the above-mentioned situations 1b, sub 1 (irreversible state of reduced consciousness, with signs that the patient is suffering) and 1c (reversible coma or state of reduced consciousness), the physician can thus perform euthanasia. In the interests of the rest of the process it is relevant whether, at the time when the patient entered a state of reduced consciousness or a reversible coma, an independent physician had already seen the patient:

- *the patient has asked the physician for euthanasia and subsequently, before the independent physician has seen the patient, the patient enters a state of reduced consciousness or a reversible coma.* The patient may also enter a state of reduced consciousness or reversible coma before they have been seen by the independent physician. In this case, the independent physician can no longer communicate with the patient and must base their assessment of the patient's request on information provided by the physician, the patient's advance directive (if there is one), the medical records and information from others. The independent physician will have to assess the patient's suffering on the basis of their own observations, physician notes and information provided orally by the physician, but also on information from other sources, such as letters from specialists and information from the patient's family or carers. Contrary to the KNMG's guidelines, the RTEs believe that this situation does not require a written advance directive.

- *the patient has asked the physician for euthanasia and subsequently, after the independent physician has seen the patient, the patient enters a state of reduced consciousness or a reversible coma.* If the patient enters a state of reduced consciousness or reversible coma after the independent physician has visited the patient and communicated with them, the independent physician need, in principle, not be called in again. In this situation an advance directive is not required, even if the patient is no longer capable of expressing their wishes in this respect at the point when euthanasia is to be performed.

Situation 2.
Coma or reduced consciousness occurs before euthanasia is planned
A patient may fall into a coma or state of reduced consciousness before the physician and the patient have completed, or even started, the euthanasia process. In order to proceed with euthanasia, there must at least be an advance directive drawn up by the patient that contains a request for euthanasia. The independent physician will have to see the patient. Here too, the independent physician will have to base their opinion partly on information from the physician, the patient's advance directive, the medical records and information from other sources. If the state of reduced consciousness is irreversible, there must also be signs that the patient is suffering.

> See also sections 3.6. and 4.1.



COMA OR REDUCED CONSCIOUSNESS: POINTS TO CONSIDER

- Euthanasia is not possible:
  - if the patient is in an irreversible coma, as they can no longer experience suffering;
  - if the patient is in an irreversible state of reduced consciousness with no signs of suffering.
- Euthanasia is possible:
  - if the patient is in an irreversible state of reduced consciousness with signs of suffering;
  - if the patient is in a reversible coma or a reversible state of reduced consciousness with or without signs of suffering.
- The patient need not be aroused from the reversible coma or reversible state of reduced consciousness (even without signs of suffering) simply to confirm to the physician and/or independent physician that the patient is still suffering unbearably, if it is likely that suffering will occur if the patient is brought back to full consciousness.
- Reduced consciousness or reversible coma sets in before the moment at which euthanasia is due to take place:
  - has the physician established the depth of coma or reduced consciousness? Have they used the GCS?
  - if reduced consciousness is irreversible, is the patient showing signs of suffering?
  - if the independent physician did not see the patient before the state of reduced consciousness or reversible coma set in, do they have enough information to form an opinion?
- Reduced consciousness or reversible coma sets in before euthanasia has been planned:
  - in addition to the above: did the patient draw up an advance directive?

4.9. Euthanasia and palliative sedation

Euthanasia and palliative sedation are two different ways of ending or alleviating a patient's unbearable suffering. In the case of euthanasia, the patient's life is terminated. With palliative sedation, the patient is brought into a state of reduced consciousness until their death. Unlike euthanasia, palliative sedation is normal medical practice, though it is subject to specific conditions. One of these is a life expectancy of two weeks or less.[40]

Some patients do not want euthanasia, and palliative sedation may be a good alternative for them. Others refuse palliative sedation because they want to remain conscious until the very end. Patients are therefore entitled to reject palliative sedation as a 'reasonable alternative'. Refusing palliative sedation is not therefore an obstacle to euthanasia.

> See also section 3.5.

Sometimes a patient may make a 'conditional' request for euthanasia. In this case the patient opts for palliative sedation but agrees with the physician that the latter will proceed with euthanasia in certain circumstances. Those circumstances may include the following:

- it takes longer for the patient to die than the patient wished;[41]

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[40] See Guideline for Palliative Sedation, 2022.

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

- the patient still shows signs of suffering, despite being in a state of reduced consciousness.

The committees emphasise that it is essential that the patient inform the physician in advance of the specific situations in which their consent to palliative sedation no longer applies and they want the physician to carry out their request for euthanasia. In such cases, the physician will have to consult an independent physician before palliative sedation is administered.

There are also cases in which the decision to grant a patient's request for euthanasia has been made, but sedation is administered prior to the procedure. This may be the case if the patient's symptoms suddenly worsen, but euthanasia cannot be performed yet, for instance because the physician is away and the locum cannot or does not wish to perform euthanasia, or because the physician has not yet received the euthanatics.

The patient is then sedated so that they enter a state of reduced consciousness, and as a result they are no longer able to repeat or reaffirm their request for euthanasia immediately before euthanasia is performed. Euthanasia can be performed if the patient reaffirmed their request for euthanasia before being sedated and only wished to be sedated to bridge the period until the procedure could be performed. It may also be performed if a situation has arisen that the patient has previously described – orally or in an advance directive – as one in which they would ask for the request for euthanasia they had already made to be actually carried out. In these cases, too, it is the committees' view that it would be inhumane to arouse the patient solely for the purpose of having them confirm the unbearable nature of their suffering to the physician and/or independent physician.

4.10. 'Completed life' or 'finished with life'

As the legislative history of the Act makes clear, the expression 'completed life' (also referred to as 'finished with life') refers to the situation of people who, often at an advanced age and without the medical profession having established that they have a disease or disorder that is accompanied by great suffering, have come to the conclusion that the value of their lives to them has decreased to the point where they would rather die than carry on living. The 'completed life' issue has been the subject of public debate for some years. The question is whether euthanasia should be allowed in such cases.[42] At present this is not yet the case. As the case law and legislative history show, unbearable suffering must have a medical dimension (see also section 3.3.). However there is no requirement that the medical condition should be life-threatening. Multiple geriatric syndromes can also involve unbearable suffering with no prospect of improvement.

> *For more on multiple geriatric syndromes, see section 3.3.*

4.11. Organ and tissue donation after euthanasia

The Act does not prescribe what can be done with the body after euthanasia, so it does not preclude organ and tissue donation after euthanasia has been performed. However, the intended donation procedure must not affect the due care to be exercised in the euthanasia process.

[42] See the report by the Advisory Committee on Completed Life, entitled 'Voltooid leven. Over hulp bij zelfdoding aan mensen die hun leven voltooid achten' ['Completed life. On assisted suicide for people who regard their life as completed'], The Hague, January 2016; and the government response and vision on 'completed life', Letter to the House of Representatives, 12 October 2016. Also see the PERSPECTIEF study 'Perspectieven op de doodswens van ouderen die niet ernstig ziek zijn: de mensen en de cijfers' ['Perspectives on the wish to die of elderly people who are not seriously ill: the people and the statistics'], ZonMw, 2020.

Organ or tissue donation is formally separate from the euthanasia process, but does have implications for that process. For instance, for organ donation to be possible, euthanasia will have to be performed in hospital. In other cases, like tissue donation, the patient's body will usually have to be taken to hospital after euthanasia has been performed.

A physician who is faced with this combination of euthanasia and organ or tissue donation should discuss the patient's wishes with respect to donation with them. Then, before euthanasia is performed, the physician must discuss the procedure in detail with the transplant coordinator at the hospital. The physician must then inform the patient and the patient's family about what will happen. The 'Richtlijn Orgaandonatie na euthanasie' ['Guidelines on organ donation after euthanasia'], 2022 version, and the 'Handleiding weefseldonatie na euthanasie' ['Instructions on tissue donation after euthanasia'] can help the physician make decisions on these matters. They can be found on the website of the Dutch Foundation for Transplants.[43]

4.12. Requirements not set by the Act

Some misconceptions exist regarding the criteria and conditions applying to euthanasia. The notifications received by the committees show that physicians and independent physicians sometimes set requirements that are not mentioned in the Act. The requirements laid down in the Act have been discussed and explained in this Code. It can also be deduced from that explanation what is not required by the Act. A summary:

- There is no requirement that the patient's medical condition be life-threatening (see sections 2.1. and 3.3.).
- The patient is not required to be in the terminal stage of their illness (see section 2.2.).
- The physician and the patient do not need to be in a treatment relationship (see section 3.1.).
- The patient is not required to make a request for euthanasia in writing in addition to their oral request (see section 3.2.).
- The patient is not required to go to a notary to register an advance directive containing a request for euthanasia in a living will (see section 4.1.).
- The patient's request must be well considered but it need not necessarily have persisted for a long period of time (see section 3.2.).
- The physician does not need the independent physician's 'permission' to perform euthanasia (see section 3.6.).
- A patient's decisional competence with regard to their request for euthanasia need not always be assessed by an independent psychiatrist. However, the situation is different if the patient has a psychiatric disorder. In such cases, the patient's decisional competence with regard to their request for euthanasia must always be assessed by an independent psychiatrist. In other cases the patient's decisional competence with regard to their request for euthanasia need only be assessed by a physician with the necessary expertise if there are reasonable doubts regarding that decisional competence (see also sections 4.2. to 4.5.).
- Palliative sedation is not a 'reasonable alternative' within the meaning of section 2 (1) (d) of the Act (see section 4.9.).
- It is generally desirable, as well as self-evident, for the patient's family to be involved in a euthanasia request, but this is not a requirement; nor is the family's consent required for euthanasia.

[43] transplantatiestichting.nl

5. Useful references

5.1. The committees' website

The committees' website can be found at www.euthanasiecommissie.nl. The site provides detailed information on the committees' procedures, as well as a selection of the committees' findings and their joint annual reports. The annual reports include case descriptions. The website also has:

- a model form for physicians to use when notifying the municipal pathologist;
- a model reporting form for the physician to include with the notification;
- a model form for municipal pathologists to use when notifying the committee;
- the Regional Euthanasia Review Committees Complaints Procedure.

5.2. The SCEN organisation

The SCEN organisation, which falls under the KNMG, fulfils a key role in relation to the due care criterion on consulting an independent physician (see section 3.6.). The preferred course of action is for physicians to consult a trained SCEN physician as the independent physician. The KNMG has drawn up guidelines for SCEN physicians, entitled 'Steun en consultatie bij euthanasie' ['Euthanasia support and independent assessment'] (2023). It is in the interests of the physician performing the euthanasia procedure that the independent physician write a comprehensive report. To help with this, the SCEN organisation has drawn up a checklist for the independent physician's report, and the KNMG provides a model reporting form for SCEN physicians: 'Modelverslag voor SCEN-artsen' (2023). For more information (in Dutch), see www.scen.nl.

5.3. Evaluations of the Act

The Act has been evaluated four times, in 2007, 2012, 2017 and 2023. The evaluation reports can be found (in Dutch) at www.zonmw.nl.

5.4. Public Prosecution Service administrative rules

Notifications of euthanasia where the committees have found that the physician failed to comply with one or more of the due care criteria are passed on to the Public Prosecution Service and the Health and Youth Care Inspectorate. The procedure followed by the Public Prosecution Service in such cases is set out in the 'Aanwijzing vervolgingsbeslissing inzake actieve levensbeëindiging op verzoek (euthanasie en hulp bij zelfdoding)' ['Instructions on prosecution decisions in the matter of active termination of life on request and assisted suicide'], which can be found (in Dutch) at wetten.overheid.nl/BWBR0039555/2017-05-17.

5.5. Medical professional standards

The KNMG has issued several position papers and guidelines on euthanasia. Examples are its position paper on end-of-life decisions (2021), the 'Richtlijn Uitvoering euthanasie en hulp bij zelfdoding' ['Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide'] (published jointly with the KNMP; 2021) and the 'Richtlijn Euthanasie bij een verlaagd bewustzijn' ['Guidelines on euthanasia for patients in a state of reduced consciousness'] (2010). These can be found, along with other relevant information, on knmg.nl (in Dutch).

The Netherlands Psychiatric Association (NVVP) has published the ‘Richtlijn Levensbeëindiging op verzoek bij patiënten met een psychische stoornis’ [guidelines on ‘Dealing with requests for assisted suicide from patients with a psychiatric disorder’] (2018). They are intended for psychiatrists and other physicians who have received a request for euthanasia from a patient with a psychiatric disorder and can be found on https://www.nvvp.net/home and richtlijnendatabase.nl (in Dutch).

5.6. Euthanasia Expertise Centre

The Euthanasia Expertise Centre provides assistance and support to physicians. They run an information hotline, provide training courses and have euthanasia counsellors. See expertisecentrumeuthanasie.nl.

Annexe – Relevant statutory provisions

Bulletin of Acts and Decrees 2001, no. 194
Act of 12 April 2001, containing review procedures for the termination of life on request and assisted suicide and amending the Criminal Code and the Burial and Cremation Act (Termination of Life on Request and Assisted Suicide (Review Procedures) Act)[44]

Termination of Life on Request and Assisted Suicide (Review Procedures) Act[45]

Chapter I
Definitions

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

Chapter II
Due care criteria

Section 2
1. In order to comply with the due care criteria referred to in article 293, paragraph 2 of the Criminal Code, the physician must:
   a. be satisfied that the patient's request is voluntary and well considered;
   b. be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
   c. have informed the patient about his situation and 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 his suicide.
2. If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests,

[44] See for proceedings in the States General: Parliamentary Papers, House of Representatives 1998/1999, 1999/2000, 2000/2001, 26 691. Proceedings of the House of Representatives, 2000/2001, pp. 2001-2072; 2107-2139; 2202-2223; 2233-2260; 2372-2375. Parliamentary Papers, Senate 2000/2001, 26 691 (137, 137a, 137b, 137c (reprint), 137d, 137e, 137f, 137g, 137h). Proceedings of the Senate, 2000/2001, see session of 10 April 2001.
[45] As applicable on 1 January 2026. See https://wetten.overheid.nl/BWBR0012410 for the most recent version.

has made a written declaration requesting that his life be terminated, the physician may comply with this request. The due care criteria in subsection 1 apply *mutatis mutandis*.
3. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or parents who have responsibility for him, or else his guardian, has or have been consulted.
4. If the patient is a minor aged between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the physician may, if a parent or the parents who have responsibility for him, or else his guardian, can agree to the termination of life or to assisted suicide, comply with the patient's request. Subsection 2 applies *mutatis mutandis*.

Chapter III
Regional review committees for the termination of life on request and assisted suicide

Division 1: Establishment, composition and appointment
Section 3
1. There are regional committees to review reported cases of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2 and article 294, paragraph 2, second sentence, respectively, of the Criminal Code.
2. A committee consists of an odd number of members, including in any event one legal expert who also chairs the committee, one physician and one expert on ethical or moral issues. A committee also comprises alternate members from each of the categories mentioned in the first sentence.

Section 4
1. The chair, the members and the alternate members are appointed by Our Ministers for a period of four years. They may be reappointed once for a period of four years.
2. A committee has a secretary and one or more deputy secretaries, all of whom must be legal experts appointed by Our Ministers. The secretary attends the committee's meetings in an advisory capacity. The appointment ends automatically on the date as of which the official in question ceases to be tasked with filling the position of secretary or deputy secretary.
3. The secretary is accountable to the committee alone in respect of his work for the committee.

Division 2: Resignation and dismissal
Section 5
The chair, the members and the alternate members may tender their resignation to Our Ministers at any time.

Section 6
The chair, the members and the alternate members may be dismissed by Our Ministers on the grounds of unsuitability or incompetence or for other compelling reasons.

Division 3: Remuneration
Section 7
1. Without prejudice to sections 4 to 6, rules are laid down by or pursuant to order in council concerning the legal position of the chairs, including at a minimum rules on remuneration.
2. The rules referred to in subsection 1 may be set differently for each of the chairs, in accordance with the nature and scope of the duties they are to perform.

Division 4: Duties and responsibilities

Section 8

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

Section 9

1. The committee notifies the physician of its findings in writing within six weeks of receiving the report referred to in section 8, subsection 1, giving reasons.
2. The committee notifies the Board of Procurators General and the inspector of the Health and Youth Care Inspectorate of its findings:
   a. if the physician, in the committee's opinion, did not act in accordance with the due care criteria set out in section 2; or
   b. if a situation occurs as referred to in section 12, last sentence of the Burial and Cremation Act.

   The committee notifies the physician accordingly.
3. The time limit defined in the first subsection may be extended once for a maximum of six weeks. The committee notifies the physician accordingly.
4. The committee is empowered to explain its findings to the physician orally. This oral explanation may be provided at the request of the committee or the physician.

Section 10

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

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

2°. for the purposes of a criminal investigation.

The committee notifies the physician that it has supplied information to the public prosecutor.

Division 6: Procedures

Section 11

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

Section 12

1. The committee adopts its findings by a simple majority of votes.
2. Findings are adopted by three members of the committee, each of whom represents one of the categories of expertise referred to in section 3, subsection 2, first sentence.

Section 13

The chairs of the regional review committees meet at least twice a year in order to discuss the methods and operations of the committees. A physician and an expert on ethical or moral issues, who each represent the other members of their category of expertise, are invited to attend these meetings.

Division 7: Confidentiality and disqualification

Section 14
The members and alternate members of the committee are obliged to maintain confidentiality with regard to all the information that comes to their attention in the course of their duties, unless they are required by a statutory regulation to disclose the information in question or unless the need to disclose the information in question is a logical consequence of their responsibilities.

Section 15
A member of the committee sitting to review a particular case must disqualify himself and may be challenged if there are any facts or circumstances which could jeopardise the impartiality of his judgment.

Section 16
Any member or alternate member or the secretary of the committee must refrain from giving any opinion on an intention expressed by a physician to terminate life on request or to provide assistance with suicide.

Division 8: Reporting requirements
Section 17
1. By 1 April of each year, the committees must submit to Our Ministers a joint report on their activities during the preceding calendar year. Our Ministers lay down the format of such a report by ministerial order.
2. The report referred to in subsection 1 must state in any event:
   a. the number of cases of termination of life on request and assisted suicide of which the committee has been notified and which the committee has assessed;
   b. the nature of these cases;
   c. the committee's findings and its reasons.

Section 18
Each year, when they present their budgets to the States General, Our Ministers must report on the operation of the committees on the basis of the report referred to in section 17, subsection 1.

Section 19
1. On the recommendation of Our Ministers, rules are laid down by order in council on:
   a. the number of committees and their powers;
   b. their locations.
2. Further rules may be laid down by Our Ministers by or pursuant to order in council with regard to:
   a. the size and composition of the committees;
   b. their working methods and reporting procedures.
   c. consultations with a representative of the Board of Procurators General and a representative of the Health Care Inspectorate.

Chapter IIIa
Bonaire, St Eustatius and Saba

Section 19a
This Act also applies in the territories of the public bodies Bonaire, St Eustatius and Saba in accordance with the provisions of this chapter.

Section 19b

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

Section 19c
Notwithstanding section 3, subsection 1, a committee will be appointed by Our Ministers that is competent to review reported cases of termination of life on request or assisted suicide as referred to in article 306, paragraph 2 and article 307, paragraph 2, second sentence of the Criminal Code of Bonaire, St Eustatius and Saba.

Section 19d
The chair of the committee referred to in section 19c takes part in the meetings referred to in section 13.

Criminal Code

Article 293
1. Anyone who terminates another person’s life at that person’s express and earnest request is liable to a term of imprisonment not exceeding twelve years or a fifth-category fine.
2. The act referred to in paragraph 1 is not an offence if it is committed by a physician who fulfils the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies the municipal pathologist of this act in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act.

Article 294
1. Anyone who intentionally incites another to commit suicide is, if suicide follows, liable to a term of imprisonment not exceeding three years or a fourth-category fine.
2. Anyone who intentionally assists another to commit suicide or provides him with the means to do so is, if suicide follows, liable to a term of imprisonment not exceeding three years or a fourth-category fine. Article 293, paragraph 2 applies *mutatis mutandis*.

Burial and Cremation Act

Section 7
1. The person who conducted the post-mortem examination issues a death certificate if he is satisfied that the death was due to natural causes.
2. If death was the result of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2 or article 294, paragraph 2, second sentence of the Criminal Code

respectively, the physician does not issue a death certificate and immediately notifies the municipal pathologist or one of the municipal pathologists of the cause of death by completing a report form. The physician encloses with the form a substantiated report on compliance with the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

3. If the physician decides, in cases other than those referred to in subsection 2, that he is unable to issue a death certificate, he immediately notifies the municipal pathologist or one of the municipal pathologists accordingly by completing a report form.

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