REGIONAL
EUTHANASIA
REVIEW COMMITTEES

RTE

ANNUAL REPORT 2020

CONTENTS

FOREWORD

The foreword to the 2019 annual report of the RTEs ended by saying that two upcoming Supreme Court judgments in a case where a request for euthanasia by a patient with advanced dementia was granted on the basis of an advance directive were eagerly anticipated. In April 2020 the Supreme Court provided guidance on three salient questions that arose during this case:

1 If the advance directive of a patient who has since become decisionally incompetent is not entirely clear, 'the patient's request should be interpreted not only on the basis of the phrasing; other circumstances from which the patient's intentions can be deduced are also relevant. There is therefore room for interpretation of the written request,' said the Supreme Court.
2 According to the next section of the Supreme Court judgment, administering premedication can in certain circumstances be an aspect of due medical care: 'When performing the termination of life, the physician will have to take into account possible irrational or unpredictable behaviour on the part of the patient. This may be a reason to administer premedication.'
3 Regarding the question of whether a physician is required to consult a decisionally incompetent patient on when and how the euthanasia procedure will be performed, the Supreme Court upheld the district court's judgment. That judgment said: 'Not only would such a conversation have been pointless because the patient could no longer comprehend the subject matter, but it could also have caused the patient to become more upset or agitated.'

The RTEs have revised the Euthanasia Code 2018 to reflect the above-mentioned sections of the Supreme Court judgments. The Code is intended to provide an accessible and up-to-date overview of the way in which the RTEs, on the basis of legislation and case law, interpret the due care criteria laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

In 2020, as in previous years, the number of notifications of cases in which a physician granted a request for euthanasia by a patient with advanced dementia on the basis of an advance directive was extremely low: 2 out of almost 7,000 notifications. However, there can be no doubt that performing euthanasia in a situation where communication with the patient is no longer possible presents the physician with complex medical, legal and ethical dilemmas. The Supreme Court judgments and the subsequently revised Euthanasia Code provide clear guidance to physicians faced with such dilemmas.

The measures taken in response to the COVID-19 pandemic naturally had far-reaching consequences for the RTEs. It would have been a highly undesirable situation for the physicians in question if the time between performing the euthanasia procedure and receiving the RTE's findings on the case had increased considerably as a result of the government's urgent request for everyone to work from home as much as possible. Great thanks are due to all the staff of the RTEs – in particular the process support staff – who made extraordinary efforts to send, as quickly as possible, digital versions of the euthanasia notifications, which are largely still submitted on paper, to the committee members for review. As a result, the time between notifications being received by the RTE and findings being sent to the physician in question was the same as in 2019: around 29 days. We are also grateful to all the RTE members who, by means of videoconferencing, continued to convene to review non-straightforward cases. We are all looking forward to being able to meet in person as soon as the coronavirus situation allows.

At the beginning of the first lockdown period, SCEN physicians were faced with the question as to whether they were permitted to see patients by means of video calls. The Act stipulates that the independent physician who must be consulted by the physician who is willing to grant a patient's request for euthanasia must 'see the patient'. At the request of the Royal Dutch Medical Association the RTEs announced that, in light of the exceptional situation, SCEN video consultations would also be permitted.

In the past year the RTEs received almost 7,000 notifications, a 9% rise compared with the number of notifications in 2019. That is 4.1% of the total number of people who died in the Netherlands in 2020. In only two of the notifications received in 2020 was a coronavirus infection the medical grounds on the basis of which a request for euthanasia was granted. In four cases, a coronavirus infection in addition to other medical conditions formed the basis for granting the request for euthanasia. It is therefore unlikely that there is a direct causal link between COVID-19 and the increase in the number of notifications.

As of 1 February 2021 I relinquished my duties as coordinating chair of the RTEs. For just under five years I performed those duties with energy and conviction. Each request for euthanasia presents the physician with medical, ethical and legal dilemmas. My experiences over the past five years have led me to conclude that the way in which physicians deal with those dilemmas demonstrates the exceptional care that is exercised in the practice of euthanasia in the Netherlands. These physicians help patients requesting euthanasia to end their unbearable suffering without prospect of improvement. For that they deserve the highest praise.

It has been a great honour to have been involved in the monitoring of compliance with the due care criteria laid down in the Act, and to have served as the 'standard bearer' of the RTE organisation. Both these elements will be in excellent hands in the person of Jeroen Recourt, to whom I have handed over the position of coordinating chair. I have great faith in his capabilities.

Jacob Kohnstamm
Amsterdam, February 2021

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

8

termination of life on request	6705
assisted suicide	216
combination of the two	17

CHAPTER I
DEVELOPMENTS IN 2020

1 ANNUAL REPORT

For more information on the outline of the Act, the committees' procedures, etc. see the revised Euthanasia Code 2018 and the website of the RTEs: https://english.euthanasie-commissie.nl.

In their annual reports the Regional Euthanasia Review Committees ('RTEs') report on their work over the past calendar year. They thus account – to society, government and parliament – for the way in which they fulfil their statutory task of reviewing notified cases of termination of life on request and assisted suicide on the basis of the due care criteria laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). This report uses the term 'euthanasia' to refer to both forms of termination of life. The distinction between termination of life on request and assisted suicide is made only where necessary.

The Euthanasia Code 2018 (revised in 2020) can be downloaded from the website of the RTEs (https://english.euthanasie-commissie.nl). A supplement can be downloaded and printed for insertion in printed versions of the Euthnasia Code 2018.

Another aim of the annual report is to give physicians and other interested parties insight into the way in which the committees have reviewed and assessed specific notifications. Chapter II therefore gives an extensive account of common and less common review findings. We have aimed to make the annual report accessible to a wide readership by avoiding the use of legal and medical terms as much as possible, or by explaining them where necessary.

MALE-FEMALE RATIO

male	3562
female	3376

2 NOTIFICATIONS

Number of notifications

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

In 2020 the RTEs received 6,938 notifications of euthanasia. This is 4.1% of the total number of people who died in the Netherlands in that year (168,566) (source: Statistics Netherlands, 5 February 2020). This represents a 9.1% rise in the number of notifications compared with 2019 (6,361 notifications) and it is the highest number of notifications the RTEs have received since the entry into force of the Act. The number of notifications relative to the total number of deaths dropped by 0.1 percentage point compared with 2019. It should however be noted that in 2020 there were around 15,000 more deaths than expected (source: Statistics Netherlands).

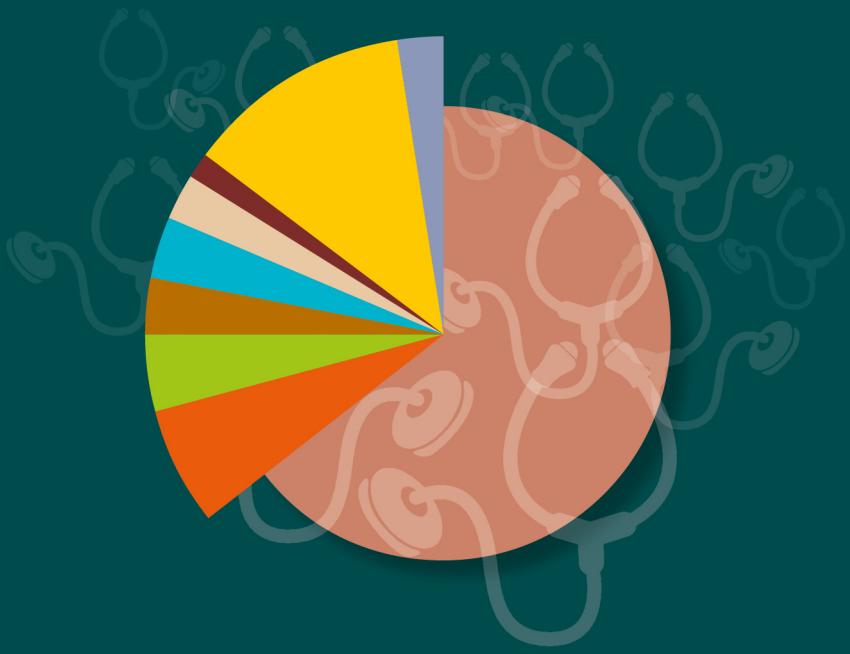
Male/female ratio

The numbers of male and female patients were again almost the same: 3,562 men (51.3%) and 3,376 women (48.7%).

Ratio between cases of termination of life on request and cases of assisted suicide

For points to consider regarding due medical care, see pages 35 ff of the revised Euthanasia Code 2018

There were 6,705 notifications of termination of life on request (96.6% of the total), 216 notifications of assisted suicide (3.1%) and 17 notifications involving a combination of the two (0.25%). A combination of the two occurs if, in a case of assisted suicide, the patient ingests the potion handed to them by the physician, but does not die within the time agreed by the physician and the patient. The physician then performs the termination of life on request by intravenously administering a coma-inducing substance, followed by a muscle relaxant.



NATURE OF CONTITIONS

cancer	4480
neurological disorders	458
cardiovascular disease	286
pulmonary disorders	209
multiple geriatric syndromes	235
dementia	170
early-stage dementia: 168	
(very) advanced stage of dementia: 2	
psychiatric disorders	88
combination of disorders	856
other conditions	156

Conditions

Most common conditions

90.6% of the cases (6,289) involved patients with:

- incurable cancer (4,480)
- neurological disorders such as Parkinson's disease, multiple sclerosis and motor neurone disease (458);
- cardiovascular disease (286);
- pulmonary disorders (209);
- or a combination of conditions (856).

Dementia

For points to consider regarding patients with dementia, see pages 46 ff of the revised Euthanasia Code 2018.

Two notifications in 2020 involved patients in an advanced or very advanced stage of dementia who were no longer able to communicate regarding their request and in whose cases the advance directive was decisive in establishing whether the request was voluntary and well considered. One of these cases is described in Chapter II and both have been published (numbered 2020-88 and 2020-118) on the website of the RTEs.

In 168 cases the patient's suffering was caused by early-stage dementia. These patients still had insight into their condition and its symptoms, such as loss of bearings and personality changes. They were deemed decisionally competent with regard to their request for euthanasia because they could still grasp its implications. Case 2020-76, described in Chapter II, is an example.

Psychiatric disorders

For points to consider regarding patients with a psychiatric disorder, see pages 43 ff of the revised Euthanasia Code 2018.

In 88 notified cases of euthanasia the patient's suffering was caused by one or more psychiatric disorders. In 35 of these cases the notifying physician was a psychiatrist, in 14 cases a general practitioner, in 6 cases an elderly-care specialist and in 33 cases another physician. In 68 cases of euthanasia involving patients with psychiatric disorders, the physician performing euthanasia was affiliated with the Euthanasia Expertise Centre (EE), formerly the End-of-Life Clinic (SLK).
The physician must exercise particular caution in cases involving psychiatric disorders, as was done in case 2020-53 (described in Chapter II).

AGE

30 years or younger	23
30-40 years	49
40-50 years	178
50-60 years	608
60-70 years	1452
70-80 years	2320
80-90 years	1722
90 years or older	586

Multiple geriatric syndromes

For points to consider regarding multiple geriatric syndromes, see pages 23 ff of the revised Euthanasia Code 2018.

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 can be the sum of one or more related symptoms. In conjunction with the patient's medical history, life history, personality, values and stamina, they may give rise to suffering that the patient experiences as unbearable and without prospect of improvement. In 2020 the RTEs received 235 notifications of euthanasia that fell into this category. A notification reviewed by the RTEs relating to multiple geriatric syndromes is included in Chapter II (2020-62).

Other conditions

Lastly, the RTEs register cases involving conditions that do not fall into any of the above categories, such as chronic pain syndrome, as 'other conditions'. There were 156 such cases in 2020.

Age

For points to consider regarding minors, see page 44 of the revised Euthanasia Code.

The highest number of notifications of euthanasia involved people in their seventies (2320 cases, 33.4%), followed by people in their eighties (1,722 cases, 24.8%) and people in their sixties (1,452 cases, 20.9%).

In 2020 the RTEs reviewed one notification of euthanasia involving a minor between the ages of 12 and 17. The oldest patient was 106. There were 72 notifications concerning people aged between 18 and 40. In 44 of these cases, the patient's suffering was caused by cancer and in 16 cases it was caused by a psychiatric disorder. In the category 'dementia', the highest number of notifications involved people in their seventies (64 cases), followed by people in their eighties (62 cases). In the category 'psychiatric disorders', there were 30 notifications involving people in their sixties and 15 involving people in their fifties. In the category 'multiple geriatric syndromes' most of the notifications concerned people aged 90 or older (150 cases).

NOTIFYING PHYSICIANS

general practitioner	5715
elderly-care specialist	243
specialist working in a hospital	254
registrar	70
other physician (e.g. doctors affiliated with the EE)	656

Locations

As in previous years, in the vast majority of cases the patient died at home (5,676 cases, 81.8%). Other locations were a hospice (475 cases, 6.9%), a nursing home (305 cases, 4.4%), a care home (214 cases, 3.1%), a hospital (136 cases, 2.0%) or elsewhere, for instance at the home of a family member, in a sheltered accommodation centre or a convalescent home (132 cases, 1.9%).

Notifying physicians

The vast majority of cases (5,715) were notified by a general practitioner (82.4% of the total number). The other notifying physicians were elderly-care specialists (243), other specialists (254) and registrars (70). There was also a group of notifying physicians with other backgrounds (656), most of them affiliated with the EE.

The number of notifications by physicians affiliated with the EE (916) hardly rose at all in comparison with 2019, when there were 904 notifications by this group. EE physicians are often called upon if the attending physician considers a request for euthanasia to be too complicated. Physicians who do not perform euthanasia for reasons of principle or who will only perform euthanasia if the patient has a terminal condition also often refer patients to the EE. In some cases, rather than being referred by an attending physician, the patients themselves contact the EE or ask their families to do so. Many of the notifications involving patients with a psychiatric disorder came from EE physicians: 68 out of 88 notifications (over 77%). Of the 170 notifications of cases in which the patient's suffering was caused by a form of dementia, 81 (47.6%) came from EE physicians. Of the 235 notifications involving patients with multiple geriatric syndromes, 105 (44.7%) came from EE physicians.

Euthanasia and organ and tissue donation

Termination of life by means of euthanasia does not preclude organ and tissue donation. The Richtlijn Orgaandonatie na euthanasie (Guidelines on organ donation after euthanasia) published by the Dutch Foundation for Transplants provides a step-by-step procedure for such cases. In 2020 the RTEs received six notifications indicating that organ donation had taken place after euthanasia.

LOCATIONS

home	5676
hospice	475
care home	214
nursing home	305
hospital	136
elsewhere	132

(for instance at the home of a family member, in a sheltered accommodation centre or a convalescent home)

Couples

In 26 cases, euthanasia was performed simultaneously on both members of a couple (13 couples). Cases 2020-148 and 2020-149 on the website are examples. Of course, the due care criteria set out in the Act must be satisfied in both cases separately. Each partner must be visited by a different independent physician in order to safeguard the independence of the assessment.

Due care criteria not complied with

In two of the notified cases in 2020, the RTEs found that the physician who performed euthanasia did not comply with the due care criteria set out in section 2 (1) of the Act. These two cases are discussed in Chapter II.

Grey areas in the review procedure

Limiting this report to an account of how often the RTEs found that the physician had not complied with one or more of the statutory due care criteria would not do justice to the complexity of the review procedure. In practice, there are grey areas. In 13 cases (including the two mentioned above where the committee found that the due care criteria had not been satisfied), the committee asked the notifying physician for further information in writing, and in one case the independent physician was asked to provide more information. In 14 cases the committee invited the notifying physician (and in one case the independent physician) to answer the committee's questions in person, sometimes after having first put written questions to the physician. Generally these oral and written explanations by the notifying and independent physicians provided sufficient clarification, allowing the committee to reach the conclusion that the physician in question had complied with the due care criteria. In addition, the committees also regularly advised physicians on how they could improve their working methods and their notifications in the future.

3 COMMITTEE PROCEDURES – DEVELOPMENTS

Straightforward and non-straightforward cases

Since 2012, notifications received by the RTEs have been processed as follows. Upon receipt, a notification is categorised by the secretary of the committee, who is a lawyer, as a non-straightforward case (VO) or a straightforward case (NVO). Notifications are categorised as straightforward if the secretary of the committee considers that the information provided is complete and the physician has complied with the statutory due care criteria, unless the notification falls into a category that is by definition considered non-straightforward. After the initial selection by the secretary of the committee, the committee reviews the notifications. This is done digitally for the straightforward cases. The committee then decides whether it agrees with the secretary's provisional view that the notification is straightforward or whether on the contrary it considers it to be non-straightforward. In the latter case the committee categorises the notification as non-straightforward. In 2020 it did so in 42 cases (0.6% of notifications).

If a notification is completely straightforward, the physician always receives an abridged findings report. This is a letter outlining the facts of the case and informing the physician of the committee's finding, based on those facts, that the physician has complied with the due care criteria. This practice was introduced in 2018 for completely straightforward cases where the patient's suffering was caused by cancer, motor neurone disease, chronic obstructive pulmonary disease or heart failure or a combination of two or more of these disorders. It has now been decided to inform the physician in this manner in all straightforward cases.

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

By providing a more complete description of certain aspects of their findings concerning non-straightforward notifications, the RTEs expect to give physicians and other stakeholders a clearer picture of the way the RTEs reach their findings and the decisive arguments underlying them.

In abridged findings and in the letter accompanying a full report of findings, the committee informs the physician that an anonymised version of the case or the findings may be published. It also asks the physician to consider informing the SCEN physician of the findings.

Example of an abridged findings report

Dear Mr/Ms [name],

On [date] the Regional Euthanasia Review Committee ('the committee') received your report and the accompanying documents concerning your notification of termination of life on request for Mr/Ms [name], born on [date], deceased on [date]. The committee has studied the documents.

In view of the facts and circumstances described in the documents, the committee has found that you could be satisfied that the patient's request was voluntary and well considered, and that the patient's suffering was unbearable, with no prospect of improvement. You informed the patient sufficiently about the patient's situation and prognosis. Together, you and the patient could be satisfied that there was no reasonable alternative in the patient's situation. You consulted at least one other, independent physician, who saw the patient and gave a written opinion on whether the due care criteria had been complied with. Lastly, you performed the euthanasia procedure with due medical care.

On the grounds of the above, the committee finds that you acted in accordance with the statutory due care criteria laid down in section 2 (1) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

The committee consisted of the following persons:
[name], chair, lawyer
[name], member, physician
[name], member, ethicist

The committee will not send these findings to the independent physician consulted. We would recommend you inform the independent physician of the findings.

Please be aware that an anonymised version of this case may be published on the website or in the annual report of the RTEs.

Yours sincerely,

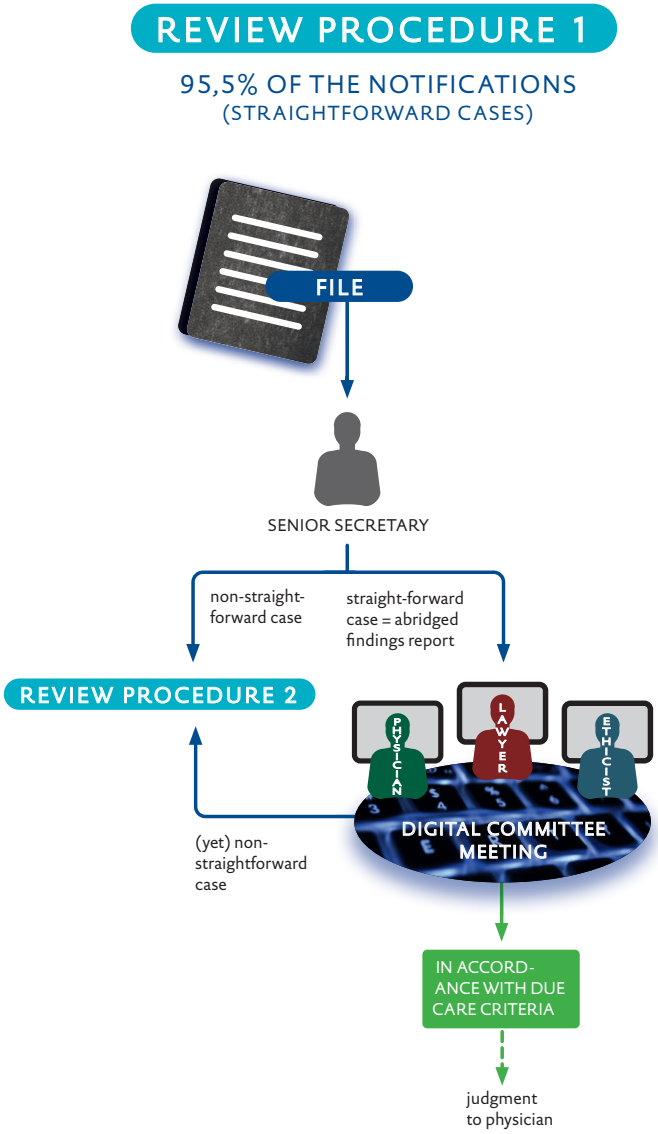
[signature]
chair

[signature]
secretary

The RTEs do not send their findings to the SCEN physician, only to the physician who has performed euthanasia.

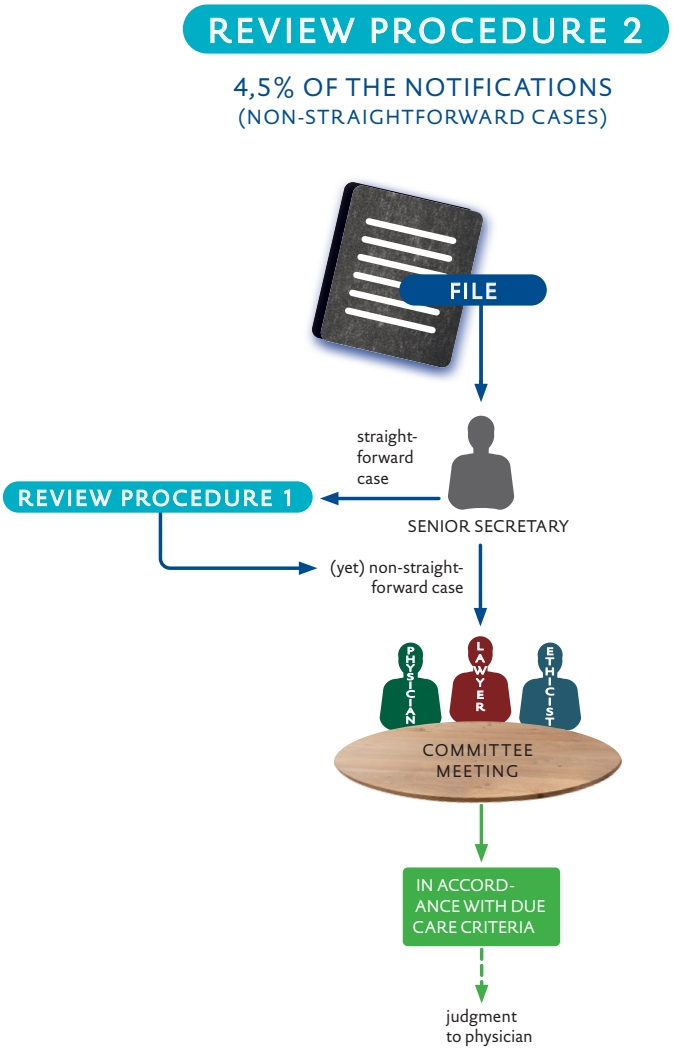
Examples of straightforward cases can be found for instance in section 2.1. It should be noted that these are summaries of the cases in question and not the abridged findings sent to the physician. Descriptions of some of the straightforward cases are published on the website of the RTEs (https://english.euthanasiecommissie.nl), along with the committees' findings in those cases.

In 2020, 95.5% of the notifications received were categorised as straightforward by the secretary of the committees, again a higher per-



centage than in the year before. This rise can mainly be explained by amended criteria on the basis of which the secretary of the committee must categorise cases as non-straightforward by default, and partly by increasingly comprehensive reporting by physicians.

Of all the notifications received, 4.5% (623) were immediately categorised as non-straightforward because, for example, they involved patients with a psychiatric disorder, there were questions about how euthanasia had been performed, or because the case file submitted by the notifying physician was not detailed enough for the committee to reach a conclusion.



In 2020 the average time that elapsed between the notification being received by the RTEs and the findings being sent to the physician was 29 days. This is within the time limit of six weeks laid down in section 9 (1) of the Act and is the same as in 2019, despite the fact that the coronavirus pandemic did not make the RTEs' work any easier.

Complex notifications

Some cases are considered to be so complex that all the RTE members should be able to have a say in the matter. This leads to intensive consultations between the committees. The standard practice is that when a committee believes a particular notification does not meet the due care criteria, it makes the case file and its draft findings available to the members of all the committees on the RTE intranet site. It reaches a final conclusion after studying the comments from other committee members.

The same is done in other cases where the committee feels it would benefit from an internal debate. The aim is to ensure the quality of the review is as high as possible and to achieve maximum uniformity in the findings. Eleven cases were discussed in this way in 2020, including the cases in which the committee found that the due care criteria had not been fulfilled.

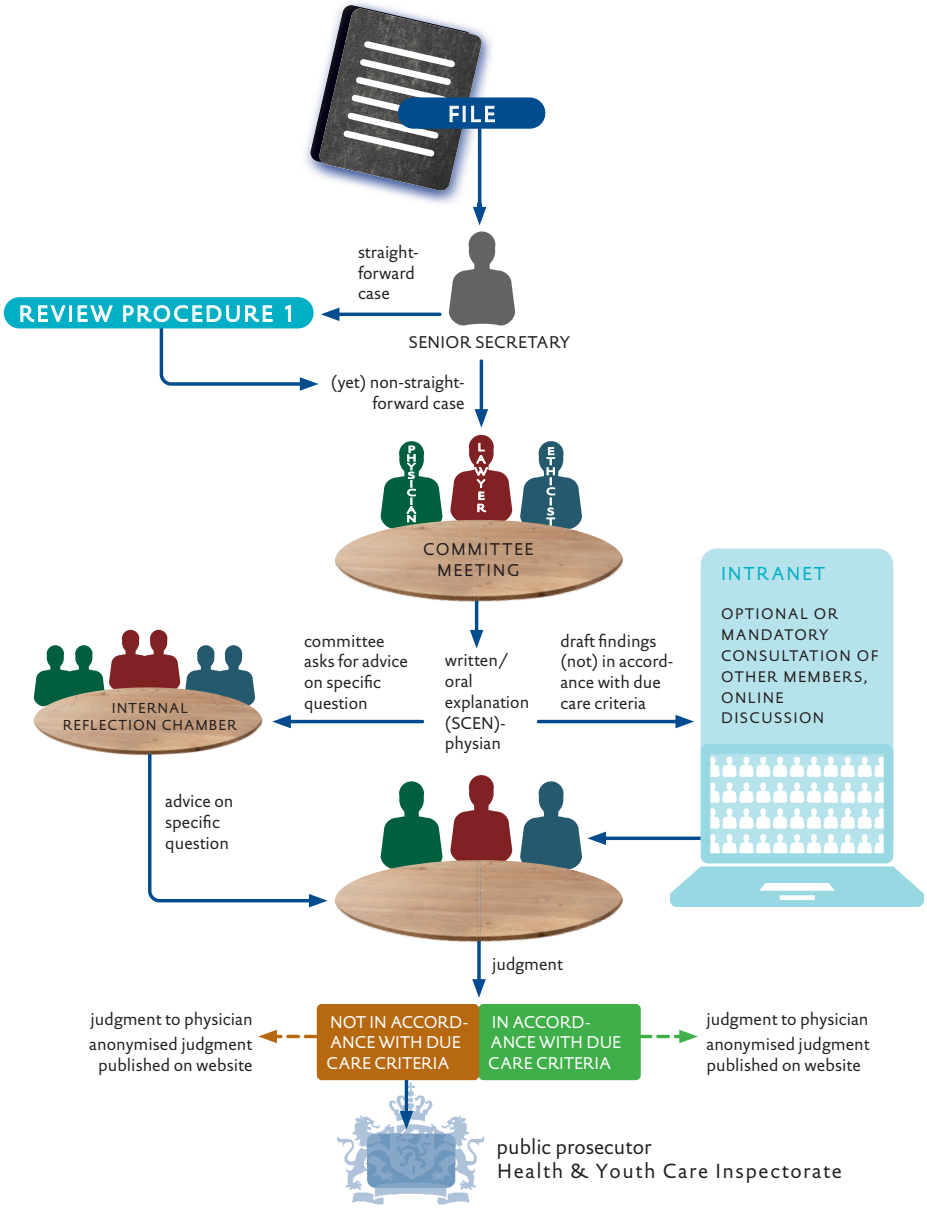
Reflection chamber

In 2016 the RTEs decided to establish an internal reflection chamber to further a number of aims, including enhanced coordination and harmonisation. The reflection chamber consists of two lawyers, two physicians and two experts on ethical or moral issues, all of whom have been a member of an RTE for at least three years and are expected to remain a member for at least another two. They are assisted by a secretary. A committee can consult the chamber if it is faced with a complex issue. The chamber does not review the entire notification, but instead looks at one or more specific questions formulated by the committee. Given the time that is needed for the reflection chamber to do its work, the notifying physician is informed that there will be a delay in dealing with the notification. The committees did not seek the opinion of the reflection chamber in 2020.

An evaluation of the reflection chamber showed that the committee members were of the opinion that the reflection chamber had proved its worth. In 2020, at the request of the national consultative council, the reflection chamber issued an advisory opinion to the council about the consequences of the Supreme Court judgments of April 2020 for the review procedure. Following that advisory opinion, the Euthana-

REVIEW PROCEDURE 3

<1% OF THE NOTIFICATIONS (NON-STRAIGHTFORWARD CASES)



sia Code 2018 was revised. In 2021 the reflection chamber will make a start on updating the Euthanasia Code 2018 in response to the developments in the review procedure of the past few years.

Organisation

As was the case for many organisations, 2020 was a difficult year for the secretariats of the RTEs. Due to the coronavirus crisis, most staff members had to work from home. As the work of the RTEs was designated as a key public service, the process support staff at the Arnhem and The Hague locations were able to ensure the work could continue. The fact that the secretariat continued to do its work without interruption, despite the crisis, is an extraordinary achievement worthy of mention in this annual report. Given that the number of notifications saw a 9% increase compared with last year, while the time between the receipt of a notification and the sending of the findings remained roughly the same, our staff members deserve high praise.

There is one RTE in each of five regions. Each region has three lawyers (who also act as chair), three physicians and three experts on ethical or moral issues (ethicists). This brings the total number of committee members to 45. The committee members are publicly recruited and appointed for a term of four years by the Minister of Health, Welfare and Sport and the Minister of Justice and Security, on the recommendation of the committees. They may be reappointed once.

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

In 2020 11 members left the RTEs. They had come to the end of their term, which started in 2012 when the number of members was expanded from 30 to 45, although several of the new members had already left the RTEs for personal reasons. Ten new members were appointed as of 1 December 2020.

In 2020 the general secretary of the RTEs, Nicole Visée, retired. She had worked for the RTEs since the entry into force of the Act. Her knowledge of the Act and the review process, as well as her drive and commitment, will be greatly missed. Her position was taken up on 1 November 2020 by Simone Madunić, in whom we have a worthy successor.

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

Secretariat staff are formally employed by the Ministry of Health, Welfare and Sport. In organisational and operational terms the secretariats fall under the deputy director of the Disciplinary Boards and Review Committees (Secretariats) Unit (ESTT). Over 100 staff members are employed in this unit, including the support unit and management (director and deputy director). The administrative assistants of the RTEs are responsible for all administrative processes, from registering the details of received notifications to sending the committee's findings to the notifying physician and/or the Public Prosecution Service and the Health and Youth Care Inspectorate.

In 2020, the costs of the RTEs amounted to over €3.7 million. Of that total, committee members' fees and allowances amounted to €778,000, while costs relating to materials, hiring external staff, IT and office accommodation were €553,000. €2,641,000 was spent on staff (management, support unit and secretariat).

In 2020 the secretariat of the committees was based at two locations in the Netherlands: Arnhem and The Hague. In March 2021 the secretariat moved to Utrecht. As soon as the coronavirus restrictions allow, all committee meetings will also take place in Utrecht.

II CHAPTER II CASES

1. INTRODUCTION

This chapter describes various findings by the RTEs. The essence of the RTEs' work consists of reviewing physicians' notifications concerning termination of life on request and assisted suicide (euthanasia).

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

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

The due care criteria say that the physician must:

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

The RTEs review notifications in the context of the Act, its legislative history, the relevant case law and the revised Euthanasia Code 2018, which was drawn up on the basis of earlier findings of the RTEs.

They also take the decisions of the Public Prosecution Service and the Health and Youth Care Inspectorate into account.

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

In its judgment of 21 April 2020 (4.11.2) the Supreme Court held that this form of review also involves an element of criminal law.

> As regards the assessment of whether the physician has exercised due medical care, the boundaries within which the physician's actions must fall are based on the opinions and standards of medical professionals. In so far as a termination of life on request leads to criminal prosecution, the criminal court may interpret the legislation, but should exercise caution in answering the question of which medical procedures are acceptable in that particular case.

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

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

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

In section 2.3 we describe four cases of euthanasia involving patients who fall into special categories: a patient with a psychiatric disorder, a patient with multiple geriatric syndromes and two patients with dementia. The majority of such cases are notified by physicians of the Euthanasia Expertise Centre. However, in the cases described in section 2.3 euthanasia was performed by an attending physician.

Section 3 describes the two cases in which the RTE found this year that the due care criteria had not been met. In one of those cases the committee found that the physician's consultation of an independent physician did not meet the requirements. In the other case the committee found that the termination of life had not been performed with due medical care.

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

2 PHYSICIAN ACTED IN ACCORDANCE WITH THE DUE CARE CRITERIA

2.1 Five examples of the most common notifications

As stated in Chapter I, the vast majority of euthanasia cases involve patients with cancer (64.6%), neurological disorders (6.6%), cardiovascular disease (4.1%), pulmonary disease (3.0%) or a combination of conditions (12.3%). The following five cases are all examples of straightforward cases. They give an impression of the issues that the RTEs encounter most frequently.

The findings are set out in most detail for the first case discussed, to show that the committees examine all the due care criteria. Detailed findings are omitted from the discussion of the other cases included in this report: the focus is on the suffering of the patients.

CANCER

KEY POINTS: straightforward notification, specific method of administering euthanatics, number 2020-153 on the website.

The patient, a woman in her seventies, was diagnosed in spring of 2020 with ovarian and fallopian tube cancer. Surgery was no longer a good option, so chemotherapy was suggested to her. At first she did not want this, as it was not a curative treatment and it would affect her quality of life. Her family urged her to try chemotherapy anyway. It quickly emerged that she did not respond well to the treatment, which caused diarrhoea and a tingling sensation in hands and feet. She therefore stopped having the chemotherapy. In late September the patient began to experience abdominal pain and severe constipation. She was given medication but it was not sufficiently effective. In terms of palliative medication she first tried cannabidiol oil, then oxycodone (a powerful painkiller) and eventually morphine. This made the pain bearable, with the exception of regular cramps. She was also given suppositories for the nausea and vomiting. They had little effect, but the patient no longer wanted to try any other methods, as this would only prolong her suffering. The physician wrote in her report that both she and the attending gynaecologists had informed the patient about her situation and prognosis.

The patient's suffering consisted of hardly being able to keep any food or drink down, constant nausea, and extreme fatigue. The fatigue affected her concentration, so she was no longer able to read or watch television. The patient also suffered from the fear of further loss of function and of progressive loss of dignity. The physician saw that the patient was exhausted. She knew her to be a positive person who wanted quality of life. That quality was now absent. The physician therefore understood that this suffering was unbearable to the patient. As the patient had severe ovarian cancer (stage 3c), there were metastases in the lining of the abdomen (peritonitis carcinomatosa) and there was no way to alleviate her suffering, the physician was satisfied that the suffering was without prospect of improvement.

Long before she fell ill, the patient had spoken to the physician about her wish for euthanasia in the event that she no longer had any quality of life. In her job as a nursing assistant and in her family, she had seen a great deal of illness and suffering and she clearly knew what she did and did not want to happen. After the patient had stopped receiving chemotherapy, she set out her wishes regarding euthanasia in writing. Euthanasia was discussed in all subsequent conversations with the physician. The day before she died, the patient indicated that her condition was so bad that she wanted euthanasia now. The physician was satisfied that the

request was voluntary and well considered, as she had spoken in private with the patient on several occasions about euthanasia and had never seen any signs of doubt. She saw the patient as an independent, intelligent person, who did not let other people influence her.

A week before her death, the patient asked for a SCEN physician to be consulted. She was afraid that if she waited any longer she would be drowsy or confused. The independent physician came the next day. In his report he gave a summary of the patient's medical history and the nature of her suffering. At the time of his visit, the patient did not quite consider her suffering to be unbearable yet. When she did, three days later, the physician contacted the independent physician and the latter came to the conclusion that the due care criteria had now been fulfilled.

The physician performed the termination of life on request using the method, substances and dosage recommended in the KNMG/KNMP's 'Guidelines for the Practice of Euthanasia and Physician-assisted Suicide' of August 2012. (These guidelines can be found at https://www.knmg.nl/advies-richtlijnen/knmg-publicaties/publications-in-english.htm. The Royal Dutch Medical Association (KNMG) and the Royal Dutch Association for the Advancement of Pharmacy (KNMP) are currently revising these Guidelines. The revised version is expected to be published in the course of 2021.)

As it was almost impossible to insert a cannula, the patient had been given a port-a-cath (an implanted port that provides direct access to a central vein) for the administration of chemotherapy. She had asked for the port-a-cath to be left in place so that it could be used if euthanasia were to be performed. The euthanatics were administered via this port. To ascertain whether the patient was in a sufficiently deep coma that the muscle relaxant could safely be administered, the physician applied a pain stimulus and checked for the absence of the eyelash reflex (the involuntary movement made when the eyelashes are touched).

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

NEUROLOGICAL DISORDERS

KEY POINTS: straightforward notification, progressive loss of motor function caused by Parkinson's disease, number 2020-95 on the website.

The patient, a woman aged over 90, was diagnosed with Parkinson's disease eight years before her death. Her condition was incurable. She could only be treated palliatively. About four years before her death the patient moved to a care home.

Her suffering consisted of the progressive loss of motor function. She had difficulty swallowing, dysarthria (a speech disorder caused by damage to the nervous system), balance problems and muscle weakness. The patient could not move around and had become completely dependent on care. She could no longer do anything for herself; even turning over in bed or shifting position in her wheelchair had become impossible. As a result she had developed a painful pressure sore (decubitus) on her coccyx. She was also afraid of choking due to her swallowing problems.

The patient was suffering from her loss of autonomy, her dependence on other people, the lack of prospect of improvement, and a realistic fear of further deterioration. She experienced her suffering as unbearable.

The physician, an elderly-care specialist at the nursing home where the patient was living, was satisfied that this suffering was unbearable to her and without prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate the patient's suffering that were acceptable to her.

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

PULMONARY DISEASE

KEY POINTS: straightforward notification, assisted suicide, number 2020-96 on the website.

The patient, a woman in her seventies, had suffered from chronic obstructive pulmonary disease (COPD) for years. It was eventually established that the condition had reached COPD GOLD 3 stage and she suffered from recurrent respiratory infections. The patient was constantly short of breath, and had even more trouble breathing after the slightest exertion, which left her completely exhausted. Eventually she could no longer do anything without help. She could not even sit up in bed. She also no longer had the energy to eat properly, and as a result she became emaciated and progressively weaker. The patient could only sit on the sofa or lie in bed, and could no longer pursue any hobbies, such as doing puzzles or reading. She said she was 'completely worn out'.

The patient was suffering from the emptiness of her existence, the lack of any prospects and the realistic fear of choking during a coughing fit. She experienced her suffering as unbearable. The patient was receiving the maximum amount of medication. She refused extra oxygen, as this would only prolong her life, which was not what she wanted in these circumstances. Her condition was incurable. She could only be treated palliatively.

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

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

CARDIOVASCULAR DISEASE

KEY POINTS: straightforward notification, refusal of amputation, number 2020-102 on the website.

The patient, a woman in her eighties, was diagnosed with ischaemia (insufficient blood supply) in her lower left leg six months before her death. Four months before her death, the condition reached Fontaine stage IV (the stage at which tissue necrosis occurs). There was hardly any blood supply to the lower leg anymore and necrosis was indeed setting in. The patient underwent angioplasty (a procedure to open up narrowed blood vessels), but this did not have the desired effect. Given her poor condition, her age and possible complications such as an infection or delirium, she did not want to have her lower leg amputated. The fact that the patient would lose her independence as a result also played a part. For her that was a terrible prospect. The patient had by this time been admitted to a hospice (an institution specialised in palliative care for people in the final stage of their life).

Her suffering consisted of constant severe pain in her left leg and loss of the ability to move around. Independence and self-determination had always been very important to her. She was suffering from the loss of control, the pain, being dependent on other people and the realistic fear of infections and sepsis, leading to further loss of dignity. The patient did not want to experience further deterioration and wanted to die with dignity. The patient experienced her suffering as unbearable.

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

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

COMBINATION OF CONDITIONS

KEY POINTS: straightforward notification, gout and kidney problems, number 2020-152 on the website.

The patient, a man in his eighties, was diagnosed with late-stage heart failure three years before his death. This had greatly reduced his ability to move around. He also suffered from gout in his hands and feet. He had lumps and lesions on his hands which made it difficult for him to use them. He had also suffered from severe kidney problems for several years. The patient indicated that from now on he only wanted treatments that he could receive at home.

Given what he had experienced when his wife had been admitted to a nursing home, he did not want to go into one. Nor did he want any treatment (such as morphine) that would lead to further loss of function or that would further affect his ability to move about.

Due to the combination of conditions, the patient had not left the house for a long time. In the last few months his dependence on others increased. He could no longer use the toilet by himself, nor could he care for himself properly. He was also in pain and short of breath. This suffering was unbearable to him.

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

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

2.2. Five cases illustrating the due care criteria in the Act

This subsection describes five cases illustrating five due care criteria: the physician must be able to conclude that (a) the patient's request is voluntary and well considered, that (b and d) the patient's suffering is unbearable, with no prospect of improvement, and that there is no reasonable alternative; the physician must also (e) consult an independent physician and (f) exercise due medical care and attention in terminating the patient's life. We have given two examples of the last criterion, in view of the exceptional nature of the notifications. These notifications too were designated as straightforward. All except one of the notifying physicians were given an abridged findings report.

The due care criteria laid down in the Act are discussed and explained in the Euthanasia Code. It can also be deduced from that explanation what is not required by the Act. In summary, there is no requirement that the patient's medical condition should be life-threatening; nor that the patient should be in the terminal stage of their illness; nor that the physician and the patient should be in a treatment relationship; nor that the patient should provide a request for euthanasia in writing in addition to their oral request; nor that the request should be persistent; nor that the independent physician should give 'permission'; nor that another physician should always be consulted to assess the patient's decisional competence; nor that the patient's family should be involved in a euthanasia request, let alone that they must agree to the request (revised Euthanasia Code 2018, p. 55).

VOLUNTARY AND WELL-CONSIDERED REQUEST

The Act states that the physician must be satisfied that the patient's request is voluntary and well considered. It follows from the Act that the patient must make the request himself. Most patients are capable of conducting a normal (i.e. oral) conversation until the moment that euthanasia is performed.

VOLUNTARY AND WELL-CONSIDERED REQUEST

KEY POINTS: straightforward notification, combination of conditions, patient's wife opposed to euthanasia, number 2020-85 on the website.

The patient, a man in his seventies, was diagnosed with motor neurone disease (a progressive disease that affects the nerve cells and muscles) almost a year before his death. He also suffered from chronic pain syndrome (constant pain for which no medical cause can be found), for which he had undergone several operations and courses of treatment with medication. All of this had yielded little result. The patient was suffering from his rapid physical deterioration, constant pain, loss of independence, realistic fear of suffocating and the lack of prospect of improvement. He perceived his situation as humiliating and experienced his suffering as unbearable.

Three months before his death, the patient requested euthanasia for the first time. His wife was fiercely opposed to euthanasia for religious reasons and could not support his request. This led to an inner struggle on the part of the patient as to whose wish he should consider more important: his wife's or his own. He withdrew his request in order to give his wife time to accept his request for euthanasia. Two weeks before his death, he asked the physician to actually perform euthanasia. That same day, the patient was admitted to a hospice (an institution specialised in palliative care for people in the final stage of their life).

The physician established that when the patient made his definitive request, two weeks before his death, he was determined and maintained his request despite his wife's opposition. His wife felt that the physician had forced euthanasia on him. The physician gave some thought to this issue, but decided to proceed with euthanasia. She did so because the patient had been so clear in his request, not only to her, but also to the nursing staff at the hospice, the independent physician and her colleague in the practice. The patient's right to self-determination carried more weight for her than his wife's objections. The physician concluded that the request was voluntary and well considered.

The committee found that the physician could be satisfied that the patient's request was voluntary and well considered. The other due care criteria had also been fulfilled, in the committee's view.

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

The physician must be satisfied that the patient is suffering unbearably and that there is no prospect of improvement. The Euthanasia Code says the following on this subject.

Suffering is a broad concept. It can result from pain and shortness of breath, extreme exhaustion and fatigue, physical decline, or the fact that there is no prospect of improvement, but it can also be caused by increasing dependence, or feelings of humiliation and loss of dignity. (revised Euthanasia Code 2018, p. 22).

It is sometimes hard to establish whether suffering is unbearable, for this is a subjective notion. What is bearable for one patient may be unbearable for another. This depends on the individual patient's perception of his situation, his life history and medical history, personality, values and physical and mental stamina. It must be palpable to the physician, also in light of what has happened so far, that this particular patient is suffering unbearably. 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 (revised Euthanasia Code 2018, pp. 24-25).

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 unbearable suffering, these must be given preference. (...) The physician and the patient must together arrive at the conclusion that no reasonable alternatives are available to the patient. The perception and wishes of the patient are important. There is an alternative to euthanasia if there is a realistic way of alleviating or ending the suffering which may – from the patient's point of view – be considered reasonable. An invasive or lengthy intervention with a limited chance of a positive result will not generally be regarded as a 'reasonable alternative'. Generally, 'a reasonable alternative' intervention or treatment can end or considerably alleviate the patient's suffering over a longer period (revised Euthanasia Code 2018, p. 27).

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

patient about the benefits and disadvantages of palliative care, as the decision whether or not to use this option ultimately lies with the patient. Refusing palliative sedation will generally not preclude granting a request for euthanasia (revised Euthanasia Code 2018, pp. 27-28).

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

KEY POINTS: straightforward notification, multiple geriatric syndromes, refusal of increased medication, Euthanasia Expertise Centre, number 2020-100 on the website.

The patient, a woman her eighties, had been suffering from degenerative scoliosis (severe curvature of the spine with wear and tear) and polyarticular osteoarthritis (wear and tear in two or more joints) for about eight years before her death. She had frequent falls and about a year before her death she had broken her wrist when she fell. Her sense of taste was affected and her vision and hearing had deteriorated. In the six weeks before her death the patient was living in a sheltered accommodation centre.

Her suffering consisted of constant pain in her hips, knees, wrists, hands and back. This pain could not be alleviated sufficiently with medication. The patient did not want the dosage to be increased, as she did not want to become drowsy and because she was afraid it would cause her to fall even more frequently. In the four months before her death, the patient's condition deteriorated rapidly. She had become practically completely dependent on care and could only walk very short distances, using a rollator. She could no longer pursue her hobbies. She spent her days sitting in a chair. As reading or watching television was too tiring, she had nothing to distract her. The patient, who had always been independent, suffered from her dependence on other people, the constant pain and the futility of her existence. She experienced her suffering as unbearable.

The physician was satisfied that this suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate the patient's suffering that were acceptable to her. The committee found that in reaching this conclusion, the physician had remained within the room for interpretation afforded him by the Act.

The other due care criteria had also been fulfilled, in the committee's view.

CONSULTATION

Before performing euthanasia, the physician must consult at least one other, independent physician who must see the patient and assess whether the statutory due care criteria concerning the request, the suffering, the absence of a reasonable alternative and informing the patient have been complied with. The Euthanasia Code 2018 says the following on this subject.

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 matters before deciding to grant the request and perform euthanasia.

The committees believe it is important for the physician performing euthanasia to request a consultation. If this is not the case, the committee will expect the physician to explain the reasons for this in his report (revised Euthanasia Code 2018, pp. 28-29).

It is not unusual for some time to pass between the independent physician's visit to the patient and the performing 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 course of the disease. The time between the independent physician's visit and the performing 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, on the basis of the independent physician's earlier findings and developments in the patient's circumstances. The physician will have to be able to explain his decision to the committee if necessary (revised Euthanasia Code 2018, p. 33).

CONSULTATION

KEY POINTS: non-straightforward notification, full report of findings, combination of conditions, 'shelf life' of consultation, physician takes over process after independent physician has been consulted, Euthanasia Expertise Centre, number 2020-147 on the website.

The patient, a woman in her eighties, suffered several transient ischaemic attacks (TIAs, a temporary blockage of one of the blood vessels that supply blood to the brain) in the 10 years before her death, which resulted in overall fatigue and muscle weakness on the left side of her body. Her left artificial hip had been removed (extirpation) and had not been replaced by a new one (Girdlestone procedure). Several years before, the patient had gone blind in her left eye and the sight in her right eye had greatly deteriorated. She was also hard of hearing. The patient was suffering from the effect her disabilities had on her life. This situation and the knowledge that there was no prospect of any improvement made her suffering unbearable. When she was already quite far along in the euthanasia process, the patient postponed the actual performance of euthanasia for some time, at the specific, emotional request of her son.

Around two and a half months before her death, the patient asked the physician assigned to her by the Euthanasia Expertise Centre (EE) to perform euthanasia. This physician had three conversations with the patient. She also contacted a SCEN physician for a consultation. The SCEN physician saw the patient about a month and a half before her death. In the opinion of the SCEN physician, the due care criteria he had to assess had been fulfilled.

At a certain point, the EE physician had to withdraw due to health risks relating to the coronavirus pandemic. Another EE physician took over for the final stages of the process. This second physician visited the patient 11 days before her death. The patient still wanted euthanasia. The physician decided to grant her request on the basis of the existing report from the independent physician.

The committee found that the course of action taken by the physician meant that due care criterion (e) – consulting at least one independent physician – had been fulfilled. The physician read the SCEN physician's report and also contacted the SCEN physician when he took over the handling of the request for euthanasia. He also indicated that he considered the SCEN physician to be independent. In assessing the independent physician's report he also took into account the findings of his EE colleague.

As regards the time that elapsed between the SCEN physician's consultation and the actual performance of euthanasia, the committee found as follows. In this case the period of over six weeks was not so long as to render the consultation less valuable. The patient's situation had not changed significantly since the independent physician's visit, nor had the change of physician prompted the independent physician to visit the patient again. It was the patient who had postponed the procedure for personal reasons. That too gave no reason to doubt the independent physician's earlier conclusion that the statutory due care criteria had been fulfilled.

The committee found that the physician had complied with the requirement of consulting at least one independent physician, who saw the patient and gave a written opinion on whether due care criteria (a) to (d) had been fulfilled The other due care criteria were also fulfilled, in the committee's view.

DUE MEDICAL CARE

The Euthanasia Code says the following about exercising due medical care.

The physician must exercise due medical care in performing euthanasia. Two aspects of this are the substances and doses administered, and appropriate checks to determine the depth of the induced coma. In assessing compliance with this due care criterion, the committees refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of 2012 (revised Euthanasia Code 2018, p. 35).

In cases of termination of life on request, the Guidelines advise intravenous administration of a coma-inducing substance, followed by intravenous administration of a muscle relaxant. The Guidelines list substances that may be used and their recommended doses. If the physician deviates from the Guidelines, he will have to present convincing arguments in support of his actions. It is advisable for the physician to inform the patient and his family beforehand what effects the substances will have. He should also comply with the patient's individual wishes as far as possible, provided they fall within the scope provided by the Guidelines (revised Euthanasia Code 2018, p. 35).

DUE MEDICAL CARE 1

KEY POINTS: straightforward case, Euthanasia Expertise Centre, cancer, higher dose of coma-inducing substance, number 2020-77 on the website.

The patient, a man in his fifties, was diagnosed with oropharyngeal cancer a year and a half before his death. His condition was incurable. He could only be treated palliatively. Four months before his death, the patient was admitted to a hospice (an institution specialised in palliative care for people in the final stage of their life) after the situation at home had become untenable.

It was very important to the patient to wait for the birth of his grandchild. After the birth, about six weeks before his death, the patient had stopped using a feeding tube and wanted to die under palliative sedation. However, the sedation did not have the desired effect; the patient kept waking up. The tumour in his neck, mouth and face also continued to grow, and as a result he not only felt as if he was suffocating, but was also in a great deal of pain. The pain could not be reduced to an acceptable level, even with a high dosage of medication. Over two weeks before his death, the patient informed the attending elderly-care specialist that he wanted euthanasia. The specialist could not grant the patient's request, for compelling reasons specific to him. The patient then contacted the Euthanasia Expertise Centre.

The physician carried out the termination of life on request by means of intravenous administration of 4000mg of the coma-inducing substance thiopental (instead of the 2000mg prescribed in the KNMG/KNMP Guidelines), followed by 150mg of rocuronium (a muscle relaxant that leads to death). The patient then died. The physician had administered a higher dose of thiopental because the patient had quickly become habituated to previously administered medication and he knew that the patient was difficult to sedate.

The physician explained his actions by reporting that the SCEN physician had advised him to consult with the pharmacy about the thiopental dose because the patient had quickly become habituated to the medication he had received. The physician then decided to administer a double dose of thiopental.

The committee found that the physician had exercised due medical care in performing euthanasia. In the committee's view, the other due care criteria were also fulfilled.

DUE MEDICAL CARE 2

KEY POINTS: categorised as a non-straightforward notification after consultation, full report of findings, cancer, personal wish concerning euthanasia procedure, number 2020-83 on the website.

The patient, a woman in her sixties, asked the physician if she could play a role in performing her own euthanasia procedure. The physician reported that the procedure was carried out as follows: after the physician had checked that the cannula was unobstructed, the patient injected herself with lidocaine (a local anaesthetic). Then the physician and the patient together began injecting the coma-inducing substance (propofol). The patient was only able to exert any pressure for the first – very small – part of that procedure.

The committee noted that the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of August 2012 state that only a physician may administer the euthanatics. The patient may play an active role, for instance opening the cannula stopcock, as long as it does not hamper careful performance of the euthanasia procedure. The Euthanasia Code 2018 (revised version, p. 35) states that it is important for the physician to comply with the patient's individual wishes as far as possible, provided they fall within the scope provided by the Guidelines.

It was clear from the documents that the patient wanted to keep control of her life until the end. The physician gave a further explanation by telephone, from which it became clear that the patient had not chosen assisted suicide. She did not want that as she had had a bad experience when an acquaintance requested assisted suicide. She also did not want to taste the possibly unpleasant flavour of the barbiturate potion.

The committee found that – entirely in line with Euthanasia Code 2018 as referred to above – the physician was allowed to fulfil the patient's wish and that this was also in accordance with the Guidelines. In the committee's view, the injection of the lidocaine and part of the coma-inducing substance by the patient herself can be seen as the active role that the patient can play in accordance with the Guidelines. It follows from the use of the phrase 'for instance' in the Guidelines that this role is not limited to the opening of the cannula stopcock. In reaching its conclusion the committee took into account the fact that the termination of life on request was carried out using the substances and doses recommended in the Guidelines and that the physician checked the depth of the induced coma in the correct manner.

In view of the above the committee found that the physician had exercised due medical care in performing the termination of life on request. In the committee's view, the other due care criteria were also fulfilled.

2.3 Four examples of cases involving patients in a special category (patients with a psychiatric disorder, multiple geriatric syndromes or dementia)

PSYCHIATRIC DISORDER

Termination of life on request and assisted suicide are not restricted to patients in the terminal phase of their life. People with a longer life expectancy, such as psychiatric patients, may also be eligible. However, physicians must exercise particular caution in such cases. This means that, in addition to the independent physician, they must consult an independent psychiatrist, mainly in order to obtain that psychiatrist's opinion on the patient's decisional competence regarding their request for euthanasia, the lack of prospect of improvement and the absence of a reasonable alternative. 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 (revised Euthanasia Code 2018, p. 45).

Another category that requires the physician to exercise particular caution is patients with intellectual disabilities. They too can make a voluntary and well-considered request for euthanasia (See also 'Medische beslissingen rond het levenseinde bij mensen met een verstandelijke beperking' ['Medical decisions at end-of-life in people with intellectual disabilities'], by the Dutch association of physicians for people with intellectual disabilities (NVAVG), 2007. In these cases, particular attention must be paid to the patient's decisional competence with regard to a request for euthanasia. This is why the physician must in principle consult – in addition to the independent physician who gives their opinion on due care criteria (a) to (d) – a physician who is an expert on decisional competence (for instance a physician specialised in intellectual disabilities). If contact with both an independent physician and an expert poses too great a burden to the patient, it may be sufficient to consult an independent (SCEN) physician who is also an expert in this field (revised Euthanasia Code 2018, p. 48).

PSYCHIATRIC DISORDERS

KEY POINTS: non-straightforward notification, full report of findings, several psychiatric disorders, intellectual disability, number 2020-53 on the website.

The patient, a woman in her fifties with an intellectual disability, had for a long time suffered from persistent depression with panic attacks, feelings of tension and anxiety, 'voices' giving her instructions (command hallucinations), constant suicidal thoughts and insomnia. Whenever the tension mounted she would bite her hand. She was sleeping badly and could no longer enjoy anything. All she wanted was to die.

Two years before her death, the patient began talking about euthanasia to various people who were treating her. Eight months before her death, the patient asked the physician to actually perform euthanasia. The physician consulted an independent psychiatrist, who examined the patient two weeks before her death. The physician consulted a SCEN physician as the independent physician. The SCEN physician saw the patient five days before her death.

On the basis of the facts and circumstances as stated in the file and in so far as they were relevant, the committee stated its considerations concerning the question of a voluntary and well-considered request, the suffering without prospect of improvement and the absence of a reasonable alternative.

Voluntary and well-considered request

In cases involving requests for euthanasia by patients with psychiatric disorders, the question of whether the patient requesting euthanasia is decisionally competent must be considered scrupulously. The committee noted that this was especially applicable to this notification, in view of the patient's intellectual disability.

In the committee's opinion the physician exercised particular caution in establishing whether the patient was decisionally competent. The committee took into account the fact that the physician explained clearly in the documents why she was satisfied that the patient's request was voluntary and well considered, on the basis of several lengthy conversations she had had with the patient. As a result of those conversations the physician established that the patient was unequivocal in her wish to die and her request for euthanasia. The physician established that the patient, after struggling for years, had taken stock and made a conscious decision to end her life. The physician considered her to be decisionally competent regarding her request for euthanasia.

The physician requested the advice of an independent psychiatrist with particular expertise on patients with intellectual disabilities. The independent psychiatrist concluded that the patient was intellectually impaired. She was therefore limited in her ability to reflect on her wish to die and was only able to emphasise that wish continually, in the same manner. The independent psychiatrist concluded that the patient was decisionally competent regarding her request for euthanasia.

The SCEN physician consulted by the physician came to the same conclusion. Although according to the independent physician the patient had difficulty expressing herself in words, she was able to tell the independent physician about her situation and her wish to die. During the conversation, the patient showed a clear understanding of her situation, was able to say what would happen if euthanasia was performed, and realised exactly what she was asking of the physician. According to the independent physician, the patient was not under any pressure from others and she had been thinking about her request for years.

The committee found, in view of the above, that the physician could be satisfied that the patient's request was voluntary and well considered.

Unbearable suffering without prospect of improvement and absence of a reasonable alternative

On the basis of the documents, the committee established the following. Since 2001 the patient had undergone lengthy treatment for her psychiatric disorders and had been hospitalised several times. After her husband died in 2014 her symptoms became more severe. The patient underwent the entire treatment protocol for psychosis and the entire treatment protocol for depression, with the exception of monoamine oxidase inhibitors, or MAOIs (an antidepressant). The patient cooperated with all treatments; a couple of times she stopped taking medication due to the side-effects. In January 2019 a treatment plan was started, focusing on her constant suicidal thoughts and melancholic depression (a form of depression where, in addition to the usual symptoms of depression, the patient suffers from early morning awakening, symptoms of depression that are worse in the morning, impaired motor activity, reduced appetite and weight loss, and feelings of excessive guilt). The patient's treatment included electroconvulsive therapy (ECT), as this had not been tried before. She stopped after 15 sessions, as she was not making any improvement and was experiencing unacceptable physical problems as a result. The physician consulted with a colleague about treatment with ketamine (an anaesthetic) and MAOIs. No treatment with ketamine was started, as this treatment is still at the clinical research stage and its effectiveness has not yet been proven. The physician discussed treatment with MAOIs with the patient, but she refused

them. After consulting with her colleague, the physician estimated that the chance of this medication having any effect would be very small.

Around four months before her death, the patient was admitted – at the recommendation of the physician – to a ward for people with intellectual disabilities and psychiatric disorders. The staff ensured that there were always people around her and there was an extensive daily programme of activities to distract her from her suicidal thoughts. Her stay in this ward had no positive effect on the patient's symptoms and she continued to say that she wanted to die.

The independent psychiatrist consulted by the physician looked into the treatment options. He established that the patient had undergone extensive treatment but never experienced any improvement. He also established that from 2019 onwards all treatments that had not yet been tried were either started or discussed. These treatments did not lead to recovery either. He agreed with the physician's conclusion that there were no realistic treatment options for the patient and that her suffering was without prospect of improvement.

The SCEN physician consulted by the physician also stated with regard to a reasonable alternative that the patient had undergone an exhaustive number of different treatments without any result. She concluded on the basis of the independent psychiatrist's report that there were no longer any reasonable treatment options. She, too, was of the opinion that the patient was suffering without prospect of improvement.

The committee found that it followed from the above that the physician had exercised the necessary particular caution with regard to establishing the absence of any prospect of improvement or any reasonable alternatives. The physician had fully investigated the options that might have improved the patient's situation. In her report, she also explained in detail and substantiated her conclusion that there were no longer any reasonable treatment options. She also consulted an expert in the field who, after thorough investigation, confirmed these conclusions. In addition, the SCEN physician supported the physician's conclusion that the patient was suffering without prospect of improvement and that there was no way to alleviate this suffering.

The committee found that the fact that the patient was suffering unbearably was sufficiently clear from the documents. It also took into account the fact that all the physicians involved in the case were satisfied that the patient was suffering unbearably. The committee therefore did not note any further considerations on this matter.

The committee found, in view of the above, that the physician could be satisfied that the patient was suffering unbearably without prospect of improvement. The committee also found that the physician could come to the conclusion, together with the patient, that there was no reasonable alternative in her situation. The other due care criteria were also fulfilled, in the committee's view.

MULTIPLE GERIATIC SYNDROMES

The patient's suffering must have a medical dimension, which can be somatic or psychiatric. There need not be a single, dominant medical problem. The patient's suffering may be the result of an accumulation of serious and minor health problems. The sum of these problems, in conjunction with the patient's medical history, life history, personality, values and stamina, may give rise to suffering that the patient experiences as unbearable (revised Euthanasia Code 2018, p. 24).

MULTIPLE GERIATRIC SYNDROMES

KEY POINTS: straightforward notification, loss of independence and mobility, number 2020-110 on the website.

The patient, a woman aged over 90, had broken her hip in a fall five months before her death. When she was discharged from hospital (almost three months before her death) she was admitted to a nursing home. She could no longer move around, could no longer stand or walk, and had to be hoisted in and out of bed. In addition she suffered from macular degeneration (an eye condition), severe presbyscusis (age-related hearing loss), recurrent urinary tract infections and urinary incontinence.

The patient's suffering consisted of her inability to move around and severe pain in her hip that could not be alleviated sufficiently with medication. She also suffered from her sight and hearing impairments. Due to her circumstances, the patient spent her days alone in her room. Having always been independent and self-reliant, the patient was suffering on account of her sudden loss of independence. Until her fall she had lived in her own home, without any form of assistance. Having to be admitted to a nursing home and being fully dependent on others was terrible for her. The patient experienced her suffering as unbearable. The physician was satisfied that this suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate the patient's suffering that were acceptable to her. The documentation made it clear that the physician and the specialists had given her sufficient information about her situation and prognosis.

From the moment she was admitted to the nursing home the patient had spoken about euthanasia with the physician, an elderly-care registrar. Over two months before her death, the patient asked the physician to actually perform the procedure to terminate her life. The physician concluded that the request was voluntary and well considered. The physician consulted an independent SCEN physician The SCEN physician saw the patient two weeks before her death and came to the conclusion that the due care criteria had been fulfilled.

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

DEMENTIA

In cases involving patients with dementia, the physician is expected 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. In the early stages of dementia, the normal consultation procedure is generally sufficient. If there are any doubts as to the patient's decisional competence, it is wise for the physician to seek the advice of another physician with relevant expertise (revised Euthanasia Code 2018, pp. 46-47).

In nearly all the cases so far notified to the committees, patients still had sufficient understanding of their disease and were decisionally competent in relation to their request for euthanasia. Besides the actual decline in cognitive ability and functioning, a patient's suffering is often partly determined by their fear of further decline and the negative impact on their autonomy and dignity in particular. 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 (revised Euthanasia Code 2018, pp. 46-47).

It is still possible to grant a request for euthanasia at the stage where dementia has progressed to such an extent that the patient is no longer decisionally competent, provided the patient drew up an advance directive containing a request for euthanasia when still decisionally competent. Section 2 (2) of the Act states that an advance directive can replace an oral request and that the due care criteria mentioned in section 2 (1) of the Act apply mutatis mutandis. The fact that the patient can no longer express their wishes will generally prompt the physician to consult a second independent physician with relevant expertise, in addition to the regular independent physician. The second independent physician assesses whether the patient is decisionally competent and, if not, whether the patient is suffering unbearably without prospect of improvement and whether there are indeed no reasonable alternatives (revised Euthanasia Code 2018, pp. 38 and 41-42).

The following case involved a patient with dementia who was decisionally competent regarding her request for euthanasia. It is followed by a case in which euthanasia was performed on the basis of an advance directive. This is comparable to the notification on which the Supreme Court gave judgment in the spring of 2020 (ECLI:NL:HR2020:712).

EARLY-STAGE DEMENTIA DECISIONALLY COMPETENT PATIENT WITH DEMENTIA

KEY POINTS: straightforward notification, Alzheimer's disease, number 2020-76 on the website.

The patient, a woman aged over 90, was diagnosed with dementia, probably resulting from Alzheimer's disease, four months before her death. Her cognitive functions were deteriorating steadily. As a result, she was increasingly unable to perform everyday tasks. She spent a large part of her day searching for things and she often lost track during conversations. She experienced feelings of shame and was increasingly losing her grip on her day-to-day life.

This situation made the patient unhappy and anxious, which was emotionally taxing. She felt an 'empty feeling in her head', which she hated. The patient suffered from the absence of any prospect of improvement in her situation, the loss of self-reliance, the realistic prospect of further deterioration of her cognitive functions and the fear of (further) loss of herself and her dignity. The patient experienced her suffering as unbearable.

She had discussed euthanasia with the physician before. Two and a half weeks before her death, the patient asked the physician to actually perform the procedure to terminate her life. The physician concluded that the request was voluntary and well considered. He established that the patient was able to express her request clearly and was aware of its implications.

The physician consulted an independent elderly-care specialist to assess the patient's decisional competence. The elderly-care specialist saw the patient around two weeks before her death and concluded that she was decisionally competent regarding her request.

The physician was satisfied that this suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate the patient's suffering that were acceptable to her. The documents made it clear that the physician had given her sufficient information about her situation and prognosis.

The physician also consulted an independent SCEN physician. The SCEN physician saw the patient nine days before her death and came to the conclusion that the due care criteria had been fulfilled.

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

ADVANCED DEMENTIA

The Euthanasia Code 2018 discussed euthanasia on the basis of an advance directive comprising a request for euthanasia (section 4.1) and euthanasia involving patients with dementia (section 4.4). These sections were rewritten on the basis of the Supreme Court judgment of 21 April 2020. In the case that follows, we first quote part of the revised sections of the Euthanasia Code, with reference to the relevant considerations of the Supreme Court. Then we explain how these considerations were reflected in the first review of a case based on an advance directive since the Supreme Court judgment. The statutory basis is as follows.

Section 2 (2) of the Act states that, in the event of an advance directive, the due care criteria mentioned in the Act apply mutatis mutandis. This means, in accordance with the legislative history, that 'the due care criteria apply to the greatest extent possible in the given situation'. This is set out in the explanatory memorandum to the amendment of the Act, concerning the addition of the second sentence to section 2 (2) (Parliamentary Papers, House of Representatives, 26 691, no. 35).

The revised Euthanasia Code states in this respect that:

> the due care criteria must be applied 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 may no longer be capable of communicating or responding to questions. The physician will generally have spoken with the patient when the patient was still capable of expressing their will. If a situation subsequently arises in which the patient's advance directive comes into play, information obtained in previous conversations with the patient will be particularly useful to the physician.

Specific mention should be made here of considerations 4.3.1 and 4.11.2 of the Supreme Court. In the first consideration (4.3.1) the Supreme Court stated explicitly that even in cases involving patients with advanced dementia a physician could grant a request for euthanasia that had been recorded in writing at an earlier stage. In the second (4.11.2) the Supreme Court commented as follows:

> As regards the assessment of whether the physician has exercised due medical care, the boundaries within which the physician's actions must fall are based on the opinions and standards of the medical profession.

DECISIONALLY INCOMPETENT PATIENT WITH AN ADVANCE DIRECTIVE

KEY POINTS: non-straightforward notification. Alzheimer's disease, advance directive, first review since Supreme Court judgment, number 2020-118 on the website.

Introduction to the case

The patient, a woman in her seventies, was diagnosed three years before her death with Alzheimer's disease on the basis of symptoms she had been suffering from for some time. In 2015 she had drawn up an advance directive in which she set out at what point she would no longer want to go on living. She discussed it around 16 months before her death with the physician, who at the time was new to her. After this conversation the physician asked an independent psychiatrist to assess the patient's decisional competence. In the months that followed, the patient still had some good moments, but as time passed her condition deteriorated further. Her cognitive deterioration was such that she eventually no longer recognised her own children and became fully dependent on others for her personal care. She also suffered from loss of dignity and a constant state of inner agitation, in which she showed feelings of sadness and helplessness. The patient was no longer able to express what was distressing her.

A month before her death, the patient's husband asked the physician to grant the patient's request for euthanasia as set out in her advance directive. The physician consulted two independent physicians who were also SCEN physicians. The first saw the patient three and a half weeks before her death. According to the patient's family it was an unpleasant conversation. The independent physician, too, was not happy about it. For that reason, and because the independent physician's report was not forthcoming, the physician consulted another independent physician. This second independent physician saw the patient nine days before her death. In the period between the two consultations, the physician had asked an independent elderly-care specialist to form an opinion, on the basis of the medical records and other documents, on possible ways to alleviate the patient's suffering.

As regards the euthanasia procedure, the physician contacted a physician at the Euthanasia Expertise centre (EE) and drew up a protocol. On the basis of that protocol she gave the patient a potion to place her under sedation. The physician subsequently carried out the termination of life in accordance with the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of August 2012.

The committee considered the case in detail with regard to all six due care criteria, taking into account the necessity to consult a physician with specific expertise.

Voluntary and well-considered request

The revised Euthanasia Code 2018 states that (in accordance with consideration 4.5.1. of the Supreme Court judgment):

> the physician must be satisfied that the patient's advance directive was drawn up voluntarily and after thorough consideration. The physician must base his conclusion on his 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 family members, as oral verification of the patient's wishes is no longer possible.

In addition (in accordance with consideration 4.5.2 of the Supreme Court judgment):

> the physician must establish that the patient's current situation corresponds to the situation described by the patient in his 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.
>
> At the very least, it must always be implicit in the advance directive that the patient requests euthanasia in situations in which he is no longer capable of expressing his will. If the patient also wants his request to be fulfilled in the event that his unbearable suffering is not of a physical nature, it must also be apparent from the advance directive that the patient considers his expected suffering in this situation to be unbearable for him and that this is the basis for his request (revised Euthanasia Code 2018, p. 39).

As regards the voluntary and well-considered nature of the advance directive, the committee noted that, around four and half years before her death, the patient had drawn up an advance directive in the presence of a notary containing a request for euthanasia with a special clause concerning dementia. The committee took into account the fact that at the time the patient had not yet been diagnosed with Alzheimer's disease and that it was clear from the advance directive itself that she had declared in the presence of a notary that she was in full possession of her mental faculties.

'I have given this request for euthanasia careful consideration, I have obtained all the necessary information and I have signed this request in full possession of my mental faculties.

This written request for euthanasia has legal effect and expressly serves as my valid, legally recognised advance directive in the event that at a later date, for whatever reason, I am no longer able to make decisions about my medical situation as referred to in this directive.
(…)

This request for euthanasia remains in full effect, regardless of the time that has lapsed since its signature. It is completely clear to me that I can retract this request for euthanasia. By signing this request for euthanasia I knowingly accept the possibility that a physician will carry out the request, about which, had I been decisionally competent, I might have changed my mind.
(…)'

It is also plausible that the patient was decisionally competent at the time because the physician established during her first conversation with the patient that the patient's capacity to understand was unaffected. The patient was still able to clearly indicate what she did and did not want.

On the basis of the documents, the committee found that at the time when the patient wrote her advance directive there was no reason to believe she was decisionally incompetent.

In the special clause concerning dementia in the advance directive the patient stated:

'The person to whom I have granted power of attorney will represent my medical interests in full if I am no longer able to, and in doing so will endeavour to have my attending physician(s) carry out the advance directives completed and signed by me. In that context, the person to whom I have granted power of attorney will bring my advance directives to the attention of my attending physician(s) and ensure that my request for termination of life is assessed seriously by my physician and granted, if possible, and that the refusal of treatment directive included in the advance directives is respected in full.'

The patient phrased her request for euthanasia as follows in her advance directive:

'If I find myself in a situation in which I am suffering without prospect of improvement; and/or in which there is no reasonable prospect of returning to what I would consider a dignified way of living; and/or in

which progressive loss of dignity is to be expected, I expressly request my physician to administer or provide to me the substances that will end my life. (…)'

The committee noted that the patient's advance directive was phrased in general terms. For instance, it did not specify what she considered to be suffering without prospect of improvement, a dignified way of living, or loss of dignity. When asked about it, the physician said in her oral explanation that she, too, found the patient's advance directive to be very general and for that reason she had asked her during their first conversation to explain to her what, for her, would constitute suffering without prospect of improvement. The patient said very specifically that she did not want to be admitted to a nursing home. She referred to a close family member who had lived in a nursing home for years in a state of anger. She wanted to prevent that from happening to her. She also said that, in her view, there would be loss of dignity if she became fully dependent on other people, was no longer able to pursue any activities independently, and was unable to recognise her children.

The documents showed that after this initial conversation the physician spoke with the patient every six to eight weeks. The reports of those conversations showed a person who was gradually becoming more and more confused. However, in response to closed questions the patient was able to indicate that she did not want to go into a nursing home. The thought of having to leave her beacon of safety, i.e. her husband, made her agitated and anxious.

It was also apparent from the documents and the physician's meeting with the committee that from about three months before her death the patient was no longer able to look after herself. She could no longer get dressed or undressed by herself or wash herself, and she now needed help to use the toilet. The patient needed her husband's assistance with everything. She was in a constant state of agitation and was unaware of her loss of dignity. She sometimes soiled herself and would then panic. Her home situation had become very problematic and admission to a nursing home was becoming likely. The patient no longer showed any signs of recognising her children and even became agitated if she was alone with her children without her husband.

About a month before the patient's death, her husband told the physician that she was no longer able to enjoy life and that she would never have wanted to be in this situation. The patient's daughter said the same when the physician asked her about it. The physician also had contact with the patient's dementia case manager (a professional assigned to a patient with dementia to give them advice and support). The latter had

seen the patient recently and said that the patient had become a different person in the past four months. She was now completely dependent on care, withdrawn, constantly agitated and subject to frequent mood swings. The case manager, who had worked with the patient for over a year and a half, said that this was precisely the situation that the patient had wanted to avoid and the reason she had drawn up her advance directive.

The committee was satisfied on the basis of all the information that when the termination of life was carried out, the circumstances described or implied by the patient in her advance directive indeed existed. In her advance directive the patient had not written exactly what she considered to be a dignified way of living or loss of dignity. On the other hand, it had been established that the patient could no longer communicate meaningfully, needed help with everyday activities, no longer had any grip on her thoughts and actions, was occasionally faecally incontinent, experienced loss of dignity and no longer recognised her children.

When the patient was still decisionally competent, the physician herself had heard her say that she did not want to be fully dependent on other people, did not want to go into a nursing home and feared a situation in which she no longer recognised her loved ones. The physician also spoke with her immediate family. They confirmed that their mother and wife would not want to be in this situation. The dementia case manager said the same.

The committee found that the physician interpreted the advance directive as its author had intended. It was sufficiently clear to the committee that the physician could be satisfied that a situation had arisen in which there was no dignified way of living for the patient, in which further loss of dignity would occur and admission to a nursing home was likely. A situation which the patient very clearly did not want.

The committee noted that it followed from the request for euthanasia, viewed together with the special clause on dementia that accompanied the advance directive, that the patient requested euthanasia in the event that she became decisionally incompetent due to the dementia and that the ensuing suffering was the basis for her request. The patient's advance directive thus was in keeping with the elements set out by the Supreme Court: an advance directive drawn up by a decisionally competent patient in which the expected suffering is described or can be made clear on the basis of information from other people.

The committee investigated whether the physician had exercised par-

ticular caution in establishing whether the request was voluntary and well considered (by consulting a physician with specific expertise who then gives an expert opinion on, among other things, the patient's decisional competence). The committee took into account the fact that physician herself had had several conversations with the patient, had studied the patient's medical situation in detail, and had spoken at length with the patient's family and the dementia case manager. The physician had also read the advance directive. In addition, the physician had consulted an independent psychiatrist, who had established 15 months before the patient's death that some communication was possible with the patient, but that she had limited spontaneous speech and often repeated words.

The independent psychiatrist noted that prominent aphasia (an impairment of the ability to speak, understand, read and write) made it impossible to form an opinion on the extent to which the patient could still assess her situation, was capable of abstract thought and could make decisions. As at the time of her assessment there was not yet a request to actually perform euthanasia, this psychiatrist did not further assess the patient's decisional competence. She did establish in hindsight that the patient had been decisionally competent when she drew up her advance directive. The committee noted that although this psychiatrist did not further assess the patient's decisional competence, this was not an insurmountable problem in this specific situation. After all, the committee found that at the time of the actual request to perform euthanasia, more than a year after the psychiatrist saw her, the patient was no longer able to express her wishes.

No need to reaffirm wish for euthanasia and absence of signs that euthanasia cannot be performed (contraindications)

The Supreme Court dealt with the question of whether a patient with advanced dementia should be able to indicate shortly before their death whether they still want euthanasia, whether signs that the patient no longer wants euthanasia should be taken into account and, if so, how (consideration 4.5.3), and whether the physician should ask the patient about this (consideration 4.10). The revised Euthanasia Code says the following on the matter:

> The physician must be alert to contraindications that are inconsistent with the request for euthanasia, as apparent from verbal utterances and behaviour on the part of the patient. The physician will have to assess whether any such contraindications preclude the performance of euthanasia. Contraindications from the period when the patient was still capable of expressing his will can be interpreted as a revocation or amendment of the previously drawn up advance directive. In that case euthanasia cannot be performed. Contraindications from the period when the patient was no longer capable of expressing his

will (for instance, due to advanced dementia) can no longer be interpreted as a revocation or amendment of the previously drawn up advance directive. They can, however, be interpreted 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. This assessment is also relevant to the question of whether the patient is suffering unbearably, which will be discussed below.

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 his will. No such requirement is laid down by the Act. The specific position of a patient who is no longer capable of expressing his will means that oral verification of his wishes and his suffering is not possible. A verification requirement would be 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 his will.

The committee noted that the physician had made several attempts to make contact with the patient in order to find out whether she could indicate orally or in another manner that she no longer wanted euthanasia. It was clear from the documents that there were no such indications. On the contrary, it was apparent from the conversations with the physician, the second independent physician and the dementia case manager that on several occasions there were utterances that pointed to the patient still wanting euthanasia. The physician stated that the patient had made remarks during their conversations such as 'I don't want this' and 'I don't want this anymore'. Although the physician found it difficult to evaluate these remarks in view of the patient's decisional incompetence, she concluded that in any event the patient did not make any utterances to the contrary. The second independent physician confirmed that the performance of euthanasia was not contrary to the patient's utterances. The committee was also of the opinion that, in view of the above, the physician could conclude that performing euthanasia was in line with the patient's advance directive and that there were no contraindications.

In view of the above, the committee found that the physician could be satisfied that the patient's request was voluntary and well considered, and that the written request for euthanasia as referred to in section 2 (2) of the Act could take the place of an oral request.

Unbearable suffering without prospect of improvement and absence of a reasonable alternative

As regards the unbearable nature of a patient's suffering, the Euthanasia Code was revised in accordance with considerations 4.6.2 and 4.6.3 of the Supreme Court:

> When euthanasia is performed, the physician must be satisfied that the patient is experiencing unbearable suffering (for an exception to the rule that the patient must be experiencing suffering, see paragraph 4.7 of the Euthanasia Code 2018). 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 he described in his advance directive as (expected) unbearable suffering.
>
> 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 (revised Euthanasia Code 2018, p. 40).

The revised Euthanasia Code continues as follows:

> The physician must always determine in a careful and transparent manner whether the patient is indeed currently suffering unbearably. The physician can base his conclusion on his 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 family members. If the physician is not satisfied that the patient is currently suffering unbearably, euthanasia cannot be performed.

On the basis of consideration 5.3.3 of the Supreme Court, the revised Code states as follows:

> 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 limited review of whether the physician could reasonably conclude that the patient was suffering unbearably (revised Euthanasia Code 2018, p. 40).

In reaching its conclusion, the committee took account of the fact that it was clear from the file and the physician's oral explanation that the physician had studied the patient's situation carefully. The physician ascertained step by step whether the patient was currently suffering unbearably. In addition the physician spoke on several occasions with

the patient, her family and the dementia case manager, and also consulted other colleagues. Following these conversations, and on the basis of observations, the physician ultimately concluded that the patient was suffering unbearably.

The physician described the patient as always having been a neat and well-groomed person who did not want to be dependent on other people. In view of the suffering that the patient had witnessed in people close to her, she was adamant that she did not want to go into a nursing home. She was no longer able to look after herself and needed help with everyday activities such as getting dressed and undressed. She also no longer remembered what she liked to eat and was unable to choose from the food and drink put in front of her. The patient regularly lost her way in her own home and had to be accompanied everywhere by her husband. She was also in a state of inner agitation, accompanied by expressions of sadness (crying) and helplessness, and a tendency to wander. The physician established that the patient was losing her dignity. During her various visits to the patient, she often saw signs of helplessness and sadness. In the end the patient was no longer able to enjoy the little pleasures of life, such as a cup of coffee or a glass of rosé in her garden. The patient repeatedly said 'I don't want this', often uttering the sentence in isolation, i.e. not in response to a question or an action. The physician concluded that the patient was no longer happy in the situation she found herself in, and was suffering from her dementia.

The first independent physician, however, concluded that the patient was not suffering unbearably. She established that the videos of the patient and the descriptions given by her family and the people treating her showed that she was sad and losing her dignity. The descriptions concerned behaviour and outward signs from which the conclusion could not automatically be drawn that she was suffering. The notion that she was suffering was how the other people viewed and interpreted it. During her visit, the independent physician saw that the patient was unhappy when she was crying and walking around the house searching for something. This dismayed the independent physician and she suspected that this was the loss of dignity the patient had referred to in her advance directive. However, during her visit the independent physician did not have the impression that the patient was suffering unbearably.

According to the patient's family, the conversation with the first independent physician had been unpleasant, and they found the way the independent physician had interacted with their wife and mother to be unfriendly. In her oral explanation, the physician said that – apparently – this independent physician bore a strong resemblance to the patient's previous GP, with whom she had a problematic relationship. After the

visit from the independent physician the patient had been upset for days, according to the physician. A few days after the visit, the independent physician took the initiative to contact the patient's husband by phone, to discuss the visit and apologise.

The physician was compelled to consult another independent physician. In her oral explanation the physician stated that she had not been seeking a positive recommendation from an independent physician. Had the second independent physician given a negative recommendation, she would have taken it seriously. Her consulting a second independent physician was prompted by what had transpired during the first independent physician's visit. Both the patient's family and the physician had felt unsatisfied with the visit and the family had lost faith in this independent physician. When the second independent physician visited, there was no report yet from the first independent physician. The physician gave further account at the end of her report concerning the fact that the first independent physician did not consider the unbearable nature of the suffering to be palpable. In view of this course of action, not only did the physician give extra consideration to the matter, she also set out clear reasons why she set aside the first independent physician's assessment of the suffering.

The second independent physician concluded that the patient was suffering unbearably. The patient could no longer express this in words, but according to the second independent physician it was apparent from the patient's helplessness and incapacity. The second independent physician had observed this during his visit and he was also able to deduce it from the available video footage and notes from her husband's diary.

In reaching its conclusion, the committee also took into account the fact that this matched what was said by the dementia case manager and the staff at the care farm where the patient had gone for a trial period several months before her death. The case manager stated in writing that she saw nothing but sadness in the patient's face, eyes and posture. The patient was completely withdrawn, and yet just four months before she had been cheerful and able to enjoy little things. It was also observed at the care farm that the patient was very anxious and agitated, and even tried to climb over the fence to escape. The general impression was that the patient was unable to express her anger and that without her beacon of safety – her husband – and outside her own environment she was losing her grip on her life.

The committee noted that in her report and her oral explanation the physician substantiated her decision-making in detail. The physician based her conclusions on her own observations, the video footage shot

by the patient's family, her conversations with the patient's immediate family and the written statements made by the dementia case manager and staff members of the care farm. The second independent physician confirmed the physician's conclusion that the patient was currently suffering unbearably. The committee also took into account the fact that, during her visit to the patient, the first independent physician also saw that the patient was wandering around her house, sometimes crying, and that the patient was unhappy at those times. Although the first independent physician did not describe this as unbearable suffering, the second independent physician and the dementia case manager did. The committee found that it followed from the above that the physician had given considerable thought to the question of whether she could be satisfied that the suffering was unbearable to the patient, despite the fact that the patient could no longer express her suffering appropriately.

As regards exercising the required particular caution, the committee noted that the physician only consulted two independent physicians, neither of whom were experts in this field. This prompted the committee to question whether the physician had indeed exercised particular caution with regard to establishing whether the patient was suffering unbearably.

The committee took the following circumstances into account in its review. The physician asked the dementia case manager to give her opinion on the patient's condition at that moment. The case manager stated in writing that during their first conversations the patient was still able to express her request for euthanasia and was clearly able to indicate what she did and did not want. During the conversations the patient was usually listening attentively and was able to make a pertinent comment now and then. But taking part in conversations gradually became more difficult. She was still able to enjoy company and having a cup of tea together, and she still had a twinkle in her eye. However, during her last visit the case manager observed that the patient was no longer the person she had been just a few months before. Her cheeks were sunken, she was almost constantly withdrawn and she stared into space, looking at a random spot on the ground.

In addition, the patient was constantly very agitated: she would sit up straight, then stand and then sit back down again, and repeatedly tensed her abdominal muscles. When asked questions the patient made comments such as 'I don't like it any more, it's not nice any more', and 'I'm so very tired, so very tired all the time', after which she would become tearful. The case manager concluded that the patient's previous cheerfulness and liveliness had disappeared and had been replaced by sadness. Sadness which the case manager observed in her face, eyes and posture.

The committee therefore concluded that the physician's view that the patient was currently suffering unbearably was confirmed not only by the second independent physician but also by the dementia case manager.

Although this does not constitute consulting an expert in the field as is considered customary in cases involving a patient with advanced dementia, the committee ultimately found that the physician had exercised due care in assessing and substantiating whether the patient was suffering unbearably. A decisive element was the fact that the physician had been able to observe and document the progression in the patient's suffering herself and that the dementia case manager wrote an extensive report, providing many details about the progression of the patient's dementia. In addition the second independent physician familiarised himself thoroughly with the case and was able to interpret his impressions thanks in part to conversations with the patient's immediate family, the dementia case manager and the physicians, and by examining the available video footage. Lastly, the committee noted that the physician had also discussed the unbearable nature of the suffering with an EE physician.

In view of the above, the committee found that the physician had exercised due care in assessing and substantiating whether the patient was suffering unbearably.

Suffering without prospect of improvement and absence of a reasonable alternative

The Supreme Court stated the following in consideration 4.8.1 of its judgment:

> 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 revised Euthanasia Code also says the following:

> The physician will have to base his conclusion on his 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 his will, it is important that the physician carefully consider what the patient has written about this matter in his advance directive and what he said when he was still able to communicate.

As noted by the committee, there was a situation as described in the patient's advance directive. The first independent physician observed that efforts to find a reasonable alternative by means of a change of environment had been abandoned very quickly, whereas people with demen-

tia in particular need more time to adjust. She considered admission to a nursing home to be a possible reasonable alternative and that an assessment could only be made after six weeks of how severely the patient was suffering in that environment.

The physician disagreed, because during their first conversation, when the patient was still decisionally competent, the patient had said expressly that she did not want to go into a nursing home. The patient had also been able to confirm this on subsequent occasions in response to closed questions. For that reason, and in light of the content of the advance directive, the physician was convinced that a trial period in a nursing home was not a reasonable alternative for the patient.

The second independent physician concurred. In his view, the patient's personality was such that she would not be able to deal with the group process in the nursing home. The patient was also no longer able to take part in activities such as games. He added that such an admission had always been the patient's worst fear.

The physician also felt her view was supported by an elderly-care specialist she had consulted. The physician had asked this elderly-care specialist whether she saw any ways to improve the patient's quality of life and alleviate her suffering to some extent. The elderly-care specialist studied the patient's medical records, her advance directive, the available video footage and the other documents. In her view, everything had been tried in the home setting (including daily activities outside the house, medication and activities at home). This had not had the desired effect. In her oral explanation the physician stated that the elderly-care specialist had indicated during a telephone conversation that she did not consider a trial period in a nursing home to be worthwhile for this patient, who did not feel comfortable at a care farm. It would feel almost like bullying, all the more so because it was expressly against her will.

The committee noted with regard to the required particular caution that the physician did not consult the elderly-care specialist officially as an expert. She contacted her on an ad hoc basis to gain more certainty regarding her own opinion. The committee considered that it would have been better if the physician had consulted this elderly-care specialist with a question focusing on the due care criteria. On the other hand, the – independent – elderly-care specialist did give her opinion on whether there were any reasonable alternatives left for the patient.

In view of the above, the committee found that the physician could be satisfied that the patient was suffering unbearably without prospect of improvement and that there was no reasonable alternative in her situation.

Informed about the situation and prognosis

In line with considerations 4.7.1 and 4.7.2 of the Supreme Court, the revised Euthanasia Code states as follows:

> The physician must be satisfied that the patient has been informed sufficiently about his situation and prognosis and about the significance and consequences of his 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, unless it is clear that these limitations make that impossible.

The committee considered that it was clear from the documents that the patient had experienced little involvement on the part of her previous GP after she had been diagnosed with Alzheimer's disease. This had damaged her trust in the GP, so the patient had moved to a different GP. When she met the new GP for the first time, the patient had described the situation she did not want to end up in, referring explicitly to her signed advance directive. In the committee's view this showed that the patient was aware of the disease from which she was suffering and its progression. It was also clear, both from the documents and from the physician's oral explanation, that the physician discussed the patient's wish for euthanasia with her. Even after it had become difficult or impossible to have a coherent conversation with her, the patient still made remarks during conversations such as 'I don't want this', or 'I don't want this anymore'. In view of the above, the committee found that the physician had endeavoured to communicate meaningfully with the patient.

As regards this due care criterion, the committee found that at the time the patient had been given sufficient information about her situation and prognosis, and on the meaning and consequences of her advance directive.

Consultation

The requirement that 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 Section 2 (1) (a) to (d) of the Act have been fulfilled

> (…) applies in full to euthanasia for patients who are no longer capable of expressing their will. The Act stipulates that the independent physician must see the patient, which is still possible in this kind of situation. There will be little if any communication between the independent physician and the patient. This means that, in addition to his own observations, the independent physician will have to base his decision and his opinion on 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 carers (revised Euthanasia Code 2018, p. 41).

The committee noted that the physician consulted two independent physicians. Both independent physicians saw the patient and spoke with her. In addition, both independent physicians did their own research by studying the advance directive, the medical records and the video footage, and speaking to the patient's immediate family. The independent physicians then each gave their opinion on whether the due care criteria had been fulfilled. As follows from the above, the committee found that the physician had sufficiently substantiated her decision to consult a second independent physician and to set aside the conclusions of the first independent physician. The second independent physician was satisfied that the due care criteria had been complied with.

As mentioned in the committee's considerations above, the physician did not consult another independent physician who was an expert on dementia. When asked about this, the physician stated that she assumed that by consulting the psychiatrist and the elderly-care specialist she had fulfilled this requirement. She also indicated that she had consulted the dementia case manager and, on the advice of the second independent physician, spoken with an EE physician. She thought she was sufficiently informed and advised by the psychiatrist's report and the advice from the colleagues she had consulted. None of these colleagues pointed out to her that it might be necessary to consult someone with specific expertise concerning the patient's decisional competence and whether she was suffering unbearably without prospect of improvement. She felt supported in her assumption that she had done enough.

This prompted the committee to examine whether the physician had indeed exercised particular caution. The committee concluded that she had, taking into account the physician's consultation of the above-mentioned physicians and the way in which the physician had thought about her actions in view of the conclusions of the independent physicians she had consulted. The committee also took into account the fact that the Supreme Court's wording – 'will generally prompt' – gives some room for consideration of all the circumstances.

Nevertheless the committee would stress that, although in these specific circumstances it could be concluded that the due care criteria had been fulfilled, it would certainly have been preferable to consult someone with specific expertise. During her oral explanation, the physician facilitated the committee's review and deliberated on her actions with regard to this notification. She stated that she thought she had fulfilled the due care criteria. However, she concluded from her meeting with the committee that, according to the rules, she should have consulted an independent expert

(with a specific question concerning the exceptional situation). She indicated that she would follow this advice in future.

In view of the above, the committee found that the physician had consulted at least one other, independent physician, who saw the patient and gave a written opinion on whether the due care criteria set out in section 2 (1) (a) to (d) of the Act had been fulfilled.

Due medical care

In consideration 4.10, the Supreme Court stated as follows:

> One element of due medical care is that the physician takes into account possible irrational or unpredictable behaviour on the part of the patient when he is preparing for and carrying out the euthanasia procedure.

The revised Euthanasia Code says the following on the matter:

> The euthanasia procedure should be as comfortable as possible for the patient. If the patient is decisionally incompetent and there are signs that he may become upset, agitated or aggressive during the euthanasia procedure, the medical standards that the physician must observe may lead him to conclude that premedication is necessary. If no meaningful communication is possible with the patient as a result of the patient's situation, it is not necessary for the physician to consult with the patient about when euthanasia will be performed and what method will be used. Not only would such a conversation be pointless, because a patient in that situation can no longer comprehend the subject matter, but it could also cause the patient to become upset or agitated.

The committee noted that the physician discussed the euthanasia procedure in detail during the consultation with the EE physician and drew up a protocol. In her oral explanation, the physician also stated that, in addition to the EE physician, she discussed the protocol with the patient's family and the pharmacist. Following the consultation with the EE physician, the physician decided she would administer premedication. In her oral explanation, the physician said that the patient's agitated behaviour was the reason for doing so. The patient drank the premedication without any problems. Once the patient was asleep, the physician carried out the termination of life in accordance with the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of August 2012.

In view of the above the committee found that the physician exercised due medical care in carrying out the termination of life on request. The committee's final conclusion was that the physician acted in accordance with the due care criteria referred to in section 2 (1) and (2) of the Act.

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

In the year under review, the RTEs found in two cases that the physician had not acted in accordance with the due care criteria in performing euthanasia. In one of the cases this concerned the requirement to consult an independent physician and in one case it concerned the way the euthanasia procedure was carried out.

Non-compliance with the criterion of consulting at least one other, independent physician

The Euthanasia Code 2018 stipulates that the independent physician must be in a position to form his own opinion. The concept of independence refers to his relationship with both the physician and the patient. Any suggestion that he is not independent must be avoided. 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, he cannot act as the independent physician. Nor can the independent physician be the physician's patient (revised Euthanasia Code 2018, p. 31).

INDEPENDENT PHYSICIAN IS THE PHYSICIAN'S PATIENT; SUGGESTION OF NON-INDEPENDENCE NOT AVOIDED

KEY POINTS: non-straightforward notification, full report of findings, consultation, suggestion of non-independence, physician should have considered whether a different physician could have been consulted as the independent physician, number 2020-151 on the website.

In this case, the physician consulted an independent physician through the dedicated call-out system. After the consultation, the physician discovered that the SCEN physician was registered as a patient in her practice. The physician thereupon contacted the independent physician. The latter indicated that he did not think that the fact that he was registered as a patient in her practice would lead to problems. In her report, the physician stated: 'No work or personal relationship. Although the SCEN physician is registered as a patient in the practice of the GP who performed euthanasia, there is no active treatment relationship, nor is there a professional relationship.' The independent physician gave the same

answer with regard to his independence. He added that in his opinion 'the independence of the physician and the SCEN physician in relation to one another was sufficiently guaranteed in this case'.

Both the physician and the independent physician met with the committee. The independent physician said that he had been registered with the physician's practice for about 10 years. In that period he had been to see her about three times to obtain a referral. The independent physician did not feel there was a doctor-patient relationship. In his view he had not been her patient.

The physician viewed the independent physician as her patient. She described their relationship as one of equality. Both physicians were familiar with the Euthanasia Code 2018. Not long ago, the independent physician had completed the SCEN training, which covered the topic of independence of the physician and the independent physician in relation to one another. He could not remember precisely whether the issue of 'the independent physician being a patient of the physician' was specifically discussed.

In response to a question from the committee, the physician said that it would have been possible to consult another, independent SCEN physician as the independent physician, but that she would have considered that problematic for her patient. This option was not discussed in the consultation between the physician and the independent physician.

The committee had no doubt as to whether the independent physician in this case formed his own, independent opinion. Nevertheless the committee found that this situation was undesirable because any suggestion of non-independence should have been avoided. The Euthanasia Code 2018 states specifically that such a relationship between a physician and an independent physician precludes the latter's acting as the independent physician. Both physicians were familiar with the Euthanasia Code 2018. The independent physician had been registered with the physician's practice for several years and they had met on a number of occasions in that context. The committee found that the physician and the independent physician should have discussed the relationship prior to the consultation. As that did not happen, the physician should subsequently have at least considered whether it was possible to consult another independent physician. The situation that arose should have been prevented in order to avoid any suggestion of non-independence.

The committee found that the physician had not complied with the due care criterion concerning the consultation of an independent physician. The other due care criteria were complied with.

POOR PREPARATION LEADING TO ALTERNATIVE ADMINISTRATION OF SUBSTANCES WITH A RISK OF THE PATIENT EXPERIENCING PAIN

KEY POINTS: Non-straightforward notification, full report of findings, euthanasia procedure, number 2020-98 on the website.

It had been agreed that euthanasia would be performed in the case of the patient, a woman in her eighties who was seriously ill, emaciated and bedridden. As the physician had ample experience with inserting cannulas (he often did this for colleagues, too) he had not expected any problems in that respect. However, he could not find a suitable vein in either the patient's arms or legs.

The physician then considered alternatives, such as calling in a specialised home care team or having a central venous catheter inserted in hospital. However, the patient did not want to delay the procedure, and the physician could understand that. Given her condition, he did not want her to have to endure being transported to hospital. It did not occur to him to ask the ambulance service for assistance or to contact an anaesthetist or a radiologist.

The physician then decided to inject the euthanatics into the right femoral artery, a procedure he had learnt years ago from his supervisor and had once used in an emergency. The femoral artery is a large vessel, which would make it fairly easy to administer the euthanatics. Administering the coma-inducing substance (thiopental) went well and the patient soon fell into a deep coma. The physician did not have the impression that the patient experienced any pain when the substance was administered. She was a little restless but soon fell into a deep coma. The physician checked the depth of the coma by applying a pain stimulus. He then administered the muscle relaxant (rocuronium). When the patient did not die, he administered another 150g of rocuronium, this time through the left femoral artery. The patient died shortly after that.

By acting in this way, the physician deviated from the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of August 2012. The committee noted that the physician was not adequately prepared to perform the procedure to terminate the patient's life. For instance, he did not follow the advice in the Guidelines to ascertain the day before the procedure whether in this patient's case it would be easy to find a vein so that a cannula could be inserted. The committee

also took into account the fact that, when it became apparent that no vein could be found for the cannula, the physician considered the alternatives known to him at that time and made a reasoned decision not to choose one of them. Furthermore, the committee took into account the fact that the alternatives listed in the Guidelines, such as asking others for assistance, had not occurred to the physician.

The committee noted that, by administering the euthanatics via the patient's femoral artery, the physician had deviated from the Guidelines in an unusual manner. The matter was put to a member of the committee for the Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide (an internist specialised in critical care), who said that administering an alkaline substance such as thiopental via the femoral artery can lead to arterial spasm, which may result in ischaemia (insufficient blood supply), causing pain. For that reason, this method of administering the substance is undesirable. The Farmacotherapeutisch Kompas (Pharmacotherapy Handbook) also advises against administering thiopental in this manner, due to the risk mentioned above. The physician was convinced that the patient did not feel any pain. Due in part to the fact that the patient suffered from atherosclerosis, he considered arterial spasm unlikely.

The committee held that, in administering the substance in this unusual manner, the physician took the risk that the patient would feel pain after the euthanatics had been administered. The fact that physician was of the opinion that the patient had not felt any pain did not detract from that. The committee understood that, in his patient's interests, the physician decided not to have her transported to hospital and that he chose not to delay the euthanasia procedure, in accordance with the patient's express wish. The committee however had no other option but to find that the physician did not exercise due medical care when terminating the patient's life.

The other due care criteria were complied with.

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